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Health Profile
of Nebraska's Latino Population

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On the Cover

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EXECUTIVE SUMMARY

Latinos are the fastest-growing population group in the United States, and Nebraska is no exception to this reality. According to the U.S. Census, the Nebraska Latino population is estimated at 167,000, which represents an increase of 70% from 2000 to 2010. Latinos are far from being a homogenous population. About three-fourths of Latinos in Nebraska are of Mexican origin followed closely by people from Central and South America and the Caribbean.[1] It is important to note that not all Latinos speak Spanish. There are over 30 different indigenous languages spoken among Nebraska Latinos. Furthermore, cultural practices also vary widely among subgroups. This is particularly important when examining health outcomes and interventions because language barriers, cultural practices, and health-seeking behaviors greatly impact health outcomes of populations.

In Nebraska, Latinos represent the youngest population group. The median age of Latinos is 22.8 years old, compared to 28.3 years for African Americans and 39.8 years for non-Hispanic Whites. Among adults 25 years of age or older, about half (50.4%) of Latinos had less than a high school education, a rate five times higher than non-Hispanic Whites (8.6%). Educational attainment directly impacts a person's income level, type of occupation, stress levels, access to resources such as affordable and safe housing, good schools, grocery stores, recreational facilities, and access to quality healthcare throughout life, all of which greatly impact health outcomes.[2] Because of these and other factors, people with more education are likely to experience better health outcomes, to live longer lives, and to practice health-promoting behaviors such as exercising regularly, refraining from smoking, and obtaining health screenings.[3] Educational attainment among adults is also linked with better health for their children, beginning early in life.[4]

Latinos have a significant gender imbalance when compared to other racial groups with a higher male to female ratio of 107 males to 100 females.[5] The national gender ratio is 97 males to 100 females.[6] One cause of this gender imbalance may be the type of jobs, such as meatpacking, construction, and service jobs that draw Latinos to Nebraska. These male-dominated industries attract young, single males and concentrate them in low-skill, low wage-jobs where the risks for accidents and injuries are high.

Unemployment rates of Nebraska's Latino population are more than twice that of non-Hispanic Whites (11.3% vs. 5.4%). Additionally, the median annual household income among Latinos in Nebraska in 2009 was $35,962 compared to $50,937 for non-Hispanic Whites, and the poverty rate is three times higher for Hispanics (27%) than for non-Hispanic Whites (9%). Also notable is the poverty rate among children under age 18. For the first time in U.S. history, the percentage of Latino children in poverty (37.3%) surpassed the percentage of poor non-Hispanic White children (30.5%).[7] According to the Pew Hispanic Center, more than two-thirds of poor Latino children have parents who are immigrants. Poverty has been shown to negatively influence a child's health and development, impacting health outcomes later in life.[8]

[1] U.S. Census Bureau. Decennial Census 2010.
[2] Robert Woods Johnson Foundation Commission to Build a Healthier America. Education Matters for Health. Retrieved on September 18, 2012 from http://www.commissiononhealth.org/PDF/c270deb3-ba42-4fbd-baeb-2cd65956f00e/Issue%20Brief%206%20Sept%2009%20-%20Education%20and%20Health.pdf.
[3] Braveman, P. and Egerter, S. *Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America.* Washington, DC: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.
[4] Chen, E. Martin, AD and Matthews, KA. "Socioeconomic Status and Health: Do Gradients Differ within Childhood and Adolescence?" Soc Sci Med, 62(9): 2161-70, 2006.
[5] U.S. Census. Resident Population by Sex, Race, and Hispanic Origin Status. Retrieved on September 25, 2012 from http://www.census.gov/compendia/statab/2012/tables/12s0006.pdf.
[6] Ibid.
[7] Lopez, M.H., Velasco, G. The toll of the great recession: Childhood poverty among Hispanics sets record, leads nation. (2011). Pew Research Center.
[8] Aber, J.L., Bennett, N.G., Conley, D., and Li, J. (1997) The Effects of Poverty on Child Health and Development. Annual Review of Public Health, 463–83. Retrieved on September 18, 2012 from https://files.nyu.edu/dc66/public/pdf/res_Annual_Review_aber_etal.pdf.

Despite the lower socioeconomic status of Latinos, Latino immigrants' overall health status is better than might be expected. Two possible explanations of this are the Latino Epidemiological Paradox[9] and the "salmon-bias." The Latino Epidemiological Paradox states that immigrant Latinos are generally younger at entry to America and carry with them a healthier, more active lifestyle with less consumption of processed foods. However, the longer their stay in the United States, the greater the decline in their health status. The "salmon-bias" states that older, sicker immigrants return to their countries of origin and may die in their homeland; therefore, they are not included in U.S. health statistics.[10]

Indeed, as Latinos acculturate to the American lifestyle, their health worsens. Many immigrants deal with their new "minority" status and tend to acquire habits that lower their health status, including the use of drugs, alcohol, and tobacco,[11] a sedentary lifestyle, and a calorie-dense diet, all of which are considered modifiable risk factors.[12] Problems with English language competency and health literacy, precarious labor and immigration statuses among immigrant families, and exposure to racism further exacerbate the acculturation stress experienced by immigrants.[13] Furthermore, Latinos have limited access to quality and affordable healthcare, especially culturally and linguistically appropriate healthcare, and are more likely to be un- or under-insured.[14] These risk factors contribute to the top five leading causes of death for Nebraska Latino adults, which are (1) cancer, (2) heart disease, (3) unintentional injury, (4) diabetes, and (5) stroke.

Nebraska Latino Health Status Highlights:

- Over 35% of Hispanic/Latino adults aged 18 to 64 years old do not have a personal physician.
- One quarter of Hispanics/Latinos rated their health status as either "fair" or "poor".[15]
- Almost one third of the Hispanic/Latino population is uninsured.[16]
- Almost one quarter of Latinas received inadequate prenatal care.[17]
- Close to 10% of Hispanic/Latino adults surveyed through the Behavioral Risk Factor Surveillance System from 2006 to 2010 had more than 10 days in the past month where they mentally did not feel well.[18] Almost a quarter of Latino youth felt sad and hopeless during the past year.[19] About 14% of Hispanics/Latinos report that they never get any emotional support.[20]
- Obesity, measured by a level of BMI at 30 or above, was higher for Hispanics/Latinos than for other groups.
- More than one-third of Hispanics/Latinos have no exercise outside of work.[21]
- The overall STD rate for Hispanics/Latinos was nearly three times the rate for Whites.[22] Also, Latinos bear a disproportionate burden of the HIV epidemic, with a mortality rate that was 3 times that of Whites.
- The teen birth rate for Latina girls was 4.9 times the rate of White girls.
- Hispanic/Latino students were more likely to smoke cigarettes on one or more of the past 30 days than their White peers.[23]

Many challenges exist in addressing health disparities among Latinos including:

- The Hispanic/Latino community in the U.S. is separated from the larger community by language barriers and different cultural and belief systems.[24] Many settle in segregated ethnic neighborhoods that buffer them from a hostile reception in the larger society and allow them to access the necessary resources to get a leg up in their integration process (such as jobs and services in their native language). However, this may also isolate them further from the larger society without proper intervention strategies and receptive integration policies.
- There is no single "Latino" culture in the U.S. Although there are many similar cultural values, many differences exist among the various Latino subgroups.

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[9] PolicyLink. Community-Based Strategies for Improving Latino Health (2004). Retrieved on September 10, 2012 from http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/COMM-BASED-STRATEGIES-LATINOHEALTH_FINAL.PDF.

[10] Abraido-Lanza, A., Dohrenwend, B. P., & Ng-Mak, D. (1999). The Latino mortality paradox: A test of the "salmon bias" and healthy migrant hypotheses. American Journal of Public Health, 89(10), 1543-1543-8. Retrieved on September 17, 2012 from http://search.proquest.com/docview/215091423?accountid=7064.

[11] A. Gil and W. Vega, "Latino Drug Use: Scope, Risk Factors and Reduction Strategies," in M. Aguirre-Molina, C. W. Molina, and R. Enid Zambrana (eds.), *Health Issues in the Latino Community* (Jossey-Bass, 2001), 437.

[12] Pew Hispanic Center. Hispanic Health: Divergent and Changing, 2002. Retrieved on September 14, 2012 from http://pewhispanic.org/files/factsheets/1.pdf.

[13] J. W. Berry, "Acculturation as Varieties of Adaptation," in A. M. Padilla (ed.), *Acculturation: Theory, Models and Some New Findings* (Boulder, Colo.: Westview Press, 1992).

[14] Aguirre-Molina, M., Molina, C.W., and Zambrana, R.E. (2001). *Health Issues in the Latino Community.* San Francisco: Jossey-Bass.

[15] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.

[16] U.S. Census Bureau, 2010 American Community Survey.

[17] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.

[18] Nebraska Youth Risk Behavior Survey. 2010 Survey Results. Retrieved on December 19, 2012 from http://www.education.ne.gov/HIV/2010_YRBS-Results/Data/2011/2010NEH%20Detail%20Tables.pdf.

