

ASIAN AMERICAN
AND PACIFIC ISLANDER
WORKSHOPS
SUMMARY REPORT
ON CARDIOVASCULAR
HEALTH



The Asian American and Pacific Islander Workshops Summary Report present recommendations from the Asian American and Pacific Islander (AAPI) strategy development workshops in Molokai, Hawaii and San Francisco, California. The strategy development workshops provided a forum for health care professionals, community advocates, educators, and consumers about effective models to identify culturally appropriate approaches to improve heart health for AAPIs. The report provides a National AAPI Cardiovascular Health Action Plan, description of the workshop agenda, a list of discussion questions used to engage participants in exploring the needs and opportunities for cardiovascular health promotion in AAPI communities. For the purpose of this database, this report has been shortened to consist only of sections with formative research findings, specifically Appendix A and B. Appendix A contains findings from key informant interviews on effective outreach activities from a limited sample of community-based organizations across the country. Appendix B contains findings from ethnographic interviews on AAPI cultural perceptions and values related to physical activity and food habits. The full report is available at:
http://www.nhlbi.nih.gov/health/prof/heart/other/aapi_sum.htm.

APPENDIX A

GATHERING COMMUNITY INPUT—KEY INFORMANT INTERVIEWS

In preparation of the workshop, key informant and ethnographic interviews were conducted. Asian American and Pacific Islander CBOs fill a critical void for AAPI populations in terms of providing a regular and accessible source of health information and resources. Specifically, these CBOs provide access to bicultural and bilingual health providers, proximity to the target community, and an environment that the community trusts.

BACKGROUND

Socioeconomic (i.e., poverty, unemployment, lack of health insurance, education) and cultural factors (i.e., language, cultural beliefs, immigration status) play crucial roles in influencing access to health care among different ethnic groups (Mayeno and Hirota 1994). Given the diversity of ethnic populations that comprise AAPIs, “researchers, policy-makers, case workers, and health workers need to be mindful of differences in languages and cultures reflecting not only more than 30 different subgroups, but also generational differences” (DHHS, May 1998). Therefore, the need for culturally competent and linguistically appropriate services is a top priority for improving the health of AAPI communities.

To identify elements of successful health promotion/disease prevention outreach strategies, the API-AHF conducted key informant interviews with a cross section of the Nation’s community-based organizations. While it cannot be concluded that the opinions, experiences, and recommendations of the key informants are representative of all CBOs serving AAPI communities, their breadth of experience in improving the health of their communities sheds light on the complexities involved in developing effective health promotion/disease prevention outreach strategies and the myriad of cultural factors which may prevent the AAPI communities from securing improved health outcomes.

Achieving the President’s goal of “eliminating racial and ethnic disparities in health requires a major national commitment to identify and address the underlying causes of disease and disability in racial and ethnic minority communities. These include poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the need for effective prevention programs tailored to specific community needs”

(U.S. DHHS, 1998).

THE APPROACH

A total of 85 CBOs were invited to participate in phone interviews to identify and discuss community-based outreach strategies which they have found to be effective for health promotion and disease prevention within their respective AAPI communities. They were chosen based on agency longevity, geographic location, and AAPI target group representation. A total of 29 CBOs (35 percent) responded to the invitation. The semistructured interview questionnaire included open-ended questions regarding their target community’s general health concerns, cardiovascular risk factors, effective strategies used to reach their target population with health promotion messages, barriers their target population faces in accessing preventative health services, and strategies they use to address such barriers.

PARTICIPANT PROFILE

These individuals represent CBOs of various geographic areas, with varied access to culturally appropriate communication resources, serving AAPI communities of varied income levels, education, age, and immigration status. They have in common, however, their family-oriented empowerment philosophies for improving the health of their communities.

They are nurses, medical doctors, social workers, and outreach workers representing 13 AAPI ethnic subgroups (Afghan, Cambodian, Chamorro, Chinese, Filipino, Hmong, Japanese, Khmer, Korean, Laotian, Samoan, South Asian and Vietnamese) and 13 states (California, Colorado, Connecticut, Georgia, Illinois, Minnesota, New Jersey, New York, Ohio, Pennsylvania, Texas, Washington, and Washington, D.C.). Among these, California, New York, Texas, New Jersey, Illinois, and Washington D.C. are among the states with the highest AAPI populations (please note that CBOs from the State of Hawai`i, which includes more than 8 percent of the Nation's AAPI population, were not included in this project).

FINDINGS

Almost 30 percent of respondents identified CVD or one of its risk factors as the major health concern of their community:

