Barriers to Healthcare Access for New Mainers

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Introduction

At the end 2017, the UNHCR recorded a global record of 68 million forced displaced people due to the continuation of decade-long wars and the rise of new spurts of violence and persecution. Although the majority of this 68 million are either internally displaced in their home countries or living in refugee camps in neighboring countries, a small number are resettled in nations around world, including the U.S. In 2016, a maximum of 85,000 refugees were resettled in the country, supported by federal grants and voluntary organizations (Catholic Charities). In Maine, about 400 - 700 refugees arrived in the state through the Office of Resettlement at Catholic Charities (Portland Press, 2013). These new groups of refugees coming from Burundi, Syria and Angola joined the older immigrant communities from Somalia, Iraq and Sudan. In addition to resettled refugees, immigrants in Maine also consist of asylum seekers, secondary migrants and undocumented individuals. However, even with the overall immigrant population in Maine of around 10,000 over the past several decades, the state of

1.3 million residents still remains relatively homogenous in terms of race and ethnicity (Catholic Charities). It is important to assess how this minority population has been accommodated into Maine's existing social and civil systems, especially for an already precarious and contested system such as healthcare. New Mainers are often escaping harrowing experiences of war and deprivation and move to the US with a need for quality physical and mental health services. Securing the best possible healthcare access and quality for immigrants not only helps them become healthier, but also speeds up their acculturation to the U.S as stable, working, civil citizens. In this report, we hope to move toward this goal by assessing the important barriers faced by immigrants in Maine in accessing healthcare, and making recommendations for areas of individual, community, and structural improvement.

Definitions

Asylum Seeker – Someone who flees their own country to seek sanctuary in another country. They must demonstrate that their fear of persecution in his or her home country is well founded in order to be recognized. Once their application has been approved, they then become asylees. (UNHCR)

General Assistance – The General Assistance Program provides Portland residents with assistance for basic needs such as rent, medication, fuel, utilities, and other essential services. (City of Portland)

ECBOs-- Ethnic-based community organizations.

Free Care – Free healthcare offered to all Maine residents with income less than 150% the federal poverty level. Available at Maine Medical Center, St. Mary's, Mercy Hospital and Southern Maine Health Care.

Federally Qualified Health Centers (FQHC) – Community-based health care providers that receive funds to provide primary care services in underserved areas.

New Mainer - A New Mainer is the umbrella term used to informally refer to the entire immigrant population in Maine. (Catholic Charities)

MaineCare – Maine's version of Medicaid. Free or Low-Cost Health Insurance for income-qualified people, including families with children and pregnant women. (Maine.gov)

RMA – Refugee Medical Assistance. Program that helps refugees by providing cash and medical assistance during their first eight months in the US.

Refugee - Someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. (UNHCR)

Seasonal Farmers– Immigrants from Central America and Jamaica who work seasonally in Maine in farm harvests under an Agricultural work permit. (Maine Mobile Health Program)

Secondary Migrant - A person who entered the United States as a refugee and was resettled in one state, but then chose to move to another state. For example, a refugee who was resettled in Chicago, IL, but then chose to move to Portland, Maine, would be considered a secondary migrant when arriving in Maine. (Catholic Charities)

TANF – Temporary Assistance for Needy Families. Time-limited cash assistance for pregnant women and families with children to pay for food, shelter and utilities while they work to become independent. (maine.gov)

Undocumented Individual – A person residing in the U.S. without legal immigration status. It includes people who entered the U.S. without inspection and proper permission from the U.S. government, and those who entered with a legal visa that is no longer valid.

Data Collection Summary

In order to collect up-to-date information and professional perspectives on the barriers to healthcare for Immigrants in Maine, we conducted a series of semi-structured interviews with key informants. Using the interview guide shown below, we interviewed a total of 26 doctors, nurses, non-profit leaders and community stakeholders for roughly 30min-1hr per interview. These interviewees were termed “Key informants” for the study as they all have extensive experience working with Maine’s immigrant community whether it be through healthcare services, political leadership or any other community organizing. Additionally, over half of these key informants self-identified as immigrants themselves and therefore had relevant personal experience informing their professional outlook.