[19] Ibid.

[20] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.

[21] Ibid.

[22] Nebraska DHHS STD program, 2006-2010.

[23] Nebraska Youth Behavioral Risk Factor Survey, 2011.

[24] Robert Wood Johnson Foundation, Proyecto HEAL.

- Based on country of origin, socio-economic status, or generational status, each subgroup may have different behavioral risk factors for the leading causes of death that are presented in the report.[25]
- There are multiple risk factors that affect subgroups of Latino populations[26] nationally and in Nebraska, including access to culturally competent care, discrimination, poverty, education, lack of medical insurance, cost of care and services, transportation, and low health literacy.[27]
- Current funding streams and state and federal policies have created barriers to education and healthcare for undocumented immigrants who live and work in Nebraska.

Given these complex challenges, the solutions to addressing health disparities among Hispanics/Latinos require comprehensive, inter-sectoral, multi-level, community-wide interventions and policy changes that address not only health, but also the social determinants of health – the circumstances in which people are born, grow up, live, work, and age, as well as the healthcare systems in place to deal with illness.[28] Policies across sectors such as education, economic development, housing, immigration, public safety, and healthcare can directly or indirectly impact disparate populations, including Latinos. Efforts to revitalize poor neighborhoods, improve the quality of schools and access to public services, guarantee access to healthy foods, and ensure culturally-competent community services and equitable policies that link Latinos to economic opportunities are promising strategies that can significantly improve the health of Latino communities in Nebraska and across the country. Indeed, ending racial and ethnic health disparities is a major challenge—but one that can be met if the research, public health practices, education and training, government, outreach, and service sectors work together.

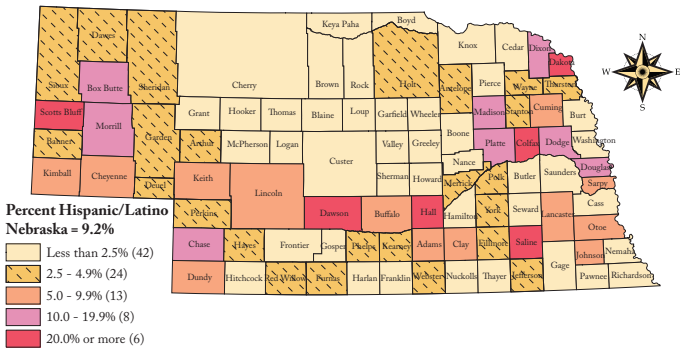
[25] Escarce JJ, Morales LS, Rumbaut RG. The Health Status and Health Behaviors of Hispanics. In: National Research Council (US) Panel on Hispanics in the United States; Tienda M, Mitchell F, editors. Hispanics and the Future of America. Washington (DC): National Academies Press (US); 2006. 9. Available from: http://www.ncbi.nlm.nih.gov/books/NBK19899.
[26] Ibid.
[27] United Way of the Midlands. (2003). Profile of Latino Youth.
[28] Centers for Disease Control and Prevention. Social Determinants of Health. Retrieved on January 9, 2013 from http://www.cdc.gov/socialdeterminants.

SOCIO-DEMOGRAPHICS

Latinos are the fastest-growing population group in the United States and in Nebraska. According to the U.S. Census Bureau's 2010 Census, the U.S. Latino population reached 50.5 million–an all-time high with an increase of 43% in the past decade.[29] The Hispanic population grew in every region of the U.S. between 2000 and 2010, and most significantly in the South and Midwest.[30] Nebraska is considered one of the "new immigrant destination" states and is among the ten states in the U.S. having the highest Latino population growth rate.[31] Today, there are almost six times as many Latinos in Nebraska as there were in 1980.

The Nebraska Latino population in 2010 was estimated at 167,000, an increase of 70% in the past 10 years. Six Nebraska counties have Hispanic/Latino populations in excess of 20% as depicted by the Nebraska county map below (Figure 1).

Figure 1: Percent of County Population that was Hispanic/Latino, 2010



Source: 2010 Census (Redistricting File Table P2), U.S. Census Bureau
Compiled and Prepared by: David Drozd - Center for Public Affairs Research, University of Nebraska at Omaha - February 6, 2012

About three-quarters of Hispanics/Latinos in the United States reported as Mexican, Puerto Rican or Cuban origin in the 2010 Census. In Nebraska, approximately three-fourths of the Hispanic/Latino population is of Mexican origin followed by people from Central America and the Caribbean.[32]

Country of origin is an important distinction because there are significant differences in Latino subgroups.

Table 1: Latinos by Origin: Groups with more than 1,000 people, 2010

	Number	Percent
Total Latino Population	167,405	100%
Mexican	128,060	76.5%
Guatemalan	8,616	5.1%
Salvadoran	6,016	3.6%
Puerto Rican	3,242	1.9%
Cuban	2,152	1.3%
Honduran	1,547	0.9%

Source: OLLAS calculations based on the U.S. Census Bureau, 2010

Notably, not all Latinos speak Spanish. In fact, there are over 30 different indigenous languages spoken by Latinos in Nebraska. Different words as well as differences in colloquial speech are apparent in communication among individuals from different Latino origins. Cultural practices and health-seeking behaviors also vary widely among the subgroups. The unique immigration waves from each country and the demographics of each wave are partly responsible for the differences among Hispanic subgroups.[33]

Latinos represent the youngest population group in the U.S. For example, in 2010, the median age of Latinos was 22.8 years old, compared to 28.3 years for African Americans and 39.8 years for non-Hispanic Whites. Two-fifths of Latinos are 17 years and younger, compared to only one-fifth of Whites and slightly more than one-third of African Americans. See Table 2 and Figures 2 & 3.

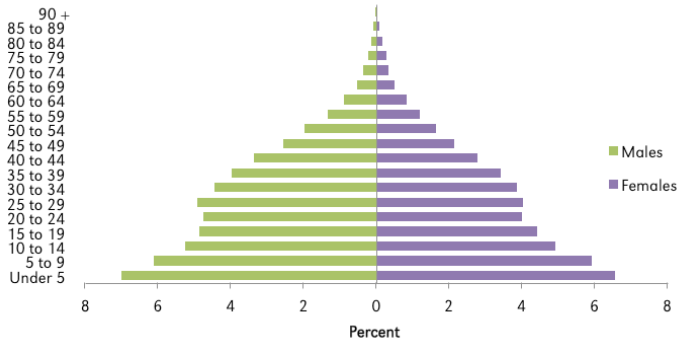
Table 2: Population Groups by Age in Nebraska, 2010

Age	Total Nebraska Population		Hispanics/Latinos		Non-Hispanic Whites		African Americans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	1,826,341	100%	167,405	100%	1,499,753	100%	82,885	100%
Under 5	131,908	7.2%	22,728	13.6%	91,307	6.1%	7,953	9.6%
5 to 17	327,313	17.9%	46,456	27.8%	241,490	16.1%	18,908	22.8%
18 to 64 (working age)	1,120,443	61.3%	93,561	55.9%	933,635	62.3%	50,610	61.1%
65 and older	246,677	13.5%	4660	2.8%	233,321	15.6%	5,414	6.5%

Source: OLLAS calculations based on the U.S. Census Bureau, 2010

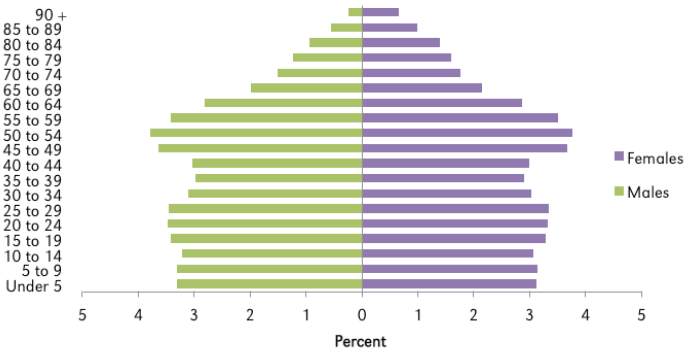
[29] U.S. Census Bureau. The Hispanic Population 2010: U.S. Census Brief. Retrieved on September 18, 2012 from http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf.
[30] U.S. Census Bureau. 2010 Census Shows Nation's Hispanic Population Grew Four Times Faster Than Total U.S. Population. May 26, 2011. Retrieved on September 18, 2012 from http://2010.census.gov/news/releases/operations/cb11-cn146.html.
[31] Gouveia, Lourdes, Christian Espinosa and Yuriko Doku. 2012. *Demographic Characteristics of the Latino Population in the Omaha-Council Bluffs Metropolitan Area*. April. Omaha, NE: Office of Latino/Latin American Studies (OLLAS), University of Nebraska at Omaha.
[32] U.S. Census Bureau. Decennial Census 2010.
[33] Galarraga, J. Hispanic-American Culture and Health. May 2007. Retrieved on September 25, 2012 from http://www.cwru.edu/med/epidbio/mphp439/Hispanic_Healthcare.pdf.

