Health Status of African Americans in Nebraska

April 2015

Office of Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services

Minority.health@nebraska.gov
www.dhhs.ne.gov/healthdisparities

Health Status of African Americans in Nebraska

Joseph M. Acierno, MD, JD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

Judy Martin, MS
Deputy Director
Division of Public Health
Department of Health and Human Services

Susan A. Medinger, RD
Administrator, Community and Rural Health Planning Unit
Division of Public Health
Department of Health and Human Services

Josie Rodriguez, MS
Administrator, Office of Health Disparities and Health Equity
Division of Public Health
Department of Health and Human Services

Report Prepared by:
Anthony Zhang, MA, MPhil
Minority Health Epidemiologist

Lianlin Zhao
Program Analyst

Table of Contents

Acknowledgement

The Office of Health Disparities and Health Equity wishes to express its gratitude to the following individuals for providing the guidelines for this report: Sue Medinger, Administrator, Community and Rural Health Planning Unit; Josie Rodriguez, Administrator, Office of Health Disparities and Health Equity; Dr. Tom Safranek, State Epidemiologist; Ming Qu, Administrator, Epidemiology and Informatics Unit.

A special thank you to Norm Nelson, DHHS Statistical Analyst, who provided Vital Statistics data and Behavioral Risk Factor Surveillance information for this report. We also wish to acknowledge several people for providing resources for this report: Bryan Rettig, Program Analyst, Cancer Registry Data; Tina Brubaker, HIV Data Analyst, HIV Surveillance Program, Brenda Coufal, DHHS Program Manager, Carol Gildert, Data Analyst, Pregnancy Risk Assessment Monitoring System (PRAMS); The Office of Health Disparities and Health Equity also thanks Sara Horner, Program Analyst, and Shandana Khattak, Research Analyst, for formatting and editing, and Whitney Clausen, Program Analyst, for final editing. Finally, thank you to Jeff Armitage for his final review.

Introduction

The Nebraska Department of Health and Human Services (DHHS) Office of Health Disparities and Health Equity (OHDHE) strives to provide a more comprehensive look at health disparities among racial/ethnic minorities in Nebraska. As a building block toward that goal, the OHDHE has compiled this data report based on the most recent statistical information available. This report presents health status facts coupled with socioeconomic status information on the African American population in Nebraska, and will show the contrast between this minority population and those of non-Hispanic or Latino White majority populations. The statistical information contained here spans several different health issues including: mortality, chronic diseases, cancer, HIV and sexually transmitted diseases, heart disease, stroke, diabetes, and infectious diseases.

For the purpose of this report, 'race and ethnicity' is defined by the United States Census Bureau and the Federal Office of Management and Budget (OMB) as "self-identification data items in which residents choose the race or races with which they most closely identify, and indicate whether or not they are of Hispanic or Latino origin (ethnicity)." The racial classifications used by the Census Bureau adhere to the October 30, 1997 Federal Register Notice entitled *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* issued by the OMB.[1] The OMB defines five minimum race categories: White, African American, American Indian, Asian, and Native Hawaiian or Other Pacific Islander. For the purpose of this report, an additional category, *some other race* was used as allowed by OMB. In addition to the five race groups, the OMB also states that respondents should be offered the option of selecting one or more races.

The following definition is provided by OMB and the U.S. Census Bureau to identify the race related to this report: It is important to note that race and ethnicity are separate questions.[2]

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "*White*," or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.
African American: A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black," "African American," or "Negro," or provide written entries such as "African American," "Afro American," "Kenyan," "Nigerian," or "Haitian."
Hispanic or Latino: A person having origins in any of the original peoples of Cuba, Mexico, Puerto Rico, South or Central American or other Spanish culture or origin regardless of race. People who identify their origin as "Spanish," Hispanic," or "Latino" may be of any race. For example, a person who considers themselves to be Hispanic may also identify as White.

[1]http://www.whitehouse.gov/omb/fedreg/ombdir15.html
[2]http://www.whitehouse.gov/omb/fedreg/ombdir15.html2000 Census of Population, Public Law 94-171 Redistricting Data File: Race. *U.S. Census Bureau.*

Non-Hispanic White: A White person who does not consider themselves to be of Spanish, Hispanic, or Latino origin. They responded “No, not Spanish/Hispanic/Latino” and reported “White” as their only entry in the race question.

This report is one of a four-part series. The Nebraska minority health disparity reports focus on one racial/ethnic group per report. The information, and analysis methodology presented here are consistent in producing the report series which provides a multi-dimensional view and tracks trends in disparities, while quantifying the potential for future progress in meeting quality goals.

Data Sources

The data sources for this report come from the U.S. Census Bureau, the Nebraska Department of Health and Human Services Office of Vital Statistics, Nebraska Behavioral Risk Factor Surveillance System (BRFSS), Cancer Registry, HIV Prevention Program, the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), and other programs. Due to the varying methodology of the sources, some data is available for non-Hispanic Whites, as in the U.S. Census Bureau American Community Survey, in which case non-Hispanic White data is used instead of White alone data. For the following sources, non-Hispanic White data is unavailable, so White alone data was used: NDHHS Vital Statistics, Nebraska Cancer Registry, and the HIV Prevention Program. For BRFSS data reported, White represents non-Hispanic White respondents, and African American represents non-Hispanic African American respondents.

Population counts data are from the 2010 census. The socioeconomic data is from U.S. Census Bureau, 2009-2011 American Community Survey three-year estimates. This report presents only part of the socioeconomic picture for African Americans in Nebraska, for a more in depth view please look for the Nebraska African American Socioeconomic Profile as published on the Office of Health Disparities and Health Equity website.[3] From Vital Statistics, different ethnic groups’ data are presented in the format of age adjusted rate per 100,000 for populations. Age adjustment is a statistical technique for calculating the rates or percentages for different populations as if they all had the age distribution of a standard population. Rates adjusted to the same standard population can be directly compared or contrasted to each other, that way any differences attributed to factors of the population is more readily seen. The BRFSS data presented in this fact sheet are age-adjusted as well, and surveys have been conducted annually since 1986 for the purpose of data collection on the prevalence of major health risk factors among adults residing in the state.

This report uses the most recent PRAMS data from 2009-2011. Previously published reports (Health Status reports for American Indians and Hispanics) use 2005-2009 data. Information gathered in these studies can be used to target health education and risk reduction activities throughout Nebraska in order to lower rates of premature death and disability. In this report, African American data is summarized and compared to total Nebraska data and White data to reveal the disparity status for various health issues.

[3] http://dhhs.ne.gov/publichealth/Pages/healthdisparities_index.aspx

Executive Summary

The African American Health Status Report shows comprehensive African American health disparity data. The data represents ethnic minority health facts and socioeconomic status in Nebraska. Generally, the minority population is compared to the White/non-Hispanic White population to determine disparities. However, in some cases, data for the non-Hispanic White population is not available and data for the White population as a whole is used instead.

Highlights of the Report Include:

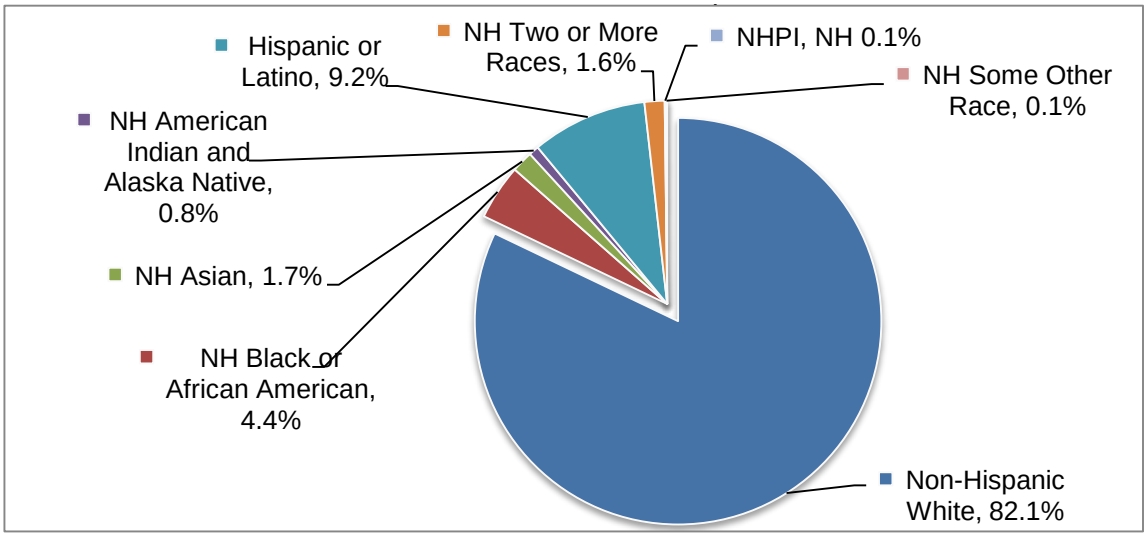
- Approximately 16% of African Americans ages 25 and older had less than a high school education and only 17.6% had a Bachelor's Degree or higher education.
- The median household income of African American households from 2009-2011 was about $27,132; which is $25,551 less than the median income of non-Hispanic White households, which was $52,683.
- During 2006-2010, African American men were 1.4 times as likely to die from all death causes as White men. African American women were 1.5 times as likely to die from all death causes as White women.
- African American males were 33% more likely to die from all cancer causes than White males. African American females were 45% more likely to die from cancer than White females.
- In 2006-2010, African American males were 1.3 times more likely to die from coronary heart disease, as compared to White males. African American females were 1.4 times more likely as White females to die from heart disease.
- The third leading cause of death for African American males was homicide (7.6%).
- The incidence rates for all sexually transmitted diseases were higher for African Americans (3,988.4 per 100,000) when compared to the White population (256.6 per 100,000 population)
- African Americans had an incidence rate per 100,000 population for Chlamydia of 2,531.9, which was about 13 times higher than that for Whites; the Nebraska total incidence rate for Chlamydia was 299.2 per 100,000 population.
- During 2006-2010, the infant mortality rate was 2.4 times higher for African Americans than for Whites.
- African Americans (20.4%) experienced significantly higher rates of inability to see a physician due to cost constraints than Whites (9.1%).
- African American adults (approximately 23.7%) in Nebraska were more likely than White adults (approximately 18%) to be current smokers. A total of 18.5% of Nebraska adults were current smokers.
- African Americans experienced higher rates of physical inactivity than Whites, 35.2% versus 21.6%.

It is our hope that this report will serve as a data resource for the African American communities in Nebraska, and for those who work for and with African Americans in Nebraska. The purpose of this report was to provide a resource to individuals interested in this type of African American data. The data in this report represents health facts and socioeconomic status of Nebraska's African American population.

Overall, the death data represents the major causes of death for African Americans in Nebraska. Maternal and child health data shows the Nebraska's African American infant health status and the well-being of young African American mothers. Pregnancy Risk Assessment Monitoring System (PRAMS) data presents African American mothers' breastfeeding situation and the support they are provided. Behavioral Risk Factor Surveillance System (BRFSS) data comes from the database of the behavioral risk factor surveillance system which collects data by conducting surveys on the prevalence of major health risk factors among adults. For BRFSS data reported, White represents non-Hispanic White respondents, and African American represents non-Hispanic African American respondents. The data presented in this report can be used to target African American health education and risk reduction activities throughout Nebraska to lower rates of premature death and disability. In this report, the African American data is summarized and compared to total state of Nebraska data and White data to reveal the disparity status for various health issues.

Demographic and Socioeconomics

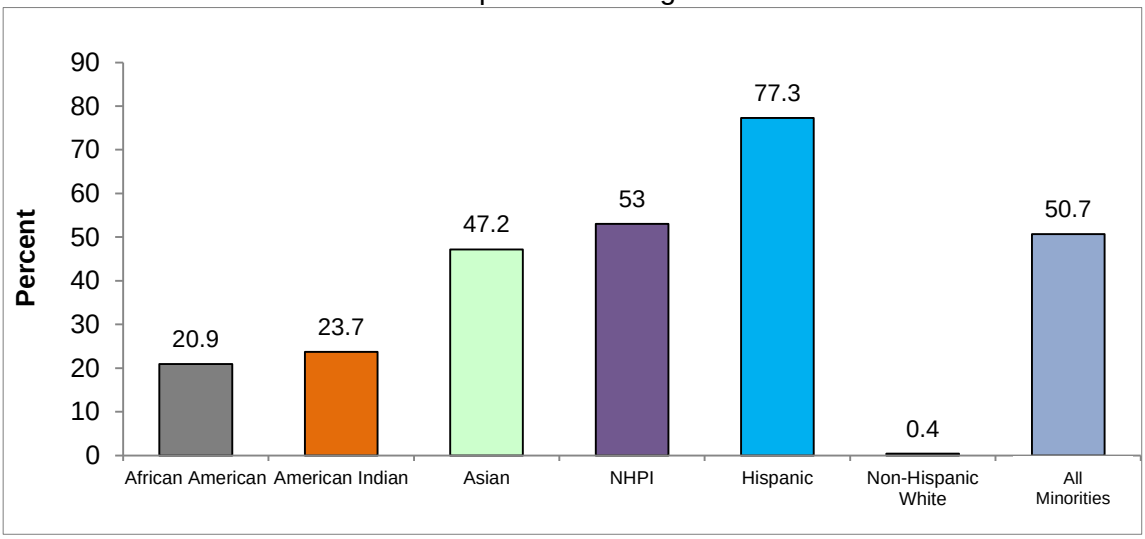
According to the U.S. Census Bureau[4], there were 82,885 African Americans in Nebraska in 2010. Since 2000, there has been an almost 21% increase in the African American population in Nebraska.



Total Population: 1,826,341

Source: U.S. Census Bureau, 2010 Census
Note: *Native Hawaiian or Other Pacific Islander; NH: non-Hispanic

Nebraska Population Change 2000-2010



Source: U.S. Census Bureau, 2010 Census
Note: *Native Hawaiian or Other Pacific Islander; NH: non-Hispanic

[4]Source: Population Division, U.S. Census Bureau, 2010 Census

Distribution of Nebraska African American Population

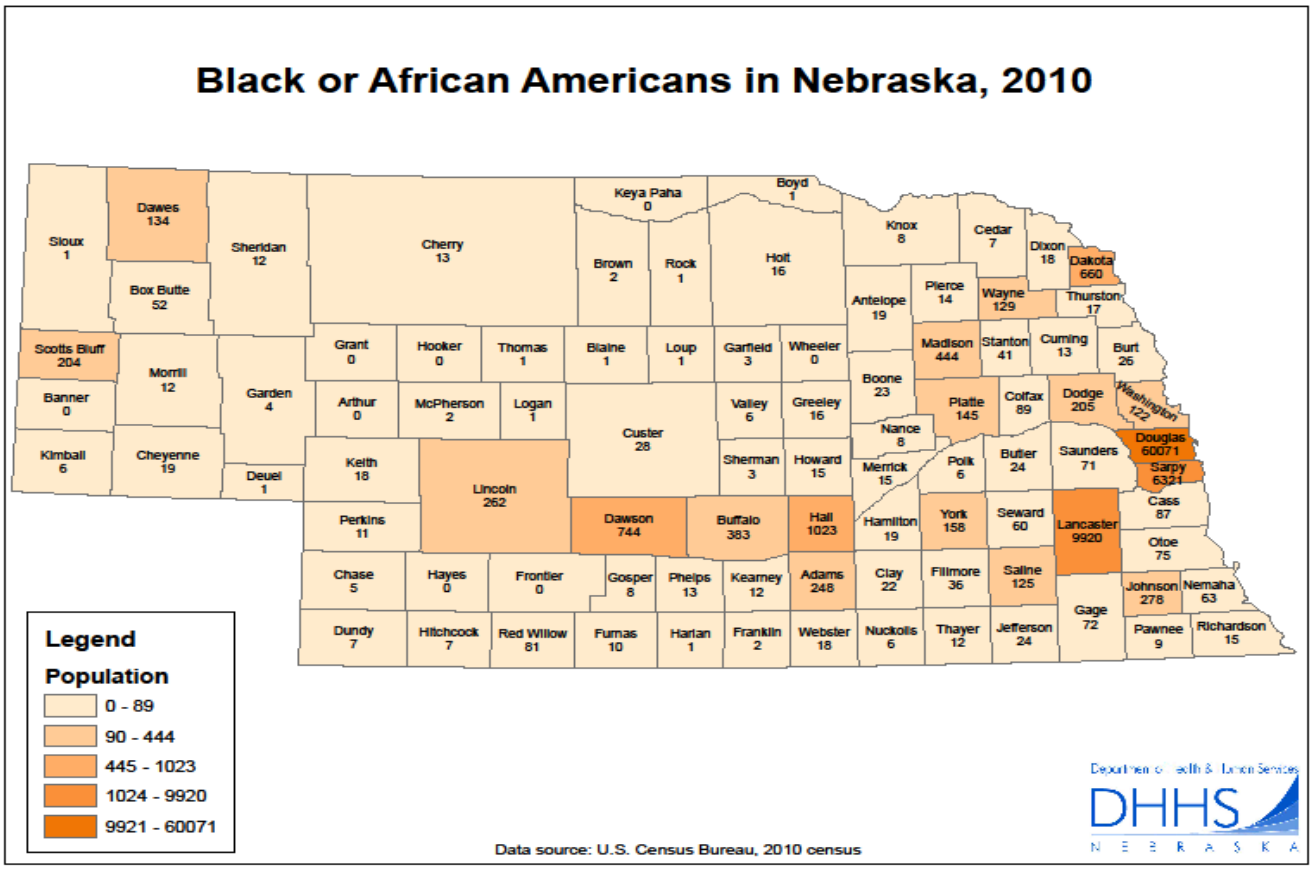
Subject	Number	Percent
Total Nebraska population	1,826,341	
RACE		
One Race		
Black or African American	82,885	4.5
Two or More Races		
Black or African American; White	11,225	0.6
Black or African American; American Indian and Alaska Native	1,317	0.1
Black or African American; Asian	442	0.0
African American; Native Hawaiian and Other Pacific Islander	106	0.0
Black or African American; Some Other Race	1,033	0.1
Black or African American Alone or in Combination*	98,959	5.4
Black or African American alone	82,885	4.5
Black or African American in combination	16,074	0.9
HISPANIC OR LATINO		
African American, Hispanic or Latino	3770	0.2
African American, Not Hispanic or Latino	80,959	4.4

Source: U.S. Census Bureau, 2010 Census

Notes: *The race concept alone or in combination includes people who reported a single race alone and people who reported that race in combination with one or more of the other race groups. The “alone or in combination” concept, therefore, represents the maximum number of people who reported as that race group, either alone or in combination with another race(s). The sum of the six individual race “alone or in combination” categories may add to more than the total population because people who reported more than one race are tallied in each race category.

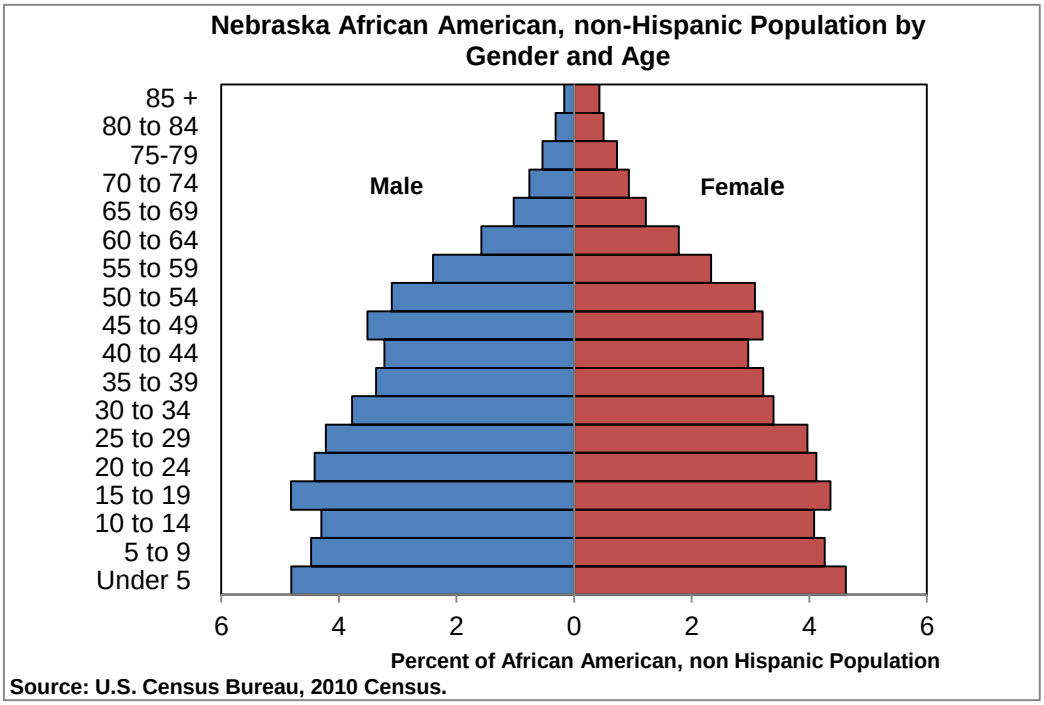
African American Population by County

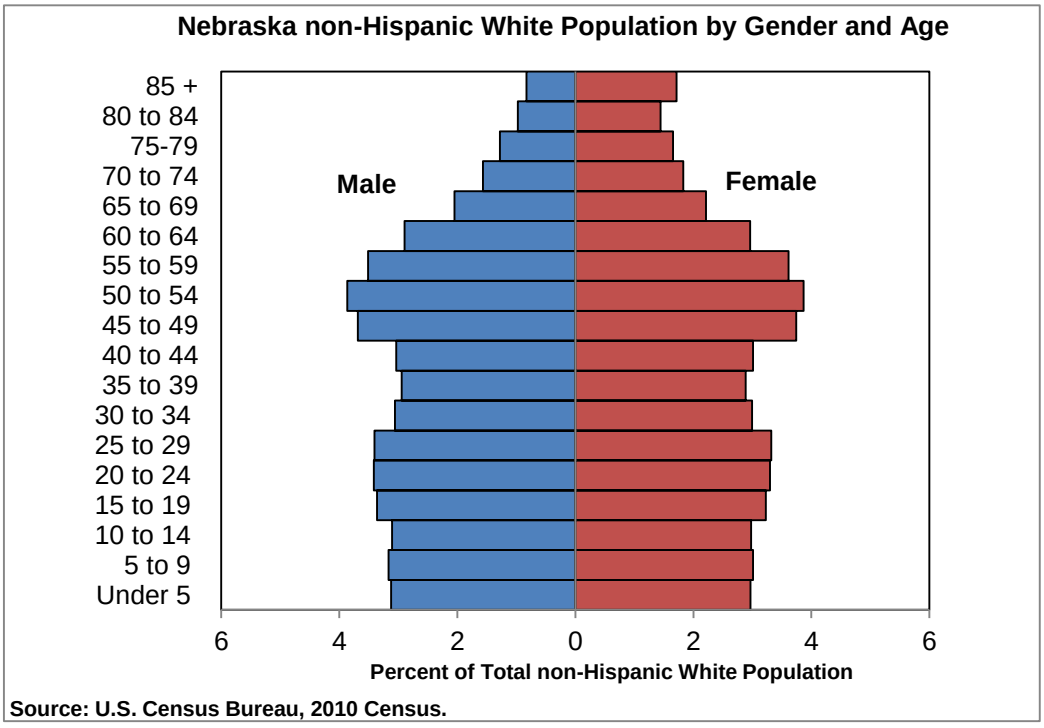
According to the U.S. Census Bureau, the total African American population in Nebraska was 82,885 in 2010. The map below illustrates the spread of this population over the different counties in Nebraska. The majority of the state's African American population lived in the counties of: Lancaster (9,920), Douglas (60,071) and Sarpy (6,321). Other counties with a population greater than 400 individuals were: Hall (1,023), Dawson (744), and Dakota (660).



African American Population by Age

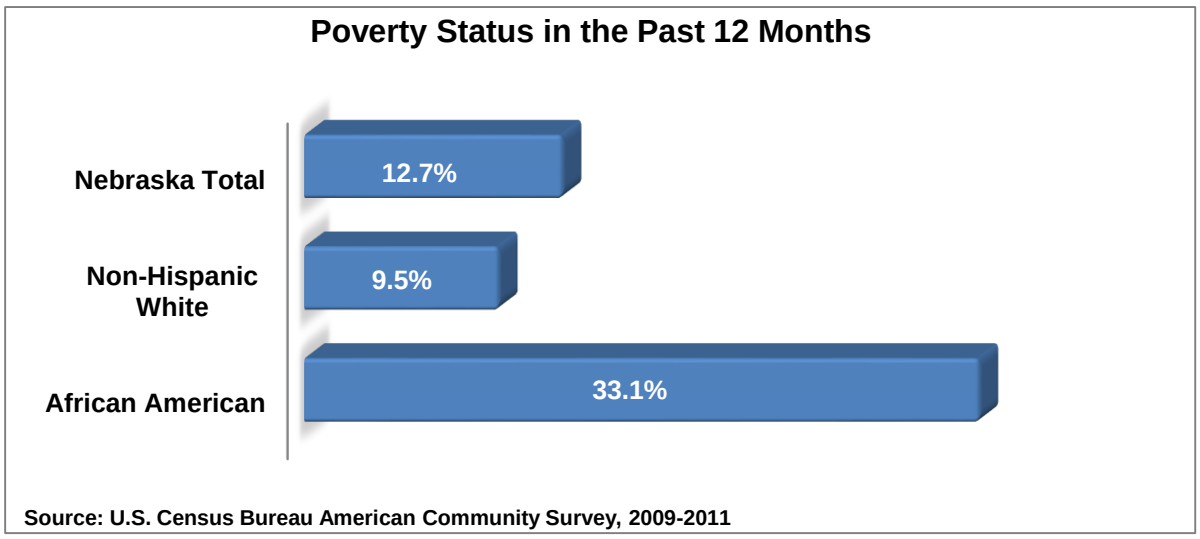
Compared with the non-Hispanic White population, African Americans had a larger proportion of young people and a smaller proportion of older people. In 2010, about 26% of the African American population was under 15 years old. About 77% of African Americans were younger than 45 (compared to 56% non-Hispanic Whites), while only 2.7% of African Americans were 65 and older (compared to 16% non-Hispanic White).





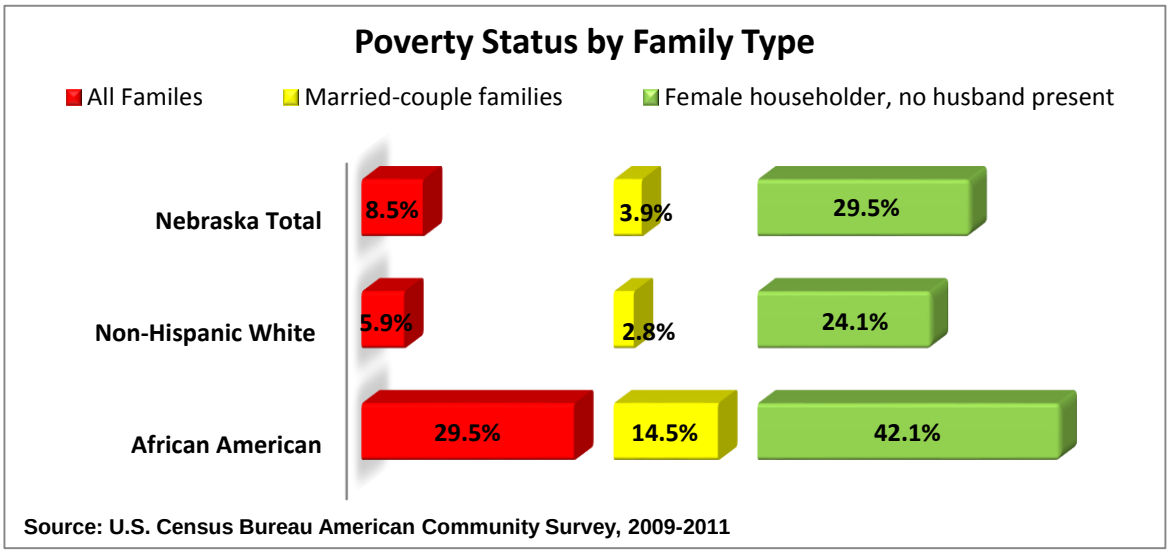
Poverty Status

The poverty rate was higher for African Americans than for non-Hispanic Whites. About 33% of African Americans were living below the poverty level in the 12 months prior to being surveyed, as compared to almost 10% of non-Hispanic Whites.



