



The
**State of
Asian Americans
& Pacific Islanders
in Arizona**

VOLUME 2

Health Risks, Disparities and Community Responses

A report presented by:
Asian Pacific Community in Action
Health Through Action Arizona Steering Committee
ASU Asian Pacific American Studies Program

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December 2011

Congratulations to the Asian Pacific Community in Action and the Arizona State University Asian Pacific Arizona Initiative on the publication of the ***State of Asian American and Pacific Islanders in Arizona***, which documents the current health related issues faced by Arizona's Asian Americans, Native Hawaiians, and Pacific Islanders today.

The publication of this report could not be timelier. The Asian American and Pacific Islander population is one of the fastest growing minority groups in Arizona, showing close to a 90% increase from 2000 to 2010. *The State of Asian Americans and Pacific Islanders in Arizona* report will help policy makers in public health and health care better understand who Arizona's Asian American and Pacific Islander community is, a growing part of the larger Asian American, Native Hawaiian, and Pacific Islander community across the nation.

We at the Asian & Pacific Islander American Health Forum (APIAHF) have worked closely with and have supported Asian Pacific Community in Action to build community through collaboration, engagement, increased visibility, leadership, and storytelling. This report and the associated symposium, entitled, "Health Through Advocacy: A vision for a healthier Arizona" are inspired and we envision the work serving as a "call to action" for our communities, both in Arizona and across the nation. These resources can also serve to drive community dialogue and engagement.

We offer our hearty congratulations for producing this report, as it is a testament to the diligent and collective effort by Asian Pacific Community in Action, ASU Asian Pacific American Studies Program and community members to offer special insight into the more than 30 Asian American, Native Hawaiian, and Pacific Islander communities who call Arizona home.

With both immigrant backgrounds as well as through generations of historical presence for over a century, Asian American, Native Hawaiian, and Pacific Islander communities enrich the lives of all Arizonans through their rich heritage, cultures and countless meaningful contributions. Moreover, the report identifies the current needs, interests and challenges among these communities and, through this document; we are afforded an opportunity to gain significant understanding and awareness.

Congratulations on this significant accomplishment.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kathy Lim Ko', written in a cursive style.

Kathy Lim Ko
President & CEO



Foreword

Two Steps Forward, One Step Back

This volume represents an effort to understand and explore a significant and growing population for whom understanding and exploration are in too short supply. Asian Americans and Pacific Islanders (AAPIs) are the fastest-growing racial/ethnic minority group in Arizona. But they garner little attention, particularly in the area of health. A group of dedicated individuals sought to refocus that lens.

The State of Asian Americans & Pacific Islanders in Arizona, Volume 2: Health Risks, Disparities and Community Responses is the second in a noteworthy series. It follows on the success and influence of 2008's Volume 1, which marked the first comprehensive picture of AAPIs in Arizona. Breaking new ground, that book took a necessary and wide-ranging look at many topics affecting the AAPI community, including history, health, economics, immigration, education, public safety and community events. In this 2011 volume, however, our survey of the landscape revealed a particular area of great need—health—which led us to our focus.

Both books are the result of incredible support from a wide variety of partners.

In 2008, we benefited from the assistance of the Asian Pacific Americans in Arizona (APAZI) community advisory committee, Arizona State University's Office of Public Affairs and ASU's Asian Pacific

American Studies program. And this year, in a volume dedicated to health prospects for the AAPI community, the community again came together. Driving the project was Health Through Action Arizona (HTAA), a Kellogg Foundation-funded grant awarded to Asian Pacific Community in Action (APCA) to build empowerment, awareness and advocacy around issues of health in the AAPI community. APCA staff and the HTAA steering committee have been involved in program planning, data analysis and leadership activities to improve AAPI health in Arizona.

So what do we know about the disconnect between a large and growing minority group and its near-invisibility from the view of policymakers?

As noted previously, the 2010 Census identified AAPIs as the fastest-growing such group in the state. Despite these numbers, their health challenges and dilemmas go largely unnoticed. Perhaps hindered by the "Model Minority" myth, which portrays all AAPIs as well-off, policymakers may fail to consider and understand the specific health needs faced by AAPI communities. And those challenges are magnified by the fact that first-generation immigrants comprise two-thirds of the AAPI population in Arizona. Given the language, socioeconomic and acculturation difficulties faced by any ethnic group writing their first chapter in a new nation, ignoring their needs may have dire consequences.

As an example of a community facing a growing crisis, AAPIs have the highest rates of tuberculosis and Hepatitis B per capita in the state. Death rates due to cancer and heart disease are increasing among AAPIs while they are decreasing in other populations. The refugee community is large, and many AAPI individuals confront language and cultural barriers in accessing health care in Arizona.

Thus, the growth in the AAPI population signifies the importance of AAPIs in the future of Arizona—two steps forward. The growing health challenges, with few resources or attention paid, are one step back.

In the pages ahead, our talented and experienced authors examine the complexity of factors affecting the health of AAPIs. By offering this information, we aim to improve the collective understanding of AAPIs, including their history in Arizona, their demographics and health status, and the social and health policies affecting their lives. The ultimate goal is that these insights will be considered in the development of programs, services and policies to improve the quality of life for Asian Americans and Pacific Islanders—as well as all Arizonans—for generations to come.

*Asian Pacific Community in Action
Health Through Action Arizona
Asian Pacific American Studies,
Arizona State University*



Overview of Asian Americans & Pacific Islanders in Arizona

“Being the youngest of five children, my parents have taught us so much about caring for others and taking care of each other. I’ve observed how they practiced what they preached. It’s what I’ve been taught and today, it’s all I know about caring for someone and it all begins with family.”

Excerpt from “My Sister,” a digital story by Elaine San Nicolas
Complete stories at <http://www.apcaaz.org/gallery.htm>

A Growing Community: Diverse Strengths and Challenges

By Doug Hirano

Asian Americans and Pacific Islanders in Arizona

The Chinese were the first Asian settlers in Arizona, arriving in the 1850s to work in the local copper mines and on the Central Pacific railroad. Japanese settlers began arriving in Arizona in the 1890s and early 1900s. Many worked in fields until they could start businesses. In general, however, the number of Asian immigrants residing in Arizona was relatively small for many decades. In 1910 U.S. Census Bureau data indicated that just 1,305 individuals of Chinese descent and 371 of Japanese descent resided in Arizona. By 1950, the total number of Asian Americans and Pacific Islanders (AAPIs) in Arizona had barely doubled to 3,204.

However, this number began increasing quickly after 1970 (see Table 1-1). Reasons for the increase include an influx of Southeast Asian refugees in the 1970s and 1980s, as well as immigration of skilled and semi-skilled workers and their families from China, Korea, India and the Philippines after 1980.

There was an 82.5% increase in AAPIs in Arizona from 2000 to 2010 (see Table 1-1). In particular, the Asian Indian population increased significantly (144%), as did the Filipino population (116%). Of the larger ethnic groups, the Japanese had the lowest rate of

increase – 19%. In Arizona a total of 226,285 individuals identified as “Asian only” or Asian and one or more other ethnicities on the 2010 census.

AAPIs reside in every Arizona county except Greenlee, for which data from the U.S. Census 2010 are not available (Table 1-2). The majority (89%) of all AAPIs in Arizona reside in either Maricopa or Pima County.

The median age for Arizona’s population overall is 34.8 years. The Caucasian population has a higher

median age (37.5 years) with AAPIs having a lower median age (34.6 and 32.5 years, respectively). The minority group with the youngest median age was American Indians, at 26.9 years.

In terms of language, 22.6% of households (6,901 of 30,428 households) in which residents speak an Asian or Pacific Islander language are linguistically isolated (no one more than 15 years of age speaks English “very well”).

There was an 82.5% increase in AAPIs in Arizona from 2000 to 2010.

Table 1-1
Population Change in Asian or Pacific Islanders, Arizona, 1960–2010

	1960	1970	1980	1990	2000	2010
Chinese	2,936	3,878	6,820	14,136	21,221	32,270
Japanese	1,501	2,394	4,074	6,302	7,712	9,152
Filipino	943	1,253	3,348	7,904	16,176	35,013
Korean	---	488	2,249	5,863	9,123	15,022
Hawaiian/Pacific Islander	---	401	1,307	3,507	6,733	12,458
Asian Indian	---	---	2,102	5,663	14,741	36,047
Vietnamese	---	---	1,932	5,239	12,931	24,216
Other	---	---	---	3,560	10,332	16,548
TOTAL	5,380	8,414	22,032	55,206	98,969	180,726

Source: U.S. Census Bureau

The Distribution of Health

Good health is not randomly distributed. For example, women live longer than men. People living in the southern United States have higher rates of obesity and cardiovascular disease than those in other parts of the country.

Race/ethnicity is a separate influencing factor related to health status. In relation to the AAPI population, some AA groups experience rates of stomach, liver and cervical cancers that are well above the national average; rates of diabetes among Pacific Islanders are among the highest in the world.

These racial/ethnic differences in health are often described as “health disparities,” and progress in decreasing or eliminating health disparities has been maddeningly slow in the United States. Indeed, for the fourth consecutive decade, the elimination of health disparities remains a key goal within the nation’s *Healthy People* strategic plan.

Arizona residents are not immune to health disparities. In 2007 the median age of death for American Indian residents was 59 years. This compares

to 78 years for non-Hispanic Whites. The infant mortality rate for African Americans in 2008 was 17.7 per 100,000 births, as compared to 5.1 for non-Hispanic Whites. From 2004–2008, the rate of new HIV/AIDS cases among African Americans was 38.6 per 100,000 residents, as compared to 9.6 per 100,000 among non-Hispanic Whites.

Given the anticipated demographic changes in Arizona over the next decade, the importance of addressing disparities in health status is magnified. Minority racial/ethnic groups currently experiencing poorer health status are expected to grow significantly as a proportion of the total population. The future health of Arizona can be influenced substantially by improving the health of these groups.

Health Outcomes for Asian American and Pacific Islanders

Asian Americans and Pacific Islanders are fast growing groups in the United States. As a whole, they fare quite well in many key health status measures, including life expectancy, overall death rate, infant mortality, and mortality due to heart disease and cancer. Indeed, the 1985 landmark report “Health Secretary’s Task Force on Black and Minority Health” stated “[T]he Asian

Table 1-2

Asian Americans and Pacific Islanders by County, Arizona

County of residence	Asian American	Pacific Islander	Total
Apache	300	30	330
Cochise	2,341	401	2,742
Coconino	1,583	225	1,808
Gila	94	142	236
Graham	178	40	218
La Paz	423	21	444
Maricopa	113,624	6,681	120,305
Mohave	1,975	245	2,220
Navajo	468	115	583
Pima	24,612	1,054	25,666
Pinal	4,106	1,370	5,476
Santa Cruz	113	193	306
Yavapai	1,437	240	1,677
Yuma	2,011	278	2,289
TOTAL	153,25	11,035	163,300

Source: U.S. Census Bureau, American Community Survey, 2005 – 2009

Table 1-3
Selected Health Statistics, Arizona 2009

	Arizona (Overall)	AZ Asian American
Pregnancies less than 19 years of age (per 1,000 females ages 10 – 19 years)	28.0	11.6
HIV/AIDS rate (reported cases per 100,000 population)	10.2	5.8
Tobacco use during pregnancy (per 100 live births)	4.8	1.7
Fewer than five prenatal visits (per 100 live births)	5.3	3.4

Source: Arizona Department of Health Services

Pacific Islander minority in aggregate is healthier than all racial/ethnic groups in the United States including whites." National and state statistics provided in Table 1-2 would seem to support this.

Data from the Arizona Department of Health Services are provided in Table 1-3. These data also suggest that Asian Americans do relatively well in many health status categories. However, there are at least two critical caveats when examining AAPI health data. The first is that there is an overall lack of health data for AAPIs, and the second is that existing data tends not to be disaggregated by specific AAPI ethnic group. Instead, data for these groups are collected under the larger categories of "Asian American" or "Pacific Islander" or sometimes "Asian or Pacific Islander" or sometimes "Other," thereby impeding the ability to look at health measures by each ethnic subgroup.

When looking more closely at AAPI health data, several areas of

health disparities become apparent. For example, it is estimated that Asian Americans constitute close to 50% of the 1.4 million Americans chronically infected with hepatitis B, even though they constitute only 4% of the nation's population. Asian Americans also have the highest race-specific rate of tuberculosis incidence and underutilize preventive services such as colorectal, breast, and cervical cancer screening when compared to non-Hispanic Whites. Furthermore, selected subgroups of Asian Americans have high rates of tobacco use.

Immigration status is also another factor influencing health. Immigrants tend to enjoy better health status than the native-born population, even when those immigrants are of lower socioeconomic status. However, the longer an immigrant's stay in the United States and the more adaptation to mainstream behaviors, the worse the health status. Because the majority of Asian Americans and Pacific

Islanders in Arizona are foreign born, their health outcomes are related both to the physical, social and cultural environment of their native lands and their new home. For example, Japanese American women now have rates of breast cancer commensurate with White women. These rates are far higher than those of women residing in Japan, suggesting the impact of Western influences. Understanding behaviors and the environment from the home country and how these differ from practices in the United States may help pinpoint and address factors contributing to breast cancer.

Adequately addressing the health challenges of AAPI groups requires increased research that recognizes and documents the great diversity in the AAPI community. Given that the AAPI community represents more than 50 nations and reflects more than 800 languages and dialects, this will be no easy task.

Doug Hirano, MPH is an epidemiologist by training and has served as the executive director of Asian Pacific Community in Action since July, 2006. He is also a past president of the Arizona Public Health Association.



Vital Communication: Language Access in Health Care

By Hong Chartrand & Zipatly Mendoza

The most basic aspect of providing health care is communication.

Perla Flores

Director of Hispanic customer services and marketing for Banner Health
Quoted in The Phoenix New Times, June 29, 2000

Lack of language access in health care is a growing issue throughout the United States, sometimes resulting in misdiagnosis and mistreatment as well as death. For example, a case from the National Health Law Program report, "The High Cost of Language Barriers in Medical Malpractice," involved a 9-year old Vietnamese girl who passed away due to an adverse drug reaction. Her parents did not speak English very well, and the patient and her 16-year old brother, rather than a professional medical interpreter, had to interpret for the medical staff and her parents. As experts who investigated the incident later stated, "the case demonstrates the failure to provide language access on multiple fronts—the failure to utilize a competent interpreter, the use of a minor child as an interpreter and the lack of a translated informed consent form and other vital documents" (Quan & Lynch, 2010).

