

LATINOS IN SAN DIEGO COMMUNITY SNAPSHOT

COMMUNITY OUTREACH & ENGAGEMENT
MOORES CANCER CENTER AT UC SAN DIEGO HEALTH



POPULATION

In 2019, San Diego County had a total population of 3.3 million, with Hispanics/Latinos making 34.1% of the county's total population [1]. This makes H/Ls the second largest race/ethnicity group in San Diego County. The South Region has the largest H/L presence 61.3% (Chula Vista, National City, Imperial Beach) [1]. Followed by Vista, Escondido, and Lemon Grove.

INCOME

Per capita income among Hispanic/Latino individuals is \$24,365, which is lower than the county's average \$40,389. Between 2015 to 2019 the median household income for H/Ls living in San Diego County was \$59,850, much lower than the median household income for San Diego County \$78,980 [2].

HEALTH INSURANCE

In 2019, 16.7 % of Hispanic/Latinos were without health insurance coverage, which was the highest of uninsured rates among all race and ethnic groups in the United States [4]. In 2019, 85.7% of H/Ls in San Diego County were insured and 14.3% were uninsured [3]. In San Diego County, H/Ls were the second group with the highest uninsured rates.

POVERTY AND UNEMPLOYMENT

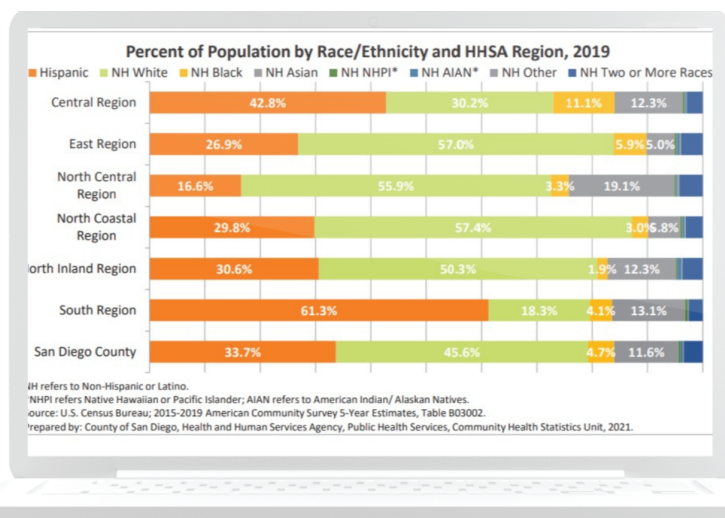
12.9% Hispanic/Latinos in San Diego County are in poverty, compared to the overall H/Ls poverty rate of 17.2% in the US [5]. The unemployment rate of H/Ls in San Diego County is 6.6%, which is higher than the H/L unemployment rate of 5.1% in the US [6].

EDUCATION

In 2019, 72.5% of Hispanic/Latinos in San Diego County had at least a high school degree or higher and 19.4% hold a Bachelor's degree [8].

OCCUPATION

According to the U.S. Bureau of Labor and Statistics in 2018, 24.2% of Hispanic/Latinos worked in service occupations. Among employed men, H/Ls were more likely to work in the construction industry (21%) than were whites (14%), Blacks (7%), or Asians (4%) [7].



CANCER TRENDS IN LATINOS

Compared to non-Hispanic white individuals, Hispanic/Latino men and women in the continental US and Hawaii have lower rates of the four most common cancers (female breast, colorectal, lung, and prostate), but higher rates of infection-related cancers like stomach, liver, cervical, and gallbladder cancer. However, there is a large variation within this aggregated group by country of origin and nativity, with risk among long-term residents and descendants of Hispanic immigrants approaching or surpassing that of non-Hispanic whites for some cancer types due to acculturation [10].

Estimated New Cases*

Males			Females		
Prostate	17,600	22%	Breast	28,100	29%
Colon & rectum	9,000	11%	Uterine corpus	7,900	8%
Lung & bronchus	6,000	7%	Colon & rectum	7,500	8%
Kidney & renal pelvis	5,900	7%	Thyroid	6,300	7%
Liver & intrahepatic bile duct	4,800	6%	Lung & bronchus	5,800	6%
Non-Hodgkin lymphoma	4,700	6%	Non-Hodgkin lymphoma	4,200	4%
Leukemia	3,700	5%	Kidney & renal pelvis	3,800	4%
Urinary bladder	3,300	4%	Leukemia	2,900	3%
Pancreas	2,800	3%	Pancreas	2,900	3%
Oral cavity & pharynx	2,500	3%	Uterine cervix	2,700	3%
All sites	80,200	100%	All sites	96,400	100%

