Georgia Department of Public Health
North Central Health District
Hancock County

2013 COMMUNITY HEALTH ASSESSMENT

Georgia Department of Public Health
North Central Health District

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INTRODUCTION

The North Central Health District (NCHD), composed of 13 individual counties, is seeking accreditation from the National Public Health Accreditation Board (PHAB). Accreditation will provide health departments the ability to improve quality, access, services, value, and accountability to stake holders within the community. One of the prerequisites for accreditation includes the completion of a Community Health Assessment.

The Community Health Assessment involves a process of collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health. It is one of the core functions of public health, which is why it's in the accreditation standards. It involves the systematic collection and analysis of data in order to provide the health department and the community it serves with a sound basis for decision-making. It should be conducted in partnership with other organizations in the community and include collecting data on health status, health needs, community assets, resources, and other community or state determinants of health status. A community health assessment links directly to Standard 1.1. The intention here is that, for accreditation purposes, the health department can demonstrate that it systematically assesses its jurisdiction's health status and can describe it. Most health departments should have access to much of the data needed. Partnerships with hospitals, academic institutions, other governmental agencies (such as schools or police), and non-profit health promotion organizations will help to access additional data needed to assess the health of the community or state. Putting it all together in an organized way to describe the health status or health profile of the community it serves might be a little different way to use the information available.

Our community health assessment is composed of the following three sections:

- **Community Strengths and Themes Assessment** -- provides qualitative information on how communities perceive their health and quality of life concerns as well as their knowledge of community resources and assets.

- **Local Public Health System Assessment** -- measures the capacity and performance of the local public health system by surveying all organizations and entities that contribute to the public's health.

- **Health Status Report** -- provides quantitative data on a broad array of health indicators, including quality of life, behavioral risk factors, and other measures that reflect a broad definition of health.

COMMUNITY STRENGTHS AND THEMES ASSESSMENT

Introduction

The Community Strengths and Themes Assessment, was determined by the Mobilizing for Action through Planning and Partnerships (MAPP) strategy. The MAPP strategy consists of six phases:

1. Organize for success and developing partnerships
2. Collaborating a shared community vision
3. Includes Four Assessments:
    a. Community Themes and Strengths Assessment
    b. Local Public Health System Assessment
    c. Community Health Status Assessment
    d. Forces of Change Assessment
4. Identify strategic issues
5. Formulate goals and strategies
6. Action Cycle that links planning, implementation, and evaluation of the community themes.

The "Community Strengths and Themes Assessment," of phase three in the MAPP process was employed to gain insight upon the quality of life in Hancock County, Georgia. This was done through interviewing key informants from each county, whom are individuals within a particular facet of the community that are considered to have a valued opinion in reference to the designated population. Each key informant was presented with a preselected set of questions that will be used amongst all 13 counties within the NCHD. The results of the assessment will provide the NCHD with a comprehensive summary of community perceived views on the current state of health in Hancock County, Georgia.

This portion of the Community Health Assessment was completed through the partnership of Dr. David Harvey, District Director, and Mercer University's Masters of Public Health Program's students under the supervision of Dr. Jimmie Smith.

Key Informants

There were 6 key informants from Hancock County interviewed. Key informants were classified as community members, teachers, tax commissioners, community advocates, and representatives from the county government, sheriff's office, and Board of Education. These individuals all lived within Hancock County.

Demographics within the interviews

Individual Interviews: 6 participants, 33% female and 67% male

Quality of Life Questionnaire

Each key informant was asked a set of 12 questions reflecting the quality of life within that county. Responses ranked on a scale of 1 to 5, with 5 being the most positive.

1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]

2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.) [IOM, 1997]

3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)

4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)

5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)

6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, the mall. Do neighbors know and trust one another? Do they look out for one another?)

7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, organizations) during times of stress and need?

8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?

9. Do all residents perceive that they-individually and collectively-can make the community a better place to live?

10. Are community assets broad-based and multi-sectoral?

11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?

12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments?

Summary of Community Themes and Strengths Assessment

After reviewing the data collected from key informant interviews, these are the most prevalent strengths and themes discussed in Hancock County:

Quality of life – Although quality of life can be difficult to measure, interviewees were asked to think about their sense of wellbeing, safety, and participation in community life and community associations. The majority of participants were satisfied with the quality of life in Hancock County, however, they did feel that there was room for improvement in regards to healthcare resources and economic development of the community.

Resources – While key informants perceive their community as being a good place to grow old, many identified the community as having limited resources. There is one grocery store within the county, but most residents commute outside of the county to go shopping for other supplies. Some citizens believed that there is a need for resources that cater towards the elderly, and provide healthier eating options for all age groups. On the contrary, there are many church organizations that provide broad-based support for the community. There is one park in Hancock County and was very highly spoken of with all interviewees. For children, resources are available through the Youth Center and Oconee Center. There is also a new, non-profit Multi-Purpose Outreach Center of Hope opening October 2014, that will focus on supporting families with education, counseling, and emergency needs.

Healthcare – Key informants mentioned that the healthcare facilities within the county did not have the updated technology that some of the others outside of the county have. There is no hospital within the county, and there is limited specialty care; thus, residents may commute to another county for emergency and specialty healthcare. Nevertheless, there is an ambulance service available that can transfer patients to other medical facilities if needed.

Education – Key informants were overall satisfied with the K-12 education system. Residents wanting higher education must commute or move outside of the county.

Economic Opportunity - Interviewees felt that there was low economic opportunity in Hancock County. Key informants mentioned that "there are local jobs available, but they are highly competitive and do not pay very well." Most residents commute outside of the county for work. Interviewees also felt that Hancock County was lacking in industry, has high unemployment rates, and thus, residents would like to see more jobs created.

Growing old – Hancock County is a great place to grow old. The community is supportive towards this population. Elderly resources include the senior center and elderly income-based housing. Transportation to healthcare services both within and outside of the county is available for the elderly. Services, such as meals on wheels, are also available.

Civic pride –Overall interviewees did not think there was much perceived pride in Hancock County individuals, but civic pride is evident in some community and governmental organizations. For example, civic pride is apparent with the revitalization of the Hancock County Courthouse that recently burned down.

Conclusion

In conclusion, Hancock County informants shared several significant themes and strengths, of which the top two included elderly resources and a lack of economic opportunity. Informants believed that although Hancock County is a nice place for growing old, there were few healthcare resources available. This theme and strength is intertwined with economic development because there are fewer physicians and specialists willing to relocate to an area that does not promise the opportunity for economic growth.

Overall, the Community Themes and Strengths Assessment proved to be a beneficial tool in evaluating the needs of a community. Key informant interview results revealed that the most commonly discussed themes and strengths were consistent with actual health statistics. This assessment is an important tool to review when implementing programs in the community because it identifies how several problems and issues are interrelated. This not only helps explain this collected data, but it gives it life. By allowing community representation in the accreditation process, the community is involved. The opinions and concerns of county citizens are documented, and will be used in improving the health in Hancock County.

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

Purpose and Background

The National Public Health Performance Standards Program (NPHPSP) assessments are a helpful tool in evaluating the current performance against a set of optimal standards. This is a partnership effort to improve the practice of public health and the performance of public health systems. This Local Public Health System Assessment (LPHS) report is intended to help the North Central Health District gain a good understanding of its performance and move on to the next step in strengthening the public system.

The 10 Essential Public Health Services (EPHS) describe the public health activities that all communities should undertake and serve as the framework for NPHPSP instruments. These include:

1) Monitor health status to identify and solve community health problems.
2) Diagnose and investigate health problems and health hazards in the community.
3) Inform, educate, and empower people about health issues.
4) Mobilize community partnerships and action to identify and solve health problems.
5) Develop policies and plans that support individual and community health efforts.
6) Enforce laws and regulations that protect health and ensure safety.
7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8) Assure competent public and personal health care workforce.
9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10) Research for new insights and innovative solutions to health problems.

Methods

The methodology was to stratify NCHD staff in three categories- county nurse managers, district management team members, and randomly selected staff members from each program, and ask them to indicate if they participated in any activity listed in the survey instrument. If so, they were asked to indicate if they had any documentation or artifacts that support their statement. The data was then summarized in to one table.

The survey results include percentage ratings for each of the full standards, based on if the individual indicators within each standard were met. These indicators represent the individual objectives that when joined together, comprise the total standard. The score for each standard category was based on the percentage of separate indicators met within the standard.

The rating system for the standards was as follows:

- **No Activity -** 0% or absolutely no activity
- **Minimal Activity** - 1% to 25% activity
- **Moderate Activity** - 26% to 50% activity
- **Significant Activity** - 51% to75% activity
- **Optimal Activity** - 76% to 100% activity

Results

This table provides a quick overview of the NCHD's performance in each of the 10 EPHS. Each score is determined by the percentage of how many individual objectives for each EPHS were fulfilled. These scores range from a minimum of 0 to a maximum of 100.

The overall performance score for all 10 Essential Public Health Services:

Significant Activity 67%

Summary of performance scores by Essential Public Health Service (EPHS)		
EPHS		**Score**
1	Monitor Health Status to Identify Community Health Problems	100
2	Diagnose and Investigate Health Problems and Health Hazards	92
3	Inform, Educate, and Empower People about Health Issues	70
4	Mobilize Community Partnerships to Identify and Solve Health Problems	71
5	Develop Policies and Plans tha Support Individual and Community Helath Efforts	45
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	50
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	86
8	Assure a Competent Public and Personal Health Care Workforce	56
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	46
10	Research for New Insights and Innovative Solutions to Health Problems	54
	Overall Perormance Score	**67**

Conclusion

While the district-wide public health system's overall rating for the 10 EPHS was categorized at "Significant Activity," it is important to note that this is a perceptual survey and that Essential Public Health Services Standards that were positively rated as a whole do not necessarily reflect a lack of need for improvement.

Action Plan

Moving forward, the next steps for improvement of NCHD's local public health system include forming a team, including public health employees and partners, to look at each EPHS individually to assess for improvements. This focus will be reflected in the NCHD's Quality Improvement Plan.

Completed: October 16, 2013

HEALTH STATUS REPORT

NORTH CENTRAL HEALTH DISTRICT OVERVIEW

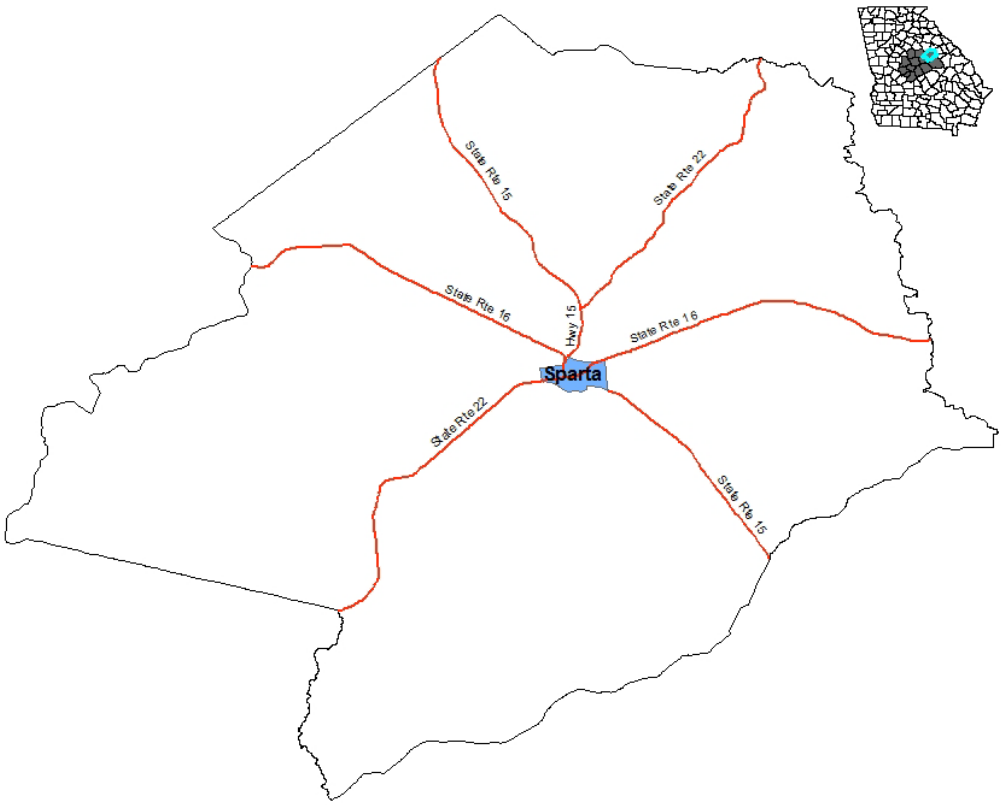
The North Central Health District (NCHD) is composed of 13 counties located in Middle Georgia. These counties are Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Washington, and Wilkinson Counties. According to the United States Census Bureau it accounts for approximately 520,905 people. The goal of the NCHD is optimal health for all Georgians and also strives to prevent diseases, promote health and protect communities against health threat. The success of NCHD is directly correlated to ideal participation and collaboration from the representative counties.

HANCOCK COUNTY OVERVIEW

History and Geography

Hancock County was created out from Greene and Washington counties in 1793 and its name honors John Hancock whose signature heads the list of signers of the Declaration of Independence. Sparta, the county seat, owes its name to the ancient Greek city, probably because its early residents realized they would need Spartan characteristics to survive so near hostile Indian territory and so far from supportive neighbors. This county remained a troubled frontier for 40 years before the state acquired and residents settled more westerly lands.

Figure 1: Map of Hancock County



General Population Characteristics

- **The NCHD is home to 520,905 individuals**.
- **Hancock County represents 2% of the population within NCHD**.
- Between 2000 and 2010 the population in Hancock County **decreased by 6%.**
- The majority of the population is within the working age group of 18-64 years of age and Black/African American is the most prevalent races.

Table 1: General Population Characteristics.

Demographic Characteristics of Hancock County Residents		
General Characteristics		
Total Population		9,429
Median age (years)		43
% Under 18 years		18%
% 18-64 years		66%
% ≥ 65 years		16%
% Male		55%
%Female		45%
Race/Ethnicity		
% American Indian/ Alaska Native		0.4%
% Asian		0.5%
% Black/ African American		74%
% Native Hawaiian/Other Pacific Islander		0.0%
%White		24%
% Other Races		0.1%
% Two or More Races		0.6%
% Hispanic/Latino (of any race)		2%
Household Characteristics		
Average Household Size		2.38
Average Family Size		2.98
Total Households		3,341
	Family Households	65.3%
	Nonfamily Households	34.7%
Family Households with Children (<18 years old)		736
	Married Couple Households with Children	42.7%
	Female Householder with Children	49.0%
	Male Householder with Children	8.3%

Source: U.S. Census Bureau

Household Characteristics

- **The number of households has increased by 3%** since 2000 in Hancock County, which is mostly seen in nonfamily and single parent households.

Employment

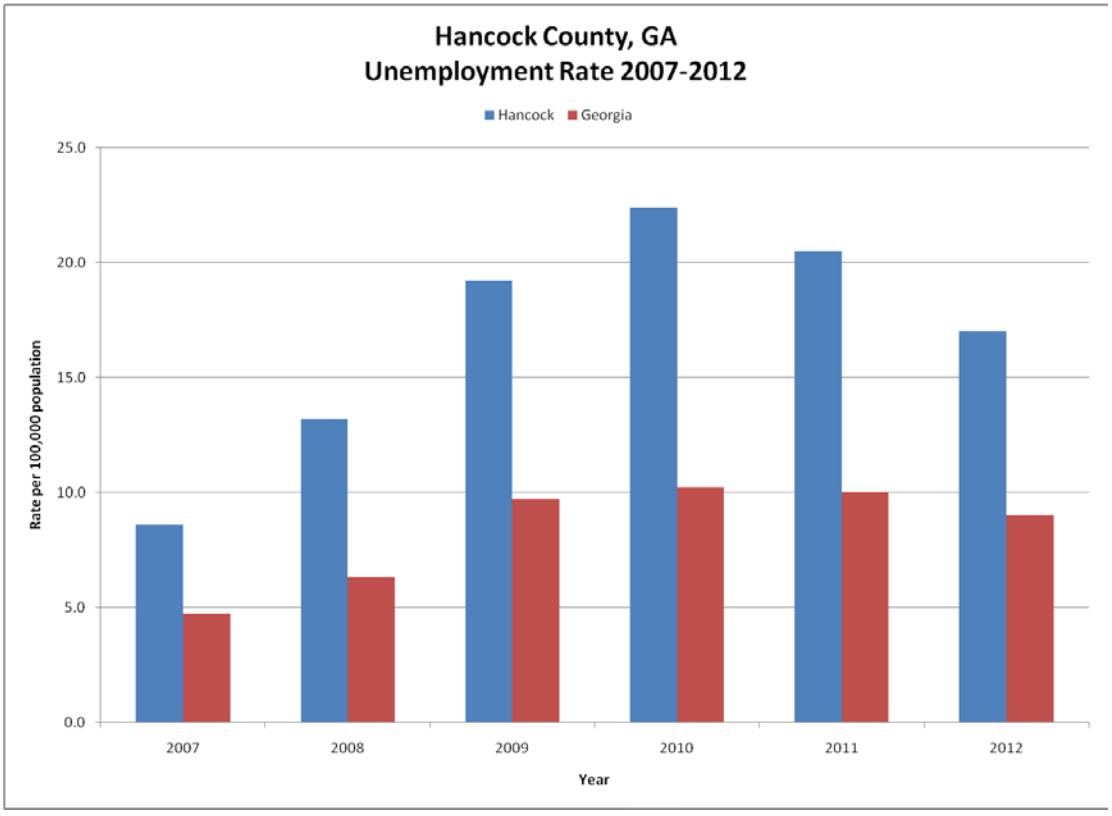
- The **unemployment rate in Hancock County has consistently stayed above the state** unemployment rate.
- The **median household income is below than the state average** and the number of children in poverty is at a higher percentage in Hancock County.

