

# Community Health Assessment Trends from African American Cultural Festivals (2012-2014)

Submitted by: Julianne Manchester, PhD  
Dayton LOMH Evaluator

The report illustrates three years (2012-2014) of descriptive and comparative data from the Dayton African American Culture Festivals. The trends reveal some consistencies in self reported healthcare access and needs, while revealing changes in age, gender, and habits that may be a reflection of outreach at the agency level. Further study with focus groups and interviews to better understand these findings may be of benefit in future years.

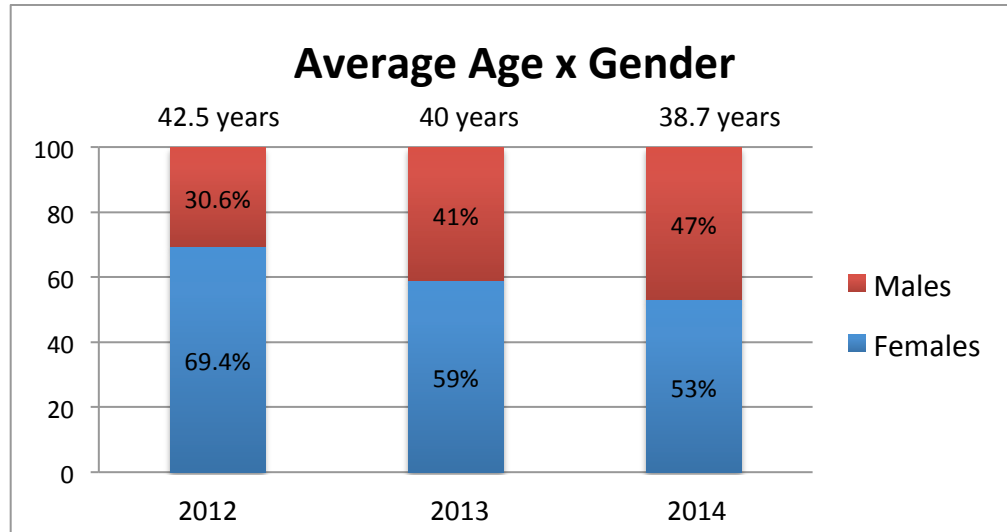
## Summary of Key Takeaways

- Since 2012 and 2014, the African American Cultural Festival (AACF) seems to be attracting a slightly different demographic. The data below, particularly in Chart 1, reveal a younger audience with noticeably higher male representation. This could be a function of venue, marketing and promotion efforts, and male, minority interest in the topic of wellness (a potential outcome for local and statewide prevention efforts). The younger, male, African American demographic alongside lowered rates of private insurance, seeing a doctor in the last 6 months, and having one's own transportation (see Table 3) begs the same questions put forth among some scholars on the topic of health disparities. Martin et al. (2015) pointed out that African American men were commonly connected with the healthcare system through the military, prison, or emergency room departments. This is combined with the issue of African American heavy communities commonly showing up on lists of health professions shortage areas (HPSAs) and medically underserved areas (MUAs). The age and gender change among the AACF attendees begs the question, to what degree do declines in self report health variables (consumption of fruits and vegetables, adequate water intake) shown in these data really relate to the male demographic, and not fluctuations in sample size or instrumentation error? Understanding the causes of the apparent differences across years, through focus groups or interviews, may help further target prevention efforts where needed.
- The samples from the AACF are likely a representative sample of the Dayton and Montgomery County, African American communities. Although the events are targeted in name to African Americans ("African American Culture Festival"), other groups such as Caucasians and Asians do attend (less than 20%). As will be shown, the similarities to the Community Health Assessment (CHA) (2014) data reveal that respondents at these events are fairly representative of Dayton and Montgomery County as a whole.
- Somewhat related to the increase in male attendees between 2012 and 2014, women have been disproportionately represented among the self-reported diagnoses categories (see Table 4), except for 2014 when fairly equal gender representation occurred (see Table 1). It shows that these categories (diabetes, heart disease) are real issues for both genders, and a fuller understanding of their prevalence becomes possible when genders become more equivalent in the data.
- The demographics pertaining to commonly occurring zip codes for the events indicate that these data should be considered alongside economic and health barriers that have already been identified at the federal level (American Community Survey, 2013) in these communities.