Estimated Deaths

Males			Females		
Lung & bronchus	3,200	13%	Breast	3,100	14%
Colon & rectum	2,700	11%	Lung & bronchus	2,300	10%
Liver & intrahepatic bile duct	2,600	11%	Colon & rectum	2,000	9%
Prostate	2,400	10%	Pancreas	1,900	8%
Pancreas	1,900	8%	Liver & intrahepatic bile duct	1,500	7%
Stomach	1,200	5%	Ovary	1,200	5%
Leukemia	1,000	4%	Uterine corpus	1,200	5%
Non-Hodgkin lymphoma	1,000	4%	Stomach	1,000	4%
Kidney & renal pelvis	800	3%	Leukemia	800	4%
Brain & other nervous system	800	3%	Non-Hodgkin lymphoma	800	4%
All sites	23,800	100%	All sites	22,700	100%

Leading Sites of New Cancer Cases and Deaths Among the US Hispanic Population—2021 Estimates. *Estimates are rounded to the nearest 100 and exclude basal and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates exclude Puerto Rico. Rankings are based on modeled projections and may differ from the most recent observed data. CA: A Cancer Journal for Clinicians, First published: 21 September 2021, DOI: (10.3322/caac.21695)

BREAST

Overall, breast cancer mortality (per 100,000) by region in San Diego: Female mortality rates were highest in La Mesa (62.9), Spring Valley (35.1), Santee (33.8) National City (33.3), and Elliott-Navajo (33.2) and lowest Vista (13.1), Sweetwater (16.3), Central San Diego (16.9), Southeastern San Diego (18.4), Chula Vista (18.5) [9].

H/L women are less likely than NHW women to be diagnosed with breast cancer at a localized stage (59% vs 67%), likely because of lower mammography utilization and delayed follow-up after an abnormal mammogram. Hispanic women also are more likely than NHW women to be diagnosed with higher grade and hormone receptor-negative tumors [10].

LUNG

In lung cancer, age-adjusted mortality rates in San Diego were highest for Coronado (48.6), Lakeside (47.6), Pauma (46.8), Fallbrook (46.7), and Harbison Crest (42.9) and lowest for National City (11.5), San Dieguito (15.6), University (15.8), Coastal (19.5), and North San Diego (21.9) [9].

Among H/L individuals, lung cancer is the leading cause of cancer death in men and the second leading cause in women; however, compared with NHWs, lung cancer incidence and death rates are approximately 50% lower in men and 65% lower in women, reflecting historic differences in smoking [10].



CANCER SITES WITH HIGHER RATES FOR THE US LATINO POPULATION

Acute lymphocytic
leukemia (ALL)
Gallbladder
Liver and
intrahepatic bile duct
Stomach (gastric)
Uterine cervix



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PROSTATE

Male mortality rates for prostate (per 100,000) in SD were highest for Jamul (57.7), Valley Center (41.0), Spring Valley (39.9), Fallbrook (34.2), and Santee (32.6) and lowest for South Bay (9.9), Mid-City (10.5), Central San Diego (12.9), North San Diego (14.0), and Chula Vista (14.1) [9].

Hispanic men have incidence and mortality rates that are 15% and 12% lower than those in NHWs, respectively. Prostate cancer death rates have declined 37% among Hispanic men since the mid-1990s and have leveled off. Most prostate cancers are diagnosed at an early stage, although Hispanic men are less likely than NHW men to be diagnosed with localized stage disease (66% vs 72%) [10].

COLORECTAL

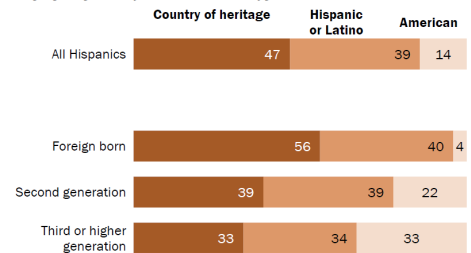
Overall age-adjusted CRC mortality rates were highest in Spring Valley (20.5), La Mesa (20.2), El Cajon (20.0), Vista (19.6), and Chula Vista (18.7) and lowest in San Dieguito (7.8), Poway (8.4), North San Diego (8.5), Peninsula (9.6), and Oceanside (10.1) [9].