Table 2: Economic Indicators

Economic Indicators		
	Hancock	**Georgia**
Unemployment Rate, 2012	20.5	9.0
Median Household Income, 2010	$23,887	$46,252
% Population Employed 16 years and over	31%	44%
Children in poverty	42%	25%
% of Households with food Stamp/SNAP benefits in the past 12 months	22%	10%

Source: U.S. Census Bureau

Figure 2: Changes in the Unemployment Rate.



Source: Bureau of Labor and Statistics

Education

- Table 3 details the number of elementary, middle, and high schools located in the county, school enrollment, free/reduced lunch, graduation rates, HOPE qualifications for the 2010-2011 school year, and educational attainment for adults (age 25 and over).
- Hancock County has a total of **3 public schools with a total enrollment of 1,131 kids and had a higher proportion of students in the school system who qualify for free/reduced lunch (87%) compared to the state (56%).**
- Of those adults 25 and over in Hancock County, only **13% have a college degree where as 53% only have up to a high school diploma**.

Table 3: Education Information

Hancock County Education Information, 2010/2011 School Year		
Total Number of Schools	Elementary	1
	Middle	1
	High	1
Total Enrollment		1,131
% Students Qualifying for Free/Reduced Lunch		87%
2011 Graduation Rate		83.5%
% 2010 Graduates Eligible for HOPE		39.2%
% Illiterate*		31%
Educational Attainment*	Less than 9th grade	16%
	9th to 12th grade, no diploma	17%
	High school graduate (includes equivalency)	41%
	Some college, no degree	12%
	Associate's degree	3%
	Bachelor's degree	7%
	Graduate or professional degree	3%

Sources:
*U.S. Census Bureau
#U.S. Dept of Ed
All other data: GA Dept of Ed

For the 2010-2011 school year, a cohort graduation rate was used. To see a description of how this was calculated go to http://gaosa.org/reportinfo.aspx#indicators.

HEALTH CARE ACCESS

Health care access requires financial coverage and access to providers. Lack of health insurance has a profound negative effect on access to health care. Those without insurance are less likely to have regular medical care and are more likely to go without care.

- **23%** of the Hancock County population was uninsured in 2010.
- **18%** of adults in the North Central Health District reported being in fair or poor health.

Residents must have access to healthcare facilities and providers and the amount of those in a community is an indicator of the adequacy of health services available.

Table 4: Health Care Resources

Health Resources		
Number of Physicians/ 100,000 population	Primary Care	21.3
	Pediatricians	53.4
	Obstetricians/Gynecologists	0
	Psychiatrists	0
	Dentists	0
Facilities	Total number of hospitals	0
	Community Health Centers	1
	Federally-Qualified Health Centers	1

Source: U.S. Department of Health and Human Services

LEADING CAUSES

Leading Cause of Mortality

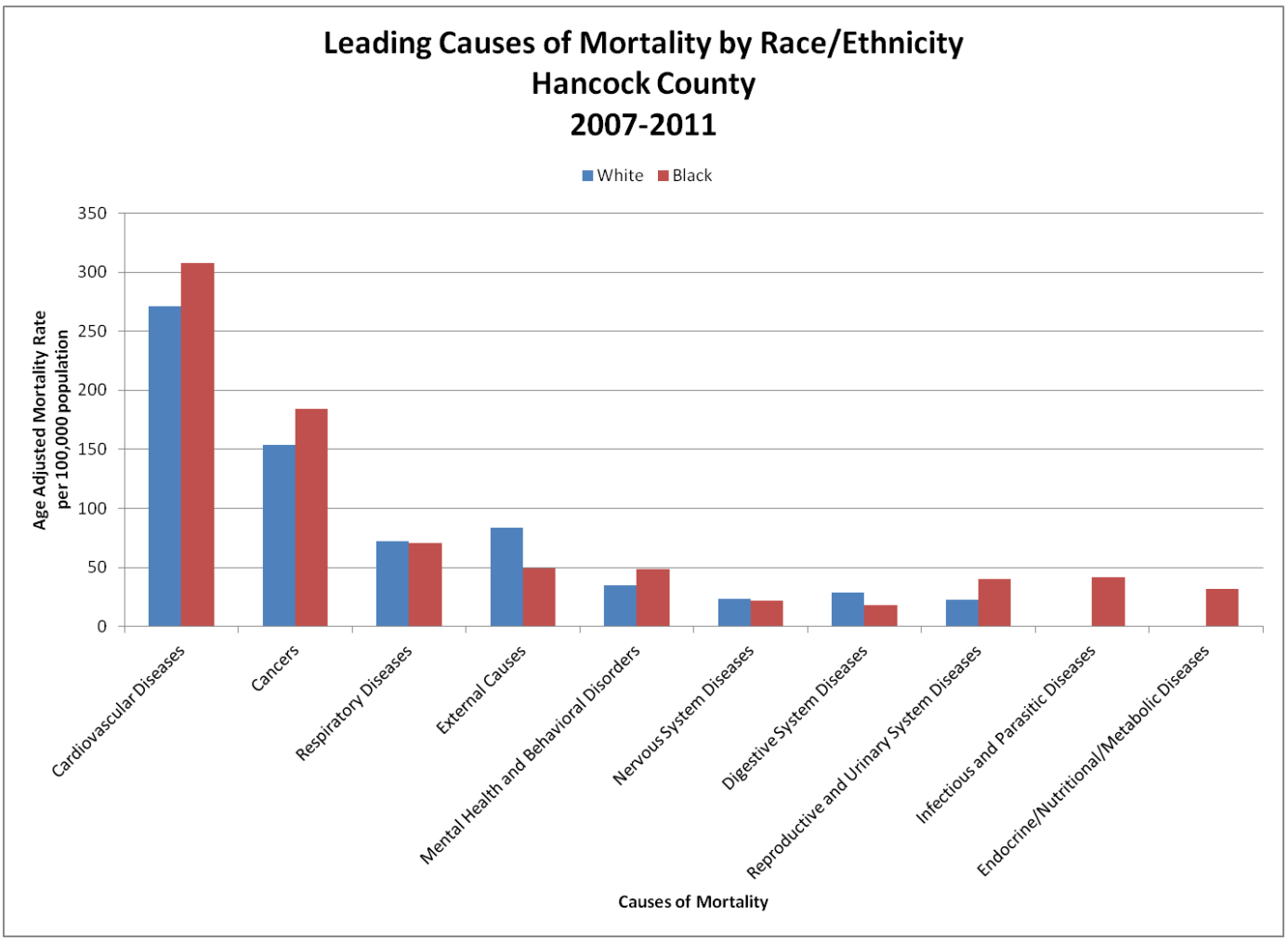
- **Heart disease and Cancer are the leading causes of death** in Hancock County.
- From 2007-2011, there were a total of 448 deaths in Hancock County, averaging **89.6 deaths per year**.
- During that same period, the overall mortality rate of the White population was 728.1 per 100,000 population and the overall mortality rate of the Black population was 858 per 100,000 population.

Table 5: Leading Causes of Mortality

Cause of Death
Cardiovascular Diseases
Cancers
Respiratory Diseases
External Causes
Mental Health and Behavioral Disorders
Reproductive and Urinary System Diseases
Endocrine/Nutritional/Metabolic Diseases
Infectious and Parasitic Diseases
Nervous System Diseases
Digestive System Diseases

Source: OASIS

Figure 3: Leading Causes of Mortality by Race/Ethnicity

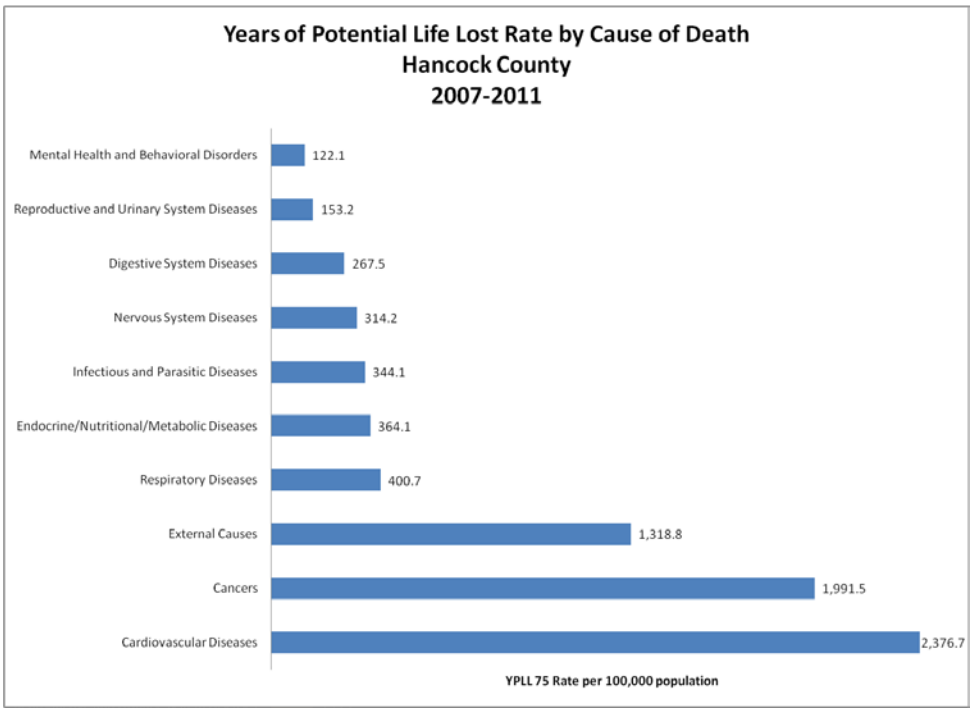


Source: OASIS

Leading Causes of Premature Deaths

- **The top 5 leading causes of premature death in Hancock County are Cardiovascular Disease, Cancers, External Causes, Respiratory, and Endocrine/Nutritional/Metabolic diseases.**
- Premature death is measured by the number of Years of Potential Life Lost (YPLL) due to a death occurring before the age of 75. The YPLL rate is calculated by taking the total years of life lost and dividing by the population younger than 75.

Figure 4: Leading Causes of Premature Death



Source: OASIS

Leading Cause of Hospitalizations

- In Hancock County, the leading causes of hospitalization were cardiovascular disease, pregnancy and child birthing complications, and respiratory diseases.

Table 6: Leading Causes of Hospitalizations

Cause of Hospitalization
Cardiovascular Diseases
Respiratory Diseases
Pregnancy and Childbirthing Complications
Digestive System Diseases
Reproductive and Urinary System Diseases
External Causes
Endocrine/Nutritional/Metabolic Diseases
Bone and Muscle Diseases
Infectious and Parasitic Diseases
Cancers
Mental Health and Behavioral Disorders

Source: OASIS

CHRONIC DISEASE

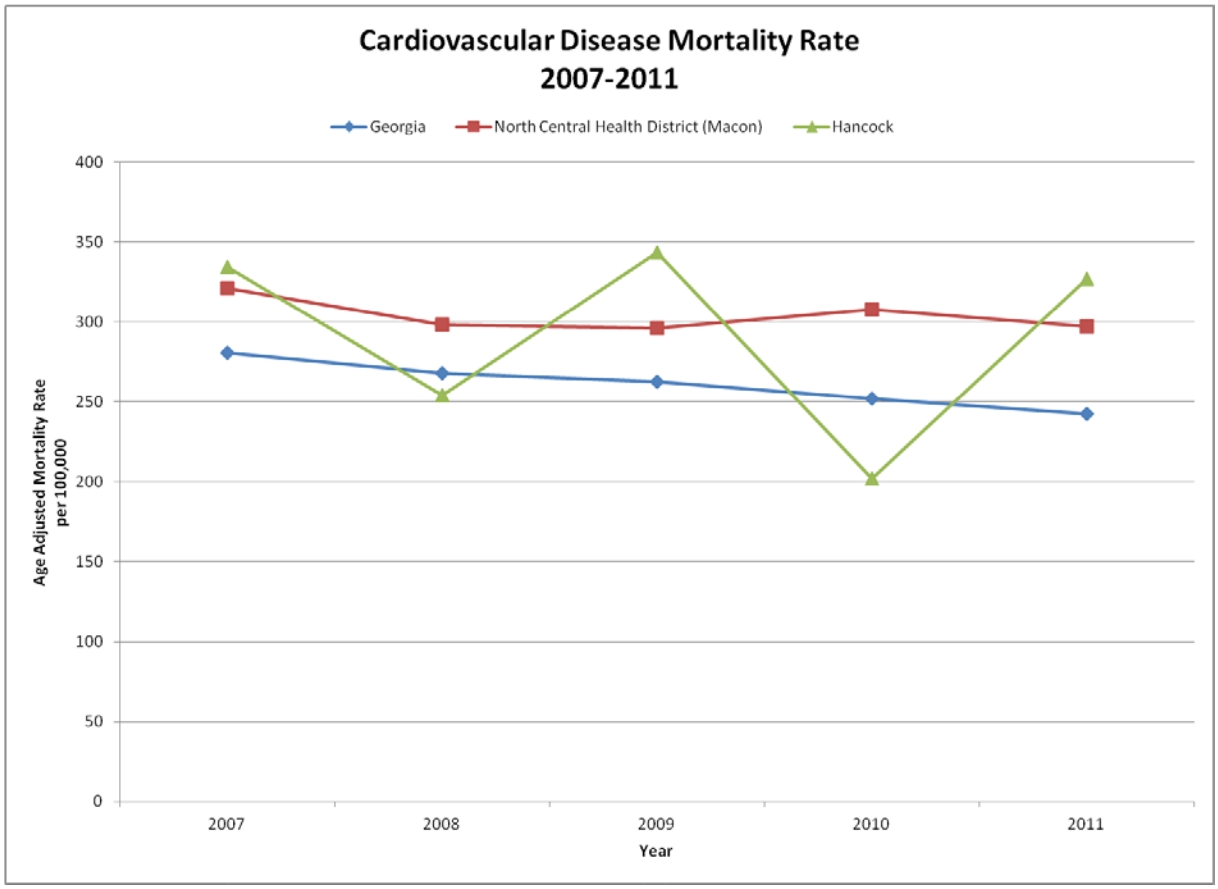
According to the Centers for Disease Control and Prevention (CDC), chronic diseases (such as cardiovascular disease, cancer, diabetes, and asthma) are "the most common, costly, and preventable of all health problems" in the country. Most chronic diseases are caused by modifiable behaviors, and are commonly ref
erred to as risk behaviors. The four most common risk behaviors are lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption.

Cardiovascular Disease

Cardiovascular disease (CVD) is the leading cause of death, hospitalization, and years of potential life lost in the district and it is the leading cause of disability in the U.S. The cost of CVD in the U.S. is estimated at $444 billion, and treatment accounts for $1 for every $6 spent on health care. CVD includes all diseases of the heart and blood vessels; such as obstructive heart disease, stroke, high blood pressure, hypertension, atherosclerosis, and aortic aneurysms. Risk factors of CVD include high cholesterol, high blood pressure, diabetes, and behavior and lifestyle choices such as tobacco use, diet, physical activity, obesity, and alcohol. Family history of CVD can also make an individual more susceptible.

- The 2007-2011 **overall mortality rate for Cardiovascular disease in Hancock County (290.9) is higher than the state rate (260.6)**.

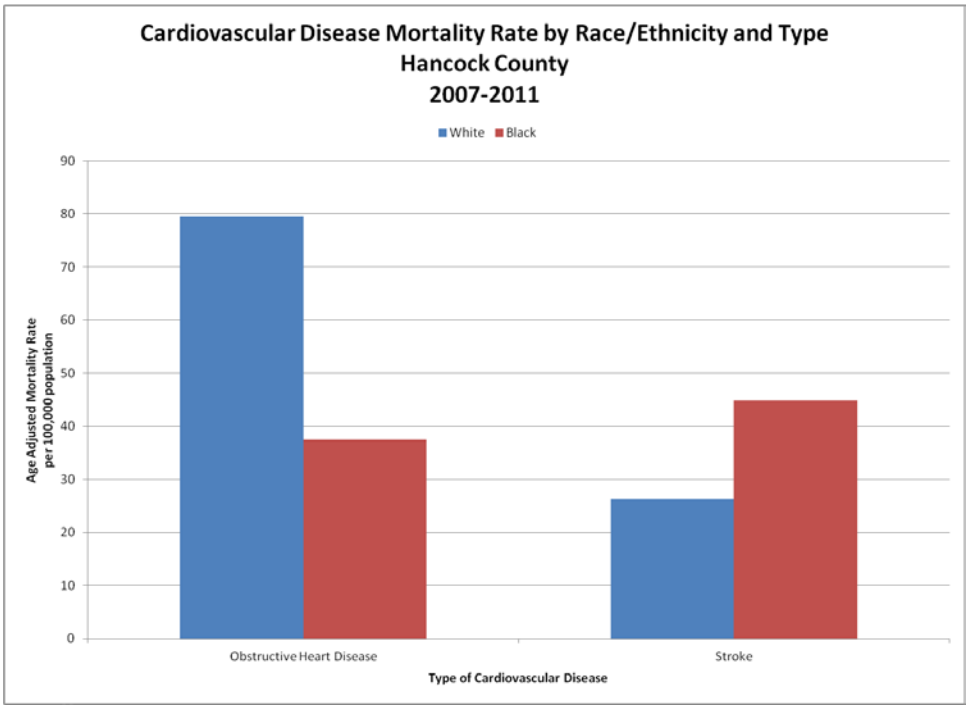
Figure 5: CVD Mortality Rate



Source: OASIS

- The mortality rate for CVD in Hancock County is **highest among the black population** from 2007-2011 at 307.7 per 100,000 population. The white mortality rate for CVD during this time was 271.1 per 100,000.