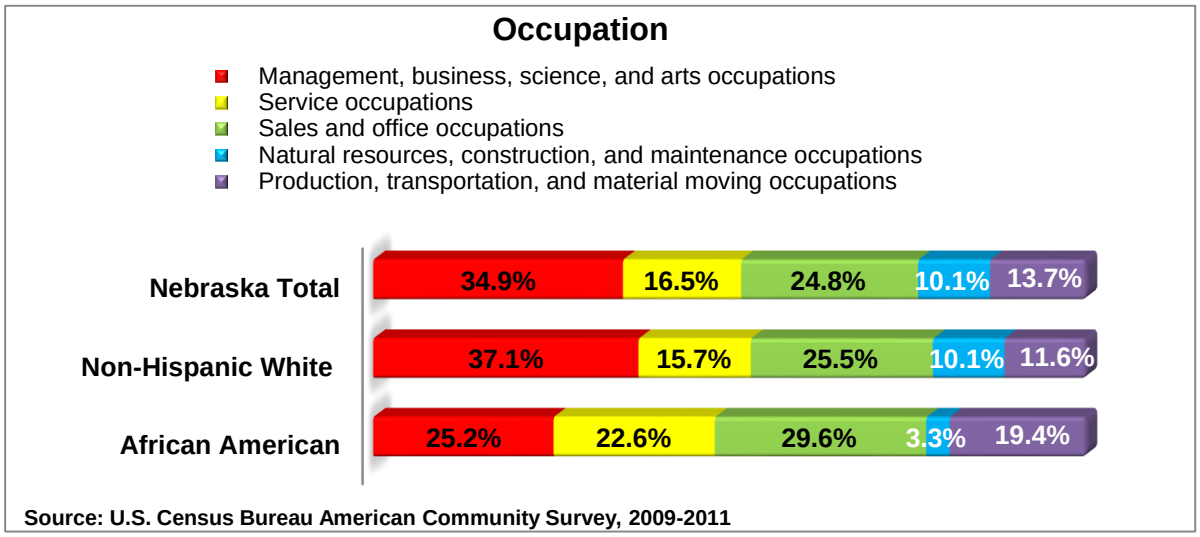
Poverty Status by Family Type

Approximately 30% of African American families are living in poverty, compared to 5.9% of non-Hispanic Whites. Twenty-four percent of non-Hispanic White female householders were living in poverty, while almost twice as many African American female householders with no husband present were living in poverty. Almost 15% of African American married-couple families were living in poverty, compared to 2.8% of non-Hispanic Whites.



Occupation

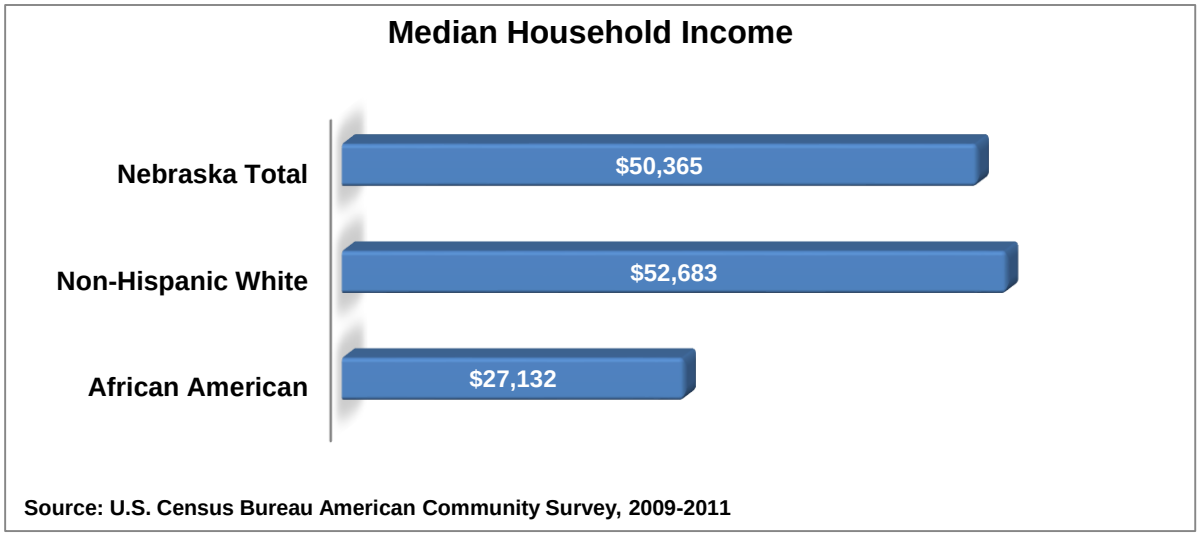
Twenty-five percent of African Americans worked in management, business, science, and arts occupations, compared to 37% of non-Hispanic Whites. Approximately 23% of African Americans worked in service occupations, compared to 15.7% non-Hispanic Whites.



Source: U.S. Census Bureau American Community Survey, 2009-2011

Median Household Income

The median annual income of African American households from the years of 2009 to 2011 was $27,132; this is nearly $25,551 less than the median income of non-Hispanic White households which was roughly $52,683.

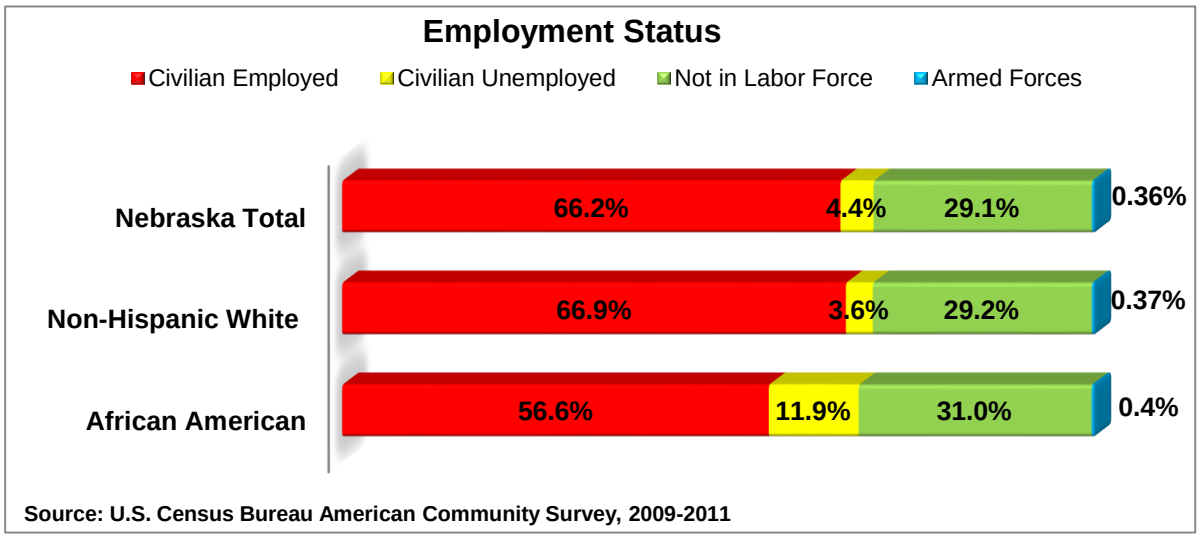


Source: U.S. Census Bureau American Community Survey, 2009-2011

Employment Status

A higher proportion (11.9%) of the African American population ages 16 years and older were unemployed, as compared to non-Hispanic Whites of the same age group (3.6%).

Between 2009 and 2011, about 56.6% of Nebraska African Americans ages 16 years and older were in the labor force. In comparison, almost 66.9% of non-Hispanic Whites 16 years and older were in the labor force.

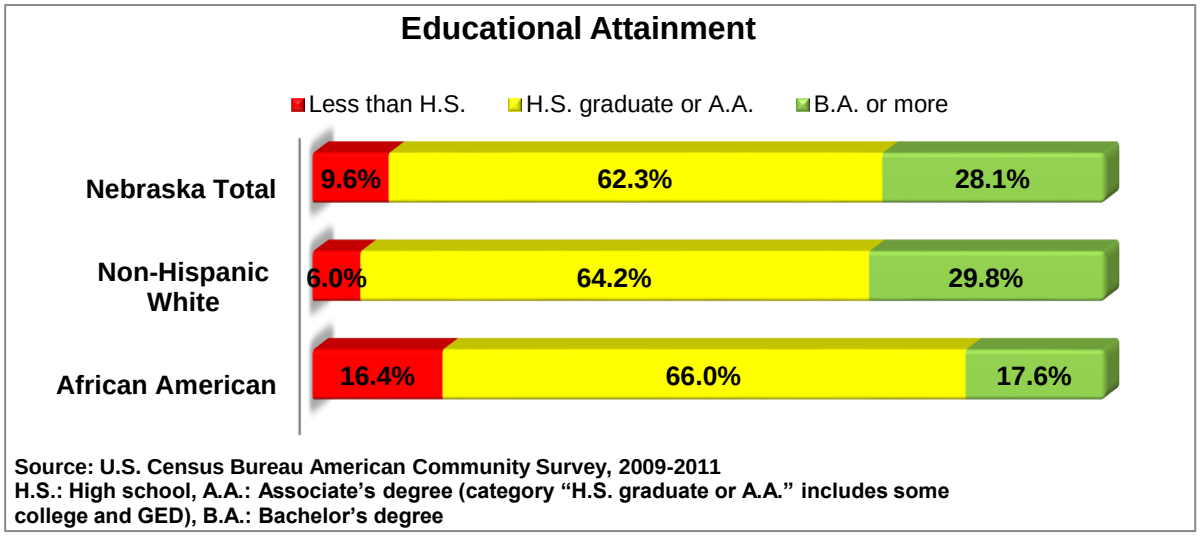


Source: U.S. Census Bureau American Community Survey, 2009-2011

Educational Attainment

Approximately 16% of African Americans ages 25 and older were not high school graduates, and 17.6% had a bachelor's degree or higher education.

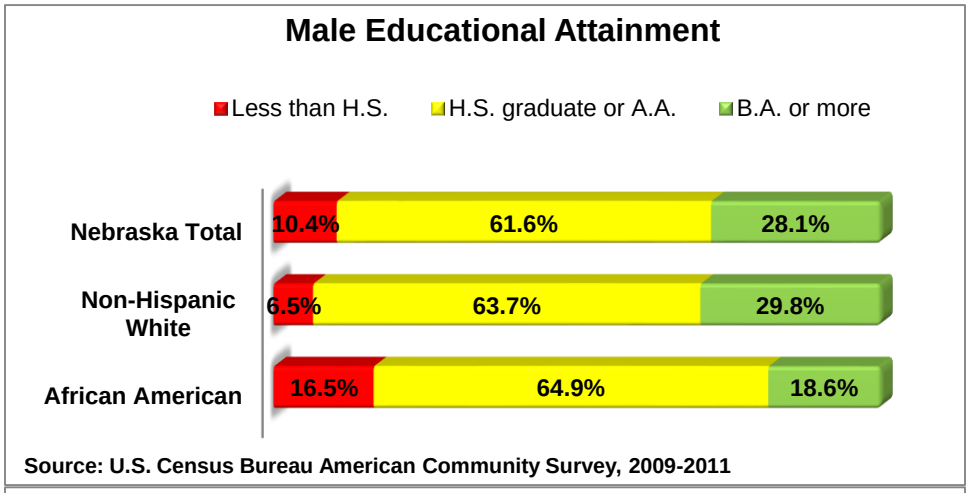
Among non-Hispanic Whites, ages 25 and older, about 6% were not high school graduates and about 30% had a bachelor's degree or higher education.



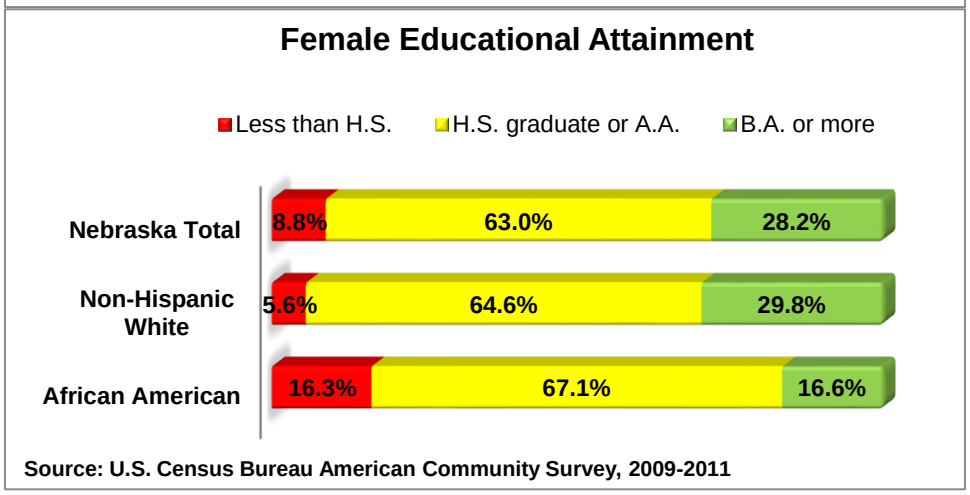
Source: U.S. Census Bureau American Community Survey, 2009-2011
H.S.: High school, A.A.: Associate's degree (category "H.S. graduate or A.A." includes some college and GED), B.A.: Bachelor's degree

Educational Attainment by Gender

Approximately 16% of both African American males and African American females have less than a high school education, compared to approximately 6% of non-Hispanic Whites. Slightly less African American females earned a bachelor's degree or more (16.6%) than African American males (18.6%); almost 30% of male and female non-Hispanic Whites have earned a bachelor's degree or more.



Source: U.S. Census Bureau American Community Survey, 2009-2011

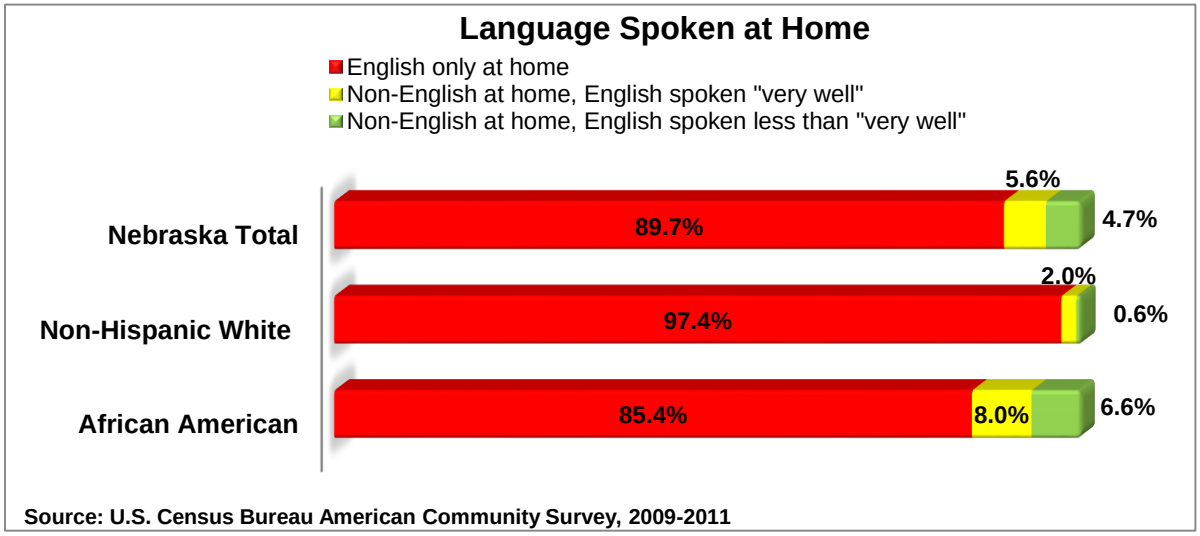


Source: U.S. Census Bureau American Community Survey, 2009-2011

*H.S.: High school, A.A: Associate's degree, B.A.: Bachelor's degree

Language Spoken at Home

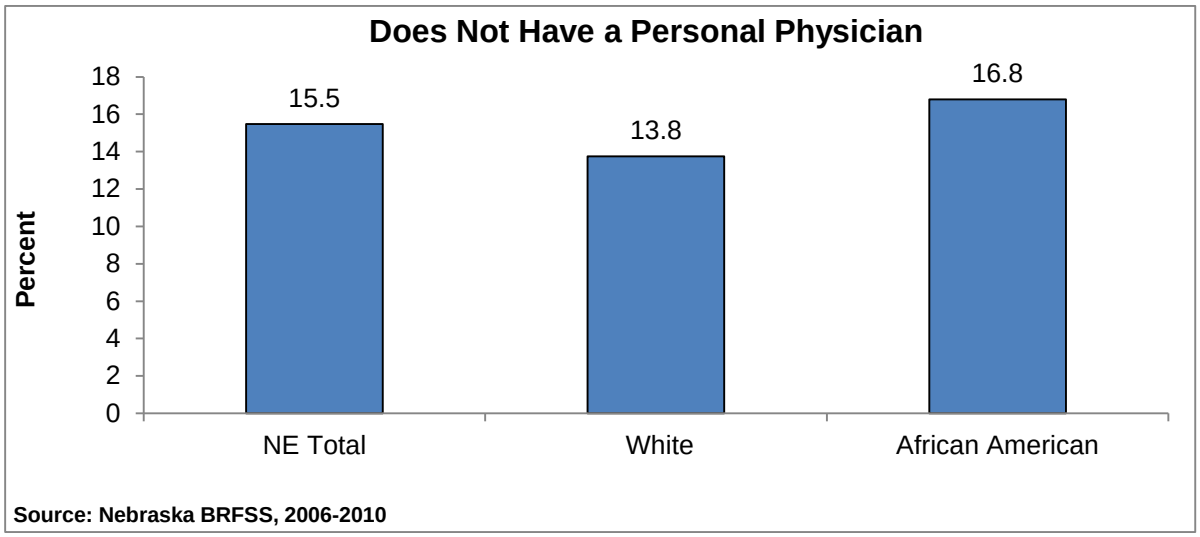
Approximately 85% of African Americans speak only English at home, compared to 97% of non-Hispanic Whites. Eight percent of African Americans do not speak English at home, but otherwise speak English very well. Almost 7% of African Americans do not speak English at home and do *not* speak English very well.



Access to Health Care

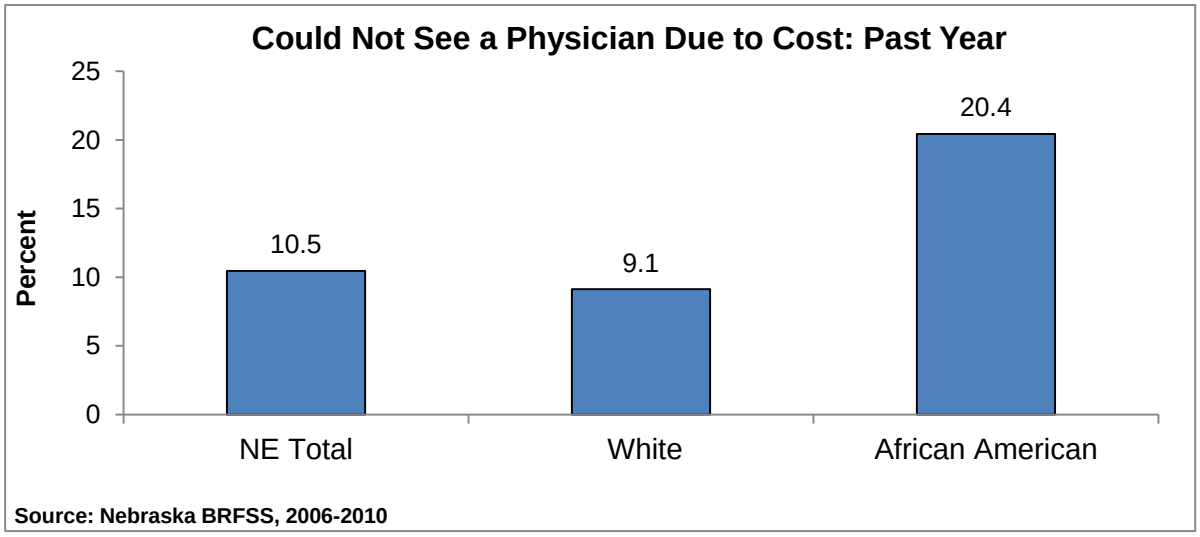
Does Not Have a Personal Physician

Altogether, 15.5% of Nebraska adults in 2006-2010 said they did not have a personal physician. African Americans (16.8%) experienced a higher percentage of not having a personal physician than Whites (13.8%).



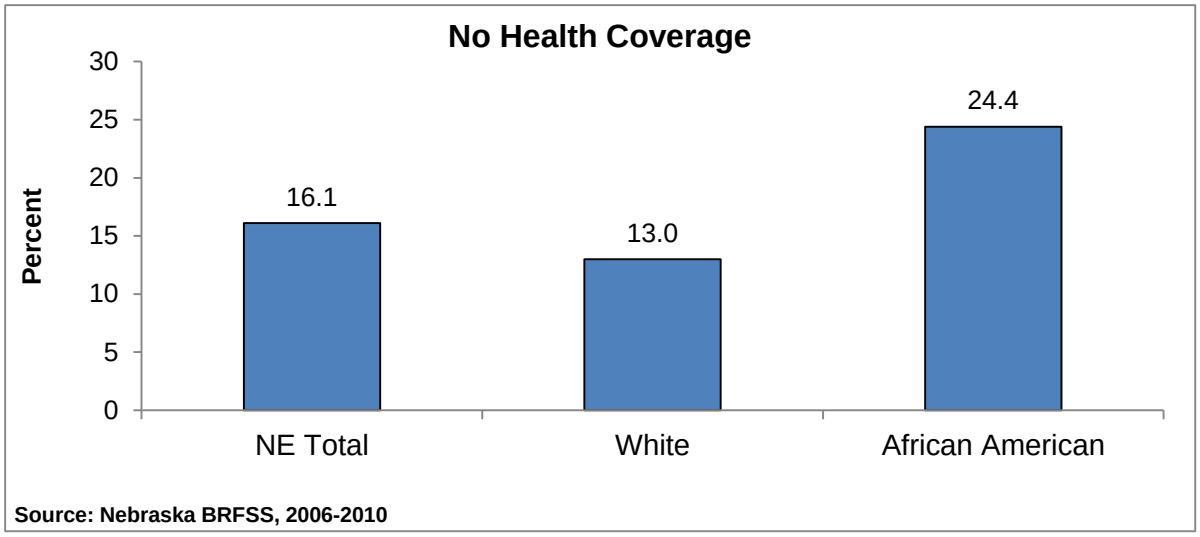
Could Not See Physician Due to Cost

Altogether, 10.5% of adults in Nebraska said they could not see a physician due to cost in the past 12 months of being surveyed. African Americans (20.4%) experienced much higher percentages of inability to see a physician due to cost than Whites (9.1%).



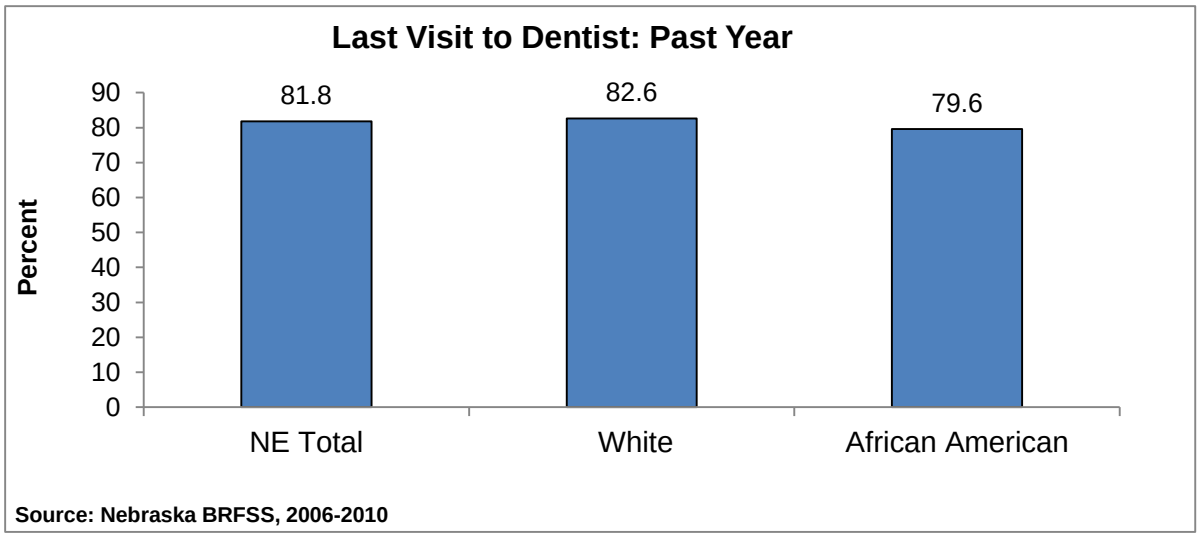
No Health Coverage

Approximately 25% of African Americans were uninsured between 2006-2010, compared to 13% of Whites and 16.1% of the Nebraska total.



Dentist Visit

Altogether, 81.8% of adults in Nebraska said they visited a dentist in the previous year. African Americans (79.6%) experienced lower percentages of visits to the dentist, within the last year, than Whites (82.6%).



Life Expectancy at Birth

The life expectancy at birth in 2008-2010 for African Americans was 73.7 years compared to 79.8 years for Whites. In 2008-2010, the life expectancy gap between African Americans and Whites was 6.1 years. The life expectancy for Whites has not changed much since 2003-2005, increasing from 79.2 to 79.8. Whereas there has been a steady increase in life expectancy at birth for the African American population during the same timeframe increasing from 72.2 to 73.7.