Figure 2: 2010 Nebraska Population by Sex and Five-Year Age Group: Hispanic/Latino Population



Source: 2010 Census, U.S. Census Bureau

Figure 3: 2010 Nebraska Population by Sex and Five-Year Age Group: Non-Hispanic White Population



Source: 2010 Census, U.S. Census Bureau

Furthermore, Latinos experience the greatest gender imbalance of all racial groups a male-female percentage of 53% to 47% compared with a 49.5% to 50.5% percentage among the total population of Nebraska. One cause for the Latino gender imbalance may be the type of available employment, such as meatpacking, construction, and service jobs. These male-dominated industries attract young single males, thus influencing the gender composition of the community. Because of the gender imbalance, there are potential social challenges and ramifications that could impact the Latino community's well-being.

Education

In Nebraska, among adults 25 years of age or older, about half (48.2%) of Latinos had less than a high school education, which is seven times more than non-Hispanic Whites (6.2%). Only about 9.5% of Hispanics/Latinos had a bachelor's degree or higher, about half that of non-Hispanic Whites (20.8%).[34]

Gender differences exist in educational attainment within these groups. Educational inequities are starker among Latino men. For example, among Latinos, age 25 and older, more females graduate from high school and attain a bachelor's degree or higher compared to males. There are more than twice as many non-Hispanic White males who have a bachelor's degree or higher than Hispanic/Latino males (30.1% versus 12.3% respectively). More than twice as many non-Hispanic White females have a bachelor's degree or higher compared to Hispanic/Latino females (30.4% versus 11.1% respectively).[35]

Occupational Status

Educational attainment impacts poverty, income, employment status, and type of employment. The majority of Hispanics/Latinos are concentrated in low-skill, low-wage jobs such as agriculture, construction, meat-packing, and service sector[36] jobs, which increases their risk for occupational injuries and exposure to pesticides and other environmental toxins. These types of jobs are also less likely to provide adequate employment benefits such as health insurance or paid sick leave.

Indeed, in the U.S. about 56% of foreign-born workers are found in "low-skill" occupations such as construction, hospitality, or service industries where the risks for accidents and injuries are high. Also, 22.5% of Latinos work in the service industry with the majority of those jobs at the lower end of the employment scale in food services or waste management where they may be deprived in terms of adequate income, benefits, and opportunities.[37] Nearly half of all immigrants (foreign born) and 50.3% of Latino immigrants in Nebraska are clustered in "Construction" and "Production" with a majority in meatpacking and construction occupations,[38] as compared to 20% for U.S. born natives. See Table 3 below.

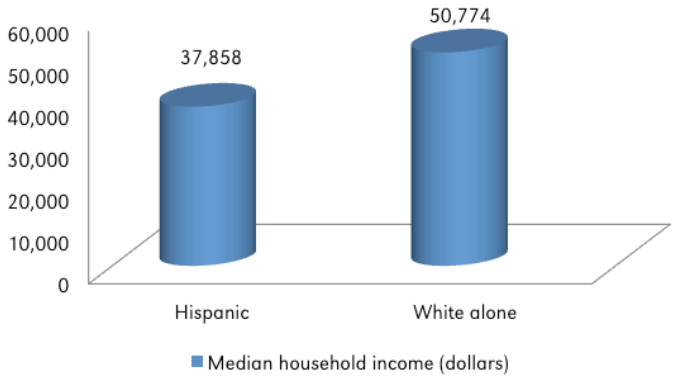
Table 3: Nebraska Occupation by Race and Hispanic/Latino, 2010

Occupation	Nebraska Total Population	Hispanic/ Latinos	Non-Hispanic Whites	Black or African American
Civilian employed population 16 years and over	935,104	69,467	804,454	30,769
Management, professional, and related occupations	35.2%	14.8%	37.2%	23.8%
Service occupations	16.9%	22.5%	15.7%	26.1%
Sales and office occupations	24.9%	16.8%	25.8%	27.3%
Natural resources construction and maintenance occupations	9.5%	14.8%	9.6%	2.6%
Production, transportation, and material moving occupations	13.5%	31.1%	11.7%	20.2%

Source: U.S. Census Bureau, 2010 American Community Survey

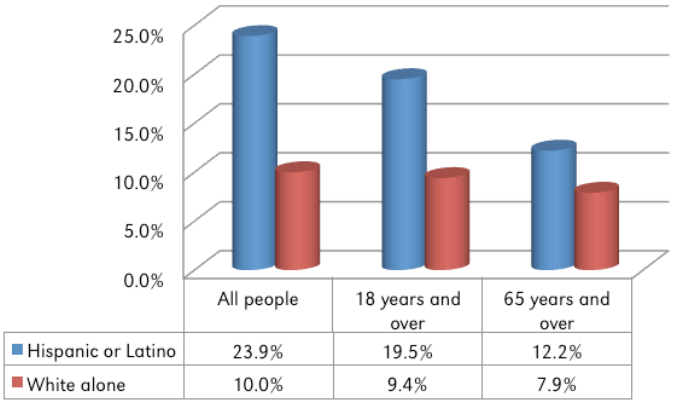
[34] U.S. Census Bureau. 2008-2010 American Community Survey.
[35] Ibid.
[36] Nebraska Department of Health & Human Services. Office of Health Disparities & Health Equity. (2008). The Socioeconomic Status of Nebraska Hispanics or Latinos.
[37] National Research Council. (2008). Research on Future Skill Demands: A Workshop Summary. Accessed on October 30, 2012 from http://www.ncbi.nlm.nih.gov/books/NBK4079/.
[38] U.S. Census Bureau. NAICS Codes. Accessed on October 31, 2012 from http://www.census.gov/foreign-trade/reference/codes/naics/naicsmst.txt.

Figure 4: Income in the Past 12 Months in Nebraska in 2010 Inflation Adjusted Dollars



Source: U.S. Census Bureau, 2008-2010 American Community Survey

Figure 5: Poverty Rates for Families of Various Races in Nebraska, 2010



Source: U.S. Census Bureau, 2008-2010 American Community Survey

Income & Poverty

In Nebraska, the median annual household income in 2010 was $37,858 among Hispanics/Latinos compared to $50,774 for non-Hispanic Whites.[39] See Figure 4.

The poverty rate was higher for Hispanics/Latinos than for non-Hispanic Whites in Nebraska. In 2010, about 22.6% of Hispanics were living below the poverty level during the 12 months prior to being surveyed, compared with about 9.9% of non-Hispanic Whites. Among female-headed households, the poverty rate for Hispanics/Latinos was 43.2% compared to 23.8% of non-Hispanic Whites.[40] Additionally, Hispanic women only earn 53 cents per dollar that a White man would earn indicating an even larger wage gap between Latina women and White men than between White women and White men.[41]

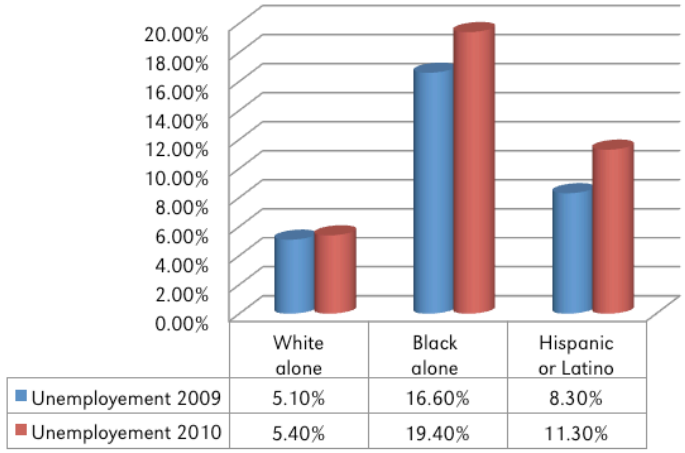
Latinos make up the largest group of children living in poverty.[42] In 2010 across the United States, 37.3% of poor children were Latino, 30.5% were White and 26.6% were Black. According to the Pew Hispanic Center, most of the 6.1 million poor Latino children have parents who are immigrants. Among Hispanics/Latinos, the groups that have the highest poverty rates are children of single mothers (57.3% poor), children of parents with a high school education or less (48.3%) and children of unemployed parents (43.5%).[43]

According to the 2010 American Community Survey, Hispanics/Latinos aged 65 and over had a poverty rate of 12.2%, compared with 8% for non-Hispanic Whites.[44] See Figure 5.

Unemployment

Hispanics/Latinos experience high unemployment rates of 11.3% compared to 5.4% among non-Hispanic Whites, which has increased between the years 2009-2010. See Figure 6.