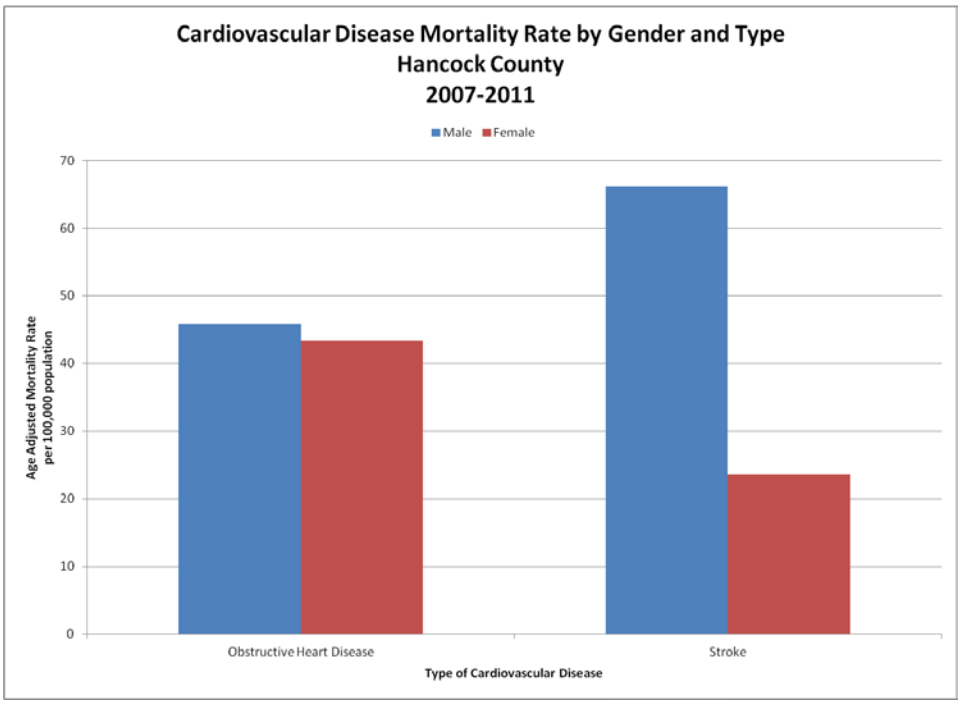
Figure 6: CVD Mortality Rate by Race and Type



Source: OASIS

- When comparing genders**, males have higher mortality rates** than females.

Figure 7: CVD Mortality Rate by Gender and Type



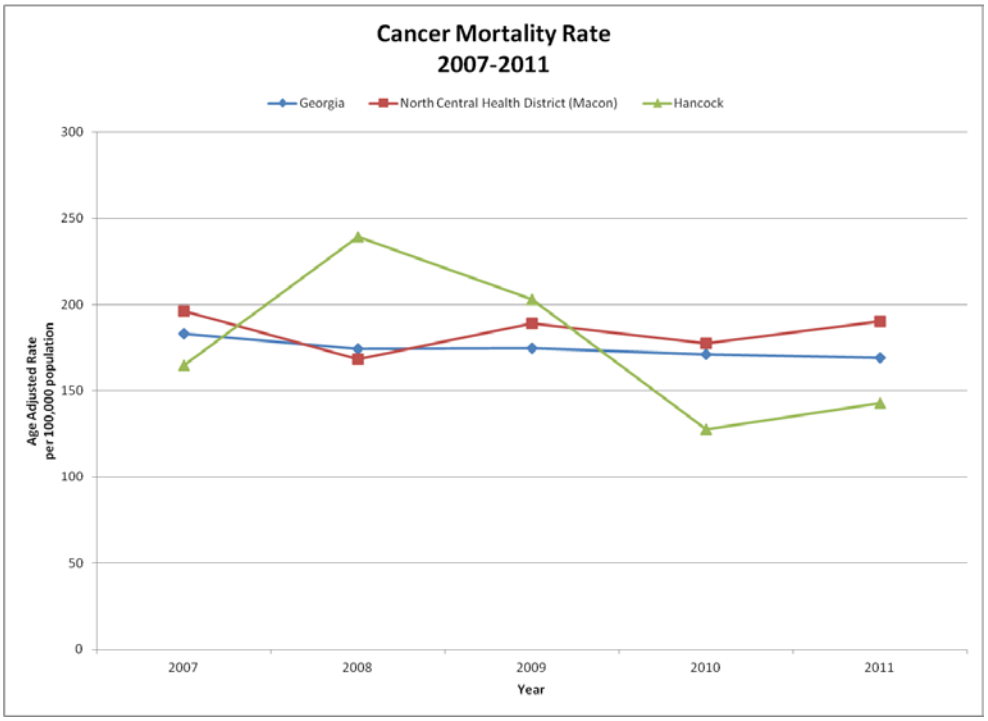
Source: OASIS

Cancer

Cancer is a disease in which cells divide abnormally without control and can invade adjacent tissues. The cells can also metastasize and spread to other parts of the body through the blood and lymphatic system. Nearly 2/3 of cancer deaths are associated with behavioral factors such as tobacco use, diet, obesity, and lack of physical activity.

- Cancer is a leading cause of death in the U.S., Georgia and in Hancock County.
- **The mortality rate due to cancer has decreased in Georgia since 2007.**

Figure 8: Cancer Mortality Rates.



Source: OASIS

- **Lung cancer is a leading cause of cancer mortality for both men and women in Hancock County and Georgia**.
- Prostate and Breast Cancer are also top causes of cancer in Hancock county.

Table 7: Mortality Rates due to Leading Causes of Cancer by Gender.

Age Adjusted Mortality Rates per 100,000 population due to Leading Causes of Cancer by Gender, 2007-2011					
Males	**Hancock**	**Georgia**	**Females**	**Hancock**	**Georgia**
Lung Cancer	97	68.9	**Breast Cancer**	27.5	23
Prostate Cancer	32.7	25.5	**Lung Cancer**	25.8	37.7

Source: OASIS

Table 8: Routine Preventative Cancer Screenings

Percent of Adult Residents Reporting Routine Preventative Cancer Screenings, 2006-2010	North Central Health District (Macon)	Georgia
Prevalence of Mammography in the Last 2 Years among Women	81%	77.7%
Prevalence of Pap Testing in the Last 3 Years among Women, AGE 18 +	89.4%	86.9%
Prevalence of ever having had a Sigmoidoscopy or Colonoscopy among Adults, age 50+	62.5%	63%
Prevalence of Adult Men, 40+ years old, who had a Prostate Cancer Screening in the Last Two Years	67.7%	59.1%

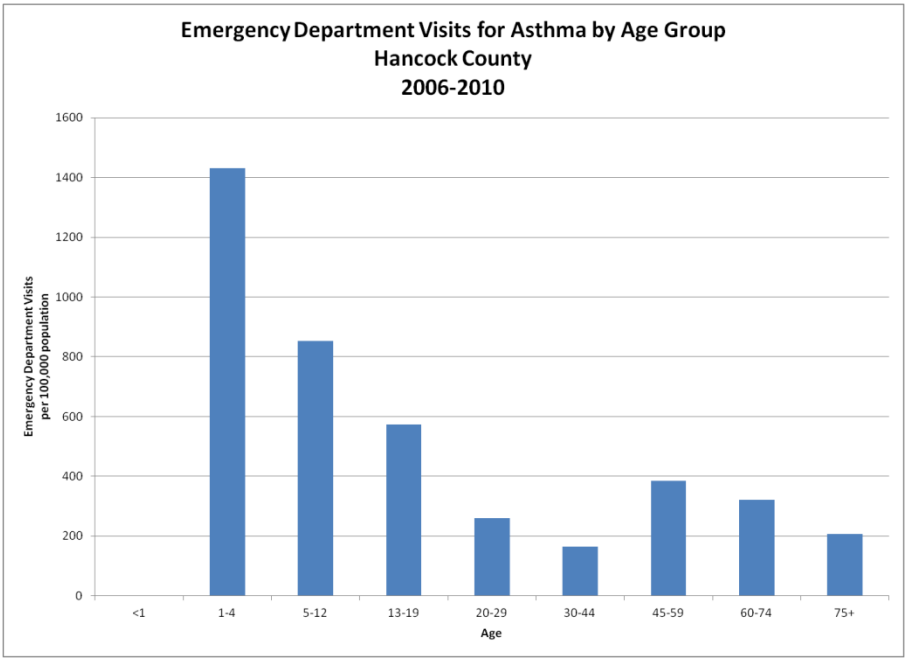
Source: OASIS

The **North Central Health District has a larger percentage of residents receiving routine cancer screenings** including: mammography, pap smears and prostate screenings compared to Georgia. However, the percentage of residents reporting sigmoidoscopy or colonoscopy is slightly lower than the state.

Asthma

Asthma is a chronic respiratory disease that affects the lungs. It causes recurring incidents of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by medication and by staying away from environmental triggers that can cause an attack. Common asthma triggers include tobacco smoke, dust mites, pollution, cockroaches, pets, and mold.

Figure 9: Emergency Department Visits by Age Group



Source: OASIS

From 2006-2010 in Hancock County, **Asthma accounted for 196 (1.7%) of emergency department visits and had a hospital discharge rate of 153.4 per 100,000**.

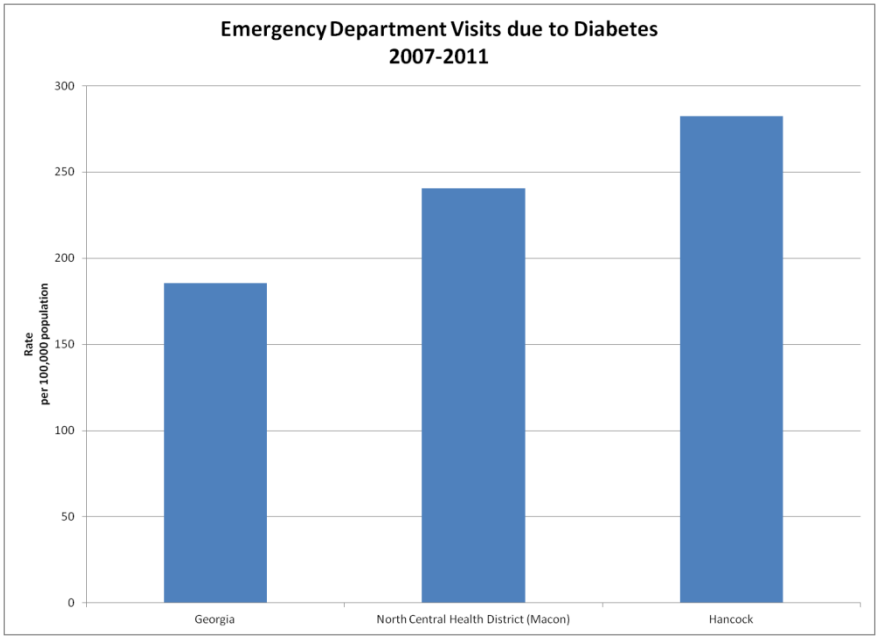
From 2006-2010 in Hancock County, children ages **1-12 were most affected** by asthma symptoms that led to an emergency department visit.

- The emergency department visit rates in Hancock County due to asthma were much **higher for blacks (512.5 per 100,000 population) compared to whites (77.1)**
- In the North Central Health District 8.1% of adults have been told they currently have asthma compared to the state of Georgia at 7.7%.

Diabetes

Diabetes mellitus is a disease characterized by high blood sugar levels. It is the result of the body's inability to produce and/or use insulin made by the pancreas. It can cause serious health complications including heart disease, blindness, kidney failure, and lower extremity amputations. Risk factors which contribute to the development of adult onset diabetes (type 2) include older age, obesity, genetics, history of pregnancy related diabetes, impaired glucose tolerance, physical inactivity, and race/ethnicity.

Figure 10: Emergency Department Visit Rate due to Diabetes



Source: OASIS

The age adjusted emergency department visit rate for diabetes from 2006-2010 was 282 per 100,000.

In the North Central Health District 11.4% of adults have been told they are diabetic compared to the state of Georgia at 9.5%.

Alcohol Use

Over time, excessive alcohol use can lead to the development of chronic diseases, neurological impairments and social problems. These include but are not limited to—

- Cirrhosis of the liver
- Pancreatitis
- Gastritis
- Cancer of the moth, throat, esophagus, liver, colon, and breast
- High Blood Pressure
- Psychiatric problems
- Cardiovascular diseases, such as hypertension and myocardial infarction (heart attack)
- Neurological problems, such as dementia and stroke
- Unintentional Injuries
- Poor birth outcomes

In the North Central Health District **11.7% of adults report binge drinking** (defined as 5+ drinks/day for men and 4+ drinks/day for women) compared to the state of Georgia at 12.5%.

Smoking

Smoking harms nearly every organ of the body and is the cause of many diseases. These include but are not limited to—

- Coronary heart disease
- Stroke
- Lung disease, such as lung cancer, emphysema, bronchitis and chronic airway obstruction
- Cancers such as acute myeloid leukemia, bladder, cervix, esophagus, kidney, larynx, lung, oral, pancreatic, pharynx, stomach, and uterus)
- Abdominal aortic aneurysm
- Reproductive and early childhood problems (infertility, preterm birth, stillbirth, low birth weight, and Sudden Infant Death Syndrome (SIDS))

The adverse health effects from cigarette smoking account for an estimated 443,000 deaths, or nearly one of every five deaths, each year in the United States. In the North Central Health District **22.9% of adults report being a current smoker** compared to the state of Georgia at 18.8%.

Overweight/Obesity

Overweight and obesity are terms used to describe weight that is above what is considered healthy. For adults, the terms are dependent on an individual's body mass index. Overweight is defined as a BMI of 25-29.9 and obesity is defined as a BMI of 30 or higher. Obesity and being overweight are associated with an increased risk of certain disease and health problems, including —

- Coronary heart disease
- Type 2 diabetes
- Cancers
- High blood pressure
- High Cholesterol
- Stroke
- Liver and gallbladder disease
- Sleep apnea and respiratory problems
- Osteoarthritis
- Gynecological problems

There are a variety of factors that contribute to being overweight or obese; these include caloric intake, environment, activity levels, genetics, and medication.

In Hancock County

- **39%** of Adults report being obese.
- **29%** of Adults report no leisure time physical activity.
- **18%** of the population are low-income and do not live close to a grocery store.
- **30%** of the population did not have adequate access to food during the past year
- **11%** of the population has adequate access to locations for physical activity

Source: County Health Rankings

INFECTIOUS DISEASE

The Georgia Department of Public Health, under the legal authority of OCGA 31-12-2 has designated certain diseases and conditions notifiable. The purpose of reportable disease surveillance is to:

- identify in a timely way any diseases or conditions that may require immediate public health intervention and follow up;
- detect changing trends or patterns in disease occurrence;
- identify areas or communities that require special public health response as a result of changes in disease patterns; and
- assess and evaluate control and prevention interventions.