- Interview Guide Template
  See Appendix (A)

- Key Informant List

Name of Informant	Organization	Title
1. Abshiro Ali, RN	Maine Medical Center	Registered Nurse, Outpatient Clinics
2. Donna Travaglini, RN	Maine State Tuberculosis Control Program	Public Health Nurse; MMC TB Clinic Coordinator
3. Hassan Mahmoud, MD	Maine Medical Center	Internal Medicine Resident
4. Ghassan Saleh, DMD, MS	MaineHealth	Director of Operational Excellence
5. Nathaniel James, MD	Maine Medical Center	International Clinic Director
6. Debra Rothenberg, MD, PhD	Maine Medical Center & Preble Street Resource Center	Faculty Physician, Family Medicine
7. Tho Ngo, MPH	Maine Medical Center	Program Manager, Telestroke

8. Mara Larkin	Maine Medical Center	Case Manager, Interim Manager of Interpreter Services
9. Dancille Nshimimana	St. Mary's Hospital	Medical Assistant
10. Molly McMahon, LCSW	Greater Portland Health	Director of Social Work
11. Renee Fay Le-Blanc, MD	Greater Portland Health	Chief Medical Officer
12. Asha Suldan	Greater Portland Health	Community Health Worker
13. Nélida Berke, MPH	City of Portland Public Health Division	Minority Health Program Coordinator
14. Anne Lang	City of Portland Health Division	Family Health Program Manager
15. Jovin Bayingana, RN	Department of Health and Human Services	Public Health Nurse
16. Claude Rwaganje	ProsperityME	Executive Director
17. Tarlan Ahmadov	Office of Maine Refugee Resettlement	State Refugee Coordinator

18. Dr. Heather Shattuck Heirdon	Office of Maine Refugee Resettlement	State Refugee Health Coordinator
19. Damas Rugama	Immigrant Welcome Center	Board President and Co-Founder
20. Mufalo Chitam	Maine Immigrant Rights Coalition	Executive Director
21. Heritier Nosso	Healthy Androscoggin	Health Promotion Coordinator
22. Hawa Abdouckader	Immigrant Rights Coalition	Volunteer
23. Lisa Tapert	Maine Mobile Health Program	Executive Director
24. Nadine Twagirayezu	Immigrant Legal Advocacy Program	Paralegal
25. Sana Osman	Maine Access Immigrant Network (MAIN)	Community Health Worker

Social Determinants of Health for a "New Mainer"

From the 25 interviews, we summarized the different spokes of identity, systems and environment which signficantly influence the health of Maine's Immigrant population. These seven determinants were the ones mentioned frequently during the interviews as they relate to all immigrants regardless of status and country of origin.

- Community Dynamic:

The size and societal presence of ethnic-based or religious-based communities significantly impacts the manner in which an immigrant acclimates to their new environment. With the majority of incoming immigrants being asylum-seekers or secondary migrants, the community that welcomes them is their initial source of housing, medical, and employment information and orientation. Thus for smaller immigrant communities, integration into the community and into the U.S. healthcare system might be more difficult or delayed. Additionally, the stigma or taboos held by an immigrant's ethnic or religious community also influences their attitudes towards health. Similarly to U.S culture, substantial stigma exists in various immigrant communities in topics surrounding mental health, sexual health and infectious diseases.

- Literacy and Education:

Not suprisingly, the literacy and education levels of an individual heavily dictates their ability to access healthcare. Navigating the health care system, setting up medical appointments, using public transportation and understanding preventative

care all become incredibly complicated when a person can not read and write in English or their native language. This makes the depedence on community organizations, cultural brokers and interpreters even greater. For the educated immigrants, the difficulty of the degree re-certification processes for many professionals also pushes them multiple steps backwards in their original career path.

- Location and Housing:

Historically, the majority of Maine's immigrant population were concentrated in Portland. However, with Portland's housing market becoming more expensive, more refugees are being resettled in new areas around southern Maine. Secondary migrants and asylum seekers from Somalia, Congo and Iraq are settling in previously majority white cities such as Biddeford, Lewiston-Auburbn and Westbrook. On one hand, more hospitals and centers in Maine are striving to become more culturally and medically competent to care for their new immigrant patients. However, this also means that there may be less standardization and greater differentiation in the care of the immigrant population. Patients seen at established refugee intake clinics and centers may receive more standardized initial work up and follow up compared with counterparts not seen at such clinics. In addition to the location of settlement, the state of housing can also have great impact on health. Some new refugees on arrival in Maine, are placed in Portland's family and adult homeless shelters next to people coping with mental health illness and substance use. This situation can be very unsettling especially for vulnerable people coming from traumatic experiences. Finally, after new immigrants are re-settled in the community, along with other low-income populations, they typically reside in older, deteriorating housing, sometimes with issues of lead poisioning, poor lighting, and bed bugs.