Life Expectancy at Birth: Nebraska Total

YEARS	*TOTAL/YRS*	*MALES/YRS*	*FEMALES/YRS*
2008-2010	79.8	77.6	82.0
2007-2009	79.4	77.0	81.6
2006-2008	79.2	76.7	81.6
2005-2007	79.2	76.7	81.6
2004-2006	79.3	76.7	81.8
2003-2005	79.0	76.5	81.3
2002-2004	78.6	76.2	81.0
Source: Nebraska DHHS Vital Statistics			

Life Expectancy at Birth: Whites

YEARS	*TOTAL/YRS*	*MALES/YRS*	*FEMALES/YRS*
2008-2010	79.8	77.5	82.0
2007-2009	79.7	77.3	81.9
2006-2008	79.5	77.0	81.9
2005-2007	79.5	77.0	81.9
2004-2006	79.5	76.9	82.0
2003-2005	79.2	76.8	81.6
2002-2004	78.9	76.4	81.2
Source: Nebraska DHHS Vital Statistics			

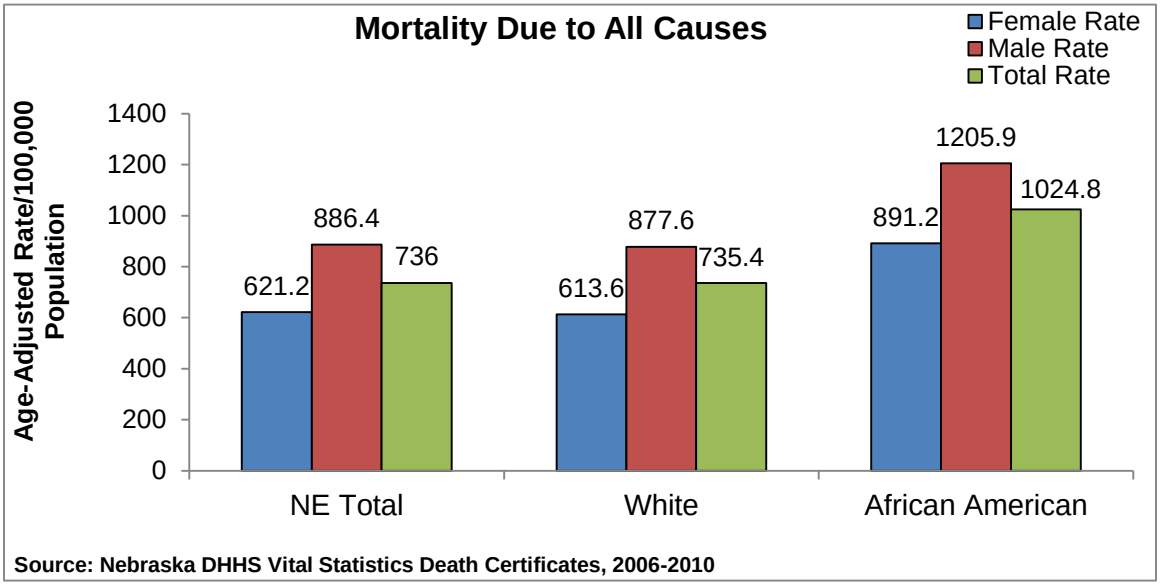
Life Expectancy at Birth: African American

YEARS	*TOTAL/YRS*	*MALES/YRS*	*FEMALES/YRS*
2008-2010	73.7	71.2	76.1
2007-2009	73.0	70.6	75.2
2006-2008	73.0	70.6	75.4
2005-2007	72.8	70.3	75.3
2004-2006	72.7	69.8	75.4
2003-2005	72.3	69.2	75.3
2002-2004	72.2	69.1	75.3
Source: Nebraska DHHS Vital Statistics			

Mortality

Mortality data acts as a mirror for current health problems, and suggests 'patterns of risk' across population sub-groups. Many causes of death are preventable or treatable, and therefore warrant the attention of public health prevention efforts. Mortality data is an important indicator of where federal, state, and local prevention efforts should be placed in building healthy communities. Mortality data is one of the best sources of information in relation to the health of communities.

The death rate from all causes is a key measure of health status across populations. An overview chart of the death rates from all causes for all ages is shown below. During the years 2006-2010, African American men were 1.4 times as likely to die from all death causes as White men. African American women were nearly 1.5 times as likely to die from all death causes as White women. African Americans were 39% more likely to die from all causes than Whites.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Leading Causes of Death for African Americans

The tables below show the leading causes of death by race and gender for both African Americans and Whites for the years 2006-2010. When looking at total death number, the top five leading causes of death break down as follows:

African Americans – cancer, heart disease, stroke, diabetes, and homicide

Whites –heart disease, cancer, stroke, chronic lung disease and unintentional injury

Leading Causes of Death: Total (2006-2010)					
Frequency	**Number (African Americans)**	**Percentage**	**Frequency**	**Number (Whites)**	**Percentage**
Cancer	569	22.0%	Heart	16,439	22.9%
Heart	492	19.0%	Cancer	16,293	22.6%
Stroke	156	6.0%	Stroke	4,192	5.8%
Diabetes	143	5.5%	Chronic Lung	4,187	5.8%
Homicide	119	4.6%	Unintentional Injury	3,213	4.5%
Unintentional Injury	111	4.3%	Alzheimer's	2,700	3.8%
Chronic Lung	73	2.8%	Diabetes	2,061	2.9%
Nephritis/Nephrosis	73	2.8%	Pneumonia	1,452	2.0%
Perinatal Conditions	67	2.6%	Nephritis/Nephrosis	1,235	1.7%
Other	788	30.4%	Other	20,168	28%
Total	2,591	100.0%	Total	71,940	100.0%

Leading Causes of Death for Males

African American Males – The top five causes of death are: cancer, heart disease, homicide, stroke, and unintentional injury. Homicide is the third leading cause of death for African American males, accounting for 7.6% of deaths.

White Males – The top five causes of death are: cancer, heart disease, chronic lung disease, unintentional injury, and stroke.

Leading Causes of Death: Males (2006-2010)					
Frequency	**Number (African Americans)**	**Percentage**	**Frequency**	**Number (Whites)**	**Percentage**
Cancer	286	21.3%	Cancer	8,539	24.7%
Heart	253	18.9%	Heart	7,978	23.1%
Homicide	102	7.6%	Chronic Lung	2,136	6.2%
Stroke	67	5.0%	Unintentional Injury	1,891	5.5%
Unintentional Injury	67	5.0%	Stroke	1,645	4.8%
Diabetes	57	4.3%	Diabetes	996	2.9%
Chronic Lung	40	3.0%	Alzheimer's	783	2.3%
Perinatal Condition	39	2.9%	Suicide	725	2.1%
Nephritis/Nephrosis	30	2.2%	Pneumonia	633	1.8%
Other	399	29.8%	Other	9,284	26.8%
Total	1,340	100.0%	Total	34,610	100.0%

Leading Causes of Death for Females

African American Females – cancer, heart disease, stroke, diabetes, and unintentional injury are the top five causes of death.

White Females – heart disease, cancer, stroke, chronic lung disease, and Alzheimer's are the top five.

Leading Causes of Death: Females (2006-2010)					
Frequency	**Number (African Americans)**	**Percentage**	**Frequency**	**Number (Whites)**	**Percentage**
Cancer	283	22.6%	Heart	8,461	22.7%
Heart	239	19.1%	Cancer	7,754	20.8%
Stroke	89	7.1%	Stroke	2,547	6.8%
Diabetes	86	6.9%	Chronic Lung	2,051	5.5%
Unintentional Injury	44	3.5%	Alzheimer's	1,917	5.1%
Nephritis/Nephrosis	43	3.4%	Unintentional Injury	1,322	3.5%
Chronic Lung	33	2.6%	Diabetes	1,065	2.9%
Alzheimer's	28	2.2%	Pneumonia	819	2.2%
Perinatal Conditions	28	2.2%	Nephritis/Nephrosis	630	1.7%
Other	378	30.2%	Other	10,763	28.8%
Total	1,251	100.0%	Total	37,329	100.0%

Mortality by Age

Homicide is the leading cause of death among African Americans between ages of 15 to 34, and it shifts to cancer between the ages of 45 to 65+. Heart disease is the second leading cause of death among 45 to 65+ year olds. Among 15 to 34 year olds, unintentional injury ranks as second leading cause of death. SIDS is the number one killer of infants, followed by short gestation and congenital anomalies.

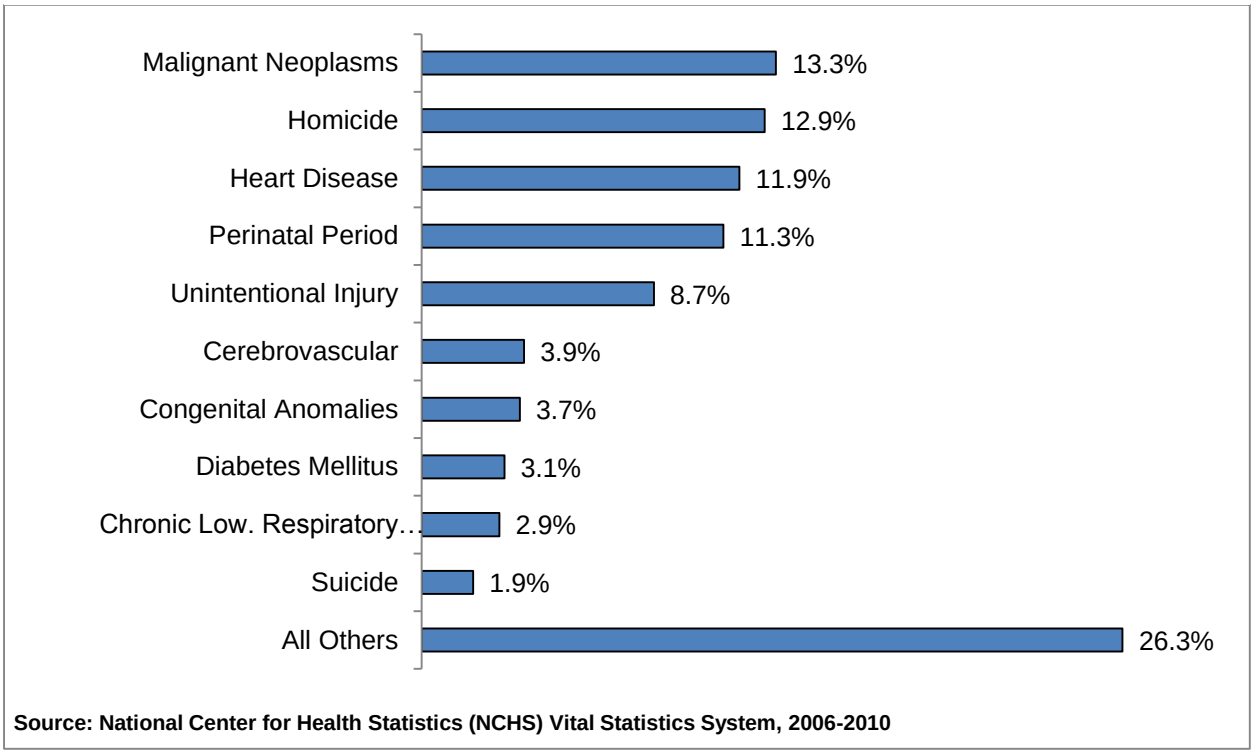
Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	SIDS 43	Unintentional Injury ---	Unintentional Injury ---	Chronic Low. Respiratory Disease ---	Homicide 90	Homicide 56	Heart Disease 68	Malignant Neoplasms 171	Malignant Neoplasms 234	Malignant Neoplasms 634	Malignant Neoplasms 1,101
2	Short Gestation 37	Homicide ---	Malignant Neoplasms ---	Heart Disease ---	Unintentional Injury 35	Unintentional Injury 32	Malignant Neoplasms 35	Heart Disease 141	Heart Disease 155	Heart Disease 603	Heart Disease 1,003
3	Congenital Anomalies 29	Malignant Neoplasms ---	Chronic Low. Respiratory Disease ---	Homicide ---	Suicide 12	Heart Disease 20	Unintentional Injury 34	Cerebrovascular 51	Cerebrovascular 56	Cerebrovascular 193	Cerebrovascular 324
4	Maternal Pregnancy Comp. 6	Congenital Anomalies ---	Homicide ---	Congenital Anomalies ---	Heart Disease ---	Suicide 12	Homicide 24	Unintentional Injury 33	Diabetes Mellitus 51	Diabetes Mellitus 182	Diabetes Mellitus 277
5	Placenta Cord Membranes ---	Perinatal Period ---	Influenza & Pneumonia ---	Unintentional Injury ---	Malignant Neoplasms ---	HIV 10	HIV 17	Diabetes Mellitus 26	Chronic Low. Respiratory Disease 36	Chronic Low. Respiratory Disease 114	Homicide 203
6	Respiratory Distress ---	Anemias ---	---	Malignant Neoplasms ---	Chronic Low. Respiratory Disease ---	Malignant Neoplasms 10	Cerebrovascular 13	Chronic Low. Respiratory Disease 22	Nephritis 28	Nephritis 99	Unintentional Injury 203
7	Influenza & Pneumonia ---	Cerebrovascular - - -	---	---	Cerebrovascular ---	Diabetes Mellitus ---	Diabetes Mellitus 11	HIV 17	Hypertension 17	Alzheimer's Disease 76	Chronic Low. Respiratory Disease 196
8	Homicide ---	Heart Disease ---	---	---	Complicated Pregnancy ---	Anemias ---	Nephritis ---	Liver Disease 16	Septicemia 16	Hypertension 57	Nephritis 154
9	Necrotizing Enterocolitis ---	Meningitis ---	---	---	---	Cerebrovascular ---	Chronic Low. Respiratory Disease ---	Nephritis 15	Unintentional Injury 15	Septicemia 41	Perinatal Period 129
10	Unintentional Injury ---	---	---	---	---	Chronic Low. Respiratory Disease ---	Suicide ---	Septicemia 14	Viral Hepatitis 11	Influenza & Pneumonia 40	Hypertension 85

Source: National Center for Health Statistics, National Vital Statistics System
Note: '---' indicates less than 10 cases

Years of Potential Life Lost

In this report, years of life lost is based on potential life span of 75 years. Cancer/malignant neoplasms (13.3%) was the leading cause of life lost among African Americans between 2006-2010 in Nebraska followed closely by homicide (12.9%). Approximately 12% of total years of life lost are due to heart disease, while 11% occurred in the perinatal period.

Years of Potential Life Lost for African Americans



Source: National Center for Health Statistics (NCHS) Vital Statistics System, 2006-2010

Years of Potential Life Lost by Cause of Death for African Americans

Causes of Death	YPLL	Percent
All Causes	45,664	100%
Malignant Neoplasms	6,076	13.3%
Homicide	5,883	12.9%
Heart Disease	5,451	11.9%
Perinatal Period	5,173	11.3%
Unintentional Injury	3,982	8.7%
Cerebrovascular	1,759	3.9%
Congenital Anomalies	1,686	3.7%
Diabetes Mellitus	1,421	3.1%
Chronic Low. Respiratory Disease	1,333	2.9%
Suicide	882	1.9%
All Others	12,018	26.3%

Source: National Center for Health Statistics (NCHS) Vital Statistics System, 2006-2010

Chronic Disease

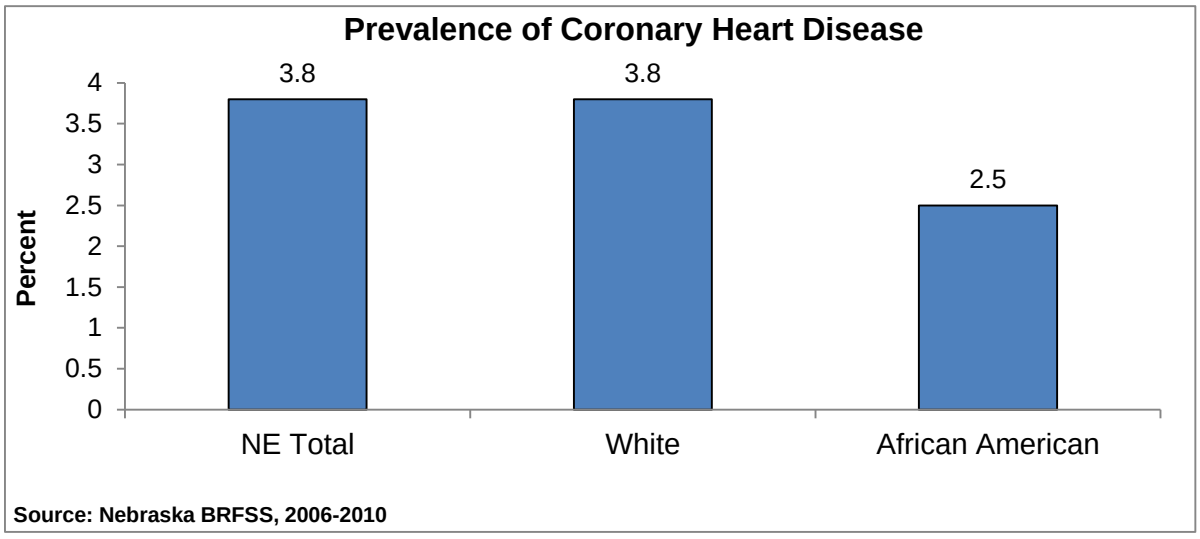
During the 20th century, chronic diseases replaced infectious diseases (e.g., pneumonia, tuberculosis, and diarrhea) as leading causes of death in the United States. Chronic diseases – including all cardiovascular diseases, all cancers, diabetes mellitus, and chronic lower respiratory diseases – accounted for a large portion of all deaths among Nebraska residents during 2006-2010.

Heart Disease

Cardiovascular disease involves the body's vascular or circulatory system, which is responsible for supplying oxygen and nutrients to the organs and cells. Heart disease and cerebrovascular disease or stroke are the major cardiovascular diseases and leading causes of death in Nebraska.

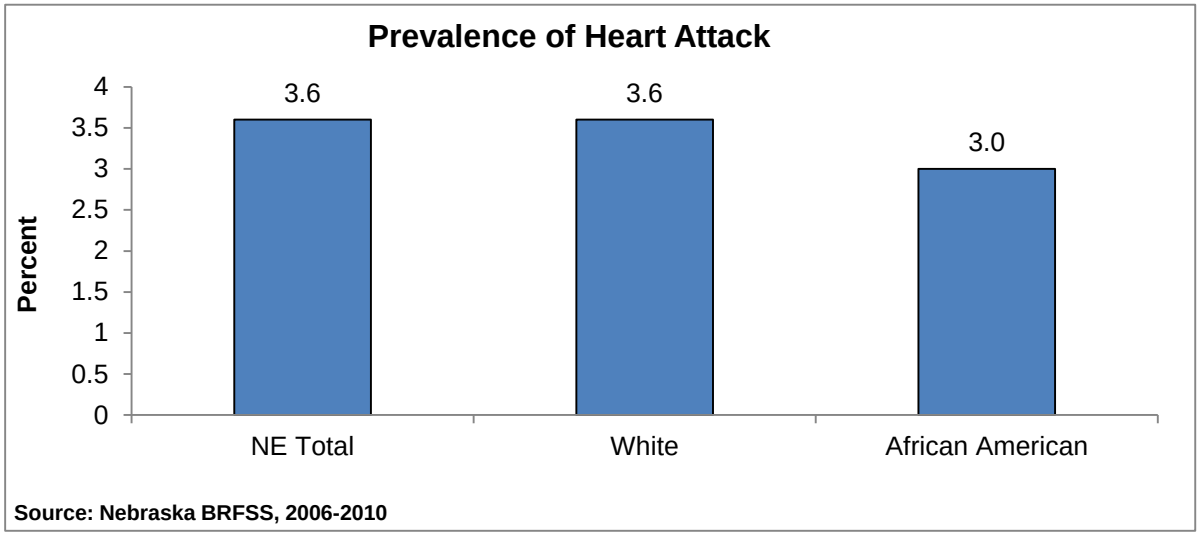
Prevalence of Coronary Heart Disease

Almost 4% of Whites had coronary heart disease in 2006-2010, compared to 2.5% of African Americans.



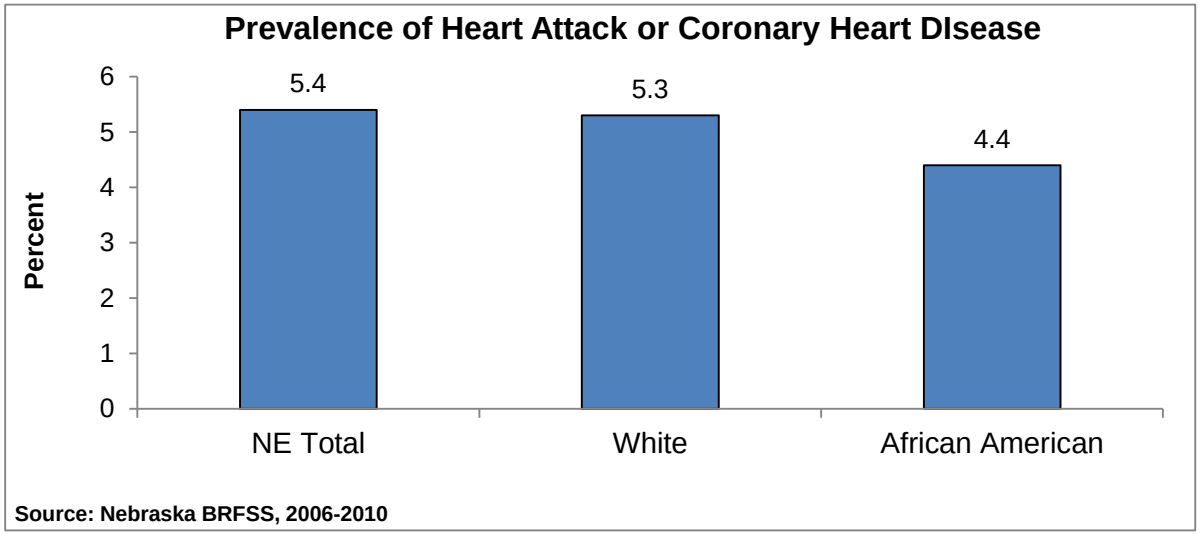
Prevalence of Heart Attack

Three percent of Nebraska African Americans had been told by a health professional that they had had a heart attack, compared to 3.6% of Whites.



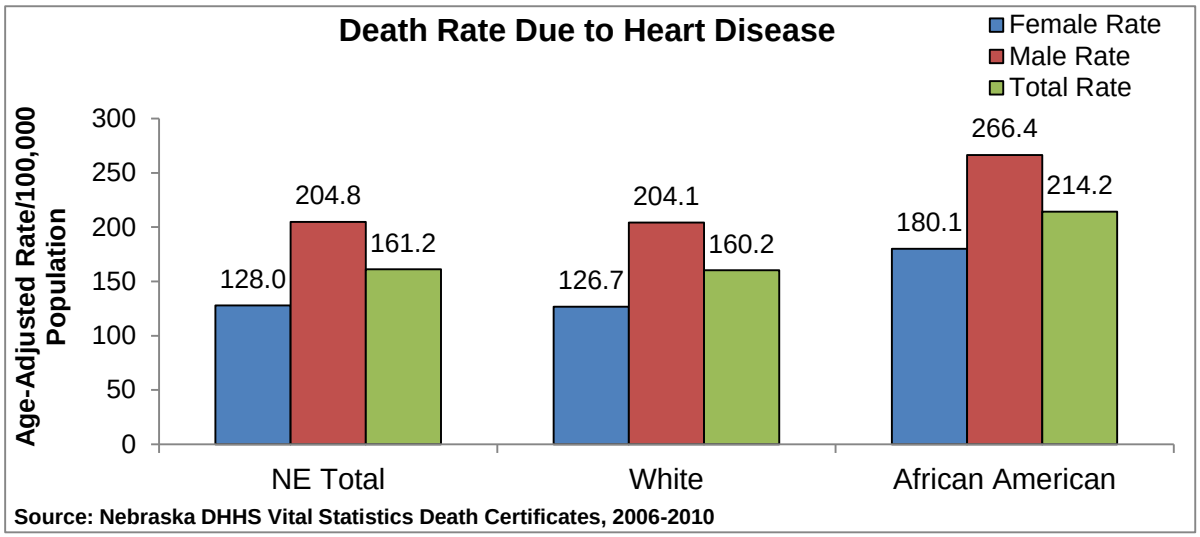
Prevalence of Heart Attack or Coronary Heart Disease

Almost 4.5% of African American Nebraskans have been told by a health professional that they have had a heart attack or that they have heart disease, compared to 5.3% of Whites.



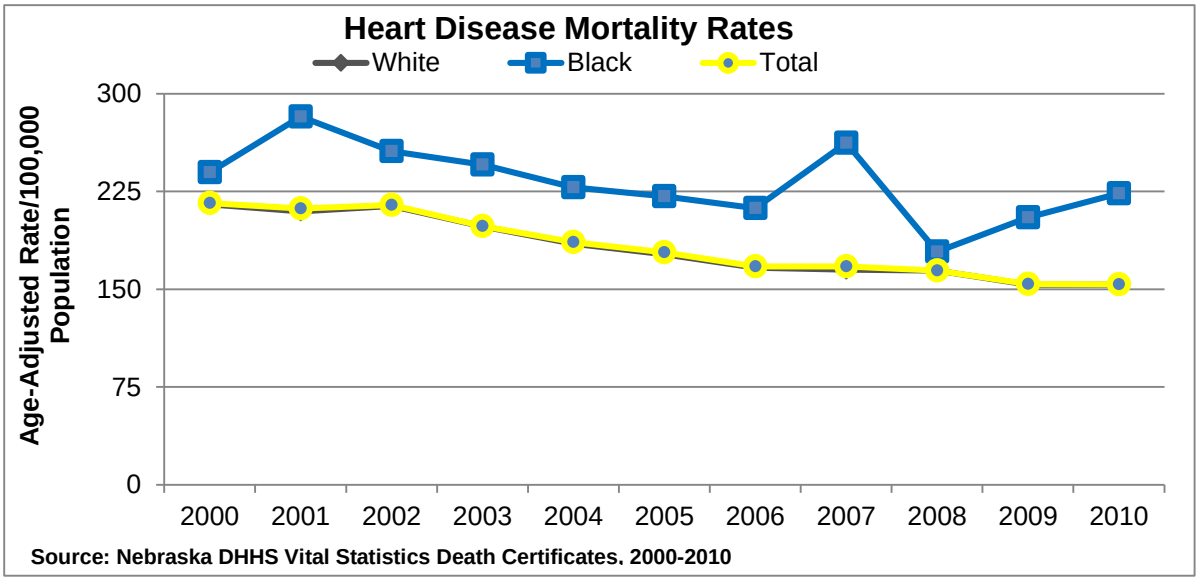
Heart Disease Mortality

In 2006-2010, African American males were 1.3 times more likely to die from heart disease, as compared to White males. African American females were 1.4 times more likely as White females to die from heart disease.



Heart Disease Mortality: Trends

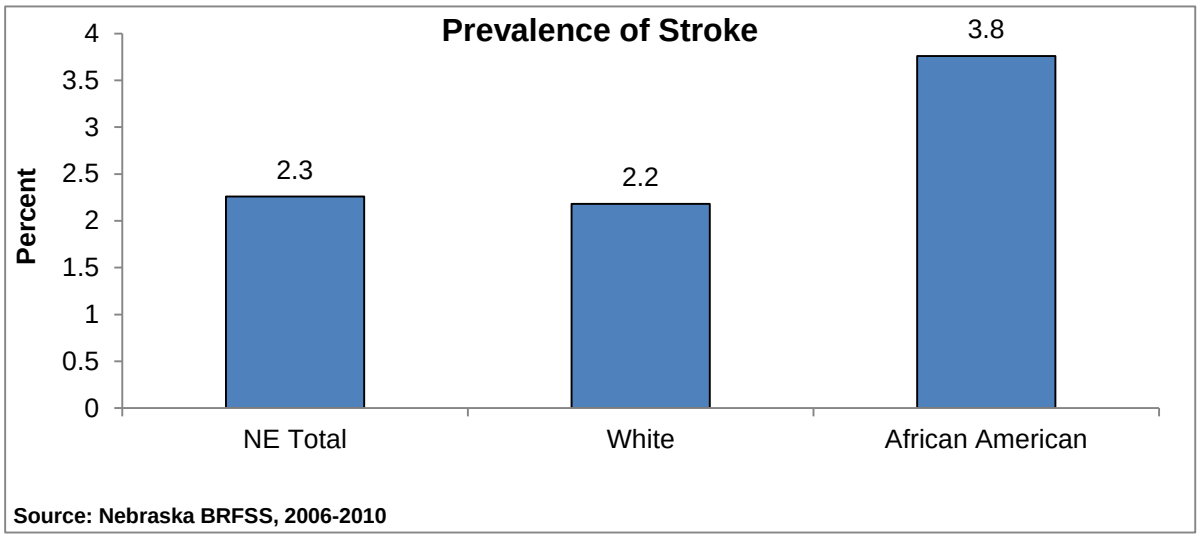
Looking at heart disease mortality data from years 2000 to 2010, there is a downward trend in deaths for African Americans. While both African American and White trend lines show a downward trend, there remains a gap in death rate due to heart disease between the two populations groups. African Americans experience higher death rates due to heart disease than Whites, which is very similar to that of the Nebraska total.



Stroke

Prevalence of Stroke

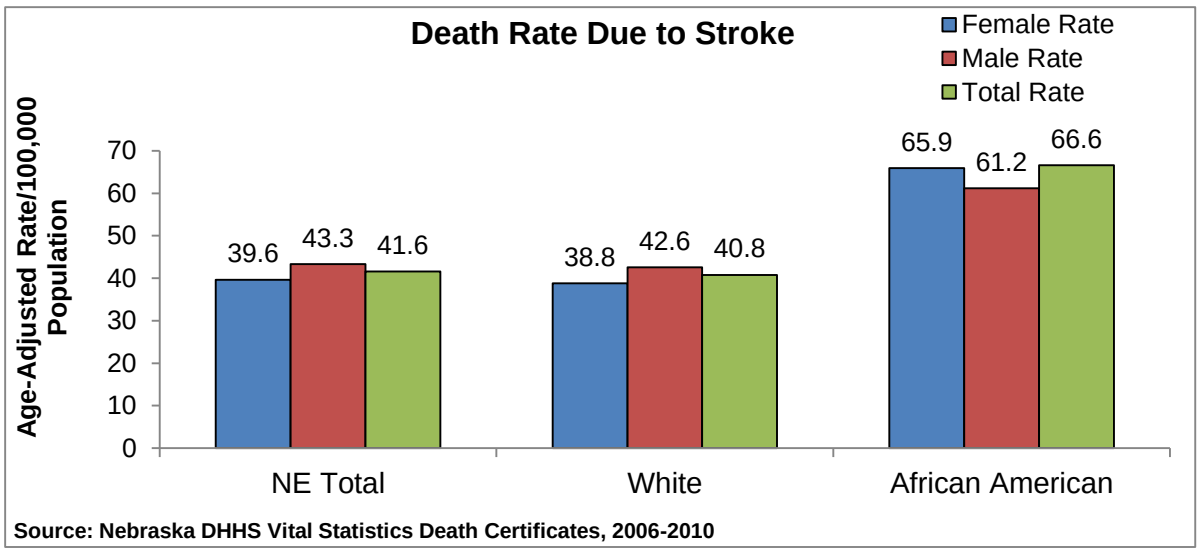
Stroke is the most severe clinical manifestation of cerebrovascular disease. Almost 4% of African Americans experienced a stroke between 2006 and 2010, compared to 2.2% of Whites.



Source: Nebraska BRFSS, 2006-2010

Stroke Mortality

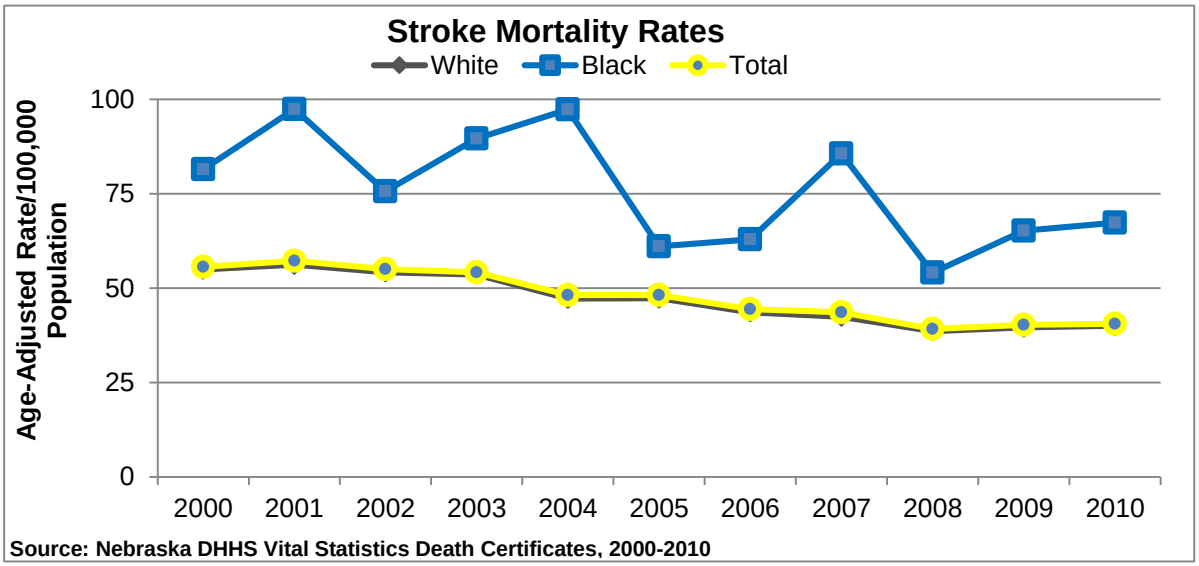
From 2006-2010, African American males were 44% more likely than their White counterparts to have a stroke. African American females were 70% more likely to die from a stroke than their White female counterparts. As a group, African Americans were 66.6% more likely as Whites to die from stroke.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Stroke Mortality: Trends

Stroke mortality data from year 2000-2010 shows that Whites as well as the total Nebraska population experienced a steady decline in death rates, where African Americans experienced a more cyclical decline-rebound pattern. Generally, stroke has declined for African Americans and Whites alike. Stroke mortality rates do remain higher among African Americans as compared to Whites.

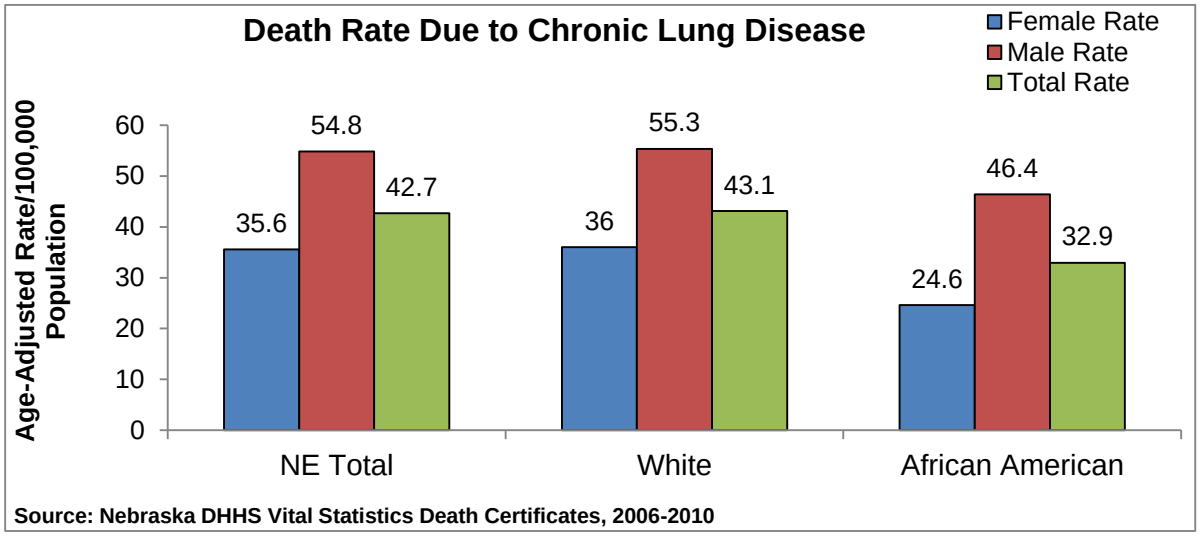


Source: Nebraska DHHS Vital Statistics Death Certificates, 2000-2010

Chronic Lung Disease

Chronic Lung Disease Mortality

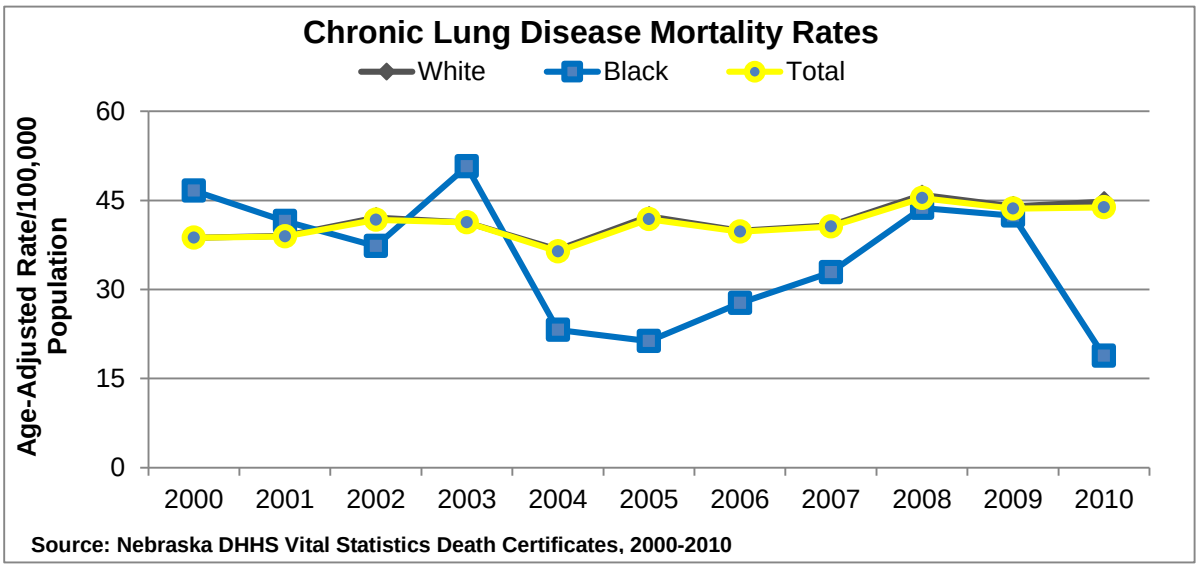
For 2006-2010, African American males had a lower mortality rate than White males due to chronic lung disease. African American females were also less likely to die from chronic lung disease than White females. African Americans were 23.7% less likely to die from chronic lung disease as Whites.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Chronic Lung Disease Mortality: Trends

From year 2000-2010 there was a decrease in death rates associated with chronic lung disease among African Americans. There has been a steady increase in the death rate for Whites. The trends for the White and total Nebraska populations were very similar.

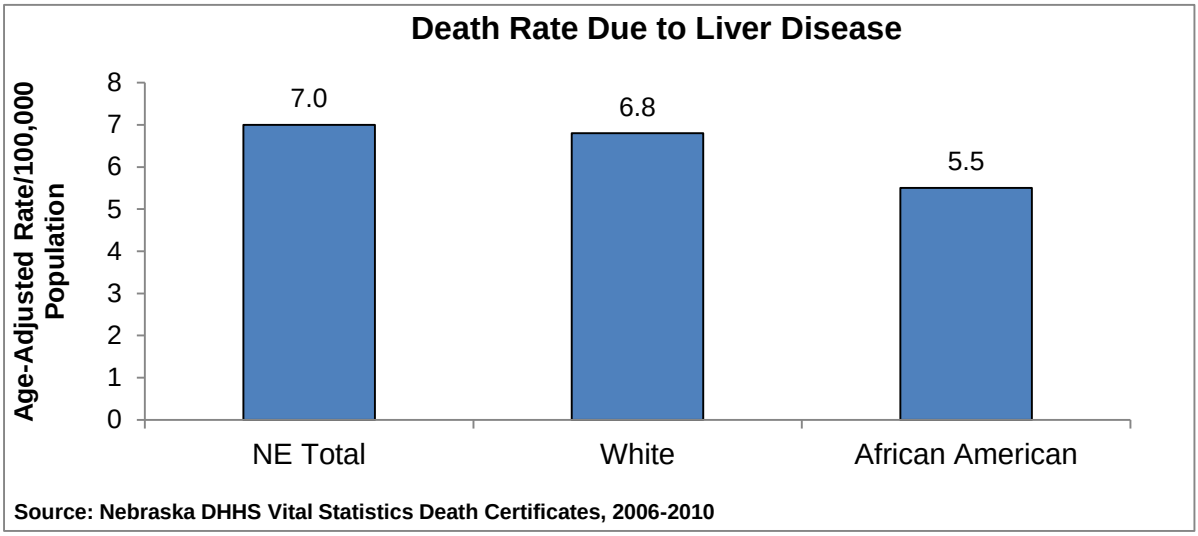


Source: Nebraska DHHS Vital Statistics Death Certificates, 2000-2010

Liver Disease

Liver Disease Mortality

African American Nebraskans experience a 5.5/100,000 population death rate for liver disease, compared to 6.8/100,000 population among Whites.

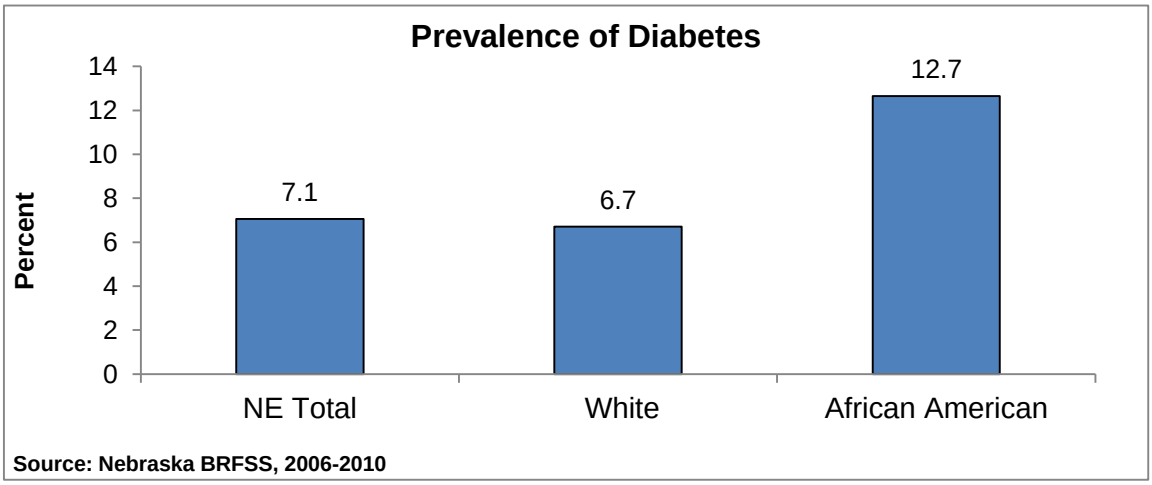


Diabetes

Diabetes mellitus is characterized by high levels of blood glucose, which result from deficient insulin production and/or insulin action.

Prevalence of Diabetes

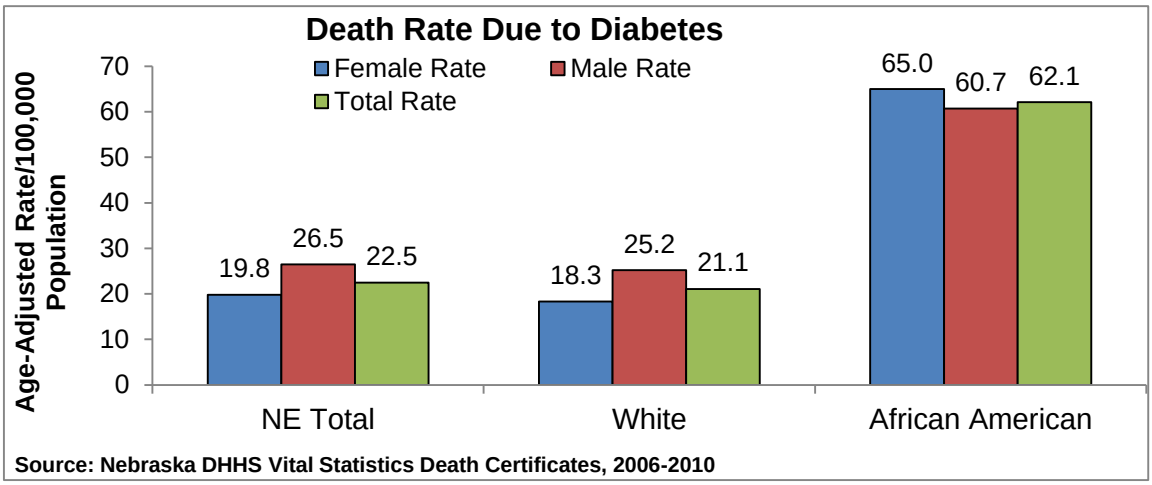
Respondents were asked “Have you ever been told by a doctor that you have diabetes?” Women with presence of gestational diabetes during their pregnancy were not included in this measure. Altogether, 7.1 % of adults in the 2006-2010 BRFSS reported that a doctor had told them they have diabetes. African Americans (12.7%) experienced significantly higher rates of diagnosed diabetes than Whites (6.7%).



Source: Nebraska BRFSS, 2006-2010

Diabetes Mortality

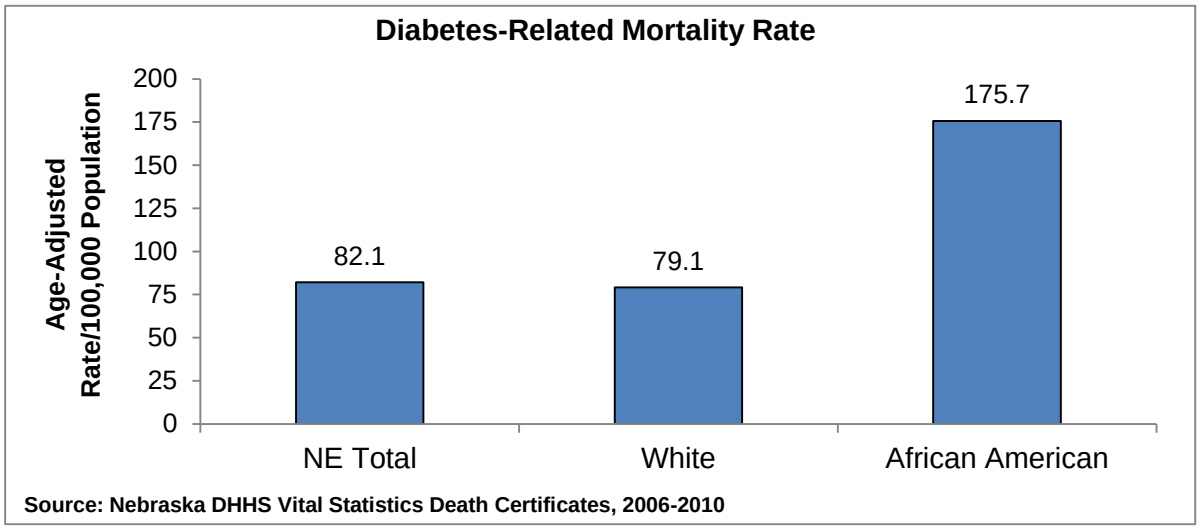
From 2006-2010, the diabetes death rates were much higher for both African American males and females as compared with those of Whites. African American males were about 2.4 times more likely than White males to die from diabetes. African American females had more than three times the death rate in contrast to White females. African Americans were almost three times more likely to die from diabetes compared to Whites.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Diabetes-Related Mortality

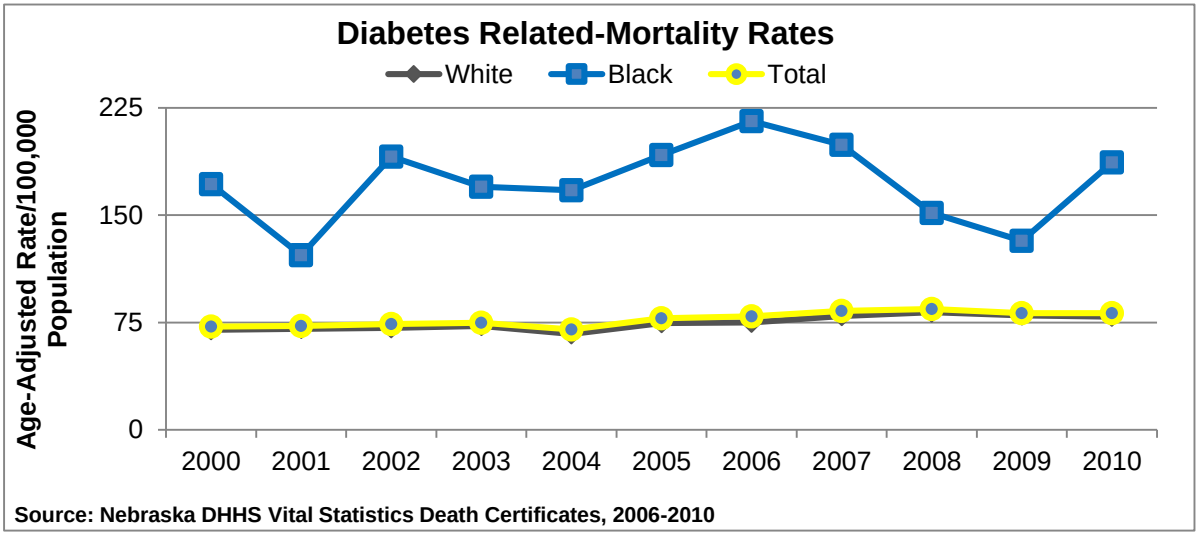
Diabetes is associated with serious complications and premature death, and people with diabetes are at increased risk for many adverse health outcomes, including heart disease and stroke. Most people with diabetes die from related complications rather than the disease itself. During 2006-2010, diabetes related death rates among African Americans (175.7/100,000) were more than double that of Whites (79.1/100,000).



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Diabetes-Related Mortality: Trends

Diabetes mortality data shows that both African Americans and Whites have a steady increase in death rates during the 2000-2010 timeframe. Although mortality rates due to diabetes show an upward trend among both groups, African Americans have a higher death rate per 100,000 population due to the disease. The trends for the White and overall Nebraska populations were similar.



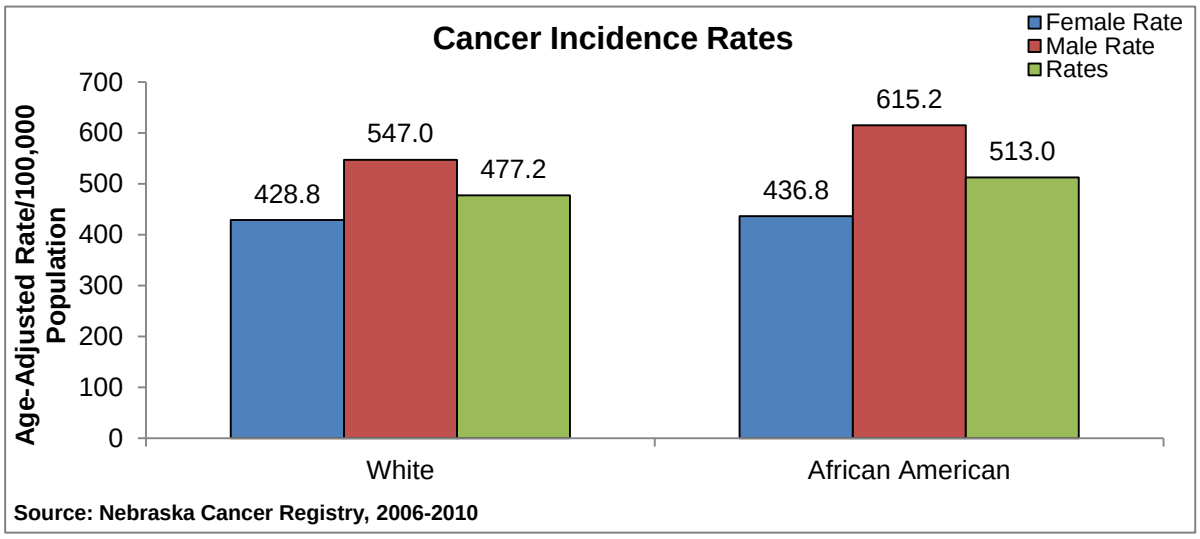
Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Cancer

Cancer Incidence

Generally, African Americans (513/100,000) experience higher cancer incidence than Whites (477.2/100,000).

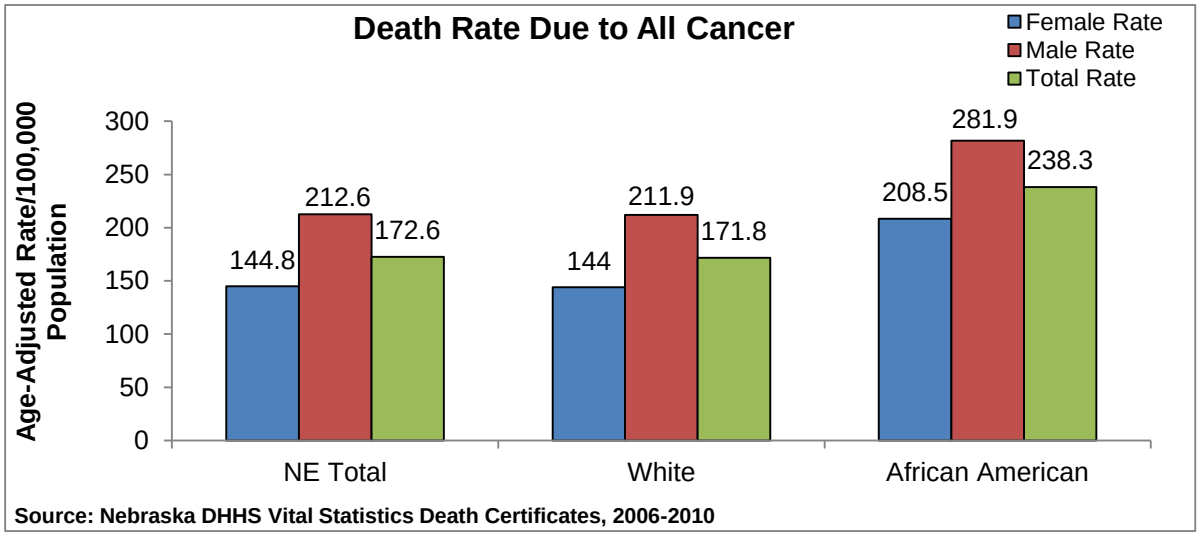
Also, females see lower rates of cancer among both Whites and African Americans.



Source: Nebraska Cancer Registry, 2006-2010

Cancer Mortality

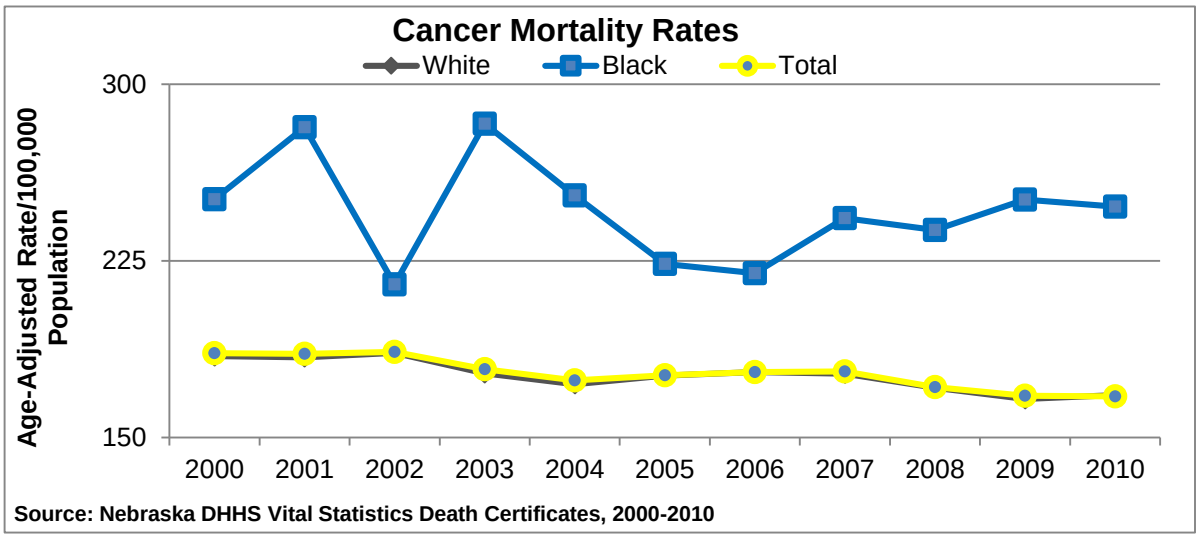
The figure below shows the death rate of all cancers for African Americans and Whites during 2006-2010. African American males were 33% more likely to die from all cancer cases than White males. African American females were 45% more likely to die from cancer in contrast to White females.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Cancer Mortality: Trends

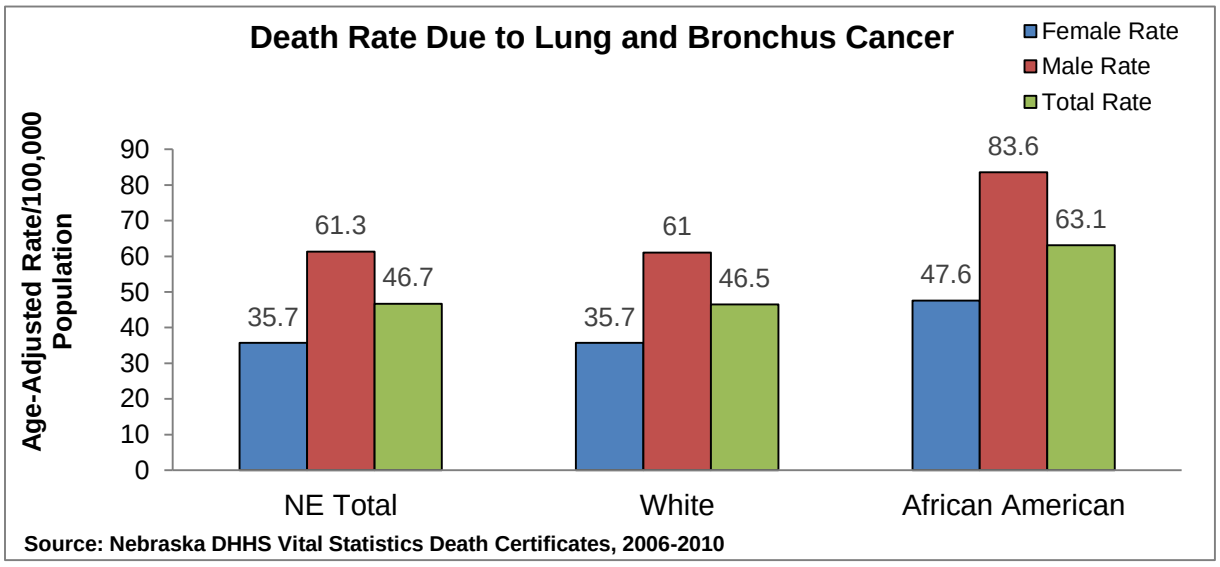
Cancer mortality data from 2000 to 2010 shows that both African Americans and Whites have a decline in death rates during the timeframe. However, cancer mortality rates remain higher among African Americans compared to Whites and the total Nebraska population.



Lung and Bronchus Cancer Mortality

African American men experienced a lung and bronchus cancer death rate of 83.6/100,000 population in 2006-2010, compared to 61/100,000 of White men.

A total of 47.6/100,000 of African American females died from lung or bronchus cancer, compared to 35.7/100,000 White women.



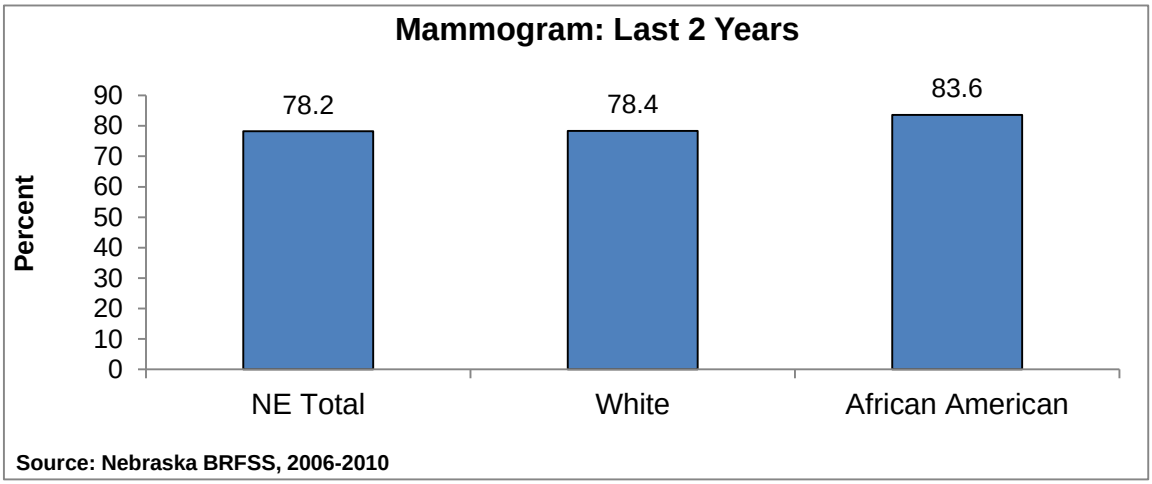
Cancer Screening

Mammogram

Women in the BRFSS survey were read a statement describing a mammogram as an “x-ray of each breast to look for breast cancer.” They were then asked if they had a mammogram in the past two years.

Mammogram: Women 50-74

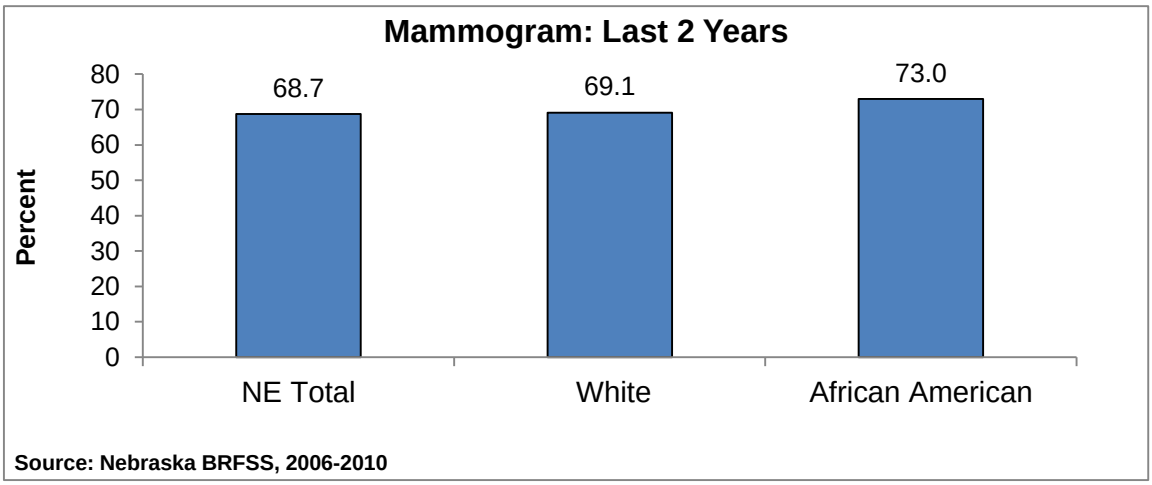
Recently, it has been scientifically suggested that only women between the ages of 50 and 74 need to have mammograms, as opposed to 40+ years old (illustrated at the bottom of the page). Almost 84% of African American women between the ages of 50 and 74 had a mammogram in the last 2 years, compared to 78.4% of White women of the same age.



Source: Nebraska BRFSS, 2006-2010

Mammogram: Women 40+

During the period of 2006-2010, 73% of African American women ages 40 and older had a mammogram in the past two years, as compared to 69.1% of White women. As such, African American women over the age of 40 were more likely to have a mammogram.



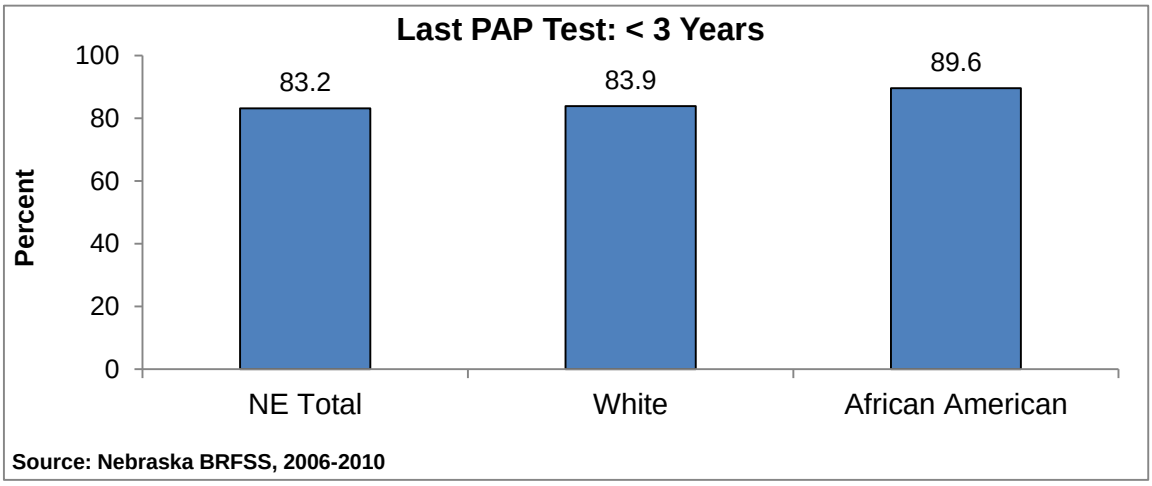
Source: Nebraska BRFSS, 2006-2010

Pap Test

Women in the BRFSS survey were given the definition of a pap test as, “a test for cancer of the cervix,” then asked if they “Ever had a pap test in past three years?”

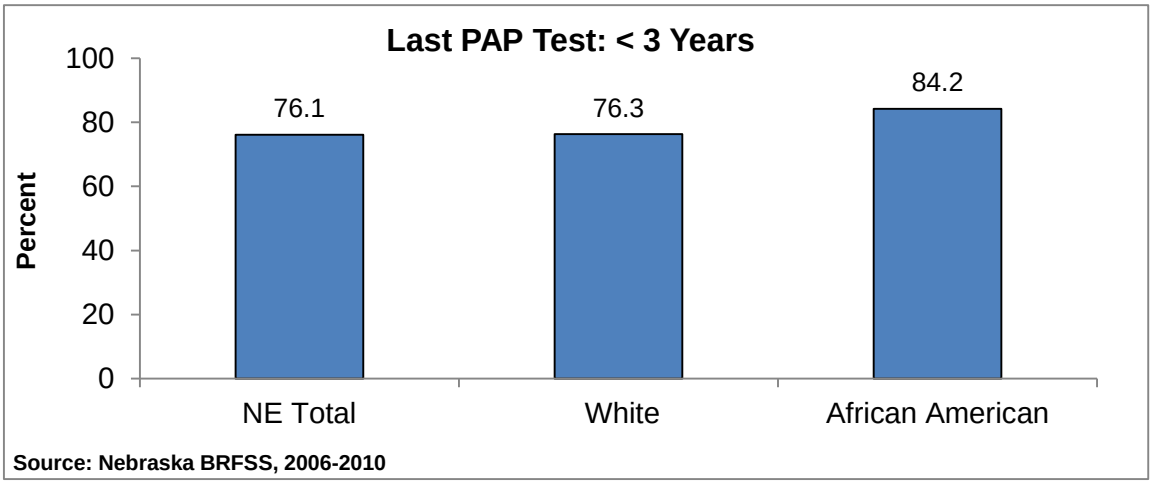
Pap Test: Women 21-64

Recently it has been scientifically suggested that only women between the ages of 21 and 64 need to get a pap test, as opposed to 18+ years old (illustrated at the bottom of the page). Almost 90% of African Americans between 21 and 64 had received a pap test within the last 3 years.



Pap Test: Women 18+

During the period of 2006-2010, African American women, ages 18 and older were more likely to have pap test in the past 3 years or less.

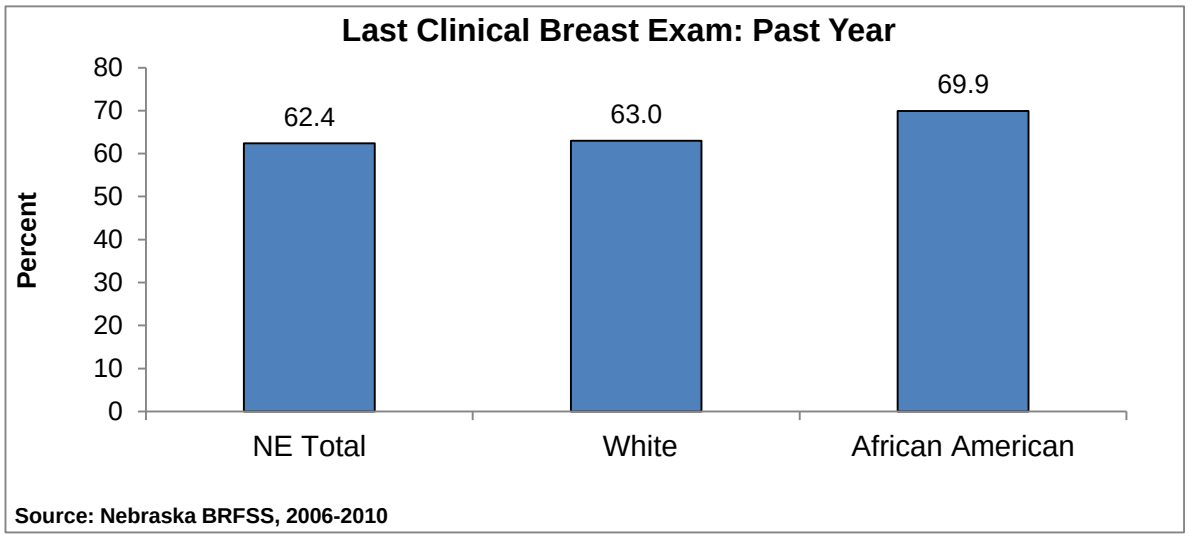


Clinical Breast Exam

Women in the BRFSS survey were given the definition of clinical breast exam as: “when a doctor, nurse, or other health professional feels the breast for lumps.” They were then asked if they had a clinical breast exam in the past year.

Clinical Breast Exams: 40+

During the period of 2006-2010, African Americans (69.9%) had a slightly higher percentage than Whites (63%) to have a clinical breast exam in the past year among all women ages 40 or older.



Infectious Disease

Due to data availability for the Nebraska populations, only data from indicators regarding HIV/AIDS and sexually transmitted diseases will be presented.

HIV/AIDS

HIV/AIDS Incidence

Race and Ethnicity	New HIV Only Diagnoses 2010 #	2010 %	2009 #	2009 %	1st AIDS Diagnoses 2010 #	2010 %	2009 #	2009 %
Non-Hispanic White	42	62	34	49	14	45	14	42
Non-Hispanic Black	20	29	20	29	11	35	9	27
Hispanic, All Races	3	4	9	13	5	16	7	21
Asian/Pacific Islander	1	1	3	4	1	3	2	6
American Indian/Alaska Native	1	1	0	--	0	--	0	--
Multiple Races	1	1	3	4	0	--	1	3

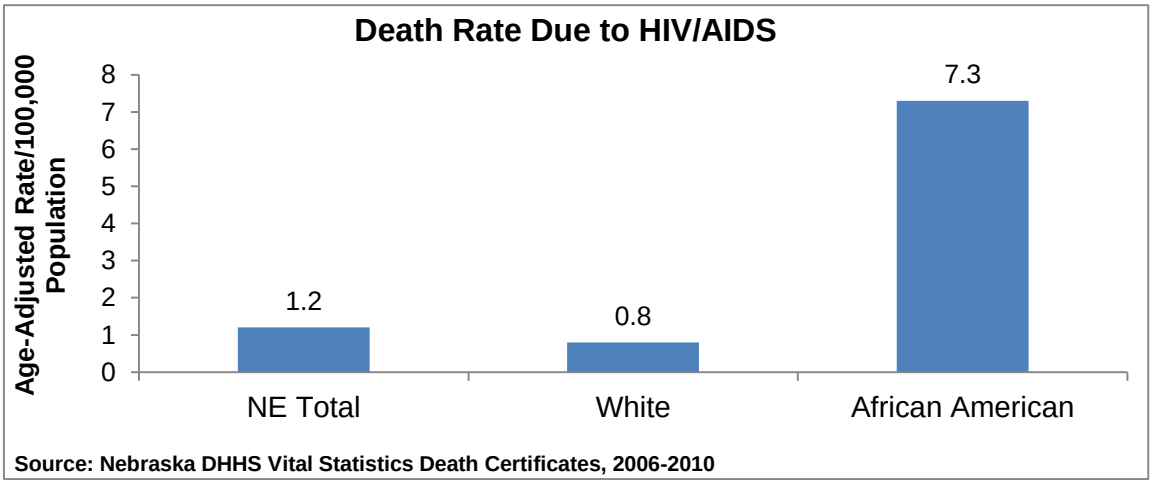
Source: Nebraska DHHS, HIV/AIDS Prevention and Care, 2010

Race and Ethnicity	All HIV Diagnoses through 2010 #	All HIV Diagnoses through 2010 %	Living HIV/AIDS Cases through 2010 #	Living HIV/AIDS Cases through 2010 %
Non-Hispanic White	1,566	60.4	966	55.6
Non-Hispanic Black	637	24.6	478	27.5
Hispanic	288	11.1	217	12.5
Asian/Pacific Islander	33	1.3	31	1.8
American Indian/Alaska Native	41	1.6	26	1.5
Multiple Races	24	.9	17	1

Source: Nebraska DHHS, HIV/AIDS Prevention and Care, 2010

HIV/AIDS Mortality

In 2006-2010, the death rate among African Americans for HIV/AIDS was 7.3/100,000 population, compared to 0.8/100,000 population among Whites.



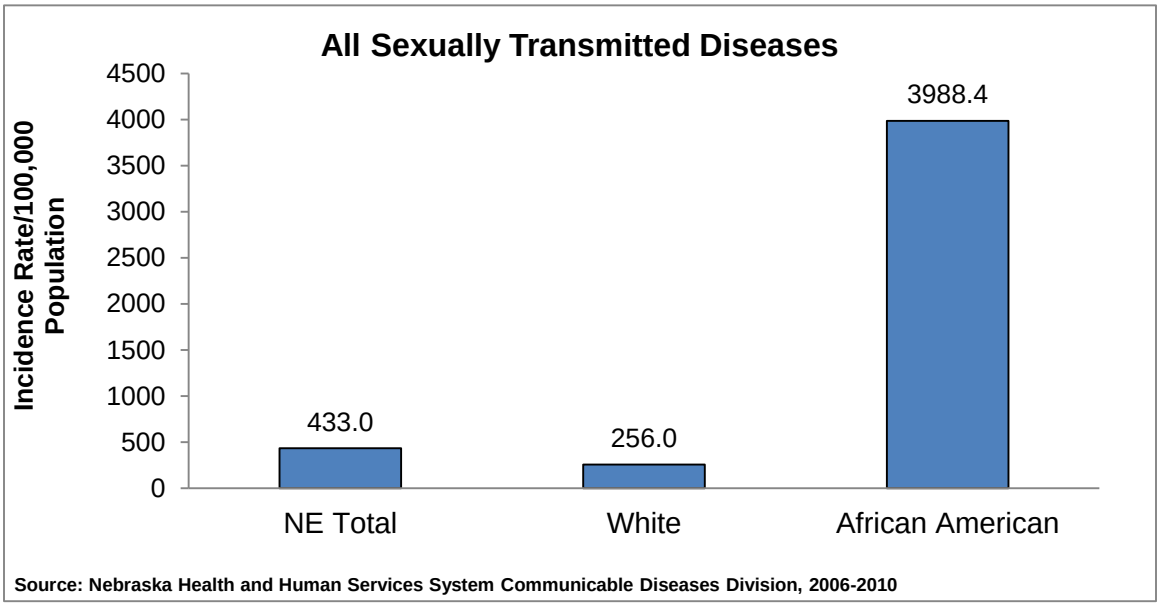
Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Sexually Transmitted Diseases

Prevalence of Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) remain a major public health challenge in the United States. STDs can cause serious complications including infertility, ectopic pregnancy, blindness, fetal and infant deaths, and congenital defects. Racial and ethnic minorities are at higher risk for sexually transmitted diseases, and experience higher rates of disease and disability than the overall population. STDs are also the cause of many harmful and often irreversible complications, such as reproductive health problems, fetal and prenatal health problems, and cancer.

In Nebraska, the incidence rate and relative risk of infection of all sexually transmitted diseases for African Americans was 3988.4 per 100,000 population, which is nearly 15.5 times greater than that of the White population, who had an incidence rate of 256.6 per 100,000 population.

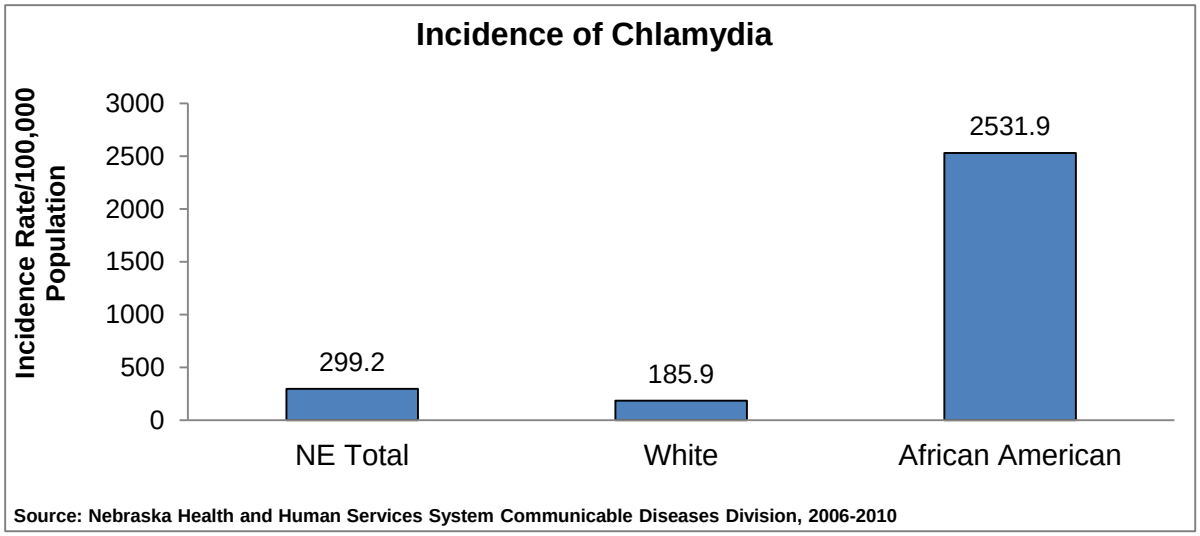


Source: Nebraska Health and Human Services System Communicable Diseases Division, 2006-2010

Incidence of Chlamydia

Incidences of chlamydia infections have increased in Nebraska, as they have nationwide. Expanded screening and improved testing methods may account for some of these increases. Chlamydia remains the most commonly reported infectious disease in the United States.

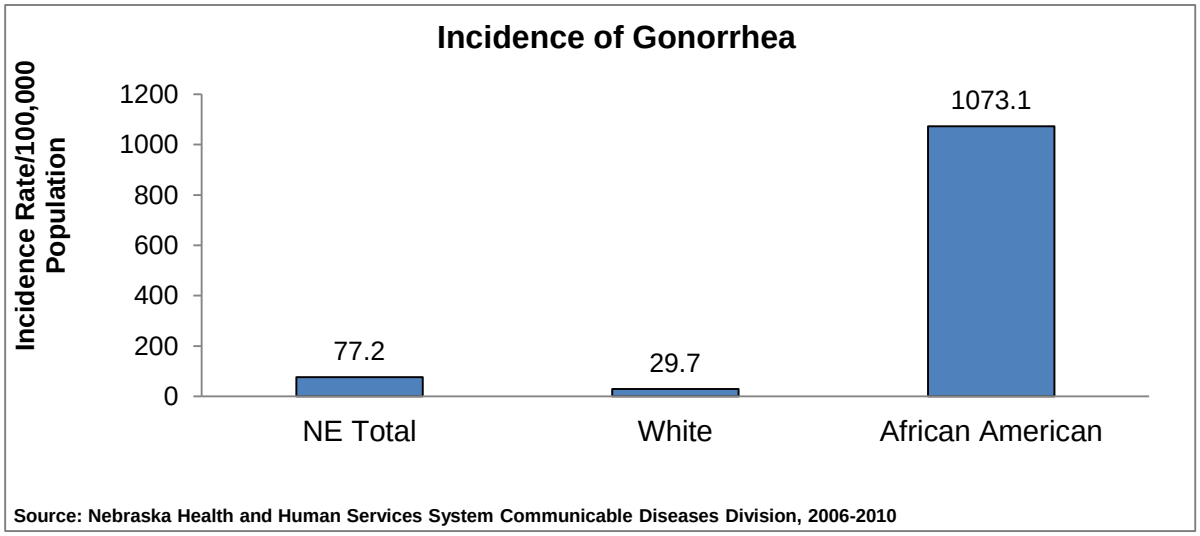
In Nebraska, during 2006-2010, African Americans had an incident rate per 100,000 population for Chlamydia of 2531.9, which was approximately 13.6 times higher than that for Whites; the Nebraska Total incident rate is 299.2.



Source: Nebraska Health and Human Services System Communicable Diseases Division, 2006-2010

Incidence of Gonorrhea

Gonorrhea is currently under-diagnosed and under-reported by about 50% in the U.S. In Nebraska, during 2006-2010, African Americans had an incidence rate for gonorrhea of 1073.1 per 100,000 population, which is about 36 times higher than the incidence rate for Whites (29.7 per 100,000).



Source: Nebraska Health and Human Services System Communicable Diseases Division, 2006-2010

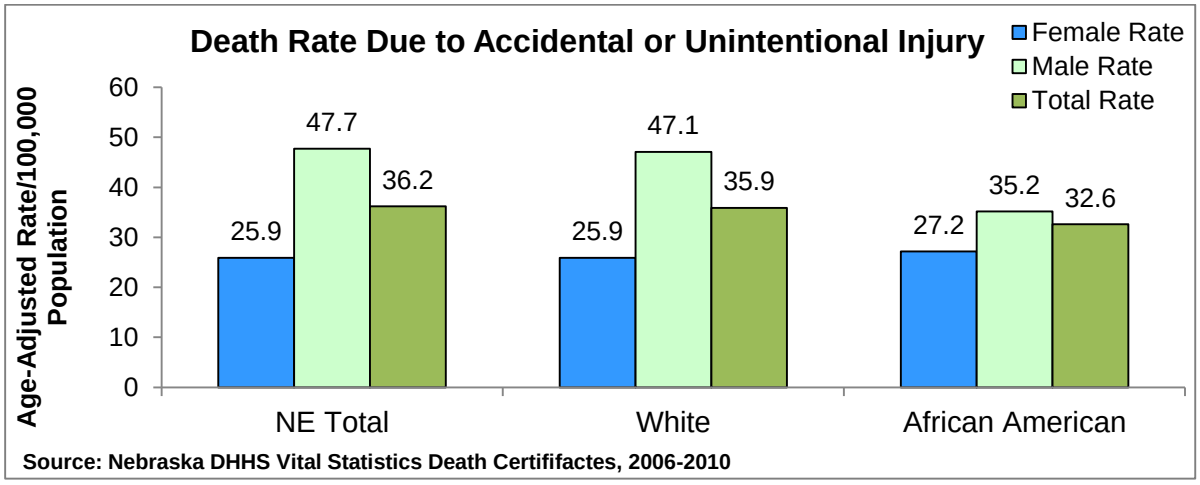
Intentional and Unintentional Injuries

Injuries are a leading cause of premature death in the United States and Nebraska. They include unintentional types, such as motor vehicle crashes, falls, and suffocation, as well as intentional types including homicides and suicides. Injury deaths, by definition, are preventable, and reducing their risk requires an understanding of how injuries vary across physical and social environments.