Figure 6: Unemployment Rate in Nebraska by Population Groups 16 years and Over from 2009-2010



Source: U.S. Census Bureau, 2009 and 2010 American Community Survey

[39] U.S. Census Bureau. 2008-2010 American Community Survey.
[40] U.S. Census Bureau. 2010 American Community Survey.
[41] Kaiser State Health Facts. Nebraska Gender Wage Gap. Retrieved on December 11, 2012 from http://www.statehealthfacts.org/profileind.jsp?rep=36&cat=9&rgn=29.
[42] Morello, C. and Mellnik, T. Hispanic kids the largest group of children living in poverty. The Washington Post, September 28, 2011. Retrieved on September 17, 2012 from http://www.washingtonpost.com/local/hispanic-kids-the-largest-group-of-children-living-in-poverty/2011/09/28/gIQArfC54K_story.html.
[43] Cohn, V. Latino Children in Poverty. Pew Research Center, September 28, 2011. Retrieved on November 28, 2011 from http://www.pewsocialtrends.org/2011/09/28/latino-children-in-poverty.
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HEALTH STATUS

Latino Epidemiological Paradox

The Hispanic Paradox or Latino Epidemiological Paradox was first coined by Kyriakos Markides in 1986.[45] It states that Hispanics/Latinos tend to have health outcomes that paradoxically are comparable or better than those of their U.S. non-Hispanic White counterparts even though Hispanics/Latinos have lower socioeconomic status, which is usually correlated with poorer health outcomes. Some reasons for this paradox may be include the "Healthy Immigrant" effect that hypothesizes that immigrant Latinos are generally younger at entry to the United States and carry with them a healthier, more active lifestyle that includes less consumption of processed foods.[46] As Latinos acculturate to the "American" lifestyle, they acquire unhealthy habits such as smoking and excessive alcohol consumption and adopt diets high in saturated fats and sugar that puts them at increased risk for disease and a lower health status.[47] Another contributing factor may be that Hispanic/Latino immigrants also must deal with their new "minority" status:[48] including problems with English language competency, health literacy, precarious labor and immigration statuses, and exposure to racism that further exacerbate acculturation stress experienced by immigrants.[49] Furthermore, Latinos have limited access to quality and affordable healthcare, especially culturally and linguistically appropriate healthcare, and are more likely to be un- or under-insured.[50]

Another explanation for this paradoxically healthier population could be due to the "salmon bias." Older, ailing Hispanic/Latino immigrants might return home for healthcare or during the latter part of their lives after having lived or worked in the U.S and may die in their home country.[51] Hence their mortality is not reflected in U.S. statistics.[52] This "salmon bias" hypothesis considers these people as "statistically immortal" which may artificially lower the Hispanic mortality rate.

Prevention

For many Hispanics/Latinos, especially immigrants, prevention is not commonly practiced or known because in their countries of origin there is no system for preventative care or the cost of these services is out of reach. Furthermore, there is a cultural norm that going to see a doctor means that you are sick. However evidence shows that prevention of disease is a much more cost-effective mechanism than treatment. In fact, it is estimated that for every $1 invested in prevention there is a 5-to-1 return on the investment.[53] Education about prevention and provision of access to preventive healthcare services is essential.

Access to Care

Hispanics/Latinos have less access to quality and affordable healthcare in the United States, especially culturally and linguistically appropriate healthcare. They are less likely to have a regular source of care or a primary care provider, less likely to have visited a physician in the last 6-12 months, and less likely to be insured. In 2006-2010, the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) indicated that 35.1% of Latino adults aged 18 to 64 years old in Nebraska did not have a personal physician, compared to 13.8% of non-Hispanic White adults.

BRFSS data also indicate that 25.2% of Hispanics/Latinos rated their health status as either "fair" or "poor", compared to 10.9% of non-Hispanic White Nebraskans.[54] During the same time period, one fifth (20.7%) of Hispanic/Latino adults in Nebraska reported that they were unable to see a doctor at some time in the previous twelve months due to potential cost of care, compared to 9.1% of non-Hispanic White adults. Altogether, 10.5% of adults in the 2006-2010 Nebraska BRFSS said they couldn't see a physician due to cost.

[45] University of Texas Medical Branch. Kyriakos S. Markides, PhD. Retrieved on September 17, 2012 from http://pmch.utmb.edu/about/faculty/kokosmarkides.aspx.
[46] PolicyLink. Community-Based Strategies for Improving Latino Health (2004). Retrieved on November 28, 2011 from http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/COMM-BASED-STRATEGIES-LATINOHEALTH_FINAL.PDF.
[47] Pew Hispanic Center. Hispanic Health: Divergent and Changing, 2002. Retrieved on September 18, 2012 from http://pewhispanic.org/files/factsheets/1.pdf.
[48] J. W. Berry, "Acculturation as Varieties of Adaptation," in A. M. Padilla (ed.), *Acculturation: Theory, Models and Some New Findings* (Boulder, Colo.: Westview Press, 1992).
[49] A. Gil and W. Vega, "Latino Drug Use: Scope, Risk Factors and Reduction Strategies," in M. Aguirre-Molina, C. W. Molina, and R. Enid Zambrana (eds.), *Health Issues in the Latino Community* (Jossey-Bass, 2001), 437.
[50] Ibid.
[51] L.A. Times. The Latino Paradox. November 14, 2010. Retrieved on September 17, 2012 from http://articles.latimes.com/2010/nov/14/opinion/la-ed-longevity-20101114.
[52] Abraido-Lanza, A., Dohrenwend, B. P., & Ng-Mak, D. (1999). The latino mortality paradox: A test of the "salmon bias" and healthy migrant hypotheses. American Journal of Public Health, 89(10), 1543-1543-8. Retrieved on September 17, 2012 from http://search.proquest.com/docview/215091423?accountid=7064.
[53] Prevention Institute. Community Prevention. Retrieved on September 18, 2012 from http://www.preventioninstitute.org/focus-areas/reforming-our-health-system/projects/561-community-prevention-talking-points.html.
[54] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.

Table 4: Health Insurance Coverage in Nebraska, 2010

Health Insurance Coverage Status	Total Nebraska Population	Hispanics/ Latinos	Non-Hispanic Whites	Blacks or African Americans
Civilian, Non-Institutionalized Population	1,802,049	165,671	1,483,394	75,878
With private health insurance coverage	74.3%	46.2%	79.8%	45.9%
With public health insurance coverage	26.5%	28.7%	25.0%	45.6%
No health insurance coverage	11.5%	29.8%	8.9%	16.4%

Source: US. Census Bureau, 2010 American Community Survey

As noted in Table 4 above, 29.8 % of the Latino population in the state is uninsured. This presents a major problem for accessing quality healthcare services for Hispanics/ Latinos in Nebraska.

Leading Causes of Death

Multiple lifestyle factors including the use of drugs, alcohol, and tobacco, sedentary behaviors, and calorie-dense diets increase with a person's length of stay in the U.S. These modifiable risk factors contribute to the top five leading causes of death for Latino adults in Nebraska, which are (1) cancer, (2) heart disease, (3) unintentional injury, (4) diabetes, and (5) stroke. The chart below compares the five leading causes of death for White Adults and Hispanic/Latino Adults in Nebraska for 2006-2010.

Table 5: Top 5 Leading Causes of Death for Hispanics and Whites in Nebraska, 2006-2010

Causes of Death (Hispanics)	Percentage	Causes of Death (Whites)	Percentage
(1) Cancer	18.6%	(1) Heart Disease	22.9%
(2) Heart Disease	14.9%	(2) Cancer	22.6%
(3) Unintentional Injury	13.9%	(3) Stroke	5.8%
(4) Diabetes	4.6%	(3) Chronic Lung	5.8%
(5) Stroke	4.6%	(4) Unintentional Injury	4.5%
Other	43.4%	Other	38.4%
Total	100.0%	Total	100.0%

Source: Source: Nebraska DHHS, Vital Statistics, 2006-2010. Retrieved from Nebraska DHHS, Office of Health Disparities and Health Equity, September 2012.

Cancers

Cancer was the leading cause of mortality among Latinos in Nebraska and the second-leading cause of mortality among Whites in Nebraska from 2006 to 2010. By primary site, cancers of the lung, breast, and prostate were the most frequently diagnosed. In the five-year period from 2006 to 2010, Hispanic/Latino men were less likely to die from any cancer cases (109.2 deaths per 100,000 population) than were White men (211.9 deaths per 100,000 population). Hispanic/Latino females were less likely to die from cancer (91 deaths per 100,000 population) than were White women (144/100,000).[55]

- **Breast Cancer**
  Among Nebraska women, breast cancer is the most commonly diagnosed cancer[56] and the second-leading cause of cancer deaths.[57] In the five-year period of 2006-2010, the breast cancer death rate for Nebraska Hispanic/Latino women was 19.3 per 100,000 population, compared to 20.2 deaths per 100,000 populations for White women.

- **Prostate Cancer**
  In the five-year period from 2006 to 2010, the mortality rate due to prostate cancer for Hispanic/Latino men in Nebraska was 22.1 per 100,000 population, slightly less than the rate for White males (23.3/100,000).[58]

Cardiovascular Disease

According to the World Health Organization (WHO), cardiovascular disease is caused by disorders of the heart and blood vessels, and includes coronary heart disease (heart attacks), cerebrovascular disease (stroke), raised blood pressure (hypertension), peripheral artery disease, rheumatic heart disease, congenital heart disease and heart failure. The major causes of cardiovascular disease are tobacco use, physical inactivity, an unhealthy diet, and harmful use of alcohol.

