

RACE AND ETHNICITY

NATIONALLY, WE KNOW:

- Biological and genetic differences do not explain the health disparities experienced by different racial and ethnic populations, especially since there is no biological basis for race. These disparities are felt to be the result of an interaction of mainly environmental factors and health behaviors.
- In March 2002, three important reports were published, all showing significant health disparities in both health status and quality of health care faced by racial and ethnic minorities in America; even when income, education attainment, and insurance status are controlled for: Institute of Medicine’s “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” Commonwealth Fund’s “Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans,” and the American Medical Association report “Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care.”
- By 2030, 40% of Americans are expected to belong to a minority racial or ethnic group, compared with 28% today.

Foreign-Born Population Of US As A % Of Total Population:			
US:		MAINE:	
1850	9.7%		
1900	13–15%	1902	13.5%
1930	11.6%		
1950	6.9%		
1970	4.7%		
1980	6.2%		
1990	7.9%		
2000	11.1%	2000	2.9%

Sources: US Census Bureau and Bureau of Labor Statistics.

2000 Maine: One-third of the 2.9% foreign-born residents in 2000 had entered the US between 1990–2000. In 1902, three-quarters of Maine’s foreign-born population were from Canada and Ireland.

Since 1980 across the US the biggest change has been an increase in immigration from Asia and Latin America.

What are Race and Ethnicity?

Race is a sociological characteristic – generally thought of as a characteristic by which one is identified by others. Often these characteristics are related to skin color and/or facial features. Genetic studies have thoroughly discredited the concept of race as a biological characteristic (among them: Witzig, R. “The Medicalization of Race: Scientific Legitimization of a Flawed Social Construct.” *Annals of Internal Medicine*. 1996; 125:675-679).

Racial categories are often overlapping, and therefore, the 2000 Census allowed respondents to claim multiple racial identities for the first time.

Ethnicity is often used synonymously with ancestry and includes concepts of culture, language, and national origin. Ethnic groups are often multiracial.

Category terms of race and ethnicity are becoming less valid, particularly as more Americans are of mixed ancestry and as biological concepts of race have been discredited. Some are replacing both these terms with “ethnic groups” or “minority population groups.” However, even as the usefulness of racial and ethnic categories in some ways is diminishing, we are also more aware of the impact these social constructs have on health status. It appears that the reasons why these factors impact health include a number of possibilities, including differences in social class, culture, behavioral risk factors, psychosocial risk factors, and the direct effects of racism, segregation, and discrimination.

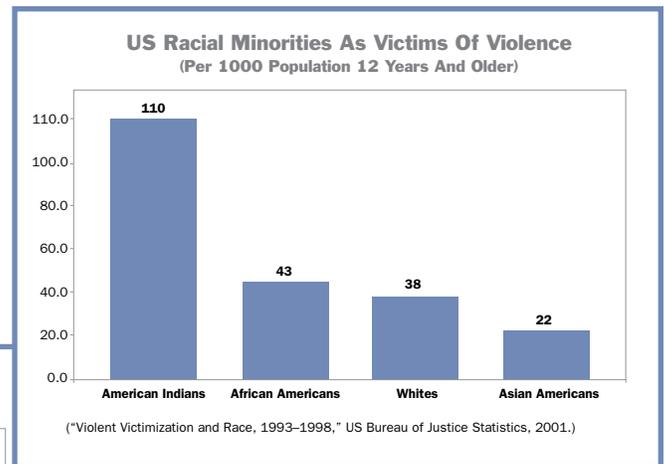
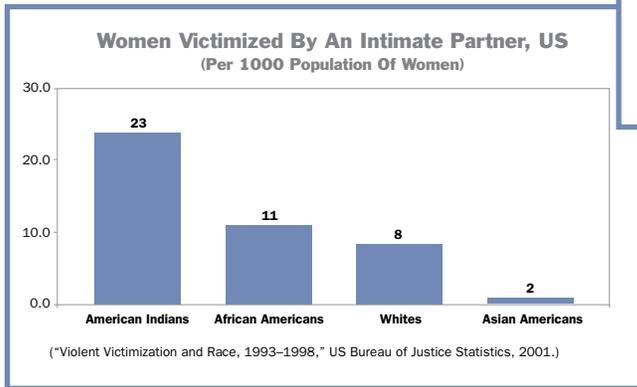
(Williams, DR, and C. Collins. “United States Socioeconomic and Racial Differences in Health: Patterns and Explanations.” *Annual Review of Sociology*. 1995; 21:349-386.)



Some highlights of health disparities known nationally include:

African Americans experience:

- Infant mortality rates more than twice that of whites;
- Death rates from heart disease more than 40% higher than that of whites;
- Death rates from cancers 30% higher than that of whites;



- Prostate cancer death rates more than twice that of whites;
- Higher death rates from breast cancer despite mammography rates being similar;
- Death rates from diabetes almost 30% higher than that of whites;

- Death rates from HIV/AIDS more than seven times that of whites;
- Death rates from homicide six times more than that of whites, making it either the leading or second leading cause of death for black males ages 1–44 years (leading cause in the 15–34-year-old age group);
- At birth, the average life expectancy for African Americans is 72 years compared to over 77 years for whites. Black males have the lowest life expectancy of all Americans: 68 years, compared with 75 years for white men. Life expectancy for black women is 75 years, compared with 80 years for white women.

Hispanics experience:

- Death rates from diabetes twice as high than non-Hispanic whites;
- Nearly twice the rate of tuberculosis than non-Hispanic whites;
- Higher rates of high blood pressure and obesity than non-Hispanic whites.

American Indians and Alaskan Natives experience:

- Infant mortality rates almost double than that of whites;
- Rates of diabetes more than twice that of whites;
- Higher death rates from unintentional injuries and suicide than whites;
- Suicide as the second leading cause of death for 15–24-year-olds, and for males in this age group, suicide rate is twice as high than for nonnative males in the same age group.

