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Portland Public Health Division
City of Portland, Health and Human Services Department

City of Portland Public Health Division
Minority Health Program

Minority Health Assessment Report

November 2018

TABLE OF CONTENTS

Minority Health Assessment Report

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Organizational Background

Minority Health Program: Who We Are

The Public Health Division (PHD), part of the City of Portland's Health and Human Services Department, has consistently demonstrated its commitment to ensuring the health of Portland's communities for nearly 120 years. All programming is guided by its mission to "improve the health of all people in the community by working together to prevent disease, promote health, and protect residents from environmental threats." To that end, the Division has developed a staff that is not only clinically competent, but also culturally competent regarding issues of health equity and disparities.

The Minority Health Program of the Public Health Division, Health and Human Services Department, City of Portland (MHP) addresses the health issues and needs of all minority communities in Cumberland County, Maine. MHP links people to needed health and social services and improves community health status through Community Health Outreach Workers (CHOWs) and clinical partnerships.

The minority populations served include the following racial, ethnic, and language groups:

Acholi	Croatian	Lingala	Somali
Arabic	French	Portuguese	Spanish
Bosnian	Khmer	Russian	Swahili
Burundi	Kinyarwanda	Serbian	Vietnamese
Chinese			

Our Vision

MHP's vision of a healthy community is one where:

- Diversity within the community is respected and valued by community members and institutions
- Everyone has access to quality health and social services
- Everyone has access to resources and conditions required for a healthy lifestyle
- Institutions and policy makers are responsive to community residents' needs
- The assets and gifts of community residents are acknowledged and shared
- Work is conducted in partnership with community members, organizations, and service providers to identify and address health priorities of minority communities

Our Mission

MHP's mission is to:

- Decrease health disparities among immigrant, refugee, and low-income Caucasian and African American populations
- Promote evidence-based public health practices and improve access to high quality and affordable health care services

- Identify, evaluate, and respond to community health needs through innovative services
- Encourage community-clinical partnerships through leadership and advocacy
- Provide consultation, education, and training to promote quality of care and best practices in our community, hospitals, and clinics

Our Objectives

MHP's objectives are to:

- Improve minority health at the community, family, and individual levels
- Increase capacity of community groups to implement a locally defined community health agenda
- Strengthen informal and formal social networks and awareness of minority communities
- Remain accessible and responsive to community interests by establishing a network of Community Health Outreach Workers (CHOWs)
- Participate in health policy forums, health plans, task forces, and committees to improve the health of minority groups

Our Values

We recognize that healthy individuals, families, and communities are vital to a healthy society.

We recognize the racial, ethnic, and language diversity and inherent worth of each individual who collectively form the backbone of our community.

We value the importance of public health preventive measures and policies that enhance health equity and reduce health disparities.

We respect the wisdom of community members, healthcare providers, faith-based leaders, and policy makers, and their efforts toward improving access to care for our minority communities in a safe and healthy environment.

Our Operating Principles

We are guided by these basic operational principles in all our services and activities:

- Acting with integrity – Integrity, trust, honesty, confidentiality, respect, and fiscal responsibility.
- Satisfying our clients and patients – helping our clients identify their needs and working diligently to meet or exceed their expectations.
- Community service – Ensuring that assets and resources of our community are utilized to improve the health and wellness of the minority communities for optimum public health indicators. Our goal is to reduce health disparities for every individual and family in our community.
- Using sound business practices – We will use proven, sound business practices to manage agency activities in a competitive environment.

Executive Summary

This report is the culmination of surveying over one thousand Cumberland County residents from many different cultural backgrounds. The purpose of the survey was to get communities' opinions about community health needs in Cumberland County. The City of Portland's Minority Health Program (MHP) and partners will use the results of this assessment to evaluate and address the most pressing needs through community action. The MHP conducts a community health assessment every two to four years to determine the needs in the minority communities in order to improve our services, enhance our communication with community members, and to provide community health needs profiles for organizations addressing health needs for these vulnerable communities.

A total of 1,076 assessments were conducted between January 26, 2018 and May 14, 2018. Since the purpose of this assessment was to learn more about Cumberland County residents, only those respondents who had a valid Cumberland County zip code were included in the analysis. This resulted in a total of 1,013 participants (or 94% of the 1,076 assessments gathered). The assessment was delivered to members of the racial, ethnic, and language minority communities in Cumberland County. This report represents the results of the assessment from the following regions[1]: East Africa (Somalia, South Sudan, Rwanda, and Burundi); Central Africa (Democratic Republic of Congo and Angola); Middle East & West/Central Asia (Iraq); Russia; China; Southeast Asia (Vietnam); South America (Colombia); Mexico, Central America and the Caribbean (El Salvador, Honduras, Guatemala, and the Dominican Republic); the United States; and the Balkan Region (Bosnia and Croatia). The groups were chosen based on their demographic population size, within Cumberland County, and their unique vulnerability in accessing public and clinical health services.
Overall, residents rated both themselves and their community as "Healthy."

The top three **most important factors for a "healthy community"** (overall) were: low crime / safe neighborhoods, good place to raise children, and access to health care (e.g., family doctor).

The top three **most important "health problems" in your community** (overall) were: diabetes, dental problems, and high blood pressure

The top three **most important "risky behaviors" in your community** (overall) were: alcohol abuse, drug abuse, and housing (unhealthy housing behaviors)

The top three **most important "health problems or risky behaviors" for you** (overall) were: stress, dental problems, and aging.

[1] Regions may have had more countries represented in the overall sample size. For confidentiality reasons, only countries with ten or more respondents were included in this list.

Methodology and Approach

Minority Health Assessment Sampling Methodology

The 2018 Minority Health Assessment was administered through a survey (written in English), orally translated, and administered to participants selected through non-random quota sampling. With multiple entry points in each community to develop the widest range of respondents within and among Cumberland County's many ethnic communities, thirteen different cultural and linguistic groups were focused on, but only eleven cultural and linguistic groups were captured. The 2018 Minority Health Assessment was submitted to the University of Southern Maine for Institutional Review Board (IRB) determination of project survey sampling and methodology and was granted approval on November 21, 2017. Adjustments between the 2014 and 2018 Minority Health Assessment questionnaire were made based on the community and clinical partner feedback from the previous survey. Please see Survey in Appendix C.

Community Health Outreach Workers (CHOWs) were trained in the methodology and deployment of the survey to people throughout Cumberland County, with a focus on Greater Portland (for more information on methodology, please contact Nélida R. Berke, MHP Coordinator, at 207.874.8735).

Implementation of the Community Health Assessment Process

1. The recruitment of Community Health Outreach Workers (CHOWs) depended on the targeted sampling groups and expected numbers of surveys in each subpopulation. A total number of 17 Contract CHOWs were utilized across the focus coverage areas, which included 11 respective communities. CHOWs are trusted, indigenous community members who served as survey implementers in their respective communities.

2. Community-Based Participatory Research (CBPR) project data training on January 26, 2018 (8am-10:30 am). Contracted CHOWs were trained on how to implement the survey, the survey logistics, and maintaining the integrity of the health information data. See details of training method and protocols in Appendix B.

3. Survey Implementation: Surveys were given in a variety of different locations. Some examples of those are: respondents' homes, Adult Education, Amistad, markets, grocery stores, barbershops, cafes, churches, mosques, clinics, coffee shops, community events, community centers, Department of Health and Human Services locations, doctors' offices, General Assistance, Immigrant Legal Advocacy Project, libraries, hospitals, Preble Street Resource Center, Southern Maine Community College, and the YMCA. Although the survey included all of Cumberland County, the vast majority of surveys given were in Portland. Other Cumberland County areas surveyed included South Portland, Scarborough, Westbrook, Gorham, Windham, Standish, Gray, and Yarmouth.

4. The final community populations that the Community Health Assessment accessed include: Somali, Spanish, Sudanese, Arabic, Serbian, French, Vietnamese, Chinese, Russian, Portuguese and low-income English/Caucasian. We were unable to secure a CHOW from the North Sudan or African American Communities. Unfortunately, in this year's assessment, outreach to the Hearing Impaired/ASL community proved to be cost prohibitive, and was not conducted.

5. Our anticipated total survey projection was 1,640 and 1,076 were actually submitted (65.6%). There were many reasons for this, including fewer CHOWs and communities than expected, implementation barriers, and insufficient responses in the given time. In some cases, populations were not as accessible as had been anticipated, and some populations were wary of participating in a survey sponsored by the city government.

Community Health Assessment Recruitment Goals

Target population goals were established for each cultural and linguistic group based on the *Minority Health Needs Assessment 2014* response rates, Catholic Charities' 2016 Refugees and Asylum Resettlement in Maine data, and the U.S. Census data (population estimates, as of July 2016). Based on the data, a specified number of respondents were set for each sub-population.

The optimal number of respondents of each regional origination/ethnicity/language was determined by the goal of reaching at least 4% of the estimated current population of each target community. See Figure 1 and Table 1 below for more information about populations surveyed.

Goals of survey population sample(s):

- Representation
- Comparability across subpopulations
- Generalizability of sample to larger community

Figure 1. Percent of ethnic or cultural group surveyed out of target.

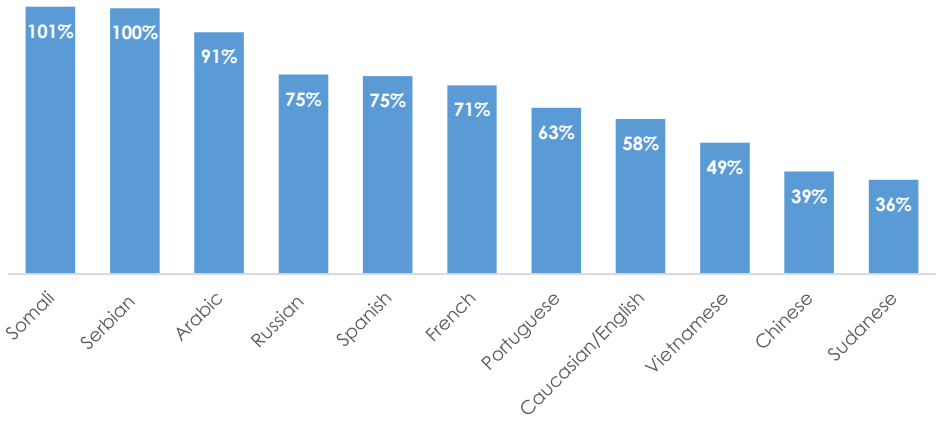


Table 1. Number of surveys collected by CHOWs for each ethnic or cultural group (n=1,076)

Cultural Group	Number of surveys
Arabic	182
Somali	161
Spanish	149
French	142
Vietnamese	87
Caucasian/English speaking	84
Serbian	80
Sudanese/South Sudanese	71
Portuguese	65
Chinese	37
Russian	18
African American/English speaking	0
Hearing impaired (ASL)	0

Snowball or Chain Sampling

A non-random quota sampling – snowball or chain sampling - methodology was used. Through respondents' referrals, community and faith-based organizations and leaders, CHOWs were able to reach a larger amount of respondents. This facilitated capturing a statistically accurate representation of the target populations' estimated respondents. Suggestions were made in regards to possible points of entry to consider when searching for respondents such as the following: friend or relative, neighbor, at community activities, nail salons, laundromats, sports events, church, mosque, temple or other religious gathering places or event, farmers' markets, English as a Second Language/English for Speakers of Other Languages classes, coffee shop or local gathering spot, hospitals, and Portland Adult Education. CHOWs were expected to ask their respondents for referrals; for example, a referral would be someone with similar or dissimilar views of politics, religion, health, children, or education.