- Nutrition and Diet

Some immigrant native diets are traditionally high in salt, sugar and carbohydrates which can contribute to the rise of diabetes and blood pressure diseases in some groups of immigrants, even before arrival. Additionally, as fast-food and processed foods are easily accessible and affordable in the U.S, poorer immigrants also adopt this unhealthy diet for themselves and their families. Community informants noted that the lack of knowledge and experience in shopping for healthy foods using SNAP also adds another nutritional challenge.

- Age

Age is a signifcant contextual factor that influences immigrants' ability to assimilate and accultrate into society. Throughout discussions of literacy, education, diet and community dynamic, many of the informants highlighted the difference between younger and older immigrants. Older immigrants are more likely to be set in their traditions, values, or religion. They may also feel the losses of leaving their home most acutely, and may be less enthusiastic about changing themsleves or their communities.Younger immigrants seek education and are often eager to assimilate into the community and tend to be more open-minded towards improving health and changing their lifestyle.

- Xenophobia

Although Maine's overall population ratio to the Immigrant population is incredibly small (97:3), a perception of scarcity and isolationary beliefs sometimes lead to an environment of xenophobia. Multiple informants shared stories of implicit bias, stereotyping and prejudice by health care providers and community members towards New Mainers. This is particularly heightened for Muslim immigrants in the current political environment. The instances of violence in Lewiston's Kennedy Park this summer are one example of this.

- Political Environment

On the state and national political sphere, policies on immigration or affecting immigrant families are rotating the newstands on a daily basis. From the "Muslim Ban," to the public charge rule, the vow in Washington to end the lottery visa program, deliberation of an immigration question on the Census 2020 and the separation at border scandal - the current administration has not hidden its anti-immigrant stance in both policy changes and inflammatory language and speeches. This has created a "climate of fear" for many of Maine's immigrant population, making them fearful of civil systems such as hospitals and police stations, and adding substantially to their emotional and physical stress.

- Trauma

The effect of ongoing communal trauma is an important environmental factor that was emphasized by key informants. The majority of immigrants are moving to the US because they are escaping harrowing, dangerous situations. The emotional and physical trauma from displacement, deprivation, sexual trauma, torture, civil war, and ethnic cleansing lingers not only on individuals who experienced these traumas but also envelops entire communites and continues over generations. This communal trauma shapes the way immigrants support each other, their values in life, and their outlook on what it means to be healthy.

Barriers to Health Care Access

Through our interviews and outside literature review we were able to summarize and synthesize the major barriers or constraints to healthcare access for New Mainers. These six areas of focus definitely do not encompass the entirety of health barriers faced by New Mainer but they were the ones mentioned the most in our interviews with Key Informants. We also included highlighted representational quotes from the informants that related to each identified barrier. They are summarized below by level of impact

