

Asian Americans and Pacific Islanders: Health Disparities

Note: The information on groups presented under Asian Americans and Pacific Islanders does not focus on Koreans and Japanese living in the US, since these subgroups are relatively small.

The available demographic and health data on Asian Americans and Pacific Islanders (AAPIs) are usually of limited value because of the attempt to encompass the broad AAPI group, in spite of the enormous diversity among the peoples included. Without disaggregating the data, it is impossible to detect the great variations in income, education, and health status among AAPI populations, hiding serious socioeconomic and health problems both within and between subgroups.

Health indicators for AAPIs overall suggest that this population is one of the healthiest in the US. However, there is great diversity within this group, and marked health disparities exist for specific segments. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis are also higher in AAPIs living in the US than in whites. (US DHHS, 2000).

Underlying Causes of Health Disparities: Income and Education

Inequalities in income and education underlie many health disparities in the US. Income and education are intrinsically related and often serve as proxy measures for each other. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of death and illness, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors. (US DHHS, 2000).

Health disparities are believed to be the result of the complex interaction among genetic variations, environmental factors, and specific health behaviors. This section of the Provider's Guide presents information on the traditional health practices and beliefs as well as the health status of different AAPI subgroups:

- **General Information on Asian Americans and Pacific Islanders**

General Information on Asian Americans and Pacific Islanders

Although AAPIs are sometimes seen as constituting a homogeneous ethnic category, the failure to make distinctions among specific ethnic groups can lead to faulty conclusions about important health needs among AAPI clients. Without disaggregating demographic and health data, it is impossible to detect the great variations in income, education, and health status among AAPI populations, hiding serious socioeconomic and health problems both within and between certain ethnic groups. The need to examine the health care issues of *specific* AAPI subgroups (e.g., Chinese, Filipino, native Hawaiian, Vietnamese) is clear. (Zane et al., 1994).

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History

- **Immigrants come from more than 20 countries.** Motivated by economic factors, political turmoil, and the desire for education, Asian Americans have immigrated to the US from more than 20 countries. They speak more than 100 different languages and represent more than 60 different ethnicities. (Ponce, 1990).
- **Traumatic sociopolitical experiences are common.** Traumatic sociopolitical experiences (war, internment camps, torture, and famine) prior to migration are common among many Southeast Asian refugees. Their adjustment to the US may include lifelong issues of separation, loss, abandonment, and guilt. (Chin and Bigby, 2003).
- **US immigration policies have been discriminatory.** Immigration policies have historically been discriminatory toward Asians and resulted in more stringent quotas and greater scrutiny and hurdles for entry and citizenship than for any other racial or ethnic group. (Chin and Bigby, 2003).

Demographics

- **The AAPI population is growing.** Approximately 12.5 million AAPIs, representing 4.4% of the total population, live in the US. (US Census Bureau, 2002). AAPIs are the fastest-growing ethnic group in the US. It is projected that by the year 2020, the AAPI population will reach 20 million. (US Environmental Protection Agency, 2002).
- **Up to 70% of AAPIs are recent immigrants or refugees.** Before 1965, there were only about 1 million AAPIs in the US. In 1965 the Supreme Court struck down immigration quotas based on national origin. (Management Sciences for Health, 2003; US Environmental Protection Agency, 2002).
- **Asian-American populations are concentrated.** More than 90% of Asian Americans reside in metropolitan centers. More than half (55%) of all AAPIs reside in California, Hawaii, and Washington; most of the other 45% live in New York, New Jersey, Illinois, and Texas. (Barnes and Bennett, 2002).
- **Five states have the largest growth in AAPI population.** The five states with the largest increase in AAPI population are Rhode Island, New Hampshire, Georgia, Wisconsin, and Minnesota. (US DHHS, 2003b).
- **AAPIs are a key source of health care professionals.** In 1990 AAPIs accounted for 11% of the nation's physicians and 4% of nurses. They represented about 25% of all physicians and nurses employed in public hospitals in New York, Los Angeles, San Francisco, and Chicago. (Kaiser Permanente, 1999).

Socioeconomic Status and Health Status

Socioeconomic status (SES) is a reliable predictor of health status throughout the world.

Generally, high SES is associated with better health status, and low SES with poorer health status. In the US, people of lower SES are less likely to adopt healthy eating and exercise patterns, and they have less access to adequate, regular health care. People of lower SES are more likely than their wealthier peers to concentrate on day-to-day survival and experience feelings of hopelessness, powerlessness, and social isolation. These disparities in education and economic resources may negatively influence health beliefs and behaviors. Even when SES changes for a person of color, the effects may not lessen. (US DHHS, 2003b).

