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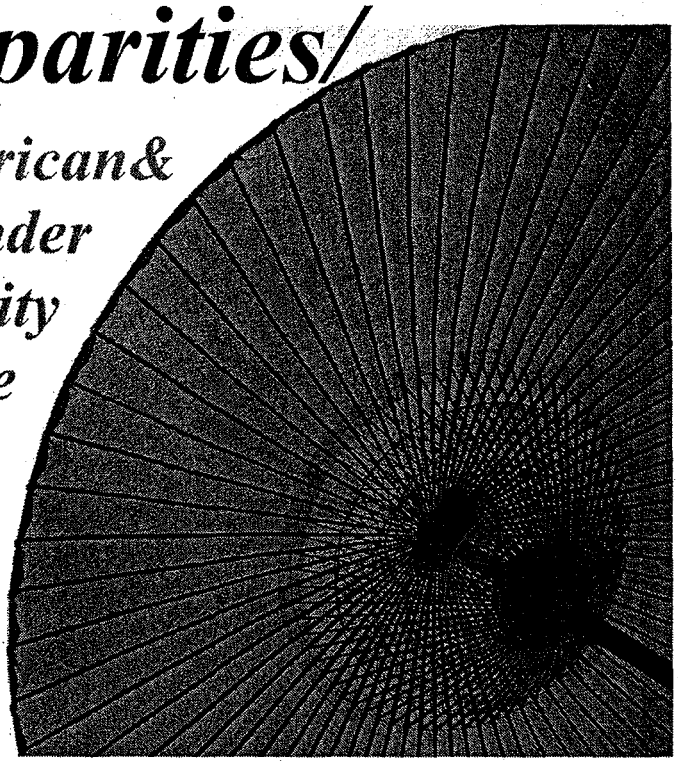
Health Disparities:

An Asian American& Pacific Islander Community Response



January 2009

A Joint Report from the Council on Asian-Pacific Minnesotans and the Minnesota Asian/American Health Coalition

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Executive Summary

This report is a joint product and a part of the ongoing work of the Council on Asian-Pacific Minnesotans (Council) and the Minnesota Asian/American Health Coalition (MA/AHC). The Council on Asian Pacific Minnesotans is a state agency and has been actively researching and advocating on Asian American and Pacific Islander (AAPI) health and mental health issues for more than a decade. The Minnesota Asian/American Health Coalition (MA/AHC) is a non-profit organization that was formed by Asian American health professionals to work with the community in addressing their issues and concerns. Chief among MA/AHC's priorities are better health access, delivery, and health data.

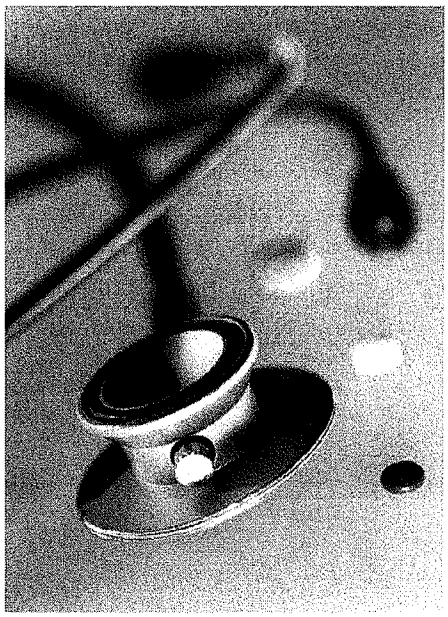
A majority of this report is taken from the oral and written testimonies that were offered at the Asian Health Disparities Forum that took place in August 2008. The forum was organized by the Council via the Hennepin County Asian American & Pacific Islander Leadership Initiative and MA/AHC. The forum was also held at the request of the US Department of Health & Human Service, Office of Minority Health and thus it was structured as a public hearing for the community to make comments to federal officials who served as listeners. The focus of the forum was on generating solutions to health disparities and assist policy makers forum find ways to really make a difference in reducing health disparities here in Minnesota for the Asian American and Pacific Islander community.

High on the AAPI community concerns were improving medical interpreter services, a need for more health education, and the lack of data on Asian health specific to a particular sub populations. Mental health emerged as a leading health condition across Southeast Asian populations (Hmong, Lao and Karen). The testimonies from the forum shed light on many of the problems contributing to health disparities in the AAPI community among them are cultural and communication barriers, lack of standards for medical interpretation, and flawed AAPI health status data. The testimony also provided insight into other issues in the AAPI community that are not widely known to policy makers such as obesity, domestic violence and lack of emergency preparedness plans.

Key Findings & Recommendations:

- Mandate standards for medical interpreters
- Health education created for communities with different cultural health beliefs
- Commitment to Funding and Desegregating AAPI health data
- Increase the number of AAPI health professionals
- Increase cultural competency training among mainstream health professionals
- Expand and utilize community non-profits on health care and health education
- Support continuing funding for the MDH-OHMH grants to AAPI sub contractors\
- Develop an Asian American and Pacific Islander community health clinic

Health is important to the AAPI community and it affects every aspect of their lives. They would like to be included in and understand the health care system and decisions that are made for them and about them.



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Putting a Face on Asian Health Disparities: Five Stories

story 1
mental health

'My wife is not healthy. She has mental problems. She has stress all the time. She yells and yells. I don't know how to help her. She takes medication prescribed by doctors. The biggest problem is I don't know how to deal with my wife. I want my wife to be calm and get out of stress.' (Lao written testimony, Brooklyn Center)

story 2
Obesity/diabetes

'There is a Hmong family here with a son age twenty-one. The son weighs three hundred pounds. He works temporary jobs and has no health insurance. The mother does sewing jobs to earn money. The father's insurance does not cover the 21 year old son. He is diabetic. The parents did not notice the diabetes until one day the mother saw the son drinking two liters of pop. "Why are you drinking (all that pop)?" asked the mother. "Because I am thirsty!" the son replied. Later he said he felt blind. "Go wash your face, your eyes!" said the mother. But he had lost his vision. He was totally blind. "Why can't you go see the doctor?" The son ended up in a coma. His diabetes score was 800. He needed six months or more of health care. He needed bed turning. They need medical assistance. That story is from my husband's cousin's son. He is a well-known Hmong singer. (Ly Vang, executive director of the Association for the Advancement of Hmong Women in Minnesota)

story 3
Health Promotion

'Our Karen people back home never go for regular checkups. I see a lot of difficulty in my community. Lack of regular check ups. Lack of understanding of Western systems. Lack of knowledge and education about health care. No health materials for them to read to get knowledge. Lack of knowing how to prevent health problems. Few medical interpreters. No transportation to medical appointments. Common health problems in our community are diabetes, high blood pressure, high cholesterol, liver, colds, and fever and ear infections. (PawWah Toe, KaRen Interpreter/Cultural Liaison)

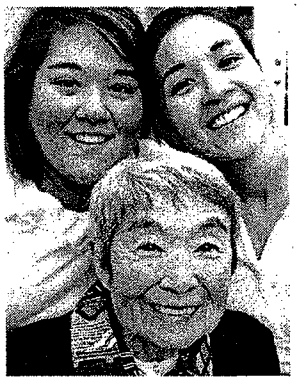
story 4
Diet/Nutrition

'I want to tell about diabetes and my health. My family's health is good because we did not smoke. The food, it is a little fat, just use oil for meals. Diet does not have any fatty food, sugar, salt, calcium. We eat small meals, rice and cereal'. (Vietnamese resident, written testimony, Ramsey County)

story 5
Interpretation

'I went with my grandfather to see a cardiologist for an EKG. I was not allowed to interpret so they sent in someone else to translate. During the current health condition questions, the nurse asked whether my grandfather had a pace maker and the interpreter DID NOT interpret the question and skipped it entirely because he did not know what a pace maker was. I wanted to interject, however I did not feel comfortable and knew that my grandfather did not have a pace maker. However, if he did have one, I would have corrected the interpreter, If my grandfather did have a pacemaker and had gone to see the doctor alone, I wonder what the magnitude of the problem would have been since the interpreter neglected to interpret pace-maker?' (Written testimony, Hmong)





Part One: Introduction

This report is the convergence of many years of work by the Asian American and Pacific Islander community and healthcare professionals and the oral and written testimonies that were offered at the Asian Health Disparities Forum that took place in Minneapolis on August 2008. Historical knowledge and experience working on health issues with the community helped to formulate the analysis and recommendations of this report.

The forum was organized by the Council via the Hennepin County Asian American & Pacific Islander Leadership Initiative and Minnesota Asian/American Health Coalition (MA/AHC). The forum was also held at the request of the US Department of Health & Human Service, Office of Minority Health and thus it was structured as a public hearing for the community to make comments to federal officials who served as listeners. The focus of the forum was on generating solutions to health disparities and assist policy makers forum find ways to really make a difference in reducing health disparities here in Minnesota for the Asian American and Pacific Islander community. Thus, the forum was an opportunity to inform government officials at federal, county and city levels about the health of Minnesota's Asia and Pacific Islander communities. The forum was structured around seven main topics:

1. Health Care Access
2. Health Promotion
3. Health Data
4. Health Conditions (internal)
5. Health Issues (external)
6. Health Professions
7. Emergency Preparedness

Questions

1. If you and *your family* are generally healthy, what keeps you healthy?

2. If you and your family are not so healthy, what is the biggest

The testimonies where then compiled and analyzed and grouped together within the topics and as part of the larger public health and healthcare arena. Communities members were creative and responsive in identifying solutions that public officials would do well to heed.