1. **National healthcare system:**
   - Limited services according to status

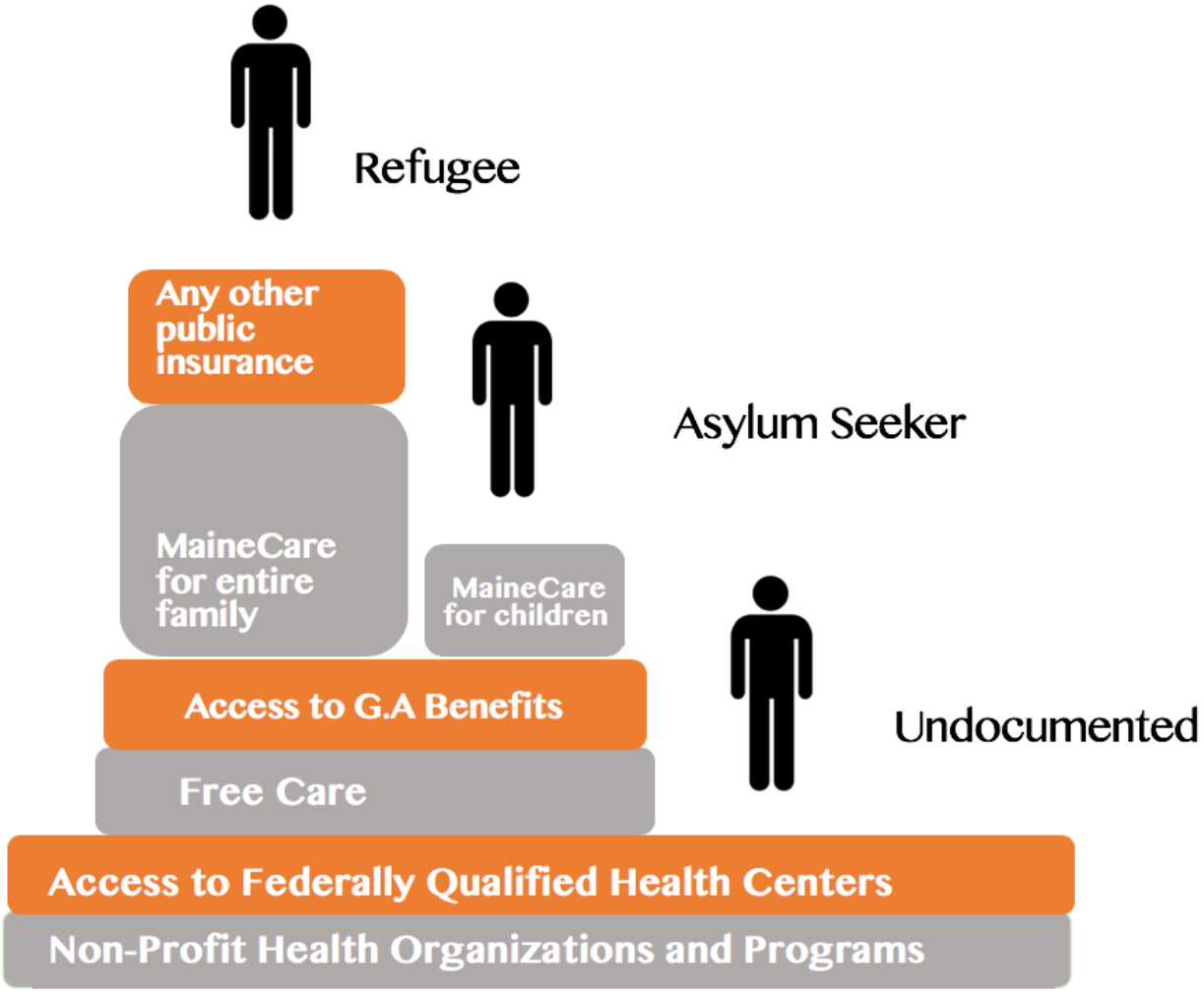
2. **Maine healthcare system:**
   - Difference in standardization across region
   - Fragmentation of the health care system that immigrants can access

3. **Medical Providers and Staff:**
   - Limited language availability and interpreter services
   - Low cultural competency of medical providers

4. **Patients/Groups of Patients:**
   - Lack of Health literacy

- Limited Services According to Status

Status-Determined Health Services in Maine:



“Refugees have a paved road.”

Following WWII, the UN established clear regulations and rights for refugees to receive the necessary health, employment and educational needs they require. In the US, similarly to all other countries, crucial efforts are made to ensure that refugees have quality healthcare equal to the citizens themselves. The health of refugees is also prioritized to account for public health needs and screen for infectious disease. Thus, refugees who come to Maine have access to MaineCare (for first 8 months), TANF, Refugee Medical Assistance and any other public insurance that other Americans have access to. However, it is important to recognize that this in the context of the U.S.’s complicated healthcare system. Although refugees have an established system, they are also gaps such as dental care and extensive mental health care. Additionally, as refugees become more settled and rise towards middle class status, they may also face difficulty in finding an affordable insurance plan as other Mainers do.

“Asylum Seekers fend for themselves.”

Although asylum seekers have legal right to reside and work in the U.S. while waiting for the asylum decision, they do not have access to MaineCare. The three major services that asylum seekers rely on are the free care services from non-profit hospitals, federally qualified health centers (FQHCs) and General Assistance (GA) to help them pay for medications. In Maine, these services are necessary for low-income asylum seekers to receive primary care. The problem for asylum seekers arises when they need to access secondary care or see specialists. Although free care from hospitals provides much-needed initial secondary care access to asylum seekers, depending on the hospital, that offers it, its employed providers, and certain contractual relationships, the efficiency and scope of

the care differs from hospital to hospital. This makes access to dental care, eye care, some mental health specialists, and various other services very difficult and sometimes impossible due to high costs.