Asians and Pacific Islanders experience:

- In general, some of the best health in the US, based on common health indicators;
- Cervical cancer rates in Vietnamese women nearly five times higher than rates for white women;
- Higher rates of hepatitis and tuberculosis than rates for whites.

The US Department of Health and Human Services is focusing on six major areas in which racial and ethnic minorities experience serious disparities in health access outcomes: diabetes, heart disease and stroke, cancer, infant mortality, child and adult immunization, and HIV/AIDS.



Definitions of Terms Commonly Used with Foreign-Born Populations

Refugees: Persons who flee their country due to a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. They are eligible for some Federal assistance programs and to work in this country upon arrival, as well as for permanent residency after one year.

In Maine, Portland is a Refugee Resettlement Center, funded primarily by the US Federal Government. Initial reception and placement services are provided by Catholic Charities of Maine.

Countries of origin of predominant refugee groups and numbers resettled in Maine from 1982–1998:

Cambodia	646	Vietnam	571
Poland	387	Afghanistan	352
Former Soviet Union	349	Bosnia Herzegovina	283
Somalia	247	Sudan	172
Iran	133	Ethiopia	125

These figures do NOT include secondary migration of refugees who first settled in other parts of the country. Secondary migration has tripled since 1997 to over 700 per year.

Asylees: Refugees who are already present in the US at the time they apply for refugee status. They are eligible for the same benefits as refugees, but only 10,000 may become permanent residents each year in the US.

Parolees: People who would not normally be admissible but are allowed to enter temporarily for humanitarian, legal, or medical reasons. They are not eligible for Federal benefits or predestined permanent residency status, except for some Cubans and Haitians.

Illegal Aliens: Also known as undocumented immigrants, persons who enter or live in the US without official authorization.

Immigrants: Legal immigrants are admitted to the US based on family relation or job. Since 1988, about 8,400 legal immigrants have moved to Maine, with Canada the most common country of origin.

Migrant Workers: People who move to different geographical regions on a seasonal basis according to job availability. Different government agencies define migrant workers in a variety of ways. Maine has a number of migrant workers, many of whom are Hispanic or Southeast Asian, who are employed in the planting, harvesting, and production of potatoes, blueberries, apples, broccoli, eggs, wreaths, seafood, and trees. Seasonal farmworkers are those who work in farming on a seasonal basis, but do not move from their home base.

(Sources: information from Meryl Troop at Maine Department of Behavioral and Developmental Services; and *Healthy People 2010*, Department of Health and Human Services.)

IN MAINE, WE KNOW:

Maine’s population is predominantly white and has a smaller proportion of racial minority populations compared with the nation.

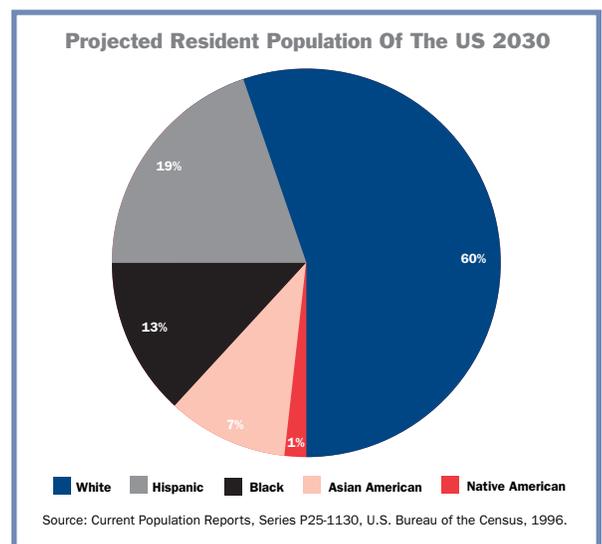
Populations By Race/Maine And US							
	White	Black	Native American	Asian	Native Hawaiian Or Other Pacific Islanders	Other	Two Or More Races
Maine Numbers, 2000	1,236,014	6,760	7,098	9,111	382	2,911	12,647
ME 1990	98.4%	0.4%	0.5%	0.5%	<0.1%	0.1%	NA
ME 2000	96.9%	0.5%	0.6%	0.7%	<0.1%	0.2%	1.0%
US 2000	75.1%	12.3%	3.6%	3.6%	0.1%	5.5%	2.4%

Source: Census, 2000 and 1990.

Population By Race – Alone Or In Combination With One Or More Races							
	White	Black	Native American	Asian	Native Hawaiian Or Other Pacific Islanders	Other	Two Or More Races
Maine Numbers 2000 Census	1,247,776	9,553	13,156	11,827	792	5,227	NA
Percentage	97.9%	0.7%	1.0%	0.9%	0.1%	0.4%	NA

Source: Census, 2000.

- According to the 2000 Census, nearly 90,000 Maine people over age five are estimated to speak a language other than English at home.
- Of those, approximately 18,000 speak English less than “very well.”
- Of the estimated 38,600 foreign-born Maine residents, 25%, or one in four, of them were born in Asia (Census, 2000).
- Of the estimated 38,600 foreign-born Maine residents, 31%, or about one in three, of them entered the US between 1990 and 2000.
- Ethnic and racial minority populations vary by region in Maine. For instance, black and Asian populations tend to account for the biggest proportion of racial minority populations in the southern counties of Cumberland, York, and Androscoggin. Native Americans tend to account for the biggest proportion of the racial minority populations in the northern counties of Washington, Penobscot, Aroostook, and Piscataquis. In fact, Washington County has the highest percentage of racial minorities in Maine with 4.4% of its population identifying themselves as Native American in the 2000 Census. Ninety-three percent (93%) of Washington County is white, compared to a statewide average of 96.9% (Cumberland County is 95.7% white).





Federal Definitions of Racial and Ethnic Categories

RACIAL CATEGORIES:

American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNIC CATEGORIES:

Hispanic or Latino: A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.