Language access includes oral interpreting and written translation. The lack of language access in a health care setting can create a health care barrier, and discourage patients with limited English proficiency (LEP) to

seek primary and preventive care and public health services. People with LEP cannot understand, speak, read or write English at a level that allows them to communicate effectively with their health care providers. Such individuals may need appropriate language assistance to access the health care services. The lack of language access services can lead to a lower quality of health care and compound health costs.

Data from the U.S. Census Bureau indicate that the Asian American Pacific Islander (AAPI) population is one of the fastest growing populations in Arizona, with over 40% foreign-born; Asian/Pacific Islander languages also rank as

one of the four main language groups (excluding English) in Arizona. Nearly 28% of the AAPI population in Arizona speaks a language other than English, and almost 11% speak English less than "very well." In Arizona, Chinese (all dialects) is the most common Asian/Pacific Islander language spoken at home followed by Tagalog and Vietnamese. Health care providers may not be aware of the distinctions among all of the AAPI languages and cultures.

Language Rights and the Laws

The rights of individuals with LEP are recognized under core civil rights law. Congress, the U.S. Supreme Court and the Executive Branch through the

Civil Rights Act of 1964, Lau v. Nichols, and Executive Order 13166 have affirmed these rights. The 2011 Joint Commission Standards emphasizes the importance of effective communication between patients and their health care providers. Table 1-4 outlines some of the key pieces of federal legislation protecting the rights of English language learners to access health care services.

The largest barrier faced by individuals with LEP is that health care providers fail to provide adequate language access. Lack of awareness and training as well as cost are often cited as obstacles to providing appropriate language access. Health

Table 1-4
Federal Legislation Protecting the Rights of English Language Learners

Federal Legislation	Description
Food Stamp Act of 1977	Requires states to provide oral and written language assistance to those with limited English abilities under certain circumstances
Public Health Service Act	Indicates that health centers, substance abuse services and other health programs serving a sizable number of English language learners have to provide competent personnel fluent in their language
Immigration and Nationality Act	Requires interpreters to be provided during the physical and mental examination of arriving immigrants
Health Equity and Accountability Act of 2007 (H.R. 3014)	Addresses the current need for culturally and linguistically appropriate health care for those with limited English proficiency
Linguistically Appropriate Healthcare Act (LAHA)	Focuses on language access issues requiring federal attention
National Standards on Culturally and Linguistically Appropriate Services (CLAS)	Addresses the needs of racial, ethnic and linguistic population groups that experience unequal access to health services



care reform offers many opportunities to improve language access by including specific provisions to increase funding, resources and services. However, it takes time to secure funding for language access services. It is important to hold accountable health care providers who are recipients of federal funds—these providers are required to provide equal access to services, which includes language access. Even without legal requirements, ethical responsibilities dictate that health care providers located in areas of culturally and linguistically diverse populations should be encouraged to create their own language access programs.

It is also important that patients with LEP know that they have the right to ask for a medical interpreter or translated information at no cost to them. According to information from the Mexican American Legal Defense Fund and Asian American Legal Center, patients who needed but did not get a medical interpreter were less likely to understand their medication instructions than those who did not need a medical interpreter or those who needed and received one. Patients with medical interpreters were more likely to use primary and preventive care and less likely to use emergency rooms than English proficient patients (Graham, Jacobs, Kwan-Gett, & Cover, 2008).

Moving Forward

The Arizona Department of Health Services (ADHS), Arizona Health Disparities Center (AHDC—the federal designee State Office of Minority Health) and community organizations are striving to improve language access and the quality of care in Arizona. Currently, the AHDC is collaborating with ADHS Office of Refugee Health to conduct a Language Access Needs Assessment at ADHS and will develop a language access policy and guidance for the entire agency based on the needs assessment.

In the future, the AHDC will work with different health care providers to conduct a language access needs assessment and training throughout the state. Unlike with other types of interpreters, such as court interpreters, there is no official state process to qualify, validate or certify the knowledge, skills and abilities necessary for medical interpreters. One long-term goal of the AHDC is to commit stakeholder leadership at the state level to begin the process toward state-wide certification for medical interpreters, as the national medical interpretation and translation industry is taking the lead to create a curriculum and exam for this purpose.

Currently, Asian Pacific Community in Action (APCA), a grassroots organization that provides health education, referral and advocacy to the AAPI community in Maricopa County, has two initiatives related to language access. Their business plan includes a medical interpretation training and

deployment program. APCA is also preparing for an advocacy policy campaign called, “Know Your Rights Campaign.”

These initiatives along with other community efforts are improving language access services and the quality of an individual’s medical care. Effective communication tools are critical to the delivery of quality health care services. Investing in proper language access standards, protocols and services is much less costly than failure to provide language services. By working together, health advocacy organizations and health care providers can improve the quality of care to individuals whose first language is not English and reduce health disparities.

Hong Chartrand, MPA & MA, is the Resource Liaison at the Arizona Health Disparities Center, Arizona Department of Health Services. Ms. Chartrand’s experience includes implementing culturally and linguistically appropriate health outreach program in the community and conducting language access needs assessment. She is a linguist by training as well.

Zipatly Mendoza, MPH, is the Office Chief of the Arizona Health Disparities Center within the Arizona Department of Health Services. Ms. Mendoza’s experience includes development of organizational Limited English Proficiency policies and procedures.





The Immigration Context

By Zeenat Hasan, Priscilla Huang & Maansi Raswant

Residents in the United States have rights to certain benefits and protections, including with respect to health care. Although some of these rights rest on immigration status, others extend to all, regardless of status.

The crafting and enactment of state laws should reflect sensitivity to the complex nature of immigration status and ensure the rights of all individuals, irrespective of immigration status, are protected. Recently, however, several states, including Arizona, have passed laws that directly or indirectly restrict access to benefits and protections for immigrant populations.

On April 23, 2010, Arizona Governor Jan Brewer signed into law the “Support Our Law Enforcement and Safe Neighborhoods Act” (introduced to the legislature as Arizona Senate Bill 1070 and commonly referred to as SB 1070), often described as an “anti-illegal immigration” law. Nearly all of the provisions of SB 1070 were eventually enjoined when various parties, including the U.S. Department of Justice and the American Civil Liberties Union, challenged the constitutionality of the law.

One of the most controversial aspects of SB 1070 would have allowed law enforcement officials to request proof of legal immigration status when there was a “reasonable suspicion” that the individual was an unauthorized immigrant. Despite the

fact that most elements of the law were suspended, misinformation and anti-immigrant propaganda increased with the law’s creation, resulting in fear throughout many immigrant communities.

Prior to SB 1070, Arizona’s legislature had enacted other laws targeting immigrants. Arizona House Bill 2008 (codified as Arizona Revised Statute §§ 1-501(E) and 1-502(E) but often referred to as HB 2008), was signed into law on November 24, 2009 and requires individuals applying for public benefits to present identification documents to prove legal immigration status. Government employees who process the benefits applications must confirm lawful immigration status and subsequently report “discovered violations” of immigration law to federal authorities.

Laws such as Arizona’s HB 2008 and SB 1070 have detrimental effects upon the health and livelihood of immigrant populations. The laws did not change immigrant eligibility rules, however HB 2008 and SB 1070 created burdensome and unnecessary requirements that make it even more difficult for individuals and families to access services. These laws may also deter health care, social work, and law enforcement professionals from pursuing cases of intimate partner violence, physical and sexual abuse, neglect, and other crimes.

The negative effects mirror those of California’s Proposition 187 (Prop 187), passed in 1994 through a ballot initiative. Prop 187 prohibited unauthorized immigrants from accessing a range of public and social services in California, including health care and public education. The law resulted in at least two deaths, attributed to delays in seeking medical care due to Prop 187. Further, there were accounts of widespread fear of reporting and deportation among California’s immigrant communities, likely contributing to reported declines in usage of minority-serving health organizations after the law was passed.

Similarly, HB 2008’s reporting requirements have deterred a significant part of the immigrant population from applying for public benefits they are eligible for and ought to receive. Immigrants are already less likely to have health insurance or use public services compared to U.S. citizens, even though they are generally healthier than their native-born counterparts. Such reporting requirements only compound existing access barriers and coverage disparities faced by immigrants, and create distrust between community members and social service administrators.

SB 1070 also threatens to remove protections for the vulnerable individuals who rely on health care providers, law enforcement and

Laws such as Arizona’s HB 2008 and SB 1070 have detrimental effects upon the health and livelihood of immigrant populations by restricting access to services.

government officials for aid.

Studies indicate that abuse reporting declines when there is fear of deportation. For example, women who are victims of intimate partner and family violence are afraid to report abuse due to fear of deportation. According to one community organization, this fear also causes victims to remain in abusive relationships, where they are often threatened by abusers (whether a partner, relative, or outsider) to call border patrol, or to leave them out in the desert, or—in the case of mothers—take away the children.

Law enforcement officers are also affected by victims’ fear of deportation. In Arizona, Mesa Victim’s Services conducted interviews during the spring of 2009, in the midst of Sheriff Joe Arpaio’s crime sweeps. The



organization reported a noticeable decrease in crime reporting overall, from authorized and unauthorized immigrants alike. Further, community organizations have noted that unauthorized status is used like a weapon against the unauthorized by authorized partners and children. As a result, both unauthorized and authorized immigrants are afraid to report crimes, undermining the community policing efforts of local law enforcement.

Finally, fear of deportation affects health care providers who suspect or respond to claims of abuse. For health care providers who are required by law to report suspected child abuse or endangerment, reporting requirements create severe ethical dilemmas. A stark example of such a dilemma is found in the results of a Massachusetts study on pediatricians. In the 200 pediatrician sample, almost half of practicing pediatricians stated that they would consider violating child abuse reporting laws if it could result in the family being deported.

Less apparent are the effects that HB 2008 has had upon the administration of state benefits. Verification of immigration status for each applicant has increased the administrative burden upon state agencies charged with benefits administration. This increase, in turn, increases the administrative overhead, which results in higher health care costs. State health care system costs also increase because individuals lose access to benefits for preventive care, only seeking care when an illness has significantly progressed, or during emergencies.

Stringent immigration laws at the local and state level can have profound impacts on the public health of communities. For vulnerable AAPIs, these laws can be an added burden to families with varying and changing immigration status. While community based organizations often respond to situations created by SB 1070 and HB 2008, there are inevitably individuals and families who will slip through and not receive needed health information and treatments.

Zeenat Hasan is the Health Through Action Program Director at the Asian Pacific Community in Action. Her interests are in public health, migration, and human rights.

Priscilla Huang, JD, is the Policy Director at the Asian & Pacific Islander American Health Forum, a health justice non-profit organization dedicated to improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians and Pacific Islanders living in the United States and its jurisdictions.

Maansi Raswant was a health law intern at the Asian & Pacific Islander American Health Forum, and is a 2011 graduate of Seton Hall University, School of Law.





Cancer Risks and Outcomes

“ I still remember the moment when the doctor told me the result. I was smiling and then my mind went blank. My best friend was there. All I could hear was her asking questions.

Stage 1 breast cancer, the aggressive type. It's not guaranteed that the cancer cells would be gone even if they removed the tumor. It could come back, in my breast or anywhere else.”

Excerpt from “Because,” a digital story by Achariya “Ying” Weerasa
Complete stories at <http://www.apcaaz.org/gallery.htm>

The Cancer Burden

By Usha Menon, Timothy J. Flood and Amy C. Woof

Examining cancer-related disparities among Asian Americans and Pacific Islanders (AAPIs) is challenging because previous studies and national level data have significant limitations. For example, in many studies English-only data gathering methods are used or all AAPI groups are aggregated (Wong, Gildengorin, Nguyen, & Mock, 2005). In addition, there are few population-based studies that use the same definitions or questions to assess cancer screening outcomes or that compare AAPIs to Whites and other minority groups.

Despite these research limitations, data indicate that cancer is the leading cause of death among AAPIs. In Arizona in particular, in three of the last five years cancer has overtaken heart disease as the top cause of death among Arizona's AAPIs (see Figure 2-1).

Female Breast Cancer

Among Asian American and Pacific Islander women, breast cancer accounts for 20% of all cancers diagnosed statewide in Arizona, making it the leading type of cancer to affect AAPI women (Flood, 2011; see Figure 2-2). According to the American Cancer Society (ACS), mortality amongst AAPI women due to breast cancer incidence nationally is 12.5 deaths per 100,000 (ACS, 2011).

Although breast cancer is not preventable, regular screening with mammograms or clinical breast

examinations (CBE) can lead to early detection of the disease. However, figures show that among Arizona AAPI women aged 40 and older, only 57.7% received a mammogram during 2004-2006 (Flood, 2011). Participation rates can be improved and, when combined with CBE, the mortality rate of breast cancer among AAPI women in Arizona can be reduced.

Tobacco-Related Cancers

Use of tobacco remains the single greatest factor leading to cancer deaths in Arizona. Cigarette smoking is causally linked to cancers of bladder, lung, larynx, colon, pancreas, kidney, esophagus, oral cavity, leukemia, cervix, and other organs. It also causes emphysema, heart disease, and exacerbates many other chronic diseases.

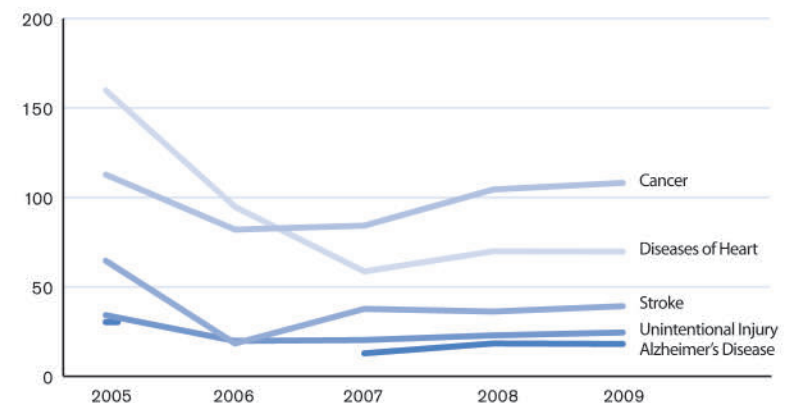
Overall cancer rates among the category of combined AAPIs generally appear low in comparison to other racial/ethnic groups. However, the rates of lung cancer (incidence and mortality) among men are intermediate and are not decreasing as noted among other racial/ethnic groups (see Figures 2-3 and 2-4). Over the last 3 years, an average of 29 AAPIs died per year from lung cancer in Arizona. And, based on data over the past 30 years, the mortality rate from lung cancer shows no decrease among men or women (Arizona Department of Health Sciences [ADHS], 2009).