CRC incidence rates among Hispanic men and women are approximately 5% to 12% lower than those among NHWs, respectively, and death rates are 13% to 25% lower, respectively. However, the rates vary substantially between Hispanic groups and may be similar to or higher than those in NHWs among some US-born Hispanic individuals [10].

HISPANIC, LATINO, AMERICAN

The terms Latinos use to describe their identity differ across immigrant generations

% saying they most often use _____ to identify themselves



Note: Foreign born includes those born in Puerto Rico. Second generation refers to those born in the 50 states or District of Columbia to at least one foreign-born parent. Third generation refers to those born in the 50 states or D.C. to parents who are also U.S. born. No answer responses not shown.

Source: The National Survey of Latinos conducted Dec. 3-23, 2019.

PEW RESEARCH CENTER

About half (47%) of Hispanic adults say they most often describe themselves by their family's country of origin or heritage, using terms such as Mexican, Puerto Rican or Salvadoran, while another 39% use "Hispanic" or "Latino." 56% of foreign-born Latinos use their origin country versus 33% among third- or higher-generation. Those who use the term "American" rises from 4% among immigrant Latinos to 33% among third- or higher-generation Latinos. Only 3% of Hispanic adults use the term *Latinx* -- the more traditional terms Hispanic or Latino are preferred over *Latinx* [11].

LIVER

For liver cancer, age-adjusted mortality rates were highest for National City (13.8), South Bay (13.7), Lemon Grove (13.6), Southeastern San Diego (12.0), and Oceanside (11.9) and lowest for Del Mar-Mira Mesa (3.2), North San Diego (4.7), Carlsbad (5.0), Coastal (5.2), Harbison Crest-El Cajon (5.4) [9].

Incidence rates in H/L men and women are double those in NHWs, similar to non-white racial and ethnic groups in the US. Notably, the risk of liver cancer in US-born H/L men is double that in foreign-born men. For example, liver cancer death rates in California among US-born Mexican men were 21.6 per 100,000 during 2008 through 2012, versus 11.8 per 100,000 among foreign-born Mexican men [10].

CERVICAL

Hispanic/Latina women have among the highest incidence of cervical cancer in the US compared with other major racial/ethnic groups, with rates 32% higher than those in NHWs. Variation in rates between H/L groups may in part reflect differences in background rates in immigrant countries of origin, as well as differences in access to and uptake of cervical cancer screening [10].

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AFRICAN AMERICAN/ BLACK SAN DIEGANS

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POPULATION

In 2019, San Diego County had a total population of 3.3 million. Among the non-Hispanic population, 4.7% (156,084) were Black. The central region of San Diego County had the largest African American/Black presence with 11.1% - cities include Lemon Grove, La Mesa, San Diego, and El Cajon. [1]

INCOME

Per capita income among African American individuals was \$29,614 [2]. Between 2015 and 2019, the median household income for African American individuals living in San Diego County was \$55,842 [3]. This was lower than the median income of \$78,980 for all households in San Diego County [3].

OCCUPATION

According to the U.S. Bureau of Labor and Statistics in 2018, 31% of AA/Bs worked in management/professional occupations. Blacks made up 12% of all employed workers, but accounted for more than 25% of those in specific occupations: nursing, psychiatric, and home health aides (36%); security guards/gaming surveillance officers (31%); and licensed practical/licensed vocational nurses (30%). [4].

POVERTY AND UNEMPLOYMENT

18.5% of all African Americans/Blacks in San Diego County are in poverty, compared to the 21% in the US [5]. The unemployment rate of AA/Bs in San Diego County is 10%, which is higher than the AA/B unemployment rate of 7.7% in the US [12].

HEALTH INSURANCE

In San Diego County, 8.9% of men were uninsured, and 7.2% of women were uninsured in 2019. Among the non-Hispanic population, 7.8% of African Americans were uninsured, compared to 6.5% in California [8].

EDUCATION

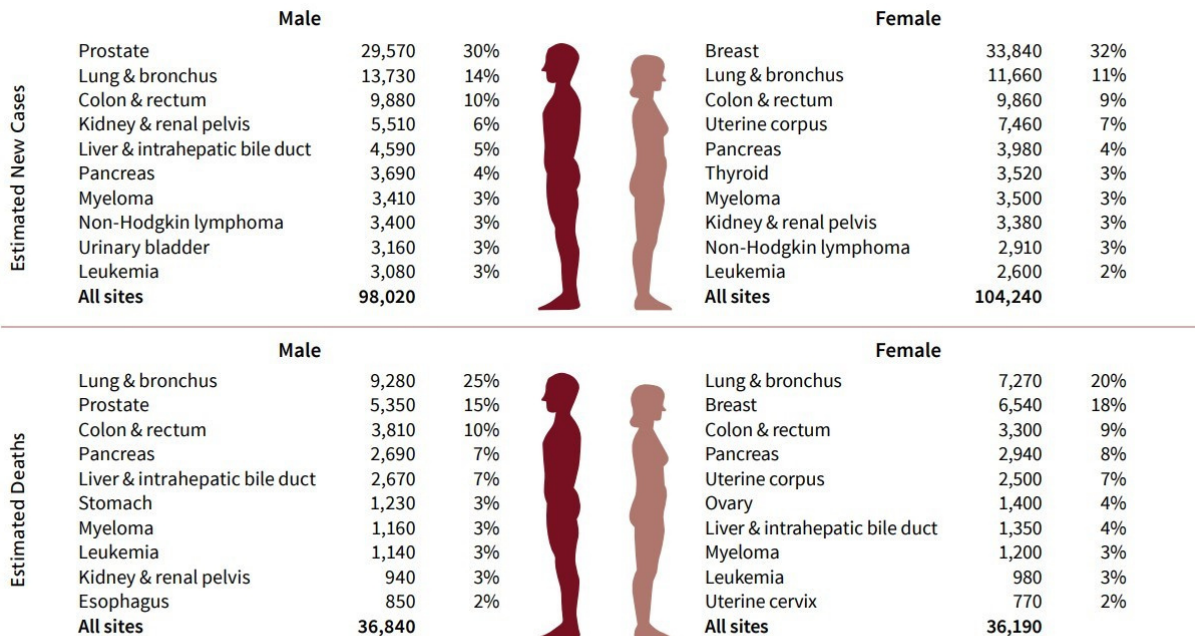
92% of Blacks ages 25 and older in San Diego County have at least a high school degree or higher and 26% hold a Bachelor's degree [6]. In the US, 77% have graduated from high school or higher and almost a quarter (23%) have a bachelor's degree or more [7].

FOREIGN-BORN PERSONS FROM AFRICA

Foreign-born persons from the continent of Africa have contributed most significantly to the growth in the foreign-born population in the City of San Diego. Over the past five years, the foreign-born population from the continent of Africa has grown by 53.8%. In contrast, during the same period, the foreign-born population in the City of San Diego from Latin America and Asia grew by 3.9% and 6.9%, respectively. Some of the fastest growing foreign-born populations come from Kenya, Sudan, and Nigeria. The foreign-born Black/African-American population accounts for 15.1% of the entire non-Hispanic Black/African-American population [9].

CANCER TRENDS IN BLACKS

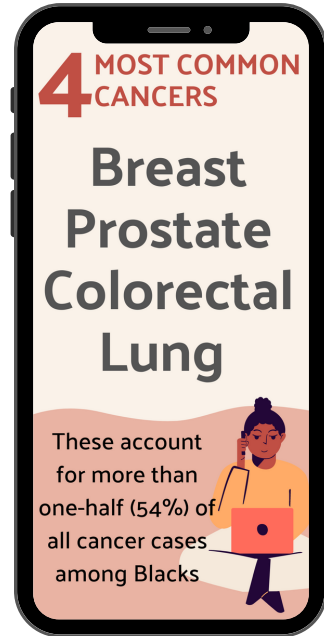
The most commonly diagnosed cancers in Black men is prostate cancer and breast cancer in Black women, each accounting for nearly one-third of cancers diagnosed in each sex. Cancers of the lung and colorectum are the second and third most commonly diagnosed cancers, respectively, in both Black men and women. The largest disparities are for cancers of the stomach, prostate, uterine corpus, and myeloma, for which death rates among Blacks are about twice as high as those among whites. Despite lower incidence rates in NH Black compared with NH white women for uterine corpus and breast cancers, death rates for these cancers in Black women are 98% and 41% higher, respectively [10].



*Estimates are rounded to the nearest 10, and exclude basal and squamous cell skin cancers and in situ carcinoma with the exception of urinary bladder. Ranking is based on modeled projections and may differ from the most recent observed data.

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Leading Sites of New Cancer Cases and Deaths Among Blacks, United States, 2019 Estimates. Estimates are rounded to the nearest 10 and exclude basal cell and squamous cell skin cancers and in situ carcinoma, except urinary bladder. Ranking is based on modeled projections and may differ from the most recent observed data. CA: A Cancer Journal for Clinicians, Volume: 69, Issue: 3, Pages: 211-233, First published: 14 February 2019, DOI: (10.3322/caac.21555)



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BREAST

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Breast cancer death rates remain 41% higher in NH Black women than in NH white women likely from a combination of factors: more advanced stage at diagnosis, higher prevalence of obesity and other comorbidities, and unfavorable tumor characteristics (eg, triple-negative, inflammatory carcinoma, higher grade), and less access and adherence to high-quality cancer treatment [10].

CERVICAL

The incidence rate of cervical cancer is 30% higher in NH Black women than in NH white women with the largest disparity among older women. The overall 5-year relative survival rate for cervical cancer among Black women is 56%, compared with 68% among white women, partly because Black women are more likely to be diagnosed with regional-stage or distant-stage disease. Racial differences in stage at diagnosis may be because of differences in the quality of screening and follow-up after abnormal results, and less screening. Cervical cancer mortality rates are 75% higher in NH Black than NH white women. A recent study estimated that 47% of Black-white differences in cervical cancer mortality are caused by treatment differences, and 19% are caused by a lack of health insurance [10].





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Prostate cancer is the most commonly diagnosed cancer among Black men and the second-leading cause of cancer death. During 2011 to 2015, the average annual prostate cancer incidence rate was 76% higher than the rate in white men. The only well established risk factors for prostate cancer are older age; African ancestry; a family history of the disease; and certain inherited genetic conditions, including mutations in BRCA1 and BRCA2 and Lynch syndrome [10].

LUNG

In lung cancer, age-adjusted mortality rates in San Diego were highest for Coronado (48.6), Lakeside (47.6), Pauma (46.8), Fallbrook (46.7), and Harbison Crest (42.9) and lowest for National City (11.5), San Dieguito (15.6), University (15.8), Coastal (19.5), and North San Diego (21.9) [11].

Black men have the highest lung cancer death rate of any racial or ethnic group. Although lung cancer rates are 15% higher in Black men than in white men, the reverse is true for women (rates are 14% lower in Black women), reflecting racial and sex differences in historic smoking patterns [10].

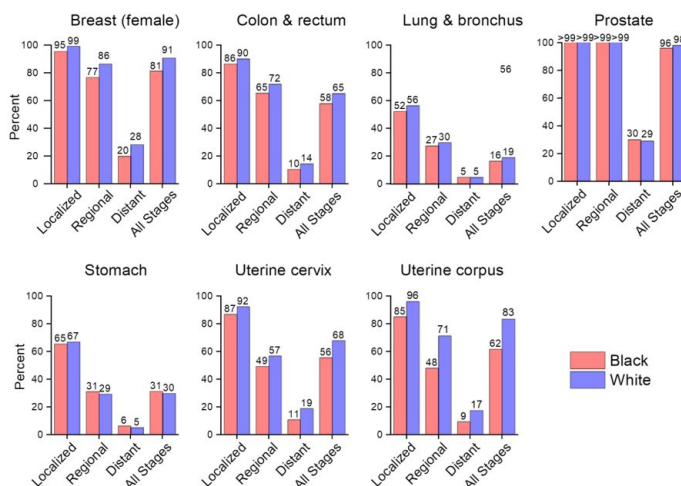
COLORECTAL

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Blacks have the highest rates of CRC of any racial/ethnic group in the United States. Compared with NH whites, incidence rates are 24% higher in NH Black males and 19% higher in NH Black females. The increased risk of CRC among Blacks may result from a higher prevalence of obesity (among women) and physical inactivity. In addition, CRC screening has historically lagged behind in Blacks compared with whites and remains slightly lower. In 2015, 62% of Blacks aged 50 years and older were up to date on guideline-recommended CRC screening, compared with 65% of whites [10].

SURVIVAL RATES

The 5-year relative survival rate is lower in Blacks than in whites for every stage of diagnosis for most cancer sites. This comes from socioeconomic barriers to timely, high-quality medical care. As a result, Blacks are more likely to be diagnosed at a later stage of disease [10].



Five- year Relative Survival Rates for Selected Cancers by Race and Stage at Diagnosis, United States, 2008 to 2014. [CA: A Cancer Journal for Clinicians, Volume: 69, Issue: 3, Pages: 211-233](#), First published: 14 February 2019, DOI: (10.3322/caac.21555)



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