- **Poverty is a factor.** In 1996, 14% of Asian families—compared with 11% of white, 28% of African-American, and 28% of Latino families—were at the poverty level or below. (Kaiser Permanente, 1999). Despite the generally high income levels among AAPIs, certain subgroups experience poverty levels higher than the national average. As a group, Southeast Asians have higher poverty levels. For example, 53% of Hmong, 41% of Cambodians, and 33% of Laotians have household incomes of less than \$15,000, compared with 22% of non-Hispanic whites. (Georgetown University, 2002).

Urban Environment: Increased Risks and Increased Alienation

Residents in urban settings have a greater risk of exposure to hazards such as toxic waste and air pollution, are exposed to a higher concentration of crime and violence, and live in older, poorly maintained buildings with inadequate heating, lead paint, and cockroach allergens. Researchers believe that exposure to violence may increase feelings of alienation, powerlessness, and hopelessness. Individuals who live under these conditions may see limited benefits in adopting health-promoting behavioral changes. (US DHHS, 2003b).

Health Status

Data

- **Limited meaningful data available.** The available demographic and health data on AAPIs are usually of limited value because of the attempt to encompass the broad group, in spite of the diversity among the peoples included. Without disaggregating the data, it is impossible to detect the great variations in income, education, and health status among AAPI populations, hiding serious socioeconomic and health problems both within and between subgroups.
- **Lack of meaningful sample sizes skews data.** The Heckler Report (Heckler, 1985) considered Asian Americans to be in good health because it failed to include a sufficiently large sample for a meaningful analysis and did not include health conditions (e.g., tuberculosis, hepatitis B) prevalent among Asian-American populations. (Chin and Bigby, 2003).
- **Limited studies have been done.** The limited studies about Asian-American health are often published in non-peer-reviewed journals because mainstream journals consider them to be of “limited scope and relevance.” (Chin and Bigby, 2003).

Leading Causes of Morbidity and Mortality

- **There are three leading causes of death.** As in both white and black populations, the three leading causes of death in AAPIs are coronary artery disease, cancer, and cerebrovascular disease.
- **Other health concerns exist, including mental health.** Other health concerns for AAPI populations are prenatal care and mental health. (Chin and Bigby, 2003). AAPI girls have the highest suicide rate for females between the ages of 15 and 24, and 30% of Asian-American girls in grades 5 through 12 reported symptoms of depression. (Georgetown University, 2002).
- **The incidence of tuberculosis (TB) is high.** The incidence of TB among AAPI populations is 41.6 per 100,000, compared with 2.8 for white non-Hispanics and 22.4 for black non-Hispanics. (APIAHF, 2003; Chin and Bigby, 2003; Chin, 1999).
- **AAPIs account for 50% of hepatitis B infections in the US.** Approximately 1.25 million people in the US are chronically infected with the hepatitis B virus (HBV). Annually, 5,000 deaths are caused by HBV-induced liver failure. Although they make up only 4.4% of the US population, AAPIs account for approximately 50% of HBV infections and 50% of deaths caused by HBV-induced liver failure. (Moritsugu et al., 2002).

Traditional Health Beliefs and Practices

Overview of Philosophies, Religions, and Worldviews

AAPI groups are diverse, and they practice many religions, including Catholicism (most Filipinos), Islam (most Indonesians), and Hinduism (many Indians).

- Both **Confucianism** and **Buddhism** have had a significant impact on lifestyles and health practices. For example, Confucianism and Buddhism encourage respect for elders and those in authority, such as health care providers. Buddhism also teaches that life is a cycle of suffering and rebirth. Hence, pain and illness are sometimes endured, and care-seeking may be delayed. (Rasbridge, 2003).
- **Buddhist and many other Eastern philosophies** teach that art and science can coexist and that healing is spiritual as well as scientific. (Yee et al., 1999).
- **Taoism**, which has its origins in China, is practiced today by many Taiwanese and Koreans in the US. The Tao, or “the way,” is based on the idea of balancing natural processes and forces (such as yin and yang) and is associated with traditional health practices such as holistic medicine, acupuncture, herbalism, and meditation, as well as with martial arts. (Robinson, 2003).