The Centers for Disease Control's (CDC) Behavioral Risk Factor Survey (BRFS) estimates the prevalence of current cigarette smokers in Arizona's AAPI adult population as almost 25% among men and 6% among women (see Figure 2-5 for total figures by race). In comparison, the general population in Arizona smokes at a rate of 19.0% (men) and 14.3% (women). The state BRFS's sample size contains too few AAPI respondents to generate AAPI race-specific data. However, a recent study by the CDC reports an elevated smoking rate among Cambodian men, and non-English speaking Vietnamese

men (Liao et al., 2010). Immigrants may bring healthy or unhealthy habits to their new country. It is not currently known how to generalize about the smoking rates in Arizona-resident AAPIs as they compare to residents in the countries of their heritage.

Tobacco cessation programs play an important role in reducing the number of smokers. Smoker "quit lines" (phone numbers that provide information about quitting) in the native language play a helpful role in reaching smokers. Even more important is the prevention of minors from becoming users—addiction to smoking is much higher in those

Figure 2-1
Leading Causes of Death Among AAPI in Arizona, 2005 - 2009
(Age adjusted mortality rate per 100,000)



who started as teens. However, the Arizona Youth Survey (2006) found that Pacific Islander youth in Arizona had the third highest rate of cigarette smoking among 8th, 10th and 12th graders, with 16.1% reporting use.

Culturally, the reasons for use of tobacco differ between the United States and southeast Asian countries, where tobacco consumption is a symbol of social status and offering tobacco is a social phenomenon seen as a sign of welcome and hospitality. A useful approach may be to educate AAPIs about tobacco's adverse economic consequences and its social unacceptability among affluent persons of the United States. The low smoking rate among Arizona AAPI women is good news and promotion of that fact may discourage other women from smoking.

Colorectal Cancer

Colorectal cancer (CRC) is the third leading cancer diagnosed among AAPIs in Arizona, with an incidence rate of 27.4 between 2005 and 2007 (ADHS, 2009). Nationally CRC is the second most commonly diagnosed cancer for AAPIs and is the third leading cause of cancer-related deaths (Landis, Murray, Bolden, & Wingo, 1999). CRC incidence is paradoxical in that about 75% of CRC is diagnosed in persons with no known risk factors. According to the National Cancer Institute, about 90% of CRC is diagnosed in people aged 50 years or older. These facts together suggest the need for broad-based screening among those aged 50 or older.

A recent report showed an increasing trend in utilization of CRC screening tests (Meissner, Breen, Klabunde, & Vernon, 2006). However, screening rates for minority groups remain suboptimal and well below the Healthy People 2010 goals, lagging behind that for prostate, cervical and breast cancer. Screening rates among AAPI remain lower than for other minority groups and non-Hispanic Whites. For example, California data showed lower screening rates for AAPIs (Chinese, Filipino, South Asian, Japanese, Korean, and Vietnamese) compared to non-Hispanic Whites (Wong et al., 2005).

Prostate Cancer

Prostate cancer is the fourth leading cancer diagnosed among AAPIs in Arizona, the leading cancer nationally diagnosed in men, and the second leading cause of cancer death in men. From 2001-2004, an average of 19 AAPI men were diagnosed with prostate cancer per year in Arizona. On average there are three deaths in Arizona AAPI men per year from prostate cancer (Flood, 2011).

Prostate cancer is not preventable but awareness of risk factors and regular screening can help to combat the disease. Known risk factors for prostate cancer include the following: age, men over 50 years of age are more likely to be diagnosed with the disease; family history and genetics, positive diagnosis of prostate cancer in close family members often means that an individual is more likely to get the disease; race, African Americans are disproportionately affected by the disease, while incidence is lower in AAPIs and Latinos (ACS, 2011b).

Summary

Control efforts should focus on eliminating tobacco usage—for example, preventing young persons from initiating the habit and encouraging current users to quit. Early detection of cancer should be encouraged through the promotion of regular screening tests such as mammography, and stool blood tests, colonoscopies, and pap smears. AAPI males are encouraged to discuss the risks and benefits of prostate screening with their doctor. A traditional Asian diet rich in vegetables and fruits may be associated with the relatively low overall cancer rates in AAPIs, and also should be promoted in lieu of the high fat diets of the western world.

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and Health Innovation at Arizona State University. Dr. Menon is a nurse and a behavioral scientist with a research focus in cancer screening interventions that are community-based for underserved populations.

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Amy C. Woof is a graduate student in the MPH program in the College of Nursing & Health Innovation, Arizona State University. Her personal interest is in health disparities and using health policy to promote positive change.

Figure 2-2
Cancer Incidence by Race for Selected Sites, Arizona, 2004 - 2008

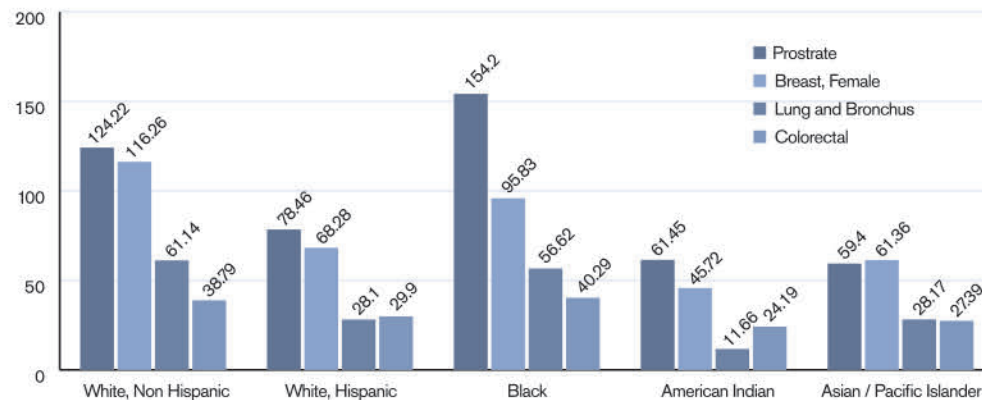
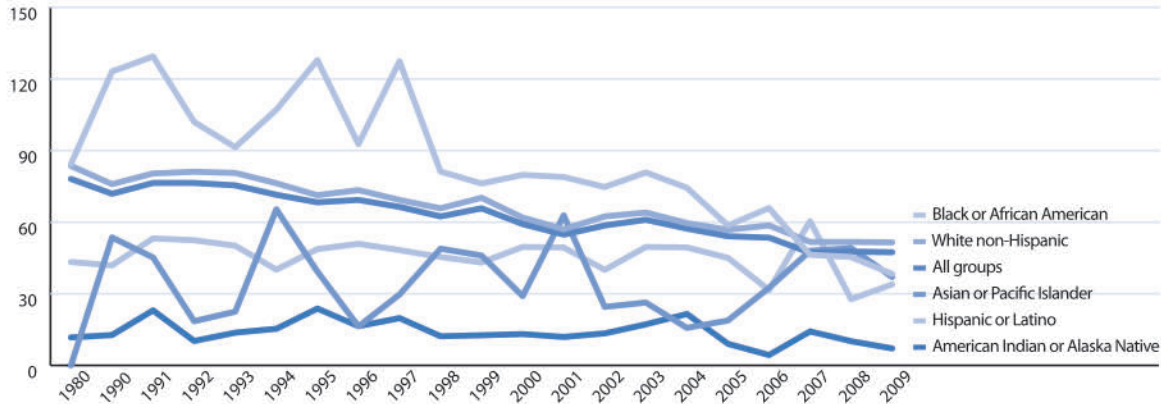
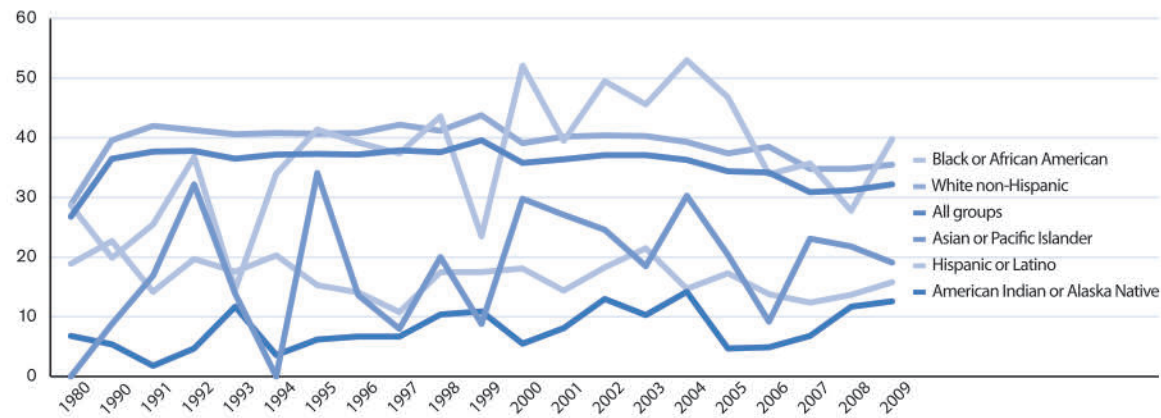


Figure 2-3
Lung Cancer Mortality Rates for Arizona Men



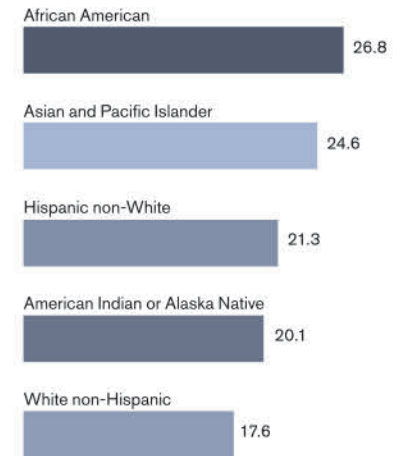
Note: Age adjusted mortality rate (per 100,000) for trachea, bronchus, and lung cancer in males.

Figure 2-4
Lung Cancer Mortality Rates for Arizona Women



Note: Age adjusted mortality rate (per 100,000) for trachea, bronchus, and lung cancer in females.

Figure 2-5
Smoking Rates 2006 - 2010
Proportion of Adults Who Smoke (Percent)





Infectious Diseases

“ My friend, Anthony was dying of liver cancer. He was in his late 30s, so his family and I decided to have a party to honor his life. He died a month later.”

Excerpt from "Life's Little Challenges," a digital story by Liza Merrill
Complete stories at <http://www.apcaaz.org/gallery.htm>

Tuberculosis and Asian Americans

By Siru Prasai

In 2009, the World Health Organization (WHO) reported 9.4 million new cases of tuberculosis (TB) bacillus. Globally, one-third of the world's population is infected with TB. Approximately 5-10% of those infected become sick or infectious at some time during their lifetime for an estimated global incidence rate of 137 cases per 100,000 people. The greatest number of TB cases occurs in Southeast Asia, which accounts for 35% of the incident cases globally.

In 2010, the Centers for Disease Control and Prevention (CDC) reported a total of 11,181 TB cases in United States, for a case rate of 3.6 per 100,000 people. Foreign-born persons and racial/ethnic minorities were disproportionately affected by TB in the United States, with the highest case rates among Filipino, South Asian and Vietnamese individuals. The TB case rate among Asian Americans was 25 times higher than among non-Hispanic Whites. In addition, TB rates among foreign-born persons were 11 times greater than among U.S.-born persons. The Philippines, India and Vietnam respectively accounted for 11%, 8.6% and 7.7 % of the total TB cases associated with foreign births.

The Arizona Department of Health Services (ADHS) reported an overall TB case rate of 3.5 per 100,000 people in 2009. However, for the same year, Asian Americans accounted for 23% of the total TB cases for a case

rate of 30.5 per 100,000 in the Asian American population; this was the highest rate of incidence among any racial/ethnic minority group in Arizona (see Figure 3-1). This rate represented a 55% increase in incidence within the Arizona Asian American population from 2008.

In 2010, out of the total TB cases reported in the state of Arizona, 56 of those individuals reported as Asian descent. Out of the 56 reported and verified cases of TB among the Asian American population in Arizona, 87.5% were foreign-born and 12.5% were U.S.-born.

Data from ADHS indicate that foreign-born cases emanated from 12 different Asian countries. Afghanistan, Bhutan, Hong Kong, Indonesia, Myanmar, Philippines, Vietnam, Bangladesh, China, India, Korea, and Nepal. The highest number of cases were seen among individuals from Philippines (25%), followed by Vietnam (14.3%), India (12.5%) and Burma (12.5%).

Summary

Among foreign-born persons in the United States, the rate and number of TB cases reported in 2010 declined by 3.4% from 2009. However, despite these declines, case rates among Asian Americans remain high. This was especially true for the Asian American population in Arizona, with case rates not only higher than the general population but increasing from previous years.

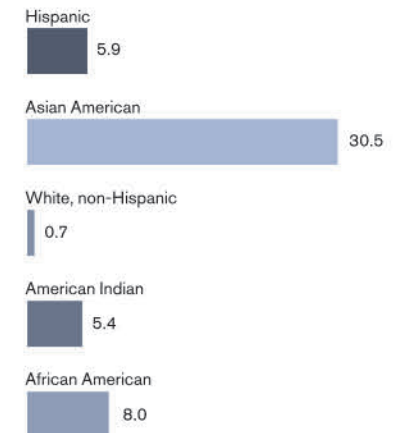
Early detection and treatment is critical for interrupting TB transmission in the community and improving outcomes of individuals suffering from tuberculosis. However, high social stigma, low awareness, low individual risk perception, and external constraints like economic limitations account for delayed care seeking and lack of compliance with the tuberculosis treatment.

To achieve the national goal of TB elimination, defined as <0.1 case per 100,000 people, TB control activities like screening and treatment need to be targeted to disproportionately affected populations. Unfortunately, historically, the Asian American population has not been identified as a high-risk population for TB. It is critical that health care providers are better educated about the increased risk for TB infection among Asian Americans—particularly those who are foreign-born. In addition, we need expanded efforts to educate Asian Americans themselves of their increased TB risk.

Siru Prasai received her M.B.B.S and MS in OB/GYN from Bangladesh and her MPH from the University of Massachusetts, Amherst. She is a TB Epidemiologist with Maricopa County, Department of Public Health and was formerly an assistant professor at Tribhuvan University Teaching Hospital, in Nepal.

Asian Americans accounted for 23% of the total TB cases in Arizona.

Figure 3-1
Arizona TB Case Rate by Race, 2009
Source: Arizona Department of Health Services





Hepatitis B: A Silent and Deadly Epidemic

By Doug Hirano, Zeenat Hasan, Joe Tabor & Howard Eng

Global Impact of Hepatitis B

Infection with the hepatitis B virus (HBV) is a serious global public health problem. More than two billion people have been exposed to the virus, and of these, 400 million people have been permanently infected with the virus. Chronic HBV infection leads to 500,000 to 1.2 million deaths annually, largely due to liver cirrhosis and liver cancer.

Asian Americans and Pacific Islanders (AAPIs) residing in the United States have the highest rates of HBV infection among all racial/ethnic groups. For example, it is estimated that one in 12 AAPIs carries the hepatitis B virus, as compared to a rate of 1 in 1,000 among all other Americans. This disproportionate disease burden is in large measure due to the fact that 65% of AAPIs are foreign born, and most were infected in their native lands, where HBV infection is common (approximately 75% of all individuals with chronic HBV infection worldwide reside in Asia).

Consequently, while constituting only 4% of the total population, AAPIs comprise more than 50% of the estimated 1.4 million Americans chronically infected with HBV. Furthermore, the Centers for Disease Control and Prevention (CDC) estimates that 65 – 75% of infected individuals are unaware of their infection status. Roughly, this means that 450,000 AAPIs are unknowingly

infected with HBV – this is greater than the total number of Americans unknowingly infected with HIV, the virus that causes AIDS.

Studies conducted throughout the United States indicate that AAPIs lack accurate information regarding HBV, its transmissibility, prevention, diagnosis and symptoms. Less than 50% have received an HBV blood test or HBV vaccination. In addition, data suggest that many health care professionals are unaware of the increased risk of HBV infection among AAPIs; therefore, many screening opportunities are missed in the medical care setting.

Community screening programs have provided HBV screening and vaccination opportunities to AAPIs, but in large measure these programs have lacked the scale to significantly impact

HBV morbidity and mortality at a local, regional or national level. The CDC is currently in the process of developing national awareness campaigns for both hepatitis B and hepatitis C.

Hepatitis B in Arizona

Chronic HBV infection among AAPIs is not limited to major population centers such as Los Angeles, San Francisco and New York City. Arizona communicable disease reporting data for the year 2010 provided by the Arizona Department of Health Services (Table 3-1) strongly suggest a significant prevalence of chronic HBV infection among AAPIs in Arizona. It should be noted that a significant number (78%) of reported chronic hepatitis B cases are of unknown race/ethnicity. The cases presented in

Chronic rates of hepatitis B are highest among AAPIs.

Table 1 are only for those of known race/ethnicity.

An examination of these data indicates that reported rates of chronic hepatitis B are highest among Asian Americans and Pacific Islanders. It should also be noted that for 2010 there were no reported cases of acute hepatitis B infection (new infections) among these two groups. This suggests that there is not a lot of new transmission of hepatitis B among AAPIs, and that case reports of chronic

Table 3-1
Hepatitis B Rates for 2010 by Race (Cases per 100,000 Population)

	Arizona		Maricopa County		Pima County	
	Acute	Chronic	Acute	Chronic	Acute	Chronic
White	0.84	1.92	0.49	1.65	1.29	2.40
Black	2.09	9.20	2.25	8.45	3.22	16.09
Hispanic, non-White	0.26	0.69	0.18	0.80	0.00	0.00
Asian American	0.00	34.60	0.00	24.94	0.00	73.19
American Indian /Alaska Native	1.17	6.60	3.38	10.13	0.00	12.73
Pacific Islander	0.00	73.00	0.00	59.50	0.00	149.70
All	2.25	14.44	2.42	19.12	1.57	9.33

Source: Arizona Department of Health Services

infection are likely due to original infection in native Asian countries and the Pacific Islands.

Table 3-2 provides cases chronic hepatitis B reporting numbers across a five-year span. These numbers show the disproportionate number of chronic hepatitis B cases among Asian Americans (representing less than 3% of the overall population) and Pacific Islanders (representing less than 1% of the overall population) over time.

Hepatitis B Knowledge Among AAPIs in Maricopa County

Given the high rate of infection within the AAPI population, a local community health organization, Asian Pacific Community in Action (APCA), has focused its outreach on hepatitis B in the AAPI community. As part of APCA's work, in 2008 staff and volunteers conducted phone surveys to measure awareness on HBV transmission. HBV may be spread through direct contact with infected blood or bodily fluids. Respondents were asked whether HBV could be transmitted by a) contaminated food, b) sneezing and coughing, c) sexual contact, or d) sharing needles; of these responses, HBV can only be spread through sexual contact or sharing needles.

Chinese Americans, Korean Americans, and Vietnamese Americans were targeted for the survey, which was adapted from the Centers for Disease Control and Prevention's Behavior Risk Factor Surveillance Survey. The final

sample included 246 Chinese adults, 266 Korean adults and 296 Vietnamese adults. Over 90% of all interviews were conducted in native Chinese, Korean or Vietnamese.

Figure 3-2 shows the percentage of each group reporting HBV could be transmitted through the different choices. Of the three ethnic groups surveyed, more Vietnamese Americans understood that HBV could be spread through infected needles and sexual contact, but a greater percentage also incorrectly believed HBV could be spread through sneezing/coughing and food. Chinese Americans were somewhat more likely to know that hepatitis B can be transmitted through sexual contact and sharing needles and not by sneezing, coughing or through food.

There were differences in knowledge about HBV transmission based on length of time in the United States., education, income level and age. Overall, those with higher income and education tended to correctly identify that HBV could be transmitted through sexual contact and needles. However, this did not mean that those with higher income/education had correct information about spreading HBV through sneezing/coughing or food. For example, among Chinese Americans although just 8% overall incorrectly believed hepatitis B could be transmitted by sneezing or coughing, respondents with lower education levels were less likely to believe so (3%) than respondents with higher education levels (12%).

A few other interesting differences were related to length of time in United States. and age. Although it might be expected that those who have been in the United States. longer would have more exposure to correct information, among Korean Americans those who have been in the United States longer were more likely to incorrectly believe HBV could be spread through food (42%) than those who were in the United States a shorter period of time (30%). And although younger respondents tended to have correct information about transmission through sexual contact and needle sharing, among Vietnamese Americans, younger respondents were more likely to incorrectly believe hepatitis B could be transmitted through sneezing and coughing (33%) than the older respondents (19%).

Hepatitis B Screening

In response to the disproportionate burden of chronic HBV infection among AAPIs, the Asian Pacific Community in Action has been offering free HBV screening in the greater Phoenix metropolitan area since 2005. HBV testing was extended to the Tucson area in April 2011. In that time, more than 2,500 individuals have received HBV screening through APCA and its many community partners—including community health centers, churches and temples, ethnic associations, and linguistic schools.

The chronic disease infection rate for the more than 2,500 individuals screened is 6.1%. Data indicate that this infection rate varies by ethnicity. For instance, the infection rate is highest

among Vietnamese at 12%, Chinese at 7%, Koreans at 4% and Asian Indians at 2%.

Screening clinics have taken place at a number of community sites. However, the greatest amount of testing has occurred at churches and temples, followed by health clinics (e.g., Mountain Park Health Center facilities), and then by other community locations (e.g., linguistic schools and community centers).

Summary

Clearly, chronic hepatitis B infection is an area of significant health concern for AAPIs residing in Arizona. Because hepatitis B is a silent infection, many individuals are unaware of their infection status and can potentially benefit from medical care and treatment. These individuals, until diagnosed, are also at risk of further transmitting the virus. Additional public education, screening and vaccination efforts are warranted. For AAPIs, culturally accessible education is necessary. As mentioned previously, the CDC is planning large-scale education and awareness campaigns around hepatitis B and C.

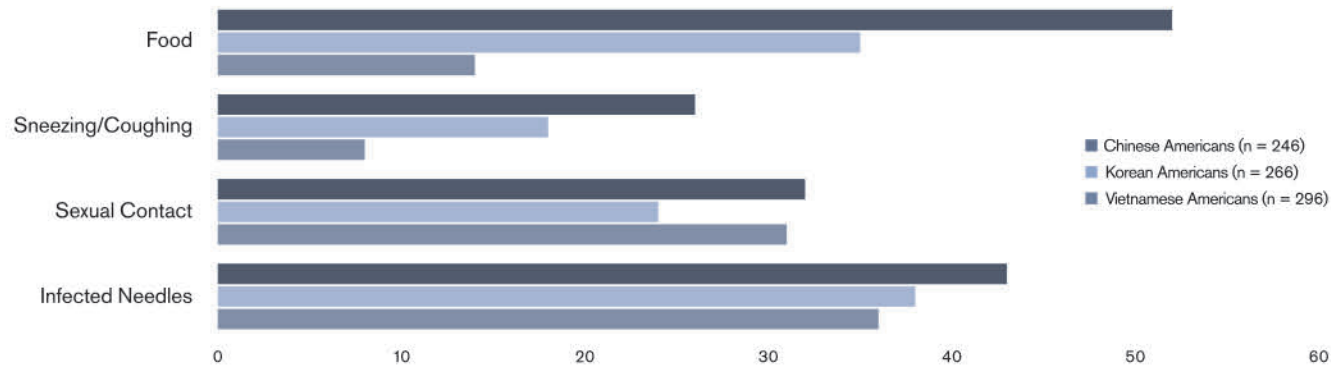
Education regarding chronic hepatitis B risk among AAPIs is also needed among health care professionals. Data from the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid program, indicate that physicians are no more likely to test Asian American patients for hepatitis B infection than any other racial group.

Table 3-2
Arizona Chronic Hepatitis B Reported Cases by Race, 2011

	2006	2007	2008	2009	2010
White	149	145	135	111	71
Black	46	52	58	44	22
Hispanic	58	59	43	37	13
Asian	89	137	189	176	59
AI/AN	30	29	10	19	17
Hawaiian/Pacific Islander	13	3	7	4	8
Other	0	0	21	13	22
Unknown	716	631	675	711	752
Total	1101	1056	1138	1115	964

Source: Arizona Department of Health Services

Figure 3-2
How is Hepatitis Transmitted?



Doug Hirano, MPH, is an epidemiologist by training and has served as the executive director of Asian Pacific Community in Action since July, 2006. He is also a past president of the Arizona Public Health Association.

Zeenat Hasan is the Health Through Action Program Director at the Asian Pacific Community in Action. Her interests are in public health, migration, and human rights.

Joe Tabor is an assistant professor and epidemiologist at the University of Arizona's Mel and Enid Zuckerman College of Public Health. His research interests include health care workforce and landscape epidemiology.

Howard J. Eng received his B.S. in Pharmacy from the University of Arizona and his Dr.P.H. in Community Health from the University of Texas. He is an assistant professor and director of the Southwest Border Rural Health Research Center, Rural Health Office in the University of Arizona Mel and Enid Zuckerman College of Public Health. He has more than 30 years of experience in health care, with training in health services and policy research, health economics, epidemiology, public health, and pharmacy.



Mental Health

“ Many time, I thought of committing suicide because I felt so alone and hopeless. But I thought of my parents. How could I give up when they worked so hard for us? When they faced their own fears of coming here?”

Excerpt from "My Family Dinner," a digital story by Yen Nguyen
Complete stories at <http://www.apcaaz.org/gallery.htm>

Underutilizing Services: Mental Health in Asian Americans & Pacific Islanders

By Maki Obana

Compared to other racial/ethnic groups, Asian Americans and Pacific Islanders (AAPIs) tend to underutilize mental health services. Data from the Arizona Department of Health Service (ADHS) indicate that AAPIs represent 2.8% of the Arizona population but just 1.0% of all clients enrolled in the publicly funded behavioral health system (see Table 4-1).

There are several reasons why AAPIs underutilize mental health services. First, stigmatization of people with mental illness has persisted in AAPI communities. Common feelings

associated with mental illness include embarrassment, guilt, and shame. Moreover, the family is considered to be more important than the individual in many AAPI cultures. Therefore, an individual may not seek mental health services to protect the family's reputation. In addition, lack of English proficiency and lack of comfort with Western approaches to mental health care may inhibit service utilization.

Foreign-born Asians utilize fewer mental health services than their U.S.-born counterparts (Bauer, Chen, & Alegria, 2010).

Foreign-born Asians utilize fewer mental health services than their U.S.-born counterparts.

Table 4-1
Client Enrollment in Arizona Publicly Funded Behavioral Health System (2007 – 2008)

Race	Client count	Percent of all clients	Percent of Arizona population*
White	161,770	85.2%	85.4%
African American	13,698	7.2%	3.9%
American Indian	9,964	5.3%	4.9%
Multi Race	2,497	1.3%	2.6%
Asian and Pacific Islander	1,882	1.0%	2.8%
Total	189,811		

Division of Behavioral Health Services, ADHS (2010)
*Does not include individuals categorized as "some other race alone"

Lastly, AAPIs rarely endorse emotional and interpersonal problems as mental health issues requiring professional help (e.g., Chen, 2005). This finding is consistent with diagnosis of AAPIs at a mental health facility under the Arizona public system. In 2007, ADHS reported that the primary diagnoses were Attention Deficit Hyperactive Disorder in the 18-21 year old age group, Cannabis (marijuana) Abuse for ages 22 to 64, and Schizoaffective Disorder (schizophrenia) for 65 and up. Their secondary diagnoses showed Alcohol Abuse in the 16 to 21 age range and Posttraumatic Stress Disorder for 22 and up (see Table 4-2).

These diagnoses are significantly different than those for Caucasians, who were predominately diagnosed with Mood or Anxiety Disorder. In

addition, Asian Americans living in Arizona experience a wide range of racial discrimination and tend to self-medicate with substance to treat the stress of racial discrimination (Yoo, Gee, & Lowthrop, 2010).

The culture of AAPIs influences many aspects of mental illness, including how AAPIs communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. It is important to increase attention to these factors to provide culturally proficient mental health outreach, education and services.

Maki Obana is a licensed psychologist at Arizona State University Counseling Services. She also has her own independent practice. She received her Ph.D. in Counseling Psychology from the University of Memphis.