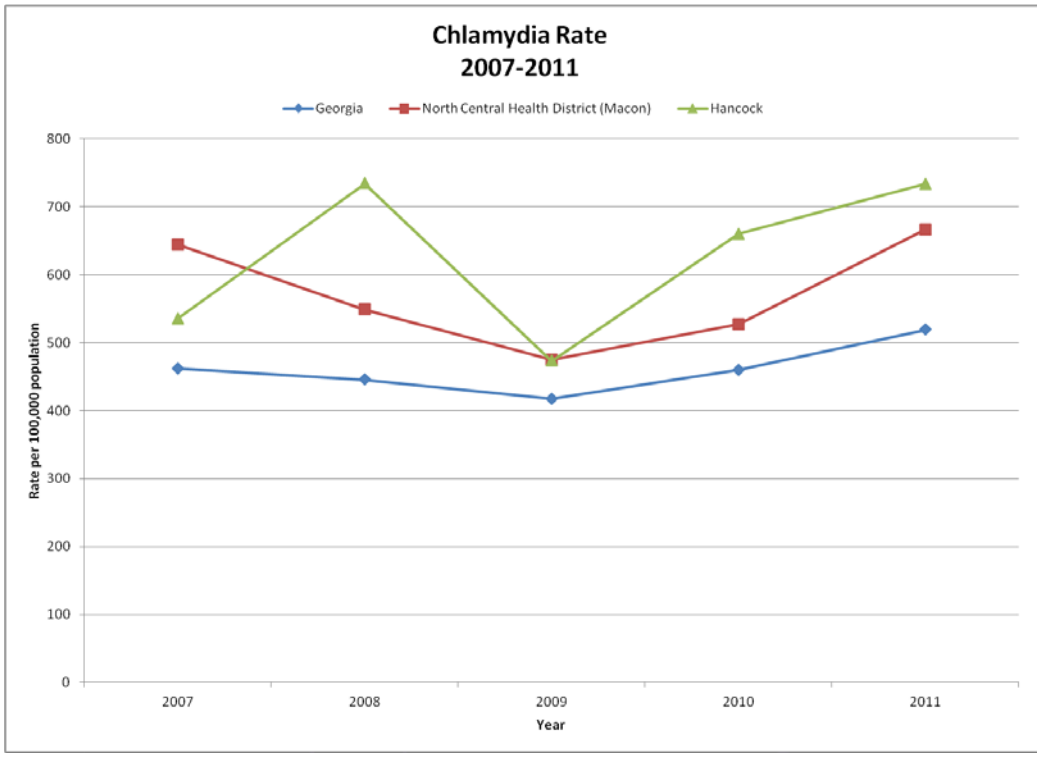
In Georgia, public health surveillance is conducted on more than 50 diseases and conditions. The data are collected by local and state health agencies who are responsible for analyzing, interpreting and disseminating the information to "those who need to know" for administrative, program planning, and decision making purposes.

Sexually Transmitted Diseases (STD)

Chlamydia
A common STD, Chlamydia is known as a silent disease because about ¾ of infected women and about ½ of infected men have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure. If untreated, Chlamydia infections can progress to serious reproductive and other health problems with both short term and long term consequences.

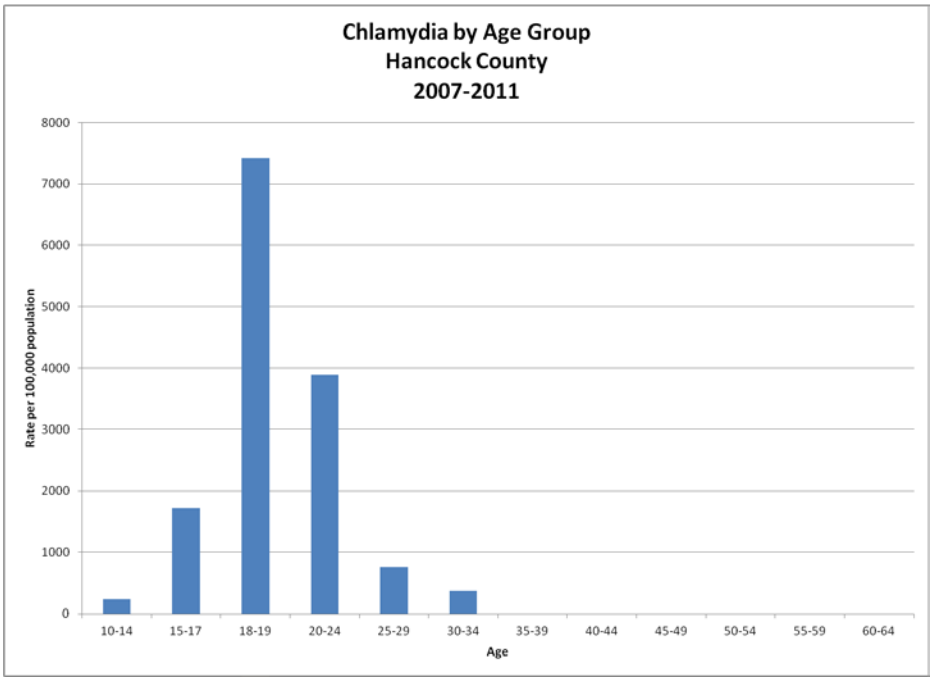
- According to 2011 data, the state of **Georgia ranks 7th highest** in the U.S. for rates of Chlamydia.
- From 2007-2011, **Hancock County ranked 32nd highest for the rate** of Chlamydia cases out of 159 counties for the number.

Figure 11: Chlamydia Rate



Source: OASIS

Figure 12: Chlamydia Rate by Age Group



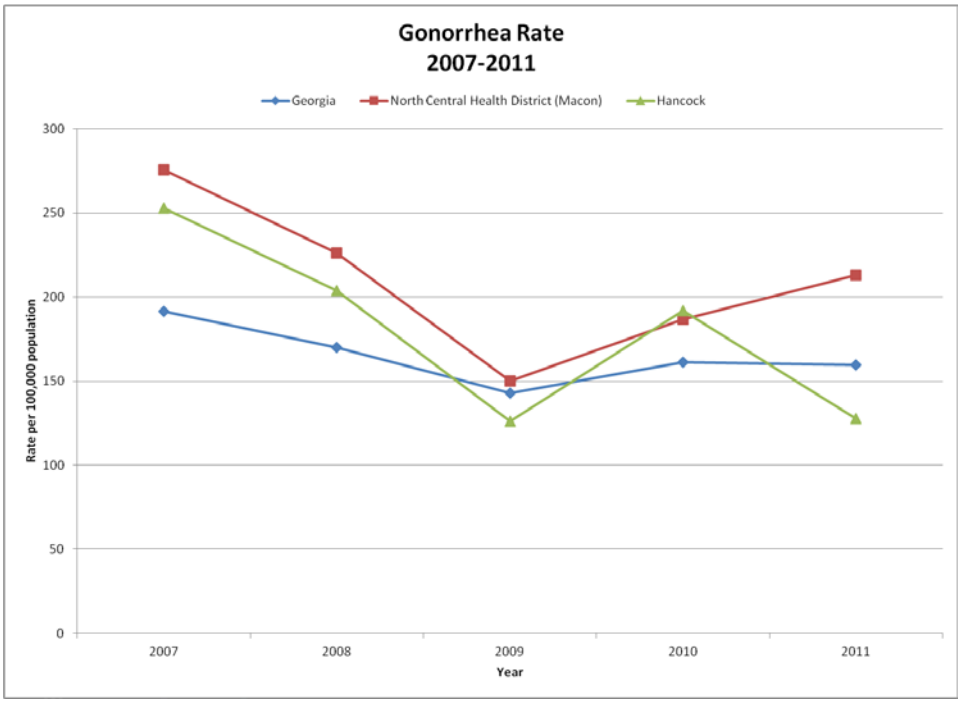
- The highest rates of Chlamydia in Hancock County are among 18-24 year olds.
- **In Hancock County, of the known Chlamydia cases where race was identified, the rate among the black population of 602 per 100,000 was significantly higher than the white population.**

Source: OASIS

Gonorrhea

Gonorrhea is an STD that when left untreated causes serious and permanent health problems. In women, gonorrhea causes pelvic inflammatory disease. In men, gonorrhea causes a painful condition of the ducts attached to the testicles that may lead to infertility if left untreated (epidiymitis). Since 2007 there has been an increase in drug resistant gonorrhea that has led to changes in national treatment guidelines.

Figure 13: Gonorrhea Rate



- According to 2011 data, the state of **Georgia ranks 6th highest** in the U.S. for rates of Gonorrhea.
- From 2007-2011, **Hancock County ranked 46th highest** out of 159 counties for the rate of Gonorrhea cases.

Source: OASIS

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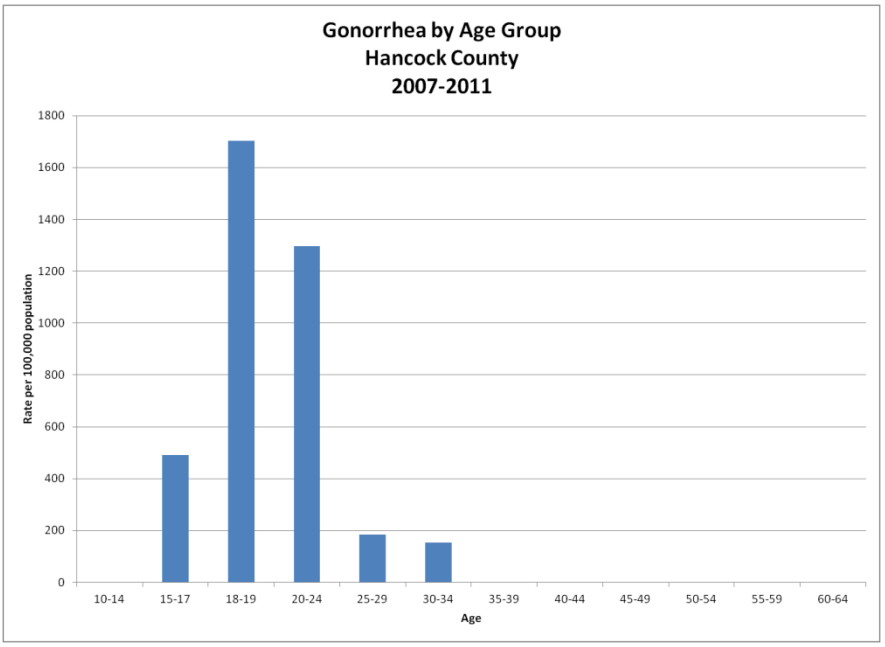
Figure 14: Gonorrhea Rate by Age Group

- The highest rates of Gonorrhea in Hancock County are among 18-24 year olds.
- **In Hancock County, of the known Gonorrhea cases where race was identified, the rate among the Black population of 189.4 was significantly higher than any other race or ethnicity.**



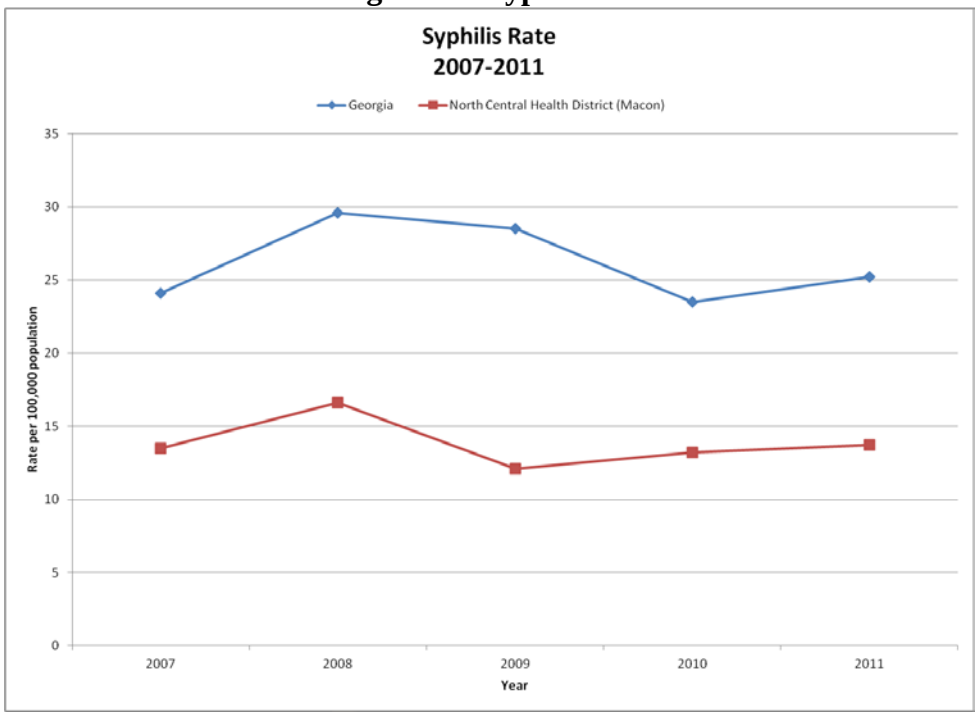
Source: OASIS

Syphilis

Syphilis is an STD referred to as "the great imitator" because many of its signs and symptoms are similar to other diseases. Initially it is characterized by appearance of one or more sores called chancres. Without treatment, the infected person will continue to have syphilis even though signs and symptoms may not be present. In the late stages, the disease may damage internal organs and lead to death.

Figure 15: Syphilis Rate

- According to 2011 data, the state of **Georgia ranks 3rd highest** in the U.S. for rates of Primary and Secondary Syphilis.
- From 2007-2011, Hancock County could not be ranked due to lack of statistics.

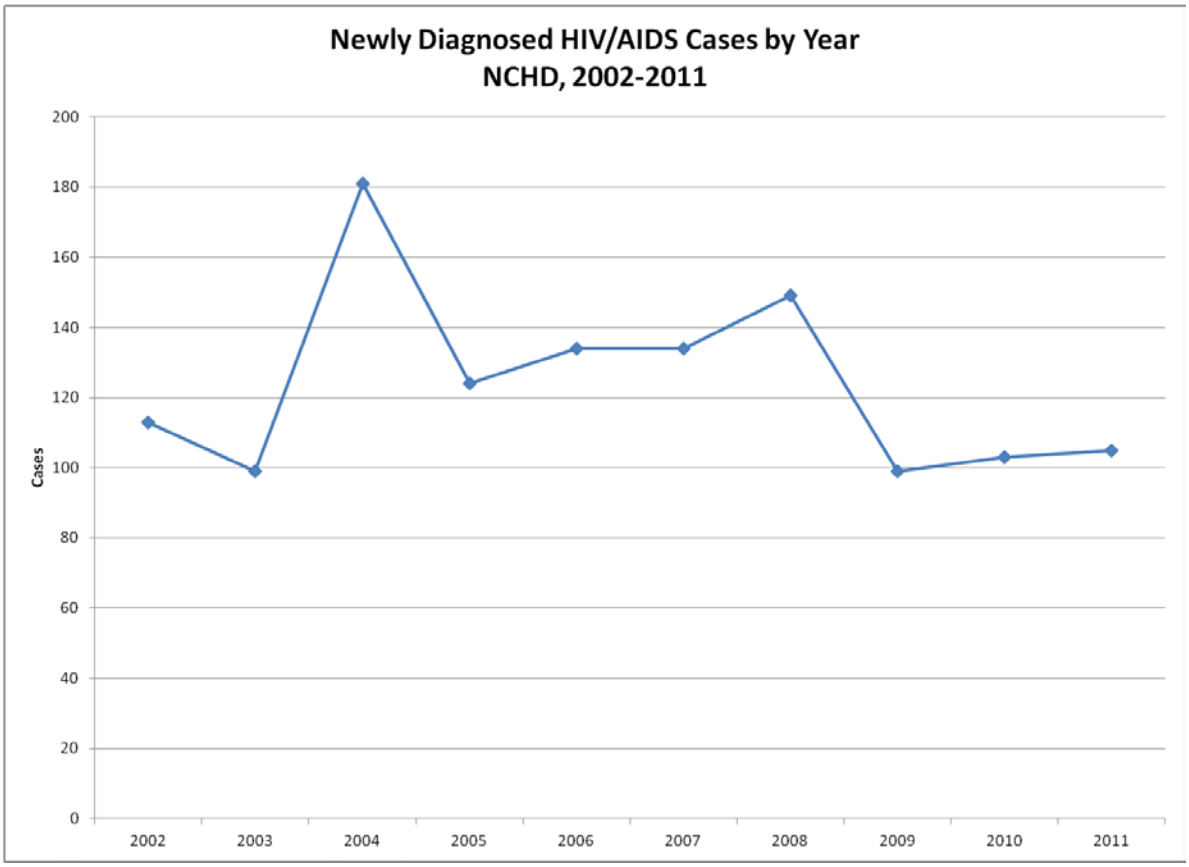


Source: OASIS

Human Immunodeficiency Virus (HIV)

HIV can lead to acquired immunodefiency syndrome (AIDS) and unlike some other viruses, the human body cannot get rid of HIV. That means that once you have HIV, you have it for life. It is transmitted by contact with infected body fluids: blood, semen, vaginal fluids, and breast milk. The most common methods of transmission are sexual intercourse or sharing needles. No safe and effective cure currently exists, but work is being done to find one. Meanwhile, with proper medical care, HIV can be controlled.

Figure 16: Newly Diagnosed HIV/AIDS Cases



Source: Georgia Department of Public Health, HIV/AIDS Epidemiology Section

- According to the High School Youth Risk Behavior Survey in 2011 (covering grades 9-12), only **12.4%** of students report that they **were never taught** in school about AIDS or HIV infection.
- Methods of transmission that are considered **high risk are blood recipients, male-to-male sexual contact, and heterosexual contact**.
- From 2006-2010, only **47% of adults in the NCHD reported ever being tested for HIV**, which was a 12% decrease from 2000-2004 (55%).

HIV/AIDS DATA
-Includes new diagnosis of HIV infection regardless of stage of disease at diagnosis
-Case counts include incarcerated persons and may artificially inflate the numbers

Tuberculosis

Tuberculosis (TB) is a bacterial disease caused by Mycobacterium tuberculosis. The most common site of disease is the lung (pulmonary TB), but other organs may be involved. Pulmonary TB causes the following symptoms: coughing that lasts longer than 2 weeks, pain in the chest when breathing or coughing, and coughing up sputum or blood. A person can either have latent TB infection (LTBI) or active TB infection. LTBI is an infection with the bacteria that are alive but inactive in the body, there are no symptoms, and individuals cannot spread TB to others however they may develop active TB later in life if they do not receive treatment. Persons at higher risk for TB are individuals who are foreign born, HIV infected, refugee or immigrant, and those living in close quarters (congregate setting).