Overview of Asian Medicine

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- **The traditional Asian view of health is holistic.** It links mind, body, and soul and focuses on establishing and maintaining a balance of life energies within each individual's unique constitution. (Chin and Bigby, 2003).
- The **Chinese philosophy of life**, practiced for more than 3,000 years, is the basis for traditional health beliefs among many Asian populations. Chinese medicine regards mind-body-spirit as an integrated whole in which each component influences the others. (Pachuta, 1993). The goal of Chinese medicine is to preserve health and cure disease by recovering the balance within the human being and between the person and his or her environment. (Management Sciences for Health, 2003).
- **Ayurvedic (Hindu) principles** have long governed the health beliefs and behaviors of many South Asians, and they continue to do so today. The underlying principle of Ayurveda is the interrelationship between the universe and the body. (Kaiser Permanente, 1999).
- The **traditional Chinese view of the human body** as a derivative of the natural world has similarities with Ayurvedic principles. The health beliefs of traditional Chinese, Japanese, Koreans, Vietnamese, Laotians, Hmong, Mien, and Cambodians are affected by Taoist principles. Ayurvedic medicine recommends a balanced diet of "hot" and "cold" foods. The Filipino concept of health is based on a similar principle of balance, *Timbang*, in accord with Ayurvedic and Chinese traditions. Specific disorders are perceived to be caused by an excess intake of one type of food. For example, "hot" foods are thought to cause arthritis and hypertension, whereas "cold" foods may bring about cancer and anemia. (Kaiser Permanente, 1999).
- The **naturalistic theory** is another variation of traditional Asian medicine in which physical and social factors are integrated to diagnose illnesses among Vietnamese, Laotians, Hmong, Cambodians, and Filipinos. Diseases are perceived to be caused by shifts in environmental forces. For instance, high winds and rainy weather are believed to result in rheumatism or respiratory diseases. (Kaiser Permanente, 1999).
- **Animism** is the belief that human beings, animals, and inanimate objects all possess souls and spirits. Although spirit worship is one of the oldest religious traditions, the only AAPI subgroups that still widely adhere to animism are Laotians, Hmong, Mien, and Cambodians from rural areas. In animism, illnesses are normally viewed either as punishment from gods, demons, and spirits or as curses from evil spirits. To alleviate sickness, appeals are often made to gods, and shamans are called on to chase away evil spirits. (Kaiser Permanente, 1999).

Suggestion

Understanding how the various AAPI worldviews shape beliefs about the causes of disease and acknowledging their role in the health care decision-making process are important elements of providing quality care. Beliefs in the interconnectedness of the mind, body, and spirit and the need for balance require a holistic approach to treatment. (Kaiser Permanente, 1999).

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Fatalism

- **Denial.** Asian patients may deny their illnesses or view them as being related to personal carelessness or weakness, as punishment, or as a result of external forces over which they have no control. (Chin and Bigby, 2003).
- **Karma.** An Asian-American patient may feel that his or her illness is caused by karma (the law of cause and effect over countless lifetimes), even though the patient understands that the illness has a biological cause. (Rasbridge, 2003).

Death and Dying

- **Autopsy.** Members of some AAPI subgroups—for example, Asian Indians—are unlikely to give permission for postmortem examinations. (Alagiakrishnan and Chopra, 2001).
- **Home care of the dying.** It may be important to AAPI elders and their families that the dying be cared for at home, so that traditional rituals can be observed. (Alagiakrishnan and Chopra, 2001).

Causes of Illness

- **Dampness,** arising from getting caught in the rain, having wet hair, or keeping on wet clothes, or drinking too many cold liquids is associated with symptoms of lethargy, indigestion, nausea and vomiting, and arthritis. (Chin and Bigby, 2003).
- Some AAPIs believe that **deficiencies of yin** give rise to symptoms of dryness (e.g., dry mouth, cough) and heat (e.g., fever, inflammation), whereas **deficiencies of yang** give rise to symptoms of poor vitality and strength (e.g., fatigue, impotence) and lack of adequate warmth (e.g., chills). (Chin and Bigby, 2003).
- **Wind** is traditionally thought to attack the upper part of the body (respiratory system); consequently, some Asians will avoid sitting near an air conditioner. (Chin and Bigby, 2003).

Possible Consequences of Specific Health Beliefs

- **Fear of surgery.** Some individuals from Asian subgroups influenced by Ayurvedic and Taoist principles are fearful of surgery because it may result in an excess loss of blood, which is believed to disrupt the humoral balance within the body. (Kaiser Permanente, 1999).
- **Reluctance to have blood drawn.** Many Asians believe that blood is not replenished when it is removed from the body; consequently, they are reluctant to have blood drawn. (Chin and Bigby, 2003).
- **Disparate treatments.** Whereas Westerners believe that a cool bath should be used to bring down a fever, Asians believe that keeping the patient warm with blankets following the use of an herbal tea will dissipate fever. (Chin and Bigby, 2003).
- **Nonadherence.** Lack of adherence to treatment recommendations is likely if they differ from people's basic health beliefs. In addition, recent immigrants may not be familiar with

Western prescriptions for pills and capsules. Whereas herbalists' instructions give clients a sense of control, since they can regulate the concentration of herbal broths, AAPI patients lose this autonomy with Western prescriptions. Lack of understanding of Western drugs may prompt clients who continue to feel ill after taking Western medications to rely on herbal medicines or to try to regulate the drug's effects by increasing or decreasing the dosage. (Kaiser Permanente, 1999).