Each CHOW focused on the specific regional origination/ethnicity/language group they were most familiar with, but at times, may also have interacted with those who identified with other cultural groups that were comfortable administering the survey in English or another shared language. If a person was interested in participating, but they preferred another language other than what the CHOW was comfortable administering accurately, they were asked for their contact information and contacted by a CHOW that spoke their language, if available.

Self-Administration and Oral Administration

The MHP is aware that there is varying fluency in spoken English and literacy in written English, as well as varying fluency and literacy in an individual's native language and other languages they use to communicate. To address this, all surveys were completed either orally in person, or a CHOW facilitated and assisted respondents who chose to self-administer. CHOWs were trained on the facilitation of the survey in order to maintain the integrity of the

data in an unbiased manner. CHOWs were also encouraged to spend time reviewing the English version of the assessment and develop a written template for use in their language. These materials were culturally tailored prior to survey administration, which increased efficiency and timeliness, and also ensured that surveys were conducted in the same manner across language groups.

Participant Eligibility

For the purposes of this assessment, the community was defined as Cumberland County, with a focus on Portland and included other areas, such as South Portland, Scarborough, Westbrook, Gorham, Windham, Standish, Gray, and Yarmouth. Eligible participants included all Cumberland County residents over the age of 18, with specific goals related to the largest cultural, ethnic, and linguistic minority groups in the area.

Ethical Considerations

The well-being of participants was a primary concern throughout this process. The purpose of conducting this assessment was to gather information in order to improve the health of the community by consulting community members on their opinions. During the survey process, participants were informed of the purpose of their participation and of the survey itself, which was to carry out the mission[2] of the City of Portland Public Health Division (PHD) through data collection and the promotion of health and social services.

CHOW interviewers were also informed of their roles as representatives of the PHD's MHP. Additionally, as members of the communities they were assessing and serving, interviewers were made aware that they may be seen as a bridge or link between their respondents and services provided by the City of Portland. Based on experiences in prior assessments, it was found that community members came to see the CHOW interviewer as a potential advocate or resource for respondents in navigating the 'system' for desired services.

In order to support the CHOWs in effectively conducting the assessment and to provide support to community members, a health and social services resource list was developed to be given to participants as a closing to the interview. This was an opportunity for community members to learn about services that may help them locally. For a list of resources made available and guidelines for CHOWs, please see Appendix B.

Analysis Methodology

The MHP and PHD recognized and partnered with University of Southern Maine's Data Innovation Project (DIP) for data analysis for the report. It was critical to utilize an outside partner to maintain data integrity, and to prevent any possible analysis biases or influences.

[2] The Portland Health Division's mission is "To enhance the health and well-being of Portland residents through collaboration with the community."

Impartiality and integrity of the data were recognized priorities. This report provides a synthesis of the findings and their implications in the section below entitled *Discussion*.

Dissemination Plan

The 2018 Minority Health Assessment report will be disseminated through various channels, including an official City of Portland press release. The MHP will share the report with all its partners, and they will be involved in the various disseminations of the final assessment report. Dissemination within communities involves the MHP's Community Health Outreach Workers (CHOWs) distributing to their communities via community meetings, community and faith-based leaders/organizations, and through trusted community leaders and representatives.

Dissemination to agencies that have interest in or are already serving minority communities will be sent a copy to inform their programs. Examples of channels include the Maine Shared Community Health Needs Assessment Community Engagement Committee, Portland Public Schools' Multilingual & Multicultural Center, Maine Immigrants' Rights Coalition, Office of Maine Refugee Services - Catholic Charities Maine, Universities of Southern Maine and New England, Multicultural Resource Centers, and health provider offices.

Discussion of Findings

A total of 1,076 assessments were gathered between January 26, 2018 and May 14, 2018. Since the purpose of this assessment was to learn more about Cumberland County residents, only those respondents who had a valid Cumberland County zip code were included in the analysis. This resulted in a total of 1,013 participants (or 94% of the 1,076 assessments gathered).

Residence of participants

Most respondents listed the zip code of their residence (97%). Respondents were then grouped by county with the exception of Portland residents, who were placed in their own group due to large numbers (Table 2).

Table 2. Residence of participants (n=1,076)

Residence	Number	Percent
Portland	653	61%
Cumberland County (excluding Portland)	360	33%
No response	38	4%
York, Androscoggin, Oxford County	25	2%

2018 Community Health Assessment Participation Rates by Region of Cumberland County

- Portland: 653
- WEST: Bridgton, Gorham, Raymond, Sebago, Standish, Westbrook, Windham: 166
- SOUTH: South Portland, Scarborough, Cape Elizabeth: 154
- NORTH: Gray, Yarmouth, Cumberland, Freeport: 40

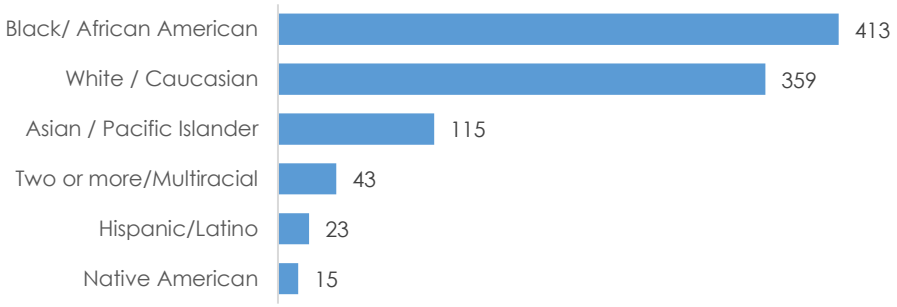
The following analysis was completed based on Cumberland County residents who reported a valid zip code only (n=1,013). It is important to note that not all respondents answered every question. If there was no response for a question, it was not tabulated in the overall percentage listed below. The total number of respondents to each question is listed in each table (n).

Demographics

The most frequently cited races/ethnicities were Black/African American, White/Caucasian, and Asian/Pacific Islander (Figure 2)[3].

3 *Other* suppressed due to small sample size.

Figure 2. Number of participants by race or ethnicity.



Participants were asked separately to identify if they were of Hispanic/Latino (Figure 3) or Middle/Near Eastern (Figure 4) origin. There were many missing responses for these questions, however they do provide more information regarding ethnic identity.

Figure 4. Hispanic/Latino Origin
(n=817, 81% response rate)

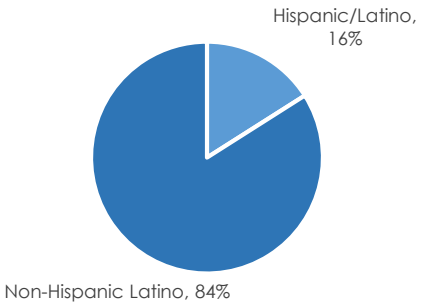
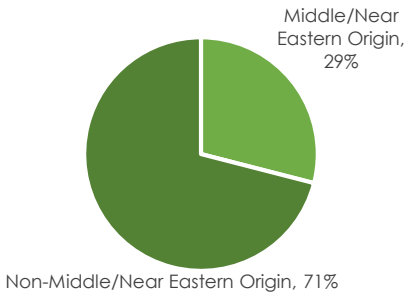


Figure 3. Middle/Near Eastern Origin
(n= 593, 59% response rate)



The top three countries of origin of respondents were: Iraq (n=167), Somalia (n=151), and USA (n=102). Countries with 20 or more respondents who live in Cumberland County are listed in the following table.

Table 3. Most frequently reported country of origin of participants (n=860)

Country	**Number**	**Percent**
Iraq	167	17%
Somalia	151	15%
USA	102	10%
Democratic Republic of Congo	86	9%
South Sudan	69	7%
Vietnam	65	6%
Angola	61	6%
Bosnia	57	6%
Burundi	28	3%
China	28	3%
Salvador	26	3%
Mexico	20	2%

Region of origin was also analyzed (Table 6). Regions are based on geographic location and the United Nations' Geoschemes, which are geographic regions, used by the United Nations' Statistics Division and are based on continental regions which are further subdivided into sub-regions and intermediary regions.[4] There are a number of benefits of analysis with this approach, including relative ease of grouping countries into regions; however, limitations do exist, such as not all countries within a region share the same languages, cultures, or beliefs.

Regions defined

The Caribbean, Central America, and Mexico were grouped into one category to achieve a larger sample size (Mexico is considered part of Central America in the UN Geoscheme). Certain regions are not included in this analysis, as there were no respondents from those regions, including Northern and Western Africa, or Northern, Western, or Eastern Europe.

West and Central Asia were combined with the Middle East (which in the UN Geoscheme is considered as "Western Asia") to achieve a larger sample size. The term Middle East was used, as this is a term more commonly recognized when discussing countries such as Iraq. China is part of Eastern Asia; however, due to those who participated in the assessment, China was the only country of that region to respond and therefore is represented as the country itself rather than the region. Southern Asia (Afghanistan, Bangladesh, Bhutan, India, Iran, Nepal, Pakistan, and Sri Lanka) was not included, as there were no respondents from these countries.

The UN Geoscheme that includes the Balkan Region is titled Southern Europe. This term was not used, as the country of origin of respondents was limited to the Balkan region. South America aligns with the UN Geoscheme and includes all countries in the South American continent. Due to small sample size, participants from Southern Africa and Australia and New Zealand (Oceania), were combined into the Other category, along with participants who responded Other as their country of origin.

Table 4. Region of origin of participants (n=1,005)

Region	Number	Percent
East Africa	268	27%
Middle East & West/Central Asia	176	18%
Central Africa	147	15%
USA	102	10%
Mexico, Central America & Caribbean	84	8%
Balkan Region	75	7%
Southeast Asia	69	7%
South America	30	3%
China	28	3%

[4] United Nations. *Methodology: Standard country or area codes for statistical use (M49).* Retrieved from https://unstats.un.org/unsd/methodology/m49/

Other	15	1%
Russia	11	1%

Of respondents, close to half (495 or 49%) responded that they can read or write in two languages, and 7% (75) responded that they can read and write in three languages. The following table describes the top languages participants reported (989 reported at one or more languages read or written, or that they did not read or write).

Table 5. Languages read or written by participants (n=989)

Languages with 10 or more respondents	Number	Percent
English	526	53%
Arabic	214	22%
French	157	16%
Spanish	133	13%
Somali	96	10%
Portuguese	65	7%
Vietnamese	59	6%
Lingala	41	4%
Swahili	38	4%
Chinese	35	4%
None	31	3%
Serbian	31	3%
Bosnian	28	3%
Kirundi	21	2%
Croatian	20	2%
Russian	19	2%
Kinyarwanda	11	1%
Khmer	10	1%

Respondents also indicated their preferred language. Six percent (63) indicated that there are two languages they prefer. The following table describes the top languages participants prefer using (939 reported at one or more languages they prefer).

Table 6. Preferred language indicated by participants (n=939)

Preferred language	Number	Percent
English	266	28%
Arabic	182	19%
Somali	147	16%
Spanish	108	12%
French	104	11%
Portuguese	58	6%

Preferred language	Number	Percent
Vietnamese	54	6%
Chinese	21	2%
Serbian	21	2%
Bosnian	14	1%
Russian	14	1%

Of the total respondents, there was a fairly even split between those who identify as female versus male. None responded as transgender.

Table 7. Gender identity of participants (n=1,009)

Gender	Number	Percent
Female	514	51%
Male	492	49%

Respondents were asked to report their year of birth rather than their age. Most respondents are approximately 40 or younger (69%).

Table 8. Approximate participant age range (n=955)

Decade born	Approximate age	Number	Percent
1989-99	20-29	272	27%
1979-88	30-39	210	21%
1969-78	40-49	177	17%
1949-58	50-59	116	11%
1959-68	60-69	116	11%
1939-48	70-79	53	5%
1929-38	80-89	11	1%

The majority of participants reported that they have a high school diploma or higher (77%).

Table 9. Education level (n=988)

Highest education level	Number	Percent
High school diploma or GED	356	36%
Some College	227	23%
College degree or higher	175	18%
Less than high school	148	15%
Only Primary School	50	5%
Professional field reported	17	2%
Other	15	2%

While not all participants reported their education level or what their degree of study was, numerous respondents reported what was interpreted to be their professional field, although it

is unclear if it is a field of study, or an actual field that they worked in (e.g. social worker, nursing, accounting, lawyer, agronomy, psychology, government administration, construction). This was categorized as "Professional field reported."

The majority of participants reported that they make less than $30,000 per year.

Table 10. Household income (n=967)

Income	Number	Percent
Less than $10,000	195	20%
$10,000 to $20,000	291	30%
$20,000 to $29,999	209	22%
$30,000 to $49,999	137	14%
Over $50,000	135	14%

Household characteristics

Participants responded to other detailed questions regarding their home life. Of respondents, there was an almost even split among those who were married or not married.

Table 11. Marital status of participants (n=981)

Marital status	Number	Percent
Married	510	52%
Not married	471	48%

The majority of respondents reported that they are living with others (e.g. with roommates or family).

Table 12. Household status of participants (n=843)

Household status	Number	Percent
Cohabitating	720	85%
Single or live alone	123	15%

Participants reported living with a range of others—from 1 to 11. Most people lived with between two and five others. When examining the average household size, the overall average was 3.56.

Table 13. Number of persons in household (n=857)

Number in household	Number	Percent
2	184	21%
3	163	19%
4	182	21%
5	133	16%

Health care, insurance and payment

Most respondents reported that they did not enroll in health insurance through the Affordable Care Act (ACA) Marketplace (89%).

Table 14. Enrolled in health insurance through the Affordable Care Act Marketplace (n=873)

Enroll via ACA Marketplace	Number	Percent
Yes	100	11%
No	773	89%

Most respondents reported that they have some type of health insurance (private, Medicaid, or Medicare) (67%).

Table 15. How participants report they pay for health care (n=986)

Method of payment	Number	Percent
Health insurance (e.g., private insurance, Anthem, MCHO)	347	35%
Uncompensated Care/Free Care	246	25%
MaineCare/Medicaid	196	20%
Medicare	119	12%
Pay cash (no insurance) or other	78	8%

Of those who reported that they have MaineCare or private insurance, 43 reported that they also have Medicare.

When participants were asked where they usually get health care, most responded that they go to a doctor's office (60%). Free care or free clinic, emergency room, urgent care, none, and Maine Medical Center were also responses. There was a lot of variability in responses to this question; other responses with more than one response included: none (people did not have a doctor, they did not have health care yet, or no insurance), Greater Portland Health, hospital, school clinic, Chinese medicine, General Assistance, or MaineCare. This number exceeds the number of survey participants as some respondents chose more than one response (even though only one response was requested).

Table 16. Where participants report that they get health care (n=1,184)

Location	Number	Percent
Doctor's office	707	60%
Free Care or Free Clinic	191	16%
Emergency Room (ER)	141	12%
Urgent Care	72	6%
None	28	2%
MMC	10	1%

Most important factors for a "Healthy Community"

The top three most important factors for a "Healthy Community" were: low crime/safe neighborhoods, good place to raise children, and access to health care (Table 17). There were a total of 3,018 responses (participants could check up to three possible responses out of 17).

Table 17. Top 10 most important factors for a "Healthy Community" (N=1,011; n=3,018)

Factor		Number	Percent
1	Low crime / safe neighborhoods	366	12%
2	Good place to raise children	342	11%
3	Access to health care (e.g., family doctor)	333	11%
4	Good jobs and healthy economy	317	11%
5	Good schools	297	10%
6	Affordable housing	284	9%
7	Clean environment	187	6%
8	Healthy behaviors and lifestyles	157	5%
9	Safety	137	5%
10	Excellent race relations	126	4%
10	Strong family life	126	4%
10	Religious or spiritual values	115	4%

Other responses that got 2% or less included: parks and recreation, low adult death and disease rates, arts and cultural events, low infant deaths, low level of child abuse, and other.

Most important "health problems" in your community

The top three most important "health problems" in your community were defined as: diabetes, dental problems, and tied for third were high blood pressure, mental health problems, and aging problems (e.g. arthritis, hearing/vision loss, etc.) (Table 18). There were a total of 2,790 responses (participants could check up to three possible responses out of a list of 23 choices).

Table 18. Top 10 most important "health problems" in your community (N=997; n=2,790)

Factor		Number	Percent
1	Diabetes	397	13%
2	Dental problems	368	12%
3	High blood pressure	335	11%
4	Mental health problems	329	11%
5	Aging problems (e.g. arthritis, hearing/vision loss, etc.)	314	11%
6	Cancer	278	9%
7	Heart disease and stroke	167	6%
8	Domestic Violence	121	4%
9	Motor vehicle crash injuries	82	3%
10	Lung disease / asthma	76	3%

Other responses that got 2% or less included: child abuse/neglect, sexually transmitted infections (STIs), hepatitis, firearm related injuries, HIV/AIDS, suicide, drug and alcohol abuse, rape/sexual assault, homicide, diarrheal diseases, tuberculosis, infant death, and other.

Most important "risky behaviors" in your community

The top three most important "risky behaviors" in your community included: alcohol abuse, drug abuse, and tied for third housing (unhealthy housing behaviors), lack of physical activity, and job instability (Table 19). Unhealthy housing behaviors can include unaffordability of housing, personal safety, smoking, exposure to lead, mold, pests, etc. There were a total of 2,995 responses (participants could check up to three possible responses out of 18 choices).

Table 19. Top 10 most important "risky behaviors" in your community N=1,008; (n=2,995)

Factor		Number	Percent
1	Alcohol abuse	457	15%
2	Drug abuse	363	12%
3	Housing (unhealthy housing behaviors)	280	9%
4	Lack of physical activity	277	9%
5	Job Instability	275	9%
6	Stress	254	8%
7	Poor nutrition	240	8%
8	Being overweight/Obese	188	6%
9	Tobacco use/Vaping	161	5%
10	Racism	151	5%

Other responses that got 3% or less included: dropping out of school, transportation, not getting vaccinations to prevent disease, unsafe sex, not using birth control, not using seat belts/child safety seats, and other.

Most important "health problems or risky behaviors" for you

The most important "health problems or risky behaviors" for you were stress, dental problems, aging, alcohol use, and diabetes (Table 20). There were a total of 2,929 responses (participants could check up to three possible responses out of a list of 37 choices).

Table 20. Top most important health problems / risky behaviors for you (N=1,006; n=2,929)

Factor		Number	Percent
1	Stress	304	10%
2	Dental problems	241	8%
3	Aging	233	8%
4	Alcohol use	220	8%
5	Diabetes	199	7%
6	Lack of exercise	186	6%
7	Heart disease and stroke	149	5%

8	Job Stability	137	5%
9	Housing issues	135	5%
10	Being overweight/obese	133	5%

Other responses that got 2% or less included: aging, poor eating habits/nutrition, dropping out of school, transportation, mental health problems, hepatitis, not getting vaccinations, not using birth control, domestic violence/abuse, child abuse/neglect, gun-related injuries, HIV/AIDS, not enough diagnostic treatment/testing, gun violence/not enough safety for kids at school, diarrheal diseases, not using seat belts/child safety seat/not wearing bike helmet, housing, , tuberculosis, job stability, tobacco use/vaping, teenage pregnancy, unsafe sex, sexually transmitted infections (STIs), other (authority, depression, DUI, physical ailment).

Rating of health

Rating of community as a "Healthy Community"

Overall, the community was given an average rating of 3.04 or *healthy*.

Table 21. Rating of community as a Healthy Community (n=995)

Scale of 1-4, 1 as Very Unhealthy and 4 as Very Healthy	
Very healthy	21%
Healthy	64%
Unhealthy	13%
Very Unhealthy	2%
Average	**3.04**

Rating of own personal health

Overall, the rating respondents gave of their own personal health was 3.13, or *healthy*.

Table 22. Rating of personal health (n=998)

Scale of 1-4, 1 as Very Unhealthy and 4 as Very Healthy	
Very healthy	31%
Healthy	52%
Unhealthy	15%
Very Unhealthy	2%
Average	**3.13**

Regional comparisons

The following section looks at regions and their demographic characteristics (average household size, age, education, income, and insurance) along with the rating of community as a "Healthy Community" and most important health problems in the community, most important risky behaviors in the community, and most important health problems or risky behaviors for you by region. Tables are organized alphabetically by region.

Demographics

Table 23. Average household size by region (n=849)

Region	Average household size
Balkan Region	2.98
Central Africa	3.80
China	3.00

East Africa	4.25
Mexico, Central America & Caribbean	4.01
Middle East & West/Central Asia	3.43
Other	2.62
Russia	3.00
South America	2.86
Southeast Asia	2.84
USA	2.97
Overall	**3.56**

Table 24. Percentage of respondents aged 20-39 (approximate age) by region

Region	Percent
Balkan Region	43%
Central Africa	56%
China	54%
East Africa	50%
Mexico, Central America & Caribbean	45%
Middle East & West/Central Asia	51%
Other, Russia, South America	*
Southeast Asia	41%
USA	73%

*Indicates data suppressed due to small sample size.

Table 25. Percentage of respondents with a high school diploma or higher by region

Region	Percent
Balkan Region	79%
Central Africa	87%
China	100%
East Africa	67%
Mexico, Central America & Caribbean	50%
Middle East & West/Central Asia	87%
Other	71%
Russia	91%
South America	72%
Southeast Asia	62%
USA	93%

Table 26. Percentage of respondents who have a household income of $29,999 or less by region

Region	Percent
Balkan Region	30%
Central Africa	93%
China	*
East Africa	85%
Mexico, Central America & Caribbean	67%
Middle East & West/Central Asia	98%
Other	*
Russia	*
South America	*
Southeast Asia	57%
USA	37%

*Indicates data suppressed due to small sample size.

Table 27. Percentage of respondents with private insurance by region

Region	Percent
Balkan Region	66%
Central Africa	15%
China	71%
East Africa	32%
Mexico, Central America & Caribbean	29%
Middle East & West/Central Asia	15%
Other	*
Russia	*
South America	77%
Southeast Asia	32%
USA	66%

*Indicates data suppressed due to small sample size.

For the following tables, N indicates the number of respondents to the question and n indicates the number of responses. For each question, respondents could choose up to three responses.

Balkan Region

Balkan Region			
Most important factors for a healthy community (N=75; n=224)		**Most important health problems in your community (N=75; n=223)**	
Factor	**Percent**		**Percent**
Good jobs and healthy economy	26%	Mental health problems	30%
Healthy behaviors and lifestyles	22%	Heart disease and stroke	17%
Low crime / safe neighborhoods	14%	Aging problems (e.g. arthritis, hearing/vision loss, etc.)	13%
Good place to raise children	10%	Cancer	10%
Strong family life	8%	Sexually Transmitted Infections (STIs)	8%

Most important risky behaviors in your community (N=75; n=225)		**Most important health problems or risky behaviors for you** (N=75; n=217)	
Factor	**Percent**		**Percent**
Alcohol abuse	24%	Mental health problems	14%
Drug abuse	15%	Aging	14%
Being overweight/Obese	14%	Being overweight/obese	11%
Poor nutrition	14%	Heart disease and stroke	10%
Tobacco use/Vaping	12%	Lack of exercise	9%

Central Africa

Most important factors for a healthy community (N=146; n=441)		**Most important health problems in your community** (N=138; n=360)	
Factor	Percent		Percent
Good place to raise children	16%	Dental problems	22%
Good schools	12%	High blood pressure	12%
Access to health care (e.g., family doctor)	12%	Mental health problems	11%
Affordable housing	10%	Aging problems (e.g., arthritis, hearing/vision loss, etc.)	10%
Low crime / safe neighborhoods	10%	Diabetes	9%

Central Africa	
Most important risky behaviors in your community (N=145; n=431)	**Most important health problems or risky behaviors for you** (N=145;

		n=427)	
Factor	Percent		Percent
Alcohol abuse	19%	Alcohol use	18%
Drug abuse	15%	Stress	11%
Job Instability	12%	Aging	10%
Housing	11%	Drug use	8%
Stress	8%	Dental problems	8%

China

Most important factors for a healthy community (N=28; n=84)		**Most important health problems in your community** (N=28; n=69)	
Factor	Percent	Factor	Percent
Safety	23%	Mental health problems	17%
Low crime / safe neighborhoods	15%	High blood pressure	14%
Good jobs and healthy economy	12%		

Most important risky behaviors in your community (N=28; n=69)		**Most important health problems or risky behaviors for you** (N=28; n=56)	
Factor	Percent		Percent
Drug abuse	16%	Stress	18%

East Africa

Most important factors for a healthy community (N=267; n=797)		**Most important health problems in your community** (N=263; n=728)	
Factor	Percent	Factor	Percent
Good place to raise children	13%	Dental problems	17%
Low crime / safe neighborhoods	11%	Diabetes	13%
Affordable housing	11%	Aging problems (arthritis, hearing/vision loss, etc.)	12%
Good schools	10%	High blood pressure	11%
Good jobs and healthy economy	9%	Mental health problems	10%

Most important risky behaviors in your community (N=266; n=791)		**Most important health problems or risky behaviors for you** (N=264; n=773)	
Factor	Percent		Percent
Alcohol abuse	13%	Stress	13%
Stress	11%	Dental problems	9%
Housing	10%	Alcohol use	8%
Lack of physical activity	10%	Aging	7%
Racism	9%	Housing	6%

Mexico, Central America & Caribbean

Most important factors for a healthy community (N=84; n=251)		**Most important health problems in your community** (N=83; n=229)	
Factor	Percent	Factor	Percent
Access to health care (e.g., family doctor)	16%	Diabetes	21%
Good jobs and healthy economy	14%	Cancer	18%
Good schools	13%	Dental problems	10%
Good place to raise children	10%	High blood pressure	8%
Low crime / safe neighborhoods	9%	Heart disease and stroke	8%

Most important risky behaviors in your community (N=84; n=252)		**Most important health problems or risky behaviors for you** (N=84; n=245)	
Factor	Percent		Percent
Alcohol abuse	22%	Diabetes	10%
Drug abuse	20%	Alcohol use	9%
Being overweight/Obese	9%	Cancer	8%
Racism	9%	Being overweight/obese	7%
Stress	7%	Dental problems	7%

Middle East and West/Central Asia

Most important factors for a healthy community (N=176; n=528)		**Most important health problems in your community** (N=175; n=519)	
Factor	Percent	Factor	Percent
Access to health care (e.g., family doctor)	12%	Diabetes	23%
Low crime / safe neighborhoods	11%	Dental problems	17%
Clean environment	11%	Aging problems (e.g. arthritis, hearing/vision loss, etc.)	17%
Affordable housing	10%	High blood pressure	15%
Good schools	9%	Mental health problems	9%

Most important risky behaviors in your community (N=176; n=528)		**Most important health problems or risky behaviors for you** (N=176; n=527)	
Factor	Percent		Percent
Housing	22%	Dental problems	17%
Job Instability	21%	Diabetes	16%
Lack of physical activity	17%	Aging	9%
Poor nutrition	16%	Lack of exercise	7%
Transportation	6%	Cancer	7%

Russia and Other

Due to small sample size, Russia and Other were combined for this portion of the analysis.

Most important factors for a healthy community (N=26; n=77)		**Most important health problems in your community** (N=26; n=71)	
Factor	Percent	Factor	Percent
Low crime / safe neighborhoods	21%	Mental health problems	14%
Access to health care (e.g., family doctor)	14%		

Most important risky behaviors in your community (N=26; n=78)		**Most important health problems or risky behaviors for you** (N=26; n=74)	
Factor	Percent		Percent
Drug abuse	21%	Stress	14%
Alcohol abuse	19%		

South America

Most important factors for a healthy community (N=30; n=90)		**Most important health problems in your community** (N=30; n=84)	
Factor	Percent	Factor	Percent
Access to health care (e.g., family doctor)	14%	Diabetes	14%
Low crime / safe neighborhoods	12%	Mental health problems	13%
Good jobs and healthy economy	12%	Dental problems	12%
Affordable housing	12%		
Good place to raise children	11%		

Most important risky behaviors in your community (N=29; n=90)		**Most important health problems or risky behaviors for you** (N=30; n=88)	
Factor	Percent		Percent
Alcohol abuse	20%	Stress	15%
Drug abuse	13%	Lack of exercise	15%

Southeast Asia

Most important factors for a healthy community (N=69; n=206)		**Most important health problems in your community** (N=69; n=207)	
Factor	Percent	Factor	Percent
Good jobs and healthy economy	18%	Cancer	25%
Access to health care (e.g., family dr)	18%	Diabetes	24%
Low crime / safe neighborhoods	14%	High blood pressure	21%
Good place to raise children	12%	Hepatitis	7%
Good schools	12%	Aging problems (arthritis, hearing/vision loss, etc.)	5%

Most important risky behaviors in your community (N=69; n=206)		**Most important health problems or risky behaviors for you** (N=69; n=206)	
Factor	Percent		Percent
Alcohol abuse	28%	Stress	15%
Drug abuse	22%	High blood pressure	11%
Stress	15%	Lack of exercise	10%
Tobacco use/Vaping	11%	Diabetes	10%
Lack of physical activity	10%	Heart disease and stroke	7%
		Housing	7%

USA

Most important factors for a healthy community (N=102; n=304)		**Most important health problems in your community** (N=102; n=277)	
Factor	Percent	Factor	Percent
Low crime / safe neighborhoods	16%	Mental health problems	15%
Good jobs and healthy economy	12%	Cancer	14%
Good schools	12%	Diabetes	11%
Access to health care (e.g., family doctor)	11%	Heart disease and stroke	11%
Affordable housing	9%	High blood pressure	10%

Most important risky behaviors in your community (N=102; n=305)		**Most important health problems or risky behaviors for you** (N=102; n=295)	
Factor	Percent		Percent
Drug abuse	20%	Stress	16%
Alcohol abuse	19%	Alcohol use	8%
Being overweight/Obese	10%	Poor eating habits/nutrition	8%
Lack of physical activity	9%	Aging	6%
Stress	8%	Being overweight/obese	6%

Demographic comparisons: Important factors for a "Healthy Community"

The following tables look at most **important factors for a "Healthy Community"** based on various sub-populations.

For the following tables N indicates the number of respondents to the question and n indicates the number of responses. For each question, respondents could choose up to three responses.

Age

Age 20-39 (N=481; n=1,433)	
Low crime / safe neighborhoods	13%
Access to health care (e.g., family doctor)	11%

Age 40-59 (N=282; n=872)	
Good place to raise children	13%
Low crime / safe neighborhoods	13%

Good jobs and healthy economy	11%
Good schools	11%
Good place to raise children	10%

Good jobs and healthy economy	11%
Access to health care (e.g., family doctor)	10%
Good schools	9%

Age 60+ (N=180; n=539)	
Access to health care (e.g., family doctor)	12%
Good place to raise children	12%
Low crime / safe neighborhoods	11%
Affordable housing	11%
Good jobs and healthy economy	9%

Gender

Female (N=514; n=1,538)	
Low crime / safe neighborhoods	12%
Access to health care (e.g., family doctor)	12%
Good place to raise children	12%
Good jobs and healthy economy	10%
Good schools	10%

Male (N=490; n=1,459)	
Low crime / safe neighborhoods	12%
Good place to raise children	11%
Good jobs and healthy economy	11%
Access to health care (e.g., family doctor)	11%
Affordable housing	10%

Marital status

Married (N=508; n=1,530)	
Good place to raise children	14%
Low crime / safe neighborhoods	11%
Access to health care (e.g., family doctor)	11%
Good schools	9%
Good jobs and healthy economy	9%

Not married (N=471; n=1,413)	
Low crime / safe neighborhoods	13%
Good jobs and healthy economy	12%
Good schools	11%
Access to health care (e.g., family doctor)	10%
Affordable housing	10%

Household status

Cohabitating (N=720; n=2,153)	
Good jobs and healthy economy	12%
Access to health care (e.g., family doctor)	12%
Low crime / safe neighborhoods	12%
Good schools	10%
Good place to raise children	9%

Living alone (N=123; n=367)	
Low crime / safe neighborhoods	13%
Affordable housing	13%
Access to health care (e.g., family doctor)	10%
Good jobs and healthy economy	10%
Good place to raise children	9%

Education level

Only primary school (N=50; n=148)	
Good place to raise children	20%
Low crime / safe neighborhoods	14%
Access to health care (e.g., family doctor)	12%
Good schools	8%

Less than high school (N=148; n=444)	
Access to health care (e.g., family doctor)	13%
Good jobs and healthy economy	13%
Affordable housing	11%
Low crime / safe neighborhoods	10%

Affordable housing	7%

Good schools	10%

High school diploma or GED (N=354; n=1,056)	
Low crime / safe neighborhoods	12%
Good place to raise children	11%
Affordable housing	11%
Good jobs and healthy economy	11%
Good schools	10%

Some college (N=227; n=675)	
Low crime / safe neighborhoods	13%
Good place to raise children	11%
Access to health care (e.g., family doctor)	10%
Good schools	10%
Good jobs and healthy economy	8%
Affordable housing	8%

College degree or higher (N=175; n=525)	
Low crime / safe neighborhoods	14%
Good jobs and healthy economy	12%
Access to health care (e.g., family doctor)	12%
Good place to raise children	12%
Good schools	10%

Other (includes professional field) (N=32; n=96)	
Good place to raise children	17%
Good jobs and healthy economy	14%
Access to health care (e.g., family doctor)	13%
Affordable housing	10%
Low crime / safe neighborhoods	10%

Household income

Less than $10,000 (N=194; n=585)	
Good schools	12%
Access to health care (e.g., family doctor)	12%
Low crime / safe neighborhoods	10%
Affordable housing	10%
Good place to raise children	9%

$10,000 to $20,000 (N=291; n=873)	
Access to health care (e.g., family doctor)	11%
Good place to raise children	11%
Low crime / safe neighborhoods	11%
Affordable housing	11%
Good schools	10%

$20,000 to $29,999 (N=208n=627)	
Low crime / safe neighborhoods	14%
Good place to raise children	12%
Access to health care (e.g., family doctor)	11%
Good jobs and healthy economy	11%
Affordable housing	9%

$30,000 to $49,999 (N=137; n=411)	
Good jobs and healthy economy	15%
Low crime / safe neighborhoods	14%
Access to health care (e.g., family doctor)	11%
Good place to raise children	11%
Affordable housing	10%

Over $50,000 (N=135; n=405)	
Good jobs and healthy economy	16%
Low crime / safe neighborhoods	15%
Good place to raise children	13%
Good schools	9%
Healthy behaviors and lifestyles	9%

Payment of health care

Health insurance (private) (N=347; n=1,036)	
Good jobs and healthy economy	15%
Low crime / safe neighborhoods	14%
Good place to raise children	11%
Good schools	10%
Access to health care (e.g., family doctor)	9%

Uncompensated Care/Free Care (N=244; n=636)	
Access to health care (e.g., family doctor)	12%
Low crime / safe neighborhoods	11%
Good place to raise children	11%
Good schools	11%
Affordable housing	10%

MaineCare/Medicaid (N=196; n=587)	
Access to health care (e.g., family doctor)	15%
Good place to raise children	12%
Low crime / safe neighborhoods	12%
Affordable housing	10%
Good jobs and healthy economy	8%
Good schools	8%

Medicare (N=119; n=357)	
Good place to raise children	14%
Low crime / safe neighborhoods	11%
Affordable housing	11%
Good schools	10%
Access to health care (e.g., family doctor)	8%

Pay cash (no insurance) or Other (N=78; n=228)	
Access to health care (e.g., family doctor)	13%
Good jobs and healthy economy	13%
Good place to raise children	10%
Low crime / safe neighborhoods	9%
Affordable housing	9%

Demographic comparisons: Most important "health problems" in your community

The following tables look at most **important "health problems" in your community** based on various sub-populations.

For the following tables, N indicates the number of respondents to the question, and n indicates the number of responses. For each question, respondents could choose up to three responses.

Age

Age 20-39 (N=475; n=1,304)	
Diabetes	14%
Dental problems	14%
Mental health problems	13%
High blood pressure	12%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	8%

Age 40-59 (N=289; n=814)	
Diabetes	14%
Dental problems	14%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	13%
High blood pressure	12%
Cancer	11%

Age 60+ (N=179; n=539)	
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	18%
Diabetes	14%
Cancer	13%
High blood pressure	13%
Dental problems	10%

Gender

Female (N=506; n=1,487)	
Diabetes	13%
Dental problems	13%
High blood pressure	11%
Mental health problems	11%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	11%

Male (N=484; n=1,408)	
Diabetes	14%
Dental problems	12%
High blood pressure	11%
Mental health problems	11%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	11%

Marital status

Married (N=505; n=1,475)	
Dental problems	15%
Diabetes	14%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	12%
High blood pressure	12%
Mental health problems	10%

Not married (N=462; n=1,352)	
Diabetes	13%
Mental health problems	13%
High blood pressure	11%
Dental problems	10%
Cancer	9%

Household status

Cohabitating (N=718; n=2,114)	
Diabetes	15%
Mental health problems	12%
High blood pressure	11%
Dental problems	11%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	10%

Living alone (N=119; n=341)	
High blood pressure	13%
Mental health problems	11%
Cancer	11%
Diabetes	10%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	9%

Education level

Only primary school (N=50; n=147)	
Dental problems	20%
Diabetes	17%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	15%

Less than high school (N=144; n=410)	
Diabetes	17%
Cancer	13%
High blood pressure	13%

Cancer	13%
High blood pressure	13%

Aging problems (e.g., arthritis, hearing/vision loss, etc.)	11%
Dental problems	10%

High school diploma or GED (N=350; n=984)	
Dental problems	15%
Diabetes	14%
High blood pressure	12%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	10%
Mental health problems	10%

Some college (N=224; n=611)	
Mental health problems	14%
Dental problems	13%
Diabetes	12%
High blood pressure	11%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	11%

College degree or higher (N=175; n=485)	
Mental health problems	15%
Diabetes	14%
High blood pressure	13%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	11%
Dental problems	10%

Other (includes professional field) (N=32; n=90)	
Diabetes	19%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	14%
Mental health problems	12%

Household income

Less than $10,000 (N=194; n=553)	
Dental problems	14%
Diabetes	11%
High blood pressure	11%
Mental health problems	9%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	8%

$10,000 to $20,000 (N=287; n=841)	
Dental problems	16%
Diabetes	16%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	15%
High blood pressure	11%
Mental health problems	10%

$20,000 to $29,999 (N=206; n=610)	
Diabetes	17%
Dental problems	15%
High blood pressure	14%
Cancer	10%
Mental health problems	10%

$30,000 to $49,999 (N=137; n=406)	
Mental health problems	14%
Diabetes	13%
Cancer	13%
High blood pressure	11%
Aging problems (e.g., arthritis, hearing/vision loss ,etc.)	9%

Over $50,000 (N=135; n=395)	
Mental health problems	18%
Cancer	12%
Heart disease and stroke	10%
High blood pressure	10%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	10%

Payment of health care

Health insurance (private) (N=346; n=1,006)	
Mental health problems	14%
High blood pressure	12%
Diabetes	12%
Cancer	11%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	9%

Uncompensated Care/Free Care (N=236; n=687)	
Dental problems	19%
High blood pressure	13%
Diabetes	12%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	10%
Mental health problems	10%

MaineCare/Medicaid (N=196; n=581)	
Diabetes	17%
Cancer	13%
Dental problems	13%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	12%
Mental health problems	12%

Medicare (N=115; n=337)	
Diabetes	18%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	16%
Dental problems	15%
High blood pressure	12%
Mental health problems	8%

Pay cash (no insurance) or Other (N=77; n=224)	
Diabetes	13%
Dental problems	11%
Cancer	11%
High blood pressure	10%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	9%

Demographic comparisons: Most important "risky behaviors" in your community

The following tables look at most **important health "risky behaviors" in your community** based on various sub-populations.

For the following tables N indicates the number of respondents to the question, and n indicates the number of responses. For each question, respondents could choose up to three responses.

Age

Age 20-39 (N=479; n=1,424)	
Alcohol abuse	15%
Drug abuse	13%
Housing(unhealthy housing behaviors)	11%
Job Instability	10%
Stress	9%

Age 40-59 (N=291; n=863)	
Alcohol abuse	14%
Drug abuse	12%
Job Instability	10%
Stress	10%
Lack of physical activity	10%

Age 60+ (N=180; n=539)	
Alcohol abuse	15%
Lack of physical activity	12%
Drug abuse	11%
Stress	10%
Poor nutrition	9%

Gender

Female (N=513; n=1,528)	
Alcohol abuse	14%
Drug abuse	11%
Job Instability	10%
Poor nutrition	10%
Housing(unhealthy housing behaviors)	9%

Male (N=488; n=1,446)	
Alcohol abuse	16%
Drug abuse	13%
Lack of physical activity	10%
Housing(unhealthy housing behaviors)	9%
Job Instability	8%

Marital status

Married (N=505; n=1,505)	
Alcohol abuse	15%
Drug abuse	12%
Housing(unhealthy housing behaviors)	10%
Lack of physical activity	10%
Job Instability	10%

Not married (N=471; n=1,395)	
Alcohol abuse	16%
Drug abuse	12%
Job Instability	9%
Housing(unhealthy housing behaviors)	8%
Lack of physical activity	8%

Household status

Cohabitating (N=720; n=2,143)	
Alcohol abuse	15%
Drug abuse	12%
Housing (unhealthy housing behaviors)	10%
Job Instability	9%
Poor nutrition	9%

Living alone (N=122; n=361)	
Alcohol abuse	17%
Drug abuse	12%
Lack of physical activity	9%
Stress	9%
Job Instability	9%

Education level

Only primary school (N=50; n=146)	
Lack of physical activity	16%
Housing(unhealthy housing behaviors)	13%
Racism	11%
Transportation	10%
Alcohol abuse	8%

Less than high school (N=148; n=441)	
Alcohol abuse	19%
Drug abuse	15%
Poor nutrition	9%
Stress	8%
Tobacco use/Vaping	7%

High school diploma or GED (N=353; n=1,053)	
Alcohol abuse	16%
Drug abuse	11%
Job Instability	11%
Housing(unhealthy housing behaviors)	10%
Stress	8%

Some college (N=226; n=669)	
Alcohol abuse	15%
Drug abuse	12%
Job Instability	11%
Lack of physical activity	10%
Housing (unhealthy housing behaviors)	9%

College degree or higher (N=174; n=515)	
Alcohol abuse	13%
Drug abuse	12%
Housing (unhealthy housing behaviors)	10%
Lack of physical activity	10%
Job Instability	10%

Other (includes professional field) (N=32; n=96)	
Alcohol abuse	19%
Drug abuse	15%

Household income

Less than $10,000 (N=194; n=576)	
Alcohol abuse	17%
Drug abuse	16%

$10,000 to $20,000 (N=290; n=867)	
Housing (unhealthy housing behaviors)	13%
Lack of physical activity	12%

Housing (unhealthy housing behaviors)	9%
Stress	8%
Job Instability	7%

Job Instability	11%
Alcohol abuse	11%
Poor nutrition	10%

$20,000 to $29,999 (N=208; n=614)	
Alcohol abuse	14%
Job Instability	12%
Housing(unhealthy housing behaviors)	12%
Drug abuse	10%
Lack of physical activity	9%

$30,000 to $49,999 (N=136; n=406)	
Alcohol abuse	21%
Drug abuse	13%
Stress	11%
Lack of physical activity	7%
Job Instability	7%

Over $50,000 (N=134; n=396)	
Alcohol abuse	18%
Drug abuse	18%
Being overweight/Obese	10%
Lack of physical activity	9%
Stress	8%

Payment of health care

Health insurance (private) (N=345; n=1,018)	
Alcohol abuse	17%
Drug abuse	13%
Lack of physical activity	9%
Stress	8%
Being overweight/Obese	8%

Uncompensated Care/Free Care (N=244; n=728)	
Job Instability	14%
Alcohol abuse	14%
Housing(unhealthy housing behaviors)	13%
Drug abuse	12%
Lack of physical activity	9%

MaineCare/Medicaid (N=196; n=585)	
Alcohol abuse	14%
Lack of physical activity	12%
Housing (unhealthy housing behaviors)	11%
Drug abuse	10%
Poor nutrition	10%

Medicare (N=118; n=352)	
Alcohol abuse	13%
Housing (unhealthy housing behaviors)	11%
Drug abuse	10%
Stress	9%
Poor nutrition	8%

Pay cash (no insurance) or Other (N=78; n=231)	
Alcohol abuse	18%
Drug abuse	14%
Job Instability	9%
Lack of physical activity	9%
Stress	8%

Demographic comparisons: Most important "health problems or risky behaviors" for you

The following tables look at most **important "health problems or risky behaviors" for you** based on various sub-populations.

For the following tables N indicates the number of respondents to the question, and n indicates the number of responses. For each question, respondents could choose up to three responses.

Age

Age 20-39 (N=478; n=1,379)	
Stress	12%
Dental problems	9%
Alcohol use	9%
Lack of exercise	7%
Job Stability	6%

Age 40-59 (N=292; n=851)	
Stress	10%
Dental problems	9%
Aging	8%
Alcohol use	8%
Diabetes	7%

Age 60+ (N=178; n=530)	
Aging	20%
Diabetes	10%
Heart disease and stroke	10%
Stress	8%
High blood pressure	7%

Gender

Female (N=513; n=1,493)	
Stress	11%
Dental problems	9%
Aging	8%
Lack of exercise	7%
Diabetes	7%

Male (N=486; n=1,415)	
Stress	10%
Alcohol use	9%
Aging	8%
Dental problems	8%
Diabetes	7%

Marital status

Married (N=505; n=1,491)

Not married (N=470; n=1,345)

Aging	10%
Stress	10%
Dental problems	9%
Diabetes	7%
Alcohol use	7%

Stress	11%
Alcohol use	7%
Lack of exercise	7%
Dental problems	7%
Diabetes	6%

Household status

Cohabitating (N=719; n=2,103)	
Stress	9%
Dental problems	9%
Diabetes	8%
Aging	7%
Lack of exercise	7%

Living alone (N=123; n=350)	
Stress	11%
Alcohol use	9%
Aging	8%
Lack of exercise	7%
Dental problems	6%
Heart disease and stroke	6%
Housing	6%

Education level

Only primary school (N=48; n=141)	
Dental problems	15%
Aging	12%
Diabetes	8%
Heart disease and stroke	7%

Less than high school (N=148; n=440)	
Stress	10%
Aging	10%
Diabetes	7%
Dental problems	7%
Alcohol use	7%

High school diploma or GED (N=354; n=1,037)	
Stress	10%
Alcohol use	8%
Dental problems	8%
Aging	7%
Diabetes	7%

Some college (N=224; n=611)	
Stress	11%
Dental problems	9%
Alcohol use	8%
Diabetes	7%
Aging	6%

College degree or higher (N=175; n=504)	
Stress	10%
Aging	10%
Dental problems	8%
Lack of exercise	8%
Diabetes	7%

Other (includes professional field) (N=32; n=91)	
Stress	11%
Lack of exercise	11%

Household income

Less than $10,000 (N=192; n=557)	
Alcohol use	9%
Stress	8%
Dental problems	7%
Aging	7%
Drug use	6%

$10,000 to $20,000 (N=290; n=855)	
Dental problems	11%
Stress	11%
Aging	10%
Diabetes	9%
Alcohol use	7%

$20,000 to $29,999 (N=207; n=613)	
Dental problems	11%
Diabetes	9%
Stress	8%
Alcohol use	8%
Housing	6%

$30,000 to $49,999 (N=137; n=398)	
Stress	11%
Lack of exercise	9%
Alcohol use	9%
Aging	7%
Heart disease and stroke	6%

Over $50,000 (N=134; n=377)	
Stress	15%
Lack of exercise	10%
Aging	9%
Poor eating habits/nutrition	9%
Being overweight/obese	7%

Payment of health care

Health insurance (private) (N=346; n=983)	
Stress	14%
Lack of exercise	8%
Aging	8%
Alcohol use	6%
Poor eating habits/nutrition	6%

Uncompensated Care/Free Care (N=242; n=713)	
Dental problems	12%
Alcohol use	10%
Stress	9%
Aging	7%
Diabetes	7%

MaineCare/Medicaid (N=195; n=578)	
Aging	11%
Diabetes	10%
Dental problems	9%
Stress	8%
Heart disease and stroke	7%

Medicare (N=118; n=345)	
Aging	10%
Stress	10%
Diabetes	9%
Dental problems	8%
High blood pressure	5%
Cancer	5%

Pay cash (no insurance) or Other (N=78; n=231)	
Alcohol use	13%
Stress	8%
Dental problems	7%
Housing	6%
Lack of exercise	6%

Demographic comparisons: Community and Personal Health Rating by demographic category

Region

Table 28. Health Rating by Region of Origin

Region	Average Community Health Rating	Average Personal Health Rating
Balkan Region	2.92	2.76
Central Africa	3.03	3.26
China	3.00	3.18
East Africa	2.88	2.91
Mexico, Central America & Caribbean	2.81	2.83
Middle East & West/Central Asia	3.53	3.40
Other	2.93	3.07
Russia	2.82	2.91
South America	2.77	2.97
Southeast Asia	3.06	3.10
USA	2.96	3.21

Age

Table 29. Health Rating by Approximate Age

Age	Average Community Health Rating	Average Personal Health Rating
20-39	3.10	3.30
40-59	3.03	3.13
60+	2.88	2.62

Gender

Table 30. Health Rating by Gender

Gender	Average Community Health Rating	Average Personal Health Rating
Female	3.02	3.10
Male	3.06	3.16

Marital status

Table 31. Health Rating by Marital Status

Marital Status	Average Community Health Rating	Average Personal Heath Rating
Married	3.05	3.04
Not Married	3.24	3.04

Household status

Table 32. Health Rating by Household Status

Household Status	Average Community Health Rating	Average Personal Health Rating
Cohabitating (e.g. roommates or family)	3.09	3.18
Single/live alone	2.91	3.02

Household income

Table 33. Health Rating by Annual Household Income

Annual Household Income	Average Community Health Rating	Average Personal Health Rating
Less than $10,000	2.93	2.98
$10,000 to $20,000	3.13	3.15
$20,000 to $29,999	3.14	3.21
$30,000 to $49,999	2.96	3.12
Over $50,000	3.00	3.24

Payment of health care

Table 34. Health Rating by Payment of Health Care

Payment type	Average Community Health Rating	Average Personal Heath Rating
Health insurance (private)	3.04	3.23
MaineCare/Medicaid	3.08	2.93
Medicare	2.81	2.92
Pay cash (no insurance) or Other	2.92	3.04
Uncompensated Care/Free care	3.18	3.30

Appendices

A. Proposal document

2018 Minority Health Assessment Proposal

Statement of Purpose:
The City of Portland's Minority Health Program and its partners intend to administer a community health assessment to 1,640 members from Cumberland County, from 13 racial and ethnic language minorities, low-income Caucasian-English speakers, and persons with hearing impairment. We will use the information to improve our services, communication with community members, and organizations addressing health needs.

The purpose of this survey is to get communities' opinions about community health needs in the Cumberland County. The City of Portland's Minority Health Program and partners will use the results of this assessment to evaluate and address the most pressing needs through community action. The City of Portland's Minority Health Program conducts a community health assessment every 2-4 years to determine the needs in the minority communities in order to improve our services, enhance our communication with community members, and to provide a community health needs profile for organizations addressing health needs for these vulnerable communities.

Project Management: Nélida R. Berke
Project Key Collaborators/Partners:

- Portland Adult Education
- Community-and faith-based organizations

Project Start Date: October 15th, 2017
Project End Date: November 30th, 2018
Project Activities:
Specific activities of the community health assessment involve a four-stage plan: 10/15/17-6/30/18

a. Partners and community engagement, and review of 2014 survey- Oct. 15, 2017 -Dec. 31, 2018:

This stage involves collaborating with new partners to achieve the assessment purpose. We also use this to rally partnership coordination with other agencies that conduct similar needs assessment plan/ projects. The Minority Health Program will collaborate with community-and faith- based organizations, Portland Adult Education, the Office of Maine Refugee Services to conduct the assessment, and other potential new partners. There will be a series of planning meetings with partners and community-and faith- based organizations to ensure adequate implementation and increase number of respondents. The surveys were pilot-tested, in 2013, with community members for time estimate for survey implementation and cultural/linguistic

appropriateness - timeframe for the implementation is 10 minutes. The health needs survey will be submitted for Institutional Review Board (IRB) determination of project survey sampling and methodology. See IRB determination appendix.

b. Implementation of the community health assessment – November 20th, 2017 - May 1st, 2018:

This stage involves:

1. The recruitment of Community Health Outreach Workers (CHOWs) per the targeted sampling groups and expected numbers of survey. We anticipate having a maximum number of 20 Contract CHOWs across the focus coverage areas and one full time English-speaking CHOW who will implement the survey among his current clients from Mercy Hospital and Portland Family Medicine. The CHOWs are trusted, indigenous community members who serve as survey implementers in their respective communities.
2. Community-based participatory research (CBPR) project data training on January 26th (8am-10:30 am). Contract CHOWs will be trained on how to implement the survey, goals, implementation plan and methodology, and, distribution of survey and supporting materials (details of sampling methodology in appendix).
3. Target areas: Cumberland County is the target area and surveys will be implemented at multiple outreach points, such as the faith-based congregations, schools, non-profit organizations, ethnic stores, community centers, universities, organizations that offer English language classes, neighborhood areas, homeless square, residential parks, etc.
4. Target Populations: Our survey will focus on the following communities; Somali, Sudanese, Spanish, Arabic, Serbian, French, Chinese, Vietnamese, Russian, African Americans, Caucasian-English speaking, Portuguese, and, the hearing-impaired /ASL communities.
5. Survey implementation: An individual plan for recruiting participants will be developed with each CHOW that includes; criteria for screening, target number of respondents, location, and approach. We anticipated a minimum of 1,640 surveys from Cumberland County respondents, however, our target number will likely increase due to the additional surveys that our full time English-speaking CHOW will implement.
6. Methods of survey implementation include one-on-one personal and group implementations by the CHOWs. Surveys will be installed in nine tablets and CHOWs will be filling out their surveys directly into the tablets (details of Tablet's Data Collection Initiative and Personal Information Protection Protocol in appendix).

c. Data collection, collation, and analysis – May 1st -31st, 2018:

The city's Minority Health Program will collect, collate, and input the data in a structured database for analysis. The analysis of the Cumberland County surveys will be done by an external consultant.

d. Assessment reporting and dissemination – June 1st – November 30th, 2018.
This period involves a draft report of Cumberland County surveys by the external consultant. The city's MHP will share the report with various communities for feedback and review. The reports will be disseminated through various channels. All project partners will be involved in the various disseminations of the assessment report. Disseminations within communities involve: community meetings, faith-based leaders, and trusted community leaders and representatives. Disseminations with agencies that have interest in or are already serving the minority communities will be sent a copy for their information to inform their programs and services delivery. Examples of channels include: the Office of Maine Refugee Services, Portland Adult Education, Universities of Southern Maine and New England, Multicultural Resource Centers, neighborhood parks/ centers, Maine Mobile Health Program Inc., medical homes and health provider offices, and through community-and faith-based organizations.

Use of Survey Information
We will use the survey information to:

- Improve our services, communication with community members, and organizations addressing health needs
- Determine health issues that community members identified as the most important
- Identify resources according to individual community needs
- Assess whether our current programs are meeting the needs of our community members
- Modify existing programs or develop new programs to address emerging health needs
- Find out where we need to communicate better with other city and private organizations to ensure communities' health needs are met
- Inform communities of existing resources to address their health concerns, thus, improve our cross-communication with community members and organizations who are addressing community health needs

B. Methodology & CHOWs training

Minority Health Program, Public Health Division, Health and Human Services Department
Community Health Assessment sampling methodology

We have tried to make this a fun project for CHOWs that produces reliable and comparative data for us to use to improve our public health programs. Your assistance in administering each survey in the most standard way possible to the many different individuals you will talk with is invaluable in ensuring that we can compare the responses within and across ethnic and

language groups. We have developed a few guidelines that will help you understand why we need you to administer the survey the same way every time – as much as possible. We hope this document will also help you answer some of the questions you will receive from participants.

Goals of survey population sample(s):

- Representativeness
- Comparability across subpopulations
- Generalizability of sample to larger community

Methodology

We will orally administer the 2018 Community Health Assessment to respondents selected through non-random quota sampling (described below) with multiple entry points in each community to develop the widest range of respondents within and among Cumberland County's many ethnic communities. We are targeting as many as 13 different cultural and linguistic groups in 2018. Based on experience, we will also receive completed assessments from members of additional ethnic and language groups.

Ethical considerations

The well-being of our participants is our primary concern. We are conducting this assessment in order to improve the health of the community by consulting community members on their opinions. Your participation in this assessment serves dual purposes: data collection and promotion of the City of Portland Public Health Division's services and mission: "to enhance the health and well-being of Portland residents through collaboration with the community."

As an interviewer for this assessment, you fill many roles. You are a representative of the City of Portland Public Health Division and the Minority Health Program. As members of the communities you are assessing, you are, or will be seen as, a bridge or link between your neighbors and services provided by the City of Portland. As a result, you are 'marketing' our services to the community as you collect information on community health interests. Achieving this ideal of balancing participant well-being and gathering useful information takes many skills.

Please use the following guidelines as a starting point:

- Please respect the concerns of potential respondents as you recruit participants, and take care to prevent any perception that you are coercing individuals into participating.
- Please ensure each respondent orally agrees to participate after you read them the introduction to the survey.
- Please answer any questions. If you are not sure of the answer, please admit that you don't know the exact answer, and assure them you will find out – or refer them to the phone number on the survey for additional information.

- Please respect individual confidentiality. Many of your respondents may prefer to have friends or family with them during the interview. In this case, the respondent is choosing to share personal information with their friend or family member. Please note on the assessment form any additional participants in the interview and their relationship to the respondent (if possible). If you feel that any respondent is uncomfortable with responding in the presence of a friend or family member, please note that on the assessment form before turning it in.
- Please, ensure coverage of diverse immigration statuses in recruitment: United States Citizens, Naturalized (Green Card holders), Refugees, Visa holders, Asylees, Asylee-pending, Visitors-nonimmigrant, seasonal workers-permit status, Undocumented persons, etc.

Please, indicate the respondent's Immigration Status on survey's top right-hand corner.

We found during the 2014 assessment that community members come to see the CHA interviewer as a potential advocate or resource for respondents in navigating the 'system' for desired services. While we want to improve the perception and usefulness of our services through this assessment - and this is part of the role you perform as a CHOW - it is a potentially overwhelming demand on your time to address individual respondent needs. As a result, we have developed a list of resource for you to provide to respondents in return for their participation. We highly recommend that you complete the oral interview before providing respondents with this list of resources. In this way, we hope the resource list serves as both a conclusion to this particular interaction and an inclusive act bringing respondents closer to available resources.

Participant Recruitment

CHOWs will start with an individual training on data entry on tablets, with Brendan Johnson. Then, CHOWs will have a training meeting with Nélida Berke to discuss our goals, design a plan to enter the community, discuss methodology, and obtain the necessary surveys and supporting materials. An individual plan for recruiting participants will be developed with each CHOW that includes:

- Criteria for screening
- Target number of respondents
- Location
- Approach

Please clearly explain the project to each participant. Respondent willingness to participate in an interview or focus group (and their responses) will depend on how well the participants understand what the study is about, what will be expected of them if they participate, and how their privacy will be respected. As you recruit participants, it is important to take special care to avoid saying anything that could be interpreted as coercive. Please emphasize the voluntary nature of participation. Use the list of projects developed or influenced by the previous

Minority Health Assessment to demonstrate how participation will improve our services to community members. Remember: Not only are you an interviewer, your participation in this project is a way for us to show our commitment to our community and their needs and interests.

On another accompanying Excel Spreadsheet titled "Preferred Sample Profile"*, we have provided a table with our goals for respondents for each ethnic/language group. Ideally we'd like to reach many age groups with this assessment. We recognize that some populations will have different age distributions, and different CHOWs will have access to different ages. Please use this table as a guideline.
*Information is available on only those ethnicities released by the US Census at this time.

Non-random quota sampling.
We have established quotas, or goals, for each cultural and linguistic group we want to target. Because we do not have a master list of all community members, we can't do truly random sampling. At the same time, we want to achieve the widest range of respondents, so we want you to use snowball or chain sampling (see below) to find respondents. Using this method will ensure that our data provides the most accurate representation of the health concerns and interests of the whole population and each distinct group, and holds up under critical scrutiny(should we encounter any).

Quotas
Using Minority Health Needs Assessment 2014 response rates, Catholic Charities' 2016 Refugees and Asylee Resettlement in Maine data and Census data (population estimates, as of July 2016), we determined the optimal number of respondents of each ethnicity that will allow us to reach at least 4% of the estimated current population of each target ethnicity. For certain ethnic and language groups, we have set higher goals. You can see the breakdown in the attached chart, and you can use the chart to track your responses. You will receive an update of this chart every week so you can see our overall progress and adjust your targets if necessary.

Snowball or Chain Sampling
With these quotas and age and gender breakdowns in mind, we ask you to make a list of 5 very different people or activities in your community. Please consider different ages, genders, languages, residential location, and political and religious views when developing this list of initial respondents. Once you have completed an interview with each of these initial respondents, please ask that person for a referral to another respondent within your target community. Ask that person "Who do you think would be good for me to talk to about these issues?" To include the full range of diversity within each culture and language group, please alternate between asking for a referral to:

- Someone with similar views on (politics, religion, health, children, education), and

- Someone with very different views on (politics, religion, health, children, education) Please do not accept more than three referrals from any respondent. This limitation will help us broaden the range of opinions in our responses.

Here is a list of possible points of entry for you to consider when searching for respondents. Please use this list to get started - and let us know your ideas for additional places to contact respondents.

- Friend or relative
- Neighbor
- Community activity
- Nail salons
- Laundromats
- Sports events
- Church, mosque, temple or other religious gathering place or event
- Farmer's market
- ESL/ESOL classes
- Coffee shop or local gathering spot
- Hospitals
- Portland Adult Education
- Other places

While each CHOW/assessor will target the specific ethnic groups you are most familiar with, you may at times encounter willing respondents in other targeted groups. If you are comfortable conducting an interview in English or other shared language, please 'nab' that additional respondent! If you are not comfortable conducting an oral interview with a willing participant, please ask for that individual's contact information, call Nélida Berke, and we will forward that contact to another CHOW with the desired language and cultural knowledge.

Oral administration

In 2018, we would like all health assessments to be completed orally and in person by the assessor. We'd also like you to use the same phrasing, in English and in your language, as much as possible. While this sometimes takes longer than handing out surveys to individuals to complete on their own, it allows you to be consistent about phrasing, responses to questions, completeness of responses and allows you to be sure the demographic information on the survey matches the respondent.

Translation

Individuals in our target populations will have varying fluency in spoken English and literacy in written English. In addition, they may have varying fluency and literacy in their native language and other languages they use to communicate. Unfortunately, we do not have the budget to translate and validate this assessment into all the languages we anticipate encountering. To address this potential obstacle for you (and data collection flaw for us!) we ask that you take one paid hour to review the English version of the survey and annotate it in the language(s) you anticipate using. Please take this opportunity to create standard phrasing that

you will use consistently throughout your interviews. Using standard phrasing in each language helps us ensure that respondents always answer the same questions.

Respondent eligibility

Eligible participants include all greater Portland residents over the age of 18. We would like to limit respondents to individuals living within the City of Portland Public Health Division's Service area – Cumberland County. Please confirm that respondents live in Cumberland County before starting the assessment interview. Some individuals from various culture and language groups are starting to move outside Cumberland County. As a result, community gathering places and events (locations of worship, community holiday fairs, etc.) may take place in York County or other locations outside Cumberland County. These events are useful in gathering respondents for the assessment. Please take the time to ensure that each respondent's residence is within Cumberland County!

We rely on the discretion and cultural knowledge of our interviewers to respect cultural norms when seeking out assessment respondents. If it is most appropriate to speak to the head of a household before interviewing individual members of a family group, please do so.

Multiple family member responses

The results of this survey will be most useful if we receive participation from a broad range of participants. You may encounter situations where you find all members of a large extended family offer to complete an assessment response. This can appear to be a useful strategy to increase the number of responses. On the other hand, given our small populations and even smaller sampling groups, taking advantage of this opportunity may mean we do not hear from the full range of voices and opinions in the community. This could result in PHD developing new programs that only meet the needs of a small number of community members. If you encounter this situation, please use the recommended gender and age breakdown provided to request one response from a representative of each gender and age in the household. (ex.: if two sisters live together and both want to respond, please first ask for only one response. If you find they wish to collaborate on their response, please note on the assessment form that the responses are a combination of two participants' opinions)

Chaperones

If you find it helpful to bring a member of the opposite sex with you on interviews to promote respondent willingness to participate, please try to team up with another CHOW trained in this assessment. A female interviewer may bring a male family member or coworker as a chaperone to facilitate the interview. A male interviewer may wish to team up with a female interviewer in order to interview female members of a household. Please remember - if you need to bring a non-CHOW chaperone of either sex with you on assessment interviews, please emphasize the

importance of preserving respondent confidentiality as well as asking questions exactly as written. Finally, please identify the individual who assisted you on the completed survey.

Family Interpreters

If you encounter a situation where you share a language with younger members of the family who offer to interpreter for older members of the family who use an unfamiliar language or one you are not fluent speaking, please use your judgment and cultural insight to determine if this situation will provide the respondent a clear understanding of the purpose of the assessment and/or the questions and potential responses. Please ensure family interpreters are over 16 years of age, and note their age and agreement to participate as an interpreter on the survey form. If you are not comfortable that the respondent understands the assessment, please feel free to discontinue the interview. If you complete the interview and still have concerns, please note those concerns on the completed assessment before turning it in.

Evaluation of assessment

To improve the 2018 health assessment and the data we collect, we interviewed CHOWs who participated in the 2014 survey for their opinions on the process. We also asked for insight and suggestions on target populations and survey wording from CHOWs who will be administering this survey. As a result of these conversations, we have made a few changes to the survey and process, including the following:

- changed the wording of a couple of other questions.
- developed a brief evaluation form and comment form for evaluators to provide feedback on this year's assessment that we can use to identify challenges this year, and use to improve the next survey.

Yes, we are doing an evaluation of our assessment! Your comments on the process of interviewing respondents to this assessment will help in many ways. This will help us share what you learn with other CHOWs, help you find ways to stay close to our preferred methodology, or suggest new approaches to find respondents. Please keep copies of the evaluation/comment form with you and complete a form whenever you have questions or concerns or unusual situations. This information will help us give you the support you need to succeed with this project. If you are having concerns or problems with any part of the survey, tell us right away!

Use the form to write down your experiences, thoughts, and comments as you progress. Keep them separate from the assessment that generated the comment – you can use one comment sheet for many comments, and you can turn the comments in anonymously if you prefer. Please turn your comments in along with the competed surveys each week. If you prefer to share your observations verbally, please call Nelida before you drop off your completed evaluations so I can chat with you.

We will also use your comments to improve the next survey. We will use your observations to train future assessors – and data crunchers! - on survey administration. Your comments will help them improve their performance and the data we collect. Ultimately, all this will help us improve our services to our community.

Thank YOU! Without you we could not continuously improve our services to our communities!

Survey

Minority Health Program, Public Health Division,
Health and Human Services Department
Community Health Assessment

Please take a moment to complete the survey below. The purpose of this survey is to get your opinions about community health needs in the Greater Portland Area. The City of Portland's Minority Health Program will use the results of this survey to evaluate and address the most pressing needs through community action.
Your participation is voluntary, and all information you share with us on this survey is considered confidential. All information collected in this survey is grouped into a summary and cannot be used to identify individual respondents. Do you have any questions? Do you agree to participate?

For this survey, your community is your age group within your racial/ethnic or language group. Thank you and if you have any questions, please contact us (see contact information on back).
Remember… your opinion is important!

What do we do with the information we collect?
We primarily use the information from this survey to improve our services for you. We also feel that this survey improves our communication with you, your community members and other organizations addressing community health needs.

We use the survey information to

- Determine what community members feel are important health issues
- Find out if different communities want different resources
- Assess whether our current programs are meeting the needs of our community members
- Modify existing programs or develop new programs to address emerging health needs
- Find out where we need to communicate better with other city and private organizations to ensure your health needs are met
- Inform you of existing resources to address your health concerns

We used information gathered in the previous surveys to address identified community health needs with public health solutions; for example:

- Established physical activity programs for the Somali and Latino communities.
- Continued to improve access to needed care by connecting community members with healthcare services and primary care providers. We provide cultural brokering, interpreting services and other healthcare medication and patient navigation.

- Provided annual health screening to identify, educate, counsel and follow-up community members with high blood pressure, diabetes, cholesterol, and oral cancer health issues.
- Enhanced our partnership and collaboration with communities and agencies to better serve our minority communities.
- Instituted disease-specific interventions, like alcohol abuse prevention, a lead prevention awareness campaign, asthma help–lines in Somali and Spanish languages, and Affordable Care Act Helplines in four languages (French, Spanish, Arabic and Somali); and, more.

1. In the following list, what do you think are the three most important factors for a "Healthy Community?" (Those factors which most improve the quality of life in a community.) Check only three:

Good place to raise children
Low crime / safe neighborhoods
Safe
Good schools
Access to health care (e.g., family doctor)
Parks and recreation
Clean environment
Affordable housing
Arts and cultural events

Excellent race relations
Good jobs and healthy economy
Strong family life
Healthy behaviors and lifestyles
Low adult death and disease rates
Low infant deaths
Religious or spiritual values
Other

2. How would rate your community as a "Healthy Community?"
Very unhealthy
Unhealthy
Healthy
Very healthy

3. How would rate your own personal health?

Very unhealthy
Unhealthy
Healthy
Very healthy

4. In the following list, what do you think are the three most important "health problems" in your community? (Those problems which have the greatest impact on overall community health.) Check only three:

Aging problems (e.g., arthritis, hearing/vision loss, injuries etc.)
Firearm-related injuries
Motor vehicle crash
Heart disease and stroke
Cancer
Child abuse / neglect
Dental problems
Diabetes
Diarrheal diseases
Domestic Violence
Hepatitis
High blood pressure
HIV / AIDS
Homicide
Infant Death
Lung disease / asthma
Mental health problems
Rape / sexual assault
Sexually Transmitted Infections (STIs)
Suicide
TB (tuberculosis)
Teenage pregnancy
Other

5. In the following list, what do you think are the three most important "risky behaviors" in your community? (Those behaviors which have the greatest impact on overall community health.) Check only three:

Alcohol abuse
Being overweight/obese
Dropping out of school
Drug abuse
Housing

Job Instability
Lack of physical activity
Not getting vaccinations/"shots" to prevent disease
Not using birth control
Not using seat belts / child safety seats
Poor nutrition
Racism
Stress
Transportation
Tobacco use/vaping
Unsafe sex
Not wearing a bike helmet
Other

6. In the following list, what do you consider to be the three most important "health problems or risky behaviors" for you? Check only three:

Aging
Alcohol use
Heart disease and stroke
Hepatitis
Not using seat belts /child safety seats/Not wearing bike helmet
Being overweight/obese
Cancer
Child abuse / neglect
Dental problems
Diabetes
Diarrheal diseases
Domestic Violence/Abuse
Dropping out of school
Drug use
Gun-related injuries
Housing
Stress
Transportation
Job Stability
Poor eating habits/nutrition
Not using birth control
High blood pressure
HIV / AIDS

Homicide
Infant Death
Lack of exercise
Lung disease/asthma
Mental health problems
Motor vehicle injuries
Not getting "shots"/vaccinations
Rape / sexual assault
Sexually Transmitted Infections (STIs)
Suicidal thoughts
TB (tuberculosis)
Teenage pregnancy
Tobacco use/vaping
Unsafe sex
Other

7b. What services have you used to address these issues in the past year?

7c. What services would you like to have available to address these issues?

7d. Where do you usually get health care?
Doctor's office
Free Clinic
Urgent Care
Emergency Room (ER)
Veterans' Administration
Other
Nowhere

Please answer questions #8-19 so we can see how different types of people feel about local health issues.

8. Country of Origin:
9. No. of years living in U.S.
10. Zip code where you live:
11. Year of birth:

12. Sex/Gender – male, female, transgender

13a.Hispanic Origin yes or no
Hispanic / Latino (specify)

13b. Middle/Near Eastern Origin yes or no

Middle/Near Eastern (specify)

14. Race/Ethnicity/Groups: Please specify all groups you identify with:

Native American
Black/ African American
Asian / Pacific Islander
White / Caucasian
Two or more/Multiracial
Other

15a. Marital Status:

Married
Not married

15b. Household Status:

Cohabitating (ex: roommates, family)
Single/live alone

15c. Number of persons in household

16. Education

Only Primary School
Less than high school
High school diploma or GED
Some College
College degree or higher
Major:_____

17a. In what language(s) can you read or write?

17b. Your preferred language:

18. Household income per year (total of all contributors)

Less than $10,000
$10,000 to $20,000
$20,000 to $29,999
$30,000 to $49,999
Over $50,000

19. Have you enrolled into health insurance through the Affordable Care Act MarketPlace?
Yes__ No__

20. How do you pay for your health care? (check all that apply)

Pay cash (no insurance)
Health insurance (e.g., private insurance, Anthem, MCHO)
Medicaid
Medicare
Uncompensated Care (Maine Med)
Free Care
Veterans' Administration
Indian Health Services
Other

21. Who do you think would be good for me to talk to about these issues?

Date of Interview:
Site of Interview:
Name of person conducting interview:

Interviewer Comments
□ Oral English □ Oral translated□ Self-Administered

C. Feedback from CHOWs on process

CHOW Survey Feedback

The number one concern for every CHOW (17 total) was insufficient compensation. Travel, translation and administering surveys were included in the compensation, but the length of travel throughout Cumberland County, time consuming factors of full complete translations, and the length of the survey concluded to be insufficient compensation. The CHOWs also expressed that the 12 minutes of time allotted per survey was grossly underestimated.
Multiple electronic tablets were made available for the entirety of the survey collection. The only requirement for tablet utilization, besides CHOWs training, was connection to Wi-Fi and access to the survey through the internet. This was extremely problematic and underutilized. Participants were hesitant on sharing their personal Wi-Fi passwords to utilize tablets. They perceived their anonymity would be breached; additionally, there was hesitation of using the tablets for fear of self-identifying.

The physical formatting on the printed copy of the survey was difficult for some CHOWs and participants. CHOWs also expressed a need for proper identification in order to verify their identity and purpose, and ensure trust with participants.

It should be noted that a large percentage of minorities from every community felt uneasy answering two personal identifying questions: their zip code, and their year of birth. Both questions made some participants feel that they were too self-identifying and chose not to disclose the information, or felt uncomfortable in doing so. Some questions asked for health information went against their personal, cultural, or religious beliefs, and as such, were abstained from, in those surveys.

CHOW Participant Feedback

Many sub-populations expressed difficulty in finding participants in the age category of 60+ willing to complete the survey. This specific age demographic was either difficult to find or unwilling to participate. Currently, the United States is undergoing policy changes that affect immigrants, minorities, and asylum seekers. This directly affected the number of survey participants negatively. Many community members shared that they had no previous knowledge of this health assessment and some expressed the need for privacy filling out the assessment, which proved to be difficult in public or community settings. The two demographic categories that were most willing to participate were women and people ages 24- 60.