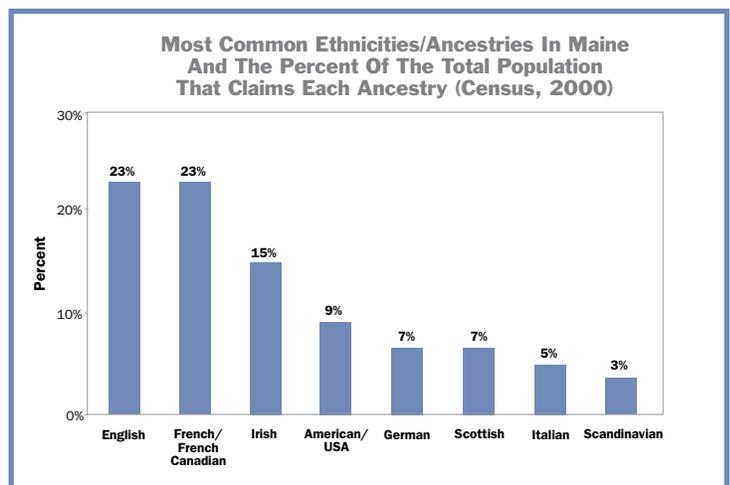
The Philippine Association of Maine Dancers at the Blaine House Summit on a Healthy Maine.

- About two-fifths (41% in 2000 and 44% in 2001) of Maine youth interviewed stated that people who know them would perceive them to know a lot about people of other races (Maine Marks 2000 and 2001 survey, Department of Education).
- About three-quarters (76% in 2000 and 73% in 2001) of Maine youth interviewed stated that people who know them would perceive them to enjoy being with people who are of a different race than themselves (Maine Marks 2000 and 2001 survey, Department of Education).
- A genetic condition called hypercholesterolemia has been found in some Franco-American families in Maine. These families share an LDL-receptor defect, resulting in dangerously high levels of LDL cholesterol. Early detection through cholesterol testing of children and young adults followed by drug treatment is a first step in preventing heart disease in this group.

- Some preliminary health assessments done by the Bureau of Health indicate health disparities among Maine's Native American and Latino populations (see inserts). It is hoped that similar assessments can be done on Maine's other minority populations. Since Maine's black and Asian communities are perceived to be quite diverse culturally and

socioeconomically, it is probable that some of the same challenges in measuring their health status may be similar, as seen in the Latino health assessment.

- Since French ancestry is rarely asked in Maine's health data sets, it is important that asking this ethnicity be implemented.



CHALLENGES

- Preliminary health assessments of Native Americans and Latinos in Maine both reveal the same three sets of challenges we face in measuring the health status of other racial and ethnic minorities in Maine: challenges regarding definitions, measurement strategies, and quality assurance.

Challenges in Definitions:

- We in Maine face challenges in defining race and ethnicity. As the health data matrix in the appendix and accompanying text show, race and ethnicity can usually be found in our health data sets, but there is currently great variability in how race and ethnicity are asked and reported.
- In 1997, the Federal Office of Management and Budget asked for revisions on how race and ethnicity should be asked by any State agency receiving Federal funds (OMB Directive Number 15):
 - There will be five minimum categories for data on race: American Indian or Alaskan Native, Asian, black or African American, Native Hawaiian or other Pacific Islander, and white. Respondents are asked to mark one or more racial categories.
 - There will be at least two categories for data on ethnicity: “Hispanic or Latino” and “Not Hispanic or Latino.”
- Very few health data systems obtain ethnic background other than Hispanic ancestry, yet we know from Census data that 23% of Maine people have some French/French-Canadian ancestry. We therefore continue to face challenges in measuring the health status of this population.
- Bureau of Health data systems are in the process of standardizing the way they ask race and ethnicity. Most likely, this will be identical to the Federal standard, with the exception of adding a Franco-American option to the ethnicity questions.

Challenges in Measurement Strategies:

- Because most of Maine’s racial and ethnic minority populations represent a smaller proportion of the overall population relative to other states, alternative methodologies need to be developed and implemented to measure the impact of race and ethnicity on health. This is important because national health data and even the limited data in Maine show that racial and ethnic minorities face health disparities. If our health data in Maine do not accurately reflect the health status of all Maine people, including racial and ethnic minorities, our health resources will not be used effectively and, as a result, all Maine people will not have the opportunity to live longer and healthier lives.
- Three common alternatives exist for collecting or analyzing data for minority populations:
 - One can use statewide sample techniques and over sample in areas with sizable populations of the minority group of interest;
 - One can directly survey the major minority populations in the areas where they dominate; or
 - One can analyze multi-year groupings of survey results for a minority population and examine trends (such as looking at five-year moving averages).

The first two methods significantly increase the cost and size of a survey, but if Maine identifies a preferred method to be used, then the process is easier to implement if additional resources are identified.

Geographic Area	Total Population	RACE							ETHNICITY
		White	Black Or African American	American Indian And Alaskan Native	Asian	Native Hawaiian And Other Pacific Islander	Some Other Race	Two Or More Races	Hispanic Or Latino (Of Any Race)
MAINE	1,274,923	1,236,014	6,760	7,098	9,111	382	2,911	12,647	9,360
COUNTY									
Androscoggin	103,793	100,658	683	282	572	40	294	1,264	988
Aroostook	73,938	71,572	281	1,005	351	19	122	588	441
Cumberland	265,612	254,291	2,815	763	3,707	99	923	3,014	2,526
Franklin	29,467	28,865	72	109	126	6	49	240	159
Hancock	51,791	50,554	130	193	196	18	105	595	336
Kennebec	117,114	114,129	404	469	690	24	206	1,192	852
Knox	39,618	38,935	94	87	141	4	49	308	225
Lincoln	33,616	33,099	57	88	124	8	34	206	155
Oxford	54,755	53,797	95	151	201	12	59	440	292
Penobscot	144,919	139,989	708	1,444	1,019	47	328	1,384	882
Piscataquis	17,235	16,862	36	89	47	4	24	173	89
Sagadahoc	35,214	33,977	323	110	222	22	133	427	391
Somerset	50,888	49,868	121	208	171	11	55	454	234
Waldo	36,280	35,513	68	144	76	5	57	417	215
Washington	33,941	31,728	88	1,505	101	4	151	364	274
York	186,742	182,177	785	451	1,367	59	322	1,581	1,301