In Hancock County from 2007-2011,

- TB occurred predominantly among **men.**
- There were **0 cases of TB in children** (0-19)
- **100% of TB Cases occurred in U.S. born individuals**.

Source: SENDSS

Vaccine Preventable Illness

Prevention of diseases is the foundation of public health. Vaccine preventable diseases, such as polio, measles, diphtheria, Pertussis, rubella, mumps, tetanus, and Haemophilus influenza type b (Hib), are costly and result in missed time from work, doctor's visits, hospitalizations, and possibly death. Through vaccination, children develop immunity without suffering from the actual diseases that vaccines prevent.

Table 9: Vaccine-Preventable Diseases

Vaccine Preventable Diseases (Cases), 2007-2011	
Disease	**Number of Cases**
Haemophilus influenzae (invasive)	1
Hepatitis B	4
Streptococcus pneumoniae	14
Varicella	1

Source: SENDSS

- From 2007-2011, there were no cases of measles, rubella, polio, pertussis, tetanus, or diphtheria in Hancock County.

- **Vaccinations to prevent serious diseases are available at the Hancock County Health Department, (706) 444-6616.**
- In 2012, the Hancock County Health Department gave 1,635 vaccinations.

Table 10: Number of Vaccinations Given

Number of Vaccines Given, Jasper County, 2012	
DTP/aP	171
Hep A	285
Hep B	126
Hib	99
Influenza	412
Measels, Mumps, Rubella (MMR)	118
Meningo (Meningitis)	113
Polio	143
Varicella (Chicken Pox)	168

Source: GRITS

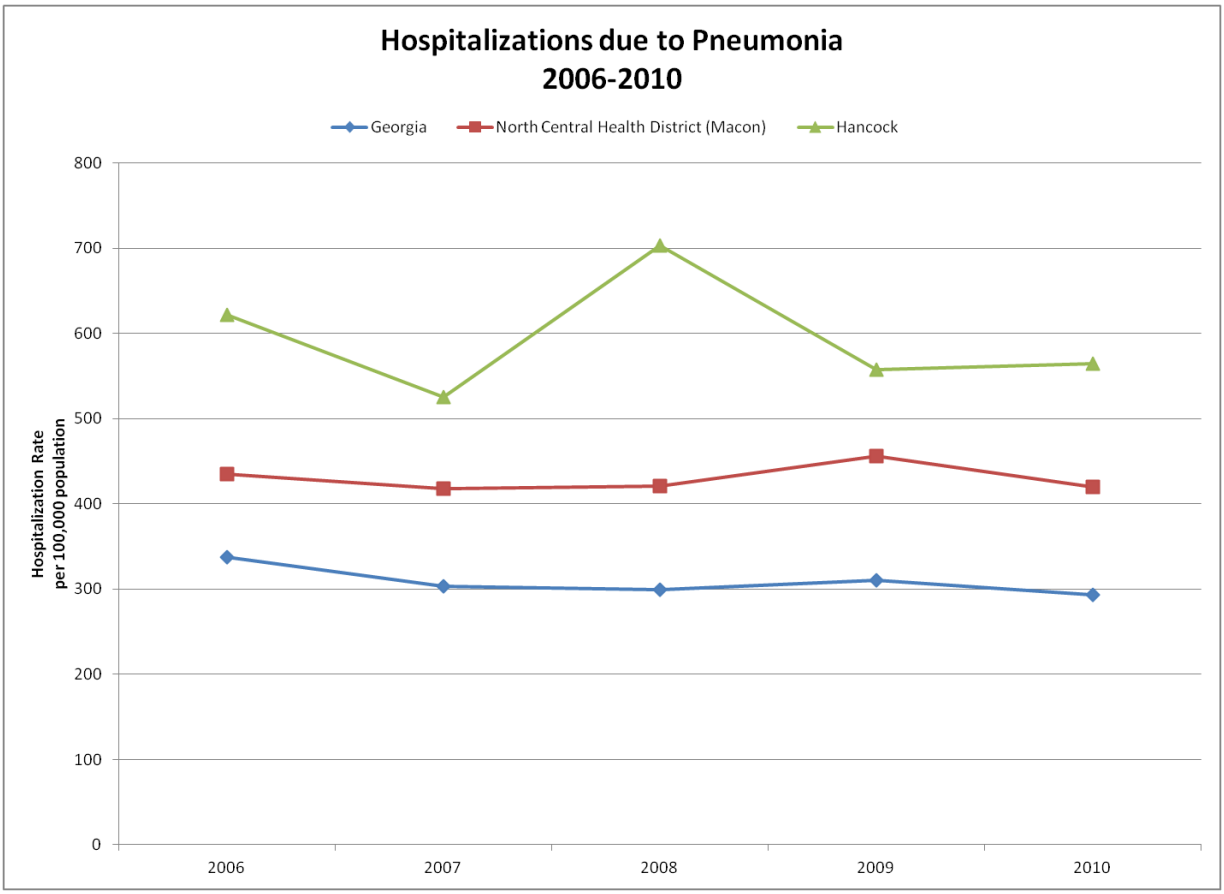
Influenza
Seasonal Influenza (flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness that can lead to hospitalization and death. Individuals that are considered to be at a higher risk for serious complications include: elderly individuals, young children, and people with other underlying health conditions. It is important to get a flu vaccination every year because the viruses included in the vaccination change.

- **412 Influenza (flu) shots** were given in the **Hancock County Health Department** in 2012.
- There were **no deaths** due strictly to influenza in Hancock County in 2011.
- From **2006-2010**, there were **10 hospitalizations** attributed to influenza in Hancock County.

Pneumonia
Pneumonia is an infection of the lungs that can cause mild to severe illness in people of all ages and is caused by bacteria or viruses. Globally, pneumonia causes more deaths than any other infectious disease. There are vaccines available that prevent pneumonia.

- From **2006-2010**, there were **287 hospitalizations** attributed to pneumonia in Hancock County.

Figure 17: Hospitalizations due to Pneumonia.



Source: OASIS

Gastrointestinal Disease

Intestinal diseases are infections that are commonly transmitted through consuming contaminated food, but can also be spread through contact with water, animals, and other environmental sources. In order for a person to be tested for an intestinal disease, their doctor must collect stool samples and send it to a laboratory for testing. Since everyone doesn't go to the doctor when they are ill and/or does not have testing done; thus many cases of intestinal disease are not reported.

Table 11: Gastrointestinal Diseases (Cases)

Gastrointestinal Diseases, 2007-2011	
Disease	**Number of Cases**
Hepatitis A	1
Salmonella	4
Shigella	3

Source: SENDSS

- Salmonella has consistently increased since 2008 and has had the **largest** number of cases from 2009-2011.

Invasive Bacterial Disease (Non-Vaccine Preventable)

Table 12: Invasive Bacterial Diseases

Invasive Bacterial Diseases, 2007-2011	
Disease	**Number of Cases**
MRSA (community associated)	11
Streptococcus (Group A)	2
Streptococcus (Group B)	4

Source: SENDSS

Invasive bacterial diseases can occur when a bacteria enters the body and causes an infection in a particular area. Streptococcal Disease Group A (GAS) is a bacterium commonly carried in the throat and on the skin, often without symptoms but it can cause mild to severe illness, such as strep throat, necrotizing fasciitis, and impetigo. Streptococcal Disease Group B is a bacterium that colonizes in the colon and genital tract of women and may cause infections in mothers and be passed to their infants at the time of delivery and cause meningitis and sepsis. It is common for an adult to carry this disease and not have symptoms. The mode of transmission in non-pregnant adults is unknown. Methicillin-resistant *Staphylococcus aureus* (MRSA) is a resistant form of staph bacteria that is primarily spread through direct skin to skin contact. Athletes, children in childcare settings, and congregate settings such as prisons and jails are at a high risk for MRSA.

To report an infectious disease contact:

North Central Health District
Epidemiology and Infectious Disease Unit
201 Second St, Ste 1100
Macon, GA 31201
Phone (478)751-6303

ENVIRONMENTAL HEALTH

The Environmental Health Section at the North Central Health District provides control and prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify and abate the environmental conditions that adversely impact human health. Additional information, including Rules and Regulations, can be found for each program by directing your web browser to the Division of Public Health Environmental Health Section: www.georgiaeh.us.

The following services are provided by local and district environmental specialists within the NCHD:

- Plan review, permitting, inspection and complaint investigation of :
  - Food Service establishments
  - Tourist accommodations
  - Public Swimming Pools
  - On-site sewage management systems and pumper operations
- Investigation of foodborne, waterborne and vectorborne diseases
- On-site sewage contractor testing and certification
- Investigation of general nuisance complaints concerning sewage, insects, rodents, solid waste, and other environmental issues
- Inspection and testing of individual water wells
- Conducts investigations and provides technical assistance to private physicians, veterinarians, hospital emergency rooms, and local animal control shelters by following the Rabies Control Law and coordinates specimen testing with the Georgia Public Health Laboratory.
- Childhood Lead Poisoning Prevention Program

Vectorborne/Zoonotic Disease

Vectorborne diseases are those bacterial and viral illnesses transmitted by mosquitoes, ticks, and fleas. Zoonotic diseases are spread between animals and humans and are caused by bacteria, viruses, parasites, and fungi.

- The NCHD Epidemiology Program interviews reported human cases of Vectorborne and zoonotic diseases. These interviews provide valuable epidemiological data as well as education to infected residents.
- The NCHD Environmental Specialists work to educate the public regarding the prevention of mosquito-borne viruses in the human and equine populations. In addition, public health environmentalists work closely with the District and State Epidemiologists in the area of surveillance, submitting specimens as needed and reporting and mapping areas of concern throughout the District.

Table 13: Vectorborne Diseases.

Vectorborne/Zoonotic Diseases (Cases), 2007-2011	
Animal Bite	10
Ehrlichiosis/Anaplasmosis	1
Lyme Disease	1

Source: SENDSS

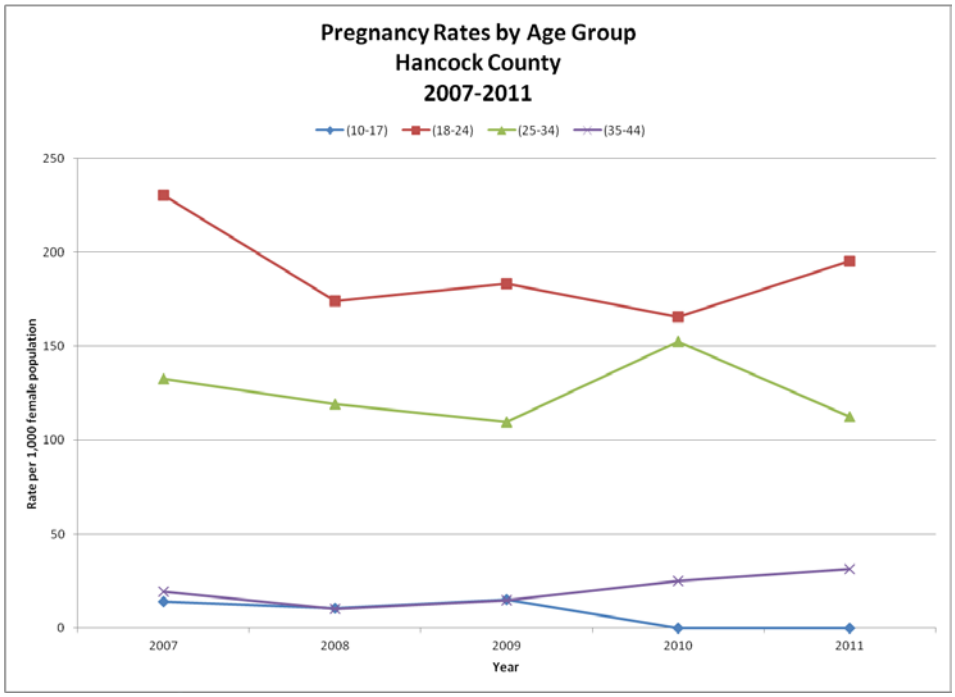
MATERNAL AND CHILD HEALTH

The well-being of mothers, infants, and children determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The objectives of the Maternal and Child Health topic area address a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families.

Pregnancy

Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children. These health risks may include: Hypertension and heart disease, Diabetes, Depression, Genetic conditions, Sexually transmitted diseases (STDs), Tobacco use and alcohol abuse, inadequate nutrition, and Unhealthy weight. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and interconception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. During 1961–2011, birth rates decreased for all women aged 15–44 years. During 2007–2011, birth rates decreased for all women aged <35 years, with rates for women aged 20–24 years (85.3 per 1,000 population) and those aged 15–19 years (31.3) reaching historic lows.

Figure 18: Pregnancy Rates by Age Group



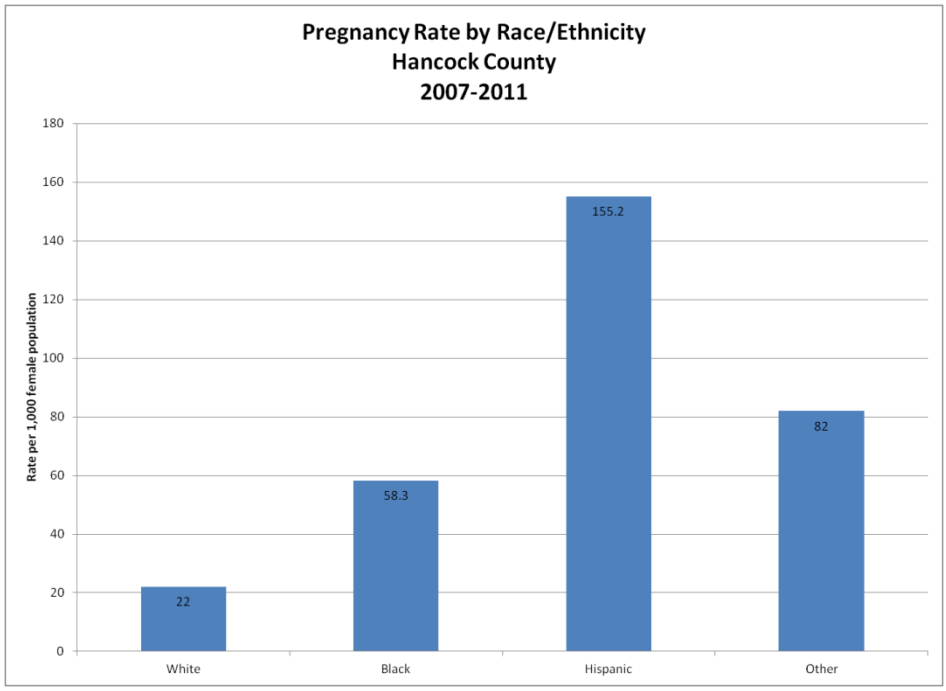
The overall pregnancy rate for Hancock County from 2007-2010 was **54.2 per 1,000 female population**, which was slightly higher than the pregnancy rate in the District of 53.3.

The total number of pregnancies which occurred in Hancock County from 2007 – 2010 was 666.

Source: OASIS

Figure 19: Pregnancy Rate by Race/Ethnicity

- From 2007-2010, Hispanic and Other women had the highest rates of pregnancy.



Source: OASIS

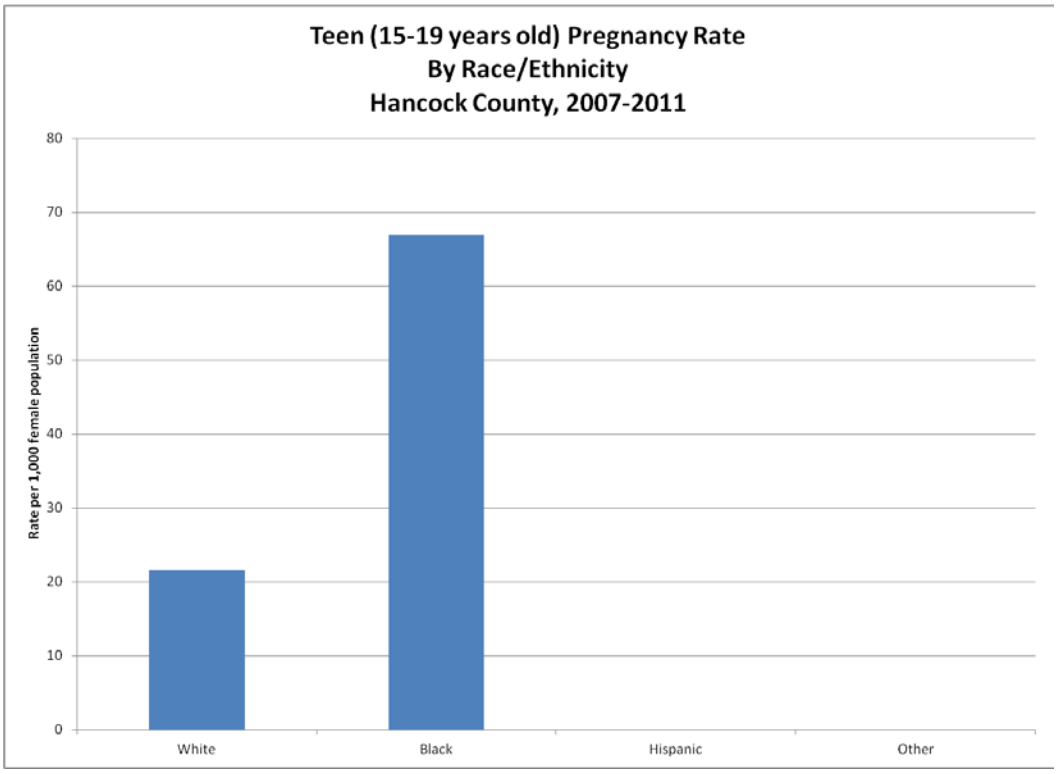
Teen Pregnancy

In 2011, a total of 329,797 babies were born to women aged 15–19 years, for a live birth rate of 31.3 per 1,000 women in this age group. This is a record low for U.S. teens in this age group, and a drop of 8% from 2010. Birth rates fell 11% for women aged 15–17 years, and 7% for women aged 18–19 years. While reasons for the declines are not clear, teens seem to be less sexually active, and more of those who are sexually active seem to be using birth control than in previous years. Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children and therefore remain a concern for public health.