Table 4-2
Most Prevalent Primary and Secondary Diagnoses by AAPI and Caucasian

Primary Diagnoses		
Age band	AAPI	Caucasian
18-21	Attention Deficit Hyperactive Disorder	Mood Disorder NOS
22-64	Cannabis Abuse	Mood Disorder NOS
65 and up	Schizoaffective Disorder	Mood Disorder NOS
Secondary Diagnoses		
Age band	AAPI	Caucasian
18-21	Alcohol Abuse	Cannabis Abuse
22-64	Posttraumatic Stress Disorder	Anxiety Disorder NOS
65 and up	None	Anxiety Disorder NOS

Arizona Department of Health Service, 2008





Challenges to Cognitive and Emotional Health for AAPI Older Adults

By Fei Sun

Arizona is witnessing a rapid growth in both the older adult and the Asian American and Pacific Islander (AAPI) populations. In 2009, Arizonans aged 65 and older accounted for 13.1% of the total population, slightly above the national average (12.9%). According to the Arizona Department of Health Services, by 2030 nearly 1 in 5 Arizonans will be 65 years or older, ranking Arizona as one of the top five states with the highest growth rate for older adults. At the same time, Arizona ranked number two in terms of its AAPI population growth in percentage, with a 63.6% increase from 2000 to 2008. As the number of AAPI older adults also increases, so does the pressure on the health and human service system that is striving to provide culturally-sensitive services.

Many AAPI older immigrants face challenges from age-related changes and acculturative stress in their adaptation to a society that is different from their home country. These challenges, if not dealt with appropriately, significantly affect the physical and mental health of AAPI elders. As dementia and depression are the two most prevalent mental disorders in older adults, the focus in this article is on the prevalence of and risk factors for dementia and depression in AAPI older populations and highlights the sociocultural and practical barriers in service access and utilization.

Dementia

Dementia is a set of symptoms associated with the loss of brain functioning such as thinking, recalling, reasoning, and language. The most common cause of dementia is Alzheimer's disease, which has become the sixth leading cause of death for older Americans. The prevalence of Alzheimer's disease in the overall adult population is around 10% for those age 65 and older, and up to 40% for those age 85 and older.

Risk factors for developing Alzheimer's disease are primarily advanced age and in part, family history. Although the prevalence of Alzheimer's disease does not differ significantly between the AAPI older adults and the general older population, it is believed that AAPI elders face more barriers to diagnosis and treatment.

In many Asian cultures, a certain degree of cognitive impairment in old age is expected. For example, in the Chinese culture, forgetfulness or mild cognitive impairment is considered normal part of aging. Because of that, Chinese American families tend to delay seeking diagnosis or treatment for a relative suffering from symptoms of dementia.

In addition, Asian Americans often think of dementia as a stigmatized mental illness. This is evidenced by the terms used to describe dementia in different Asian languages, such as chi

dai in Chinese, kichigai in Japanese, kabaw in Filipinos, and binh tam and dien in Vietnamese, which all connote a meaning of craziness (Braun & Browne, 1998). The stigma attached to dementia extends to family members, who are often the primary caregivers of the person with dementia. The participants in my ongoing research project on the caregiving experience of Chinese American dementia caregivers in Phoenix have reported experiencing stigma and social isolation.

Depression

Unlike dementia, depression is a mood disorder. Although it is estimated that about 8-20% of community-dwelling older adults experience depressive symptoms, a much higher percentage of AAPI older adults (18-31.1%) experience such symptoms (Kuo, Chong, & Joseph, 2008). Major depression is the main reason for suicide, and according to the National Institute of Health, AAPI older adults have the second highest suicide rates, preceded only by non-Hispanic Whites. Risk factors for depressive symptoms in older adults often include late life loss, loneliness, and physical illness.

Yet, many AAPI older adults in America may be more vulnerable to depressive feelings due to the stress from adapting to a new culture. There is emerging evidence suggesting that lack

of English language proficiency and a lower level of acculturation contribute to increased depressive symptoms in AAPI older adults (Kuo, Chong, & Joseph, 2008).

Despite their service needs, AAPI older adults appear to have more sociocultural service barriers to treatment and supportive service access. First of all, compared to their Caucasian counterparts, older Asian Americans have limited knowledge of dementia and depression, which increases the likelihood of missing the early signs of these mental disorders (Ramsay, 2010).

In addition to a deficit of knowledge of these conditions, AAPI families may be discouraged from seeking professional help due to feelings of shame and stigma associated with a family member being diagnosed with a mental disorder. As evidenced in a study on recent immigrant Chinese Americans in California, Braun and Browne (1998) concluded that the stigma attached to the symptomatology of dementia often brought condemnation of both patients and their family members. Concerns about being stigmatized might lead to a "silent epidemic," a term coined by Ross et al. (1997) to describe the prevalence of concealed mental illness among older Asian Americans.



Summary

The lack of culturally appropriate medical and social support services is a significant barrier. It is essential that service professionals, both mainstream and those specifically targeting ethnic minorities, be sensitive to Asian cultures, with special emphasis on help seeking behaviors. Furthermore, other practical barriers, such as, but not limited to, language barriers and lack of transportation, can prevent AAPI older adults from timely and adequate care.

Being cognitively intact and free of depressive symptoms are critical to the well-being of AAPI elders. Compared to their Caucasian counterparts, AAPI

older adults face more sociocultural and practical barriers to appropriate medical care and social services. Advocates or community program designers need to create educational and skill training programs that are tailored to the special needs of the AAPI older adults and their families. Furthermore, to facilitate the use of these programs and services tangible assistance such as translation or transportation must be provided. Lastly, health and mental health professionals in Arizona need to be trained to be able to deliver culturally-competent practice with an understanding of the cross and within cultural/ethnic differences in AAPI older populations.

Fei Sun is an assistant professor in the School of Social Work at Arizona State University. He is a Hartford Geriatric Social Work Scholar. His research primarily focuses on physical and mental health issues in ethnic minority older populations. He is carrying out two research projects in Phoenix, AZ. One examines the stress and coping experience in Chinese American family caregivers who provide care for a relative with dementia. The other one examines the beliefs and knowledge of Alzheimer's disease in Chinese American older adults.





Perceived Discrimination and Mental Health in AAPI College Students

By Angela Chia-Chen Chen, Usha Menon & Laura Szalacha

Researchers have documented racial and ethnic disparities in the incidence of depression and depressive symptoms. For example, relative to White adolescents, Asian American and Pacific Islander (AAPI) adolescents reported higher levels of depressive symptoms, were more withdrawn, and experienced more social problems (Lorenz, Frost, & Reinherz, 2000).

Chen and colleagues (2011) found similar outcomes in their study of depressive symptoms from adolescence to early adulthood in Chinese American and White young adults. In their analysis, Chinese American women had the highest depressive symptoms sustained across 7 years; Chinese American men over age 15 had higher depressive symptoms than did their White male counterparts. Neither socioeconomic status nor acculturation was significantly associated with the differences in the trajectories.

Perceived discrimination may contribute to the higher rate of depressive symptoms among AAPI adolescents and young adults. Researchers have found that racial/ethnic discrimination is a salient feature of Asian American adolescents' daily experiences (e.g., Juang & Cookston, 2009). Perceived racial/ethnic discrimination has been found to be

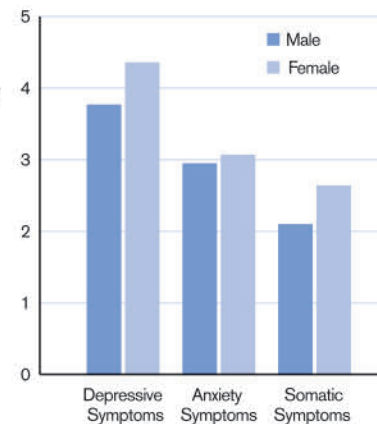
associated with depressive symptoms among AAPI adolescents (Huynh & Fuligni, 2010), including Chinese American adolescents (Benner & Kim, 2009; Juang & Cookston, 2009).

Consistent with the literature, a recent study by Chen, Menon and Szalacha (2011) found perceived discrimination was positively associated with AAPI college students' depressive symptoms. The study used a web-based survey to examine AAPI college students' mental health (i.e., anxiety, depression, somatic symptoms) and behavioral issues (e.g., risky sexual behavior, substance use) (see Figure 4-1). The researchers also found the relationship between perceived discrimination and depressive symptoms remained the same when sociodemographic characteristics (e.g., age, biological sex, parent education), acculturation level and ethnic pride were kept constant. Similar to depressive symptoms, AAPI college students' perceived discrimination was also positively associated with higher levels of anxiety and somatic symptoms. The results indicate the close relationship between perceived discrimination and a variety of mental health issues in AAPI young adults.

Asian Americans have been often labeled as the "model minority," meaning they work hard, behave well, and can take care of themselves. Nevertheless, this label may lead to

adverse effects on their psychological health because they are not seen as "at risk" or in need of support, and thus may contribute to limiting resources, services, and policy attention needed by this population. To rely on the academic achievement of AAPI youth as a sole indicator of their well-being can be misleading (Choi, 2007). The discrimination perceived by AAPI youth and young adults, and its association with their mental health, indicates the need for a more comprehensive assessment and understanding of factors contributing to their well-being.

Figure 4-1
Depressive, Anxiety and Somatic Symptoms Score in Arizona College Students



Angela Chia-Chen Chen, PhD, RN, PMHNP-BC, is an Associate Professor in the College of Nursing and Health Innovation at Arizona State University. Dr. Chen is a trilingual nursing scholar and psychiatric/mental health nurse practitioner who works primarily with racial/ethnic minority populations, her program of research centers on mental health and behavioral issues of vulnerable populations, particularly immigrant families and ethnic minority youth.

Usha Menon, PhD, RN, FAAN, is Pamela Kidd Distinguished Research Professor in the College of Nursing and Health Innovation at Arizona State University. Dr. Menon is a nurse and a behavioral scientist with a research focus in cancer screening interventions that are community-based for underserved populations.

Laura Szalacha, PhD, is an Associate Research Professor in the College of Nursing and Health Innovation at Arizona State University. Dr. Szalacha is an applied statistician and methodologist. The focus of her substantive work has been the development and health of racial/ethnic minorities and other underserved populations.



Special Populations and Issues

“ I grew up in a culture that doesn't speak about women's health, or bodies. Often time, we avoided the subject and talk about other things instead. In 2006, I started working for the Asian Pacific Community in Action. I had to talk with women about their bodies, including cervical cancer.”

Excerpt from “Pearl,” a digital story by Yen Nguyen
Complete stories at <http://www.apcaaz.org/gallery.htm>

Starting Off Right: The Health of Mothers and Children

By Khaleel Hussaini

From 2006-2010 there were 483,585 births in Arizona; approximately 5% (16,320) of these births were of Asian American or Pacific Islander (AAPI) descent. Although maternal-child health (MCH) indicators look favorable for the AAPI population overall, it is important to consider the variability among the many groups that fall under the broad AAPI category.

Table 5-1 compares select mother and child outcomes to overall outcomes in Arizona. The information is based on a sub-sample analysis of all AAPI births in Arizona during 2006-2010. Some of the critical MCH indicators are preterm birth (<37 weeks of gestation), low birth weight (<2500 grams), size for gestational age (small, appropriate or large for gestational age), prenatal

care, alcohol use during pregnancy, smoking during pregnancy, socio-demographic risk factors (e.g. maternal age, education, insurance status) and marital status.

In general, AAPI outcomes were better when compared to the State with regards to socio-demographic indicators (e.g., percent of mothers younger than 20 years of age, percent

The proportion of low birth weight infants is significantly higher among AAPIs compared to other racial/ethnic minority groups in Arizona.

Table 5-1
Maternal and Child Health (MCH) Indicators for Resident Births in Arizona, 2006-2010

#	MCH Indicators for AAPI in Arizona	Other AAPI	Chinese	Filipino	Hawaiian	Japanese	All Arizona
1	Percent preterm births (<37 weeks of gestation)*	9.82%	7.20%	12.68%	8.91%	11.15%	10.20%
2	Percent low birth weight (<2500 grams)	8.65%	6.30%	9.75%	8.14%	8.27%	7.10%
3	Percent small for gestational age*	14.11%	11.71%	12.31%	8.53%	15.52%	9.20%
4	Percent large for gestational age*	5.63%	4.28%	6.45%	11.63%	8.66%	9.00%
5	Percent of mothers who had a c-section delivery*	19.9%	15.9%	21.0%	9.3%	20.9%	15.05%
6	Percent of mothers who were less than 20 years of age*	2.73%	0.34%	3.79%	10.47%	1.80%	12.08%
7	Percent who did not receive any prenatal care	1.40%	0.45%	1.30%	0.78%	0.72%	1.96%
8	Percent of mothers who had education less than high school*	6.82%	3.53%	4.75%	11.63%	2.18%	26.03%
9	Percent who were on State Medicaid (AHCCCS)*	25.18%	17.21%	22.48%	48.44%	16.85%	53.18%
10	Percent never married from conception to delivery*	15.80%	6.98%	21.22%	43.36%	11.59%	45.19%

Note: Other AAPI in this table are those who are not captured in any other categories as Chinese, Filipino, Hawaiian, and Japanese
*Indicates significant differences in proportions within AAPIs as indicated through chi-square tests at p < 0.01

who did not receive any prenatal care, percent with less than a high school education, percent on Arizona Health Care Cost Containment System [AHCCCS], and percent never married). However, within group variability in the AAPI group is evident. For example, outcomes for Chinese American mothers were generally favorable, but outcomes for Hawaiian mothers (e.g., large for gestational age, percent of mothers younger than 20 years of age, percent with less than high school education, percent on AHCCCS, never married) were unfavorable.

Figure 5-1 compares overall low birth weight among AAPIs and Arizona overall. According to the Centers for Disease Control and Prevention, low birth-weight infants, when compared to infants of normal weight, may be at an increased risk for many negative outcomes including the first six days of life (perinatal morbidity), infections, and in some cases longer-term consequences of impaired development, such as delayed motor and social development or learning disabilities. As the figure indicates, the proportion of low birth weight infants is significantly higher among AAPIs compared to other racial/ethnic minority groups in the State.

Figure 5-2 compares size for gestational age for AAPIs and the State. Both small for gestational age

(SGA) and large for gestational age (LGA) have been associated with various neonatal morbidities, mortality, and adverse maternal and neonatal outcomes. Weight gain during pregnancy is associated with SGA and LGA (Stotland et al., 2006).

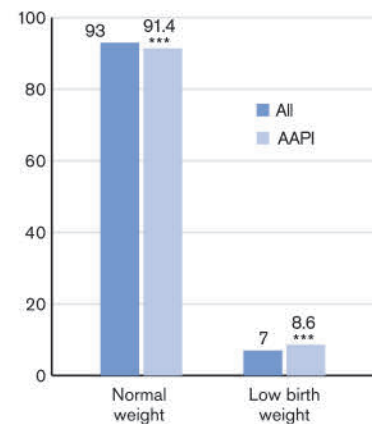
No significant differences were observed in the percent of preterm birth among AAPIs and the State. In other analyses, we found that although Chinese American women were less likely to have a preterm birth, Filipina women were 30% more likely to have preterm births compared to non-Hispanic Whites similar to African Americans (45%). All minority women except Native Hawaiian and American Indian/Alaskan Native were at higher risk of delivering a small for gestational age infant. AAPIs were two times more likely to deliver a small for gestational age infant compared to non-Hispanic White.

