ASIAN AMERICAN HEALTH PRIORITIES

A Study of Montgomery County | MD | 2008

Strengths, Needs, and Opportunities for Action

Asian American Health Initiative

Together To Build A Healthy Community

ACKNOWLEDGEMENTS

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AAHI Staff

Julie Bawa, MPH
Program Manager

Chun Man (Perry) Chan
Program Assistant

Christine Liang
Cancer Program Coordinator

Roanne Calizo
Administrative Assistant

Anne Marie Poblador
Outreach Coordinator

Consultants

Grace X. Ma, PhD
Professor, Department of Public Health
Director, Center for Asian Health
Temple University

Hee-Soon Juon, PhD
Associate Professor
Department of Health, Behavior and Society
Johns Hopkins Bloomberg School of Public Health

Maryland Asian American Health Solution (MAAHS)
University of Maryland School of Public Health

Sunmin Lee, ScD
Principal Investigator
Assistant Professor
Department of Epidemiology and Biostatistics
University of Maryland College Park School of Public Health

C. Ed Hsu, PhD
Co-Principal Investigator
Assistant Professor
Department of Public and Community Health
University of Maryland College Park School of Public Health

Genevieve Martinez, MA
Faculty Research Assistant
Department of Public and Community Health
University of Maryland College Park School of Public Health

Bertina Su, MPH
Project Manager
Department of Public and Community Health
University of Maryland College Park School of Public Health

Jennifer Choi
Research Assistant
Department of Public and Community Health
University of Maryland College Park School of Public Health

Special Thanks

Dushanka Kleinman, DDS, MScD
Associate Dean for Research and Academic Affairs
Professor, Department of Epidemiology and Biostatistics
University of Maryland College Park School of Public Health

Harry Kwon, PhD, MPH, CHES
Consultant
University of Maryland College Park School of Public Health

Lisa Canda, CHES
Former AAHI Staff
Program Assistant

Members from the Following Community Organizations

Ahmadiyya Muslim Community Center
Cambodian Buddhist Temple
Chinese Culture and Community Service Center, Inc. (CCACC)
Emmanuel Indonesian Presbyterian Church
Maryland Vietnamese Mutual Association (MVMA)
Muslim Community Center Clinic
Philippine Medical Association of Metropolitan Washington
Taiwanese American Senior Association
Taipei Economic and Cultural Representative Office (TECRO) Culture Center
Taiwanese American Senior Association
Washington Japanese Christian Community Center
Wat Thai

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MESSAGE FROM THE COUNTY EXECUTIVE

As County Executive, I serve a community that is remarkably diverse in ethnic and linguistic composition. Montgomery County is home to many rich and vibrant populations—some that have been here for generations, others that have more recently arrived. One of the challenges and opportunities we face as a County is making certain that every resident has access to health care and health care information.

It is my honor to introduce a publication that will play an important role in meeting the health care needs of a large, diverse and growing population in Montgomery County—Asian Americans. *Asian American Health Priorities: Strengths, Needs, and Opportunities for Action* is the result of a visionary and collaborative process involving the Asian American Health Initiative and a variety of partners. Through an intensive outreach, data collection, and assessment process, we now have a more comprehensive understanding of the health care needs of our Asian American population, and more importantly—a blueprint for how to expand and improve health care services to meet those needs.

I thank the many people who have guided this process—from its earliest inception to its recent completion. Because of your efforts, a tangible difference will be made in the lives of Asian Americans who call Montgomery County home. I wish the Asian American Health Initiative much success as it moves toward the implementation and expansion of its many programs.

Isiah Leggett
Montgomery County Executive

MESSAGE FROM THE DIRECTOR OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Montgomery County is a very diverse county. Statistics issued in 2005 show that 29% of our population is foreign born and 44% is ethnic minority. These statistics bring home to us the urgency of being sensitive to possible disparities in social and health outcomes and the importance of data in assessing the scope of the problem and in supporting our efforts to develop effective strategies.