In 2008, teen pregnancy and childbirth accounted for nearly $11 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers. Pregnancy and birth are significant contributors to high school dropout rates among girls. Only about 50% of teen mothers receive a high school diploma by 22 years of age, versus approximately 90% of women who had not given birth during adolescence. The children of teenage mothers are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult.

These effects remain for the teen mother and her child even after adjusting for those factors that increased the teenager's risk for pregnancy, such as growing up in poverty, having parents with low levels of education, growing up in a single-parent family, and having poor performance in school.

Figure 20: Teen Pregnancy Rate by Race/Ethnicity



Source: OASIS

- From 2007-2011, **Black** teens (15-19 years old) had the **highest** pregnancy rate.

Table 14: Repeat Teen Births

Repeat Teen Births, Hancock County, 2007-2011	
Age of Mother	**Number of Births**
10 to 14	0
15 to 17	2
18 to 19	20

Source: OASIS

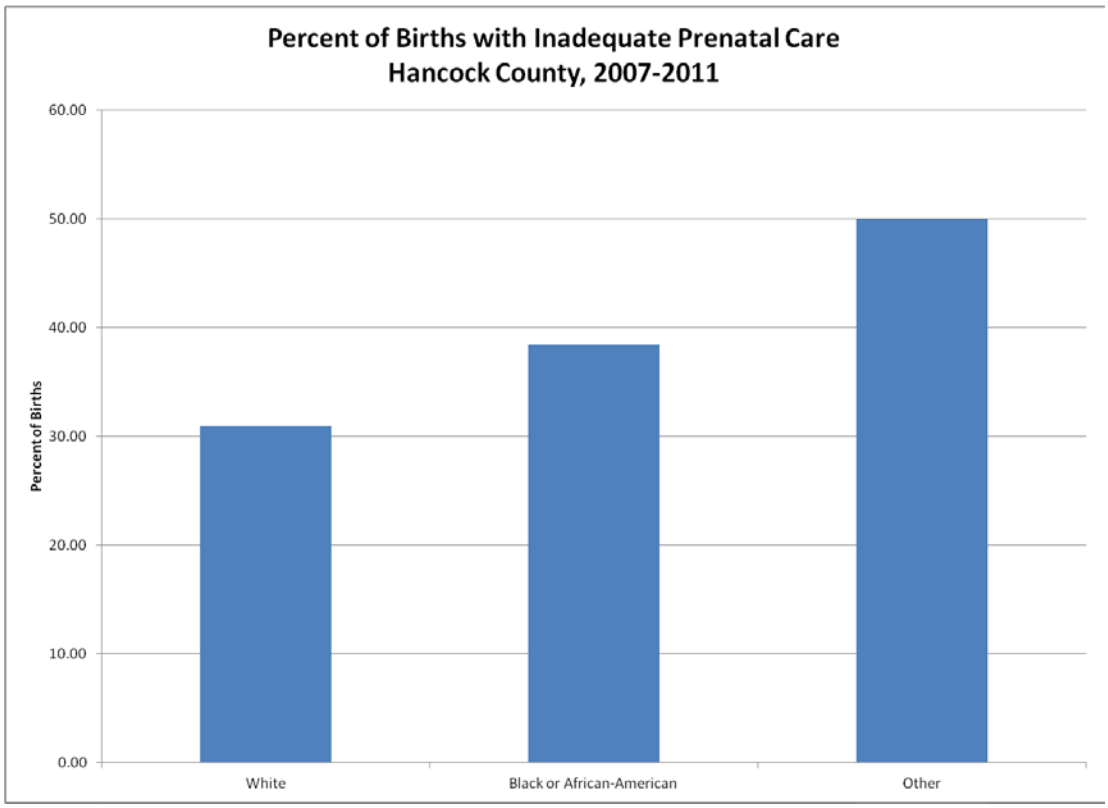
- In Hancock County (2011), repeat teen births occurred most often in the **18-19 year old age group**.

Prenatal Care

Women who see a healthcare provider early and regularly during pregnancy improve their chances of having healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy.

The Kotelchuck measure is an index of adequacy of prenatal care based upon month of entry, number of prenatal visits and gestational age of infant at birth. It uses American College of Obstetricians and Gynecologists standards for number of visits. The number of births by the "inadequate" value from the Kotelchuck Index, per 100 live births. Formula = [Number of Live Births with Inadequate Kotelchuck Value / Number of Live Births] * 100. Based on the Kotelchuck index, inadequate prenatal care is defined by a score of 79% or less.

Figure 21: Percent of Births with Inadequate Prenatal Care



Source: OASIS Miner

- From 2007-2011, women categorized as **Other had the highest number** of births with an inadequate Kotelchuck Index.

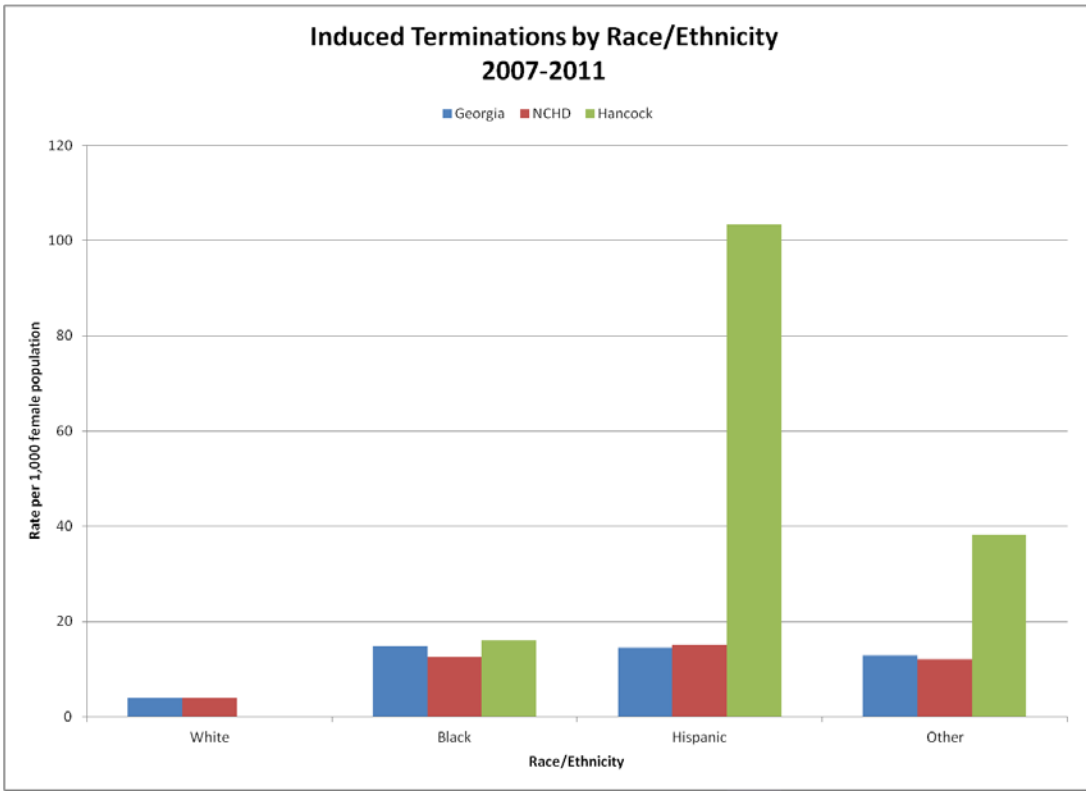
Abortions

A legal abortion is defined as an intervention performed by a licensed clinician that is intended to terminate an ongoing pregnancy. Abortion data is used to document the number and characteristics of women obtaining legal induced abortions, evaluate the effectiveness of programs for reducing teen pregnancies and unintended pregnancies among women of all ages, calculate pregnancy rates, on the basis of the number of pregnancies ending in abortion, in conjunction with birth data and pregnancy loss estimates, and monitor changes in clinical practice patterns related to abortion, such as changes in the types of procedures used, and weeks of gestation at the time of abortion. This information is needed to calculate the mortality rate of specific abortion procedures.

In 2009, 784,507 legal induced abortions were reported to CDC from 48 reporting areas. The abortion rate for 2009 was 15.1 abortions per 1,000 women aged 15–44 years and the abortion ratio was 227 abortions per 1,000 live births. Women in their twenties accounted for the majority of abortions in 2009 and throughout the period of analysis. The majority of abortions in 2009 took place early in gestation: 91.7% of abortions were performed at ≤13 weeks' gestation, and of the abortions performed at ≤13 weeks' gestation, 69.8% were performed at ≤ 8 weeks' gestation.

- The number of abortions reported in Hancock County from 2007-2011 was **181** and the rate was **14.7 per 1,000 female populations**.

Figure 22: Induced Terminations

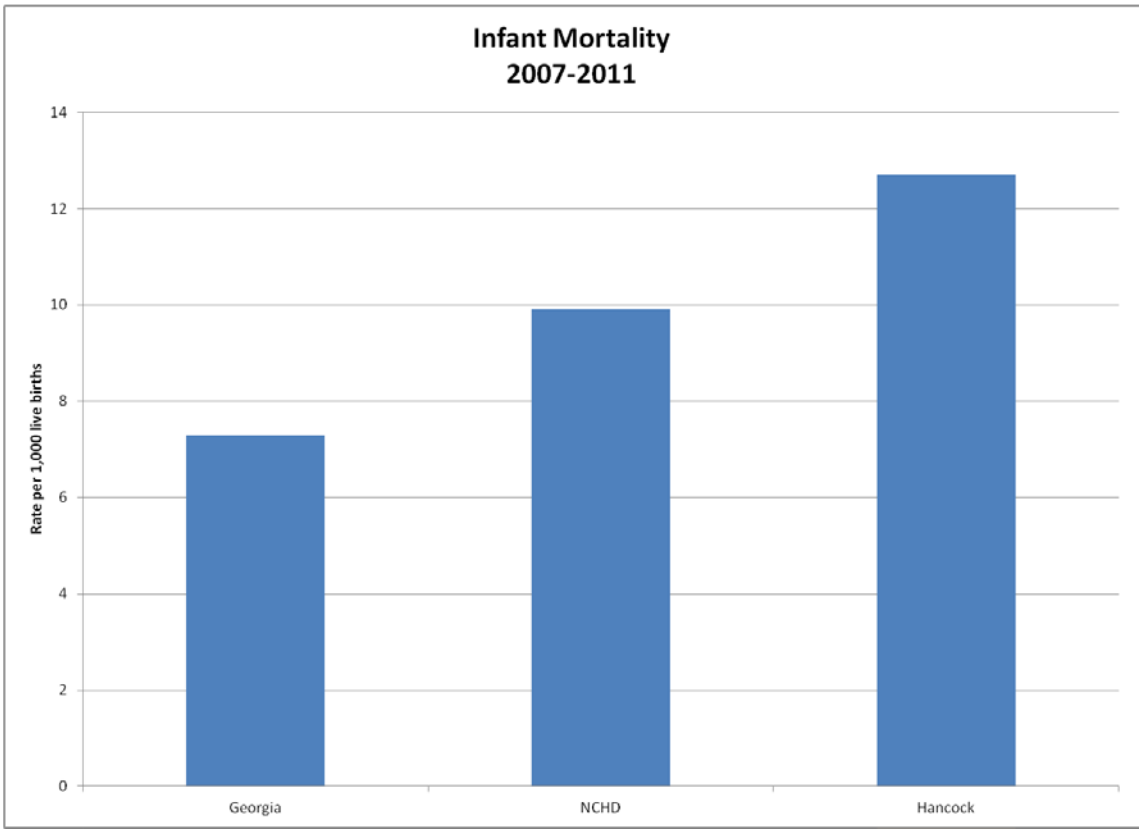


Source: OASIS

Infant Mortality

- From 2007-2011 the infant mortality rate for Hancock County is **higher** than that of the State but in 2010 and 2011 the rate was lower.
- Infant Mortality rates are **highest in the black population**.

Figure 23: Infant Mortality



Source: OASIS

Table 15: Top Causes of Infant Deaths

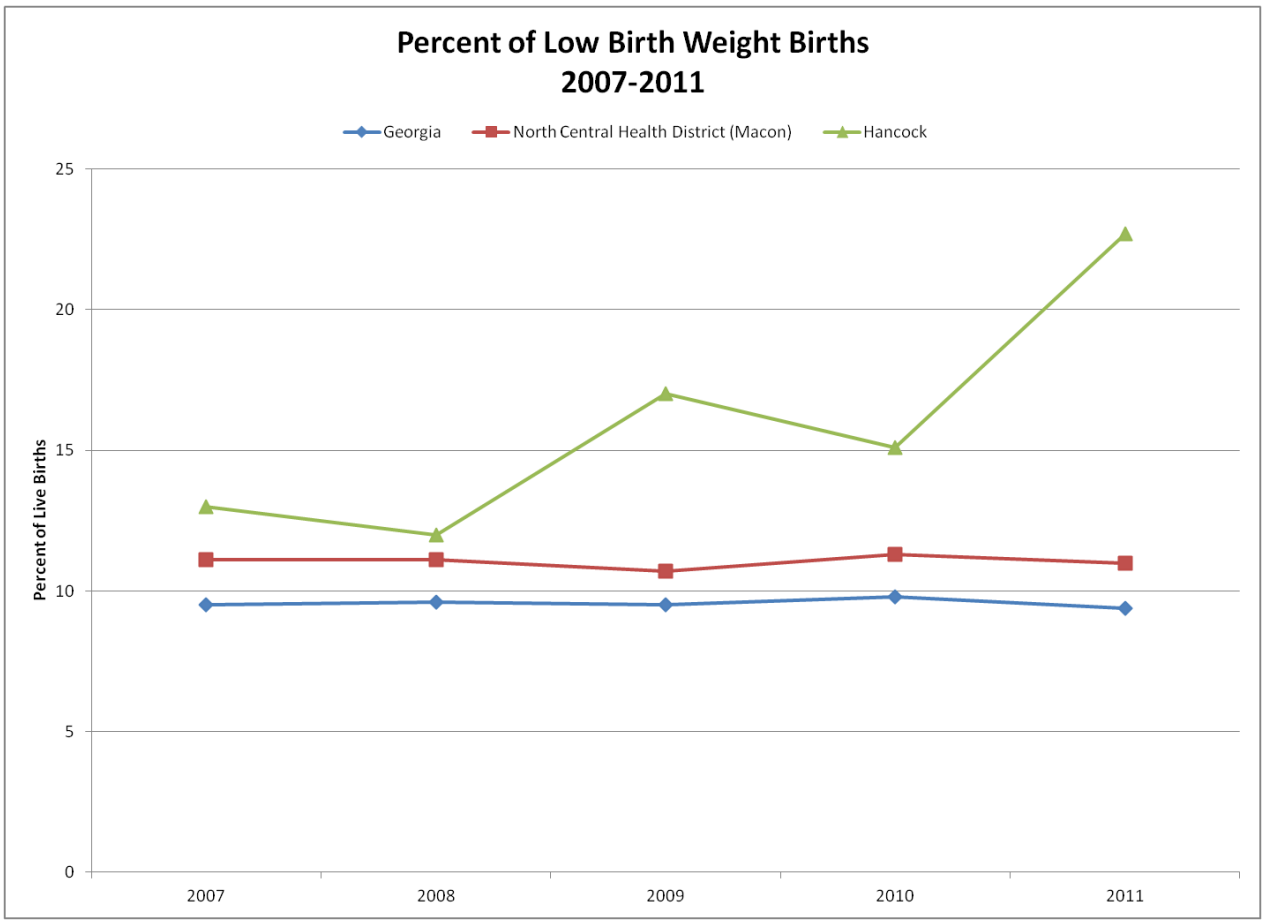
Top Causes of Infant Deaths, Hancock County, 2007-2011
Cause of Death
Birth Defects
Sudden Infant Death Syndrome (SIDS)
Respiratory Distress Syndrome (RDS)

Source: OASIS

Low Birth Weight Births

A weight of less than 5.5 lbs, or 2500 grams, at birth is considered to be low birth weight. A low birth weight infant can be born too small, too early, or both. This can happen for many different reasons which may or may not be related. Some causes may be smoking or drinking alcohol while pregnant, lack of weight gain, and be younger than 15 years or older than 35 years. Low birth weight babies are at an increased risk for serious health problems, disabilities, and death.