Results

All data are based on sample sizes as follows: 2012- n=147; 2013- n=191; 2014- n=91. As shown in Chart 1, below, the proportion of males has increased since 2012 by 16.4% (30.6 % to 47%) and the average age has gone down by about four years (42.5 to 38.7 years). In 2014, 21% of attending males were 35-44 years and 67% were between 35 and 64 years.

Chart 1  
Age x Gender (2012-2014)



Ethnicity has stayed constant for all three years, but shows the most change between 2013 and 2014. African Americans comprised 88% of respondents in 2012; 100% in 2013; and 76% in 2014. “Other” categories for all three years include Caucasian, Asian and Hispanic. Most attendees consistently report not having children in the home: 82.3% (2012); 93% (2013); and 81% (2014).

Table 1 below shows differences in healthful behaviors and easy (walkable) access to grocery stores where fruits and vegetables could be purchased. Although the majority of attendees have reported getting adequate exercise per week, the percentage in 2014 is noticeably less than in previous years. This trend is true for all four items listed below.

Table 1  
Self-Report Health-Related Behaviors

Behaviors	2012 (n=147)	2013 (n=191)	2014 (n=91)
20-30 minutes of physical exercise 3 times per week	80%	85%	59%
At least 5 servings of fruits/vegetables per day	46%	60%	41%
8, 8-oz glasses of water per day	74%	75%	49%
Lives within walking distance of a grocery store	53%	54%	31%

The top five zip codes for each year are shown below in Table 2, in order from most frequent to less frequent for each year. For example, 45406 was the most frequently cited for years 2012 and 2014 and

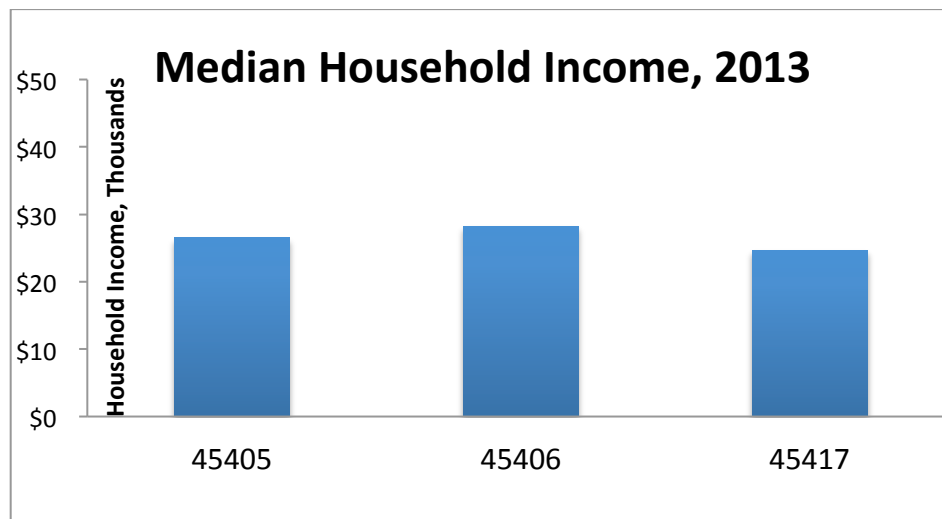
cited second to 45417 for 2013. Likewise, 45405 was consistently represented in the top 5 for all three years. Other zip codes show less consistency. For example, 45408 is present only in 2012 among the top 5. Some of these differences can be attributed to changes in venue, marketing efforts and so forth with particular groups. However, all zip codes shown below consistently represent a very targeted demographic comprised mostly of African Americans.

Table 2  
Top Five Zip Codes

2012	2013	2014
45406	45417	45406
45402	45406	45405
45405	45405	45417
45408	45322	45449
45417	45416	45415

For the three zip codes present all three years, 45405, 45406, and 45417, there are clear indicators that these attendees face significant challenges to housing, income, and health stability. Chart 2 below shows that median family incomes (American Community Survey, 2015) for these areas fall well below the national trends (median of \$51,939 in 2013).

Chart 2  
2013 Median Household Income for Consistently Represented Zip Codes



Median household income ranged from a low of \$24,623 (45417) to \$28,244 (45406). Collectively the areas represent a 94% difference in household income from the national median. The majority of these areas are African American (range = 62% to 82%), with a higher rate of female, single headed households with related children than husband-wife households with related children. For example, in 45405, 70% of

households with related children were characterized as a female household (no husband) versus 41% of households with related children characterized as husband-wife.