Methodology: Gathering Health Stories

In preparing for the forum and this report, organizers worked with community members to collect health stories around two basic questions. People did not have to look far or hard for stories in their communities. Testimonies were drawn from extended families and or people/professionals who have experiences working with clients. Here is written testimony that sheds light on the role of a community agency in health care.

> *'Our agency, United Cambodian Association of Minnesota (UCAM), functions as a cultural fitness center. Elders come here from ten a.m. to one p.m. three times a week. The elders share food and socialize together. We use these informal social times to help them understand health issues. For example, we talk to them about foods and high blood pressure, and encourage healthy eating. We have a fitness equipment room and the elders can be seen regularly enjoying the stair masters and treadmills. In winter the elders face high levels of stress. We organize fitness events. We take elders to the Mall of America for walking, and also the Roseville Mall and Maplewood Mall (three geographically different areas of the Metro Area). So now you will see Cambodians as well as Caucasian seniors exercising in winter in these indoor centers.' (Mr. Yorn Yan, Executive Director, UCAM)*

Here is a more personal story about a family member.

> *'I would like to tell my personal story as a care-giver. My husband's father died from liver cancer in Laos. He was age forty-five. An older brother died from stroke in California Six months ago a brother died of liver cancer age 33. Plus now I have a younger sister diagnosed with breast cancer. She is in Laos. Now my husband has been diagnosed with liver cancer. He has gone for regular checkups but had not be diagnosed until in the process of switching life insurance companies they did a medical checkup and found cancer and so rejected him.' (Bounleuth Gowing, Lao community health worker, Lao Assistance Center)*

10 largest API groups in Minnesota

Hmong	52,202
Asian Indian	26,739
Vietnamese	23,717
Chinese	20,588
Korean	16,686
Lao	11,339
Cambodian	8,755
Filipino	8,139
Japanese	3,992
Thai	1,167

(US Census)

Understanding the AAPI Demographics

There are over forty different Asian Pacific groups in Minnesota that can be grouped under the umbrella term Asian American and Pacific Islander (AAPI). According to the U.S. Census Bureau 2006 American Community Survey the total API population was over 210,000. Minnesota has a one of the largest population of Korean adoptees. Minnesota also the largest Tibetans and Karen communities in the US at 2,000 each.

Part Two:
Voices from the Community

This section of the summarizes the testimonies given on the seven major topics and the open public comment session. Community members were not hesitant to share their stories or to offer solutions. For many, this was the first time they had ever made comments in a public setting. For others, they were well versed and looking to make a difference and seeing change. High on people's concerns were medical interpreter services, a need for health education and lack of health status data specific to a particular sub group within the Asian communities. Mental health emerged as a leading health concern in several Southeast Asian populations (for example Lao, Hmong and Karen). A lack of Asians entering the health professions was addressed as was the need for emergency health preparedness planning. A highlight of the morning was testimony from a Hmong shaman speaking through an interpreter about the spiritual beliefs of the Hmong and how those beliefs were real and can be a part of the healing process.

Topic 1: Health Care Access:

Medical Interpreters: The Need for Training & Standards

A major issue affecting health access is the lack of quality control over medical interpreters and medical interpreter training. Other issues under health care access include access to affordable health care & insurance, senior access to culturally sensitive facilities, senior access to assisted living, language barriers, limited English proficiency, transportation, and affordable medications.

> *'One in three has problems accessing health care.26% did not know how to access health care.' (Emily Wang, City of Minneapolis Health Department)*

> *"It is critical to have standardization Clear and culturally sensitive communication is important in healthcare." (Vinodh Kutty, Hennepin County Office of Multicultural Services)*

> *'Interpreters are a huge problem.' (Raj Chaudhary, SEWA: Asian Indian Family Wellness Center)*

> *'Asians have the highest rates of English Limited Language ELL and the highest cultural diversity.' (Emily Wang, MA/AHC)*

'I think a lot of people who need interpreters can be helped if there were better ways to train and regulate interpreters. I think some agencies hire incompetent people who may do more harm than good' (Hmong written testimony)

Problems with medical interpreters were high on people's concerns. Throughout the day testifiers complained about a lack of skilled medical interpreters as one of the key factors affecting health care access. The testimony contained many complaints about the quality of interpretation.

Families experience intergenerational conflicts around healthcare beliefs and traditions and often do not share the same language to define similar problems.

'Chinese elders and adults have problems with medical interpreters.' (YiLi You, Chinese Services Center)

'My community, we are refugees. Help with interpretation is important. I have a client with hemorrhoids. The doctor gave her medications. She understood him to say take and put in water for two hours, Wrong directions. She went home and sat in a bath tub for two hours. The interpreter should listen carefully. Explain how to use the meds.' (Vietnamese)

'We worry about interpreter issues, worry about medical terminology. Many of the young interpreters have only a limited understanding and knowledge of our Hmong language and customs.' (Ly Vang, executive director of the Association for the Advancement of Hmong Women in Minnesota, AAHWMN)

Ly Vang spoke about the younger generation of interpreters not being culturally sensitive. They may be fluent in English, but their understanding of the patient's native language and the culturally appropriate way in which they should interact with them is often time lacking. She said the young second-generation interpreters need to be trained on how to work with elders. She drew attention to age differences and the need for interpreters to be cultural sensitive. There is a problem when younger interpreters don't respect or understand language customs, and don't respect cultural differences around talking about health with SE Asian elders. If the interpreters don't pay attention to these clues then the issues of credibility and trust can not be established. Directness is a problem:

It is offensive to use the straight direct word. Medical language can be shameful for an elder. Concept of shame. Hmong talk in metaphors and stories, use analogies. With the young interpreters there is a lot of misinterpretation. The young interpreters need help using their own language. (Ly Vang, AAHWMN))

Health Insurance and Health Access

Medical health insurance is an issue most affected by socio-economic factors such as poverty and lack of livable wage jobs that have health coverage. And while AAPI's are often praised for their entrepreneurial spirit in opening small businesses – statistics shows that employees

of small businesses have the lowest amount of health coverage. . Ly Vang said that there are many Hmong families who do not have medical insurance and she explained how this impacts on their health.

> *'So they don't do check ups. They are not detecting disease and illness in the early stages. They wait till the last stage. Some of the medical insurance from their employers is limited. Costs of some tests go uncovered. Costs of co-payments are a problem. Today's economy is negatively affecting health prevention. People do not have the money to pay for hospital and clinic bills for early check ups.' (Ly Vang, AAHWMN)*

Many Asians experience problems navigating the health systems. ELL or illiterate adults need help from the Asian professionals to complete paperwork They cannot read their mail and either throw it away, get their younger children or literate elatives to help or take it to a bilingual professional at a community agency. The MAA staff spends hours of uncompensated time trying to assist their community navigate their way around complicated and impersonal health systems. Even the more educated Asians struggle with bureaucracy. Bounleuth Gowing, a Lao community health worker, wrote in her testimony of how she only discovered a medical problem in her own family when her husband was trying to change to a different life insurance program.

> *'I am the one who takes him to appointments, follow up appointments, and gives him medications. We went back to our doctor then to a specialist. They did not want to treat him at first. They did not do anything. We talked to a family doctor then another specialist.' (Bounleuth Gowing, Lao Community Health Worker)*

How sponsorship of refugees is structured was mentioned as a factor that seems to have an impact on health care access. If the families who sponsor the refugees have limited health care access themselves then this seems to carry over to the newcomers.

Religious & Cultural Practices About Health

Religious and cultural beliefs play a big part in how and when the community access western healthcare.

We Hmong know that for physical sickness we go to the doctor, but for sickness resulting from the spiritual realm, we go to the shaman. Sometimes the two can be separated, but sometimes they are intertwined and both have to be treated accordingly. The American way does not honor our Hmong way and does not allow us to heal our people especially when they are hospitalized. Then we do not get access to our people and get to do the "spiritual calling."(Hmong Shaman or traditional healer)

"Die Another Day"

The patient's preference for folk remedies or western medicines and surgery is based, according to the report, is a balance of "fear ofdisease and pain" to the "fear of doctors and complications from interventions and anesthesia." This is where the philosophy of "die another day" enters to reflect the mood of the patient to divert or postpone more severe consequences until another time explained Dr. Kathleen Culhane-Pera. (*Asian American Press, October 15, 2007*)

Language Barriers Affect Health Access

One of my clients sat there for hours. They were passed over. No one helped the person, no one talked to them. (SeAM Parish Nurse)

Guidelines have been set nationally. In Minnesota an Interpreter Stakeholders Group meets regularly and is looking at ways to implement and enforce standardized training. One of the testifiers did speak up in defense of the interpreters who do a good job and work with passion. But agencies trying to assist clients access health care are frustrated with some of the unethical practices occurring among interpreters who try to take the clients to the clinics of their choice and not the clients.
A repeated theme from Anne Bennett, one of the federal listeners, from the Department of Civil Rights, was that Asian clients need education about their rights to medical interpreters. She repeatedly urged the community to file complaints through her office.