"Undocumented don't have a voice at all. In my experience I've never seen any undocumented patients."

The groups of the immigrant population with the most extensive lack in services are undocumented persons and agricultural workers. Living in a "climate of fear" especially in the past few years, undocumented individuals from all over the world—but especially Central and South America—live under the radar from all types of federal services. Although FQHCs and free clinics are open to everyone regardless of status, most undocumented people fear exposing their identity in any way and may not seek care. This means that they also lack advocacy and are invisible in any discussions focused on immigrant health needs.

- Difference in Standardization across region

"Some centers have had longer relationships with the community"

In the past ten years, although more immigrants expanded outwards from Portland, the services they found streamlined in Portland may not have expanded accordingly. This growth occurred due to two main reasons. Firstly, secondary migrants from various communities settled in different cities across the Portland area. A large Somali community settled in Lewiston, and groups of Iraqi secondary migrants and Congolese asylum seekers settled in Biddeford. Additionally, with Portland's housing prices continuously rising, new refugees have started to settle elsewhere in Maine,

including in Biddeford and Westbrook. Health care services have not have kept pace with this spread in the immigrant population. Cultural competency varies greatly by city, some health providers do not offer adequate access to interpreter services, and the application processes of free care can be very delayed in different parts of the region. Furthermore, with the recent reduction of public health nurses from 58 to 12, the follow-up of patients living further from major centers of care has become more complicated. Thus, depending on where an immigrant is living, their access to care can be extremely hindered or delayed. For example, for infectious diseases treatment in places without TB clinics, patients are expected to go to the Department of Health and Human Services (DHHS) once a month to pick up their TB medicine. The transportation and time constraints combined with the issue of public stigma results in some immigrants avoiding taking medication for latent TB.

- ## Fragmentation of Free Care system

"Accessing care once you have free care is fine; it is the application process that is a barrier."

Free Care is one of the pillar systems that helps immigrants receive good quality primary care. However, it is also one of the most confusing and complicated processes—especially for a non-English speaker new to the US. Firstly, due to the difference in standardization mentioned above, some centers have very long waits and complicated requirements for free care. Patient also have to re-apply for free care after every 6 months and for every hospital that they receive care from. Applying for free care means traveling back and forth from the DHHS – which is not on the bus line --- to the hospitals to notarize and formalize papers. This process amounts to a

great deal of transportation and literacy issues that further delays access to care. Additionally, the lack of education and outreach on how free care works can lead to heavy financial setbacks for unknowing patients. When a patient enters the hospital seeking free care, they are instructed to get a free care card from the registration office, attend their medical appointment, receive a bill a few weeks later, and send the bill along with the free care card to the billing office in order to waive medical fees. However, for new immigrants who have no one to help them navigate this system, they assume that once they have received the free care card from registration, all is done. This means that they ignore the medical bills, and the billing office may then send these bills to a collection office, which influences the patient's credit score. For medications, patients may have to revisit the G.A. or other non-profits to cover essential medications that they might need for chronic disease management.

- ## Limited Language Accommodation and Interpreter Services

"Having a third person in the room makes things more complicated."

Maine's immigrant community is unique in its scope of diverse language and ethnicity. Compared to other urban cities such as Philadelphia or Boston that have 4-5 major immigrant languages, Portland has to accommodate a much greater diversity of people. Just from Portland data, there are over 58 languages spoken by children of Immigrants at Portland High School. Hiring enough interpreters, regardless of their ability, becomes a problem itself. The next challenge comes with the training and certification of interpreters. The foreign language interpretation field is very new and continuously

evolving nationwide. In the past 20 years, more and more advocacy and regulations on interpretation has been developed but there is still room for a lot of change. Right now, interpreters are hired by health centers from different external companies all over southern Maine. Some hospitals, however, train, hire and pay their own interpreters. The majority of Interpreter training programs in Maine all require completion of the Certification Commission for HealthCare Interpreters (CCHI) written test but not the oral test, as it does not accommodate the diversity of Portland's languages. Depending on the interpreter company and hospital, this can be the extent of official training that an interpreter receives. Significant gaps in interpreter training thus includes further medical qualifications, trauma-care education, cultural competency, and professionalism. The aspect of trauma related care is also very critical for new immigrants coming from conflict-ridden situations. In addition to lack of trained interpreters, the lack of language accommodation is also visible in the structure of the healthcare center and actions of medical providers. In most health centers all the pamphlets, posters, front office staff are English-only. Then, even with the access to interpreters, medical providers may see working with non-English speakers as an added burden especially if they are not used to working with interpreters. The issues of language availability and interpreter capacity is a significant barrier to healthcare for non-English speakers. The risk is not only for extreme cases of misunderstanding, but also discouraging immigrants from seeking healthcare in general.

- Variable cultural competency of medical providers

"Doctors need to understand why some patients stand, why some sit and why they don't take their medicines."

In a patient-doctor interaction, multiple parties are coming at play. Immigrant patients coming from a diverse range of ethnicity, religion and culture bring the values and ideals of that identity in their attitude towards medical providers. Hospitals and health centers also bring Western medicine, New England culture, and their own personal values as well. This creates a space rife for conflict, misunderstanding, judgement, bias and fear. Informants shared various scenarios where the lack of cultural competency on the part of medical providers hinders valuable patient-doctor relationships. Even at the onset of a medical appointment, providers might fail to recognize the trauma-sensitive questions on a medical history write-up: for example, a majority of refugees and asylum seekers have deceased family members who were murdered or tortured in the conflicts they ran away from. Next, some patients might want same-gender providers and interpreters due to religious reasons or as an outcome of rape-trauma. In the appointment, crossing cultural barriers for sensitive tests – colonoscopies, vaginal tests, and pregnancy tests—can also be complicated for Muslim patients or any immigrant who is not accustomed to these preventative care tests. Cultural taboos and stigma for infectious disease also needs to be understood by the provider in order to explain them appropriately to the patient: For example, providers should recognize that TB is seen as an "unclean disease" in many East African nations. This is especially relevant for mental health issues as many cultures and religions view mental health very differently from Western society. One informant shared how in Hispanic communities of Central America for example, many

populations see their mind, body and soul as separated. They do not see the soul as work for the hospital but rather the church. Understanding this outlook would be very helpful for a doctor trying to reach a compromise with a Hispanic immigrant needing mental health attention. The different ways in which patients share their mental health anguish is also very important for a provider to notice: An informant working as a provider mentioned a story of a reserved, elderly patient who characterized her depression by saying "I am not sleeping." Even with access to care, immigrant patients are at an extreme disadvantage in improving their health if they do not have a trusting and mutually respective relationship with their provider.

- ## Lack of Health Literacy

"If you look there is help. The problem is going to look for it, knowing the resources, understanding how it works."

On the patient side of things, the biggest hurdle to health access is understanding when to seek care and how to seek care. For many immigrants, the healthcare system in their countries of origin in centered on emergency care due to low-resource budgets. Thus, once they arrive in the U.S, the idea of preventative care consisting of a primary care physician and routine check-ups is another new system to adjust to. One informant gave us an illuminating comparison of someone getting a fever in Bujumbura, Burundi vs. Portland, Maine. In Bujumbura, the patient would seek professional care only after the fever has lasted for a while. They would visit the hospital directly, receive a diagnosis with any doctor on site at the moment, and then proceed to buy medications that the doctor prescribes. In Portland, the patient would call or message their primary care advisor about

this fever before it gets to be unbearable. If nothing changes, they would schedule an appointment with the primary care provider who makes a diagnosis considering the patient's past history and on-site files. Medicine might be prescribed or not but a follow-up appointment or call would be set up to observe the patient's progress. Clearly, a switch from both these two systems of care brings about significant challenges. Many immigrant patients first interact with the healthcare system when they visit the emergency department to receive urgent care for a single medical issue. Once set-up in primary care clinics, many new immigrants have difficulty keeping appointments. Additionally, many patients do not understand the structure of the western medical appointment: when to bring up current concerns, when to conclude etc. This prevents the provider from addressing their patient's main concerns and takes away time for other appointments as well. Health literacy is also especially lacking for chronic management education and prevention. Patients with chronic diseases such as high blood pressure, diabetes and high cholesterol ignore the importance of maintaining a healthy diet, regular exercise and taking daily medication. The effect of multiple stressors also adds to this nonchalance towards preventative care. As one informant put it, "Immigrants don't prioritize wellness but rather providing for their children." Finally, the last aspect of health literacy that also affects access to care is community stigma for infectious diseases. Due to a lack of education on diseases such as latent TB and HIV/AIDS, patients are afraid to express their concerns. For example, patients with latent TB find idea of taking medications for 6 months when you do not feel "sick," very hard to comprehend which makes case management complex.

Recommendations

1. **Fighting for policy change**: "Without the policies changing it's like you're climbing a tree from the top." The biggest barrier to health access facing all immigrants is the lack of laws and policies that legally give them access to care. For undocumented immigrants, especially, support or services for their healthcare do not exist. Increasing the capacity and outreach of "status-blind" centers such as the Maine Mobile Health Program and Greater Portland Health would be one step in helping this group of people access quality primary care. For asylum seekers, streamlining access to free care and finding innovative programs to subsidizing secondary care would greatly improve access to and use of the already existing services. One successful example of this is the Smile Partners + Community Dental partnership program that help un-insured patients access dental care. Finally, for all immigrants in general, expanding Medicaid in Maine is a very necessary step in bridging the middle-class gap for healthcare access. Right now at the Immigrant Welcome Center, the major focus has been on registering 11,000 eligible immigrants to vote in the upcoming elections. Immigrants themselves consist of a sizeable portion of Portland and Maine's voting population, and thus should be educated and sensitized on policy change so they can have a say in the overall structures shaping their lives.

2. **Expanding the concept of cultural competency to cultural humility**: "There is no way to be "culturally competent" in over 58 different

ethnicities and cultures." The idea of cultural competency should not be understood as a "checklist" or class to complete because that would be impossible with the world's diversity, but rather as an ever-growing consciousness. Medical centers can train their providers to cultivate a sense of open-mindedness, education and empathy overall. The first step in respecting others' cultures and values comes with acknowledging your own. By recognizing the power of societal structures in their own lives, and working on individual bias and stereotypes, then a medical provider can become more attuned and empathetic to a patient from a whole other culture and upbringing. This can be achieved through self-reflective seminars and trainings to start incorporating such reflection in daily practice. The next step in working towards a mindset of cultural humility is through education. Continuing education through guest speakers, workshops, and key readings may be helpful. Ideally, programming in cultural humility should be inter-professional, with all members of the care team participating together.

3. **Increasing numbers of cultural brokers and public health nurses**: "CHOWS are worth their weight in gold." Community Health Workers from different communities were hired, trained and paid by the state and then work with different organizations and hospitals to do the important background public health work for immigrants such as chronic disease management education. In addition to CHOWs, public health nurses from the state were also in charge of home visits for infectious diseases and preventive health initiatives for the whole community, including immigrants. In recent years, there were cuts to the public health nurse numbers, from 58 to 12 and fewer numbers of hired CHOWS. This led to the issues of differentiation in standardization across Maine. In addition to policy change to re-hiring the past CHOWs and public health nurses, more cultural brokers should also be trained to accommodate for the expansion

and diversity of the immigrant community in Southern Maine. Right now, for example, there is a great need for Angolan and Congolese CHOWS as these are the large groups of people coming to Maine for the first time.

4. **Innovation in health literacy education**: The challenge in educating immigrants on preventive care is surmountable with efficient collaboration between medical centers and community organizations. From the interviews with community organizations we had, health literacy was a shared struggle. Different parts of various organizations seem to be doing small pieces of health literacy education depending on their specific area of focus. For example, some organizations are leading outreach for early detection of breast cancer or latent TB management or nutrition education. Although this works in sensitizing immigrants on specific diseases or once-only screenings, it does not tackle the bigger issue at hand: the lack of understanding of preventive care. One collaborative program explaining the structure of U.S. Healthcare, and value of prevention over treatment, is what is missing in the pool of immigrant NGOS in Maine. This form of "orientation" will give immigrants the foundation to take in all the other following parts of health literacy such as cancer screenings and chronic disease management. Although all these different organizations have various communities or topics of focus, this is one project that would have equal benefit to everyone. Additionally collaboration on one major project would alleviate budget concerns, as the cost would be spread out. Involving ECBOs would also help in having a greater representation from all different ethnic communities in Southern Maine. Finally, the structure of health literacy education is also important to consider. One informant noted that "all immigrants are not digital natives." Programs and events aimed at the immigrant population should consider this as a majority of the older refugees are illiterate or are not accustomed to learning through

technology. The use of a combination of culturally and age appropriate mediums should be considered while organizing such programming.