Although few attendees (average of 15% for three years) at this conference report children living in the home, the cited demographics of ethnicity, low median income and the substantial number of female-headed households in these geographical areas indicate significant community challenges (e.g., around or less than half living in walking distance of a grocery store or getting adequate fruits and vegetables, see Table 1) that would impact most inhabitants. These zip codes are designated within Health Professions Shortage Areas (HPSAs) (HRSA, 2015), indicating few primary care providers in proximity.

Table 3 shows differences across the years in health care characteristics. Most have consistently held private insurance and also dental insurance, reported understanding prescriptions, have their own transportation and have seen a doctor in the last 6 months. However, these percentages have declined over the three years, for all categories. The yellow shading in Table 3 indicates the lowest percentages occurring in Year 3. As stated earlier, Year 3 attendees are comprised of a larger percentage of males than in previous years.

Table 3  
Self Report Health Care Access and Knowledge

<b>Health Care Access and Knowledge Indicators</b>	<b>2012 (n=147)</b>	<b>2013 (n=191)</b>	<b>2014 (n=91)</b>
Have health insurance- Private	63%	68%	55%
Have health insurance- Medicare	18%	25%	13%
Have health insurance- Medicaid	20%	21%	16%
Have prescriptions/medications	54%	53%	48%
Understand prescriptions and related dosages	65%	62%	59%
Been to doctor in last 6 months	81%	87%	60%
Have own regular transportation (car, motorcycle)	78%	79%	63%
Have an emergency or unmet medical need	12%	16%	12%
Have an emergency or unmet dental need	16%	16%	10%
Have dental insurance	73%	65%	64%

Table 4 shows the breakdown of previously diagnosed conditions for all three years. As males have increased in attendance, their self reported diagnoses have risen. For example, all Type II diabetes cases were Female in 2012 with a steady decline to 60% in 2014. As males have increased their numbers in terms of attendance, it makes sense that their diagnoses are going to take on a greater presence in the data as compared to the previous two years. Self reported high blood pressure also fell noticeably among females, from 86% in 2012 to 54% of sample in 2014. Of note, Type I diabetes is an option for the AACF

assessments; however, they are not included here due to a high rate of missing data on the Gender by Type I Diabetes variable.

Table 4  
Previously Diagnosed Conditions x Percentage of Females Reporting

Conditions	2012 (n=147) (%Female)	2013 (n=191) (%Female)	2014 (n=91) (%Female)
Pre-diabetes	n=12 (100%)	n=16 (100%)	n=6 (33%)
Type II diabetes	n=12 (100%)	n=18 (78%)	n=10 (60%)
Stroke	n=4 (100%)	n=5 (80%)	n=2 (50%)
Heart disease	n=5 (80%)	n=13 (85%)	n=3 (0%)
Cancer	n=6 (100%)	n=11 (82%)	n=1 (100%)
High blood pressure	n=48 (86%)	n=71 (81%)	n=28 (54%)

The statistics shown here in Table 4 coincide with data shown in the Community Health Assessment (CHA) (2014), Public Health Department- Dayton and Montgomery County. Table 4 above shows Type II Diabetes rates to be between 8% to 11% (n=12 to 10, respectively). Similarly, the CHA (2014) cites the percentage of adults with Diabetes (regardless of race) in Montgomery County to be at 12.9%, a close figure. The CHA (2014) cites high blood pressure as impacting 35% of adults in Montgomery County. Similarly, it is cited in AACF data at the rate of 33% (n=48), 37% (n=71), and 31% (n=28) respectively for 2012, 2013, and 2014.

## References

American Community Survey (2013 estimates) (2015). Retrieval from US Census, American Fact Finder, [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts)

Community Health Assessment (2014). Public Health- Dayton & Montgomery County. Retrieval from <http://www.phdmc.org/resources/cha>

Martin, S.A., Harris, K., & Jack, B.W. (2015). The health of young African American men. *Journal of the American Medical Association: Viewpoint*, 313 (4), p. 1415-1416.

HRSA Data Warehouse 2015. Retrieval from: <http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx>