8

Stats and Maps

In this chapter, *Stats and Maps*, we explore various sources of information that can be helpful to our learning and understanding about culture and diversity. We will examine the roles of epidemiology and human geography and discuss some of the limitations and pitfalls of large-scale data. We explore some of the myths and stereotyped ideas that can interfere with culturally safe practice and attempt to counter some of the misconceptions with an overview of the demographic and health statistics. We also consider the use of maps as sources of information.

Chapter Objectives

After completing this chapter, you should be able to:

- identify sources of demographic and health information
- understand the use of maps as sources of information for understanding health and well-being

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- understand the value and limitations of statistical information in health and human service delivery.

Awareness

We learned earlier in this book about the cyclical nature of the components required for culturally safe practice. One component of culturally safe practice is cultural awareness, including self-awareness. Awareness of differences and also commonalities is essential for culturally safe practice. We already learned about the importance of historical differences between groups of people and how those histories influence contemporary health and well-being and the delivery of health care and other human services. We'll now look at information, such as statistics and maps, that we might access to inform our understanding of disparities in health and well-being. We've also briefly discussed how data only provide us with part of the story.

Culturally safe practice requires ongoing learning. Remember, culturally safe practice does not end at awareness, but is just one part of the process. The more we learn about ourselves and who we are, we gain an appreciation for the complexity and diversity of those in our care. In that spirit, let's explore some sources of information that can help us to understand ourselves and others and how to use that information in culturally safe ways.

Epidemiology and COVID-19

Epidemiology is the field of health and medicine that studies and analyzes health-related conditions and diseases in populations. Epidemiologists study the incidence and prevalence of illnesses and other health-related events. Incidence is the number or rate of new cases while prevalence is the number or rate of an illness or condition in a population at a particular point in time or period of time. For example, during the COVID-19 pandemic, the number of daily new cases reflected the

incidence, while prevalence would reflect the total number of people currently sick with COVID-19.

Website
For a brief history of the beginnings of modern epidemiology, read the story of John Snow provided at the link below. This overview describes how Western medicine has theorized health in the past and that what is commonly accepted today was thought too radical to be believed.

Vachon, D. (n.d.). *Doctor John Snow blames water pollution for cholera epidemic*. UCLA Department of Epidemiology. https://www.ph.ucla.edu/epi/snow/fatherofepidemiology.html.

We can further understand health and illness by looking at the distribution of an illness such as the frequency or locations or other patterns that indicate where an illness is more likely to occur or population groups more at risk. Using COVID-19 as an example again, collecting and analyzing the age, gender, and race of those who got sick was critically important to understand how the virus was spreading and who was more likely to be affected (risk). The elderly and those with pre-existing health conditions were found to be most at risk. Additionally, following cases geographically, informed quarantine and lockdown decisions as a way to help reduce the spread.

While the number of cases and deaths from COVID-19 was attracting a great deal of attention, it became apparent that collecting and reporting on hospitalization numbers was also critical. Most people could test positive for COVID-19 (a case), yet never get sick enough to go to the hospital. While knowing the number of cases lets us know how the virus was spreading, it didn't tell us the whole story. It was also important to know how many people were getting so sick that they required hospitalization so that hospitals could plan and be prepared. The COVID-19 pandemic exposed some of the harshest realities of who we are as a nation and became politically and socially divisive.

The dominance of the biomedical model in our country quickly became more apparent as strategies were swiftly employed to isolate and

quarantine and billions were spent on testing, developing, and delivering a vaccine. The problems with our healthcare system, and the disaster of linking health insurance through employment were quickly apparent as businesses closed down and people lost their jobs and health insurance. As already discussed, the pandemic also exposed weaknesses in housing and education.

With COVID-19 impacting people with pre-existing health conditions, our continued failure to create healthy environments and prevent chronic health conditions was undeniable. At the time of writing, it is still unclear the full damage the epidemic had on our nation, our communities, families, and individuals. We will hopefully learn from the experiences and enact sustainable changes that create a more equitable, healthy society for all.

Life Expectancy

Generally, health status and outcomes for health are measured and determined through a wide range of sources and types of information. For example, life expectancy is a statistic that indicates the number of years a person can expect to live, on average. Disparities, or differences, in life expectancy between various groups can indicate disparities in access to health care, the quality of living and working environments, and indicate inequalities in incomes. Clearly there are a number of factors relevant to understanding this measure, but the important thing to know as professionals (unless you are specializing in life expectancy) is that there are huge disparities in life expectancy between groups.