Suggestion

By paying attention to the patient's age, generation, language proficiency, and length of time in the US, providers can often gauge the patient's familiarity with Western health beliefs and adherence to traditional concepts. By asking appropriate questions regarding health beliefs, providers demonstrate respect and sensitivity for the patient's culture and can strengthen their relationships with patients. Trust in the provider is essential and can only be accomplished over time. (Kaiser Permanente, 1999).

Risk Factors and Challenges

Access to Health Care

- **Providers can help dispel fears and concerns.** Fear of deportation and concerns about jeopardizing their chances of obtaining citizenship or permanent residency can discourage AAPIs from seeking health care. Many recent immigrants and refugees are confused about their eligibility for services and reluctant to visit Western physicians. (Kaiser Permanente, 1999).
- **Lack of familiarity with Western health care systems.** Immigrants who are unfamiliar with Western health care systems tend to underutilize health care services, delay seeking health care, and not adhere to treatment recommendations. (Chin and Bigby, 2003).

Suggestion

Programs can be established to educate AAPIs, especially those new to the country, about the concept of HMOs and how best to use the system. It is important that materials be available in languages that the patients can read.

Lack of Insurance

- **About 19% are uninsured.** In one older study, 27% of Asians were uninsured, compared with 12% of whites, 19% of blacks, and 27% of Hispanics. (Gold and Socolar, 1987). The percentage of AAPIs who were uninsured had declined to 19% in 1999–2001 (three-year average), however. (US Census Bureau, 2002).
- **Limited or no coverage is available for alternative medicine.** Even with health insurance, culturally accepted medical treatments such as acupuncture and herbal medicines often are not covered, which may limit access to health care by Asian Americans. (AAHF, 1990).

Language

- **Language is a barrier.** Access to care via complicated telephone systems that are unresponsive to non-English-speaking clients can be problematic for Asian-American immigrants and refugees. Longer waits for services occur when interpreters cannot be found, and child family members are sometimes called on to interpret. (Chin and Bigby, 2003).
- **Some subgroups, especially the elderly, are not fluent in English.** The percentage of persons 5 years or older who do not speak English varies by Asian-American group: 61% of Vietnamese, 51% of Chinese, 24% of Filipinos, and 24% of Asian Indians are not fluent in English. A very large proportion of Asian Americans over 65 years of age cannot speak English well. (Tucker and Tervalon, 2003).

Suggestion

Ensure comprehension of medical information by asking questions or using an interpreter. (Kaiser Permanente, 1999). Seek patient education materials in the patient's language.

- **Lack of interpreters is a problem.** The absence or limited supply of interpreters and bilingual providers impedes access and communication. Even when interpreters are available, the multiple languages and dialects among different Asian ethnic groups make communication difficult. (Chin and Bigby, 2003).

Parasitic Infestations

- **Incidence of parasitic infestation.** The incidence of intestinal parasitic infestation among AAPIs entering the US has been shown to be as high as 80%, and multiple parasitic infestations have been found in as many as 55% of the Southeast Asian refugees screened. (Hann, 1994).
- **Common types of parasites.** Hookworm is by far the most common (38%), followed by *Giardia* (9%), *Ascaris* (7%), and *Strongyloides* (6%). (Hann, 1994).
- **Southeast Asians at risk.** The prevalence of parasitic infestation varies significantly among different ethnic groups. Hmong are the most frequently infected (75%), followed by Cambodians (74%) and Vietnamese (47%). The distribution of parasite types also varies among ethnicities: *Ascaris* and *Trichuris* are more common in Vietnamese; *Clonorchis* species are more prevalent in Laotians; and Cambodians show more multiple infestations by *Strongyloides*, hookworm, and *Giardia*. (Hann, 1994).
- **School-aged children most heavily infested.** Youngsters less than 4 years old are least infested, and school-aged children are most heavily infested, by *Trichuris*, *Giardia*, and *Strongyloides*. Adults have a majority of the hookworm and *Clonorchis* infestations. (Hann, 1994).
- **Malaria among Southeast Asian refugees.** Although malaria is not a significant problem in the US, it may occur among refugees and travelers from endemic regions or military personnel stationed there. Thus, more than 99% of cases are imported; 55% occur in Southeast Asian refugees, more occur in males than in females, and the highest incidence is

in the 10 to 29 age group. Vivax malaria is the predominant form (82%) among refugees in the US. (Hann, 1994).

Smoking

- **Male smoking rate is higher.** Among AAPIs age 18 and older, 24% of men and 7% of women smoke. (Tucker and Tervalon, 2003). Some social structures may encourage negative health behaviors. For example, smoking rates exceed 50% among immigrant male restaurant workers.
- **Females have higher exposure to secondhand smoke.** Female AAPI nonsmokers are exposed to more secondhand cigarette smoke than are male AAPI nonsmokers. It is believed that the women's exposure to secondhand smoke is due to male smokers in the household. (APIAHF, 2001).

Diet and Exercise

- **Diet in the US.** The adoption of Western dietary habits has been shown to negatively affect the overall health status of AAPIs. For example, animal meat and fat generally replace fish as the primary sources of protein. (Kaiser Permanente, 1999).

Suggestions

Encourage AAPIs to retain the positive elements of their traditional diets, but warn them about the risk associated with nitrates in traditional pickled, smoked, and salted foods. Urge more consumption of fruits and vegetables. (Kaiser Permanente, 1999).

When dealing with the Southeast Asian population, pay special attention to nutritional status. Become familiar with the various foods consumed by AAPIs and the nutritional content of these foods. Consult published guides that offer this specific information. (Kaiser Permanente, 1999)

- **Lactose intolerance.** Because 90% of Asian Americans are lactose intolerant, the absence of dairy products is believed to result in a low intake of calcium among AAPIs. (Kaiser Permanente, 1999). Asian women are at high risk of osteoporosis.
- **Traditional exercise is in decline.** A daily regimen of healthy behaviors and exercise is common in Asian cultures, consistent with a holistic view of the mind, body, and spirit as important to wellness. Tai chi, a form of exercise, and qigong, the development of internal energy, are viewed as supportive of longevity, health, and strength. (Chin and Bigby, 2003). Among Asian-American immigrants, however, traditional forms of exercise have declined because of economic demands and work schedules.

Suggestion

Encourage exercise, including traditional exercise, if appropriate. Traditional exercise can be done almost anywhere, alone or with others, and there is no need to purchase equipment or invest in a health club membership.

Stress

- **Adaptation to a new culture causes stress.** Asian immigrants and refugees may suffer from stress-related illnesses (cardiovascular disease, carcinoma, depression, and drug or alcohol abuse) triggered by the stress of adapting to a new culture or by feelings of isolation from the larger society. (Tyler et al., 1991).

Suggestion

Health care professionals need to consider contextual factors, such as ethnicity, personal history, personal characteristics, and sociocultural environment, when providing services to their Asian-American clients. Knowing clients' personal and family histories is crucial to understanding and meeting their health care needs.

- **Education may not reap commensurate rewards.** For some Asian Americans, stress may result from frustration at not reaping benefits in the form of high-paying, high-status jobs commensurate with their expectations based on their educational level and the status of similarly educated white Americans. (Takeuchi et al., 1992).

Suggestion

Become acquainted with the education or training of your Asian-American patients when taking a social history. (Chin and Bigby, 2003).

- **Separation from family** can be a source of stress for Asian immigrants. Many Asian immigrant families are split households; one member immigrates to the US and is joined later by others. (Orlandi, 1995).
- **Elderly refugees may feel isolated** from the larger US society, whose cultural norms are very different from their own. (Yee, 1990, 1992; Yee and Hennessey, 1982). Family estrangement and generational conflicts can create emotional distress for elderly refugees; these are their most frequently cited problems. (Yee, 1992).
- **Racism** adversely affects the psychoeconomic status of Asian Americans, as is the case for other peoples of color. As a result of a multitude of social forces over which they have no control, Asian Americans may feel alienated and experience identity conflict. These feelings may be accompanied by loneliness, a sense of not belonging, helplessness, powerlessness, low self-esteem, and, for some, loss of a sense of the meaning of life.
- **Denial of stress-related problems.** A culturally negative view of mental illness, drug abuse, and other less apparent stress-related conditions makes early identification, diagnosis, and treatment difficult. These factors, combined with fear of shame and stigma, reinforce the denial of problems. (Orlandi, 1995). Sometimes, a patient's denial of illness is associated with economic factors, such as the need to keep working, or with social factors, such as the inability to ask for help. (Chin and Bigby, 2003).
- **Posttraumatic stress.** Many Southeast Asians have lived through war, dangerous escapes, and refugee camps. Some may suffer from posttraumatic stress disorder.

- **Pressure on children to succeed.** Some Asian Americans emphasize high educational achievement. However, the pressure that Asian-American parents place on their children can be stressful for the children. (US DHHS, 2001).

Pertinent Fact

Research on Asian immigrants has documented how they cope with many stressors, including those created by the acculturation process, stressful life events, employment, and economic hardships. (Kuo and Tsai, 1986; Lin et al., 1984).

Lack of Knowledge of Risk Factors

- **Blood pressure and heart disease.** The lack of knowledge about risk factors or preventive behaviors for various diseases can be a problem for Asian Americans. One study among Southeast Asian populations in central Ohio revealed that 94% of those surveyed did not know what blood pressure is, and 85% did not know what could be done to prevent heart disease. (Tamir and Cachola, 1994).
- **Cancer.** Lack of knowledge about cancer risk factors may result in failure to conduct breast self-examinations or to get screening tests, such as mammograms or Pap smears. (Chen and Hawks, 1995). The mistaken belief that cancer is inevitably fatal may also be a factor in lack of screening. (Pham and McPhee, 1992). Although 97% of the women surveyed had heard of cancer, many did not know the common signs, symptoms, and risk factors for breast or cervical cancer.

Strengths and Protective Factors

As noted earlier, most data on AAPIs regarding education, income, and employment are not disaggregated. This lack of specific data hides the fact that while some AAPI subgroups may be doing very well, others are experiencing serious hardships. The lack of disaggregated data perpetuates the model minority myth, or the perception that all AAPI groups do well in the US.

Education, Income, and Employment

- **Education.** Among AAPIs over the age of 25, 50.9% of men and 43.8% of women had at least a bachelor's degree, compared with 31.7% and 27.3%, respectively, of non-Hispanic whites. However, AAPIs were also more likely to have less than a ninth-grade education, a fact that points to the great disparities among different groups. (Reeves and Bennett, 2003).
- **High-tech, managerial, and professional workers.** More than 7% of high-tech workers in the US are AAPIs, according to recent data, and this figure represents a significant portion of the nation's best-educated scientists and technicians. (Kaiser Permanente, 1999). In 2002, 41% of AAPI males 16 years and older worked in managerial and professional occupations (versus 33.4% of non-Hispanic white males); the figure for AAPI females was 37.2% (about the same as for non-Hispanic white females). (Reeves and Bennett, 2003).
- **Income.** In 2001, 40% of AAPI families had incomes of \$75,000 or more, compared with 35% of non-Hispanic white families. However, AAPI families were also more likely to live in poverty than were non-Hispanic whites (10% versus 8%). (Reeves and Bennett, 2003).

Family and Social Life

- The **extended-family structure** is an important social pattern in most Asian communities. In the US, AAPI households are also more likely to be extended-family households, and AAPI families tend to be larger than non-Hispanic white families. (Reeves and Bennett, 2003). Ethnic enclaves that re-create the social and community systems of support left behind in the countries of origin are common among many Asian-American immigrant and refugee groups. It is not uncommon for these social structures to be organized around family clans. (Chin and Bigby, 2003). Extended-family social structures may sustain positive health behaviors, such as the shared practice of tai chi among the elderly.
- Traditionally, the **Asian family unit** is the pillar of strength and stability for all its members, and it plays a critical role in the ongoing development and support of children, even into adulthood. Familial decision-making usually includes extended-family members such as grandparents and other significant relatives. (Yee et al., 1994).

Suggestion

Ask the patient to whom his or her medical information should be communicated. Among some groups, the patient's hearing of bad news is believed to speed up the process of death. (Kaiser Permanente, 1999).

- **Asian family cohesiveness and stability.** As illustrated by a lower divorce rate, AAPI families tend to be a protective force and a deterrent against youthful problem behaviors such as alcohol or drug use and other antisocial and self-defeating behaviors. (Management Sciences for Health, 2003).
- In some communities, **Asian-American organizations** (e.g., temples, churches, benevolent association, cultural associations) serve as focal points for social and other activities. (Orlandi, 1995).

Suggestion

Developing contacts with and working through community-based organizations can be a useful way for providers to develop an understanding of the health and social services needs of Asian-American clients.

Diet and Exercise

- **Traditional diet.** Some Asian diets are low in saturated and unsaturated fats, are high in complex carbohydrates, and include a wide range of fruits and vegetables. (Kaiser Permanente, 1999).
- **Tai chi** involves slow movements that stimulate and exercise internal parts of the body. **Qigong** involves the practice of breathing, relaxation, meditation, and martial arts to achieve calmness and a feeling of centeredness or to develop stamina and strength. These traditional forms of exercise have been practiced for centuries to promote health, build resiliency, and improve circulation. (Chin and Bigby, 2003).