Accidental or Unintentional Injury

Accidental or Unintentional Injury Mortality

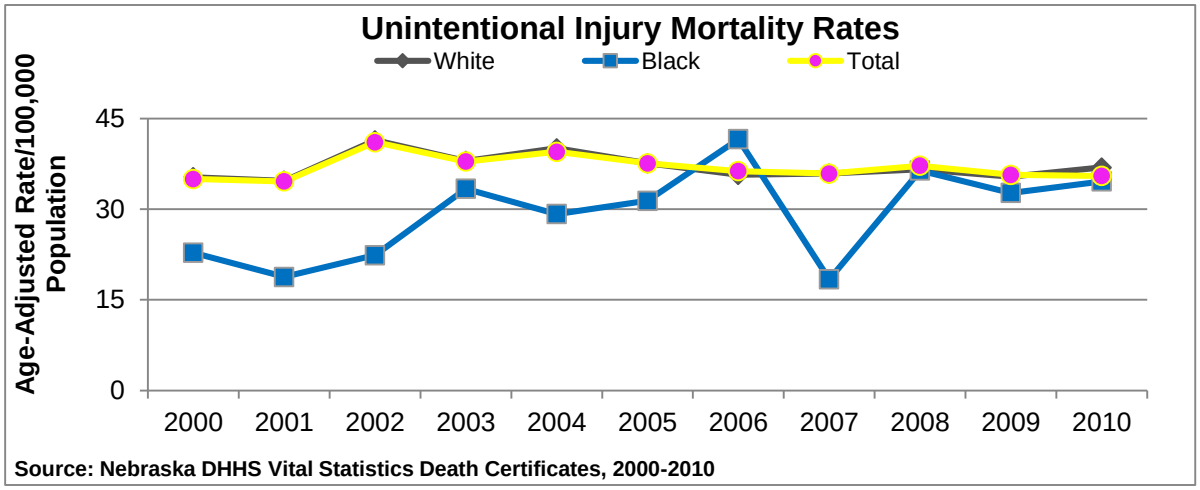
African American males (35.2) were less likely to die from accidental or unintentional injury compared to white males (47.1). African American females were slightly more likely to die due to an accident or unintentional injury than White females.



Source: Nebraska DHHS Vital Statistics Death Certifiactes, 2006-2010

Unintentional Injury Mortality: Trends

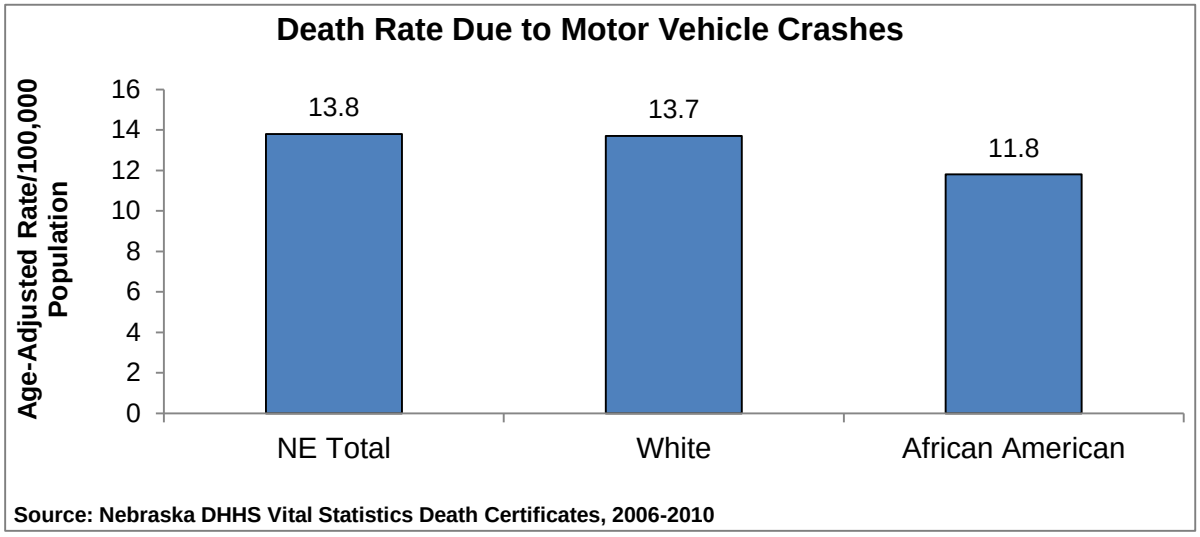
Looking at unintentional mortality rate data from the years 2000-2010 there was an upward trend in death rate for African Americans. The rate of mortality remains lower than Whites and the total Nebraska population.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2000-2010

Motor Vehicle Crashes

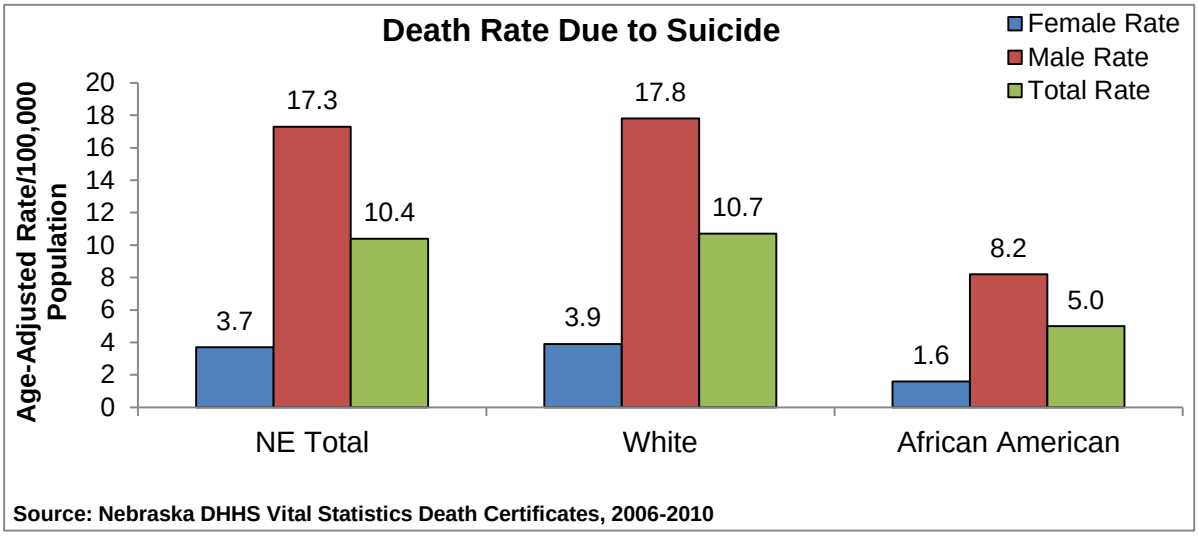
In Nebraska, during 2006-2010, African Americans had a death rate per 100,000 population for motor vehicle accidental death of 11.8, compared to 13.7 per 100,000 of Whites.



Intentional Injury

Suicide

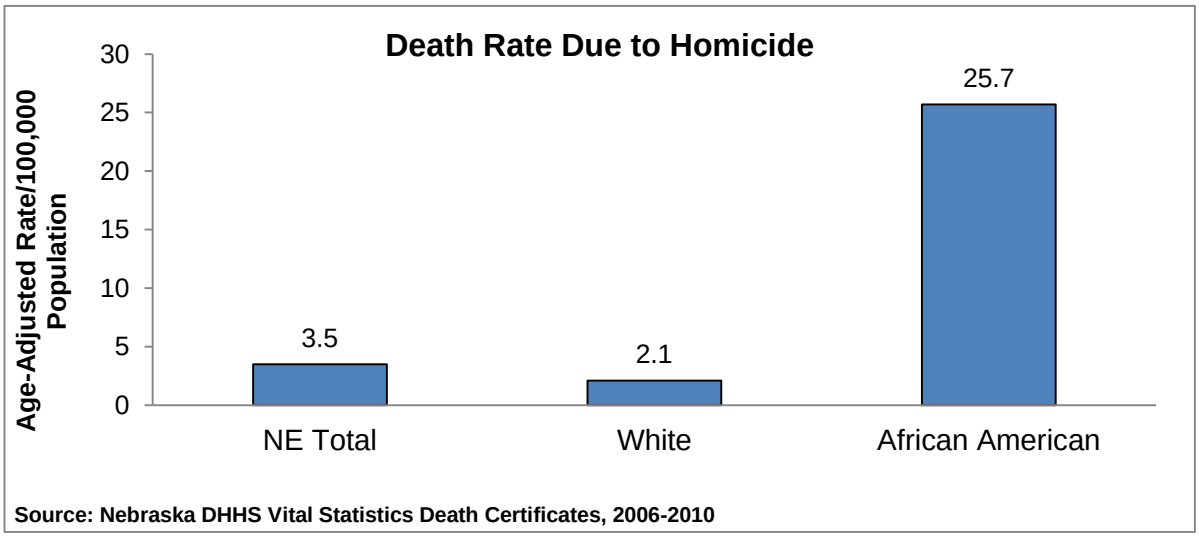
The incidence rate of 5 per 100,000 population of suicide for African Americans is half as much as Whites, which is 10.7 per 100,000. African American males are 53% less likely to die from suicide than White males. African American females are 58.9% less likely than White females to die from suicide.



Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Homicide

Homicide, by definition, includes deaths inflicted by another person with the intention to injure or kill. During 2006-2010, African Americans were 12.8 times more likely to die from homicide than Whites.

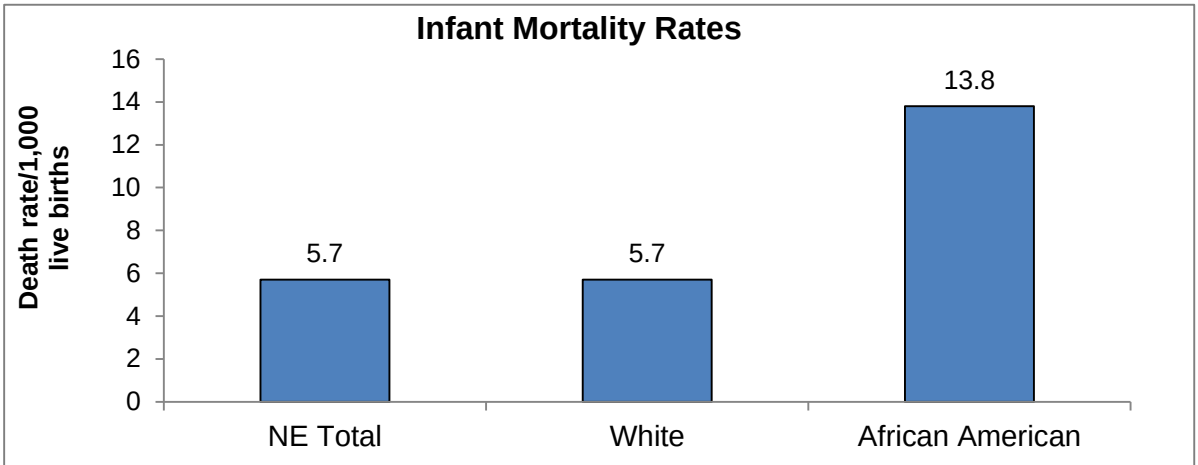


Source: Nebraska DHHS Vital Statistics Death Certificates, 2006-2010

Maternal and Child Health

Infant Mortality

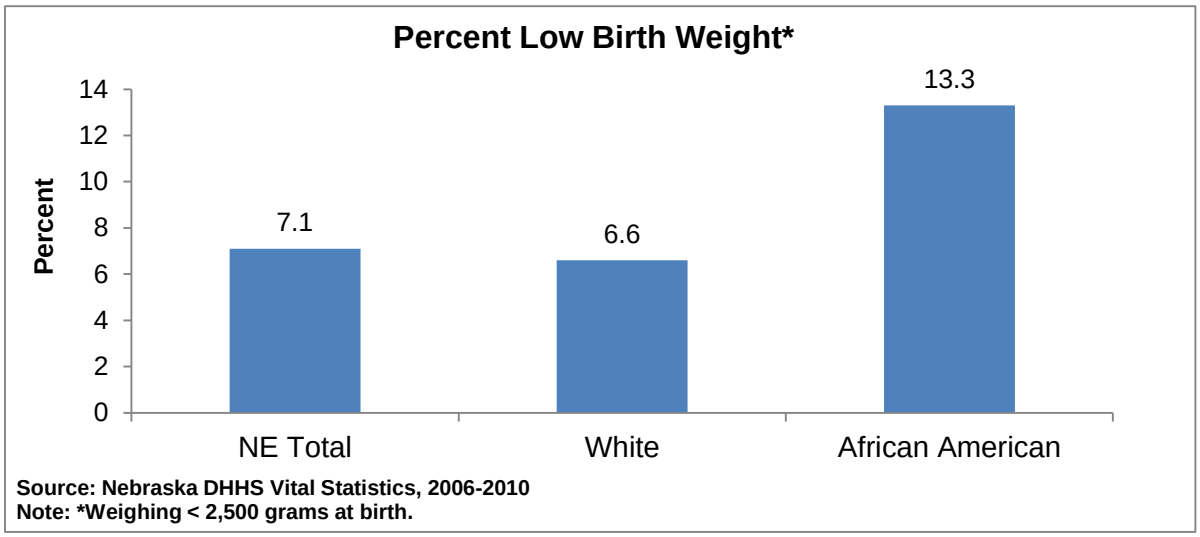
Infant mortality is a long-established measure, not only of child health, but also of the well-being of a society. It reflects the level of health status and health care of a population, and the effectiveness of preventive care and the attention paid to maternal and child health. Often considered the benchmark of the existence of unmet health needs, maternal and child health in Nebraska is first assessed by infant mortality rates. The figure below shows the infant death rate for African Americans and Whites. In the five-year period of 2006-2010, the infant mortality rate was 2.4 times as high for African Americans compared to Whites.



Source: Nebraska DHHS Vital Statistics Birth Certificates, 2006-2010
Note: Rate per 1,000 live births (Deaths under one year of age)

Low Birth Weight

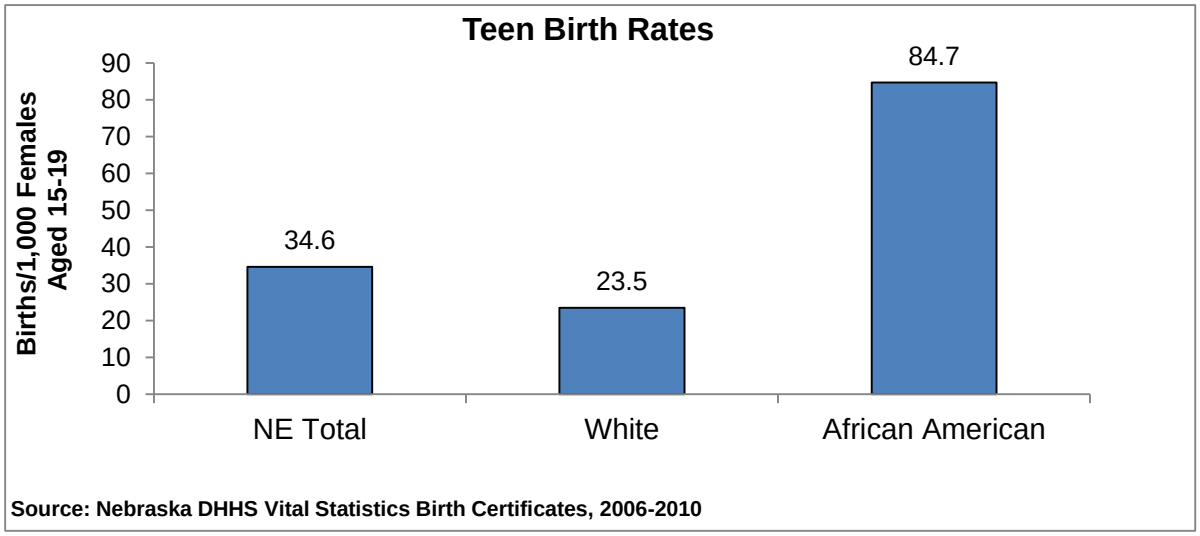
A newborn is considered to be of low weight if he/she weighs less than 2,500 grams at birth. These babies experience higher proportions of illness and death than other infants. During 2006-2010, the proportion of low birth weight infants was twice as high for African Americans as compared to Whites.



Source: Nebraska DHHS Vital Statistics, 2006-2010
Note: *Weighing < 2,500 grams at birth.

Teen Births

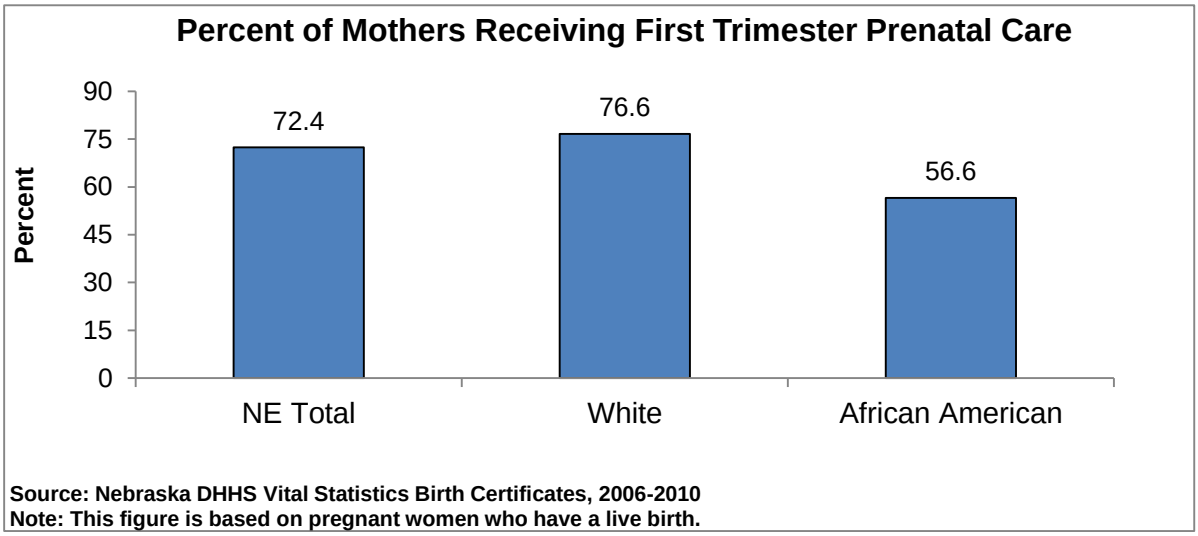
Teen births are detrimental to the well-being of young mothers, fathers, and their babies. In Nebraska, the teen birth rate for African Americans was higher than the rate for Whites. During 2006-2010, the teen birth rate for African American female teens was 3.6 times the rate for White female teens.



Source: Nebraska DHHS Vital Statistics Birth Certificates, 2006-2010

Mothers Receiving First Trimester 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 risk. In the five-year period of 2006-2010, the percentage beginning prenatal care in the first trimester for African American mothers was 56.6%, compared to 76.6% for White mothers.

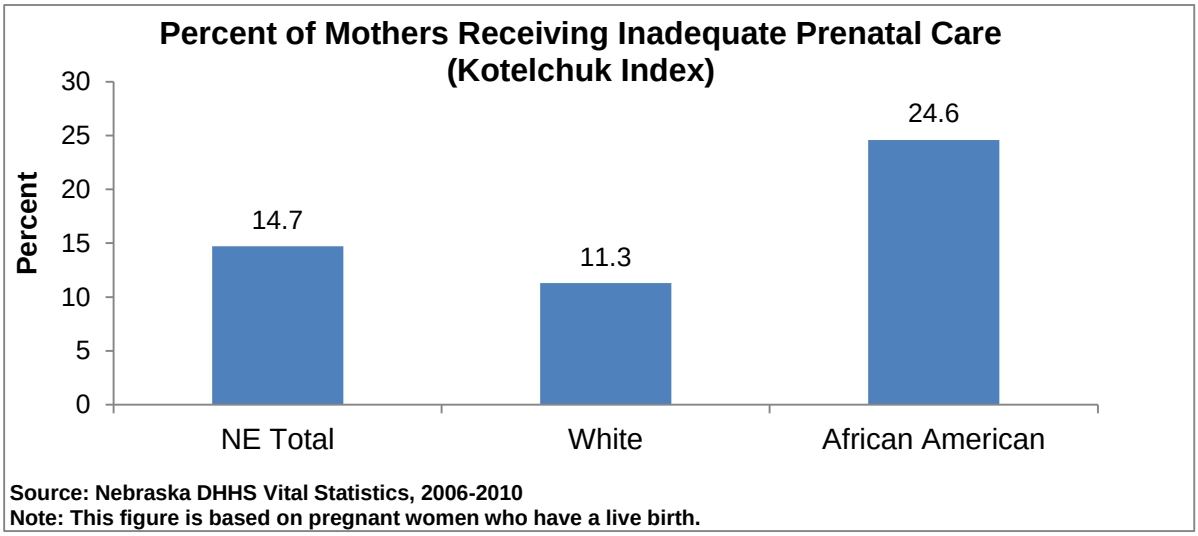


Source: Nebraska DHHS Vital Statistics Birth Certificates, 2006-2010
Note: This figure is based on pregnant women who have a live birth.

Kotelchuck Index

The Kotelchuck Index is a measure of adequacy or inadequacy of prenatal care by using a combination of: number of prenatal visits, gestation, and what trimester prenatal care was started.

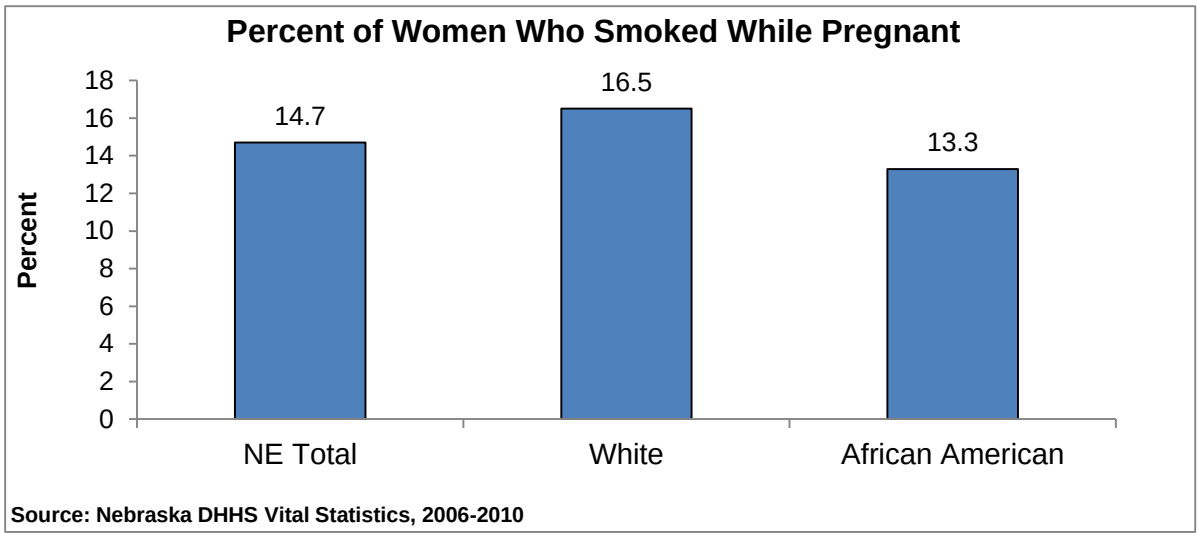
Based on the Kotelchuck Index, in 2006-2010, among African American mothers, around one fourth (24.6%) received inadequate prenatal care, as did 11.3% of White mothers.



Source: Nebraska DHHS Vital Statistics, 2006-2010
Note: This figure is based on pregnant women who have a live birth.

Smoking During Pregnancy

During 2006-2010, African American women were less likely to smoke while pregnant than White women, and they were less likely to smoke while pregnant than the NE total.



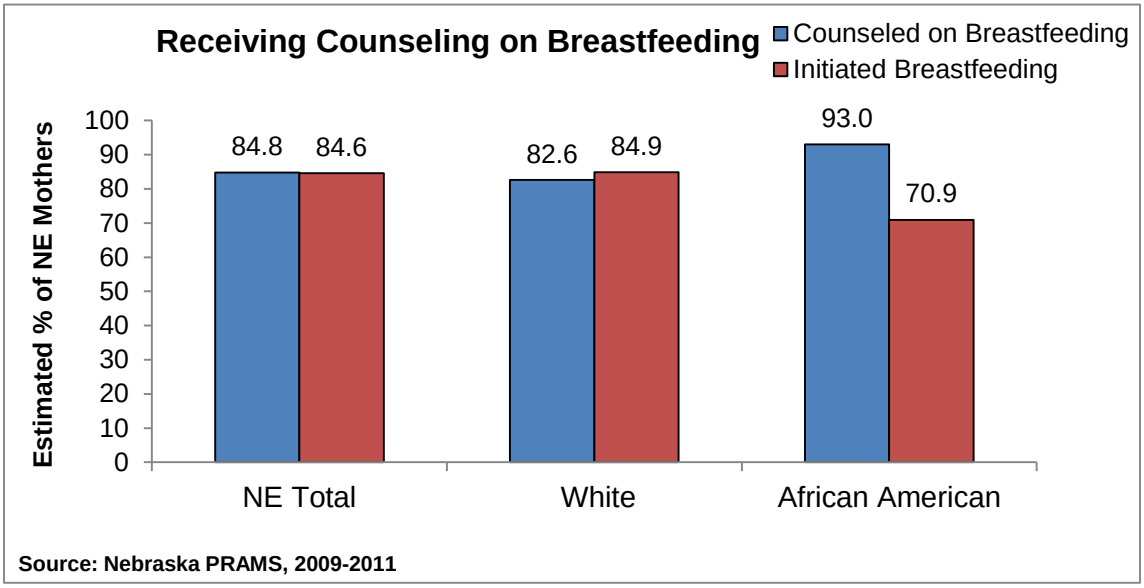
Source: Nebraska DHHS Vital Statistics, 2006-2010

PRAMS and Breastfeeding

The Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based surveillance system of maternal behaviors and experiences before, during, and after pregnancy. It is an initiative to reduce infant mortality and low birth weight infants, and was developed to supplement vital records data by providing state-specific data to be used for planning and evaluating prenatal health programs. Breastfeeding is associated with numerous health benefits for both infants and mothers. Breast milk strengthens infants' immune systems, thus resulting in fewer cases of illness for newborns. Breastfeeding has also been associated with a decreased risk of pre-menopausal breast cancer in women. However, breastfeeding rates remain low among some groups of women, such as women who are young, below the Federal Poverty Threshold, unmarried, or not college-educated. Many women also stop breastfeeding soon after initiation for various reasons, such as smoking, medication use, physical and mental health issues, or the need to return to work.