Reading

See this article for some in-depth exploration of racial and ethnic differences in life expectancy in the U.S.

Cantu, P. A., Hayward, M. D., Hummer, R. A., & Chiu, C. T. (2013). New estimates of racial/ethnic differences in life expectancy with chronic morbidity and functional loss: Evidence from the National

Health Interview Survey. *Journal of Cross-cultural Gerontology, 28*(3), 283–297. https://doi.org/10.1007/s10823-013-9206-5.

Life expectancy is a statistical measure that is often used to assess or compare the health of populations. This can be measured in a few different ways. Life expectancy at birth is probably the most common measure and can be measured by cohort or period. For example, cohort life expectancy takes into consideration that someone born in the 1940s may not have the same life expectancy as someone born in the 1990s. Period life expectancy is the measure commonly used by agencies and organizations. Life expectancy numbers can be used to guide policy and funding decisions as well as planning for care needs.

Activity

Look at this interactive map for life expectancy in the U.S. from the National Center for Health Statistics: https://www.cdc.gov/nchs/data-visualization/life-expectancy/. This map allows the user to drill down to census tract level. Users can also explore data by state and county and enter specific addresses. For example, users can see that in some Census tracts in Delaware County, Pennsylvania, the life expectancy is as low as 67 years, but only a few short miles away, the life expectancy is as high as 86 years, with a state average of 78.6 years. At the state level, we can see that Mississippi has a life expectancy of 74.9, while life expectancy in California is 81.3 years. Within Mississippi, life expectancy is just 59.5 years in Harrison County, and is 26 years higher in Coahoma County at 85.5 years. Explore the map for the statistics on life expectancy in your area. What have you learned about how your area compares to neighboring communities or the state?

But how do we interpret this information? What does it mean when life expectancy is so extremely different among people who live just a few miles from each other?

We can look at life expectancy between groups of people, such as that shown in Fig. 8.1. This figure shows that, overall (on average), women

live longer than men, in any group. We also see a large disparity in life expectancy between groups (on average), with Black Americans living shorter lives and Hispanic American living longer. These large-scale data can be useful in drawing our attention to *something*, but we also need to be mindful that these numbers do not represent a *person*.

Other data and measures for understanding health status and health outcomes are to look at morbidity and mortality (death) rates; self-assessed health; disabilities; low birth weight; maternal mortality rate and other birth and pregnancy outcomes; and various health service information (such as hospitalizations). It is important to recognize that sometimes we have the data to show there are differences between groups, but these data do not necessarily tell us *why* there are differences. It is in the interpretation of the data that we have to be very careful.

So, what do these statistics mean? Why do some groups die earlier than others from the same condition? Are they receiving different, and maybe worse, health care? Why are some babies more likely to die? While it

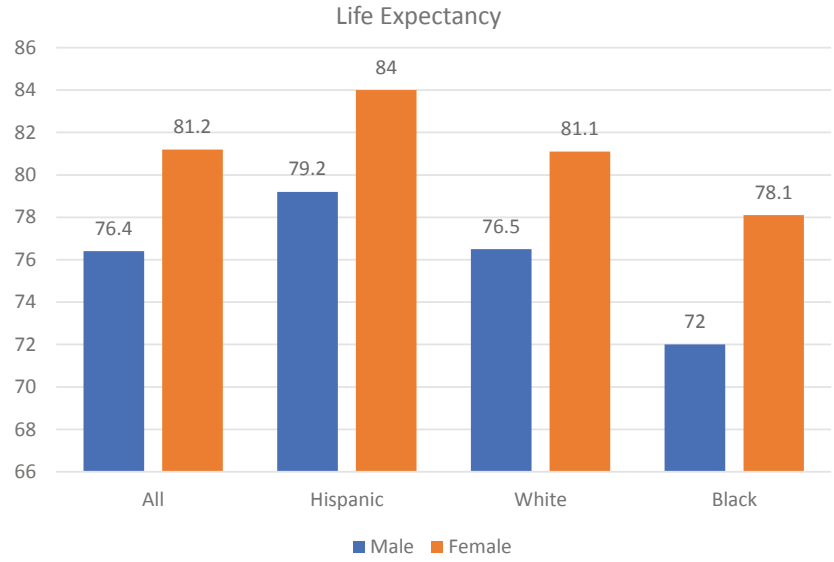

Fig. 8.1 Life expectancy for male and female and White, Black, and Hispanic (*Source* Arias, 2016)