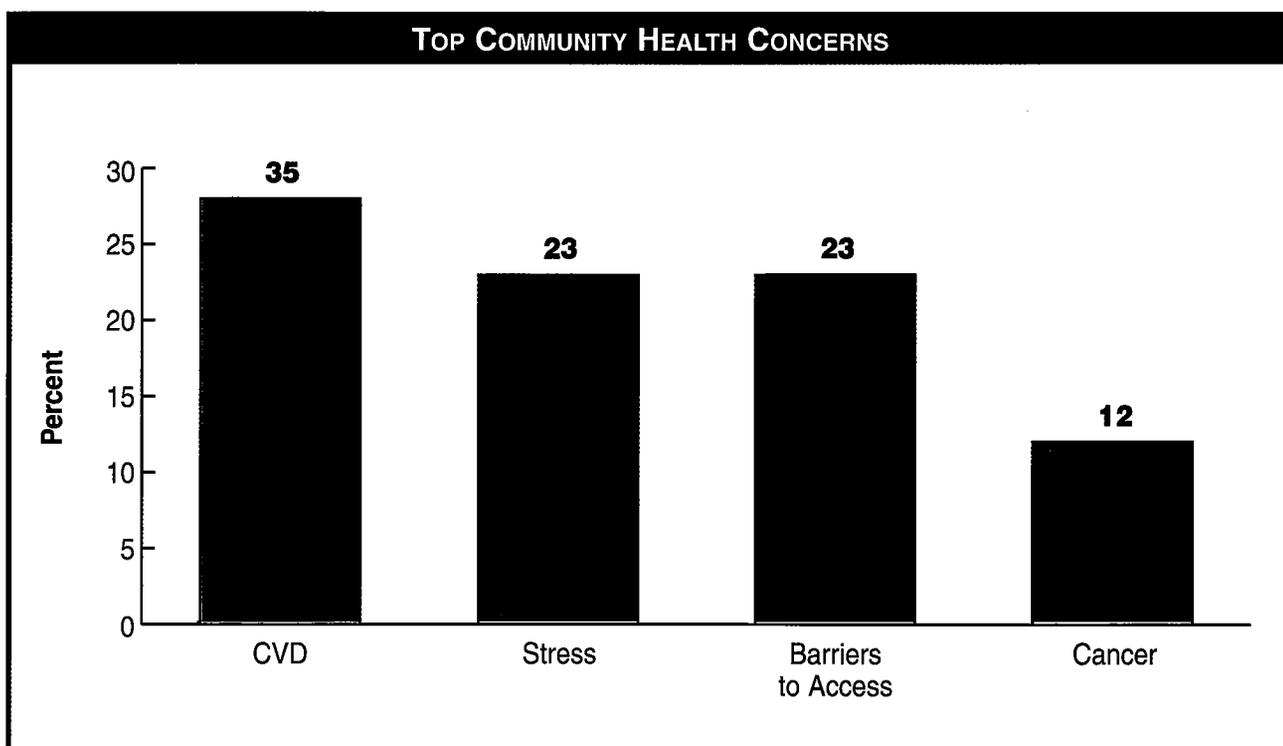
“Almost 70 percent of Samoans in Seattle have diabetes,” Washington-based health educator.

“Hypertension and diabetes are the top health problems of the elderly Asians in San Francisco,” California-based health advocate.

“With Korean, Chinese and Vietnamese youth, smoking is a very serious problem,” Georgia-based health educator.

Almost a quarter identified stress, depression, or anxiety as a major health concern in their community. Respondents working with refugee groups or recently arrived immigrants noted how the stress and anxiety related to transitioning into a new culture are burdens to their communities:

“Anxiety from immigration status and poverty are the main issues affecting our community's health,” New York-based health educator.



“Almost 70 percent of Samoans in Seattle have diabetes.”

Washington-based health educator

“Stress and depression from unemployment, poor housing, and isolation due to language barriers are seriously affecting the Afghan community’s health,” California-based health educator.

Those working with refugee survivors of war note more severe anxiety-induced health problems, such as premature aging, which adversely affects all other health conditions. For example, a Connecticut-based nurse who works with Cambodian and Khmer survivors of war said that due to traumas associated with war, *“about 75 percent of the Cambodian community is a high risk group suffering from severe anxiety, high blood pressure, and mental health problems.”*

Although the majority of this population has lived in the United States for over 15 years, she notes that *“research on trauma survivors shows that the longer they’re in a country, the more problems they have due to premature aging making them feel like a 65-year-old when they’re only 40.”* This, in turn, increases their anxiety levels because they have more difficulties dealing with their young children and other life stressors.

Almost a quarter (23 percent) identified the myriad of cultural, economical, and logistical barriers

“About 75 percent of the Cambodian community here is at high risk, suffering from severe anxiety, high blood pressure, and mental health problems.”

Connecticut-based community activist

which prevent their communities from accessing preventative health care as the major health concern of their community:

“We’re not used to having open dialogues about health issues,” Samoan community health educator based in Southern California.

“Language is a serious issue for the recent Chinese and Vietnamese immigrants and refugees, and it’s preventing them from using preventative health services,” Texas-based community outreach worker.

Almost half of all respondents identified high blood pressure/hypertension (24 percent) or tobacco use/exposure (24 percent) as the major cardiovascular-related health concerns in their communities:

“New immigrants and the older generation are heavy smokers, and that’s severely affecting their heart,” Texas-based health educator.

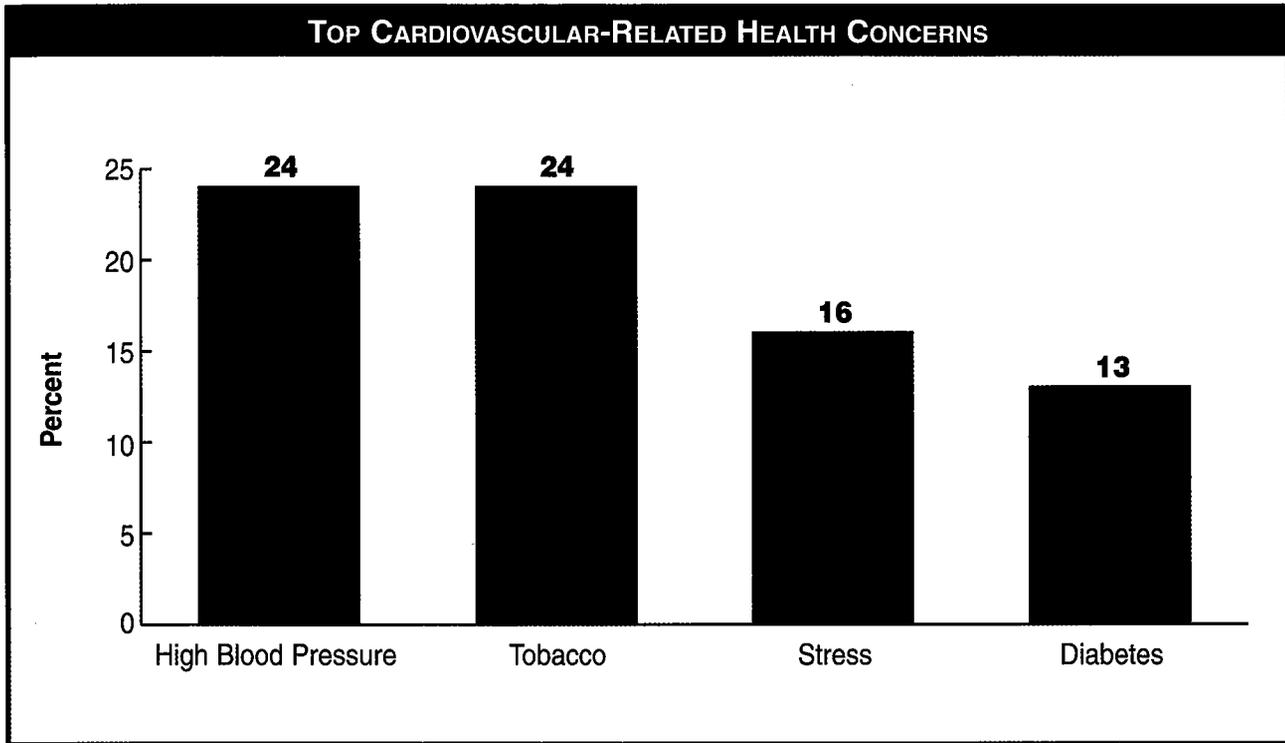
“Heart attacks are a serious health problem of the Afghan community, and they’re caused mainly by the community’s high blood pressure and smoking,” California-based community activist.

Stress, anxiety, depression, and the psychosomatic illnesses caused by such conditions were identified by 16 percent of respondents as the serious risk factors affecting the cardiovascular health of their communities:

“High blood pressure is the number one risk factor in the Korean community here in Chicago, and I think it’s because they have too much stress in their lives from working too much,” Korean health educator.

“South Asian women in New York are under tremendous stress and suffer from depression because of adjustments to a new life here, immigration problems, and domestic violence. All this stress severely affects their heart conditions,” New York-based health educator.

“There are people who don’t leave the house because their anxiety level is too high,” Connecticut-based health educator.



Diabetes was identified by 13 percent of respondents (mainly those who serve Southeast Asian, Chinese, Chamorro, Filipino, Japanese, and Samoan populations) as a major cardiovascular-related health concern in their community.

The use of all available multimedia channels of communication was identified by the majority of respondents as a top outreach strategy. They include talk shows and public service announcements on local ethnic radio and television stations, articles and advertisements in local ethnic newspapers, and health education pamphlets or posters used in conjunction with health education classes.

Radio and television talk shows were rated as very effective because they reached a high proportion of the target community and provided a means to ask health-related questions anonymously. However, because of the higher cost of producing television shows, radio was noted as the more feasible alternative. Advertisements and health-related articles in local ethnic newspapers were widely used as effective outreach strategies:

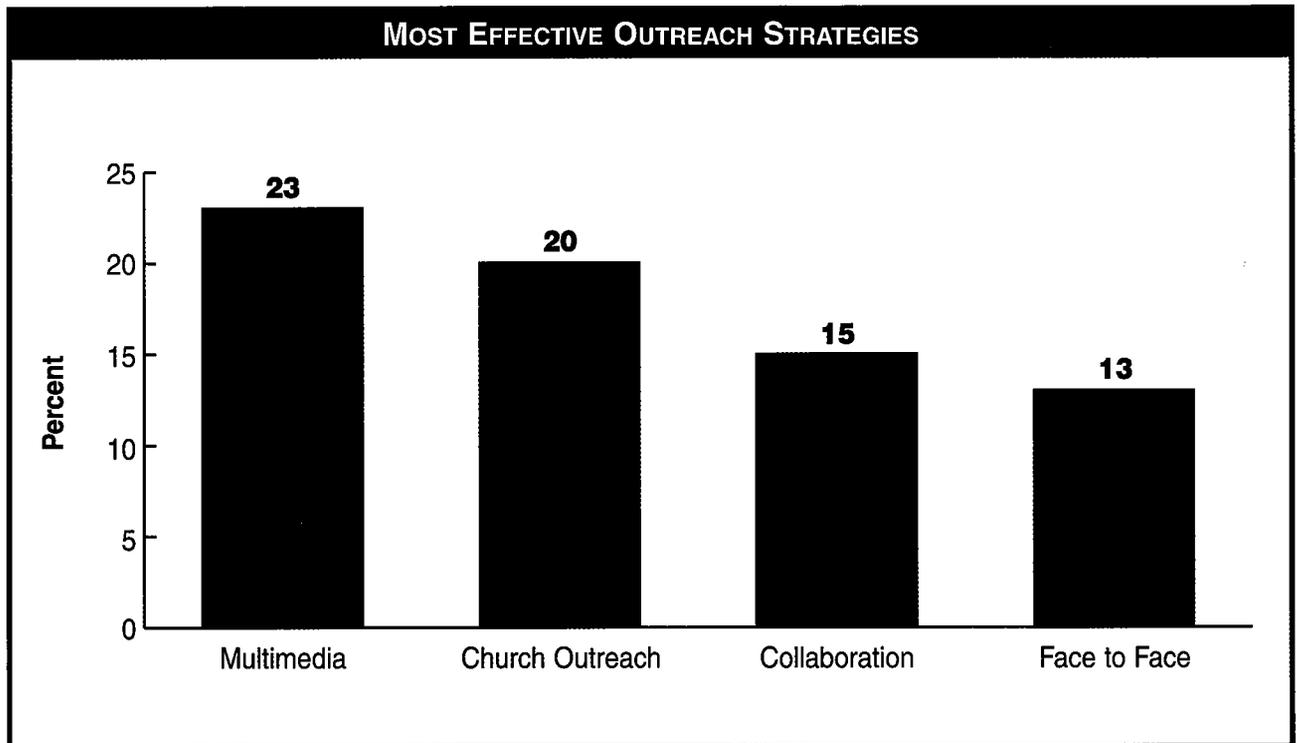
"We send out press releases to Japanese newspapers, radios, and television. Our community is so isolated because of language."

"Tobacco is a major contributor to the four leading causes of premature death in San Francisco."

San Francisco Department of Public Health, 1998

"Native Hawaiians are twice as likely to be diagnosed with diabetes than whites."

Hawai'i Diabetes Control Program



So, this is really the best way we can let them know about preventative health issues,” California-based Japanese health educator.

“Radio and newspapers are our best strategies in making sure our community knows about the importance of preventative health care and our clinic. We have weekly radio health programs in Cantonese. Also, Chinese people read lots of Chinese newspapers,” New York Chinatown health educator.

“Koreans read lots of Korean newspapers and listen a lot to Korean TV news programs, so those are great ways to make sure they hear or read about health issues,” California-based health educator.

The majority stressed the importance of establishing trust with the community as the key to ensuring the success of any health promotion strategy.

The use of health education videos was identified as a potentially effective way of reaching AAPIs either by incorporating them in the beginning of Asian movie videos or using them in conjunction with health education classes. The use of computers and the Internet as a possible means of disseminating culturally and linguistically relevant health education materials was suggested by many respondents, especially those who live in areas with limited AAPI media resources.

Over 30 percent said there are no local ethnic radio or television programs available in their geographic region. These respondents serve the Asian American populations in Colorado, Georgia, Connecticut, New Jersey, Ohio, and Pennsylvania; and Pacific Islander populations in California and Washington:

“The Midwest is an English-only world; we need access to linguistic resources,” Ohio health provider.

“The use of ethnic media channels needs serious exploration. It’s a non-obtrusive way for the community to hear about health,” Ohio-based educator.

Thirty five percent identified outreach to places of congregation (20 percent) and collaboration with community leaders (15 percent) as a top health promotion strategy:

“Hmong people go to their clan leaders first. There are over 18 clan leaders, so we must educate them first,” California-based Hmong health educator.

“There are over 40 Samoan churches in Seattle, and we have to first convince the pastors of the importance of health issues and have them announce our programs at their church. The people really listen to pastors,” Samoan health educator in Washington.

“Our Laotian clients are afraid of leaving their houses. So, we send our outreach workers to their homes to educate them about health issues. They’ll open their homes to us only if they’ve heard of us through word of mouth,” California-based health educator.

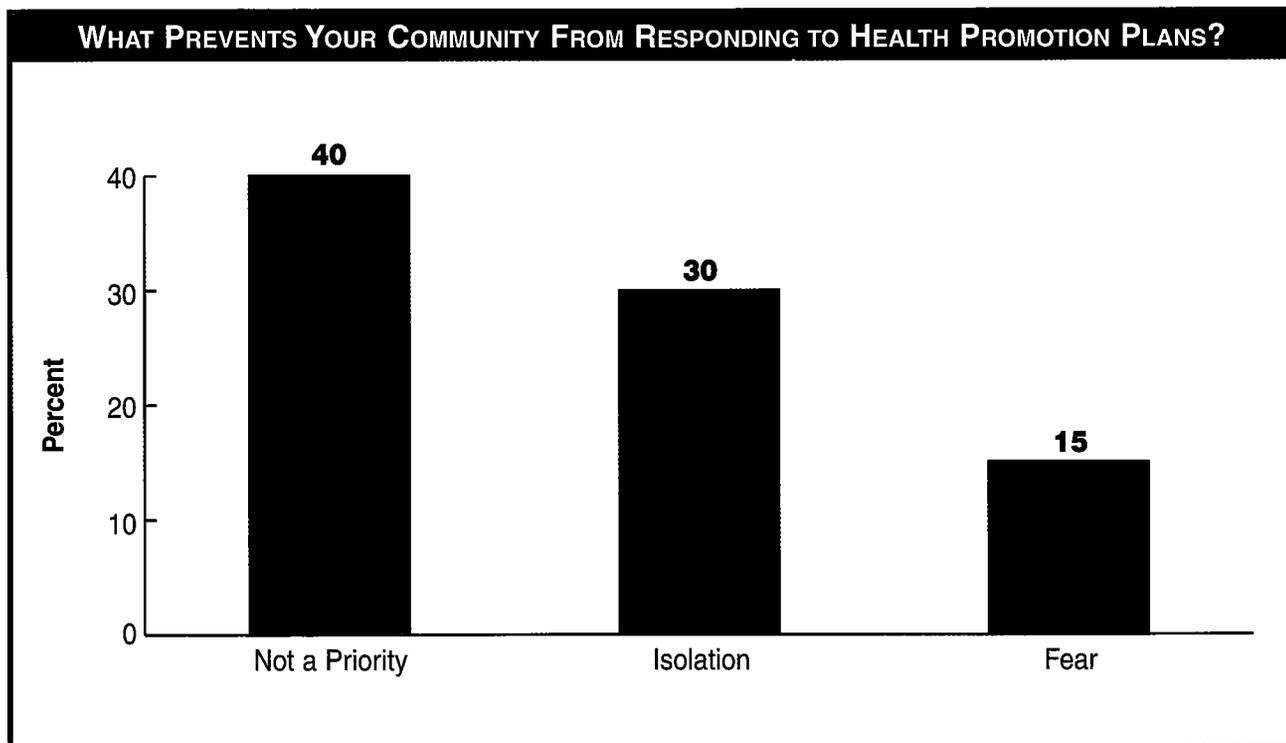
Almost 40 percent said preventative health care is not a priority to their community or that their community is busy with many other responsibilities and do not access health services until a serious health condition arises.

“Refugees and recent immigrants are too busy trying to survive daily life to think about preventive health care.”

Texas-based health educator

In educating low income Vietnamese women in California about breast and cervical cancer screening, a health educator noted that the women *“don’t think they’re at risk of any serious problems because they don’t have the symptoms yet.”* A Texas-based health educator said the refugees and recent immigrants *“are too busy trying to survive daily life to think about preventative health care.”*

Almost one-third (30 percent) identified isolation of their community due to language barriers, transportation, or mistrust of other Asian populations as the main barriers to accessing preventative health services:



“Those from traditional backgrounds have a certain pride in not receiving any free services from an outside group, so we have to educate peer educators to tell them to use our services and listen to our health education classes.”

California-based health educator

“The recent immigrants are really suspicious of strangers, and because of historical roots certain Asian communities don’t even trust other Asians,” Texas-based health educator.

Fear or superstition toward Western-style preventative/screening health services was reported by 15 percent of the respondents:

“Many of the Asians we work with don’t trust Western-style medicine or Western health providers,” Pennsylvania-based health educator.

“Many don’t think about getting sick because they believe talking about it is bad luck,” Ohio-based health educator.

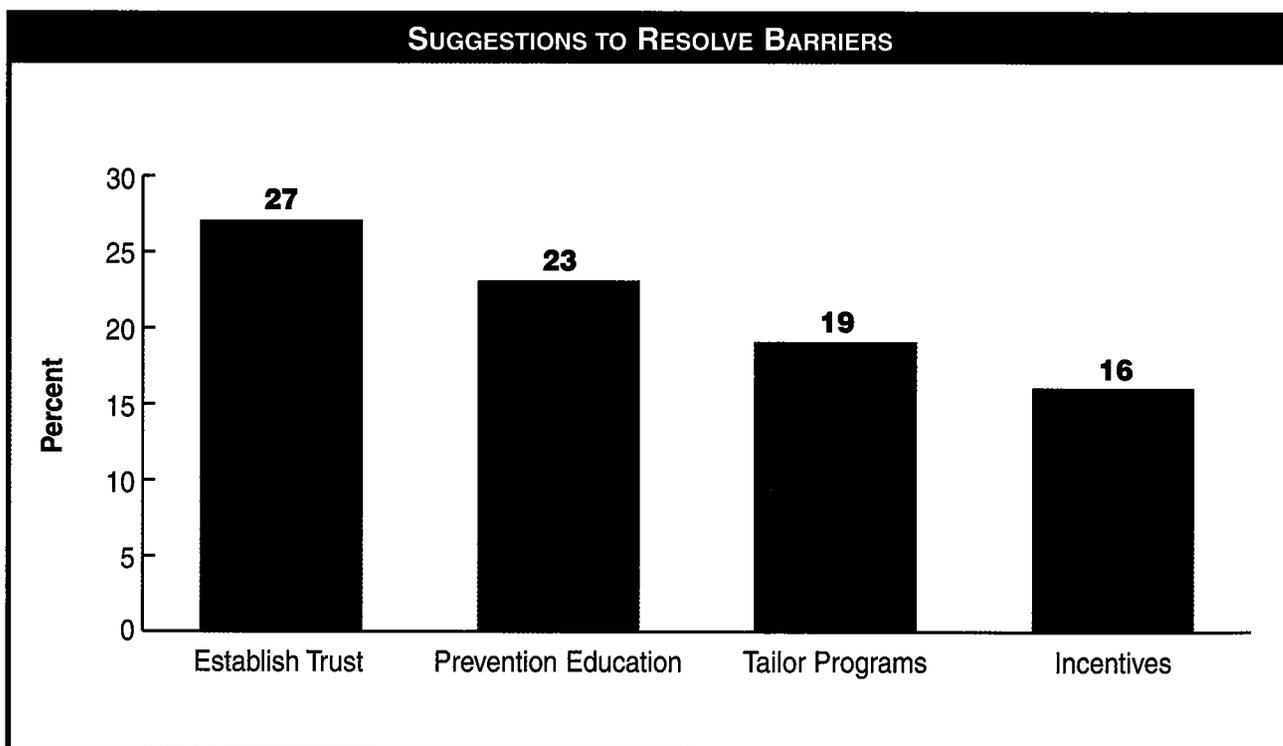
Almost 10 percent suggested feelings of shame or denial of health problem as the barrier which keeps their community from accessing preventative health services:

“The Samoans are very private people, so they’re ashamed to admit their health problems,” Washington-based Samoan health educator.

The theme of establishing trust with the community was voiced by most respondents as the way to remove barriers to health care access through community involvement in program planning:

“The community must really feel like they own the program, so we get them involved in the planning and advertising,” New Jersey-based health educator.

Almost 20 percent said tailoring health education programs to include topics of interest to the community is essential in removing barriers to preventative health care access:



“The concept of preventive care as defined in Western medicine, which usually includes a physical exam in the absence of symptoms, often does not fit many AAPI’s understanding of health and their explanatory models of illness.”

Addressing Cardiovascular Health in Asian Americans and Pacific Islanders: A Background Report, NIH Publication No. 00-3647

“We try to contextualize health issues into major community concerns like immigration issues,” New York-based South Asian health educator.

Almost a quarter of respondents (23 percent) identified education of family members and the community about the benefits of preventative/screening

services as important in removing barriers to access:

“Sometimes they’re so afraid of screening services that we have to reassure them that it’s not painful and it’s free—it’s best done through word of mouth from people who trust and know us,” California-based Japanese health educator.

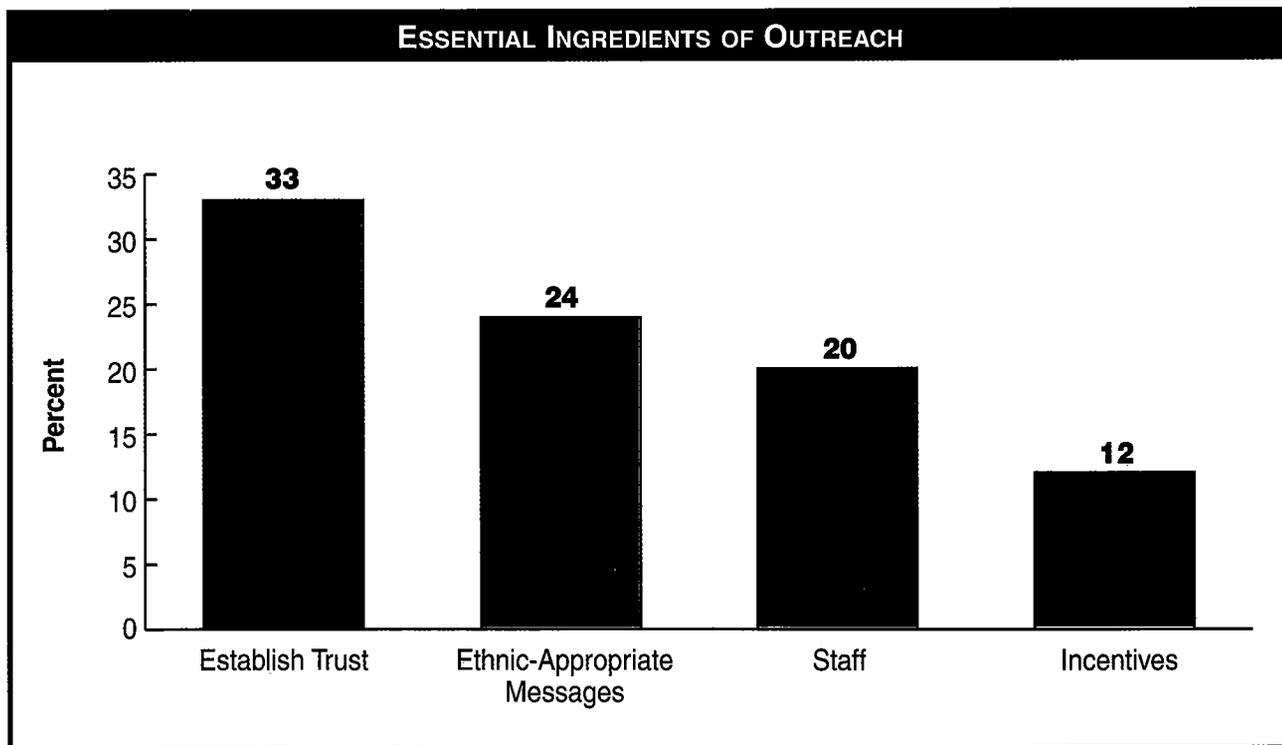
“Talk shows on the radio or local television with experts is a good way to make them take preventative health care more seriously,” California-based health educator.

Providing interpreters and incentives (food, money, transportation, entertainment, etc.) was identified by 16 percent of respondents as key to improving access to preventative health services:

“Providing some sort of an immediate reward usually gets them to attend health education classes,” Ohio-based health educator.

About one-third identified the establishment of trust with the community as the key to ensuring a successful outreach program:

“You must be known as a reputable resource in the community if you want them to listen



to you. You get that by maintaining confidentiality and respect,” Ohio-based health educator.

“Trust—it’s the only way they’ll listen to our education programs. You must prove you’re not fake,” Pennsylvania-based health educator.

Almost a quarter (24 percent) identified the use of ethnic and linguistically specific messages and targeted media as essential in ensuring the success of any outreach strategies:

“Our health education material has to be in their language and at their own literacy level,” New York-based health educator.

“Newspapers and TV are very good, but you must know which groups read what newspapers—so you do targeted media,” California, health educator working with elderly.