- **Heart Disease**
  During 2006-2010, Hispanics/Latinos were less likely to die from heart disease (89.7 deaths per 100,000 population), than were Whites (161.2 deaths per 100,000 population). Hispanic/Latino men had a death rate of 99.1 for heart disease, compared with the rate of 204.1 for White men. Hispanic/Latino women (78.2) were also less likely than White women (126.7) to die from heart disease.[59]

- **Diabetes**
  During 2006-2010, Hispanics/Latinos had a mortality rate that was 1.6 times the rate for Whites for diabetes mellitus (28.8 deaths/100,000 as compared to 18.3 deaths/100,000).[60]

[55] Nebraska DHHS Vital Statistics, 2006-2010.
[56] Nebraska Cancer Registry.
[57] Nebraska Death Certificate Registry.
[58] Ibid.
[59] Nebraska DHHS Vital Statistics, 2006-2010.
[60] Ibid.

- **Stroke**
  During 2006-2010, Hispanics/Latinos had a rate of 23 deaths per 100,000 from stroke, which was lower than the rate for Whites (40.8/100,000).[61]

Unintentional Injury

Unintentional injuries are those caused by such events like car accidents, fires, falls, poisonings, or cuts and piercings from instruments or objects.[62] In Nebraska, injury was the second-leading cause of potential years of life lost following cancer.[63]

Across the U.S. from 2006-2010, there were 9,998,960 unintentional injuries among Hispanics/Latinos.[64] During 2006-2010, the death rate due to unintentional injuries for Hispanics/Latinos in Nebraska was 29.5 per 100,000 population, which was less than the rate for Whites (35.9/100,000).[65]

Health Indicators

Prenatal Care

Mothers who initiated prenatal care after the first trimester of pregnancy and those who received no prenatal care at all are considered at higher risk for poor pregnancy outcomes such as infant mortality or low-birth weight babies. During 2006-2010, 56.6% of Hispanic/Latino mothers began prenatal care in the first trimester, compared to 76.6% of White mothers. The Kotelchuk Index is a measure of adequacy or inadequacy of prenatal care by using a combination of the total number of prenatal visits, gestational age of the infant at birth, and the trimester in which prenatal care was started. Based on the Kotelchuk Index, in 2006-2010, among Nebraska's Hispanics/Latinos, almost one quarter (24.2%) received inadequate prenatal care. The proportion of White mothers who did not receive adequate care was only 11.3%.[66]

Infant Mortality

Often considered the benchmark of the existence of unmet health needs, infant mortality rates are the key assessment of maternal and child health. In the five-year period 2006-2010, the infant mortality rate was similar for Hispanics/Latinos as for Whites at 5.7 deaths per 1,000 live births in Nebraska.[67]

Low Birth Weight

A newborn is considered to be of low weight if he or she weighs less than 2,500 grams at birth. These babies experience higher rates of illness and death than other infants. During 2006-2010, Nebraska Hispanics/Latinos had similar rates of low birth weight as Whites at 66 low-birth weight babies per 1,000 live births. It should be noted that despite a much higher rate of inadequate prenatal care among Hispanics/Latinos compared to Whites (24% vs. 11.3%), the pregnancy outcomes were comparable between these two groups, which is another indicator of the immigrant paradox described earlier.[68]

Obesity

As of 2010, 29.6% of all Nebraska adults were obese.[69] In fact, Nebraska was named the 24th most obese state in the country, according to the eighth annual F as in Fat: How Obesity Threatens America's Future 2011, a report from the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF). The obesity rate in Nebraska increased more than 80% over the last 15 years. For Hispanics/Latinos in Nebraska, the obesity rates were even higher, at 31.8%.[70]

"Body Mass Index" (BMI) correlates with the amount of fat in the body. An adult who has a BMI between 25 and 29.9 is considered overweight, and an adult who has a BMI of 30 or higher is considered obese.[71] During 2006-2010, 36.7% of Nebraska adults reported their BMI as being between 25 to 29; the percentage of people reporting BMI from 25 to 29 was lower for Hispanics/Latinos (35%) than for non-Hispanic Whites (36.8%). Furthermore, 27.3% of Nebraskan adults reported their BMI of 30 and above. The rate of reported BMI at 30 and above was higher for Hispanics/Latinos (41.7%) than for non-Hispanic Whites (26.7%).[72]

Racial and ethnic group specific data for children in Nebraska is limited; however, the prevalence of obesity among Hispanic/Latino students in Nebraska (30.9%) is much higher than national obesity prevalence estimates for school-aged youth ages 6-19 years (23.2%).[73] Children who are overweight or obese are at higher risk of developing chronic diseases. This disparity is particularly alarming given that Latino children comprise 22% of all

[61] Ibid.
[62] Nebraska DHHS. Injury in Nebraska 2004-2008. Retrieved on December 11, 2012 from http://dhhs.ne.gov/publichealth/Documents/InjuryInNebraska2010.pdf.
[63] Nebraska DHHS. Report Identifies Injuries as Major Problem in Nebraska. Retrieved on December 21, 2012 from http://dhhs.ne.gov/Pages/newsroom_newsreleases_2011_apr_injuries.aspx.
[64] Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. WISQARS Nonfatal Injury Reports. Retrieved on December 21, 2012 from http://webappa.cdc.gov/cgi-bin/broker.exe.
[65] Nebraska DHHS Vital Statistics, 2006-2010.
[66] Nebraska DHHS Vital Statistics, 2006-2010.
[67] Ibid.
[68] Ibid.
[69] Centers for Disease Control and Prevention. U.S. Obesity Trends. Retrieved on September 27, 2012 from http://www.cdc.gov/obesity/data/trends.html.
[70] Trust for America's Health. Key Health Data about Nebraska. Retrieved on November 27, 2011 from http://www.healthyamericans.org/states/?stateid=NE.
[71] Centers for Disease Control and Prevention. Defining Overweight and Obesity. Retrieved on September 12, 2012 from http://www.cdc.gov/obesity/adult/defining.html.
[72] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.
[73] Nebraska DHHS. 2010-2011 Youth BMI Surveillance Project Report.

U.S. youth and they represent the largest, youngest, and fastest-growing minority group in the nation.[74]

Violence

Violence is the "threatened or actual use of physical force or power against another person, against oneself, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, or deprivation."[75] Violence, including gang violence, is a growing concern among communities. Although there is a perception that gangs target people who are not of their own ethnicity, research has shown that most gang conflicts take place between gangs of the same ethnicity.[76]

Violence also includes intimate partner violence (IPV). The Centers for Disease Control and Prevention (CDC) uses the term "intimate partner violence" to describe physical, sexual, or psychological harm by a current or former partner or spouse. Nebraska does have legislation that defines domestic violence and IPV, including violence between same-sex partners.[77] It is estimated that there are approximately 200,000 Nebraskans who are victims of IPV and 188,000 are in fear and concerned about their safety.[78] In 2011, there were 3,964 simple domestic assaults (those without a weapon) and 339 aggravated assaults.[79] IPV is a serious issue within the Hispanic/Latino community. 3,798 Hispanic/Latinos children and adults were served through Nebraska Domestic Violence Sexual Assault Coalition member agencies in 2011.[80] Alcohol use has been correlated to IPV,[81] which is a grave and damaging yet often unreported problem in Latino communities. Many reasons for not reporting include fear of deportation, jeopardizing legal status, or having children removed prevent Hispanics/Latinos from seeking assistance for intimate partner violence.[82]

During 2006-2010, the mortality rate due to homicides was 2.6 times as high for Hispanics/Latinos (5.4 age-adjusted deaths per 100,000 population) as the rate for Whites in Nebraska.[83] The results of one study suggested that differences in homicide rates among Hispanics/Latinos and non-Hispanic Whites were a result of the social context, and that if Hispanics/Latinos were subject to the same set of social conditions, their homicide rate would actually be lower than that of Whites.[84] Evidence suggests that inequality and feelings of relative deprivation, more than poverty, are significant influential factors for crime and violence.[85]

Incarceration rates for Hispanics in Nebraska in 2008 were more than double the rate for Whites in Nebraska (684.7/100,000 vs. 306.4/100,000) also highlighting a disparity within the criminal justice system.[86] Some studies indicate that if African Americans and Hispanics were incarcerated at the same rates of Whites, today's prison and jail populations would decline by approximately 50%.[87]

In Nebraska, suicide was the second-leading cause of injury death; however, Hispanics/Latinos had relatively lower suicide mortality rates (4.7 deaths per 100,000) during 2006-2010 compared to Whites at 10.7/100,000.[88] However, across the country, Hispanic/Latina females aged 12 to 17 were at higher risk for suicide than other youths.[89] In Nebraska, close to 13% of Latino youth in 2011 reported that they had made a plan on how they would attempt suicide.[90] Almost a quarter of Nebraska's Latino youth reported feeling sad or hopeless almost every day for two weeks or more, which stopped them from doing some of their usual activities.[91] Most Hispanic/Latino youth across the United States at risk for suicide during the past year did not receive any mental health treatment.[92]