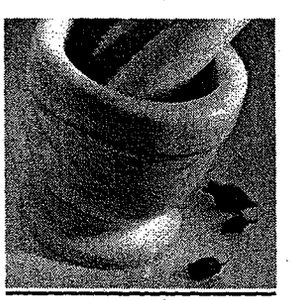
Social Economic Determinants of Health

Throughout the forum there were comments that economics determined health status.
A testifier from a Vietnamese agency said that if a family is not healthy, the biggest problem to getting healthier is money. Health care is expensive and most people cannot afford it.

'Without health we cannot secure a job.' (Somly Sitthisay)

Elder health care is impacted by poverty. Many Hmong, Lao and Chinese elders live in poverty and cannot afford medications due to insufficient income for co-payments.
Emily Wang from the City of Minneapolis said that Hmong have the highest poverty rates. But more statistics about Hmong health are needed. She estimated that 47% are below poverty. Poverty rates and housing problems affect the quality of health for a community.

'One co-payment of $10 to $15 may not seem very much. But for an elder on limited income with six, ten or more medicines to buy monthly, it adds up. Costs of co-payments affect compliance and health. Elders are known to skip meds, or stretch out one month's supply over two months.' (Vietnamese Elder)



Socio-economic determinants have a significant impact on health. One example is how medical compliance is affected:
Yorn Yan described in his written testimony how Cambodian elders try to save in ways that undermine their health:

'They have their own ways of using the medications. They skip medications or try to stretch one month's supply over two months. Why pay $100 a month if you can make the medication last for two?'

Topic 2: Health Promotion

> *'Our Karen people back home never go for regular checkups. I see a lot of difficulty in my community. Lack of regular check ups. Lack of understanding of Western systems. Lack of knowledge and education about health care. No health materials for them to read to get knowledge. Lack of knowing how to prevent health problems. Few medical interpreters. No transportation to medical appointments. (PawWah Toe, KaRen Interpreter/Cultural Liaison)*

Health promotion professionals define good health promotion to be a comprehensive, systematic, and coordinated approach to affecting long-term health behavior change by influencing the community (cultural) norms through education and community organization. If this is the case then the AAPI community is lacking a good health promotion plan. With the formation of MA/AHC the community is being to garner a coalition of AAPI organizations and ethnic communities around health promotion that would focus on both long term and comprehensive action. The organization is in its first year of programming and must be supported to continue to grow and thrive. The community has yet to drive the agenda, to chose the promotional and educational vehicle in which to do its work, and to identify and utilize evaluation tools in which to measure the effectiveness of its work in terms of cultural shift and changed norms.

The Vietnamese Social Services Association is able to do health promotion with grants funded through the MN Department of Health Office of Multicultural and Minority Programs (MDH-OMMH). They hold health conferences for the Vietnamese elders, educate on health issues through Vietnamese radio programs, cable TV, newspapers and media to reach out to the Vietnamese, not just in the metro area but throughout the state. VSS develop their own culturally sensitive materials for distribution in the community.

Sometimes organizations come together to address a common concern like tobacco, gambling and chemical dependency. They pull their resources together to develop strategies and promotional materials that would change cultural norms and understanding about that specific topic.

Religious diversity and health care

The diversity within the Asian communities needs to be factored in to program planning. Planning for ethnic and cultural differences should also take into account the many different religions. The Asian communities include Filipino & Vietnamese Catholics, Lao, Tibetan, Cambodian, Burmese Buddhists, and Chinese Confucians. The Asian Indian community alone includes Hindus, Muslims, Sikhs and Christians.

Topic 3: Health Care Access

Rates of inadequate/no prenatal care are 3-4 times higher (10% AAPI vs. 3% white women) among *populations of color* in Minnesota compared to rates of white pregnant women. *Source: MDH. Populations of Color in Minnesota - Health Status Report. Update Summary. Fall 2003.*

The Asian community is over overlooked by policy makers and officials. Part of the reason is because of the lack of data representing Asian communities in research and reports. One of the main problems with any existing health data on the API communities is that the API data is aggregated. Data labeled "Asian" or "Asian Pacific" is too consolidated and massed together. Lumping together such widely different populations as Chinese, Asian Indian, Hmong or Lao distorts the situation for a specific population. Each one of these communities has a very different culture and history and health profile.

Xiaoying Chen from the MDH-OMMH gave examples of the problems the API communities face from over generalized data. The generalized data for API masks problems in a particular community. The Asian community is seen as a model minority but health disparities exist. Domestic violence exists, suicides exist. HIV AIDS exists. The Vietnamese have the highest rates of cervical cancer. The Hmong have a high incidence of kidney stones. There are low rates of immunization of children in some of the communities. Also, data on 'Asian' income hides the fact that 14% of Chinese are in poverty.

> *'They say we all look alike, but we are all very different, culturally, languages, food, everything.' (Doua Lee, SE Asian Community Council SEACC, an agency serving Hmong)*
>
> *'We are all lumped together. But each community has its sub culture. (Raj Chaudhary, Asian Indian Family Wellness Center))*
>
> *The data is overly generalized.' (Dr, Zha Blong Xiong)*
>
> *'The data we get is too focused on written reports and we forget the knowledge of the elders.' (Researcher, Rainbow Research)* '

Dr. Zha Blong Xiong, a researcher in Family Social Science at the University of Minnesota, spoke about intergenerational research. He said there are challenges with the health data. In eight years of doing research he has experienced problems with the comparative studies of Asian Pacific Islanders. A common complaint was problems with surveys. Emily Wang from the City of Minneapolis said that a survey of 579 respondents only shows 7% from an ethnic group. She concluded: *'That's too small a sample size. For example, three percent of one hundred respondents is a very small sample size.'*

'It's very hard to analyze. Asian Pacific Islanders are not the same across the different communities. Data is very generalized.' (Dr. Zha Blong Xiong, U of Minnesota)

The problem of lack of quantitative Asian Health Data on sub populations

There is little data available from the Health Departments on Hmong health. Hmong all get lumped together under an umbrella API term. It's meaningless and useless. However, testifiers in the community agencies have their own creative ways to obtain estimates. Ly Vang provided insight on missing data about Hmong health.

There are six Hmong funeral homes. Hmong funerals last three days. Based on four funerals a month at each of the six funeral homes, that is a total of twenty four Hmong funerals a month. (Over 308 per year.) My staff and I estimate that only a few of these deaths are from old age, natural longevity. I estimate that 70-80% of these deaths are due to stroke, diabetes and cancer. Suicide accounts for another 10-15%. These last few months (May, June, July 2008) I heard that five deaths were from suicides. This is the mental health issue – depression, PTSD, home foreclosures, the economy. (Ly Vang, Executive Director of the Association for the Advancement of Hmong Women in Minnesota, AAHWMN)

Similarly data on mental health is available only as an API aggregate. For example, the state might be able to come up with a number on 'Asian' suicides, but no one can break that down and give the number of Hmong Suicides. No one can tell you how many were Hmong suicides, or Lao suicides, or suicides among refugees.

Several other researchers commented throughout the day on problems with data. Mei Ding, from the SHAPE study, speaking about data on obesity, said:

'We need local data not national data. For example, obesity in Minnesota; who in the API communities is disproportionately overweight? They don't get weight loss advice.' (Mei Ding)

Dr. Hee Yun Lee from the University of MN said we tend to use Western ways of doing research and that using the traditional research model is hard. For example, phone conversations do not work with Korean elders.

'Phone surveys are not a good way to collect data in the Asian community. Telephone interviews do not work with API and SE Asian populations.' (Dr. Hee Yun Lee, University of Minnesota)

Researchers cited measurement issues in data collection about mental health. Regarding research on mental health, there is a problem trying to collect data on depression in Asian communities with instruments developed for middle class whites. There is a need to develop alternative measures that are more culturally relevant. Another problem is translation. There is no direct equivalent for words like 'depression' or 'autism' or 'cancer' in many of Asian languages.

Data issues emerged throughout the forum. For instance a testifier said that according to the National Cancer Institute, Vietnamese women are at 7.4 times higher rate that the lowest incidence rates for other populations and nearly five times higher than the general population. She said a study shows that only 18% of Vietnamese women over 50 have periodic breast cancer exams. Lack of data is a problem in developing prevention programs.

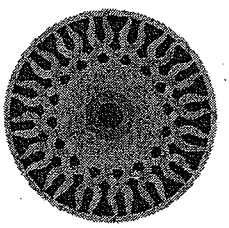
Data needed for effective prevention programs on HIV AIDS
Lack of data collection on HIV AIDS in the Asian communities is a huge issue. Gilbert Achay explained how it is a problem in planning prevention and outreach.