Figure 24: Percent of Low Birth Weight Live Births



Source: OASIS

- **15.9% of births** in Hancock County from 2007-2011 were babies with low birth weights, compared to 9.5% for Georgia.

- Blacks give birth to low birth weight babies at a **higher percentage** than any other race/ethnicity.

Childhood Morbidity

Table 16: Emergency Department Visits in Children

Cause of Emergency Department Visit	Hancock County	
	Number of ED Visits	Ed Visit Rate per 100,000 population
External Causes	859	8,330.90
Falls	199	1,930.00
Motor Vehicle Crashes	123	1,192.90
Respiratory Diseases	678	6,575.50
Asthma	87	843.8
Bronchitis	41	397.6
Infectious and Parasitic Diseases	184	1,784.50
Digestive System Diseases	167	1,619.60
Reproductive and Urinary System Diseases	124	1,202.60
Bone and Muscle Diseases	147	1,425.70
Mental Health and Behavioral Disorders	23	223.1
Endocrine, Nutritional and Metabolic Diseases	28	271.6
Nervous System Diseases	22	213.4
Blood Diseases (Anemias)	7	67.9

Source: OASIS

Injury and respiratory illnesses are the leading causes of emergency department visits in children 1-19 years of age in Hancock County from 2007-2011.

Childhood Immunizations

The results of the 2011 Immunization Report for Georgia indicates that District 5-2 (North Central Health District) immunization rate of children by 24 months of age was higher than the state rate (83.5% vs. 82.4%). By the end of data collection, the district up-to-date (UTD) immunization rate was higher than the state rate (99% vs. 94%).

Table 17: Leading Causes of Emergency Department Visits in Children aged 1-19

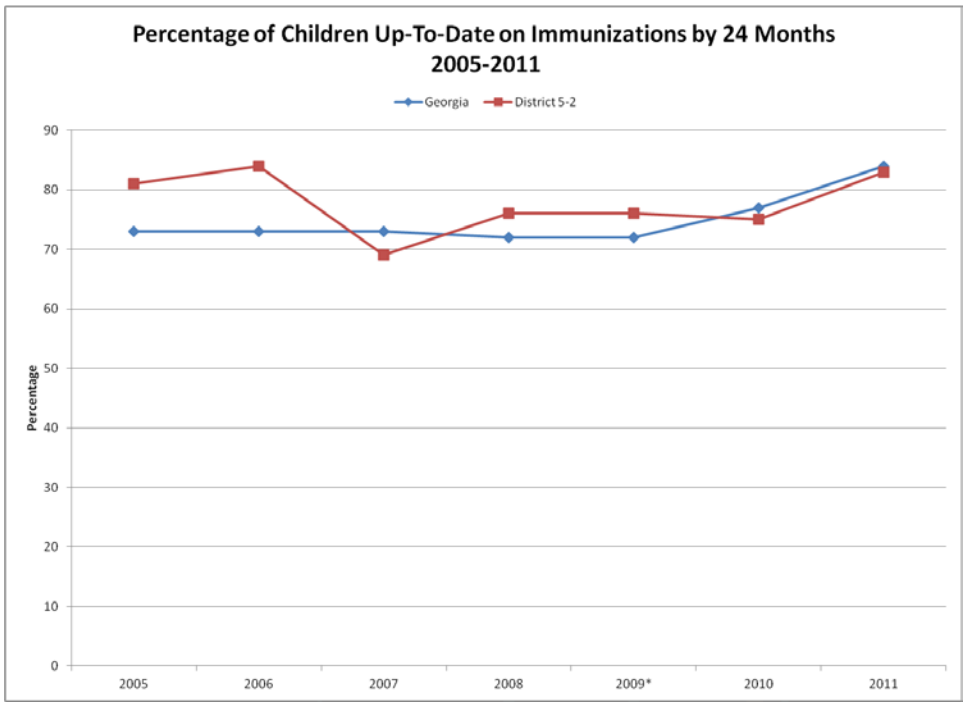
Immunization Summary by Series & Antigen, District 5-2, 2011		
	District	State Average
UTD immunization rate* by 24 months	83.5	82.4
UTD immunization rate* by end of data collection[1]	99.0	94.0
4 Dtap by 24 months	87.6	85.8
3 Dtap by 24 months	99.0	97.5
3 IPV by 24 months	96.9	96.7
1 MMR by 24 months	96.9	93.0
UTD Hib by 24 months	94.9	95.1
3 Hep B by 24 months	97.9	96.5
1 Varicella by 24 months	96.9	93.9
UTD PCV by 24 months	97.9	96.7
2 Rotavirus by 24 months	68.0	83.8
2 Hep A by 24 months	55.7	53.1
1 Influenza by 24 months	53.6	60.1
2 H1N1	24.7	27.1

Source: Georgia 2011 Immunization Report

[1] This value includes children who become UTD during the data collection period. This number, when compared to the values followed with "by 24 months", is a testament to the efforts of district staff to reach the children originally listed as incomplete in their district.

* This rate includes children up-to-date by ACIP-recommended catch-up schedule.

Figure 25: Percentage of Children UTD on Immunizations



Source: Georgia 2011 Immunization Report

From 2010 to 2011: The District 5-2 UTD immunization rate by 24 months increased by 11% from 2010 to 2011. The district UTD immunization rate by the end of data collection increased by 2.1% from 2010 to 2011.

Table 18: Immunization Coverage by 24 months of age

Antigen-Specific Immunization Coverage (%) by 24 months of age, District 5-2, 2005-2011						
	2005	2006	2007	2008	2010	2011
4 Dtap by 24 months	84.2	86.3	76.9	81.3	81.2	87.6
3 Polio by 24 months	92.1	95.4	91.0	88.8	95.5	96.9
1 MMR by 24 months	91.4	93.1	84.6	89.6	93.2	96.9
UTD HiB by 24 months	89.2	92.4	82.1	85.8	90.2	94.9
3 Hepatitis B by 24 months	90.7	93.9	88.5	91.0	97.0	97.9
1 Varicella by 24 months	92.1	93.9	84.6	88.1	95.5	96.9
UTD PCV by 24 months	43.2	75.6	78.2	85.1	90.2	97.9
2 Rotavirus	-	-	-	-	65.4	68.0
1 Influenza by 24 months	-	-	-	-	49.6	53.6

Source: Georgia 2011 Immunization Report

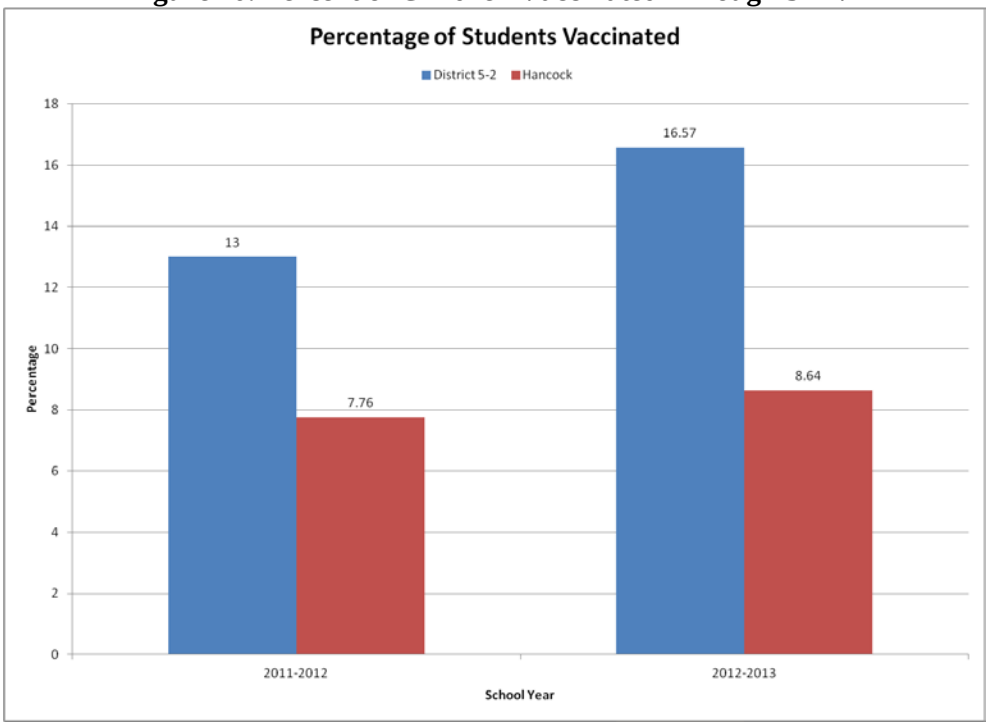
Immunization Rates by Antigen: In District 5-2, the UTD immunization rate by 24 months for most antigens fluctuated from 2005-2010.

Increasing to higher rates for all antigens in 2011.

Among antigen rates in 2011, the DTaP UTD immunization rate was the lowest at 87.6%, up from 81.2% in 2010. The Hib UTD immunization rate was second-lowest at 94.9%, up from 90.2% in 2010. Since first being ACIP-recommended in 2002, UTD coverage by 24 months for he pneumococcal conjugate vaccine increased from 43.2% in 2005 to 97.9% in 2011.

Influenza

Figure 26: Percent of Children Vaccinated Through SLIV



Source: NCHD SLIV Program

School-Located Influenza Vaccination Programs
Influenza is a contributing factor to school absences. School-located influenza vaccination (SLIV) programs provide greater access for students to be immunized.

Hancock County has seen an increase in participation in the SLIV program.

Youth Risk Behaviors

Health risk behaviors are often established during childhood and adolescence and can extend into adulthood. Encouraging the adoption of healthy behaviors during childhood is easier and more effective than trying to change unhealthy behaviors during adulthood.

Youth Obesity

Obesity in children and adolescents has immediate and long-term effects on health and well being and continues to be a major public health concern in the U.S. Immediate health effects includes cardiovascular disease such as high cholesterol or high blood pressure, prediabetes, bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem. Long-term health effects include heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.

According to the High School Youth Risk Behavior Survey in 2011 (covering grades 9-12):

- **15% of Georgia high school youth were estimated to be obese** compared to the U.S. rate of 13%
- **Black youth had the highest percentage of obesity** at 17.6%, compared to whites at 12.8% and Hispanics at 16.5%.
- **43.1% ate vegetables less than one time per day** compared to 37.7% in the U.S.
- **53.8% did not attend physical education classes in an average week** (when in school).
- **36.6% reported watching television** for 3 or more hours per day.
- **27.8% reported using a computer** for 3 or more hours per day.
- **81.9% drank a can, bottle or glass of soda/pop** at least once during the week.

According to the Middle School Youth Risk Behavior Survey in 2011 (covering grades 6-8):

- **35.3% did not attend physical education classes in an average week** (when in school).
- **45.2% reported watching television** for 3 or more hours per day.
- **30.5% reported using a computer** for 3 or more hours per day.

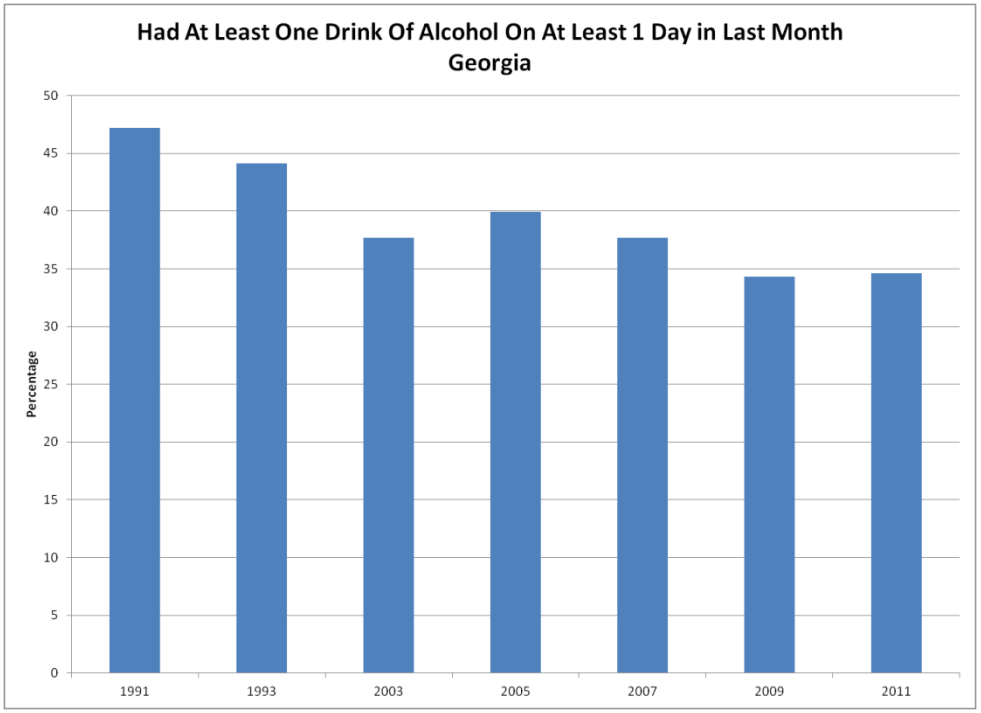
Alcohol and Other Drug Use

Alcohol and other drug use among our nation's youth remains a major public health problem. Substance use and abuse can increase the risk for injuries, violence, HIV infection, and other diseases.

In 2011:

- High school students that report drinking alcohol has **decreased** over the years, however **34.6% of high school students report current alcohol use and 66.1% have had alcohol at least once in their lifetime**.
- **17.5% of high school students report having five or more drinks of alcohol** in a row within a couple of hours on at least 1 day in the past month.

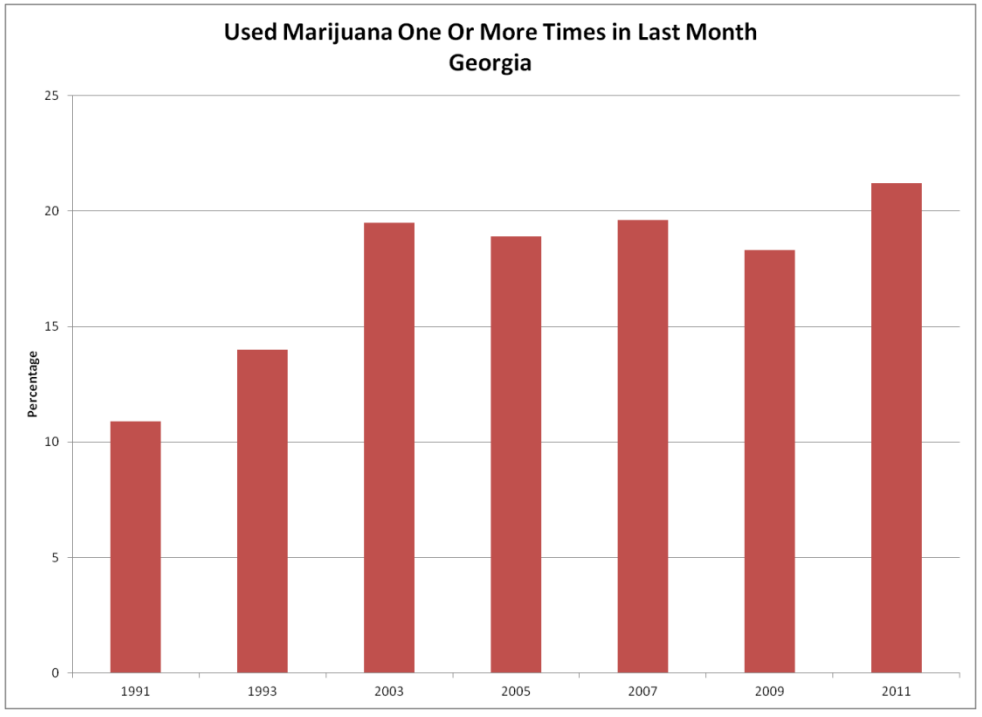
Figure 27: Teens currently using alcohol



Source: YRBSS

Figure 28: Teens currently using marijuana

- High school students that report marijuana use has **increased** over the years
- **21.2% of high school students report current marijuana use and 37.9% have used marijuana at least once in their lifetime**.
- 6.7% of high school students report ever using cocaine, 4.7% report heroin use, 6% report methamphetamines use, and 8.5% report ecstasy use.