might be desirable to have simple answers to these questions, the reality is that there are no simple answers. Be wary of reports or publications that attempt to simplify the answers down to abstract or generalized conclusions. For example, we might say that higher suicide rates are the result of loss of identity related to loss of land, culture, and traditions. But what does that really mean in practice and how can you, as a professional, do something about it? Similarly, we might say that there are 'barriers to accessing health care', which is why some groups are more likely to die from conditions at a younger age. But what exactly are these barriers and how do we alleviate them?

All of this suggests that while statistics have a valuable role to play in identifying issues of concern, they need to be interrogated to ensure they do not distort the realities on the ground. Also, statistics, even those shared here, need to be used cautiously. Imagine attending a lecture or conference where you and your family were portrayed as likely to die younger, likely to develop a range of chronic diseases, likely to be incarcerated or whatever the interpretation of the data suggested. What impact might that have on your own well-being? Health statistics represent groups of people, and no singular person in particular. When using such information in practice, it is important to be sensitive. A colleague watching a presentation on life expectancies noted his own ethnic group on the graph, and said, 'I should be dead by now. Maybe I should retire'. How might information be shared with individuals and groups in a culturally safe way?

Demographic Profile

While epidemiology specifically focuses on health issues and illnesses, demography is the statistical study of populations in general such as births, deaths, marriages, or various descriptions of the population as a whole; the kind of information collected, analyzed, and reported with the census. Populations can be viewed by age, race or ethnicity, gender, religion, etc.

Human geography is the study of relationships between people and places, such as migration patterns. Having an understanding of human

geography helps us to understand who we are and how we fit in to our local and wider communities, as well as understanding who are the populations we are serving as health and human services professionals.

Activity

Think about some of the characteristics of your own identity. How does who you are fit into the patterns of populations in your area? Before going to the statistics, take a moment to write down your current beliefs about the identities of people who live in your town, county, or state. A good first place to look is the U.S. Census Quick Stats for data on your local area. What have you learned about yourself or the people who make up your communities? Explore various topics for your immediate or larger area. You might want to explore variables such as age, gender, religion, disability, ethnic or racial identity, sexual orientation, and socioeconomic variables such as home ownership, education levels, poverty levels, and employment.

- How do the demographics of your location differ from your state or the overall U.S. population?
- Look at various statistics such as the actual number versus the proportion of the population. What relevance might these numbers have?

Let's look at an example for the American Indian and Alaska Native population. Table 8.1 shows that 1.7% of the U.S. population identified as American Indian or Alaska Native (AI/AN) in the 2010 Census (Census, 2012) and includes 5.2 million people. If you were to allocate funding based on numbers alone, how would this information inform your decisions? Numbers are not always a good indicator of need. What information do we need to make different decisions about allocation of funding or healthcare and human services needs?

Where do you think the majority of the AI/AN population live in the U.S.? Which states do you think have the highest AI/AN population? The numbers alone are not the whole story but are part of the story and may lead to asking more questions. Such as, where are the greatest number of hospitalizations among AI/AN populations? Is this enough

Table 8.1 American Indian and Alaska Native population (alone or in combination) by state and (% of total 2010 state population)

State	AI/AN	State	AI/AN	State	AI/AN
Alabama	57,118 (1.2)	Louisiana	55,079 (1.2)	Oklahoma	482,760 (12.9)
Alaska	138,312 (19.5)	Maine	18,482 (1.4)	Oregon	109,223 (2.9)
Arizona	353,386 (5.5)	Maryland	58,657 (1.0)	Pennsylvania	81,092 (0.6)
Arkansas	47,588 (1.6)	Massachusetts	50,705 (0.8)	Rhode Island	14,394 (1.4)
California	723,225 (1.9)	Michigan	139,095 (1.4)	South Carolina	42,171 (0.9)
Colorado	107,832 (2.1)	Minnesota	101,900 (1.9)	South Dakota	82,073 (10.0)
Connecticut	31,140 (0.9)	Mississippi	25,910 (0.9)	Tennessee	54,874 (0.9)
Delaware	9,899 (1.1)	Missouri	72,376 (1.2)	Texas	315,264 (1.3)
District of Columbia	6,521 (1.0)	Montana	78,601 (7.9)	Utah	50,064 (1.8)
Florida	162,562 (0.9)	Nebraska	29,816 (1.6)	Vermont	7,379 (1.2)
Georgia	84,024 (0.9)	Nevada	55,945 (2.0)	Virginia	80,924 (1.0)
Hawaii	33,470 (2.5)	New Hampshire	10,524 (0.8)	Washington	198,998 (3.0)
Idaho	36,385 (2.3)	New Jersey	70,716 (0.8)	West Virginia	13,314 (0.7)
Illinois	101,451 (0.8)	New Mexico	219,512 (10.7)	Wisconsin	86,228 (1.5)
Indiana	49,738 (0.8)	New York	221,058 (1.1)	Wyoming	18,596 (3.3)
Iowa	24,511 (0.8)	North Carolina	184,082 (1.9)	Puerto Rico	35,753 (1.0)
Kansas	59,130 (2.0)	North Dakota	42,996 (6.4)	Total U.S. alone or in combination	5.2 million (1.7)
Kentucky	31,355 (0.7)	Ohio	90,124 (0.8)	Total U.S. alone	2.9 million (0.9)

Source U.S. Census Bureau (2011, 2012)

now to decide where funding should be allocated? What about those who don't get to access health services, or who don't even get counted in the data collection?

Statistics can answer specific questions such as how many, what proportion, and so on, but more information is needed to interpret and analyze the data. For example, in the report 'Twice Invisible, Understanding rural Native America' (Dewees & Marks, 2017) researchers note that outdated definitions and poor data quality have led to misunderstandings about Native Americans and rural America. Specifically, with their re-analysis of data, they found that the oft-cited information that the majority of Native Americans live in urban areas is wrong and that, in fact, most Native Americans live in rural or small-town areas or in or near reservations.

Activity

- Study the information presented in Table 8.1. What states have the largest numbers of AI/AN by number? What states have the highest proportion of AI/AN? Look at the information for your own state. Were these numbers surprising to you?
- Is there a Federally Recognized Tribe or State Recognized Tribe in your state? Why might this be important? See the National Congress of American Indians website for information and resources about Tribal Recognition in the U.S. https://www.ncai.org/about-tribes.

Urban, Suburban, Rural

As we continue to build our awareness, of self and of others, let's now look at where people live and why and when that might matter as health and human services professionals. Where do people live in the U.S. and how does this impact culture, identity, health behaviors, and healthcare access and outcomes? What could be important for us to understand as health and human services professionals when it comes to these varying contexts?

People living in rural areas in the U.S. generally experience greater health disparities when compared to people living in urban or suburban areas. In general, life expectancy is lower, mortality rates are higher, and diseases and disabilities are higher in rural areas. People in rural areas are more geographically isolated which can mean accessing health care and other services can be much more difficult. Employment and educational opportunities can also be more limited.

Resources
See the Rural Health Information Hub for information about rural health in the U.S. including statistics, how to find statistics, data visualizations and maps: https://www.ruralhealthinfo.org/.

See this Pew Research Center report, May 2018, *What unites and divides urban, suburban and rural communities*: https://www.pewsocialtrends.org/2018/05/22/what-unites-and-divides-urban-suburban-and-rural-communities/.

Table 8.2 shows the geographic distribution of healthcare professionals. Importantly, this table shows that the distribution of the health workforce is not aligned with the distribution of the U.S. population. For example, while 20% of the U.S. population live in rural or remote areas, only 11% of physicians are in those areas. While more primary care professionals are in rural areas compared to specialists, they are still more concentrated in urban areas.

Resources
American Medical Association, *Health Workforce Mapper*: The AMA Health Workforce Mapper is a free, customizable, interactive tool that illustrates the geographic distribution of the health care workforce. https://www.ama-assn.org/about/research/health-workforce-mapper.

Table 8.2 Geographic distribution of healthcare professionals, 2010 (%)

Geography	All specialties			Primary care					U.S. population
	NP	PA	Physicians	NP	PA	Family physicians/GPs	General Internal medicine	General pediatrics	
Urban	84.4	84.4	89.0	72.2	75.1	77.5	89.8	91.2	80
Large rural	8.9	8.8	7.1	11.0	11.7	11.1	6.7	6.2	10
Small rural	3.9	3.8	2.6	7.7	6.9	7.2	2.4	1.8	5
Remote rural/ frontier	2.8	3.0	1.3	9.1	6.3	4.2	1.1	0.8	5

Source Agency for Healthcare Research and Quality (2018)

Film and Website
Watch the documentary *Remote Area Medical* and view their website for information about their work and how to sign up to volunteer: https://www.ramusa.org/.

- What other barriers can you identify that would prevent certain populations from accessing health care?
- What strategies could overcome some of the barriers identified?

Age Distributions

One way we can understand the health and well-being and other social issues for a community is to explore the age distribution within that community. Age is not distributed in the same ways for different groups. Perhaps large families may be more likely in some communities compared to others.

Table 8.3 shows the median age of males and females in various population groups from the 2019 Census Annual Estimates (U.S. Census, 2020). These data show us that the median age for White Americans (39.5) is higher compared to all the other groups and is nearly 10 years higher than for Native Hawaiian/Pacific Islander Americans. Median age can be a useful simple indicator of how youthful a particular population is or how much that population is aging. But we might want to know

Table 8.3 Median age by sex and race in the U.S

	Male	Female	Total
Black	30.6	34.1	32.3
AI/AN	30.5	32.1	31.3
Asian	33.7	36.3	35.0
NHPI	29.1	30.1	29.6
White	38.3	40.8	39.5

Source https://www.census.gov/data/tables/time-series/demo/popest/2010s-national-detail.html (Median age and age by sex, race, and Hispanic origin, 2019. This table shows total race which includes Hispanic for each of the race groups)

more detail about how a population is distributed. For this, we might use population pyramids.

Figure 8.2 depicts the population pyramids showing that there are very different age structures between these selected population groups which include Native Hawaiian/ Pacific Island (NHPI), Asian, American Indian/Alaska Native (AI/AN), Black and White. Schaeffer (2019) shows that the most common age among Whites is 58, which is more than double that for racial and ethnic minorities.

Activity Why Do Population Structures Matter?

- Do you notice anything startling from the population pyramids? Look at the proportion of ages in these populations. Which groups have the most people older than 55 years? Which groups have the least? Which groups have a greater proportion under 24? What impact might these differences have on these populations?

Think about the current age criteria for retirement in the U.S. Generally, this is about 65 years old. If life expectancy for many groups in the U.S. is known to be significantly less than average, how might the criteria for retirement actually disadvantage certain groups, such as those living in poverty? Is there any argument for an adjustment or is equal treatment actually equitable? Are there other age-related policies that you can think of that might lead to inequities given these population variations? How might health and social outcomes be related to these population structures and variations?

Critical Thinking

- Who are the dominant institutions that collect and disseminate population health data?
- What worldview or philosophical perspectives inform the data collection, interpretation, and dissemination?
- How do the data and information we have access to paint a deficit picture of certain groups?

Fig. 8.2 Population pyramids for Native Hawaiian and Pacific Islanders (NHPI), Asian, AI/AN, Black and White males and females in the U.S.

- How could that information and data potentially conceal understanding of wellness and well-being from the perspective of other worldviews?

Maps

Data visualizations, GIS or Geographic Information Systems, and other maps can show us much more than where places are or help us to navigate from place A to place B. Maps tell stories. They can provide us with information in a picture that helps us to see the information in a whole new way. Maps can show us where people have lived in the past and where they live now. Over time, we can see how and when people move from place to place and get a better understanding of migration, identity, and many health or psychology concerns such as illness, jobs, housing, culture, education and much, much more. Maps can help us to 'see' information in ways that have an entirely different impact on our perceptions and understanding than when presented in a table or other graphs.

We can see the diversity of the U.S. by looking at maps or data visualizations of Native identity, birthplaces, racial, or cultural identities. For example, explore this map from the *Washington Post* showing the most common ancestry group for each county in the U.S. https://www.washingtonpost.com/blogs/govbeat/wp/2014/04/18/ethnic-america-mapped-your-countys-biggest-ancestral-populations/.

What is the most common ancestry group in the county where you live? Did that surprise you? Where do some of your ancestors come from? Do they appear on this map?