> *'How can you construct a program when you don't know which sub population is being infected. We don't know what sub population they come from. We don't know if they have language barriers, things of that nature.'*

Topic 4: Health Conditions

The health conditions (diseases/internal health conditions) panel was the largest during the forum. The testifiers on health conditions identified over twelve health diseases affecting the API communities – alcoholism, asthma, breast cancer, cervical cancer, colds, diabetes, diseases of the kidneys, ear infections, fevers, heart disease, hepatitis B, high blood pressure, hypertension, HIV AIDS, liver disease, lung cancer, malnutrition, mental health (depression, PTSD), obesity, and renal failure. A testifier also commented on tobacco related diseases such as asthma, heart disease and lung cancer, emphysema, and nicotine addiction. Another testifier drew attention to the high prevalence of kidney stones in the Hmong community probably related to changes in diet among Hmong in America.

The health conditions that were most on the minds of community members are diabetes, cancer, Hepatitis B, mental health, plus testimony that drew attention to three newly identified problems, HIV AIDS, kidney stones and obesity in Southeast Asian communities.



Diabetes: Asian Indians may be at higher risk for type two diabetes, because of the way their bodies convert fuel, according to a new Mayo Clinic study. "Asian Indians are less sensitive to insulin action, number one. Which means the same amount of insulin disposed of much less glucose in Asian Indians than Northern European Americans," explained Dr. Nair. (MPR , March 2008)
In a national study, *Type 2 Diabetes Prevalence in Asian Americans*, researchers found that while similar proportions of Asian and non-Hispanic white Americans report having diabetes, while after accounting for the lower BMI of Asians, the adjusted prevalence of diabetes is 60% higher in Asian Americans. (Marguerite J. McNeely, MD, MPH[1] and Edward J. Boyko, MD)

'Common health problems in my community are diabetes, high blood pressure, high cholesterol, liver problems, colds, fevers, ear infections both children and adults.' (Paw Waw Toe. Health Interpreter, Karen community)

'Diabetes is a problem affecting 60% of Cambodians age forty and over. These are adults who came here as refuges from the Khmer Rouge. We don't know why diabetes is becoming such a huge issue. Depression affects over 60%. The depression stems from experiences suffered under the Pol Pot regime and also depression can result from the stresses of adjusting to life here. We see an increase in heart disease as a problem. Cancer has increased. There are 115 Cambodians diagnosed in Minnesota per annum.' (Yorn Yarn, Executive Director of the United Cambodian Association of Minnesota, UCAM)

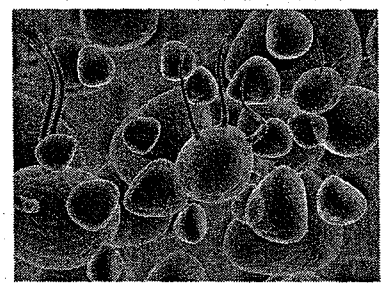
'The biggest health problems in the Hmong community of Minnesota, which now numbers over 80,000, are number one mental health, followed by high blood pressure, diabetes, obesity, all ages, from children to elders fifty plus, cancer, strokes and deaths from suicides. Cancer includes cervical, colon, liver, pancreas, ulcer, lymph glands, sinus, and bone marrow cancer. I would say only one to two percent are breast cancer.' (Written testimony from Ly Vang, Executive Director, Association for the Advancement of Hmong Women in Minnesota, AAHWMN)

Cancer

I just wanted to share with you the concern we have in the Vietnamese community. We all know that cervical cancer is 100% preventable. And if breast cancer is detected early and with proper treatment, survival rates are very high. But our women are dying in great numbers. The reason is there is a great need for more awareness about cancer preventative care and screening and proper cancer treatment information. (Ms Minh-Hien, Vietnamese Social Services)

'Cancer in the Asian populations includes cervical, colon, liver, and pancreas, ulcer, lymph glands, sinus and bone marrow cancer. I would say only 1-2% breast cancer. My sister in law had colon cancer, refused chemo treatment. She needed counseling to explain how surgery would improve her condition. Hmong people need our agency staff to help them explain medical practices. We need a Hmong support group with people we trust.' (Ly Vang, Association for the Advancement of Hmong Women in Minnesota, AAHWMN)

'Cancer has increased in the Cambodian community. I estimate that there are about 15 Cambodians diagnosed with cancer in Minnesota every year.' (Yorn Yan, Executive Director, United Cambodian Association of Minnesota, UCAM)



Cervical Cancer: Black women in Minnesota have a cervical cancer incidence rate that is four times as high as the rate for white women. American Indian and Asian/Pacific Islander women have a cervical cancer incidence rate that is three times as high as the rate for white women. Deaths due to cervical cancer also occur at a higher rate among Asian Pacific Islanders and blacks compared with white non- Hispanics. (MDH)

Cervical Cancer Incidence: 1995-1997 Rate per 100,000	
American Indian	*19.9
Asian/Pacific Islander	*17.9
Black	*25.9
White	6.2

*Indicates a rate significantly

Hepatitis B & Liver Cancer

Hepatitis B is a liver disease caused by infection with hepatitis B virus (HBV). HBV infection can cause lifelong liver damage and even death. Babies and young children who are infected are likely to develop lifelong infection. This lifelong infection is called chronic HBV infection and can lead to cirrhosis (scarring of the liver), liver failure, and liver cancer later in life. Chronic HBV infection develops in as many as 9 of 10 infected infants, 3 out of 10 young children, and about 2 out of 100 infected adults. Though people with chronic HBV infection might not feel sick, they carry the virus in their blood and can pass it to others. Although recognized more than 40 years ago and it is now preventable with a safe and efficacious vaccine.

Sunny Chanthanouvong spoke about the problems in the Lao community in regard to a lack of understanding about hepatitis B, the need for check-up, and the treatment especially for pregnant women.

My aunt was about 48 years old when she was diagnosed with liver cancer. She was so young and so healthy, we could not believe it. We did not know what to do. The cancer was so advanced, she decided on no treatment. She died. Then a couple of years later, another aunt died of liver cancer. Today, many in my family know about the disease and about how it kills so fast, but they do not go for testing. (Hmong woman)

I am pregnant and my doctor just told me that I am a HBV carrier. When I found out I was shocked. I've never known this. I am adopted and I guess my mother must have passed it on to me. I do not want to pass it on to my child. My doctor and I have talked about immunization shots for my newborn. (Pregnant woman)

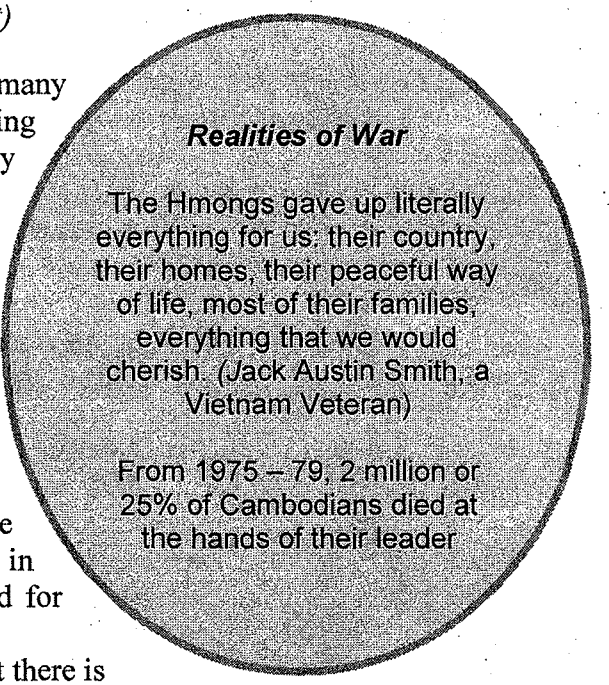
National Task Force on Hepatitis B Focus on Asian and Pacific Islander Americans (February 2005)

New estimates of chronic HBV incidence in the United States that takes into consideration of the four fold increase in the high incidence and prevalence APIA population (from 3.7 million in 1980 to 14.4 million in 2002), and 3.3 fold increase inthe foreign-born APIA population (from 2.5 million in 1980 to 8.3 million in 2002) in the last 20 years. A separate section to recognize and specifically discuss the reasons behind the disproportionately high rates of chronic HBV in adult and foreign born API Americans to educate the unaware health professionals. After all, the disparate rate of HBV and liver cancer is a major health disparity between APIA and white Americans. Without this information, many doctors do not routinely perform a one-time blood test to screen their APIA patients for chronic hepatitis B, or counsel them to also have their family members tested and vaccinated.

Compared with all Minnesotans, the Hmong population had increased PIRs for nasopharyngeal cancer (PIR, 39.39; 95% confidence interval [95% CI], 21.01-66.86), gastric cancer (PIR, 8.70; 95% CI, 5.39-13.25), hepatic cancer (PIR, 8.08; 95% CI, 3.88-14.71), and cervical cancer (PIR, 3.72; 95% CI, 2.04-6.20) and had decreased PIRs for prostate cancer, breast cancer, Hodgkin disease, and melanoma. Cancer in the Minnesota Hmong populationJulie A. Ross, Ph.D. (May 29, 2003)

Mental Health and Southeast Asian Refugees

> *'We have never healed [refugee experience]. Most of us are illiterate. It is hard to adjust to a new life in America, especially for those not able to read or write. It takes three to five years to adjust to culture shock, learn how to write checks et cetera.' (Wilfred Tun Baw, Karen Support Project)*



Mental health is a major health problem for many Southeast Asian refugees in Minnesota including the Karen new arrivals due to the trauma they received as refugees fleeing war and persecution and as new arrivals to the United States of America. When not treated the ramifications have been significant leading to suicide, depression, family violence, gambling, drug addictions. Tony Yang, director of Southeast Asian Services at the Wilder Foundation, a leading agency providing mental health services and counseling to Southeast Asian youth and families, said that national studies have shown that large numbers of refugees arriving in the US are depressed. He spoke about the need for psychiatric services and estimates 36,000 Southeast Asians need mental health services but there is not the staff or resources available for them to access culturally competent services.

'Between 2000 and 2005 Ramsey County Mental Health Center screened mental health needs of over 420 new Hmong refugees arriving from Thailand. They found that these new arrivals were clinically depressed. But only 26 received any mental health services at that time.' (Tong Yang, Southeast Asian Services Center, Wilder Foundation)

He went on to describe the underserved populations in Minnesota.

> *Sixty percent of new SE Asian refugee arrivals are clinically depressed. Many suffer from undiagnosed mental illness. In a Hmong population of 60,000 that is a lot. We estimate only three percent get services. At Wilder we see about seven hundred clients annually. The impact on the Hmong community of untreated mental illness impacts on their children. We don't have enough staff trained from each of the SE Asian communities.*

Tong Yang and his staff have been active for many years as agency host of the informal Hmong Mental Health Providers Network (HMHPN). This group is a community initiative driven by Hmong professionals to find solutions to the problems of mental health. It was formed in response to a series of tragedies in the Hmong community where mental health

services have not reached families in time to avert tragic outcomes. The tragedies pointed to the need for more crisis intervention and follow up mental health services.

The past history of refugees in war torn countries was mentioned several times as a cause of mental health problems. Many refugees suffered trauma before coming to Minnesota. Professionals from the Hmong and Karen communities testified on the need to provide more staff to address mental health issues in a culturally competent way. Staff from agencies serving the Karen, Hmong and Cambodian families spoke up about mental health issues:

> *'Depression affects over 60% of Cambodians. Their depression stems from their experiences suffered under the Khmer Rouge during the Pol Pot Regime. And also depression can result from the stresses of adjusting to live here.' (Yorn Yan)*

Hmong, Cambodians, Lao, Vietnamese and Karen testifiers said that mental health is an issue in their communities. There is also a growing need for mental health services in one of Minnesota's newest populations, the Karen refugees displaced from Burma. The Karen, endured decades of trauma under the Military Junta in Burma. William Tun Baw, Executive Director of the Karen Support Project, described the challenges.

> *'The trauma has not healed completely. Depression is a major issue for the Karen; they don't want to admit it because of shame.' (Wilfred Tun Baw)*

The health needs of elders will be addressed in section three. But it should be noted here that elders suffer from isolation. This can lead to mental health and depression. When not treated, it may lead to suicide. The data on death by suicide often remains hidden in the communities.

Obesity, Diabetes & Unhealthy Nutrition

Sunny Chanthanouvong, Ly Vang and Doua Lee, three prominent SE Asian agency directors, are concerned about obesity in SE Asian children. They see a need for a program to address obesity in SE Asian children and educate the communities about healthy nutrition. Testifiers spoke about an increase in incidence of diabetes, heart diseases and kidney stones. These conditions are related to changes in diet. There is a need to education refugee communities about maintaining healthy nutrition.

There was evidence of ongoing education on healthy lifestyles from the community agencies. A testifier from a Vietnamese agency spoke about health life styles. She said that about 78% of the Vietnamese are healthy. She said, 'a healthy life style keeps them healthy. Physical exercise,

The Case of a young Hmong adult who weighed 300+ lbs.

Ly Vang's written testimony of a young Hmong adult age twenty one who weighed three hundred pounds illustrates the lack of understanding in the Hmong community about diabetes. The family didn't understand the symptoms. When he went blind, his mother said, "Go wash out your eyes". "Why are you drinking two liters of pop?" The story illustrates how there was no understanding of diabetes in this Hmong family or of how obesity is linked to diabetes. And little understanding of treatment.

healthy eating styles, and keeping everything in moderation.'

Obesity is linked to other health conditions such as diabetes. In the Cambodian community diabetes is a problem affecting 60% of Cambodians forty years of age and older. Mei Ding referred to the problem of obesity in her testimony on data - there is a need for local data on these problems, not just data from national studies. These problems also point to the need for more health education:

> *We need more educational materials for Hmong on healthy nutrition. I think changes in the Hmong diet in America is a cause of diabetes and stroke. Rice is the main dish. But here the people eat too much pork and beef. Once meat was for special events in the villages. But now meat is readily available from Hmong butchers.' (Ly Vang, AAHWMN)*

Kidney Stones, Failure & Dialysis

The testimony raised awareness on some important health conditions such as Kidney Stones. Changes in diet in the US for refugees are linked to kidney stones. MaiKhia Moua brought up the issue of Hmong kidney stones. She cited a leading urologist's report that shows the incidence of kidney stones in the Hmong community as four times that of the incidence of kidney stones in the mainstream community. It is treatable. Medications exist that dissolve the stones.

★★★★★★★★★★

A review urological charts of Hmong patients that seemed to suggest that the Hmong as a group had higher rates of kidney stones, uric acid stones, and complications from kidney stones than non-Hmong patients. "The prognosis is generally an acute and non-life-threatening problem," she said. "But there is some concern about kidney failure." Kathleen A. Culhane-Pera, MA, MD

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Tobacco & Alcohol

Minnesota has a tobacco prevention program aimed at reducing tobacco use. Southeast Asian staff funded to work on tobacco prevention, say second hand smoke from tobacco is a problem in families with children whose parents smoke. A testifier said that sometimes Asian smokers do not understand an issue or a problem. For example, they do not see tobacco as a problem. They used tobacco in Asia. They have smoked for thirty years.

> *'Sometimes elders do not understand an issue or a problem. For example they do not see tobacco as a problem. They used tobacco in Asia. They have smoked for thirty years. We have to present tobacco as a combination, talk to them about eating, exercise and tobacco.' (Yorn Yan, UCAM)*

Some Asian adults and even teenagers struggle with alcoholism. Alcoholism was mentioned as a problem in Asian communities in relation to social adjustment problems. Alcohol becomes a problem when used to adjust to life in America. Testifiers spoke about how alcohol abuse in their communities is linked to the decades of oppression, injustice and torture in home countries such as Burma and how excessive alcohol use brings more problems into a family. They see alcoholism related to mental health issues, domestic violence and to the behavior of children in families that are less structured due to an alcoholic

parent. Alcoholism affects the family and brings more problems into the family. One testified said families with alcoholics become unstructured.

Topic 5: Health Issues (External)

The testimony raised awareness on issues of domestic violence and health and health issues of Asians living in crowded and unsanitary housing. The theme of socio economic conditions grew out of a discussion between the listeners and testifiers.

Domestic Violence

Domestic violence is a major hidden problem shared across API communities including Asian Indian, Chinese, Hmong, Lao, Karen and Korean. It was mentioned in the testimony on data that battered wives are an estimated 9.8 %. In a non-profit agency staffed by Hmong women serving Hmong, and Asian Indian women serving Asian Indians, they see domestic violence abuse issues related to mental health.

> *'In my work in a non-profit agency staffed by Hmong women serving Hmong, we see family domestic violence abuse issues related to mental health.' (Ly Vang, AAHWMN)*

> *I have been with SEWA for five years. There is a problem with domestic violence in the Asian Indian and Tibetan community. ((Raj Chaudhary, Asian Indian Family Wellness Center, AIFW-SEWA)*

Youth: Schools, Crime & Violence

> *'We hear immigrant parents despair they don't know how to raise their children in America.' (Lydia Lee, Minneapolis School Board)*

Lydia Lee, herself an Asian American educator, told the panel of listeners about gang violence as a health and public safety issue. The Hmong Gang Violence Prevention HGVP task force is trying to see what they can do to prevent gang violence. Working with community agencies. Holding meetings where police can get to know students. The work of the Hmong Gang Violence Prevention is raising awareness about mental health issues. Ms. Lee also mentioned nutrition and obesity. She finds there is a lack of education on health prevention issues such as diabetes control.

> *'Many in the Asian community have the unrealistic expectation that it can be cured after just one visit. They do not understand the need for ongoing treatments over a person's lifetime. They think if it is controlled, it is cured, and they stop taking medication.' (Lydia Lee, Minneapolis School Board)*

The schools can play a bigger role in education about prevention. Problems with medical compliance can be resolved through education.

Several other testifiers addressed the needs of youth. Doua Lee linked poor health is a cause of the crime rate.

Mental health problems, physical health, environmental health, channel down from the adults in their families to the children.' (Doua Lee, Executive Director, Southeast Asian Community Council, SEACC

Housing & Poverty

Other issues of concern in the AP communities were the high costs of medications and affordable housing. In her testimony, Somly Sitthisay said that living in cramped housing causes depression. Inferior housing and poverty rates affect medical compliance.

Topic 6: Professional Development

We need more health workers to educate our community how to prevent illnesses and to understand how important it is to take medicines and follow up with the doctor.' (PawWah Toe, Karen Liaison)

The health care 'pipeline'

There is a lack of diversity in heath care professionals. There are insufficient numbers of Asians training for and entering careers in health care and the medical field. There is a shortage of Southeast Asian social workers, mental health workers, and community health workers. Issues of attraction, recruitment and retention were raised under the general topic of how to get more Asian students interested in careers in health care. Agencies such as Wilder Foundation do not have the capacity to meet the needs of the community. One of the major barriers is that students do not perceive health related jobs as financially lucrative careers.

Professional development

Professionals at Wilder Foundation, volunteers at the Minnesota International Health center and members of the Hmong Mental Health Network (HMHPN) help and support each other in professional development through regular meetings, conferences and workshops. The written testimony from Bounleuth Gowing is a good illustration of professional development within the API communities. She was the only Lao person at a national conference on cancer. The conference gave Bounleuth an opportunity to meet national leaders.

"I met Susan Matsuko Shinagawa, the co-founder and Ho Luong Tran MD, MPH. I found this very helpful to me as a care giver. I learned more about how to encourage the community on cancer prevention and why they should go to get

regular screenings and how to support the care-givers' (Bounleuth Growing, Lao community health worker).

Cultural Competency

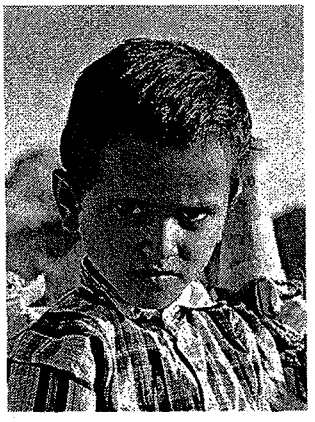
Throughout the testimony listeners heard about the need for more culturally appropriate services for Asians. In addition to efforts to attract more Asians into health care, there needs to be an ongoing focus on the training of mainstream health professionals for increasingly culturally diverse populations in both urban and rural areas.

Dr. Linda Gensheimer in her dissertation, "Hmong Mental Health Providers: A Hermeneutic Approach to Understanding Their Experience," interviewed several Hmong mental health providers to look at the complexities of their "culture, language, refugee experience, trauma, resettlement, Western education, being Hmong, commitment, perseverance, creativity, and hope." She concluded there is a need for greater capacity, more licensed staff and supervisors from the Southeast Asian community.

Topic 7: Emergency Preparedness

There is a need to educate the Asian communities about preparing for and responding to natural and human engineered disasters. The Asian and Hmong outreach coordinator for the American Red Cross testified how outreach efforts on Emergency preparedness are hampered by language barriers:

'Seniors and Hmong immigrants only speak their native language at home or in public. And the majority of them have no formal education. So they have language barriers. And most of them still practice shaman or traditional healing first rather than Western culture. Most of these people rely on children. Families,



Part Three: Solutions from the Asian Community Health Disparities Forum

> *'The health issues are very complex and not the same as health issues among Caucasians. Culture and health are intertwined. We need to take broader approaches. One solution in our community is to bring nurses and doctors together to talk about health issues and find culturally appropriate ways to tackle problems.' (Yorn Yan, UCAM)*

This section presents the community based suggestions on ways to reduce health disparities. The forum was focused on finding solutions to the problems and many were generated. The solutions are first presented around the seven topics, followed by further solutions from an analysis of the discussions.

1. Health Access: Reducing Disparities

A top priority to address under health access is communication and the need for an improvement in medical interpreter services. A proposed solution is to mandate at the state and local levels a requirement for standardized interpreter training.

Medical Interpreter training and mandated standards

> *'I think a lot of people who need interpreters can be helped if there were better ways to train and regulate interpreters. I think some agencies hire incompetent people who may do more harm than good.'(Testifier)*

- Implement standards for medical interpreter training and a certification process for medical interpreters
- Locate and distribute a set of universal signs and color codes used in health care settings in other states
- Educating the community on how to file complaints about flawed interpreter services with the Federal Office of Civil Rights
- Help the Office of Civil Rights identify best practices in compliance reviews of health organizations.
- Assist the Office of Civil Rights conduct workshops, technical assistance and training to help Asian communities on how to file complaints

A solution suggested by the listeners at the federal level is to file complaints about interpreter services or lack thereof with the Federal Office of Civil Rights:

- Convene workshops and technical assistance and training from the Office of Civil Rights to help the API communities get action through an increase in the number of complaints filed
- Help the Office of Civil Rights identify best practices to help them in their compliance reviews of health organizations

Other solutions to health care access at the local level are:

- Increase communication skills of Asian refugees and immigrants so they are able to communicate with their doctors effectively
- Provide educational materials written in Asian languages in an effort to overcome language barriers.

'I would like to encourage all providers who see Karen patients, could you please provide all information in our Karen language, all information that they should need or understand. It will be better with a written note in their Karen language, not only information verbally through an interpreter.' (PawWah Toe, Karen Interpreter and Community Liaison)

2. Health Education/Health Promotion

A greater focus and attention to health education in the Asian communities will bring about solutions to many of the problems in topic areas such as health conditions and health issues. Health education through community agencies emerged as a key strategy. The recommendations are:

- Increase emphasis on health education in the Asian communities
  - Increase health education, prevention and treatment programs on cancer, diabetes, hepatitis B and clinical depression
- Increase health education in the communities about the dangers to health from obesity
  - Implement an obesity education program
  - Implement healthy nutrition workshops
- Emphasis on prevention of health disparities
- Work with shamans to improve on health care
- Increase understanding of barriers to medical compliance
- Continued legislative support for the Office of Minority and Multicultural Health (MDH-OMMH) health disparities initiatives and grant programs

The director of a leading Hmong agency said 'we want to start working with our clients on teaching them healthy nutrition.' We need to recognize the key role of Mutual Assistance Associations and Community Based Organizations in health education, promotion and access. The education of the newer refugee communities on health disparities is best achieved through recognizing the role of the MAAs.

This will require continued legislative support for the Office of Minority and Multicultural Health (MDH-OMMH) health disparities initiatives and grant programs

3. Correcting problems with API Health Data

We heard strongly about the need for data. Without data Asian sub populations are invisible. Given that much of the API data is useless, meaningless, and overly generalized, researchers suggested energetic research to correct the faults. Improvements in data would lead to

attention on the specific health care needs in a particular community such as cancer, diabetes, or obesity. Policy makers and grant writers need data that is meaningful and useful. There is an urgent need for desegregated data. Desegregated data would allow relevant conclusions to be drawn for a specific population currently lumped under the API umbrella category.

Desegregated data

Break down aggregated data group as 'Asian Pacific' into ethnic specific data on different sub populations (e.g. Hmong, Chinese, Asian Indian, and Korean).

Improvements in data collection

- Use of more culturally appropriate research models for collecting data
- Researchers suggested research models that combine qualitative with quantitative approaches

Testifiers suggested ways to improve data collection using participatory research methods. Surveys as a method for API data collection are not reliable enough. The community agencies could be trained to help with data collection. Through collaboratives with researchers at the University of Minnesota Health Disparities Research Department, descriptive analyses could be collected across the agencies.

- Identify new improved methods of data collection on the API Communities that would shed light on Health Disparities in different communities
- Fund small projects to improve data collection
- Explore creative ways to improve on data collection
- Form collaborations with communities to improve on data collection
- Establish a data committee to work on these issues (either across the four diversity councils, and MA/AHC, including researchers and epidemiologists)

4. Health Conditions

The solutions to the problems of health conditions can be resolved through greater efforts in health education. We need to recognize the role of Mutual Assistance Associations in spreading health education and serving as centers of healthy activities Yorn Yan's point about bringing nurses and doctors together to talk about health issues and find culturally appropriate ways to tackle problems underlines a key strategy. Health education. needs to be a collaborative between health professionals and community agencies. The agencies are playing a major role to ensure cultural health and fitness.

- Health education through or in collaboration with community organizations
- Support for the MAAs as cultural health and fitness centers
- Smoking cessation programs

Cultural health and fitness centers

Bringing the elders together for shared cultural and social activities in community agencies greatly contributes to their individual health and mental health. The Asian mutual assistance associations working with youth, families and elders play a key role health promotion. They achieve great results working with very limited resources. There are few licensed mental

health counselors to counsel elders but elders participate in programs and classes at community agencies and senior day care centers. They talk, play and exercise. These formal and informal activities play a big role in reducing health disparities.