Twenty percent (20 percent) said recruitment of staff members with whom the community can relate to (linguistically and in terms of shared

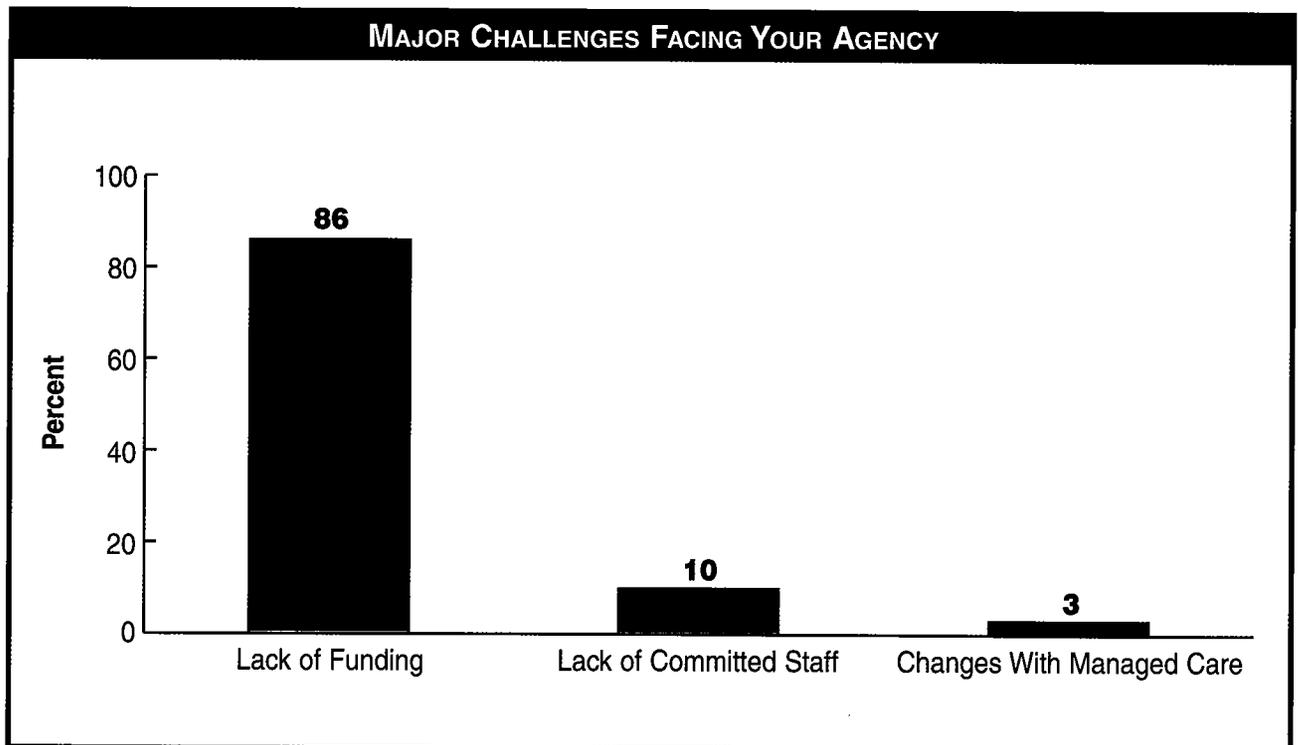
historical backgrounds) is a key factor in the success of their outreach programs because it instills trust between the community and the CBO:

“Language is not enough. Nationality is not enough. The health educators must sympathize with the plight of refugees. That’s so important in making a successful program,” Georgia, health educator and community activist.

“Having staff members who the community can identify with is crucial if we want our education programs to work,” Colorado, health educator.

Almost all of the respondents (86 percent) reported that lack of continuous funding was a major challenge facing their agency as they plan for their future programs:

“There are serious cuts in Minnesota’s social programs budgets. So, it’s always a struggle to get stable funding and help our community,” Minnesota-based health educator.



“Our funding sources are not secure or continuous. That’s our biggest problem,”
California-based Filipino health educator.

“In the Midwest, there’s a lack of stable funding streams due to the invisibility of the AAPIs and lack of committed and competent AAPI staff,” Ohio-based health educator and community activist.

“Our grants only cover half of our budget, and they’re not continuous. It’s always a problem to make sure we have the money to cover our expenses,” New York-based health educator.

Others identified lack of committed qualified staff, lack of free screening services, changes with managed care, and lack of child care in their community as major challenges:

“We need qualified staff, but we can’t get qualified workers if we can’t pay them!”
Colorado-based Southeast Asian health educator and social worker.

“With the changes in managed care, we don’t know what the role of small CBOs would be,” New York-based South Asian health educator.

“We need child care and senior care in our community, but we need the money to support these services,” California-based Hmong health educator.

CONCLUDING REMARKS

These interviews, though not comprehensive, reveal the respondents’ expert knowledge of their community’s health-related behaviors, cultural norms, and the resources available to improve their health. As such, the inclusion of community-based organizations in national health promotion/disease prevention planning efforts is critical in understanding the intricacies involved in improving the health behaviors and health care access of AAPI communities.

APPENDIX B

GATHERING COMMUNITY INPUT—ETHNOGRAPHIC INTERVIEWS: FOOD HABITS AND PHYSICAL EXERCISE

Ethnographic interviews (EIs) were conducted to provide a better understanding of how cultural and environmental factors influence cardiovascular attitudes and behaviors. The results of the EI are presented below. These descriptive data provide useful ideas on how to tailor heart health activities for AAPIs.