5. **Promoting diverse representation in medicine**: All the informants that we talked to stressed the importance of having the "faces of the community as part of the health providers." At the end of the day, there is no one who will understand or treat an Iraqi mother better than an Iraqi doctor or midwife. Fortunately, there are more and more first-generation immigrants seeking training and taking positions as doctors, nurses and public health workers in Maine. As aforementioned, over ½ of the key informants for this study were immigrants themselves from all parts of the world who are now choosing to represent their communities as non-profit organizers, medical providers and state leaders. In order to continue this trend, more outreach and sensitization for medical and leadership opportunities can be targeted to immigrant communities through academic fairs, cultural events or shadowing programs.

6. **Collecting data on race and ethnicity**: "Policy is based off numbers and evidence." Although the numbers of Immigrants in Maine have continued rising over the past decade, there are still invisible in data related to Maine's policy. In state and federal research, refugees and accepted asylees are accounted for in terms of their race only. For example, a Congolese asylee and an African-American are placed in the same group when they have completely different needs and concerns. On the other hand, asylum seeker and undocumented populations are not accounted for at all. This Invisibility in data eliminates the ability to structure appropriate public health measures on health literacy for the immigrant community. The Office of Refugee Resettlement has addressed this issue before at their recent community meetings to gather immigrant health concerns in light of missing state data. Right now, the Minority Health Assessment done

annually by the City of Portland Minority Health Program is the only health data source that includes ethnicity as a determinant. More research and data collection that considers the breadth of Maine's immigrant diversity is vital in order to continue working towards policy change and initiating public health programs for this population.

7. **Incentivizing Interpretation**: "The problem is that there is no buy in from Interpreter services." Interpretation is a valued and difficult job and it should be treated as such by the medical community. In order to gain more well-qualified and professional interpreters, the interpreter position should require official medical interpretation certification, trauma-care and cultural competency training and an appropriate salary. Having fewer, well-paid and well-qualified interpreters is worth more for the patients' and health services' benefit. In instances where a face-to-face qualified interpreter is unavailable telephone and computer web-cam services can provide a temporary solution. Additionally, annual re-certifications or assessments should be done for current interpreters, just like all other professions, rewarding exceptional interpreters and educating those with misuse/misunderstanding of power issues. Finally, recognizing that the language barrier doesn't start or end with the interpreters, medical providers should seek to make their practice more language-friendly for non-English speakers. For example, having medical forms and posters in a variety of languages. In connection with the "orientation" idea for health literacy, an informative tool depicting the process of preventative care could be synthesized in representative languages of Maine's immigrant populations.

Conclusion

Overall, Maine does a very good job in streamlining New Mainers into the healthcare system. Initial medical screening and re-settlement is done appropriately, Maine is the only state where G.A. benefits are extended to asylum seekers (which helps with medication payments), and major hospitals around the Southern Maine area have continuously aimed to improve and extend their services and outreach for this minority population. As outlined in this report, however, there is much room for improvement. This is especially true for undocumented patients who have extremely limited access to care. Understandably, healthcare access for immigrants is a complex issue that touches on multiple social systems, and improvements can be constrained with lack of resource and time. However, we believe that with continued, innovative and collaborative efforts between community organizations, healthcare systems and immigrant populations these gaps in access can be narrowed.

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Appendix

A. Interview Guide Template

Immigrant Health Interview Guideline
Informant Information
Name:
Organization:
Position in Organization:
Date:

Interview Questions

1. What are your organization's roles in the Immigrant community of Portland?

2. In your organization's daily tasks, do you administer any programs or projects related to healthcare? Or encounter issues surrounding healthcare? If so, please describe.

3. What do you think are the strengths of the way the health care system supports immigrant health in Maine? What are we doing right?

4. What do you think are the weaknesses of the way the health care system supports immigrant health in Maine?

5. Do you observe any difference in access for different types of Immigrants? Some with larger communities/smaller communities, asylum-seekers/refugee, African vs Middle Eastern etc.

6. Do you have any suggestions about how access or quality of healthcare for New Mainers could be improved?
    a. What could the health care system do?
    b. What can community partners do?
    c. What can the patients or groups of patients do?

References

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