Most people have multiple ancestries. If you had to choose only one, how do you choose to identify? If your ancestry does not appear, what might that indicate? As with most information, when we start to look more closely, we might find that we have even more questions and questions that we didn't even realize were questions.

Statisticians are constantly having to make decisions about what information to include or exclude and how to categorize or summarize data

so that it makes sense. We also might wonder about the quality of the data. We are assuming that everyone who answers ancestry questions are answering 'honestly' or 'truthfully', but have you ever had the experience of changing how you might answer questions about identity? Maybe in some contexts you provide certain answers, but in other contexts, you provide a different answer. That doesn't mean that you were dishonest. To create an ancestry map such as the one above, people had to answer questions about ancestry. Many things can influence how a person answers those questions as discussed in the chapter about history. There have been many groups throughout history that have been discriminated against and would therefore have good reasons to change the ancestry they identify with, if at all possible. Keep in mind as a health or human services professional that some clients may well hesitate to answer such questions due to these histories and even current political or other issues.

Websites

Here are a number of websites with various forms of data visualization and maps that tell a story about significant events that have shaped our country and therefore the health or ill-health of our people, particularly Black and Indigenous people. For example, in the History chapter we talked about the history of segregation, but have you thought about how segregation might look today? What other maps or data visualizations can you find for health or population issues of interest to you?

Here are some maps showing segregation and integration and diversity:

- University of Iowa, *Placing Segregation* project, Explores spatial patterns of residential segregation in Washington, DC, Omaha Nebraska, and Nashville Tennessee: https://dsps.lib.uiowa.edu/placingsegregation/.
- University of Virginia, Racial Dot map of the 2010 census: https://demographics.coopercenter.org/racial-dot-map.
- National Geographic race, ethnicity, diversity in the U.S. interactive map: https://www.nationalgeographic.com/magazine/2018/10/diversity-race-ethnicity-united-states-america-interactive-map/.

- *Washington Post*: Segregation in U.S. Cities interactive map: https://www.washingtonpost.com/graphics/2018/national/segregation-us-cities/.

The following are a few maps and resources relating to historical events such as slavery, emancipation, and lynching.

- These maps from the *Smithsonian Magazine* show how slavery expanded across the United States. https://www.smithsonianmag.com/history/maps-reveal-slavery-expanded-across-united-states-180951452/.
- *Civil War Washington* examines the U.S. national capital from multiple perspectives as a case study of social, political, cultural, and medical/scientific transitions provoked or accelerated by the Civil War. The project draws on the methods of many fields to create a digital resource that chronicles the war's impact on the city. https://civilwardc.org/.
- The University of Richmond in Virginia created the *Visualizing Emancipation* website that explores the more complicated process of emancipation through a series of events and interactions between federal policies, armies in the field and actions of enslaved men and women. https://dsl.richmond.edu/emancipation/.
- *Lynching in America* is a project by the Equal Justice Initiative https://lynchinginamerica.eji.org/. This website includes stories, videos and interactive maps about the 4,000 lynchings in the U.S. between 1877 and 1950 and the Great Migration.
- *Mapping the Stacks*, http://mts.lib.uchicago.edu/ is a University of Chicago project that aims to identify and organize uncatalogued archival collections that chronicle Black Chicago between the 1930s and 1970s, in order to increase their use by researchers and the general public. The project includes various kinds of artifacts: literary manuscripts and visual illustrations; rare books and home movies; correspondence and photographs; ephemera and tape-recorded sound.
- The University of Delaware, *The Colored Conventions Project* is a collaborative project that brings nineteenth-century Black organizing to digital life through convention records and exhibits. https://coloredconventions.org/.

Below is a list of maps relating to Native American diversity and languages.

- Wang, H. L. (2014). *The map of Native American tribes you've never seen before*. NPR. https://www.npr.org/sections/codeswitch/2014/06/24/323665644/the-map-of-native-american-tribes-youve-never-seen-before.
- Sturtevant, W. C., & U. S. Geological Survey. (1967). *National atlas. Indian tribes, cultures & languages: United States*. Reston, VA: Interior, Geological Survey. [Map] Library of Congress. https://www.loc.gov/item/95682185/.
- *Native Lands*, crowd-sourced global interactive map: https://native-land.ca/. Check out your location on this map to find out the Indigenous groups for the land that you live on.
- 1881 Map of Linguistic Stocks of American Indians Library of Congress https://www.loc.gov/item/2001620496/. This map is an interesting look at the diversity of Indigenous languages.