In general, AAPI women were less likely to deliver a large for gestational age infant compared to non-Hispanic White. With regards to low birth weight, AAPI women in general were 36% more likely to deliver a low birth weight infant compared to non-Hispanic White women, with Filipina American women in particular 54% more likely. Finally, AAPI women overall and Filipina American women in particular were more likely to have a C-section compared to non-Hispanic White women (21% and 25%, respectively). Hawaiian women were 47% less likely to have a C-section compared to non-Hispanic White women.

While there are several protective factors for AAPI women overall, from the analysis of 2006-2010 data, AAPI women overall appear to be at higher risk for delivering via C-section and having a small for gestational age and low birth weight infant.

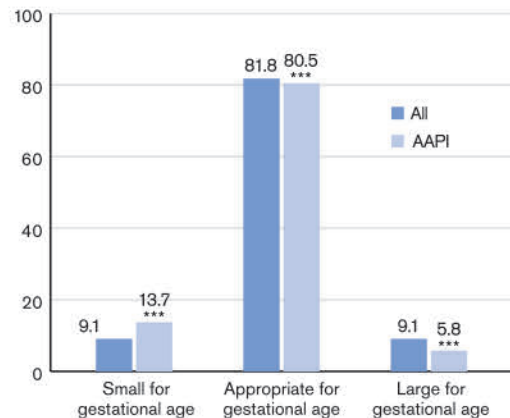
Khaleel Hussaini, MD, heads the Office of Assessment and Evaluation in the Arizona Department of Health Services. He provides technical advice surrounding assessment, evaluation, and research of maternal and child health programs in the State of Arizona. His research interests have focused on immigrant adaptation specifically those relating to acculturation, assimilation, and global identities and the intersection of civil society and its implications on maternal and child health and well-being.

Figure 5-1
Differences in Birth Weight
Proportion of Births by Weight (Percent)



***Chi-square indicates significant difference $p < 0.01$

Figure 5-2
Differences in Size for Gestational Age
Proportion of Births by Size (Percent)



***Chi-square indicates significant difference $p < 0.01$





Reproductive Health and Family Planning

By Jennifer Jung

Family planning helps women and their families prepare for the birth of healthy children and prevent unplanned pregnancies. The child of an unplanned pregnancy is at greater risk of low birth weight, death in the first year of life (infant mortality), abuse, and receiving insufficient resources for optimal early child development. Unplanned pregnancies are also very costly. In Arizona, 67% of births resulting from unintended pregnancies were publicly funded, compared with 52% of all births and 42% of births resulting from intended pregnancies in 2006. Public costs in Arizona for births from unintended pregnancies were over \$288 million dollars in 2006 (Sonfield, Kost, Benson Gold, & Finer, 2011).

Family planning services may be received through private and public insurance. Publicly funded programs include AHCCCS, Title X, Title V,

community health centers, local governments, primary care programs, and Indian Health Service. Federal Title X funding is dedicated solely to providing comprehensive family planning.

The Arizona Family Planning Council (AFPC) is one of three recipients of Title X funding in Arizona. AFPC is a not-for-profit organization established in 1974 which began receiving the Title X Grant in 1983. AFPC distributes Title X family planning funds to agencies serving low-income communities. Services are free or low cost based on family income. AFPC has a network of 12 community-based healthcare organizations, comprised of 37 health centers, serving nine counties in Arizona. Services are available to both teens and adults. Minors are encouraged, but not required, to involve a parent or legal guardian in their

reproductive health decisions. Services include birth control, counseling and education, physical exams, pregnancy testing and counseling, sexually transmitted infection (STI) and HIV testing and treatment, and emergency contraception. Abortion is not considered a contraceptive service and is not provided with Title X funding.

During 2009 and 2010, AFPC served 1,209 clients (2% who self-identified themselves as Asian, Native Hawaiian, or other Pacific Islander. Of the 1,209 clients, over half were between the ages of 20 and 44 (71%), 26% were 19 years or younger, and 3% were over the age of 44. About 93% of the clients were female and 7% were male. Of the 1,209 clients, 65% were at or below 100% federal poverty level (FPL; e.g. family of two earning under \$1,200/month), 17% were over 250% FPL, and 18% were between

The relatively low rates of STIs among AAPIs are suggestive of patterns of sexual behaviors different from other racial/ethnic groups.

Table 5-2
Arizona Sexually Transmitted Infection (STI) Rates Per 100,000 Population, 2004-2009

STI	All race/ethnic groups, Arizona	Asian/Pacific Islanders, Arizona
Chlamydia cases	394.3	150.6
Gonorrhea cases	49.3	11.5
Syphilis cases (Primary & Secondary)	3.5	0.6
HIV/AIDS prevalence (2009 only)	216.3	96.9

Sources: Sexually Transmitted Diseases in Arizona: 2009 Annual Report; Arizona HIV/AIDS Annual Report 2011

101-250% FPL. The top two primary methods of birth control were oral contraceptives or the Pill (43%) and male condoms (22%).

To assess the reproductive health of a population, researchers often look at indicators such as STIs, infant mortality, and teen pregnancy rates. In Arizona, Asian Americans and Pacific Islanders (AAPI) had the lowest rates of STIs and other reproductive health indicators when compared to all race/ethnic groups (see Tables 5-2 and 5-3). In Arizona, all racial/ethnic groups experienced a decrease in pregnancy rates for females 15-19 years from 2000, with AAPI teens having the largest decrease (40%).

The relatively low rates of STIs among AAPIs are suggestive of patterns of sexual behaviors different from other racial/ethnic groups; however, local or statewide data are not available related to sexual behaviors, knowledge or attitudes. National study

data, however, consistently indicate that AAPI adolescents lose their virginity at a later age, show more sexually conservative attitudes and behavior and are less likely to have had sexual intercourse than all other race/ethnic groups (e.g., Tosh & Simmons, 2007). However, data from the National Longitudinal Study of Adolescent Health showed that AAPI youth are less likely to use condoms at first intercourse than all other race/ethnic groups (Dye & Upchurch, 2006).

Although there are many differences between Asian cultures, researchers have identified similarities in cultural views about sex that may impact sexual health decisions of young AAPI women. Sexual discussions are often difficult and regarded as inappropriate and sexual intercourse outside of marriage is often considered unacceptable among AAPI cultures (Okazaki, 2002). Parental involvement also plays a greater role in sexual activity among

young AAPI women than among young AAPI men. Hahm, Lahiff and Barreto (2006) found that young AAPI women with medium and high levels of parental attachment are less likely to have had sexual intercourse.

Even though the AAPI population has lower risk factors, reproductive health cannot be ignored or neglected. Both AAPI men and women can benefit from preventive health services including annual physical exams, cancer screenings, contraceptive methods and counseling, and STI testing and treatment. These measures are not only important for one's health but also for the birth of healthy children and prevention of unintended pregnancies.

Jennifer Jung, MSPH, is an epidemiologist by training and currently a Program Manager for the Arizona Family Planning Council.

Table 5-3
Arizona Reproductive Health Indicator Rates Per 100,000 Population, 2009

Health Indicator	All race/ethnic groups, Arizona	Asian/Pacific Islanders, Arizona
Infant Mortality	5.9	3.8
Teen Pregnancy (females 15-19 years)	56.1	23.6

Source: Arizona Health Status and Vital Statistics 2009 Report





Refugee Health in Arizona

By Renuka Khurana

Refugees arriving in United States face a multitude of dilemmas including language and cultural barriers, loss of identity, and financial insecurity. These and many other issues contribute to a range of health problems. Refugee screening guidelines established by the Centers for Disease Control include screening all newly arriving refugees for communicable diseases to include tuberculosis, hepatitis B and parasitic diseases.

Tuberculosis (TB)

TB is one of the leading causes of death due to communicable diseases, infecting at least one-third of the world's population. The World Health Organization reported that in 2009 TB killed 1.7 million people worldwide, with more than half of the deaths occurring in Asia. Southeast Asia accounts for 35% of all notifiable cases of tuberculosis, while India accounts for 20% of the cases. TB case rates from Bhutan, Thailand and Myanmar are also very high with increasing rates of multi-drug resistance.

Refugees are more vulnerable to TB because of overcrowding, malnutrition, poor health care, high stress with an unstable environment and coexisting communicable diseases like HIV. Over 85% of the refugees originate from areas where TB is endemic and with rates of 50% infection with TB.

Among the Asian American population in Arizona, rates of

tuberculosis are highest among all racial/ethnic groups and have been steadily increasing. In 2008, the case rate for Asian American TB cases was 19.7 per 100,000 individuals (compared to 0.8 per 100,000 among non-Hispanic Whites). This case rate increased to 30.5 per 100,000 in 2009. Refugee screening in Arizona includes screening all new arrivals for tuberculosis with a chest x-ray and a TB blood test.

Hepatitis B (HBV)

HBV is a viral infection with a worldwide distribution. It is transmitted by exposure to infected blood or body fluids. It is a preventable disease by universal use of a very effective vaccine that has been available since 1982. The World Health Organization estimates that approximately 30% (over 2 billion) of the world's population has been exposed to HBV and about 350 million are chronically infected with HBV, potentially leading to cirrhosis and liver cancer.

The prevalence of chronic hepatitis infection among refugees reflects the patterns of HBV infection in the countries of origin of the arriving refugees. Infection rates are highest among refugees arriving from Southeast Asia, which is an area where HBV is prevalent (8-20% of the population is chronically infected).

Chronic hepatitis rates for Asian Americans living in Arizona were 103.5

per 100,000 of population (total cases 180) for 2009 as compared to 16.9 per 100,000 in African American, and 2.0 per 100,000 and 2.8 per 100,000 in Hispanics and Whites respectively.

Parasitic Infections

Refugees originating from Southeast Asia are commonly infected with intestinal parasites, such as hookworm, roundworm and whipworm. Since 1999, preventive treatment has been provided to all refugees more than two years of age, at risk for intestinal parasites. This strategy has led to a reduction in the overall prevalence of intestinal infections from 21.5% to 8%.

Renuka Khurana MD MPH FAAP, is a Clinical Medical Director for Maricopa County Department of Public Health, Deputy TB Control Officer for Maricopa County and Clinical Assistant Professor at University of Arizona in the department of Family and Community Medicine. In her current position she is responsible for STD, HIV and Tuberculosis Control and Prevention including Refugee Health Screening for newly arrived refugees.

Refugees are more vulnerable to TB because of overcrowding, malnutrition and poor health care.



Domestic Violence in the Asian American and Pacific Islander Community

By Sapna Gupta

Domestic violence in Asian American and Pacific Islander (AAPI) communities tends to be underreported because it is highly stigmatized across the diverse groups that form the AAPI population. One national phone survey found just 12.8% of Asian women reported having experienced physical assault by an intimate partner (Tjaden & Thoennes, 2000; Yoshihama & Dabby, 2009). However, other studies on specific AAPI groups have found much higher rates—for example, a study in Boston found 41% of South Asian women experienced abuse and sexual violence (Raj & Silverman, 2002) and a study in Los Angeles estimated 61% of women of Japanese descent had faced domestic and sexual violence (Yoshihama, 1999). The National Coalition of Domestic Violence estimates that as many as 1 in 4 women will be abused at least once. This pervasive underreporting makes it difficult to estimate its true extent in AAPI populations.

Domestic Violence in Arizona AAPI Communities

To date, there are no studies on the prevalence of domestic abuse in Arizona's AAPI communities. However, there is information on the nature and context of abuse. Like AAPI communities in other parts of the United

States, the dynamics of domestic abuse in AAPI communities in Arizona differ in significant ways from that of the general population, particularly for those who are less “assimilated” into U.S. culture:

- An abuser from the AAPI community is more likely to threaten to find another spouse, take away the children, or jeopardize the partner's legal residence status.
- AAPI women facing domestic violence can face multiple abusers within the household: sometimes parents-in-law or siblings-in-law also attempt to exert control over the victim's movements or harass or physically abuse her. The abused woman's own biological family may pressure her to keep quiet and endure the abuse while actively discouraging her from seeking help.
- AAPI women facing domestic abuse may not realize they can seek assistance from the police and courts particularly if they are recent immigrants or refugees.
- In AAPI communities, particularly immigrant communities, tradition dictates silence in the face of domestic abuse and when domestic abuse survivors do speak out, they are more likely to be stigmatized and shamed into silence.

First generation AAPI women and those who are not as assimilated are less likely to seek assistance from agencies that support survivors of domestic abuse because of language

and cultural barriers. They are also less likely than assimilated AAPI women or Caucasian native-born women to call the police to report incidences of domestic violence or to seek refuge at shelters to escape a violent situation (Yoshihama & Dabby, 2009). The inability to properly communicate with fellow shelter residents, interact with law enforcement, and navigate the court system can be overwhelming for these women. In many cases, even if they speak English fluently, they are not aware of their legal rights or that domestic abuse is a crime that can be prosecuted.

According to local advocates and shelter operators, the absence of English proficiency is the greatest obstacle facing immigrant and refugee AAPI women who have left an abusive situation. Although shelter staff and other advocates can access a language line through the Arizona Coalition for Domestic Violence, some of the lines originate from the east coast and close early. In other cases, a translator for a particular dialect might not be available at short notice, leaving the shelter staff unable to communicate with the survivor in the short term, further compounding her distress and sense of isolation. Even when interpreters are available they may not know the correct dialect.

The dynamics of domestic abuse in AAPI communities in Arizona differ in significant ways from that of the general population.

There are several factors specific to Arizona that further compound the sense of isolation that AAPI women in abusive situations face, particularly ones who are not fully assimilated into American society:

- The signing of SB1070 (anti-immigrant legislation) in April 2010 and the general anti-immigrant climate discourage immigrant and refugee women from reporting abuse and seeking assistance due to fear of being jailed, deported, or separated from their children. Both documented and undocumented immigrant women are fearful because the abuser can use the threat of refusing to renew residency papers as a control mechanism.
- The spread-out, low-density housing developments and the lack of convenient public transportation can reinforce a victim's sense of isolation. For example, the abuser can withhold the use of a car, effectively keeping the victim physically stranded.
- The absence of neighborhoods with a high concentration of AAPIs can further compound a victim's sense of isolation and helplessness.