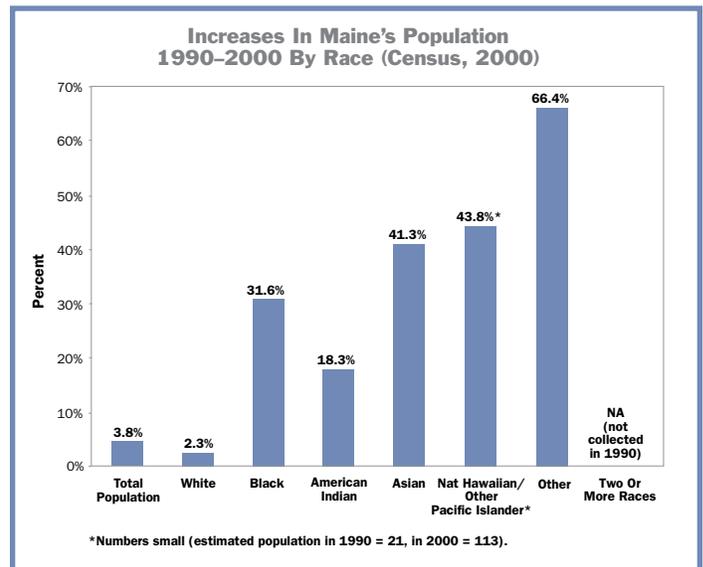
Source: US Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2.

- The 2000 Census was the first to use the category of “two or more races.” Interestingly, this category accounts for the largest numbers of Maine people in a racial category. However, when one examines the racial categories specified by those who designate themselves as two or more races and add those to the single race categories, Native Americans become the most prevalent racial minority in Maine.
- Many people feel the Census undercounts racial and ethnic populations. Some of the reasons include that some racial minorities may have been concerned about being counted in the Census.

Challenges in Quality Assurance:

- It is important that the Bureau of Health works to improve quality assurance of its vital statistics with regards to the racial and ethnic minority population statistics it collects. Nationally, it is known that vital statistics (death, birth, abortion, marriage, and divorce records) can lead to both overcounts and undercounts of minority populations’ disease rates.

For instance, Native Americans and other minorities, particularly in urban areas, are often under-counted. This can lead to an overestimation of mortality rates because the population base (denominator) used to determine these rates is reported to be smaller than it is.



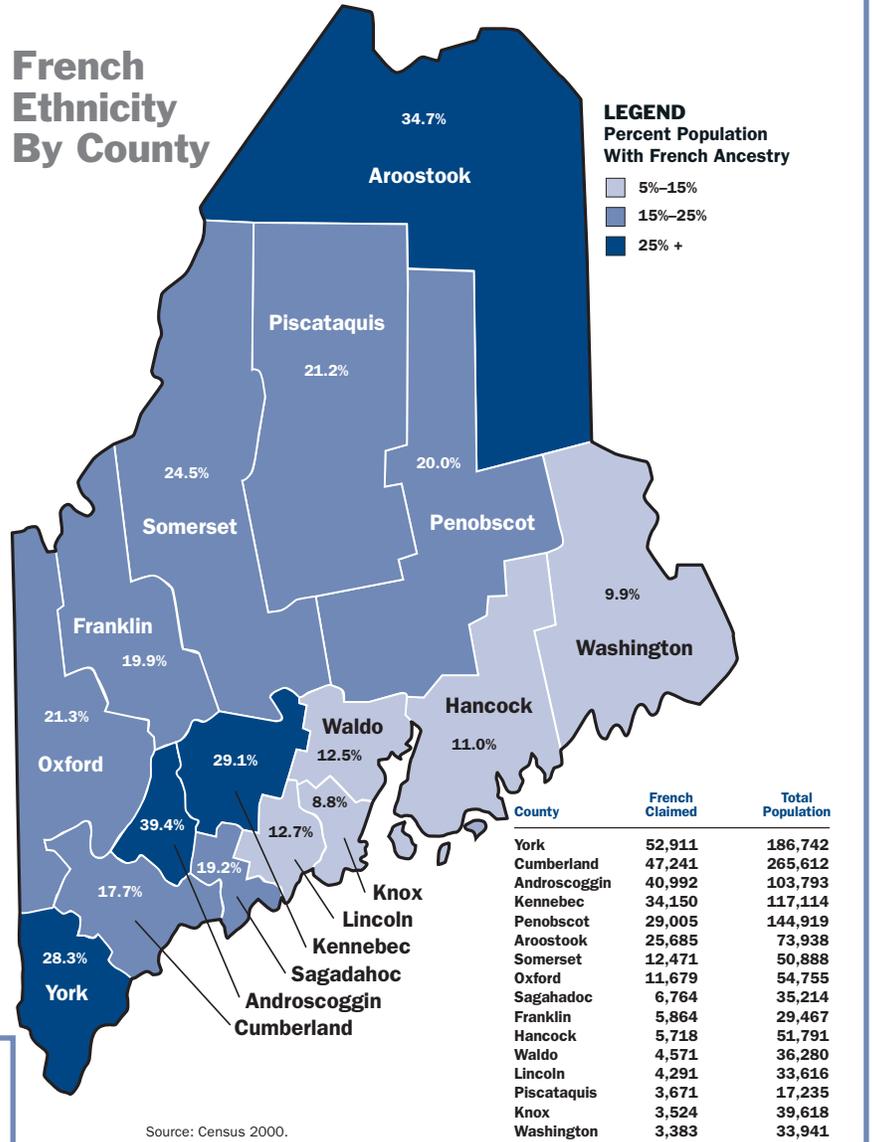


Race And Ethnicity

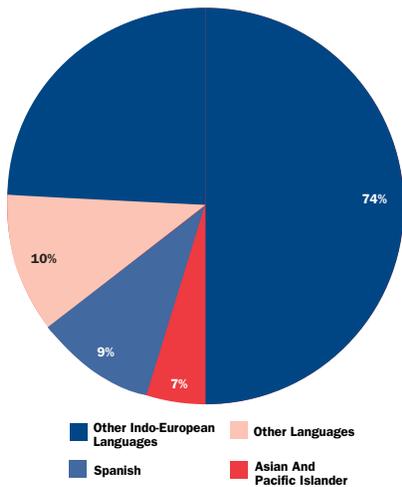
On the other hand, minorities can also be misidentified. There is some evidence that may be happening here in Maine, at least among Native Americans and Latinos (see pertinent sections in this chapter). This can lead to underestimates of disease rates, since the numbers of people with a certain disease (the numerator in disease rates) is lower than what is real.