Below are a few maps relating to religions in the U.S.

- The Religious States of American in 22 Maps, *The Washington Post*. https://www.washingtonpost.com/blogs/govbeat/wp/2015/02/26/the-religious-states-of-america-in-22-maps/.
- The Pew Research Center has an interactive map for religions in the U.S. https://www.pewforum.org/religious-landscape-study/.

This *Smithsonian Magazine* map shows queer geography over time in the U.S.

- *Smithsonian Magazine*, this interactive map visualizes the Queer geography of the 20th Century; *Mapping the Gay Guides* visualizes local queer spaces' evolution between 1965 and 1980. https://www.smithsonianmag.com/history/interactive-map-visualizes-queer-geography-20th-century-america-180974306/.

Critical Thinking About the Statistics: Identity

The categories of 'race' and ethnicity have gone through many changes. For example, the 'one drop rule' or the 'one Black ancestor rule' implied that if a person had even 'one drop' of Black ancestry they would be identified as Black. This 'rule' was able to be exploited by plantation owners or others looking to maintain high numbers of those they enslaved. Different states at various times altered or modified the requirements for Black identification also showing how random and unscientific the notion was. But ask yourself this: if your identity, as indicated by checking a box on a form, could result in enslavement on the one hand, or freedom on the other, which box would you check, if you could?

On the other hand, Native American identity has been (and continues to be) subjected to the opposite rule. That is, minimum 'blood quantums' are required to be legally considered Native American and to gain membership in various tribes (and therefore, access to various resources). Why might minimum blood quantums be required for Native American identity (with increasing requirements over time), but the opposite true for Black Americans (albeit, in the past)?

Rarely is identity ever fixed in neat categories. Look at the example of the Native American Freedmen. Early in the 1800s, some Black Africans were enslaved by Native American groups in the south such as the Cherokee, or had escaped slavery and joined other groups, such as the Seminole. During the movement west with the Trail of Tears, these Black Africans traveled with the Native tribes on the Trail of Tears to places such as Oklahoma. After the Civil War and emancipation, the citizenship of these groups came under scrutiny and has been contested ever since.

Resources

Healy, J. (2020, September 8). Black, Native American and fighting for recognition in Indian Country. *The New York Times*. https://www.nytimes.com/2020/09/08/us/enslaved-people-native-americans-oklahoma.html.

Film: *By Blood*. (2015). Marcos Barbery and Sam Russell. This film tells the story of the 'freedmen'—African Americans who trace their lineage to freed slaves who became members of various tribes, including the Seminole and Cherokee Nation. The Cherokee and Seminole Nations, 150 years later, now wealthy tribes with land, casinos and business holdings, continue to deny tribal rights to Freedmen descendants arguing that they are not members of their tribe 'by blood'.

See the below articles for updates on the controversies relating to the Freedmen:

Healy, J. (2020, September 8). Black, Native American and fighting for recognition in Indian Country. *The New York Times*. https://www.nytimes.com/2020/09/08/us/enslaved-people-native-americans-oklahoma.html.

Walker, M. (2021, February 24). Cherokee Nation addresses bias against descendents of enslaved people. *The New York Times*. https://www.nytimes.com/2021/02/24/us/politics/cherokee-nation-black-freedmen.html.

Currently, most of the data available about the Indigenous population in the U.S. are limited to the categories of American Indian and Alaska Native (AI/AN). Sometimes Native Hawaiian and Pacific Islanders are put into a category together, and sometimes those groups are included within the Asian category. As we have already described, AI/AN refers to a person having origins in any of the original people of North or South America (including Central America) and who maintains tribal affiliation or community attachment (U.S. Office of Management and Budget, 1997). In the 2010 Census, 2,932,248 identified as AI/AN 'alone' and 5.2 million identified as AI/AN alone or 'in combination' with other race or ethnic identities. Racial or ethnic identity in the U.S. Census is self-selected, so anyone can choose to put anything they want on the census forms.

The Hispanic ethnicity category makes identity even more complicated as viewed through data sources such as the Census (see Cohn, 2010). Overall, our point here is that rarely does identity fall into neat categories of 'Black', 'White', 'Native American', or any other identity. While we have used racial and ethnic identity as examples in this section,

we could just as well have discussed the complexities of other identities such as gender or sexualities, religion, or disabilities.