- Bringing elders out of isolation
- Providing social and recreational programs for elders

Many of the older adults and elders in the Asian communities are unlikely to use mainstream fitness programs such as Curves or Bally's or even the YMCA and YWCA facilities. . Yet they engage in healthy activities including using exercise equipment when available at their community organizations and day care centers. Organizations such as UCAM have exercise equipment. The concept of the community agency as a cultural fitness center is one that emerged through our reflection on observations in cultural organizations and day care centers.

- Find ways to reimburse the MAAs, CBOs and Community health workers in their role as health educators.
- Recognize their important role as cultural mediators
- Find ways to develop the MAAs as cultural health and fitness centers

5. Health Issues

Many of the health issues such as help to Asian victims of domestic violence, and HIV AIDS prevention can be best addressed through the community service providers. Solving socio economic problems will help reduce Asian health disparities. Raising people out of poverty will have a positive impact on their quality of health care and health access. Specific solutions proposed were as follows:

- Help Asian community agencies access funding for domestic violence prevention
- Help Asian community agencies access funding for HIV AIDS prevention
- Help elders who cannot afford the high cost of co-payments
- Build housing designed to meet the needs of Asians for larger units for extended families

6. Asian Health Professionals

The forum suggested several solutions to the need for more Asians in health care. It is part of the larger problem of not enough minorities employed in the health professions. Minnesota will need to devote more resources to recruit, train and retain more Asian health professionals. The number of Asian health professionals needs to include a greater number of SE Asian professionals.

- There is a need for more Asians in health care
- There is a need for more Asian licensed social workers
- There is a need for more Asian community health workers (CHWs)

Ways to increase the number of minorities entering the pipeline are:

- There are more scholarships and loan forgiveness programs needed to recruit more Asian students into the professions
- There are reforms needed in evaluations of credentials so that API and other foreign born professionals trained outside the US can adapt their skills and be employed.
- There are reforms needed in licensing exams to help competent professionals who face hurdles in getting their licenses to practice. If they can't get their training recognized here they cannot enter the pipeline.

Increase cultural competency training for all health professionals including mainstream and American born younger generations of Asian Americans

- Increase the required hours of cultural competency training among all health care professionals in training.
- Increase the number of workshops available in continuing health education for mainstream professionals
- Increase attention to cultural competency education for all health professionals
- Increase understanding among mainstream health provider professions about the spiritual beliefs of Asian communities and how these beliefs impact health care

7. **Solutions specific to Asian youth and elder's health**

'Focus on the youth now. Our youth are our future' (Doua Lee, SEACC)

Asian Youth: health and mental health

- Support the MAA youth programs
- Provide more focus on screening the children for mental health in the early grades. (Tong Yang).
- Make mental health screening as high a priority as physical health screening

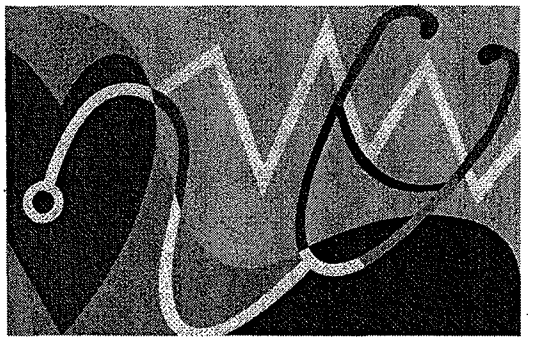
Asian adults and Asian elders: health and mental health

- Increase the number of professionals serving Asians
- Increase healthy eating through healthy nutrition programs
- Continued support for tobacco cessation programs that help Asians quit smoking
- Reduce the high cost of medical co-payments for elders and alleviate the hardships of elders on limited incomes

Two longer term solutions to resolve many of the above problems would be to establish an Asian Community Health Center (ACHC) and an Asian Pacific Cultural Center (APCC).

'The model I would like to see implemented is a federal (Asian) community health center. The model must have cultural competency. (Emily Wang responding to a question from Gregory Gray)

Part Four: Analysis of the data & key findings



An analysis of the data reveals a further set of themes woven into the testimony in addition to the seven predetermined topics. This section presents the data on these three themes - the health of youth, the health of elders, and the role of the MAAs

A). Health Disparities: Youth

This section of the report contains insights from the API health forum analyzed from the perspective of youth. The health needs of youth are different and sometimes need different approaches to resolve them.

Dr. Thompson, a psychiatrist from HCMC working with Hmong and Lao families at Northpoint Clinic said that SE Asian children are under-served. Social services are much harder to access. Behavioral problems in the SE Asian population increase significantly with age. Yet appropriate behavioral and mental health resources are almost non-existent.

- Asian youth are an underserved population
- Asian youth need education on HIV AIDS
- Asian youth and families need education on obesity
- There is a lack of mental health service for youth and their families
- Youth need information on planned parenthood
- Southeast Asian youth need teen pregnancy prevention

There are many barriers to reducing pregnancy among Asian teens. Bi-lingual staff from Planned Parenthood is active in one Hmong agency helping to raise the awareness of Hmong youth and their families about teen pregnancy. They said there is a need to get Asian parents involved. There is also a need for health prevention materials targeted for youth. Regarding HIV AIDS prevention and API youth, Mr. Gilbert Achay said that API youth are victimized by other ethnic youth. This is a major cause of truancy. Doua Lee explained how poor health led to other problems and underscored that mental health is an intergenerational issue that need the entire family to address.

B.) Health Disparities: Elders

Health disparity issues were identified around the needs of Asian elders. Two key topics are isolation and the impact of cultural and spiritual beliefs on health. Many elders in different communities are lonely and isolated. We heard that isolation is a problem throughout the

Asian communities. It is a common problem among Hmong, Cambodian, Vietnamese, Lao, and older immigrant groups such as Asian Indian and Filipino.

Community programs bring elders out of isolation
The elders who come to community organizations can get help on health care from staff. The staff in the MAAs and CBOs are often the first to hear about their problems.

> *'Elders complain to us that their health costs are high. Some of our elders cannot afford co-payments. When an elder is on ten or fifteen different medications, the co-payments add up and are unaffordable. A co-payment might seem reasonable but when you multiply an average of $10-15 co-payment ten times for ten different prescriptions you have elders on limited incomes with a monthly total of $100-150 for medications." (Yorn Yan, UCAM)*

All the Asian communities struggle with an aging population and lack of culturally appropriate services. Elders across the Asian communities need access to meals on wheels that meet Asian food preferences. There are some excellent programs but not enough. There is an assisted living program for elders in the Korean community, and excellent senior day care centers for Hmong Elders, and programs for Asian Indian, Cambodian and Vietnamese elders. Vinodh Kutty advocated for an Asian Pacific Cultural Center. This space would have brought the elders together. But the funding for APCC was vetoed by the governor in the closing of the legislative session.

Mental Health Issues of Refugee Elders
The process of resettling in America has been hard on elders. Testimony brought to light that there are a lot of clinically depressed elders. Many struggle with mental health problems. Mental health of refugees is one of the major health problems of refugees in the US. Mental health and depression is a leading health issue, leading to suicides. Many struggle with mental health problems.

> *'I want to draw attention to the health of the Lao in Minnesota. The elders fought in the Lao army for the Americans. Two hundred thousand were recruited as American allies. Casualties were high on the battlefield.' (Khao Insixiengmay, Executive Director of Lao Advancement in America)*

Elders come with many cultural and spiritual beliefs on health from their countries and cultures of origin. These Cultural factors affect medical compliance.

Previous Cultural History
Many of the older first and second waves of Asian Pacific immigrants have been here for generations. But the story is different for the last waves of refugees. We need to be mindful of the impact on health of the traumatic cultural, social and economic changes refugees have been through. Across Minnesota, in large and small towns where the refugees are resettling many elders are still clinging to older traditional cultural belief systems. In Minnesota we

have Hmong and Karen extended families living now in cramped housing in urban housing environment who remember their life growing up in rural mountainous highland villages.

We have known for decades how culture and health beliefs are intertwined. The stories illustrate how culture and health can be linked into best practices.

Cultural Health Beliefs and Traditional Cultural Practices

> *'I'm working at Health East Roselawn Clinic as the Karen speaking interpreter helping the Karen refugees with their medical appointments to see a primary doctor. Our Karen back home in Burma, we never go to a clinic for medical check ups, we only see a doctor when we are sick. There is a lack of doctors and medicines. Most of the time when we feel sick we buy medicines at the drug store without a doctor's orders, so it is very different from here. I saw a lot of difficulty adapting to Western medicine in my community.' (Karen Interpreter)*

Testifiers described lack of regular checkups, lack of understanding of western systems, lack of knowledge and education about western theories of health, disease and practice of health care. There is a scarcity of health materials for Asians to read in their own languages, and a corresponding lack of knowledge and understanding about prevention of health diseases.