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[74] Salud America. Retrieved on September 27, 2012 from http://www.salud-america.org/obesity.html.
[75] Foege WH, Rosenberg ML, Mercy JA. Public health and violence prevention. Current Issues in Public Health 1995;1:2-9.
[76] Center for the Study and Prevention of Violence. Gangs and Youth Violence. Retrieved on September 14, 2012 from http://www.colorado.edu/cspv/publications/factsheets/cspv/FS-001.pdf.
[77] Domestic Violence, Sexual Assault, and Stalking Data Center. Retrieved on December 21, 2012 from http://www.jrsa.org/dvsa-drc/nebraska/index.shtml.
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[79] Nebraska Commission on Law Enforcement and Criminal Justice. Domestic Assault Series, 2011. Retrieved on December 21, 2012 from http://www.ncc.ne.gov/pdf/stats_and_research/2011_Domestic_Assaults.pdf.
[80] Nebraska Domestic Violence Sexual Assault Coalition. 2010-2011 Statewide Report. Retrieved on December 21, 2012 from http://ndvsac.org/wp-content/uploads/2010/06/Annual_Rep_2011_FINAL1.pdf.
[81] Caetano R, Schafer J, Cunradi CB. Alcohol-related intimate partner violence among White, Black, and Hispanic couples in the United States. Alcohol Res Health 2001;25:58–65.
[82] Alizanza. Retrieved on September 18, 2012 from http://www.dvalianza.org.
[83] Nebraska DHHS Vital Statistics, 2006-2010.
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[87] NAACP. Criminal Justice Fact Sheet. Retrieved on December 19, 2012 from http://www.naacp.org/pages/criminal-justice-fact-sheet.
[88] Nebraska DHHS Vital Statistics, 2006-2010.
[89] SAMSHA. Risk of Suicide Among Hispanic Females Aged 12-17. Retrieved on September 17, 2012 from http://oas.samhsa.gov/2k3/LatinaSuicide/LatinaSuicide.cfm.
[90] Nebraska Youth Risk Behavior Survey. 2010 Survey Results. Retrieved on December 19, 2012 from http://www.education.ne.gov/HIV/2010_YRBS-Results/Data/2011/2010NEH%20Detail%20Tables.pdf.
[91] Ibid.
[92] SAMSHA. Risk of Suicide Among Hispanic Females Aged 12-17. Retrieved on September 17, 2012 from http://oas.samhsa.gov/2k3/LatinaSuicide/LatinaSuicide.cfm.

Major Behavioral Risk Factors

Alcohol Use

U.S.-born Latinos have higher rates of alcohol use than Latino immigrants.[93] Latino men in their country of origin may not drink frequently, but when they do they are more likely to drink to intoxication. Latina women are less likely to drink alcohol than are Latino men as there are strong social norms against women drinking.[94]

Latino youth are more likely to initiate drinking and get drunk at an earlier age than non-Hispanic Whites or African American youth.[95] Latino youth are also more likely than their counterparts to have consumed alcohol in their lifetimes and to report current use of alcohol.[96] At the eighth-grade level, Latino youth are significantly more likely to report binge drinking in the past two weeks than either non-Hispanic Whites or African American youth and are slightly more likely to do so in the 10th grade. In Nebraska, 21.5% of Latino youth have reported binge drinking or having at least 5 or more drinks in a row within a couple of hours during the past 30 days. In comparison, only 15.6% of White youth reported binge drinking during that same time period.[97] Latino youth are also more likely than both African American and non-Hispanic Whites youth to have consumed alcohol prior to driving or have ridden with a driver who had consumed alcohol.[98] For example, Latino youth in Nebraska are more likely than non-Hispanic White youth to have ridden 6 or more times in a car driven by someone who had been drinking (6.6% vs. 3.1%).[99]

"Heavy drinking" refers to the self-reported consumption of more than 60 drinks for men (an average of more than two drinks per day) and 30 drinks for women (an average of more than one drink per day) during the past month, or 30 days preceding the survey. Hispanics adults (2.5%), 18 and older in Nebraska, were less likely than non-Hispanic White (4.8%) adults, 18 and over, to report heavy drinking.[100]

Emotional/Mental Health

Latinos are particularly vulnerable to depression, anxiety, and post-traumatic stress disorder, arising from many sources including family separation issues, social isolation, migration to a new country, and the ramifications of war in their countries of origin.[101] A study found conclusively that long-term residence in the United States significantly increased rates in mental disorders, with particularly dramatic increases in the rates of substance abuse.[102] Close to 10% of Hispanics/Latinos in Nebraska reported that they had 10 or more days during the past month where they mentally did not feel well.[103]

Poverty level also affects mental health status. Hispanics living below the poverty level, as compared to Hispanics over twice the poverty level, are three times more likely to report psychological distress.[104] Hispanics/Latinos in Nebraska were more likely to report that they never receive any emotional support than Whites (14% vs. 2.8%).[105]

Hispanics/Latinos face many obstacles to accessing mental health care, including a lack of culturally and linguistically competent mental health resources,[106] services, and residential treatment facilities; knowledge of available resources; health insurance; sensitivity by emergency department personnel regarding mental health issues; and services for the chronically mentally ill. In addition, fragmentation of existing mental health services, including the lack of bilingual bicultural mental health providers, does not help matters.

Fruit/Vegetable Consumption

Nutrition intake is an important determinant of health status. Fruit and vegetable consumption is one of the few commonly available indicators of individuals' dietary habits. During the 5-year period from 2006 to 2010, 19.1% of Hispanic/Latino adults in Nebraska reported having five or more servings for either fruits or vegetables, compared to 22% of Whites.[107]

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[93] De La Rosa, M., Sanchez, M., Dillon, F., Ruffin, B., Blackson, T., Schwartz, S. Alcohol Use Among Latinos: A Comparison of Pre-Immigration, Post-Immigration, and US Born Latinos. Journal of Immigrant and Minority Health: 1557-1912.
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[95] L.D. Johnson, e. a. National Survey Results on Drug Use for Secondary School Students (2004). *Monitoring the Future* , Tables D-63, D-66, D-69, D-70.
[96] Sokol-Katz, J. a. (1992). Family structure and adolescent risk-taking behavior: A comparision of Mexican, Cuban, and Puerto Rican Americans. *International Journal of the Addictions*, 1197-1209.
[97] Nebraska Youth Risk Behavior Survey. 2010 Survey Results. Retrieved on December 19, 2012 from http://www.education.ne.gov/HIV/2010_YRBS-Results/Data/2011/2010NEH%20Detail%20Tables.pdf.
[98] Caetano, R. a. Alcohol use and alcohol-related problems among Latinos in the United States. In M. Aguirre-Molina, *Health Issues in the Latino Community* (pp. 383-412). San Francisco: Jossey-Bass, 2001.
[99] Nebraska Youth Risk Behavior Survey. 2010 Survey Results. Retrieved on December 19, 2012 from http://www.education.ne.gov/HIV/2010_YRBS-Results/Data/2011/2010NEH%20Detail%20Tables.pdf.
[100] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.
[101] Latino Health Initiative. Retrieved on September 18, 2012 from http://www.lhiinfo.org/en-ir-Data-Resources/Health_Profile.asp.
[102] Vega WA, Kolody B, Aguilar-Gaxiola S, et. al. Lifetime Prevalence of DSM-III-R Psychiatric Disorders Among Urban and Rural Mexican Americans in California. Archives of General Psychiatry. 1998; 55(9): 771-778.
[103] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.
[104] Office of Minority Health. Mental Health and Hispanics. Retrieved on December 11, 2012 from http://minorityhealth.hhs.gov/templates/content.aspx?lvl=3&lvlID=9&ID=6477.
[105] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.
[106] Craft, C. (2012) U.S. mental health programs little help to Latinos, UC Davis study says. *The Sacramento Bee.* Retrieved on December 11, 2012 from http://www.sacbee.com/2012/06/26/4588629/us-mental-health-programs-little.html#storylink=cpy.
[107] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.

Physical Activity

A sedentary lifestyle contributes greatly to the obesity epidemic. Hispanics/Latinos are reported to be highest among all ethnic groups in leisure time inactivity.