The Bureau is committed to start evaluating the reliability of its vital records regarding ethnicity and race as well as taking steps, resources permitting, to improve the quality assurance of its vital records and other health data sets.

French Ethnicity By County



Languages Spoken At Home By Maine People Who Speak A Language Other Than English At Home (Census, 2000)





MIGRANT AND SEASONAL FARMWORKERS IN MAINE

Definitions

Different government agencies that serve farmworkers, such as US Departments of Health and Human Services, Labor, Education, and Agriculture, have different definitions for migrant and seasonal farmworkers. For instance, some do not include those who work in tobacco, cotton fields, plant nurseries, fishing, poultry, meatpacking, cattle, or forestry industries.

Migrant workers are often not counted by such data systems as the Census and various health surveys, so these data are unreliable when applied to migrant farmworkers. Therefore, service data, such as clinic data, are often used to characterize health issues farmworkers face.

There are an estimated 5,225 migrant farmworkers on an annual basis in Maine. There are also some children and other dependents, not working on the harvest, who accompany the migrant farmworkers. There are also about 15,000 seasonal farmworkers in Maine. Migrant and seasonal farmworkers are most commonly found in the blueberry, apple, broccoli, egg, and forestry industries.

Blueberry Harvest:

Maine produces more wild blueberries than any other state. In Washington, Hancock, and Waldo counties there are about 10,000–12,000 farmworkers employed for the blueberry harvest; the vast majority being migrant and seasonal workers. Of the migrant workers employed for this harvest, many of them are Hispanic, from southern Texas, Mexico, Puerto Rico, and Central America. The Hispanic migrant workers usually come to Maine as a family unit of 1–14 members. Additionally, many of the farmworkers for this harvest are historically and currently MicMac Indians from the Canadian Maritime Provinces.



Apple Harvest:

Apples are harvested in late August through October in Androscoggin, Cumberland, Kennebec, and Oxford counties, using a workforce that is predominantly single adult males from Jamaica through the Federal H-2A Program. It is estimated that at least 700 migrant or seasonal farmworkers are employed to harvest apples in Maine each year.

Broccoli Harvest:

Approximately 350–500 workers are hired each season (July–October) to harvest about 3,000 acres of broccoli in the Presque Isle and Caribou areas of Aroostook County. These are primarily Hispanic and Philippino workers from California and Texas, many of whom travel with their families and return to work Maine's broccoli harvest every year. However, this workforce is down in numbers for 2002 from previous years because of economic difficulties among some broccoli growers.



Egg Industry:

An estimated 300 seasonal or migrant farmworkers, many of whom are Hispanic, are employed in the egg industry, primarily in Androscoggin County.

Forestry:

Hispanic workers from Central America, who also work in the Southwestern US, are employed during the summer and fall in the forestry industry to plant and thin trees, particularly in Somerset, Franklin, Aroostook, and Piscataquis Counties.

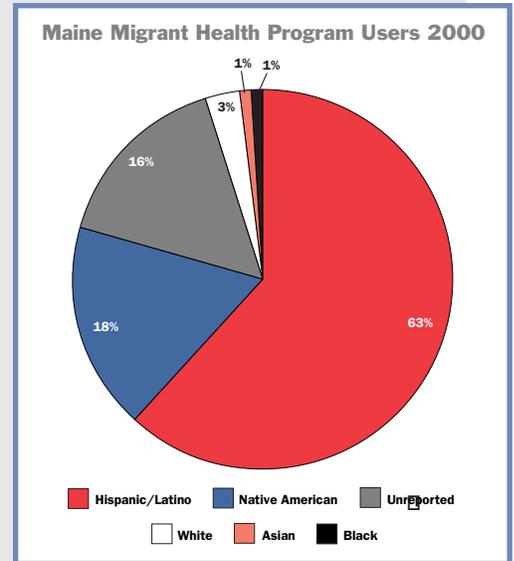
How much do migrant workers earn?

Many migrant workers in Maine, about 550 annually, are H-2A workers who are temporary foreign workers overseen by the US Department of Labor. Their wage must be the prevailing wage, the employers' wage offer, or \$7.68 per hour, whichever is higher. Housing must be provided for free by the employer. Nine out of ten Migrant Health Program users in Maine in 1999 earned below the Federal poverty level (below \$739 monthly income for a family of one; below \$1,509 for a family of four).

What about the health status of migrant and seasonal farmworkers?

Cultural, language, lifestyle, and general economic barriers cause migrant and seasonal farmworkers to have difficulty accessing services. For instance, many services are only available during business hours, yet migrants often do not want to or cannot leave work (their income source) during those hours to access services. Although many farmworkers may qualify for benefits such as Medicaid, eligibility varies from state to state, and there is no portability of eligibility. Additionally, most migrant workers have few connections to the local community and may live in social isolation.

Available national statistics show that migrant and seasonal farmworkers are at greater health risk, and their health status is substandard compared to other American workers. For instance, nationally, infant mortality is 25% higher than the national average and one study showed that poor health status is three times more common among migrant children.



What about race and ethnic backgrounds of Maine's migrant and seasonal farmworkers?

What are some Maine programs that address specific health issues migrants face?