Receiving Counseling on Breastfeeding and Initiating Breastfeeding

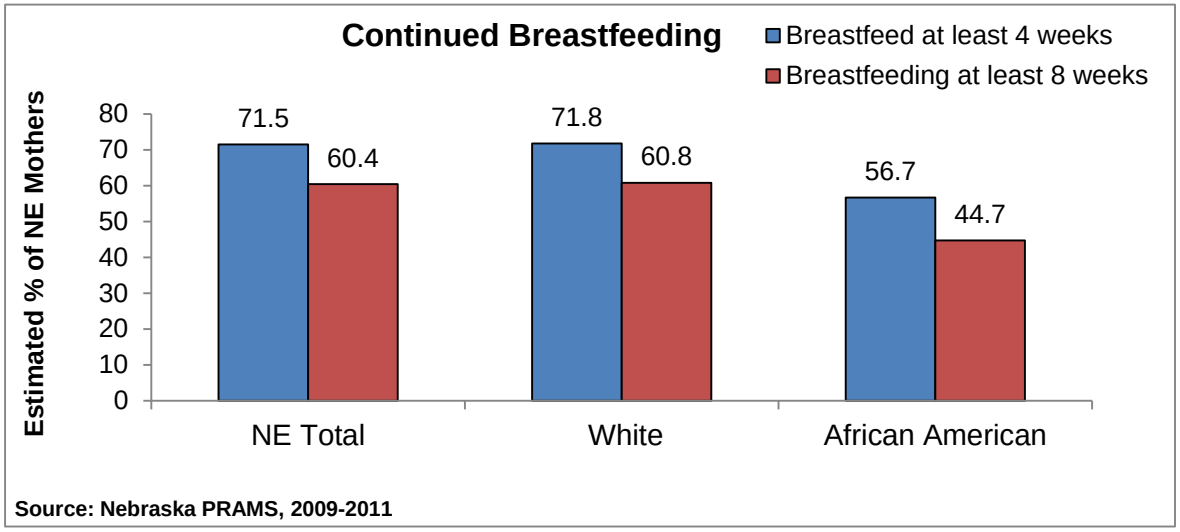
The question asked on the PRAMS survey for breastfeeding initiation: "Did you ever breastfeed or pump breast milk to feed your newborn after delivery?" The prevalence of breastfeeding initiation among White mothers during this period was 84.9%, while African American mothers' breastfeeding initiation was 70.9%. When asked about receiving counseling on breastfeeding, 93% of African American mothers received counseling while only 82.6% of White mothers received counseling.



Source: Nebraska PRAMS, 2009-2011

Continued Breastfeeding

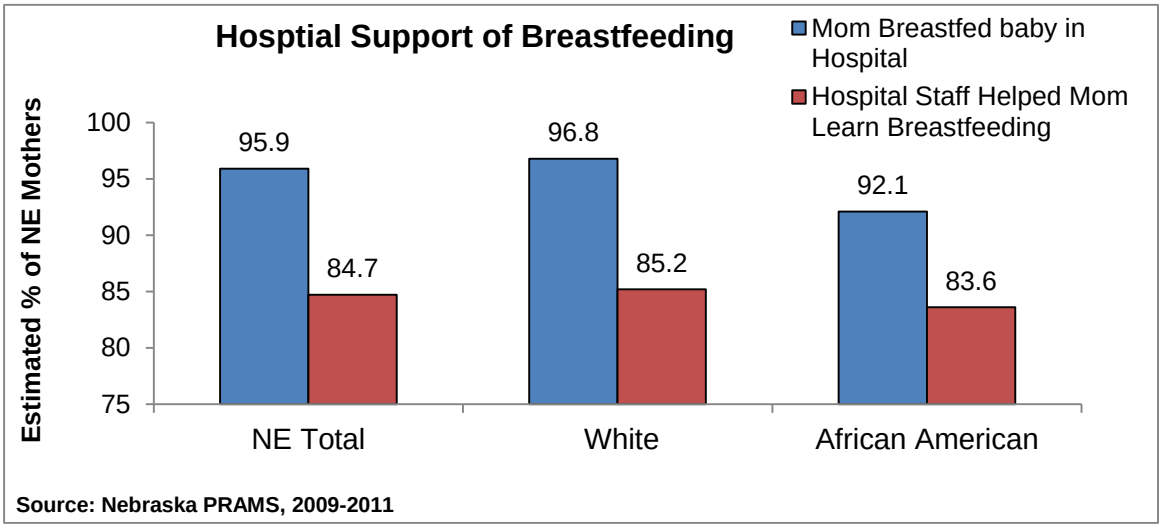
'Continued breastfeeding' is estimated among those who initiated it after giving birth. Exclusive breastfeeding at four weeks is based on the age when an infant received anything other than breast milk. Based on Nebraska PRAMS 2009-2011 data, a total of 71.8% of White mothers continued to breastfeed at 4 weeks, while 56.7% of African American mothers continued breastfeeding at 4 weeks. Almost 44.7% of African American mothers continued to breastfeed at least 8 weeks, compared to 60.8% of White mothers.



Source: Nebraska PRAMS, 2009-2011

Hospital Support of Breastfeeding

There was a slight difference in hospital staff supporting breastfeeding in favor of White mothers as compared to African American mothers. About 92.1% of African American mothers breastfed their baby in the hospital, about 4.7% less than White mothers, who breastfed 96.8% of the time while they were in the hospital.



Source: Nebraska PRAMS, 2009-2011

Behavioral Risk Factors

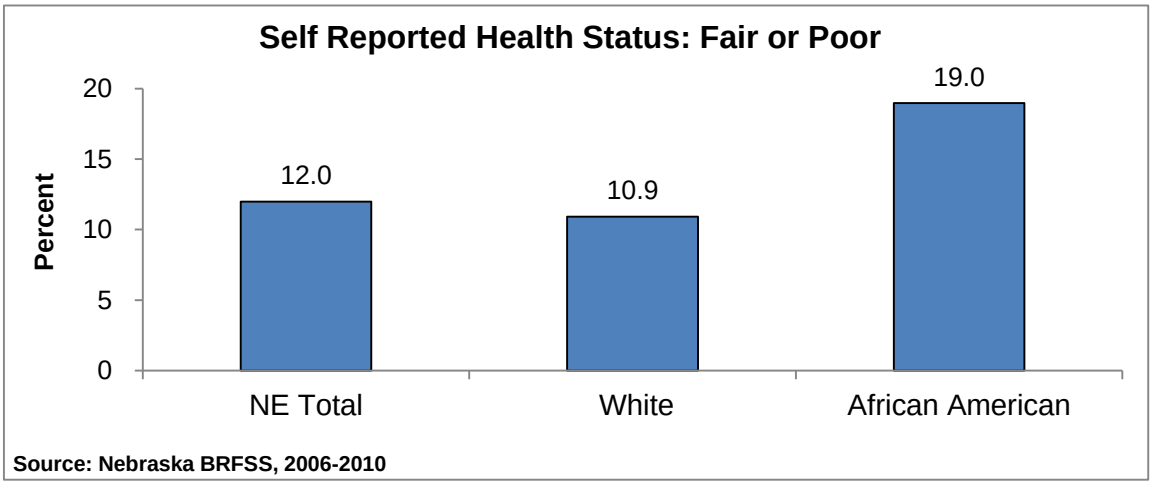
Health Status and Quality of Life

Health-related quality of life measures seek to determine how adults perceive their own health, and how well they function physically, psychologically, and socially during their usual daily activities.

For BRFSS data, White represents non-Hispanic White respondents, and African American represents non-Hispanic African American respondents.

Fair or Poor Health

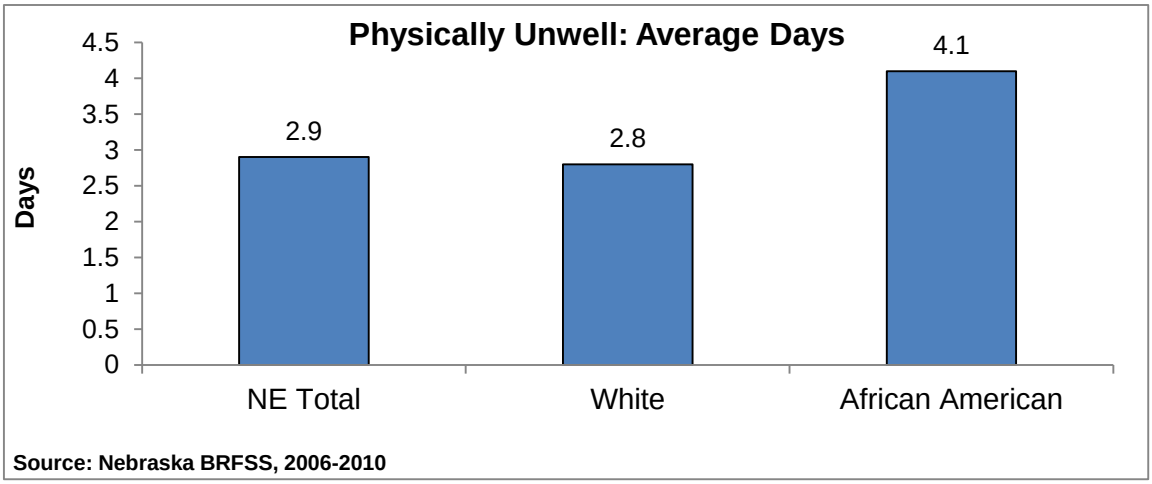
Respondents were asked, "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?" Nineteen percent of African American adults in Nebraska reported being in fair or poor health, compared to approximately 11% of Whites. A total of 12% of adults in Nebraska reported having Fair or Poor health.



Source: Nebraska BRFSS, 2006-2010

Physically Unwell: Average Days

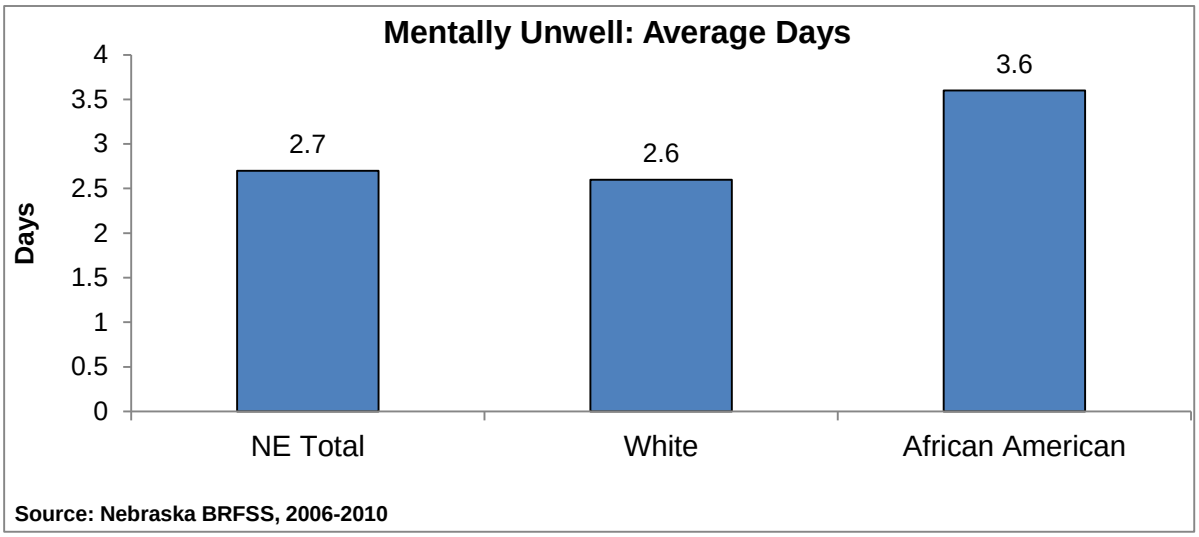
On average, African Americans felt physically unwell 4.1 days in the previous month, compared to 2.8 days among Whites.



Source: Nebraska BRFSS, 2006-2010

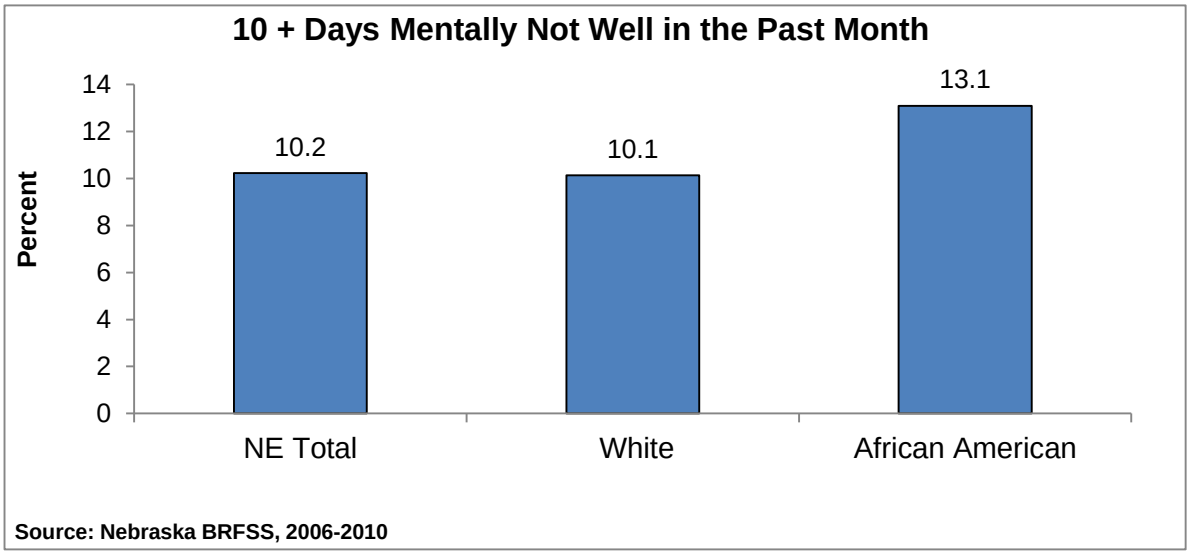
Mentally Unwell: Average Days

Respondents were asked about the average (mean) number of days that one's mental health was not good. African Americans, on average, spent 3.6 days of the previous month mentally unwell, compared to 2.6 days among Whites.



Mentally Unwell: 10+ Days

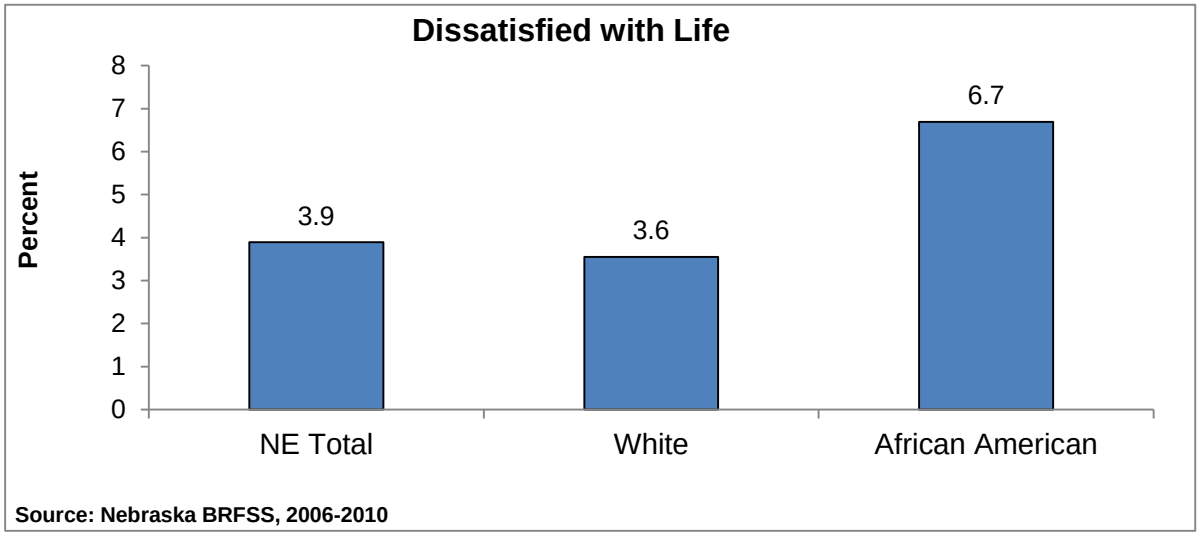
In 2006-2010, 10.2% of Nebraska adults reported not being mentally well at least 10 days in the past months. The rate was slightly higher for African Americans (13.1%), than for Whites (10.1%).



Life Satisfaction

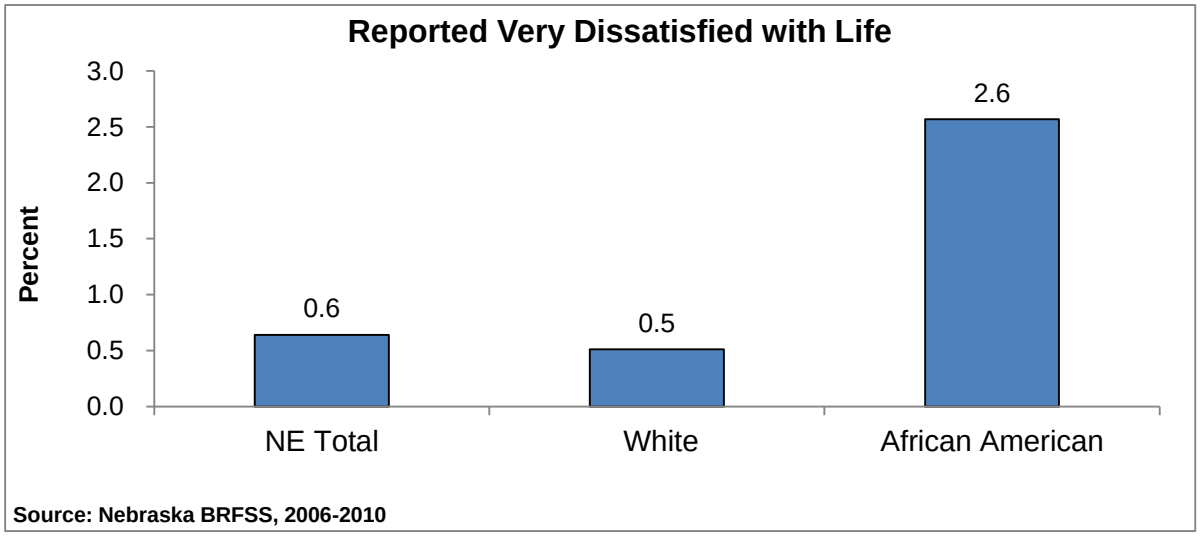
Dissatisfied with Life

The question asked to gauge satisfaction with life was; “In general, how satisfied are you with your life: Very satisfied, Satisfied, Dissatisfied, Very Dissatisfied?” African Americans were nearly twice as likely to report being dissatisfied with life (6.7%) as compared to Whites (3.6%).



Very Dissatisfied with Life

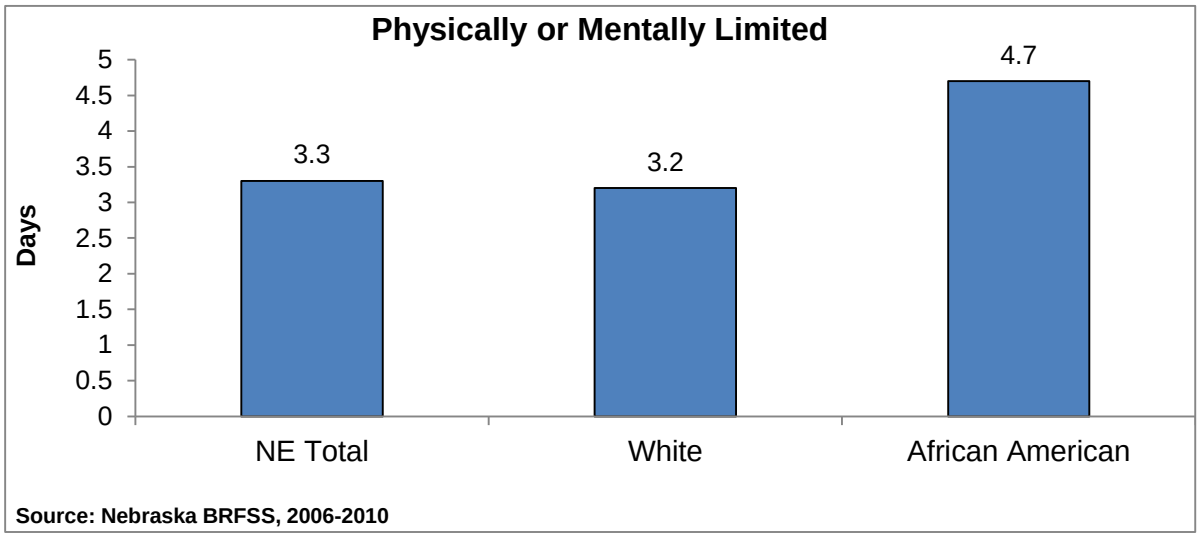
Unlike the chart above that illustrates those who are dissatisfied with life, this chart discusses those who are *very* dissatisfied with life. African American adults (2.6%) in Nebraska were more likely than White adults (0.5%) to be very dissatisfied with their life.



Activity Limitation

Activity Limitation: Average Days

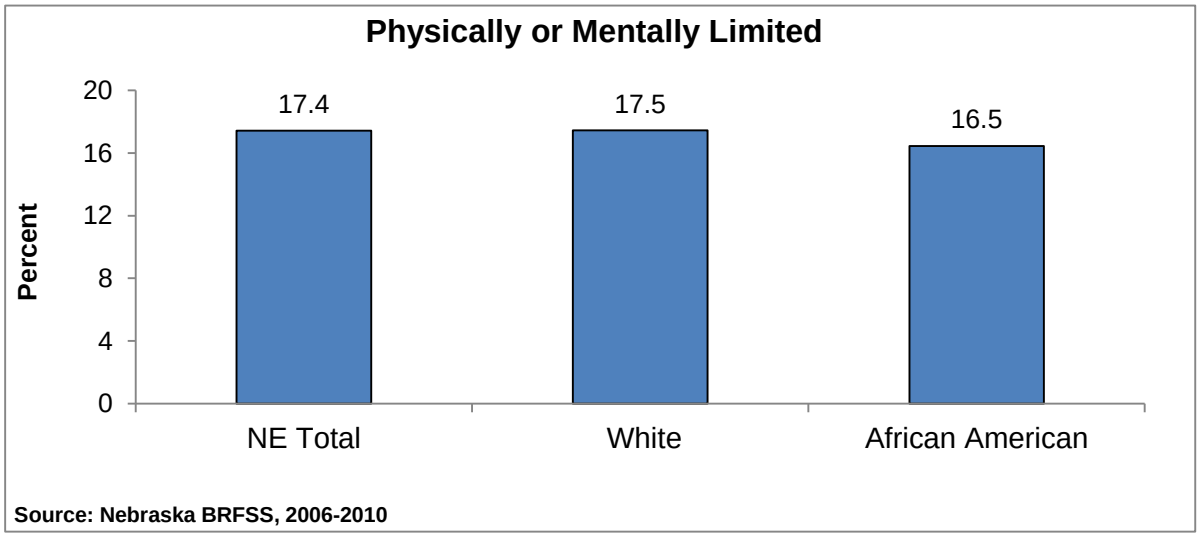
Adults in this survey were read the following description of activity limitation: "Are you limited in any way in any activities because of physical, mental, or emotional problems?" African Americans spent almost 5 days in the previous month physically or mentally limited, compared to 3.2 days among Whites.



Source: Nebraska BRFSS, 2006-2010

Activity Limitation: Percent

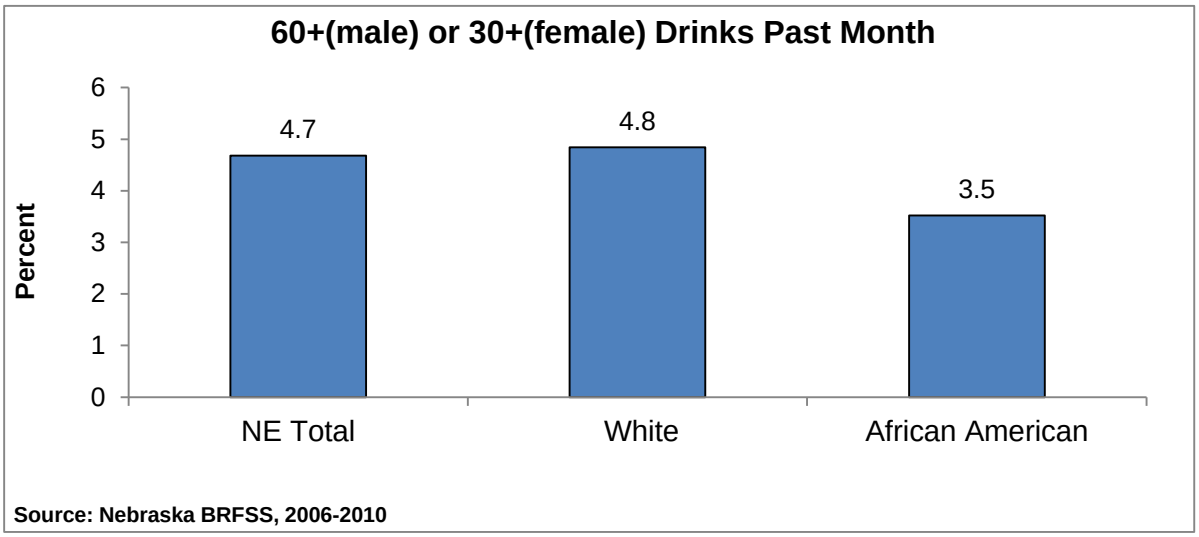
Altogether, 17.4% of adults in the 2006-2010 Nebraska BRFSS said they have limited activity due to physical and/or mental problems. African American adults (16.5%) experienced lower rates of limited activities than White adults (17.5%).



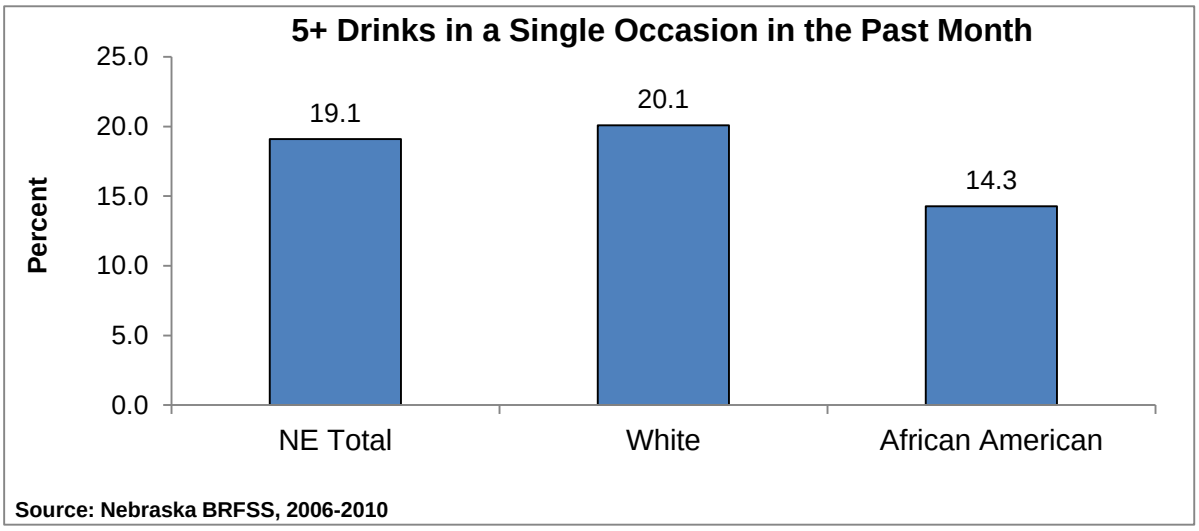
Source: Nebraska BRFSS, 2006-2010

Alcohol Consumption

In general, African Americans reported less alcohol consumption compared to Whites and the Nebraska total.
The chart below includes 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. Of those 18 and older, African American adults (3.5%) in Nebraska were more likely than White adults (4.8%) to report heavy drinking.