Low Rates of Alcohol Abuse

- Although little research has been done on alcohol or substance abuse among Asian Americans, **available data suggest that Asians may use and abuse alcohol and other substances less frequently than members of other racial or ethnic groups.** (Zane and Kim, 1994). AAPI adolescents, college students, and women appear to have a lower risk of alcohol abuse than do the same groups among other ethnicities. (Makimoto, 1998; Collins and McNair, 2003). **There are marked differences among groups, however, with some data suggesting that Japanese, Korean, Samoan, and Vietnamese men may be more likely to abuse alcohol than other AAPIs.** (Kuramoto, 1994; Makimoto, 1998).

Adherence Factors

Decision-Making

- In almost all AAPI groups, **the eldest male traditionally acts as the head of household and assumes the position of primary decision-maker.** An exception is Hmong society, which is more egalitarian. Decision-making, including important health care decisions, normally involves many members of the family, particularly elders. (Kaiser Permanente, 1999).
- When the patient is an Asian woman, the eldest male in the family—not the patient—is often the primary decision-maker. (Kaiser Permanente, 1999).

Suggestion

Handle organizational rules about who makes health care decisions and whether and how an individual will be told about a life-threatening diagnosis with respect for the client's belief system.

- As in Western cultures, **Asian women are often the ones responsible for health care.** They also sustain rituals related to health, such as preparing herbal tonics and medicinal soups to restore health following childbirth or surgery. (Chin and Bigby, 2003).

Communication

- Whereas Western values stress getting one's point across, Asian values stress **politeness** in verbal discourse. As a result, Westerners typically value verbal fluency, whereas Asians typically value not showing overt disagreement. (Chin and Bigby, 2003).

Suggestion

Do not assume that a smile or nod indicates agreement with your diagnosis and treatment recommendations.

- **Indirect means of expression.** Asian cultures usually rely more on the nonverbal context for information than on the verbal context. Some Asians use indirect methods to communicate their intent. (Chin and Bigby, 2003). Avoidance of self-disclosure and of public display of emotion is characteristic of many AAPI subgroups. (Kuramoto, 1994). Patients may not always express their needs directly. (Yu, 1999)

Suggestion

In the beginning of a relationship with an AAPI patient, you may have to read between the lines to understand his or her complaint or need. In an ongoing relationship, you have the opportunity to teach your patient direct communication strategies to enhance your relationship. Shift from asking general questions to more specific ones. For taboo subjects, tactfully speak the unspeakable. (Yu, 1999)

- **Avoidance of eye contact.** Hindu women traditionally avoid direct eye contact with men. Showing deference to elders and authority figures, including health care providers, may also dictate avoiding eye contact. (Jambunathan, n.d.).

Diet

- **Diet as medicine.** Asian diets are often designed to treat many ailments and to maintain the balance of yin and yang properties in the body. Consequently, herbal soups and tonics are commonly used to restore health or maintain well-being. (Chin and Bigby, 2003).
- **Yin and yang balance.** Diets may be altered or tonics prepared to restore yin-yang balances. Foods such as black pepper, ginger, yam, logan, and garlic are considered high in yang properties. Foods such as seaweed, tomato, kidney, lettuce, and liver are considered high in yin properties. (Lu, 1986).

Suggestion

Recommendations about diet modification and exercise to address cholesterol and hypertension, for example, and to address chronic disease prevention and management are more likely to be followed if concepts of Asian dietary practice are taken into account. For examples of Asian food pyramids, see www.semda.org.

- **Hot and cold balance.** Due to the influence of Ayurvedic and Chinese traditional medicine, foods may be perceived as “cold” or “hot” and are believed to either calm the body or heat it up. Optimal health is achieved through a balanced diet of “cold” and “hot” foods.

Suggestion

In seeking to recommend a diet that is culturally relevant, explore how a Western diet can complement traditional AAPI diets. To ensure optimal health for AAPI clients, be sensitive to the varied role that food plays in their lives. (Kaiser Permanente, 1999).

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) has growing social, economic, and clinical significance in the US. It is important for providers to understand the implications of CAM for their patients: what it is, who uses it, and why. CAM covers a broad range of healing philosophies, approaches, and therapies that the US medical community does not commonly use, accept, or study. (Kaczmarczyk and Burke, 2003).

CAM

The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as:

“a broad range of healing philosophies (schools of thought), approaches, and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine to promote well-being or treat health conditions.

“People use CAM treatments and therapies in a variety of ways. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a complementary or an integrative approach.

“Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional, and spiritual aspects.” (Cited in US DHHS, 2003a).

Use

- **Wide variety of practices.** The use of non-Western medicine among AAPIs ranges from healing rituals to massage, acupuncture, and herbal intake.

Suggestions

Health care providers need to be aware of the multiple forms of traditional medicine practiced by AAPI groups in their specific locales. They should respect the role of traditional medicine and explore ways that traditional medicine can complement biomedical health care systems. Providers should also be aware of the issues that may be raised by the mixing of medical systems. (Kaiser Permanente, 1999).