Violence Against Women Act

Battered immigrant women living in Arizona have two types of recourse under the Violence Against Women Act (VAWA), which was initially passed in 1994: they may claim domestic violence as a defense to deportation and they may also self-petition for permanent resident status. To qualify for legal

permanent residence, the woman must prove battering by a U.S. citizen or by a lawful permanent resident spouse and be married or divorced, within two years of application.

However, Arizona's high-tech "Silicon Desert" and large universities have attracted a large number of engineers and scientists who enter the United States with H-1B visas. Their spouses, most often wives, enter on H4 visas that preclude them from seeking employment. Furthermore, their legal residence status is dependent on them remaining with their spouse, who is also the sole source of income. If they find themselves in an abusive situation, their abuser's H-1B visa status does not qualify them for the recourse accorded other immigrant women married to permanent residents or citizens under VAWA. Abused AAPI women on H4 visas who want to leave an abusive household find themselves in an untenable situation: they cannot leave an abusive and potentially dangerous situation without losing their legal residence status.

One potential option for an abused woman who does not qualify for VAWA's protections is to seek a U visa, which would allow her to work and petition for legal residence. But there are multiple hurdles for qualifying for the U category including a lack of knowledge by local law enforcement officials and, in some cases, a lack of cooperation. For example, we know of one incident where a local police department refused to provide the certification that would have allowed a battered immigrant Asian woman to apply for a U visa, erroneously claiming

that it would involve the police in immigration policy.

Organizations Addressing AAPI Domestic Violence in Arizona

To date, Arizona South Asians for Safe Families (ASAFSF) is the only AAPI 501(c)(3) in Arizona with the mission of serving victims of domestic abuse. Entirely volunteer-run since 2004, it operates a toll-free helpline and referral service and provides culturally and linguistically appropriate assistance to survivors of domestic abuse from South Asia, including emergency cash assistance for rent, childcare, transportation, and legal fees.

ASAFSF does not operate its own shelter but serves as a resource and provides technical assistance to shelters that receive residents of South Asian origin. It conducts outreach in the community via fundraisers, its website, and "Chai Chats" -- informal teas where a group of women gather to discuss how to prevent domestic violence and help those who face abusive situations. ASAFSF also participates in monthly meetings convened by the Arizona Coalition Against Domestic Violence. It reports that more than 50% of the women who have called its helpline reside in the United States on H4 visas.

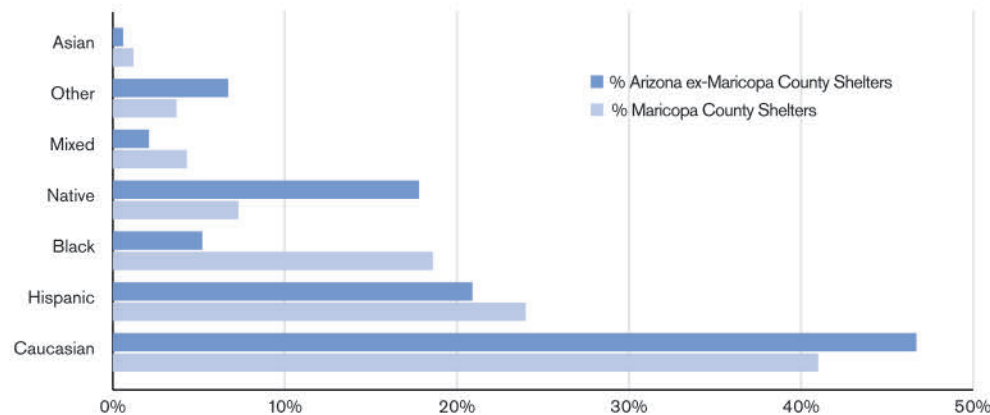
The Council of Filipino Organizations began a Domestic Violence Committee in November of 2010 and has placed advertisements in Filipino newspapers inviting women who are in abusive situations to contact two volunteers, one in the East Valley and one in the West Valley, who can provide assistance and advice. There is

anecdotal evidence that besides cases of domestic abuse in households where both partners are Filipino, there are domestic abuse cases in households with Filipina women who have married U.S. servicemen, with language and cultural barriers being a contributing factor.

The Arizona Coalition Against Domestic Violence (AZCADV) operates a toll-free legal advocacy hotline and serves as a clearing house for domestic violence-related initiatives, laws, and developments in Arizona. It also provides technical assistance to its members. Out of the 2,332 calls to the hotline in calendar 2010, less than 1% self-identified as Asian.

Over thirty shelters in Arizona provide shelter and transitional housing for women and their children fleeing abusive situation. Several agencies and nonprofits run programs that provide transitional housing and job training. Arizona's Department of Economic Security collects quarterly information on the race of women and their children who seek refuge in Arizona's 30 domestic violence shelters. During a 12-month period starting March 2010, 1.3% of the women residing in domestic violence shelters self-identified as Asian (see Figure 5-3). However this number is likely inaccurate as intake staff routinely check the "Other" category if a woman self-identifies as Indian or Pakistani rather than Asian. In Maricopa County, where the majority of Arizona's AAPI population resides, 6.44% of the women residing in shelters were listed with their race as "Other."

Figure 5-3
Percent of Adult Women Using Shelters, April 2010 - March 2011, By Race
Proportion of Births by Weight (Percent)



Source: Arizona Department of Economic Security, April 1, 2010 - March 31, 2011

Summary

As Arizona’s immigrant and refugee population grows, advocates and state agencies are recognizing the need to provide culturally and linguistically appropriate responses. For example, the Arizona Coalition Against Domestic Violence is working with the Arizona Peace Officers Standards and Training Board and federal agencies to develop training on dealing with cases of domestic violence in immigrant and refugee communities. More work is needed and will require Arizona’s AAPI community to come together with other immigrant groups to demand more resources for fighting domestic violence and providing assistance in culturally and linguistically appropriate ways.

Sapna Gupta received her Master’s in Public Policy from the Harvard Kennedy School and her B.A. in Public Policy Studies and Anthropology from the University of Chicago. She has researched and written about the provision of social services to immigrants and on their changing settlement patterns, as well as worked on regional housing planning issues. She is a volunteer with Arizona South Asians for Safe Families and previously served on the board of Apna Ghar Inc. (Our Home), a full-service agency and shelter serving survivors of domestic abuse with a primary focus on the South Asian and other immigrant communities.



Community Responses

“ In 2006, my boss advised me to attend Powerful tools for caregiver courses at Area Agency on Aging. The classes taught me how to get support and take care of myself. I called a family meeting to make a care plan for my mom. I needed a break.”

Excerpt from “Caregiver,” a digital story by Trinh Vu
Complete stories at <http://www.apcaaz.org/gallery.htm>

Community-Based Health: Programs and Resources

By Lili Wang & Nicole Bruno

Community-based organizations play important roles in promoting the health and well-being of the Asian American and Pacific Islander (AAPI) populations in Arizona. They educate the AAPI community on major health issues, provide services to those who have limited or no access to health care, advocate for disadvantaged AAPI populations, such as refugees, battered women and children, promote culturally appropriate medical practices, and influence policy changes to benefit the AAPI community.

Most of the community-based organizations serving the AAPI communities in Arizona are located in the Phoenix Metro area and Southern Arizona, Pima County. The services provided by these organizations include health education, immunization and screening, free or low-cost dental care and physical examination, referral services, medical interpretation, transportation, and other medical services.

The majority of the community-based organizations serving the AAPIs are relatively young, compared to those serving other ethnic minorities. In this essay, we focus on the services and programs provided by two formally incorporated non-profit organizations serving AAPIs in the Phoenix Metro

area and one health coalition in Southern Arizona. Table 6-1 provides a list of some of the active community organizations and coalitions serving the health of the AAPI community in Arizona.

Asian Pacific Community in Action (APCA)

Founded in 2002, the Asian Pacific Community in Action (APCA) promotes the health and well-being of AAPIs in the greater Phoenix metropolitan area. APCA offers health education workshops (e.g. tobacco education, prevention and cessation), provides access to preventive services (e.g. diabetes screening, Hepatitis B screening and vaccination), makes medical referrals (e.g. for mammograms and pap smears), conducts applied research and builds community-wide partnerships. The organization focuses its efforts on major health concerns in the AAPI community, which include Hepatitis B, breast and cervical cancer, diabetes, emergency readiness and tobacco use.

Notably, the organization's cancer education program uses lay health advisors to facilitate culturally responsive cancer education in the settings where people live, work, play and learn. Their cancer education has

reached out to refugee groups such as Burmese, Bhutanese, Nepalese and Iraqis. Additionally, APCA provides medical interpretation services to improve the accessibility of health care services for AAPIs. They also help AAPI individuals and families find health care providers and apply for the publicly funded health insurance programs—Arizona Health Care Cost Containment System (AHCCCS). Community outreach is an important part of the organization's work.

APCA staff members and volunteers speak 19 different AAPI languages, which allow them to reach diverse groups of AAPI population. Thousands of AAPIs are touched annually through APCA's programs and services. In addition to health education and health-related services, APCA collaborates with other ethnic and health advocacy groups on policy matters that affect the AAPI community and other disenfranchised groups more broadly.

Health Through Action is a partnership between the W.K. Kellogg Foundation and the Asian and Pacific Islander American Health Forum to improve health and reduce health disparities for the AAPI community. APCA is the lead agency of the Health Through Action Arizona (HTAA) coalition, which focuses on preventing

The majority of community-based organizations serving Arizona AAPIs are relatively young.

cancer among AAPIs through systems and policy change.

Since its inception, APCA has organized several AAPI health fairs and health forums, completed AAPI health needs assessment targeting local Chinese, Vietnamese, Korean and Filipino communities, developed health education curricula, and conducted community health education outreach/screening events at local community festivals and venues.

Arizona South Asians for Safe Families

Arizona South Asians for Safe Families (ASAFSF), a 501(C) (3) organization established in October 2004, is dedicated to increase awareness of domestic violence and provide culturally and linguistically appropriate support services to victims of domestic violence in the South Asian community in Arizona. The organization emphasizes the importance of a safe family environment and mobilizes the community to end domestic violence. Currently, ASAFSF is run by a team of committed and trained volunteers.

The main services and programs offered by ASAFSF include a toll-free and secure Helpline, direct services to victims of domestic violence, training, parenting support, and community outreach. The Helpline, started in 2006,

has received 500 calls from survivors, local shelters, prosecutors' offices and domestic violence organizations, both in-state and outside. Additionally, they have handled about 1,700 service-related queries via email since August 2006. On average, they serve 3-4 active cases at any given time of the year.

The direct services they provide for victims of domestic violence include financial assistance for child care, rent, legal service, transportation, and emergent personal needs. ASAFSF's family advocates accompany and support victims and their dependent children in courts, medical appointments, and lawyer appointments. Although it does not have a shelter for victims, ASAFSF is connected with local shelters and offers referrals. They also provide interpretation and immigration services as needed.

Direct service providers must have 40 hours of training in Domestic Violence 101 or Arizona Coalition Against Domestic Violence "the Sharing Experience: training. ASAFSF organizes general and culture-specific and legal advocacy training for members and volunteers. The organization also assists victims of abuse to readjust to positive parenting. To increase its community outreach, ASAFSF holds conferences and other community outreach events annually. Chai Chat (Tea with ASAFSF) is a

community-based outreach project focusing on small informal groups hosted by community members.

Southern Arizona Asian and Pacific Islander Health Coalition

In Tucson, Arizona, the Southern Arizona Asian and Pacific Islander Health Coalition is a new and young community-based program in collaboration with the Tucson Unified School District and Asian Pacific American Studies. There is a growing recognition to expand and diversify community initiatives and programs to include the Asian and Pacific Islander populations in Arizona. As a result, more outreach and community collaboration is occurring to help address the health needs and issues for this diverse and spread out population throughout the state.

The Southern Arizona Asian and Pacific Islander Health Coalition conducted their first health fair in spring of 2011 and offered blood pressure and cholesterol checks, depression screenings and helped connect the AAPI community to local resources to help them with other issues such as access to medical care, language barrier issues and many other needs. They provided flyers and services in the following languages: Nepalese, Vietnamese, Korean, Marshallese, Arabic, and Chinese. They have seen

a great need to help Bhutanese-Nepalese refugees and the Marshallese in the southern Arizona region and are continuing to do outreach to help connect them to resources. Their next project is to help organize and develop resources for the senior citizens in the area to help them deal with life and aging issues.

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Table 6-1
List of Organizations and Resources for the Health of the AAPI Community

Organization	Contact Information	Main Services
Arizona Statewide		
AHCCCS	Phone: 800-528-0142	Public health insurance for low income or qualified Arizona residents
Phoenix Metro Area		
Area Agency on Aging	1366 E. Thomas Rd. Suite 108 Phoenix AZ, 85014 Phone: 602.264.2255; 888.783.7500 http://www.aaaphx.org/	Senior help line, home and community based care, elder rights, legal help, housing, disability resources, etc.
Arizona Medical Clinic	1847 W. Heatherbrae Drive, Suite A Phoenix, AZ 85015 Phone: 602.274.2100	Family practice for Burmese, Bhutanese, Cambodian, Nepali, Vietnamese, etc.
Arizona South Asians for Safe Families	ASAFSF, PO Box 2748, Scottsdale, AZ 85282-2748 Helpline: 1-877-SAFE-711 Email: info@asafsf.org or asafsf@gmail.com http://www.asafsf.org/	Help line, financial assistance, legal support, referrals, transportation and interpretation for victims of domestic violence in the South Asian community
Asian Pacific Community In Action	6741 North 7th Street, Phoenix, Arizona 85014 Phone: 602.248.0496 Email: info@apcaaz.org http://www.apcaaz.org/	Hepatitis B screening, diabetes screening, cancer prevention, tobacco education, health care access, medical interpretation, emergency preparedness, advocacy,
International Rescue Committee	5227 North 7th Street, Phoenix, AZ 85014 Phoenix: 602.433.2440 http://www.rescue.org/Phoenix	Well Being Center for refugees with traumatic experiences, mental therapy referrals, pre & post natal program, dental assistance, health insurance outreach, child care, interpretation, etc.
Maricopa Integrated Healthcare Systems (MIHS) Refugee Women's Health Clinic	2525 E. Roosevelt St., Phoenix, AZ 85008 Phone: 602.344.1445 (appointments) 602.344.5407 (general messaging)	Comprehensive healthcare and women's care for refugees, with in-person interpreter
Vietnamese American Coalition of Arizona	2013 A W. Bethany Home Road Phoenix, AZ 85015 http://www.vacaz.org/	Health education and awareness, access to health care, interpretation
Vietnamese Health Professional Association	2051 W. Warner Road, #23 Chandler, AZ 85224-8725 Phone: 480.917.0181	Health screening
Southern Arizona		
Southern Arizona Asian and Pacific Islander Health Coalition	940 South Craycroft Tucson, Arizona 85711 Phone: (520) 982-6681 Email: kevindwong52@yahoo.com	Health screening, health fairs, access to health care, connection to resources



Staying Healthy: Planning For the Flu

By Yen Nguyen

In 2010 Maricopa County Department of Public Health worked with community organizations to develop a detailed plan to increase flu vaccination rates among Asian Americans and Pacific Islanders (AAPI). A questionnaire was developed by the Maricopa County Department of Public Health, and additional questions were added specifically for the AAPI community. The final questionnaire was then translated into Chinese, Korean, Vietnamese, and Thai. The questionnaire was distributed to AAPIs through a variety of means: at health fairs and churches, through personal distribution by community leaders, and by e-mail or phone. Distribution took place in the middle of August until the second week of September 2010.