The Maine Migrant Health Program provides health services through a mobile health unit, nurse outreach services, and school-based services at the Rakers' Centers in the blueberry harvest camps, Maine Migrant Education Program's two Harvest Schools (one for blueberry rakers in Washington County and one for broccoli workers in Caribou), and the two Migrant Head Start sites (one in Harrington for blueberry rakers and one in Caribou for broccoli workers). Additionally, Maine's rural health centers and hospitals often provide services to migrant and seasonal farmworkers. Public Health Nurses from the Maine Department of Human Services' Bureau of Health provide direct nursing services, such as home visits to families with or expecting young children, and tuberculosis testing, and outreach.

(Data from Maine Migrant Health Program, Augusta, ME)



“How often do we look at a plateful of fruits and vegetables and think about the people who harvest our food? Migrant workers are particularly invisible – they are not counted in most of our health statistics; they are not seen in many of our stores, schools, and neighborhoods, and yes, they are not even thought of very often. But they live and work here among us.”

Barbara Ginley, Director, Maine Migrant Health Program



Maine’s Hispanic/Latino Population

How Many Hispanics Live in Maine?

2000 Census	Population count was 9,360, or 0.7% of the population
1990 Census	Population count was 6,829, or 0.6% of the population
An increase of 37% from 1990 to 2000	

Maine’s Hispanic/Latino Population Ancestry	
Total Hispanic/Latino	9,360
Mexican	2,756
Puerto Rican	2,275
Cuban	478
Other	3,851

Source: Census 2000

Many feel Maine’s Hispanic population is actually much higher in 2000 because of possible undercounting by the Census.

About 40% of Maine’s Latino population resides in Cumberland and York counties. One percent of the populations of Cumberland and Androscoggin counties are Latino.

A recent Bureau of Health review of some health data regarding Maine’s Latino population (Paul Kuehnert, RN, MS, and Ruby Spicer, MPH, RN, “Health Status and Needs Assessment of Latinos in Maine,” Maine Bureau of Health, June 2002) poses some paradoxes. While clinic data from the Maine Migrant Health Program clearly indicate Latino seasonal and migrant farmworkers are at a socioeconomic and health disadvantage, analysis of data that is primarily focused on non-migrant Maine Latino populations paints a different picture.

For instance, some Census, BRFSS, Vital Statistics, and PRAMS data suggest higher rates of health risks among Maine Latinos (physical inactivity, obesity, hypertension), while mortality data suggest lower rates of age-adjusted death rates from chronic disease. Likewise, other data suggest poor health status (shorter life expectancy, higher rates of domestic violence during pregnancy), while other data suggest the opposite (low infant mortality rates, higher rates of mammogram screening).

Socioeconomic data also suggest some paradoxes. Some data suggest Latinos in Maine are at a socioeconomic disadvantage (per capita income and education attainment from Census data, and PRAMS data identifying child care, transportation, and lack of insurance as barriers to care). Other data suggest Maine Latinos are similar to other Mainers (low unemployment levels and BRFSS data showing similar levels of income and health insurance).

It appears these paradoxes may be due to multiple factors, including:

- Possible undercounting by the Census and other surveys;
- Possible inaccuracies and misclassifications in the collection of ethnicity in health data sets, including death and birth certificates;
- Statistical analyses problems such as widely variant outcomes commonly encountered when working with small sample sizes;
- Additionally, key informants tell us that Maine’s Latino population is diverse culturally and socioeconomically. This diversity may also be reflected in our inability to make accurate broad characterizations of this population.

Juan A. Perez-Febles, Director of the Division of Migrant and Immigrant Services for the Maine Department of Labor



“Finding affordable and accessible health care is a critical issue to members of Maine’s Hispanic migrant worker population.”

“Another challenge is acknowledging that we do have a large Hispanic population in this State. Health care providers have an opportunity to get to know this diverse population, which would enrich their lives culturally and professionally.”

Native Americans in Maine



Barry L. Dana, chief of the Penobscot Indian Nation, drumming and singing.

Penobscot, Passamaquoddy, Maliseet, and Micmac people make up most of the over 7,000 Native American people in Maine.* They are all part of the Wabanaki group of tribes found in Maine and Eastern Canada. The vast majority of Native Americans live in or near five small rural communities of Indian Island (Penobscot Nation), Pleasant Point (Passamaquoddy tribe), Indian Township (Passamaquoddy tribe), Houlton (Houlton Band of Maliseet), and Presque Isle (Aroostook Band of Micmac). With the exception of Presque Isle, each of these communities includes a reservation or defined land where many tribal members live.

The Indian Health Service (IHS) funds health care services provided or purchased by the tribes. Although IHS reports it serves about 60% of American Indians and Alaskan Natives, services in urban areas and in non-reservation rural areas are very limited.

Each of Maine's tribes receives funding from IHS, the level determined by the number of tribal members. According to tribal health directors, this funding has been essentially flat. It also must be used for both prevention initiatives and direct health services. Therefore, funding for prevention is vulnerable to sudden increases in health care costs, such as a severe illness in one or several tribal members. According to the tribal health directors, about half to two-thirds of Native Americans in Maine live off reservation, and many of these live outside the service area for the IHS centers.

Indian Health Services provides some funds for five health centers in Maine: Penobscot Nation Health Department, Maliseet Health Center, Micmac Health Center, Pleasant Point Health Center, and Indian Township Health Center.

Some health data indicate Native American people in Maine compared to all of Maine's population:

- Are younger;
- Have lower per capita and household incomes;
- Experience higher rates of unemployment;
- Attain higher education at lower rates;
- Have higher birth rates, including teen birth rates;
- Die at a younger age (on average 60-years-old versus 74 for all Mainers);
- May die at higher rates from cancer, particularly lung cancer; and
- Experience higher rates of tobacco addiction, problem alcohol use, and overweight.

(Sources: Census; Maine Bureau of Health Office of Data, Research, and Vital Statistics; Micmac 1998 Behavioral Risk Factor Survey.)

* The terms "Native American" and "American Indian" are used interchangeably in this text. "American Indian" is used by the Federal government as a racial classification, and "Native American" is used by many other sources.