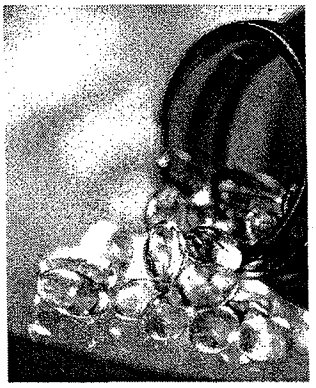
- Elders use traditional medicines. Hmong adults and elders still favor traditional medicines
- Many Hmong go to shamans to find spiritual ways to heal themselves
- Many elders are resistant to changing their beliefs and behavior about health
- Cultural and spiritual beliefs impact on their health

One example is in medical compliance. Elders may not understand that western medicine is different from a health ritual with a shaman. Some elders think they are cured after one treatment. They do not understand the need to stay on a course of prescribed medications. They stop taking medicines. Thus a Hmong elder's cultural and spiritual beliefs can affect his or her medical compliance.

Stigma and Taboos

Stigma and taboos were two other cultural health issues mentioned. Seeking help on mental health means 'you are crazy.'

- Stigma around mental health can inhibit AAPI from seeking mental health counseling and other services
- Stigma and taboos can prevent victims of domestic violence from seeking help
- Communities and families are hesitant to work with professionals on reproductive health



Medical Compliance

Many community members spoke about family members going to see the doctors, getting their prescriptions, taking them for a few days, feeling better and then stop taking the medication, especially around anti-biotics, cholesterol controlling medication, and or anti-depressants. The community still has strong cultural beliefs that medication is to be taken only when one feels unwell. There is a lack of understanding between medicines and their physiology. This attitude has led to the death, repeat strokes and heart attacks and blindness or loss of limb due to diabetes.

C.) Community Service Delivery Networks

This section of the report discusses the role of community agencies in health education, health promotion, and accessing health care. . Asian children, youth, adults and elders all experience disparities and the MAAs play a major role in tackling them. The community agencies are a major tool in tackling the disparities that exist throughout the life span of Asians. The testimony attests to the important role of the MAAs in tackling health disparities of Asian children, youth, adults and elders.

'We have the spirit to help each other. But we need help.' (Wilfred Tun Baw)

This comment by the Karen leader aptly summed up the situation in the communities. There needs to be a greater recognition of the key role played by community agencies. This is an area where more collaboration can occur between the health care system and the parallel infrastructure in the communities. Since the 1980s, the SE Asian communities have established a strong infra structure of self help through over eighteen Southeast Asian mutual assistance associations, known as the MAAs. They are reaching out to other groups such as the Somali and Karen. Many of the MAA's such as Lao Family, HAP, CAPI and VSS have extended their services to the new arrivals. VSS made a commitment to sharing their experience with the Karen. The Vietnam Center hosts the Karen Support Project.

The MAAs greatly contribute to the healthy lifestyles of the communities. The MAAs help relieve the suffering of elders by providing activities that break their isolation and loneliness. They play a positive role in serving persons who would otherwise be clinically depressed.

Recognizing that the activities in the MAAs and CBOs contribute to health, a key solution is to support the Asian Mutual Assistance Centers and Community based Organizations in their role as health educators and cultural health mediators. We need to find ways to recognize, engage, finance, support and reimburse the Mutual Assistance Associations and Community Based Organizations (MAAs and CBOs) for their work in health disparities. The solutions that address this are:

- Increase funding to MAAs so they can do health prevention and education
- Increased recognition and support for MAAs and CBOs in their role of cultural health and fitness centers

- Find ways to recognize, engage, finance, support and reimburse MAAs and CBOs in their role as health educators and cultural mediators
- Support for Home visits
- Support for Asian Senior Day Care programs
- Support activities in the MAAs and CBOs that contribute to improved health and mental health through physical, social, cultural, sports and other healthy fun activities.

Currently there are elder day care centers serving the Hmong populations and an assisted living program serving the Korean elders. There needs to be an expansion of these senior day care centers and assisted living centers to other Asian communities such as the Cambodian, Asian Indian and Chinese, modeled on the best practices in the Hmong and Korean communities. This will require:

- increased sharing of expertise about Asian senior day care centers and assisted living programs
- learning how to access funding for day care centers and assisted living programs

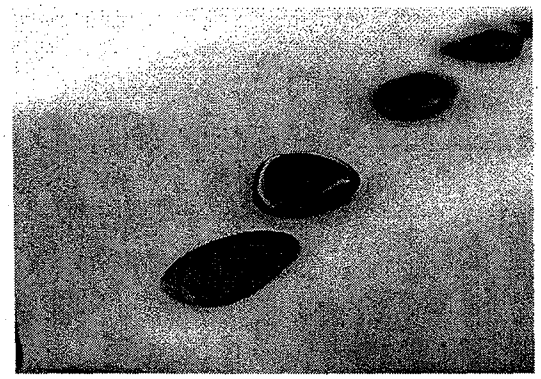
It should be noted too that the Asian population is aging. There will be many Asian elders not mobile enough to travel to the Asian cultural centers. Currently, Southeast Asian Ministry has a bi-lingual Asian staff of pastoral nurses who conduct home visits. The MAAs need to learn from the SeAM model and develop their capacity to serve home bound elders. This will require:

- Increased funding for Asian agency staff to make home visits
- Increased access to existing meals on wheels services
- An appropriate change in meals on wheels menus to accommodate Asian food preferences
- An expansion in the number of agencies providing meals and wheels services

The immediate problems to address are health access, standards of medical interpretation, need for health education for Asians with different cultural health belief systems. Some of the solutions and best practices can be implemented through the community agencies. They are already working on specific health conditions such as diabetes, hepatitis, and cancer. Problems like medical compliance can be partly resolved by having clinics collaborate more with the Asian Mutual Assistance Associations and develop their role as Community Health Centers. Supporting and reimbursing the community health workers are an expedient means to achieving this goal.

Part Five: Summary & Conclusions

'[We] are here today, to share experiences of our community, to let the officials know, so we can start to reduce health disparities that affect us.'



(Nancy Pomplun, Minnesota Asian/American Health Coalition)

The major problems and solutions presented under each topic were:

Medical interpreters standards

The testimony and stories reveal that problems with medical interpreters and the quality of medical interpretation is a major cause of health disparities. Misinterpretation affects medical access, medical care and medical compliance

- There was an urgent call to address the lack of standards in the quality and training preparations of medical interpreters

Asian Health Promotion

- There needs to be greater collaboration between health departments and the community service providers
- There needs to be an increase of funding to the MAAs

Asian Health Data

Asian health status data and data collection methods are seriously flawed and render data meaningless. The report documents how to resolve the issues and improve on Asian health data and collection.

- Desegregated data
- Asian Data collection through participatory research with community agencies

Asian Health Conditions and Asian Health Issues

The solutions to the problems identified require capacity building and collaborations

- Develop the capacity of community social service agencies to play a larger role in health care promotion and prevention.
- Involve community service providers, temples, mosques and churches in health care.
- Recognize that community agencies play an important yet often unacknowledged role in health care.

Asian Health professions

- There are insufficient numbers of Asians students training for and entering careers in health care such as social work, mental health workers and community health workers
- We need to find ways to attract and recruit more API students into the 'pipeline.'
- Grants and forgiveness loans
- An increase needed in cultural competency training.

In today's context of state and federal budget deficits, health care costs are high but policy makers need to be aware that greater attention to the health needs of the Asian communities in prevention and proactive ways suggested by this report will result in overall economic savings, reduce health disparities and help lower health care costs.

Appendix

**Testifiers at the forum included a Hmong shaman, researchers, professors, public officials, executive directors, program managers and staff from the following community agencies:*

Asian Indian Family Wellness Center '('SEWA' – AIFWC)
Association for the Advancement of Hmong Women in Minnesota (AAHWMN)
Chinese Services Center (CSC)
Karen Support Project
Korean Services Center (KSC)
Lao Assistance Center (LAC)
Lao Advancement of America
Minnesota Institute of Public Health MIPH)
Southeast Asian Community Council (SEACC)
United Cambodian Association of Minnesota (UCAM
Vietnamese Minnesota Association (VMA)
Vietnamese Social Services VSS)
Wilder Southeast Asian Services Center

Officials present in the role of 'Listeners' include:

Mildred Hunter from the Office of Minority Health,
S Magnum, Commissioner for Health,
Mitchell Davis, MDH-Office of Multicultural and Minority Affairs,
Gretchen Musicant, Commissioner for Health in the City of Mpls,
Mike Siebenaler, Health Advocate from Congressman Keith Ellison's Office,
Chao Lee form Congresswoman Betty McCollum's Office,
Gregory Gray from the Legislative Commission to End Poverty,
Andrea Lindgren from the Office on the Economic Status of Women (OESW, Representative Erin Murphy,
Representative Joe Mullery
Representative Willie Dominique
Alice Seiffert from the office of State Senator Linda Higgins.
Jamie Olson from the Office of State Senator Linda Scheid