The 2006-2010 Nebraska BRFSS indicated that more than one-third of Hispanics/Latinos (35.4%) had no exercise outside of work, compared to 21.6% of White Nebraskans.[108] Ethnic differences in physical activity patterns likely begin in childhood, as early as age four. Some researchers found that Hispanic/Latino preschoolers spend less time engaging in moderate-to-vigorous physical activity; consequently, expending fewer calories compared with non-Hispanic White preschoolers, and this pattern continues later into life.[109]

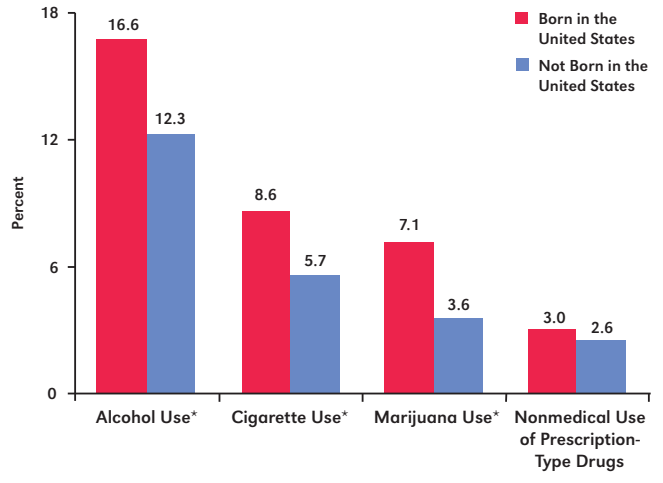
In one particular study, Mexican-American women had the highest rate of no leisure time physical activity when compared to Mexican-American men and non-Hispanic black women. Mexican-American women and other women of color over the age of 40 and without a college education had the lowest levels of participation in leisure time physical activity when compared to non-Hispanic White women.[110] Those who were less acculturated (Spanish speakers and Spanish and English speakers, as well as those born in Mexico and living in the United States for less than 5 years) were more likely to be inactive during leisure time than more acculturated Mexican Americans, after controlling for age, education, income, birthplace, years living in the United States, and language.[111] Hispanics/Latinos high in leisure time physical activity whether male or female, received more social support from friends to exercise, and placed greater importance on physical activity outcomes than male or female Hispanics/Latinos who were low in leisure time physical activity.[112]

Risky Sexual Behaviors

The overall sexually transmitted disease (STD) rate for Hispanics/Latinos in Nebraska (534.7 cases per 100,000 population) was nearly three times the rate for Whites (256.5 cases per 100,000 population). The prevalence rate of Chlamydia among Hispanics/Latinos (433.3) was 2.3 times higher than that of Whites (185.9) in 2006-2010.[113]

Hispanics/Latinos bear a disproportionate burden of the HIV epidemic. In 2006-2010, the mortality rate due to HIV/AIDS was three times as high for Hispanics/Latinos (2.6 age-adjusted death rates per 100,000 population) as the rate for Whites (0.8).[114] The rate of new HIV infections among Hispanic/Latino men was almost three times that of White men, with gay and bisexual men particularly affected.[115]

Figure 7: Past Month Substance Use among Hispanics Aged 12 to 17, by Nativity: 2004 to 2009



* The difference between Hispanic adolescents born in the United States and those not born in the United States is statisticall significant at the .05 level.

Source: 2004 to 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs)

Substance Use

Among Hispanic/Latino youth in grades 9 through 12 in Nebraska in 2010, 21% had used marijuana within the last 30 days.[116] Latino youth in the state were also more likely than other youth to have tried cocaine, methamphetamines, taken a prescription drug (eg. OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a prescription, or participated in sniffing or huffing. In fact, 10.6% of Latino youth had tried cocaine compared to only 3% of White youth, and 17% of Latino youth had sniffed glue, breathed contents of aerosol spray cans, or inhaled paints and sprays to get high compared to 7.6% of White youth.[117]

Immigration status also affects substance use and abuse

[108] Ibid.
[109] Olvera, N., Kellam, S., Menefee, K., Lee, J. and Smith, D.W. (2010) "Physical Activity in Latino Children: Research and Its Implications," *Journal of Applied Research on Children: Informing Policy for Children at Risk*: Vol. 1: Iss. 1, Article 3.
[110] President's Council on Physical Activity and Fitness. Retrieved on November 28, 2011 from http://www.fitness.gov/enewsletter/Summer07_featurearticle.htm.
[111] Crespo, C.J., Smit, E., Carter-Pokras, O., and Andersen, R. Acculturation and Leisure-Time Physical Inactivity in Mexican American Adults: Results From NHANES III, 1988–1994. Am J Public Health. 2001 August; 91(8): 1254–1257.
[112] President's Council on Physical Activity and Fitness. Retrieved on November 28, 2011 from http://www.fitness.gov/enewsletter/Summer07_featurearticle.htm.
[113] Nebraska DHHS STD program, 2006-2010.
[114] Nebraska DHHS Vital Statistics, 2006-2010.
[115] CDC. HIV and AIDS Among Latinos (October 2011). Retrieved on September 17, 2012 from http://www.cdc.gov/nchhstp/newsroom/docs/FastFacts-Latinos-FINAL508COMP.pdf.
[116] Nebraska Youth Risk Behavior Survey. 2010 Survey Results. Retrieved on December 19, 2012 from http://www.education.ne.gov/HIV/2010_YRBS-Results/Data/2011/2010NEH%20Detail%20Tables.pdf.
[117] Ibid.

rates. For example, among Hispanic/Latino youth, those who were born in the United States had higher rates of past month cigarette use, alcohol use, and marijuana use than those who were not born in the United States.[118]

Teen Pregnancy/Births

Teen births can have lasting ramifications on the health status, educational attainment, and long-term earning potential of young mothers and fathers. During 2006-2010, the teen birth rate for Hispanics/Latinos (114.6/1,000 females aged 15-19) girls in Nebraska was 4.9 times the rate for White teens (23.5/1,000 females aged 15-19).[119]

Tobacco Use

Tobacco use is the single most preventable cause of morbidity and mortality in Nebraska and the U.S. as a whole.[120] Each year cigarette smoking contributes to a large number of chronic disease deaths, including deaths due to cancer, cardiovascular disease, and respiratory diseases. Current cigarette smoking was defined as currently smoking every day or on some days among people reporting having smoked at least 100 cigarettes during their lifetime. In 2006-2010, approximately one in every six adult Nebraskans (18.5%) was a daily or some days smoker,[121] reflecting a decline from 21.4% in 2005. The Hispanic/Latino adult smoking rate at 16.8% is lower than that of White Nebraskans (18.1%).[122] Hispanic/Latino students (23%) were more likely to smoke cigarettes on one or more of the past 30 days than their White (14%) peers.[123] Hispanic/Latino smokers are mainly males as there is a strong social norm against women smoking especially among specific subgroups such as people from Mexico.

From 2006-2010, Hispanics/Latinos had the lowest death rate of lung disease of any racial/ ethnic group in Nebraska with an age-adjusted rate of 17.8 deaths per 100,000 population, while the rate for Whites was 46.5 deaths/100,000.[124]

[118] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (October 4, 2011.) *The NSDUH Report: Substance Use among Hispanic Adolescents*. Rockville, MD. Retrieved on September 27, 2012 from http://oas.samhsa.gov/2k11/007/WEB_SR_007.htm.
[119] Nebraska DHHS Vital Statistics, 2006-2010.
[120] Centers for Disease Control and Prevention. (2011). Tobacco Use: Targeting the Nation's Largest Killer. Retrieved on September 27, 2012 from http://www.cdc.gov/chronicdisease/resources/publications/aag/osh.htm.
[121] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.
[122] Nebraska Behavioral Risk Factor Surveillance System, 2006-2010.
[123] Nebraska Youth Behavioral Risk Factor Survey, 2011.
[124] Nebraska DHHS Vital Statistics, 2006-2010.

SUMMARY

Many Latinos are new immigrants who come to the United States to work, attend school, and/or to be reunited with family. Often they immigrate based on what they learn about employment opportunities from others who have preceded them. Research shows that Hispanic/Latinos born in different countries have different behavioral risk factors for the leading causes of death that have been presented in this report. However, despite these differences, they share many similar cultural values and therefore, many immigrants settle in segregated ethnic neighborhoods and ethnic enclaves that allow the possibility of sharing a common language and culture in a new society.[125] This residential settling pattern allows them to access the necessary resources to get a leg up in their integration process such as finding jobs and services in their native language. However, this may also isolate them further from the larger mainstream society without proper intervention strategies and receptive immigrant-integration policies.

These and many other issues such as the ones listed below can affect health and the social determinants of health[126] – the circumstances in which people are born, grow up, live, work, and age, as well as the healthcare systems in place to deal with illness. Those other issues include:[127]

- Access to Care
- Language
- Patient Care Philosophies[128]
- Discrimination
- Poverty
- Education
- Lack of Medical Insurance
- Immigration Status
- Cost
- Transportation
- Low Health Literacy

RECOMMENDATIONS

The WHO defines health as not merely the absence of disease, but instead an overall state of well-being. Failure to address root and upstream causes of health disparities – the social determinants of health – is only putting a bandage on the problem rather than solving the problem. Systems change is necessary to improve outcomes.[129]

Data & Research Recommendations

Health disparities, in part, can be addressed through improving access to affordable, quality health care that meets the linguistic and cultural needs of the community, but there is a lack of data on the Hispanic/Latino population at the local, state, and national levels. In 2011, the

[125] Robert Wood Johnson Foundation, Proyecto HEAL.
[126] Centers for Disease Control and Prevention. Social Determinants of Health. Retrieved on January 9, 2013 from http://www.cdc.gov/socialdeterminants.
[127] United Way of the Midlands. (2003). Profile of Latino Youth.
[128] Dr. Gouveia recently interviewed some Venezuelan doctors, many of whom are proud to continue their native country's practice to give patients their cell phone and to refuse insurance so they can talk to patients for as long as they want given their strong belief that the best diagnosis are made when you know as much as you can about your patient.
[129] Center for Health Disparities Solutions, Johns Hopkins University.