Providers build trust with their patients by demonstrating an interest in and a respect for patients' efforts to care for themselves. Respect goes beyond tolerating or overlooking other forms of healing, and showing interest does not necessarily indicate a sharing of common beliefs. (Yu, 1999).

- **Eastern and Western medicine practiced simultaneously.** Many Asian Americans practice both Asian and Western healing methods or resort to the other when one fails. When these beliefs contradict each other, poor adherence to Western medicine and practitioners is likely to occur. (Chin and Bigby, 2003).

Suggestion

Providers should be open to the complementarity of Western treatments and the traditional medical practices of many AAPIs. Providers can consult traditional healers or support the patient's choice to do so, in addition to prescribing Western forms of treatment. (Kaiser Permanente, 1999).

- **Asian-American women are more likely to report using traditional health practices** and medicines than are Asian-American men—69% versus 39%. By ethnic group, 96% of Cambodian women, 18% of Laotian women, and 64% of Chinese women reported using traditional health practices. (Buchwald et al., 1992).
- **CAM use is common.** Perhaps the safest assumption to make is that every client is potentially using CAM products or practices. (Kaczmarczyk and Burke, 2003).

Suggestion

Ask in a respectful, supportive way about the use of acupuncture and herbal medicine in tandem with Western medicine. (Chin and Bigby, 2003).

- **Eastern versus Western medicine.** Asians often view Western medicine as more powerful for acute illness and Eastern medicine as essential for regulating daily health. (Chin and Bigby, 2003).

Suggestion

With recent immigrants, assess their familiarity with Western prescriptions in the form of pills and capsules, and emphasize the importance of adhering to treatment. Lack of proper understanding of Western drugs could prompt patients who continue to feel ill to resort to herbal medicines or to attempt to regulate the drug's effects by increasing the dosage. (Kaiser Permanente, 1999).

Specific Practices

- **Coining or cupping.** Be aware of such practices as coining or cupping to avoid mistaking reddened welts or marks on the skin as self-abuse or child abuse. (Kaiser Permanente, 1999).
- **Acupuncture.** Almost all Asian subgroups rely on acupuncture for the treatment of illnesses. Rooted in traditional Chinese concepts of health, acupuncture is a sophisticated and codified form of medicine that involves the insertion of fine needles, often no thicker than a human hair, into strategic points on the body. These specific sites are believed to be meridians for energy sources that help maintain homeostasis. (Kaiser Permanente, 1999). All acupuncture points have local effects and are useful for treating pain or dysfunction in a specific area. Other acupuncture points have general effects on the body as a whole or treat specific patterns of disease. (How alternative medicine can help you: Acupuncture, n.d.).
- **Herbal medicine.** Chinese herbal medicine is the practice of combining individual herbs into formulas to promote health. There are thousands of herbs that can be used medicinally, but only about 400 are in common use. Although a single herb is sometimes used, combinations of herbs, typically 5 to 15, are more common. The art of devising an herbal formula is complex and takes years to master. Each herb also has contraindications and specific doses that must be taken into account. (How alternative medicine can help you: Herbal medicine, n.d.).

- **Qigong.** Qigong, which has been practiced in China for centuries, is the art of moving *qi* (vital life energy) through the body using physical movements and mental concentration. Qigong may be used preventively, to promote and preserve health, or it may be practiced in response to specific disorders. Chinese medicine holds that when the body and mind are harmonized through the practice of qigong, *qi* can be generated, blockages of *qi* can be released, and health increases. (How alternative medicine can help you: Qigong, n.d.).

Possible Concerns

- **Unintentional overdose of jin bu huan,** a traditional Chinese herbal product used as a sedative and analgesic, was found to result in a rapid onset of life-threatening bradycardia and acute hepatitis. (Kaiser Permanente, 1999).
- **Combining herbs with certain Western drugs can have dangerous interactive effects.** For example, the combination of ginkgo and warfarin (Coumadin) increases the risk for bleeding, and glucomannan (used for weight loss) affects diabetes drugs such as glyburide (Micronase, DiaBeta). (Kaczmarczyk and Burke, 2003).
- **Members of different AAPI subgroups may metabolize certain prescription medications differently.** (Kuramoto, 1994; Jambunathan, n.d.). Asian Americans show increased sensitivity to beta blockers, for example. (Matthews, 1995).

Suggestion

Victor S. Siepina, MD, a family medicine physician, offers an ABCDE approach to speaking with patients about the use of complementary and alternative therapies and integrative health care.

Ask, don't tell.

Be willing to listen and learn.

Communicate and collaborate.

Diagnose.

Explain and explore options and preferences.

(US DHHS, 2003a).

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