According to a report by the American Indian Health Care Association, although American Indians are culturally very diverse, they generally share the following experiences historically, all of which impact their health:

- **Rapid and forced change from a cooperative, clan-based society to a capitalistic and nuclear family-based system;**
- **Outlawing of language and spiritual practices;**
- **Death of generations of elders to infectious diseases or war; and**
- **Loss of the ability to use the land walked on by their ancestors for thousands of years.**

(Scott S., and M. Suagee. *Enhancing health statistics for American Indian and Alaskan Native communities: an agenda for action - A report to the National Center for Health Statistics*. St. Paul, MN: American Indian Health Care Association, 1992.)

Barriers to health identified by Maine's tribal health directors include:

- Transportation;
- Low income;
- Prejudice and racism;
- Shortages of qualified health personnel;
- Inadequate State and Federal funding;
- Lack of accessible and/or culturally appropriate health care, especially for substance abuse treatment and nursing home care;
- Threats from environmental toxins such as dioxin, mercury, lead, arsenic, and cadmium; and
- Inequitable public policy such as a result of no voting representation to the Maine Legislature.

(Source: Paul Kuehnert, MS, RN, "Health Status and Needs Assessment of Native Americans in Maine," Maine Bureau of Health, January 2000; and a July 2002 Native American Health Assessment report by the Wabanaki Mental Health Association to the Bureau of Health.)

Factors that may be hindering adequate health assessment of Maine's Native American population include factors in common with other racial and ethnic minority populations:

- Undercounting by the Census and other surveys;
- Inaccuracies and misclassifications in the collection of race in health data, including death and birth certificates; and
- Statistical analyses problems such as widely variant outcomes commonly encountered when working with small sample sizes.

An evaluation is underway by the Maine DHS Bureau of Health and Maine's tribal health directors to assess the accuracy of death certificate information. Studies elsewhere have shown Native Americans to be misclassified on death certificates, yielding low estimates for some diseases. One study found evidence of American Indian heritage being misclassified, and as a result under-reported by 65% on death certificates, leading to low estimates of deaths due to diabetes (Rousseau, P. "Native American elders: Health care status." *Clin Geriatr Med* 1995; 11(1): 83-95). Since funeral directors and physicians unfamiliar with the decedent's life often fill out death certificates and since there is no formal quality assurance for Maine's vital records, it is very possible that Native American heritage is inaccurately reported in Maine's death certificates, as well as in other health data.

One Mainer's Perspective as a Native American Health Director

Patricia Knox-Nicola, Health Director, Penobscot Nation, Old Town

"During the past 20 years since the Indian Health Centers in Maine were established, we have been playing 'catch up' with health care."

"The current system for tracking ethnicity is not collected accurately or consistently. State agencies must train those who fill out forms how to accurately fill them out. Once accurate data are available, the Native American population and other minority groups will be better able to compete for funding, and ultimately the success rate of programs should increase."

One Mainer's Perspective as a French American

Judy Ayotte Paradis, Frenchville, Maine, former State Senator and Chair of Health and Human Services Committee of the Maine Legislature

Two Major Maine Franco-American Populations:

Acadians – French-speaking people living in the Maritimes, many of whom were forced by the British to flee New Brunswick and Nova Scotia during the 1750s and 1760s. While a number settled in faraway places such as Louisiana, Maryland, and even France, some settled in the St. John Valley in northern Maine.

Quebeçois: – French Canadians from Quebec, many of whom immigrated to Maine and other New England states in 1850–1900 and settled mostly in mill towns such as Lewiston, Waterville, Biddeford, and Augusta.

“Our French-American cultures – both Acadian and Quebeçois – teach us to be optimistic, and we have a tradition of strong spiritual faith. I think this optimism and strong faith in God contributes greatly to our good health. French-American families take care of each other – our extended families are very important. Also, we have a long tradition of working hard, particularly physical labor. I think smoking cigarettes or abusing alcohol is relatively rare in our populations.”

“We have traditionally relied on home remedies that have been passed on from generation to generation to maintain our health. Many of us also have Native American ancestry. This has often been hidden, but can be seen in some of our traditions such as home remedies.”

“French Americans with Quebeçois or Acadian ancestry tend to try to please and give optimistic answers, in part not to be burdensome. So, for instance, when encountering questions from health care providers about how they are doing, they may say “fine,” even when things are not. I think it is important that if health care providers believe this may be happening that they ask the family member accompanying the patient as to how the patient is doing. The family member is more likely to give a direct answer than the patient.”

“An example of this desire to be pleasing and not burdensome is when my parents have been hospitalized, they never wanted to ring the bell requesting assistance. Since we knew that, we made sure someone in the family was always with them. Also, I think it would help if hospital or nursing home staff make sure they periodically ask those patients and their family members how they are doing, rather than wait for the bell to ring.”

“Language barriers are often seen among older Maine people with French-American ancestry. Even though they sometimes converse okay in English, a health care provider is often not going to get as accurate an answer unless they ask for the answer in French.”





“Quebeçois and Acadian cultures are generally matriarchal since fathers so often had to work long hours away from home, or even away from the town in the woods and the mills. The mothers, therefore, were home and ruling the home. However, fathers do traditionally have the last word on some issues.”



“My father recently died after a short illness at age 89. He had been in excellent health and I think this was because of his French-American culture. Like many Mainers with French-American ancestry, our family has Quebeçois and Acadian ancestry that both contribute to our culture. My parents had ten children. We were raised with no alcohol and no smoking allowed at home. Because my father was away so much working in the mill, my mother was the strong parent. Our extended family was very involved in raising us. We also took care of extended family members when they were ill or elderly.

We were raised with a strong faith in God. I often saw my father on his knees praying and we prayed together as a family. When my father was recently terminally ill, he did not indicate much pain or ask for things. I think he didn't want to bother anyone and wanted to put forth an optimistic front. My parents' cultural legacies of hard work, optimism, and strong faith are seen today in us and all of their grandchildren. I'm very proud of this heritage my parents and ancestors gave to us.”