Revisiting Identity, Languages

In healthcare and human services work, we often are required to ask our clients their racial or ethnic identity. For culturally safe practice, it's important to consider how you ask these questions. Sometimes, it might be culturally safe to explain first why you are asking particular questions. If an individual's response could have resulted in a loss of rights, deemed illegal or immoral or any other imposed judgment experienced in the past, the seemingly harmless question asked by professionals today could trigger mistrust or anxiety for some people.

Throughout this book, we have talked about the complexity of the Indigenous populations and the terms used to describe them. Is 'Indigenous', as a category, adequate to understand the 'Indigenous' population in the U.S? Look at the map above of languages of Native America. There were originally hundreds of Indigenous languages in the U.S. with less than 200 Native languages spoken today. In California alone there have been 64 distinct languages (California Department of Parks and Recreation, n.d.). Each language group has its own culture—its own traditions, rituals, and beliefs. While there may be overlap, overall, what this shows us is that the 'Indigenous' population is diverse and has evolved over time. What you might learn or understand about people in New York, for example, may not necessarily apply to people in Chicago or Tulsa.

Reading
Hinton, L. (1994). *Flutes of fire: Essays on California Indian languages*. Berkeley, CA: Heyday Books.

There are over 350 different languages spoken in homes in the U.S. (U.S. Census, 2015) and what those languages are can be very different

depending on what city you are looking at. For example, 38% of homes in the New York metro area speak a language other than English at home. In Los Angeles, it's 54% and around 15% in Philadelphia. Most cities have well over 100 different languages spoken at home. This diversity of languages, within and between cities and regions in the U.S., is just one example that illustrates the importance of 'keeping it local', which we discuss often throughout this book and is important to constantly keep in mind. How might knowing that there is so much language diversity in the U.S. and possibly in your local area influence how you practice in more culturally safe ways?

Reading

Below is the abstract from a paper that explored Appalachian identity. Geographic residence in the U.S. can be a strong aspect of identity such as for those who live in areas described as Appalachia. As with many identities, stigmas associated with this identity can influence self-identification and health and well-being.

Krok-Schoen, J. L., Palmer-Wackerly, A. L., Dailey, P. M., & Krieger, J. L. (2015). The conceptualization of self-identity among residents of Appalachia Ohio. *Journal of Appalachian Studies, 21*(2), 229–246.

Abstract: Social identity and its association to culture, place, and health is an important, but understudied, area of research. One social group that illustrates this connection between place and identity is people living in Appalachia. This exploratory mixed-method study investigates the appropriateness of the self-concept of Ohio Appalachian adults with cancer as 'Appalachian', the context associated with that identity and its association with community identification, rural identity, Appalachian Regional Commission (ARC) status, demographic data, and clinical trial (CT) enrollment. Forty-nine adults with cancer residing in Appalachia were recruited. Participants were cancer patients who (1) were offered a randomized clinical cancer trial; and (2) lived in or were treated in one of the thirty-two rural Appalachian counties in Ohio. Forty-seven percent of participants identified themselves as Appalachian and were reluctant to self-identify as Appalachian because of negative stereotypes or uncertainty about the term. Furthermore, many participants endorsed their residence within Appalachia but not their own identity. Future studies should

utilize a culturally grounded approach and community-based methodology to explore how residents of Appalachian communities define their community and self-identification in order to improve health in the region.

Making It Local

- How are various population groups in your area presented in the media?
- Are there different media outlets for different groups or communities? For example, are there newspapers, radio stations, or Facebook groups for specific groups in your area?

In addition to statistics, maps, health data and information, television, news, movies, and literature can all provide ways for us to increase our awareness and sensitivity to cultural differences. What can you find for other groups within your community?

Conclusion

In this chapter we provided a wide range of data and information to think about when learning about health in the U.S. It is important to be careful interpreting statistics which, while useful, must be examined in conjunction with other sources of 'evidence'. Population structures, demographic mapping, languages, and other data show some stark differences that should be considered when setting up and delivering health services. All of the statistics presented in this chapter relate to real people. While the numbers may be important for health and human services professionals, the lived experiences gives insights that the statistics cannot provide.

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