A problem that our Nation, our State and our County are consistently encountering is the issue of disparate outcomes in key areas of health, education, and economics. The Asian American Health Initiative (AAHI) in the County is attempting to address the issue of health disparities in Asian American minority populations. Not only are certain conditions and diseases prone to one racial or ethnic group over another, but access to care can also favor certain groups. This is a problem that Montgomery County has been facing head on. We are aware that various barriers to care exist and we acknowledge the fact that there are cultural and linguistic factors to take into consideration. Because of this, our county has developed programs to respond to the needs of the minority populations and cater specifically to their needs. There are three such initiatives known as The African American Health Program, The Latino Health Initiative, and The Asian American Health Initiative (AAHI). This report responds specifically to the need to define the scope of the problem of health disparities in the Asian American populations.

The Asian American community in our County has some very unique characteristics in that it encompasses an extremely diverse population with many underlying risk factors that make it quite challenging to develop effective outreach and intervention strategies. However, AAHI, with support from their advisory committee, staff and consultants, have in this report identified the problem and have paved the way for consideration of effective strategies aimed at addressing disparate social and health outcomes in the Asian American population. We are proud to share this comprehensive needs assessment with you. We believe this will be an important building block in our County's efforts to address disparities and work towards more equitable interventions for the Asian American community. I am confident that this report will further enhance and guide AAHI's efforts towards eliminating health disparities for the Asian American population in Montgomery County, Maryland. I urge you join us in this very important effort.

Uma Ahluwalia
Director

MESSAGE FROM THE PROGRAM MANAGER OF THE ASIAN AMERICAN HEALTH INITIATIVE

The Asian American Health Initiative (AAHI) is proud to release the *Asian American Health Priorities: Strengths, Needs, and Opportunities for Action* report for the Asian American community in Montgomery County, Maryland. AAHI was created in 2005 to eliminate health disparities that exist between Asian Americans and their non-Asian counterparts in the county. This report is a part of our continuing effort to meet the demands of the ever-changing health needs of the Asian American population.

Asian American communities continue to confront significant challenges to improving their health and overall well-being. The health needs of Asian Americans call for sensible and sensitive considerations of the cultural, social, economic, behavioral, and occupational characteristics of Asian American communities. Not all Asian American communities are alike. There are differences in culture and language as well as in economic, educational, and social status. Although many Asian Americans are afflicted with similar chronic illnesses, Asian American groups do not necessarily have similar resources to address their health needs—and therefore place their most vulnerable members at risk for serious health conditions. It is important to recognize the differences among diverse groups of Asian Americans in order to develop adequate health interventions.

In this report, a county-wide assessment was performed to identify the unique health needs of 13 Asian American groups. The report is framed around three fundamental questions: Who Are We? What Are Our Concerns? And What Will We Do? As the county's Asian American population continues to increase at a rapid rate and outpaces the growth of many other minority groups, this population remains at risk of widening health disparities due to barriers to health care access and lack of adequate health information. AAHI, with its mandate to identify Asian Americans' health needs and improve their health care and education, is in a unique position to help bridge the health and health care gap in these diverse communities. We will expand our existing services and, if necessary, create new programs for areas that were reported as emerging concerns for the Asian American community. AAHI will also continue to work collaboratively with community-based and faith-based organizations to reach the increasingly diverse populations we serve. Along with our partners, we will build a community of opportunity, of prosperity, and of health.

Julie Bawa, MPH
Program Manager

Executive Summary

GOLDEN BUDDHA IN ASIA

OLD CARVED SCULPTURE IN ASIA

EXECUTIVE SUMMARY

Asian American communities, including those living in Montgomery County, are confronting unprecedented challenges with the advent of the 21st century. The challenges are characterized by, among other things, being at-risk of widening health disparities due to health care access barriers and a rapid population growth, which outpaced many other minority groups. In 2006, 124,605 Montgomery County residents identified themselves as Asian Americans. This population has been increasing rapidly, growing at a rate of 62% from 1990 to 2006.