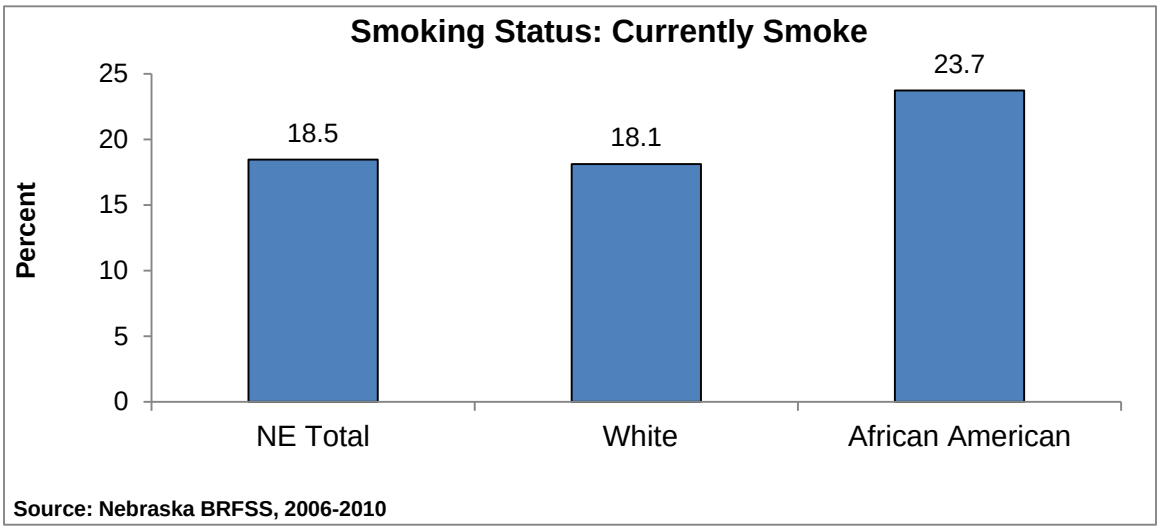
Approximately 14% of African Americans reported drinking five or more drinks on one occasion in the past month, compared to almost 20.1% of Whites.



Tobacco Use

Cigarette Smoking

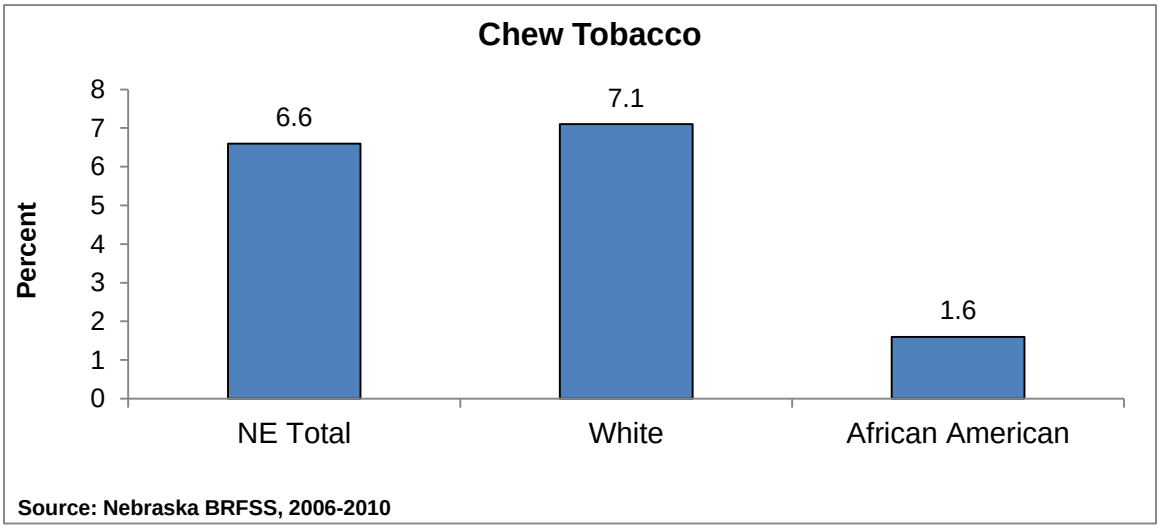
Cigarette smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung disease. Smoking may also result in injuries, death, and environmental damage due to fire. Respondents were classified as current smokers if they reported smoking at least 100 cigarettes in their lifetime, currently smoked, and smoked all of the past 30 days. African American adults (23.7%) in Nebraska were more likely than White adults (approximately 18%) to be current smokers. A total of 18.5% of all Nebraska adults were current smokers.



Source: Nebraska BRFSS, 2006-2010

Chew Tobacco

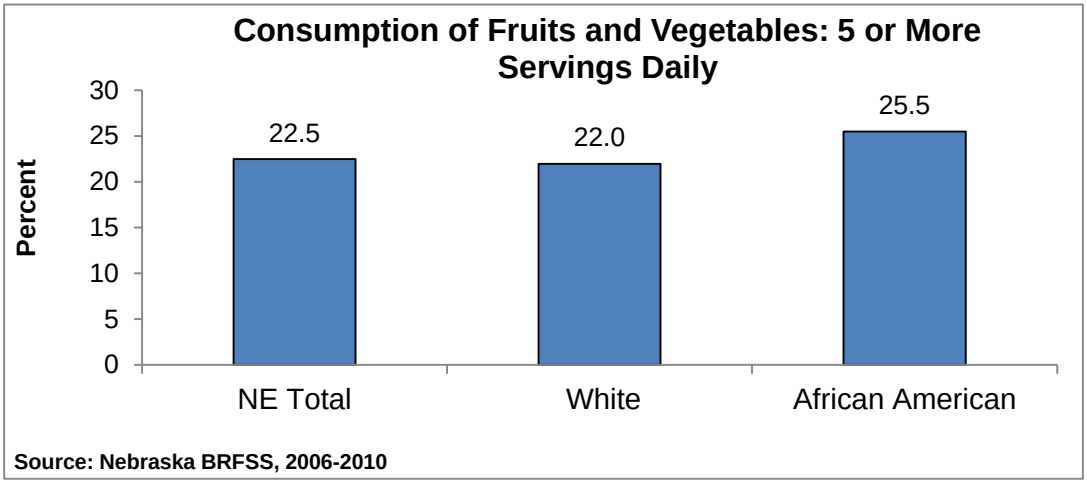
Whites (7.1%) were more than four times as likely as African Americans (1.6%) to chew tobacco in 2006-2010.



Source: Nebraska BRFSS, 2006-2010

Consumption of Fruits and Vegetables

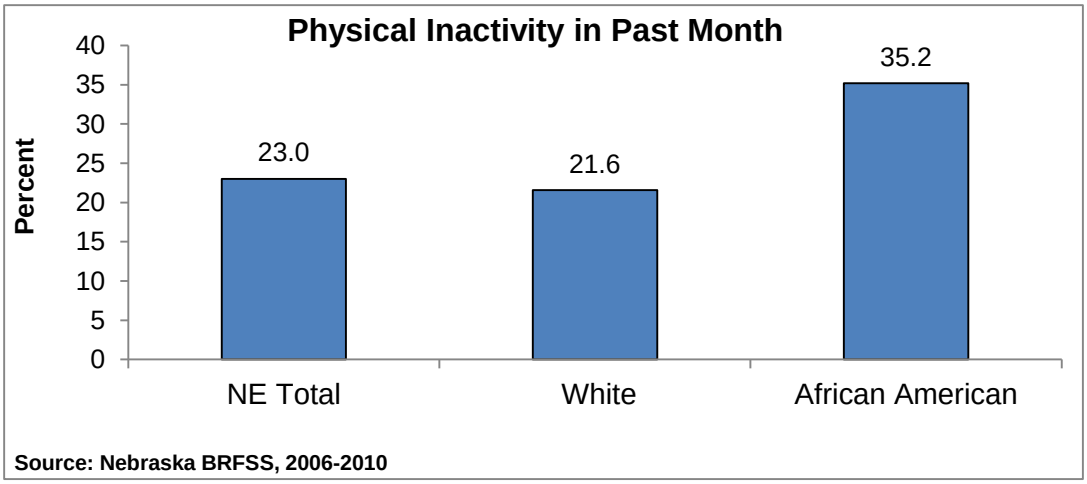
The 2000 Dietary Guidelines for Americans recommended five or more servings of fruits and vegetables per day for good nutrition. These guidelines serve as the basis for BRFSS questions on fruits and vegetables. BRFSS respondents were asked a series of questions about the foods and drinks they usually consumed. African American adults (25.5%) in Nebraska were more likely than White adults (22%) to have five or more servings of fruits and vegetables per day, which is slightly more than 22.5% of all Nebraska adults.



Source: Nebraska BRFSS, 2006-2010

Physically Inactive

The definition of physically inactive was the answer of "no" to the question; "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" Altogether, 23% of adult Nebraskans in 2006-2010 were physically inactive. African Americans reported higher rates of physical inactivity than Whites, with 35.2% and 21.6%, respectively.



Source: Nebraska BRFSS, 2006-2010

Overweight and Obesity

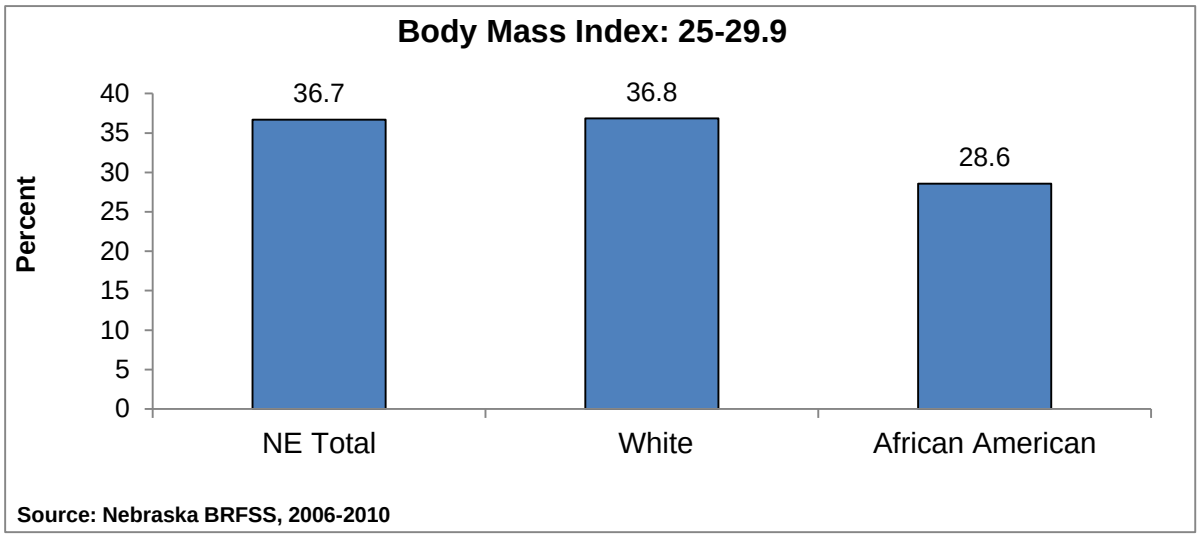
Being overweight or obese has been linked to increased risk of death. In addition, being overweight or obese substantially raises the risk of illness from heart disease and stroke; high blood pressure; elevated blood cholesterol levels; type 2 diabetes; endometrial, breast, and colon cancers; liver and gallbladder disease; arthritis; sleep disturbances; and breathing problems. Obese persons, both children and adults, may also suffer from social stigmatization, discrimination, and low self-esteem.

The Body Mass Index (BMI) is used as a proxy measure for overweight and obesity in adults, until a better method of determining actual body fat is developed.
BMI is calculated by dividing a person's weight in kilograms by the square of the person's height in meters.

- Overweight or obese: A BMI reading of 25.0 or greater
- Obese: A BMI reading of 30.0 or greater
- Overweight but Not obese: A BMI reading of 25.0 to 29.9

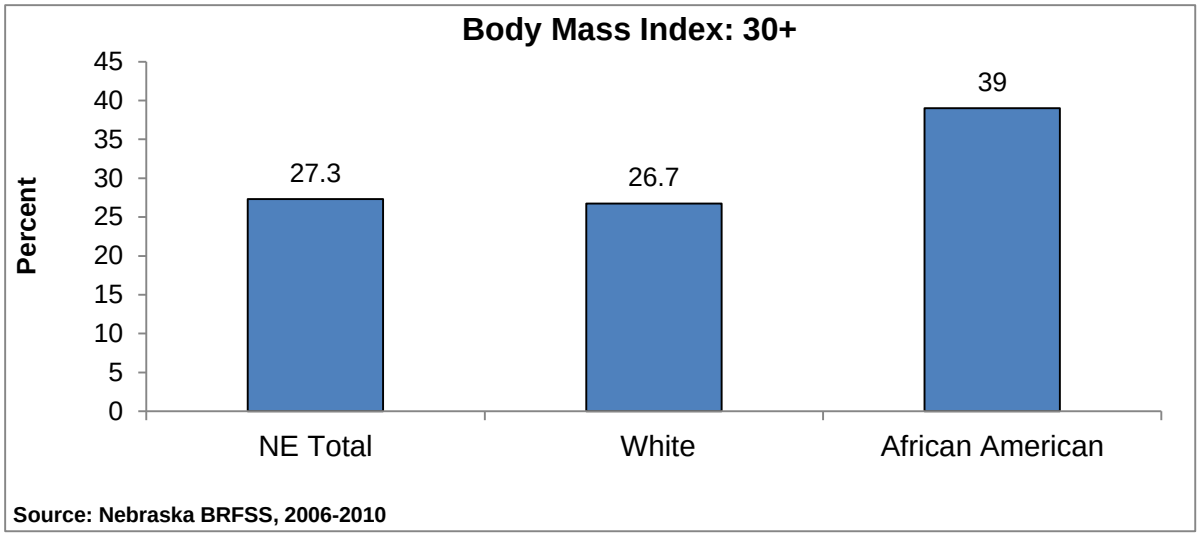
BMI 25-29.9: Overweight

In the 2006-2010 BRFSS, 36.7% of Nebraskan adults reported their BMI from 25 to 29; the rate of reported BMI from 25 to 29 was lower for African Americans (28.6%) than for Whites (36.8%).



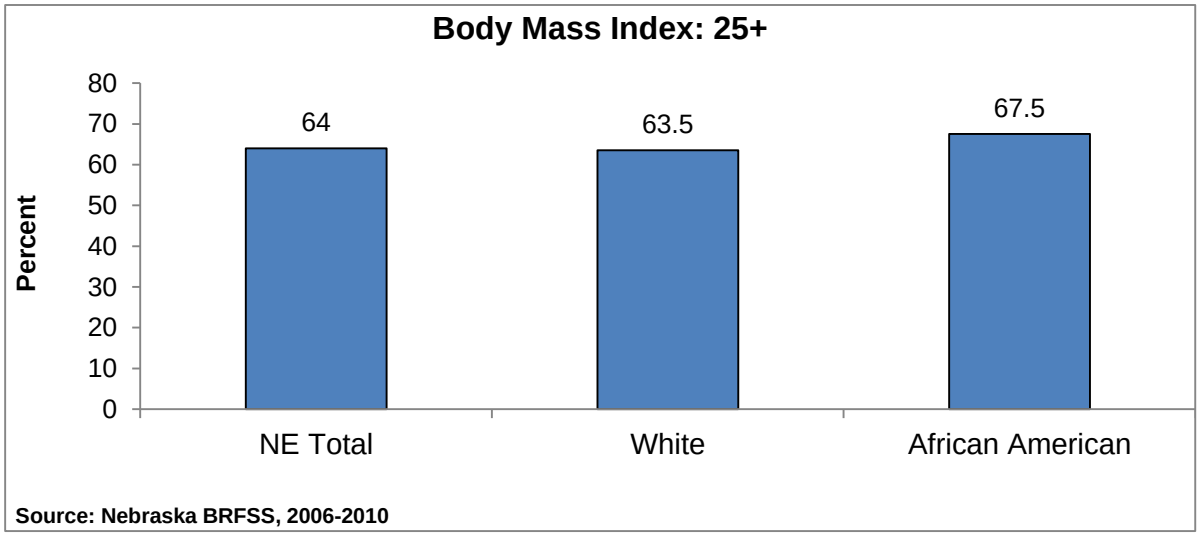
BMI 30+: Obese

In 2006-2010, 27.3% of Nebraskan adults reported a BMI of 30 and above. The rate of reported BMI 30 and above was higher for African Americans (39%) than for White (26.7%).



BMI 25+: Overweight or Obese

In 2006-2010, 67.5% of African Americans had a BMI of 25 or greater, compared to 63.5% of Whites.



Conclusion

The purpose of this report is to provide a snapshot of the health status of African Americans in Nebraska. A large proportion of the African American population was without health coverage; relatedly, a similar proportion could not see a physician due to cost. Access to health care is an increasingly important issue, as it can have an impact on multiple risk factors for illness and disease.

Another critical phenomenon is related to morbidity and mortality. Even though a lower percentage of African Americans had heart disease, compared to Whites, African Americans are dying due to heart disease at a higher rate than Whites. African Americans also saw almost double the proportion diagnosed with diabetes, but experienced triple the diabetes death rate compared to Whites. The same, lower diagnosis/higher death rate relationship can be seen across cancer as well. An examination of the reasons why African Americans are similarly or less affected by the prevalence of disease but are more affected by death from that disease could help determine interventions to decrease this disparity.

Sexually transmitted diseases (STDs) are a significantly important issue, especially in Nebraska where almost 4,000/100,000 African Americans have a sexually transmitted disease. The African American rate is more than 15 times the rate of Whites (256/100,000 population). These staggering disparities were seen across specific STDs as well (i.e. Chlamydia and Gonorrhea).

African Americans are much more affected by homicide than Whites and the Nebraska total, with a homicide death rate almost 13 times the rate of Whites. African Americans in Nebraska also saw poor maternal and child health with higher infant mortality, low birth weight, teen birth rates, and reception of inadequate prenatal care.

Implementing and evaluating interventions to address these issues will help to reduce disparities.

Appendix

African American Profile of General Population and Housing Characteristics, 2010

Subject	Total Population		Males		Females	
	Number	Percent	Number	Percent	Number	Percent
Total population	82,885	100.0	42,138	50.8	40,747	49.2
Under 5 years	7,953	9.6	4,051	4.9	3,902	4.7
5 to 9 years	7,324	8.8	3,749	4.5	3,575	4.3
10 to 14 years	6,986	8.4	3,595	4.3	3,391	4.1
15 to 19 years	7,631	9.2	3,998	4.8	3,633	4.4
20 to 24 years	7,098	8.6	3,666	4.4	3,432	4.1
25 to 29 years	6,819	8.2	3,525	4.3	3,294	4.0
30 to 34 years	5,913	7.1	3,116	3.8	2,797	3.4
35 to 39 years	5,456	6.6	2,792	3.4	2,664	3.2
40 to 44 years	5,102	6.2	2,665	3.2	2,437	2.9
45 to 49 years	5,513	6.7	2,881	3.5	2,632	3.2
50 to 54 years	5,050	6.1	2,543	3.1	2,507	3.0
55 to 59 years	3,875	4.7	1,963	2.4	1,912	2.3
60 to 64 years	2,751	3.3	1,290	1.6	1,461	1.8
65 to 69 years	1,837	2.2	842	1.0	995	1.2
70 to 74 years	1,389	1.7	628	0.8	761	0.9
75 to 79 years	1,030	1.2	437	0.5	593	0.7
80 to 84 years	666	0.8	258	0.3	408	0.5
85 years and over	492	0.6	139	0.2	353	0.4
Median age (years)	28.3	(X)	27.9	(X)	28.7	(X)
16 years and over	59,105	71.3	29,957	36.1	29,148	35.2
18 years and over	56,024	67.6	28,321	34.2	27,703	33.4
21 years and over	51,445	62.1	25,944	31.3	25,501	30.8
62 years and over	6,879	8.3	2,979	3.6	3,900	4.7
65 years and over	5,414	6.5	2,304	2.8	3,110	3.8

African American Profile of General Population and Housing Characteristics, 2010

Subject	Number	Percent
Total population	82,885	100.0
In households	78,570	94.8
Householder	30,185	36.4
Spouse [2]	7,251	8.7
Child	28,583	34.5
Own child under 18 years	22,448	27.1
Other relatives	6,521	7.9
Under 18 years	3,169	3.8
65 years and over	389	0.5
Nonrelatives	6,030	7.3
Under 18 years	711	0.9
65 years and over	132	0.2
Unmarried partner	2,592	3.1
In group quarters	4,315	5.2
Institutionalized population	2,838	3.4
Male	2,362	2.8
Female	476	0.6
Noninstitutionalized population	1,477	1.8
Male	975	1.2
Female	502	0.6
HOUSEHOLDS BY TYPE [3]		
Total households	30,185	100.0
Family households (families) [3]	18,508	61.3
With own children under 18 years	10,911	36.1
Husband-wife family	7,826	25.9
With own children under 18 years	3,929	13.0
Male householder, no wife present	2,079	6.9
With own children under 18 years	1,132	3.8
Female householder, no husband present	8,603	28.5
With own children under 18 years	5,850	19.4
Nonfamily households [3]	11,677	38.7
Householder living alone	9,820	32.5
Male	4,938	16.4
65 years and over	633	2.1
Female	4,882	16.2
65 years and over	1,155	3.8
Households with individuals under 18 years	12,466	41.3
Households with individuals 65 years and over	4,337	14.4
Average household size	2.58	(X)
Average family size	3.30	(X)

	Number	Percent
HOUSING TENURE		
Occupied housing units	30,185	100.0
Owner-occupied housing units	10,576	35.0
Population in owner-occupied housing units	29,188	(X)
Average household size of owner-occupied units	2.76	(X)
Renter-occupied housing units	19,609	65.0
Population in renter-occupied housing units	48,648	(X)
Average household size of renter-occupied units	2.48	(X)

"X" Not applicable.
[1] When a category other than Total Population is selected, all persons in the household are classified by the race, Hispanic or Latino origin, or tribe/tribal grouping of the person.
[2] ""Spouse"" represents spouse of the householder. It does not reflect all spouses in a household. Responses of ""same-sex spouse"" were edited during processing to "unmarried partner."
[3] ""Family households"" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households are included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present are tabulated in nonfamily households. ""Nonfamily households"" consist of people living alone and households which do not have any members related to the householder.

Source: U.S. Census Bureau, 2010 Census.
Note: As part of the release of Summary File 2 (SF2) data, the Census Bureau released quick-table DP-1 for 38 states between December 15, 2011 and April 5, 2012. Some of the data cells in these tables were found to be erroneous (the male institutionalized population count and percentage). The tables were removed on April 9, 2012, and the data cells were corrected and re-released on April 26, 2012."

Glossary of Terms

Age-Adjusted Death Rate: A weighted average of a crude death rate according to a standard distribution. Age adjusting is a process by which the age composition of a population is held constant so that changes or differences in age composition can be eliminated from the analysis. This is necessary because older populations have higher death rates merely because death rates increase with age. Age adjusting allows the researcher to make meaningful comparisons over time and among groups in the risk of mortality. The death rates in this report have been adjusted according to the age distribution of the United States population in 2000 so that these rates are stabilized from fluctuation due to changes and difference in age composition of the population under study. This is calculated by the sum of age-specific death rates for each age group, multiplied by standard population in each age group, and divided by the total standard population.

Body Mass Index (BMI): A measure of weight relative to height. A BMI of less than 25 is considered ideal or healthy; a BMI of 25-29 is considered overweight; and a BMI of 30 or higher is considered to be indicative of obesity. BMI is calculated by dividing an individual's weight in kilograms by the individual's height in meters squared.

Death Rate: A death rate is a ratio between mortality and population; the number of deaths per specific number of people. This is the most widely used measure to determine the overall health of a community. Death rates are usually computed per 100,000 population. Rates allow meaningful comparisons between groups of unequal size.

Diabetes: Often times called diabetes mellitus, is a disease of the pancreas in which the body does not produce or properly use insulin, a hormone that is needed to convert glucose into energy. According to the Centers for Disease Prevention and Control and Prevention, "Diabetes mellitus is a group of diseases characterized by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can be associated with serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications."

Employed: Employed includes all civilians 16 years old and over who were either (1) "at work" -- those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were "with a job but not at work" -- those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons. Excluded from the employed are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are people on active duty in the United States Armed Forces. The reference week is the calendar week preceding the date on which the respondents completed their questionnaires or were interviewed. This week may not be the same for all respondents.

Household: A household includes all the people who occupy a housing unit. (People not living in households are classified as living in group quarters.) A family household consists of a householder and one or more people living together in the same household who are related to the householder by birth, marriage, or adoption. It may also include people unrelated to the householder. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated people who share living arrangements.

Householder: The person, or one of the people, in whose name the home is owned, being bought, or rented.

Incidence: Incidence is an estimate of the number of new cases of disease that develop in a population in a specified time period, usually one year. Incidence is often used as an indicator of the need for preventive measures, or to evaluate the effectiveness of existing programs.

Infant Death Rate: The number of infant deaths per 1,000 live births, calculated as number of infant deaths divided by number of live births, multiplied by 1,000.

Infant Death: Death of a person under one year of age.

Injury deaths: Include deaths that are caused by forces external to the body. Examples of causes of injury death include drowning, fall, firearm, fire or burn, motor vehicle traffic, poisoning, and suffocation.

Kotelchuck Index: It is a prenatal care index. Special natality data summaries are prepared by the Office of Health Care Information. The office uses special programs to create an adequacy of prenatal care index, as formulated by Dr. Milton Kotelchuck. The index characterizes births as inadequate, intermediate, adequate and adequate plus as evaluated for when prenatal care began, weeks' gestation, and number of recommended physician's visits.

The Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck Index, is one of the methods used to assess adequacy of prenatal care. Data for assessing prenatal care is taken from information collected on birth certificates. This index combines the month of pregnancy when prenatal care began with the number of prenatal visits to their health care provider during pregnancy. It also takes into account the length of gestation. Using these criteria, prenatal care is rated inadequate, intermediate, adequate, or intensive use.'

Labor Force: All people classified in the civilian labor force plus members of the U.S. Armed Forces (people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard).

Morbidity: A term used to describe disease, sickness or illness, as a departure from normal physiological and psychological conditions. It is normally expressed as a morbidity rate. Morbidity rates give the closest frame of the quality of life and health status in a given population.

Mortality: A term used to describe death. It is normally expressed as a rate, expressing the proportion of a particular population who die of one or more diseases or of all causes during a specified unit of time, usually a year. It is also the probability of dying within a specified time period. This rate is also called the “crude death rate.”

Not in Labor Force: All people 16 years old and older who are not classified as members of the labor force. This category consists mainly of students, housewives, and retired and seasonal workers interviewed in an off season who were not looking for work, institutionalized people, and people doing only incidental unpaid family work (less than 15 hours during the reference week).

Poverty: Following the Office of Management and Budget’s Directive 14, the U.S. Census Bureau uses a set of money income thresholds that vary by family size and composition to detect who is poor. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being "below the poverty level.”

Race: The following are the definitions of race as provided by the Office of Management and Budget and the U.S. Census Bureau.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “*White*,” or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.
African American: A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black,” “African American,” or “Negro," or provide written entries such as “African American,” “Afro American,” “Kenyan,” “Nigerian,” or “Haitian.”
Hispanic or Latino: A person having origins in any of the original peoples of Cuba, Mexico, Puerto Rico, South or Central American or other Spanish culture or origin regardless of race. People who identify their origin as “Spanish,” Hispanic,” or “Latino” may be of any race. For example, a person who considers themselves to be Hispanic may also identify as White.
Non-Hispanic White: A White person who does not consider themselves to be of Spanish, Hispanic, or Latino origin. They responded “No, not Spanish/Hispanic/Latino” and reported “White” as their only entry in the race question.

Unemployed: All civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness.

Unemployment Rate: The unemployment rate represents the number of unemployed people as a percentage of the civilian labor force. For example: if the civilian labor force equals 100 people and 7 people are unemployed, then the unemployment rate would be 7%.


Department of Health & Human Services
DHHS
NEBRASKA