Three hundred forty-four (344) people participated in the survey; 63% were women and about 1/3 had a college degree or at least 4 years of college. Including all of the people in the households for all of the respondents, 26% were between 35-49 years old, 18% were between 50-64 years old and 10% were from 5-9 years old. Over 76% of the respondents were covered through health insurance. The five largest ethnicity groups consisted of Chinese (25%), Korean (21%), Vietnamese (19%), Asian Indian

(12%) and Filipino/a (12%). The four primary languages spoken at home were Chinese (23%), Korean (19%), Vietnamese (17%), and English (17%).

Vaccination Against the Flu

Table 6-2 summarizes the respondents' reasons for and against receiving a flu vaccination. When asked the reasons for not getting fall flu vaccinations, 24% of respondents stated that cost was a barrier, 24% indicated they never get a flu vaccination, and 17% said that they did not know where to get vaccinated.

In contrast, some of the influences that would increase the likelihood of getting the fall flu vaccination included having a convenient location (60%), access to low cost vaccines (23%), if a doctor/medical provider said it was a good idea (22%), and media influences (17%). In addition, 42% of people mentioned pharmacies and/or grocery stores as convenient locations to get a flu shot. Other convenient locations mentioned were doctor offices (34%), churches (33%), or workplaces (25%).

Table 6-3 shows the percentage of respondents who received H1N1 and seasonal flu vaccinations last year. Children under 14 years old were more likely to get the H1N1 vaccination. Only 18% of the age group between 19-24 years received the H1N1 vaccination.

A multi-lingual flu hotline should be developed to serve AAPIs and other groups.

Table 6-2
Reasons for Not Getting Fall Flu Vaccination (N=192)

Reasons	Percent Reporting
Cost	24
Never get one	24
Don't know where to go	17
Don't need it	15
Vaccination makes me sick	14
Don't believe it works	11
No transportation	2
Never get the flu/do not get sick	1
Believe there are side effects from shot	1
If doctor recommended	1
Don't know enough about it	1
Other	8
Don't know	15

Table 6-3
Percent of Those Receiving H1N1 and Flu Vaccination Last Year, By Age (N=352)

Age Category	Percent Who Received H1N1 Vaccine	Percent Who Received Seasonal Flu Vaccine
Under 5	38	60
5 to 9 years	46	62
10 to 14 years	42	51
15 to 18 years	30	43
19 to 24 years	18	29
25 to 34 years	33	42
35 to 49 years	36	47
50 to 64 years	31	54
65 to 79 years	39	67
80 or older	30	50
No answer	6	7

Less than 50% of the respondents between college-age and middle-age groups received H1N1 or seasonal flu vaccinations, whereas people aged 50 years or older were more likely to get the seasonal flu vaccination. A majority (60%) of all respondents stated that they will get the seasonal flu vaccination this fall, while 21% are not sure if they will get the vaccination this year.

Summary

Two key findings from the survey data are 1) efforts are needed to increase flu awareness and education among AAPIs in Maricopa County, and 2) having convenient locations to get the flu vaccine is an important consideration for AAPIs.

Based upon these themes, outreach plans to increase the number of AAPIs getting the flu vaccine could include the following activities: Disseminate flu educational materials at health fairs, cultural events, ethnic grocery stores, and AAPI faith institutions; develop a multi-lingual flu hotline through local AAPI serving organizations; publish educational articles about flu prevention and vaccination in the local AAPI media; and provide flu vaccines at AAPI supermarkets, faith institutions, and senior centers.

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Preparing for Disaster

By Yen Nguyen

How different groups are prepared for, and can respond, to emergencies and disasters is an important aspect of public health. In order to better understand the capacity of Asian American and Pacific Islander (AAPI) communities to respond to disasters, the Maricopa County Department of Public Health worked with the Asian Pacific Emergency Preparedness Coalition to survey AAPI organizations about emergency preparations. Leaders and representatives from churches and organizations were invited to join the Emergency Preparedness Coalition. Each Coalition member was asked to complete the survey on paper, online or by phone. Twenty-five coalition organizations completed the survey between May and June 2011.

Preparing for Disasters

Respondents were asked what disasters they thought “likely” or “very likely” to take place in the next 10 years. Not surprisingly, 80% responded that extreme heat was likely or very likely to occur, followed by fire (44%), loss of power (40%), and violent crime (36%). In addition, 36% of the respondents thought it was likely that a disease outbreak would arise.

Figure 6-1 includes information on how prepared each organization felt in terms of handling emergency events. Nearly one third reported feeling somewhat prepared, but the majority of organizations either were unsure or not at all prepared. None felt well-prepared.

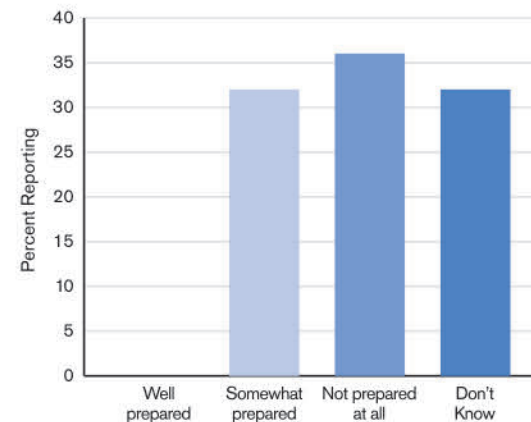
In terms of responding to specific emergency events like extreme heat or fire, few felt somewhat prepared.

Although many organizations did not feel prepared for an emergency, more of the organizations were able to report specific ways they could respond if needed (see Table 6-4). Over 75% of the organizations reported that all staff in their organization knew to call 911 in an emergency. Half stated they had fire extinguishers, had several people in their organization that had taken a first-aid or CPR class, and knew how to exit the facility in an emergency. Sixty percent felt they could provide information to participants about emergencies and just over half responded they could contact participants/population if there were an emergency (56%).

However, less than half of the respondents said their organizations either did not have or they did not know if their organizations had water and non-perishable food for at least 20 people at the organization’s facility or a disaster recovery plan for use after an emergency is over. Less than half of the respondents also did not know whether the organization had practiced an evacuation drill at least once in the past year; whether there was an assembly location or temporary shelter for the staff if they were evacuated from the facility or whether their organization had an emergency communication plan for participants/population. When respondents were asked about their

None of the community organizations serving the AAPI population in Arizona felt well-prepared for an emergency.

Figure 6-1
How Prepared is Your Organization for an Emergency?
(N = 25)



organizations having an emergency preparedness plan, only 2 stated yes (and that included flu shots and some sort of training); 13 stated no and 10 did not know.

In the event of an emergency, respondents were asked what services their organization could provide. Overall 7 organizations indicated they could provide food, shelter, transportation, medical aid/professionals/supplies, volunteers, language assistance, disseminating information, respite for emergency workers and Internet access.

Emergency Communication

With respect to communication, 7 organizations had an established method of communicating during an emergency. If there were a large-scale emergency event, organizations expected they would communicate information via email (81%), Internet or cell phone (75%), land-based telephone (70%) or text message (68%). Television, email and Internet/website were considered the best methods for each organization to receive information in an emergency.

Ten organizations completed an open-ended portion of the survey on getting emergency and public health information to the public. Some recurrent themes include language issues, lack of awareness, timing and staff size. Other agencies also mentioned barriers such as transportation, lack of telephone, lack of funding and that the elderly population was not responsive.

Summary

Two overarching themes emerged from the study. First, efforts are needed to increase emergency awareness and education among AAPIs in Maricopa County, and second, efforts are needed to build a communication system within the AAPI community.

There are several recommendations to help ensure emergency preparedness for this hard to reach population through raising awareness, preparation and communication. Some potential actions that can be conducted in the AAPI community include: 1) disseminating emergency preparedness educational materials to ensure that AAPI residents have the minimum core knowledge to prepare for emergencies, 2) develop a communication system to carryout emergency-related information in the local AAPI communities, 3) publish educational articles in the local AAPI media and translated educational information on the Internet, and 4) provide training and services to equip AAPI faith-based organizations for disasters.

Yen Nguyen holds a Masters degree in Public Health from the University of Arizona, and is the Special Projects Coordinator at Asian Pacific Community in Action. Yen is a community advocate and works with numerous organizations to bring health information to the Vietnamese community. She is the co-founder for the Vietnamese American Coalition of Arizona, and the liaison for American & Pacific Islander Emergency Preparedness Coalition.

Table 6-4
Organization Preparations for Emergencies (N=25)

	Percent Reporting
There is a fire extinguisher at our main location	52
All staff in the organization know to call 9-1-1 in an emergency	76
We have an emergency communication plan for our participants/population	20
Our organization could provide temporary shelter to people who have been evacuated from their homes	12
In an emergency, my organization could provide information to my participants/ population	60
Several people in our organization have taken a first-aid or CPR class	52
All members of the organization know how to exit the facility in the event of a fire, earthquake, etc	52
There are battery operated lights or flashlights available	48
We have practiced an evacuation drill at least once in the past year	16
Our organization has an assembly location for our staff if they are evacuated from the facility	16
Our organization would contact our participants/population if there were an emergency in the community	56
We have a disaster recovery plan for use after an emergency is over	12
There is water and non-perishable food for at least 20 people at our main location	12





Recommendations

Gaining Voice, Building Momentum

As Asian Americans and Pacific Islanders (AAPIs) in Arizona increase in number, they represent a collective voice that can shift the public health dialogue throughout the state. Here, we summarize some of the recommendations that arise from the collective voice of our authors. These 10 recommendations provide a blueprint for community members, practitioners, advocates, and public policy makers.

1. Realize the diversity of the AAPI community.

The great diversity of the AAPI community—across generations, languages, racial/ethnic backgrounds—must be acknowledged. Only by recognizing AAPI diversity will we move forward in addressing varying needs. As one example, differences between AAPI groups provide better understanding of disparities on maternal and child outcomes than looking at AAPIs overall. Such finer-grained data are necessary in order to understand how health challenges, outcomes and treatment may vary among specific AAPI groups.

2. Embrace the strengths of AAPI communities.

With diversity comes great opportunity. As we understand more about the diverse AAPI population, we can also more effectively harness existing strengths in the community.

For example, a traditional Asian diet rich in vegetables and fruits may be associated with the relatively low overall cancer rates in AAPIs, and should be promoted in lieu of the high fat diets of the western world.

3. Champion language access.

Health care facilities and providers ought to invest in proper language access standards, protocols and services. Public health and emergency messages should be appropriately translated and public safety officers, hotlines and shelters must have AAPI language interpreters available. These steps are less costly than the steep price paid for not providing language access services.

4. Defend the health care rights of all AAPIs.

Ensure all AAPI individuals know their rights with respect to health care and services. Not everyone knows they have the right to receive a medical interpreter or translated information at no cost to them. Newer AAPI populations are sometimes unaware of the fact that domestic violence is a prosecutable offense. And defending the rights of all requires support of immigration policy reforms that respect and promote the health and well being of families and community.



5. Prepare health care providers and first responders to be culturally-responsive.

Providers and responders ought to be trained in delivering services with an understanding of cultural/ethnic differences between different groups and within particular AAPI groups. Culture influences many aspects of health such as how AAPIs communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. With mental health and domestic violence in particular, providers should understand the stigma attached to these issues and ensure AAPI individuals will seek and receive appropriate treatment and support.

6. Promote better mental health.

Those working with AAPI populations should be aware of the difficulties many AAPI individuals face in accessing and using mental health services. Health care providers and advocates, community program leaders and school personnel ought to recognize the impact of discrimination on the physical and mental health of AAPI individuals. Educational and skill training programs should be tailored to the mental health needs of AAPI populations. Provision of tangible

assistance, such as transportation and translation, is needed to facilitate the use of mental health services in many AAPI communities.

7. Target disparities in cancer, hepatitis B and tuberculosis.

Cancer is the number one cause of death among AAPIs both nationally and in Arizona, and AAPIs have the highest incidence rates of hepatitis B and TB. More education is required in the AAPI community to promote early detection of cancer, hepatitis B and TB through testing and regular screening. It is critical that health care providers be better educated about the increased risk for TB and hepatitis B infection among Asian Americans, particularly for those who are foreign-born, and for recent immigrants and refugees from countries where rates of TB and hepatitis B are high. Cancer control efforts should include a focus on eliminating tobacco usage, promoting a traditional Asian diet with a low animal fat content, and daily physical activity.

8. Support community-based initiatives.

Community-based organizations play important roles in promoting the health and well-being of the AAPI populations in Arizona. More organizations working with AAPI communities are needed to provide education on major health issues, offer services to those who have limited or no access to health

care, advocate for disadvantaged AAPI groups, promote culturally appropriate medical practices, and influence policy changes to benefit the AAPI community.

9. Cultivate allies.

Addressing the needs and challenges of the diverse AAPI community requires allies. We must create networks of support. Health Through Action Arizona was one step in the process of building a broad-based coalition around issues of health and social justice. Continuing work is needed to sustain this coalition and bring in new allies.

10. Advocate and speak out.

The AAPI community is poised to take a greater role in civic leadership and to advocate around a variety of issues to promote social justice and health. This volume provides a starting place for education and advocacy. For more information and data on AAPI health, examples of strategies to address health issues, inspiring digital stories from those who faced health challenges and ideas for ways to get involved, go to www.apcaaz.org. Exercise your voice and effect change!



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