BACKGROUND

The EIs were conducted jointly by San Jose State University, Social Science Department, and the APIAHF. The need for the ethnographic study arose out of several concerns. First, there are very few “cross ethnic” cardiovascular risks or incidence studies of AAPI. Most studies examine one AAPI group, and the vast majority of studies, to date, focused on Japanese Americans only. Second, of the studies examined, virtually all were epidemiological in nature investigating incidence of CVD or related risk health conditions. Third, there are few AAPI studies on cardiovascular risk in the areas of nutrition, physical activity, tobacco/alcohol use, and cultural attitudes regarding health care seeking. Again, among the studies that do exist, most are single AAPI ethnic group focused and address only one or two of the cardiovascular risk areas. Given the paucity of data, it was decided that a pan-AAPI ethnographic pilot research project would provide insight on how culture and environment influence behaviors and attitudes of AAPI relative to cardiovascular risk activities.

THE APPROACH

An ethnographic approach was chosen to develop a more qualitative and indepth understanding of respondents behaviors and attitudes. This ethnographic study provides useful qualitative data and formal analysis for CBOs based on actual behaviors and attitudes relative to cardiovascular health

and prevention programming ideas. Moreover, the ethnographic study aims to provide quantitative researchers empirically warranted direction and hypotheses for large sample studies.

This study explored six topic areas:

1. Recreational and Physical Activities
2. Eating Behaviors and Nutrition
3. Tobacco and Alcohol Use and Exposure
4. Health History
5. Personal and Demographic Information
6. Health Education and Attitudes

Unstructured interview questions were used to provide the interviewer with a guide and coding form to lead the respondent through a guided discussion on the various topics/facets of food habits, health, and physical activity. Three-point Likert scale questions assessed cognitive attitudinal areas of health education.

The 63 participants represent the Chamorro, Chinese, Filipino, Japanese, Korean, and Vietnamese subgroups and reside in 19 cities in Northern and Southern California. The majority (85 percent) are U.S. citizens, (65 percent) are foreign born and about 92 percent have lived in the United States for 8 or more years. They ranged in ages from 17-85 years. They were chosen on a nonrandomized snowball sampling methodology stratified for Asian Pacific Islander ethnicity, age, gender, and generation in the United States.

Due to study limitations (including, small sample size, no pilot testing, limited time frame for indepth analysis of qualitative and quantitative data, limited funding), generalizations cannot be made. However, the preliminary findings presented here suggest certain ethnic differences and similarities among AAPI populations in relation to CVD and its related behavioral risk factors.

FINDINGS

The study findings suggest that further exploration of the differences among AAPI subgroups is warranted. While some overarching themes of behavioral characteristics are similar among all AAPI subpopulations, the differences appear to be the key in understanding cardiovascular risk factors and ethnic community specific health outreach strategies. For example, understanding that AAPIs tend to view physical activity as an opportunity for social interaction gives us programmatic suggestions. Additionally, recognition of the differences between men and women with regard to the perceived benefits of physical activity is instructive. Outreach and recruitment of women should stress the emotional benefits of physical activities, while men will respond better to physical benefit messages.

Data on eating behaviors tell us that AAPIs persist in eating their ethnic foods. Even Japanese Americans who demonstrated the highest non-Asian food consumption continue to eat Asian foods at equal rates to non-Asian foods. Thus, an important question to consider is, how can Asian foods be prepared in a more cardiovascular friendly manner? The finding on red meat consumption was also informative. Though red meat does not comprise overwhelming amounts of the protein intake of AAPI, when red meat is consumed it is more likely to be nonlean meat and prepared outside the home. This suggests that AAPIs go out to eat red meat rather than prepare it at home. The EIs suggest that the red meats come from fast food sources. What can be done to combat the attractiveness of convenience and low cost associated with fast food chains such as McDonalds and Burger King?

Tobacco and alcohol play important roles in cardiovascular health. Secondhand smoke exposure rates of the respondents are a concern. The surprise here was that foreign-born and U.S.-born AAPIs were both heavily exposed. Why? What role does smoking in the country of origin play in

increased risk, especially for immigrants? What does smoking symbolize for the respondents? Is smoking perceived as a health risk? Unfortunately, the results of this investigation do not permit the provision of answers to these questions at this time. However, the answers are vital for effective prevention and cessation programs.

The ethnographic study has opened the door to giving program planners limited empirical support for our “common knowledge.” This study confirms that aggregated nationwide data on AAPIs do not fit specific segments of the AAPI community, and pronouncements of “no risk” for AAPIs leave segments, such as the Chamorro population, at risk. The preliminary analysis suggests that in addition to documenting the rates of CVD and risk factors among AAPIs, there is a need to gain a better understanding of “meaning” associated with perceptions of health and healthy behaviors.

For example:

- ❑ What do physical activities mean to AAPIs and what role does it play in their social and family lives?
- ❑ What do AAPI foods signify to AAPIs and how would changing ingredients affect its acceptance and value?
- ❑ What do non-AAPI foods mean to AAPIs? Are the increased consumption of non-AAPI foods seen as desirable and a symbol of “fitting-in”?
- ❑ What does smoking symbolize? Is smoking seen as a threat to one’s family as well as to oneself?
- ❑ What does body image mean to AAPIs? Is it similar across groups? Is it okay to be “chubby”? Is being large a symbol of “wealth” or status?
- ❑ What is wellness and health? And conversely, what “causes” illness?

Certainly, there is much to be done...