Cultural Competency

Cultural competency is a set of behaviors and attitudes that enable us to understand and work effectively in cross-cultural situations. The result of cultural competency is the establishment of positive helping relationships that effectively engage people, and the significant improvement of quality of services such as public health and health care. In order to achieve cultural competence, the following should be included:

- **Valuing diversity;**
- **Having the capacity for cultural self-assessment;**
- **Being conscious of the dynamics inherent when cultures interact;**
- **Having institutionalized cultural knowledge; and**
- **Adapting service delivery based on understanding of cultural diversity.**

(Source: Office of Minority Health, DHHS.)



One Mainer’s Perspective as a Southeast Asian American

Pirun Sen, Member of Maine’s Cambodian Community and Home School Social Worker at the Multilingual Center, Portland Public Schools

According to Pirun, people from Cambodia prefer to be referred to as Southeast Asian Americans, not just Asian Americans.

“There are roughly 2,500 Cambodian Americans living in Maine, with a majority living in Portland, Sanford, and the Berwicks, while others are scattered across the State. The Buddhist Temple in Portland is often felt to be the center of the Cambodian Community in Maine.”

“People from rural Cambodia especially often do not recognize the need for a doctor. In Cambodia, you could buy medicines very easily from a pharmacy without seeing a doctor. When most Southeast Asians finally go to a doctor, they usually go because they want medicine. They often do not understand the reasons behind the physical exams and tests.”

“Life expectancy is very low in Cambodia – about 45 years old. People are not used to worrying about smoking or nutrition because in Cambodia something else will kill you before you have to worry about chronic diseases.”

“Obesity was never a problem for us in Cambodia. We had to walk everywhere and ate a healthy diet. Here in the US our children do not have to walk like we did. Cambodians do not understand the push for physical activity – we never had a lack of physical activity before.”

“Medical professionals do not understand Southeast Asian response to pain. They think we have a high pain tolerance. This is a misunderstanding. The pain is usually there and it hurts, but the old Cambodian belief is not to complain and hold it in, even if it is terrible. Also, our Buddhist religion tells us that if we’re in pain, we’re alive and should be happy.”

“In Cambodian culture, our young children are mostly cared for by their grandparents and

extended family. Adolescence is the time when parents become very involved with their children, in order to prepare them for adulthood. It is very difficult for Cambodian parents in this country when extended family is not present and when adolescents want to spend most of their time away from them.”

Refugees

Of new immigrants, refugees especially experience many losses. They often:

- Are severely traumatized by their past experiences;
- Worry about families and friends left behind;
- Lose much of their prior identity – such as leaving behind a profession and taking an entry-level job in the US; and
- Lose the cultural and physical environment that is familiar to them.

(Source: Office of Minority Health, DHHS.)



One Mainer’s Perspective as an African American

Anthony (Chan) Spotten, Executive Director and Founder of Health 2000, an organization working to raise awareness of AIDS among all Maine people of African descent. Chan was born in Maine and grew up in Old Town. His racial background is African American and Native American. He also is living with AIDS.

“Health issues for African Americans should not be separated from the history of being black in this country and the legacy of slavery. Life expectancy is the lowest among black men, HIV infection is in epidemic proportions among blacks, a significant proportion of the US prison and death row populations are black, and drug arrests are much higher among blacks. It is no surprise blacks sometimes may not take care of themselves better, considering they don’t expect to live long anyway. Also, I think African Americans often feel that going to a doctor for preventive care would be considered unnecessarily taking up the doctor’s time.”

“I believe Maine needs an Office of Minority Health. There is insufficient health data and resulting efforts on minority health status in Maine, and this Office would assure the black community some inclusion and representation in Maine’s health efforts. It would also train Maine’s public health professionals on minority health and related data needs.”

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One Mainer’s Perspective as an African American

Carl M. Toney, P.A. Assistant Professor and Project Director, Center for Transcultural Health, University of New England

“For African Americans, as well as for virtually all ethnic and cultural populations, the problem comes down to access to culturally appropriate care. Patients often lack confidence that their health care providers understand the health and social beliefs that are inherent in their cultures. This can become a barrier to individuals seeking care or feeling satisfied with a provider’s response.”

“African Americans are historically at risk for problems associated with cardiovascular disease and diabetes. When you combine these health factors with the issue of finding culturally sensitive care, it becomes a double-edged sword.”

“The challenge is for health providers to establish a dialogue and a level of trust with patients of all ethnic populations. To successfully serve Maine as a whole, all parts must be accounted for and understood.”





Two Mainers' Perspectives on Maine's Emerging Somali Population

Phil Nadeau, Assistant City Manager, Lewiston

Azeb Hassan, a Somali Community Interpreter and Advocate in Lewiston

Phil: *"I believe there are approximately 5,000 Somalis living in Maine, with about 3,500–4,000 living in Portland, and most of the remainder living here in Lewiston."*

Azeb: *"Tension is growing in many traditional Somali families around male and female roles within the family and community. It is customary for Somali women to remain in the home and care for children. Usually she does not leave home without her husband or his permission. It is also culturally acceptable to hit or beat your wife or for parents to discipline their children this way. Many Somali women are beginning to realize that they do not have to live this way anymore – being treated unfairly. Living in the US has showed them they can*

have jobs, interact freely with the external community, and have many options. However, these cultural differences are causing increased divorces and tensions."

Azeb: *"Somalis living in Maine are mostly Muslim with strong religious and family values."*

Phil: *"Many of the Somali population suffered or witnessed torture of family members before coming to the US. We have been focusing on meeting basic housing and food needs, but it is clear we need to also connect people to appropriate mental health services."*

Azeb: *"We feel free here in Lewiston. We feel safe. We can go outside and not see anyone we're afraid of. My children are happy."*

Azeb: *"The Somali people want to work. We want to have jobs and own businesses. We want to contribute to the Lewiston community."*

Phil: *"I think the influx of Somali refugees in Lewiston will help turn around Lewiston's economy and will revive this city. We have been losing population for a long time now. The City of Lewiston has a wonderful history of immigration and it was the contribution of immigrants in the past that built this city. I believe the Somali people will also be an asset to Lewiston."*