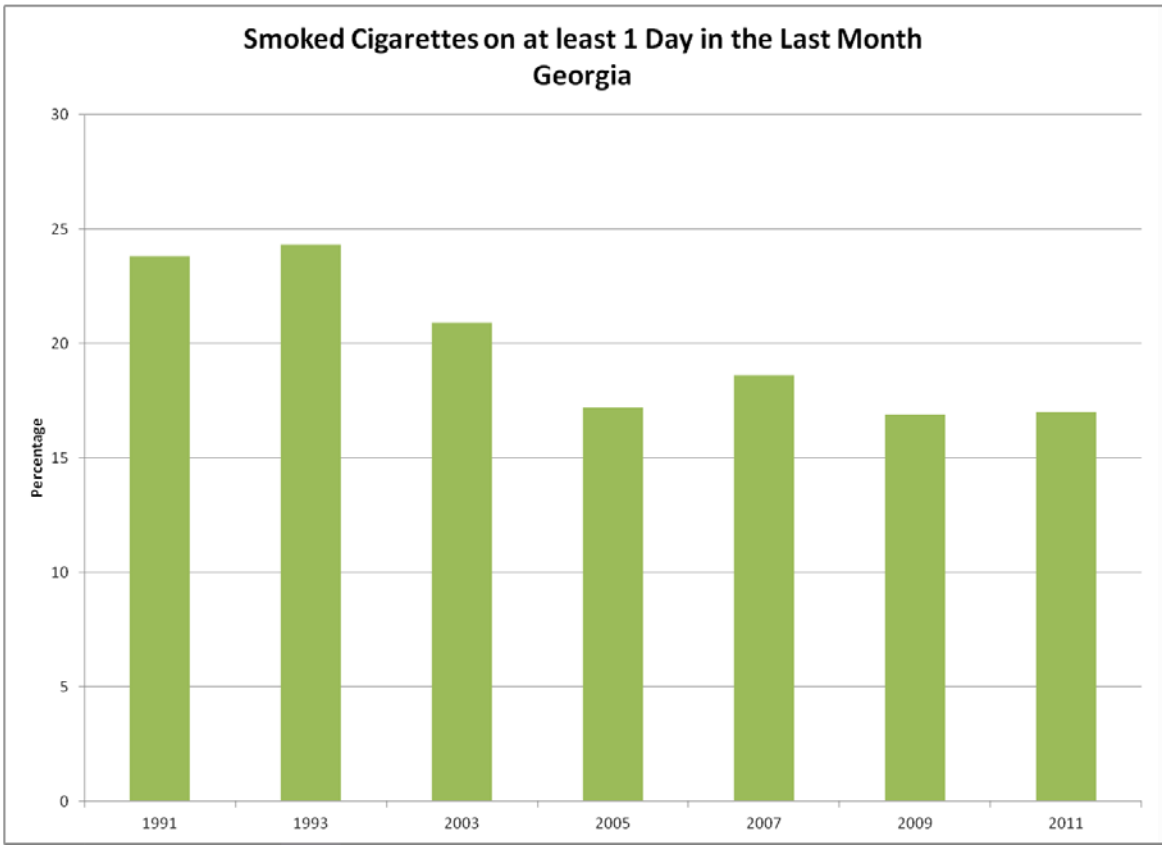


Source: YRBSS

Youth Smoking

According to the 2012 Surgeon General's report on tobacco and youth, more than 600,000 middle school students and 3 million high school students smoke cigarettes. Rates of decline for cigarette smoking have slowed in the last decade and rates of decline for smokeless tobacco use have stalled completely. Smoking can cause bad breath, coughing, increased heart beat and blood pressure, respiratory problems, reduced immune function, increased illness, tooth decay, gum disease, and pre-cancerous gene mutations. Smoking during youth is also associated with an increased likelihood of high risk sexual behavior and using illegal drugs and alcohol. Some risk factors associated with youth tobacco use include low socioeconomic status, tobacco use by family and friends, lack of skills to resist tobacco use, lack of parental support or involvement, ease of access to tobacco products, low levels of educational achievement, low self esteem and aggressive behavior (e.g., fighting, carrying weapons).

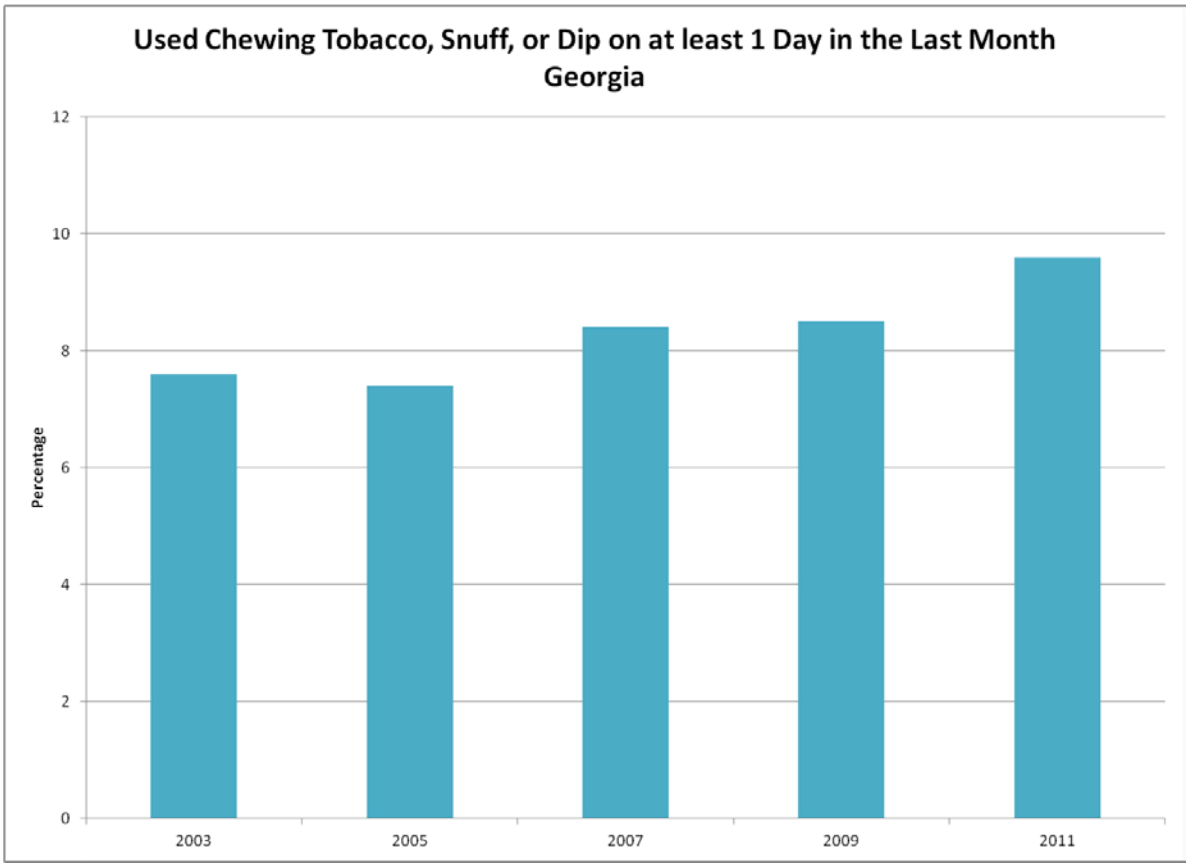
Figure 29: Teens currently using cigarettes



Source: YRBSS

- **47.1 %** of Georgia high school and **26.1%** of Georgia middle school students **have tried cigarette smoking**, even one or two puffs, during their lifetime.
- Among those that currently smoke, **51.4%** of Georgia high school students **did not try to quit smoking within the past year.**

Figure 30: Teens currently using chewing tobacco, snuff, or dip



Source: YRBSS

- Use of smokeless tobacco products has increased in Georgia over the past 10 years.
  - **9.6%** of Georgia high school and **4.7%** of Georgia middle school students are **currently using smokeless tobacco products**.

BEHAVIORAL AND MENTAL HEALTH

Mental health disorders are common in the United States and can begin at any age without respect to gender or sex. They are thought to be caused by a variety of biochemical, genetic, and environmental risk factors and many individuals suffer from more than one disorder at a time.

According the National Institute of Mental Health:

- It is estimated that in any given year **25% of adults** are diagnosable for one or more mental health disorders.
- **Women are no more or less likely than men** to experience any disorder over their lifetime.
- Non-Hispanic **blacks are 30% less likely** than non-Hispanic whites to experience any disorder during their lifetime.
- **Average age of onset is 14 years old.**
- Among all Americans, 36.2 million people paid for mental health services totaling **$57.5 billion in 2006**. This means the average expenditure per person was $1,591. Within this group, 4.6 million children received mental health services totaling $8.9 billion. The average expenditure per child was higher than that for the average American at $1,931.
- **36% of those with a disorder are receiving treatment.**

Table 19: Immunization Coverage by 24 months of age

Prevalence Estimates for Mental Disorder in U.S. Adults (18+)		
Type of Disorder		**Estimated 12-Month Prevalence (%) of U.S. Population**
Any Anxiety Disorder		18.1
	Generalized Anxiety Disorder	3.1
Any Mood Disorder		9.5
	Bipolar Disorder	2.6
	Major Depression	6.7
Any Personality Disorder		9.1
Attention-Deficit/Hyperactivity Disorder		4.1
Schizophrenia		1.1

Source: NIMH

CRIME AND SAFETY

Violence is a serious public health problem in the United States. From infants to the elderly, it affects people in all stages of life. Injuries—including unintentional injuries, homicide, and suicide, are the leading cause of death for people ages 1 to 44.

Crime

Table 20: Number of Violent and Property Crimes by Offense

Crime Statistics, Hancock County (2008 - 2012)							
Year	**Murder**	**Rape**	**Robbery**	**Assault**	**Burglary**	**Larceny**	**Vehicle Theft**
2008	0	2	1	9	28	54	13
2009	0	0	1	13	29	42	3
2010	0	1	2	9	63	66	2
2011	0	2	2	10	55	69	4
2012	0	0	2	5	42	70	8

Source: GBI

- From 2008-2012, **Larceny was the most frequently** committed crime in Hancock County.
- The violent crime rate of Hancock County in 2012 was 50.4 per 100,000 population, lower than the Georgia rate of 366.4.
- The rate of property crimes in Hancock County for 2011 was 863.3 per 100,000 population, lower than the Georgia rate of 3,575.9.

Family Violence

- According to GBI, the most common type of family violence incidents is superficial wounds, in Hancock abusive language is the most reported.
- The most common weapon used in occurrences of domestic violence is a person's hand/fist and most of the incidents the aggressor was a family member or member of the same household.

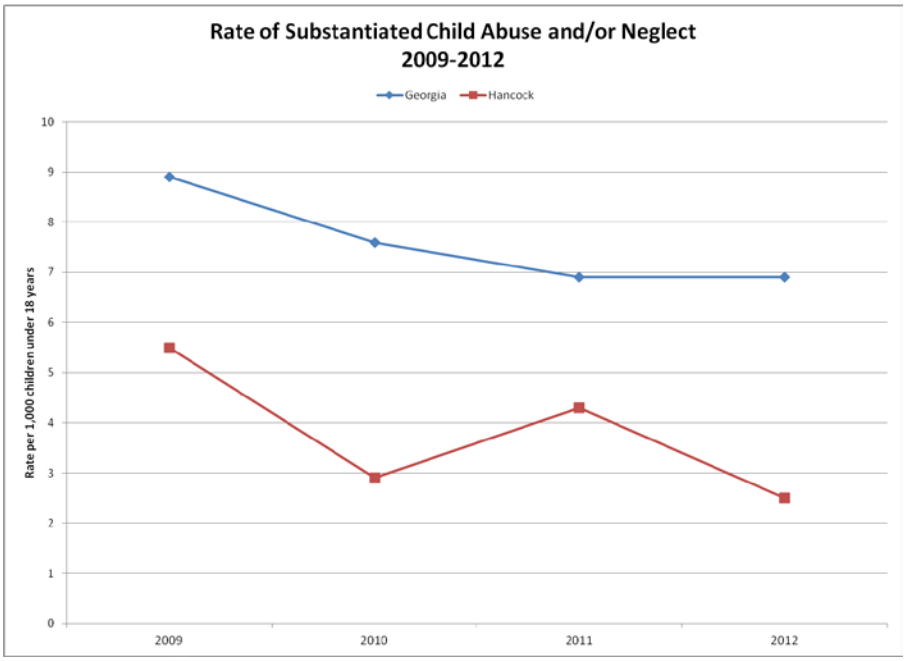
Table 21: Number of Family Violence Incidents By Type and Aggressor

Number of Family Violence Incidents By Type and Aggressor, Hancock County, 2012		
Abuse Type	**Male**	**Female**
FATAL INJURY	0	0
PERMANENTLY	0	0
TEMPORARILY	1	0
BROKEN BONES	0	0
GUN/KNIFE WOUNDS	0	0
SUPERFICIAL WOUNDS	9	3
PROPERTY DAMAGE	3	1
THREATS	5	0
ABUSIVE LANGUAGE	26	6
SEXUAL ABUSE	0	0
OTHER ABUSE	13	10

Source: GBI

Child Maltreatment

Figure 31: Child Abuse and Neglect Rate



In 2012, Hancock County ranked **5th lowest** of the 159 counties reporting in Georgia for the rate of child abuse and or neglect.

Source: KIDS COUNT

Injuries

Injuries due to external causes account for 19% of all emergency department visits in Hancock County from 2006 to 2010 **and falls are the number one cause of emergency department visits** due to injury. During this time period, the rate of emergency department visits for **falls was highest in the elderly**, over age 75, with a rate of 4,119.1 per 100,000 visits compared to 1,521.7 for all age groups.

Table 22: Emergency Department Visit Rate due to External Causes

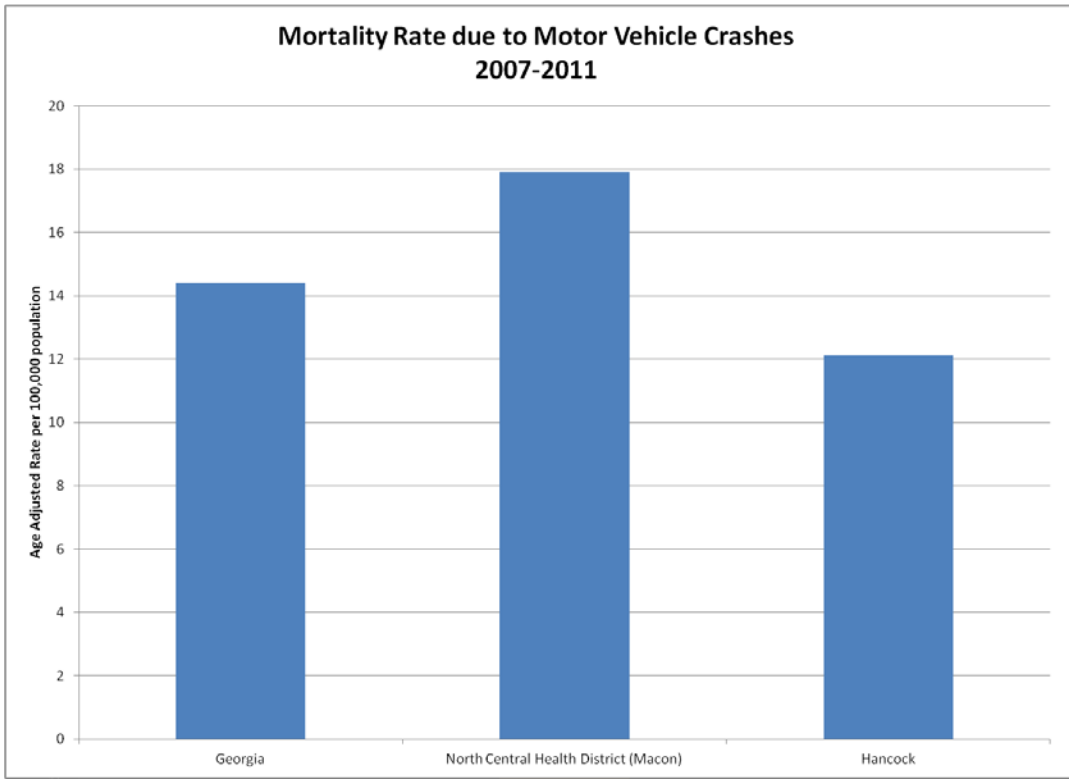
ER Visits Age Adjusted Rate, Hancock County, 2006-2010	
Falls	1,521.70
Motor Vehicle Crashes	1,095.60
Homicide	436.7
Poisoning	70.2
Suicide	33.7
Fire and Smoke Exposure	12.2
Accidental Shooting	22.2

Source: OASIS

Motor Vehicle Crashes

The emergency department visit rate for motor vehicle crashes (MVCs) from 2006-2010 in Hancock County was 1,500.4 per 100,000 visits higher than the state rate of 1,081.8.

Figure 32: Mortality Rates by Age due to Motor Vehicle Crashes



The mortality rate for MVCs in Hancock County is lower than the both the district and the state.

Source: OASIS

Table 23: Number of Motor Vehicle Crashes by Person/ Crash Type

Number of Motor Vehicle Crashes by Person/ Crash Type in Hancock County, 2003 - 2008	
Passenger Vehicles	587
Intersection Related	181
Child Passenger (Ages 0-15)	98
Young Adult Driver (Ages 15-20)	128
Elderly Driver (Ages 65 and older)	80
At Least 1 Unrestrained Driver	72
Motorcycles	8
Pedestrians	7
Speeding Involved	6
Bicyclist (or other cyclist)	2

Source: OASIS

Most MVCs occurred with passenger vehicles and in intersections.

Appendix

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District Epidemiologist:
Amber Erickson, MPH

District Public Health Nursing & Clinical Director:
Debbie Liby, RN

District Environmental Health Director:
Carla Coley

District Emergency Preparedness Coordinator:
Laurice Bentley

District Administrator:
Curt Reynolds, CPA (through 2013)
Morris Hutcheson (2014 - present)

District Child Health Coordinator:
Evans Ward

District Infectious Disease Unit Supervisor:
Ronald Boone

District Public Information Officer:
Jennifer Jones

District Human Resources Director:
Marsha Stone