U.S. Department of Health and Human Services (HHS) published new guidelines for the collection of health data on race, ethnicity, sex, and primary language gathered under its guidance or by using HHS funding.[130] Additionally, the Patient Protection and Affordable Care Act (ACA) called for improvements in data collection for underserved populations that experience health disparities. These are all steps in the right direction; however, more data and research are needed.[131]

- Improve data systems ensuring the collection of specific data on Latino subgroups, which is needed to further analyze risk and protective factors that affect health, including mental health.
- Collect data on an individual's assessment of his or her level of English proficiency and on the preferred spoken and written language to be used in healthcare encounters.[132]
- Increase Latino participation at all stages of health research.
- Research processes are needed to build trust and capacity within the community and be respectful of and responsive to community priorities.
- Efforts should also ensure the sustainability of interventions.
- Partner with local communities and involve Latino community leaders in the research process from idea to implementation. Provide timely feedback of information to ensure that research is culturally and linguistically appropriate and benefits the community.

Health Careers Recommendations

Hispanics/Latinos are underrepresented at every level of the healthcare professional workforce.[133] There is currently a shortage of physicians who are of racial and ethnic minority groups, other than non-Hispanic Whites. In fact, in 2011 there were only seven Hispanic/Latino graduates from medical school in the entire state of Nebraska.[134] Healthcare works best when health professionals resemble their patient base. More Hispanic/Latino public health practitioners, researchers, and healthcare professionals are needed, including doctors, nurses, and allied medical staff.

- Develop a healthcare career pipeline to increase the number of Hispanic/Latino professionals in the health sciences.
- Provide scholarships and educational funding to Hispanic/Latino students to enable them to pursue careers in the health sciences.
- Invest in interdisciplinary research training and mentorship for bilingual and bicultural health science professionals.
- Provide specific training for healthcare providers and staff so that they have a better understanding of Latino culture and its implications for health and well-being.
- Increase healthcare provider knowledge, understanding, and respect of the valuable role of non-traditional, alternative healing practices in order to build relationships with their Hispanic/Latino patients.

Culturally Competent Policy Recommendations

Throughout the state, more culturally and linguistically appropriate services are needed. Health information and services must be available in Spanish and other indigenous languages. To meet the needs of the community, medical interpreters and translators should be bicultural, trained, and certified to ensure high quality interpretive services are provided to the public. Interpreters should also be seen as an integral part of the healthcare team.

- Adopt human resource policies that incorporate cultural and language competency training for staff of organizations serving the Hispanic/Latino community.
- Ensure that there are bilingual and bicultural people on staff.
- Enforce the Culturally and Linguistically Appropriate Services (CLAS) Standards in healthcare organizations and increase awareness of the same among the community.[135]

Public Health Practice Recommendations

Adopting innovative, holistic, culturally relevant, data- and evidence-driven public health practices that address the individual behavior as well as the social determinants of health is critical.

- Develop more culturally tailored health promotion programs and interventions. Ensure that these programs and adaptations are evaluated so that they can contribute to the evidence-base as "model programs" or "promising practices."

[130] U.S. HHS. Implementation Guidance on Data Collection Standards. Retrieved on December 27, 2012 from http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml.
[131] Healthcare.gov. Read the Law. Retrieved on December 28, 2012 from http://www.healthcare.gov/law/full/index.html.
[132] Wong, C., Hosotani, H., and Her, J. (2012). Information on Small Populations with Significant Health Disparities. University of Massachusetts. Retrieved on December 26, 2012 from http://www.iaas.umb.edu/publications/general/AA%20Health%20Data.pdf.
[133] The Health of Latino Children Urgent Priorities, Unanswered Questions, and a Research Agenda, Journal of the American Medical Association, July 3, 2002.
[134] Kaiser State Health Facts. Distribution of Hispanic Medical School Graduates by Hispanic Ethnicity, 2011. Retrieved on December 11, 2012 from http://www.statehealthfacts.org/profileind.jsp?ind=455&cat=9&rgn=29.
[135] U.S. Department of Health and Human Services. Office of Minority Health. National Standards on Culturally and Linguistically Appropriate Services (CLAS). Retrieved on January 11, 2013 from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

- Build collaborative partnerships with other organizations working within the Hispanic/Latino community, including faith-based groups, social service organizations, community coalitions, and neighborhood associations.
- Employ public health strategies such as community health workers or promotores de salud, interventions in beauty shops, and collaborations with non-traditional health organizations to relay much-needed health information, including health policy changes related to the Affordable Care Act, Medicare, and Medicaid, screening, treatment and prevention of disease.
- Explore non-traditional activities and methodologies to reach the Hispanic/Latino community such as through soccer leagues and the arts.
- Include family members in healthcare decisions in order to improve patient adherence to the specific recommendations.
- Public health interventions that include inter-generational family member participation (grandparents, parents and siblings) should be developed and implemented, especially for programs after school or when schools are not in session.[136]
- Identify and integrate alternative healers and practices, such as curanderos or santeros, to enhance the acceptance and effectiveness of service delivery to Hispanic/Latino populations.
- Incorporate the use of relevant technology in developing innovative and sustainable public health interventions.
- Support social and environmental policy strategies that change the social norms and environment of the community to support healthier behaviors.
- Cultivate binational partnerships with "sending countries" to help educate, inform, and provide services to immigrant populations within the U.S. such as through working with Mexico's Instituto de Mexicanos en el Exterior (IME).

Communications Best Practices:

Latinos often look to the media as a resource on health topics, and receive significant health information from television, newspapers, magazines, or radio.[137] Additionally, there is increased usage of online sources through mobile devices to access information.

- Develop and utilize relationships with Hispanic/Latino specific media outlets, including radio and TV stations and personalities, to disseminate health information.
- Use various media outlets, including social networking sites such as Facebook and Twitter, to provide health information to the public in Spanish and other indigenous languages.

Prevention and Access to Care Recommendations:

Preventative services should be made available in communities that have less access to quality health information and services. Funding for bilingual public health and health education/promotion programs is essential to address health disparities. Programs should focus on examining the cultural influences and the impact of acculturation as well as the overall health and wellness benefits of implementing necessary lifestyle changes.

- Cultivate and promote a culture of prevention through education and awareness within the Hispanic/Latino community by adopting and evaluating evidence-based population programs.
- Prevention programs should take into account cultural norms (e.g., accessing health care only when sick) and the impact of acculturation, incorporating strategies to change community norms in implementing necessary behavior and lifestyle changes.
- Develop community-relevant solutions that address access barriers such as transportation, child-care, and location of services.
- Innovative dissemination strategies that provide information to the community on changes in healthcare policy related to the Affordable Care Act, Medicare, and Medicaid affecting prevention, screening, and treatment of disease is essential.

Social Determinants of Health and Public Policy Recommendations:

Reducing risk factors for disease requires comprehensive, community-wide interventions that address not only health, but also the social determinants of health and the circumstances in which people live, work, and play. Public policy efforts to revitalize poor neighborhoods, improve transportation, the quality of schools, guarantee access to healthy foods, increase the availability of other public services, ensure culturally-competent community policies, and link Latinos to economic opportunities are promising strategies that can significantly improve the health of Latino communities in Nebraska and across the country.

[136] Olvera, N., Kellam, S., Menefee, K., Lee, J. and Smith, D.W. (2010) "Physical Activity in Latino Children: Research and Its Implications," Journal of Applied Research on Children: Informing Policy for Children at Risk: Vol. 1: Iss. 1, Article 3.
[137] Kaiser Family Foundation, What's the Diagnosis? A Series of Three Reports on Latinos, Media & Health, 1998.

- Find ways to tie health into community development and government policies and practices by increasing the use of health impact assessments.
- Ensure quality public education for all and develop pathways to allow all students an opportunity to pursue higher education.
- Support immigration reform policies that ensure there is a clear path to legal status for those immigrants already in the U.S. and those seeking to enter the U.S.
- Support and enforce laws against racism and discrimination at the local, state, and federal levels. Education for the public is needed on how these laws apply within the context of the Hispanic/Latino community.
- Conduct equity audits and make the elimination of health disparities a priority in all organizations.
- Support policies that expand health and preventative services to the public.
- Implement new regulations for high-injury related industries, such as construction and food production, and encourage additional safety training and use of personal protective equipment for all employees.
- Understand transnational health issues and collaborate to develop health promotion policies and strategies in partnership with the Consulate of Mexico and other foreign entities.
- Convene community leaders to explore comprehensive strategies to reduce and eliminate health disparities through policy changes.

Ending racial and ethnic health disparities is a major challenge—but one that can be met if all sectors of the community work together.

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