This report, *Asian American Health Priorities: Strengths, Needs, and Opportunities for Action*, is part of the Asian American Health Initiative's (AAHI) continuing effort to meet the demands of the ever-changing health needs of the Asian American population. Part of the Montgomery County, Maryland, Department of Health and Human Services, AAHI is the first health-related program that directly addresses the health needs of the Asian American community in Montgomery County. AAHI was established and funded in fiscal year 2005 to help eliminate health disparities that exist between Asian Americans and their non-Asian counterparts. Since its inception, AAHI has partnered with numerous community and faith-based organizations within the county to improve the health and well-being of the Asian American population.

Recognizing the importance of collecting comprehensive health information to reduce health disparities among all minority groups, AAHI conducted two health needs assessments, the first in 2005 and the second in 2007, to identify the health needs of the county's Asian American communities. Thirteen Asian American communities in the county participated in the 2007 health needs assessment and included representatives from the Asian Indian, Burmese, Cambodian, Chinese, Filipino, Indonesian, Japanese, Korean, Nepali, Pakistani, Taiwanese, Thai, and Vietnamese communities. This report incorporates the findings of the 2007 assessment with those of the 2005 assessment. Together with an analysis of the scientific literature and available health status data, this report provides a first-time snapshot of the health issues raised by more than a dozen Asian American communities in Montgomery County, and proposes recommendations to improve the health and well-being of these Asian American populations.

Population-based studies and the scientific literature provide general health status data for Asian American populations. For example, these data reveal that cancer is the leading cause of death for Asian Americans and Pacific Islanders, followed by heart disease. Further, when compared to other racial/ethnic groups in the United States, Asian Americans have the highest infection rates of hepatitis B and tuberculosis. Other conditions, such as diabetes and osteoporosis, disproportionately affect Asian Americans. The data also reveal that acquiring mental health care may be a challenge for Asian Americans. The available scientific literature and findings from health surveys provide a general perspective on Asian American health. In order to obtain a greater understanding and first-hand personal insights regarding the health needs of the Asian American communities and county residents, qualitative approaches including focus groups and interviews were necessary to gather this information.

Representatives from Montgomery County's Asian American communities discussed a variety of health issues such as general health knowledge and concerns (e.g. general health conditions, the health of children, adolescents, women, and seniors); lifestyle behaviors; accessing and receiving health care (e.g. attitudes and knowledge, financial access to health care services, physical access to health care services, patient-provider communication, physician preference, alternative or complementary health options, and disseminating information to the community). Mental health emerged as a significant health concern, particularly for young adults, adolescents, and seniors. Other frequently mentioned health concerns were cardiovascular diseases and related conditions, diabetes, and cancer. Hepatitis B virus infection also was seen to be a risk in some communities.

Most communities perceived that a combination of lifestyle factors such as poor diet, lack of physical activity, and high stress increased their risk of chronic diseases. Some communities exhibited concern regarding the effects of a traditional versus a Western diet for children, youth and adults, and increased sedentary behavior after immigrating to the United States. Youths pointed out that the cultural influences which emphasize academic performance rather than physical activity during childhood affect their activity level in adulthood. Some groups mentioned risk behaviors such as smoking as an important health concern for men and noted that smoking is also prevalent in Asian American youths.
Many focus group participants commented on issues that highlight financial, physical, and communication barriers to health care and access to important screenings to prevent common chronic illnesses. When in need of health care, many Asian Americans prefer an Asian health care provider. Asian American communities reported that obtaining current and accurate health education information as well as information on health care resources, delivered in culturally and linguistically appropriate formats, is critical for improving their members' overall health.

RECOMMENDATIONS AND ACTION PLANS

The following recommendations address the major themes that evolved from the analysis of the focus groups, the scientific literature, and selected available data on health status. Action steps are provided in the report for each recommendation area.

Recommendation: Expand health promotion and disease prevention programs to raise awareness and the level of knowledge of health issues that disproportionately affect Asian Americans.

> *Implementing health education programs is a part of the mission of the Asian American Health Initiative. As the only county health program that specifically addresses the Asian American community, it is imperative that health promotion and disease prevention programs not only continue, but expand to provide additional information on health issues that disproportionately affect Asian Americans.*

Recommendation: Strengthen access to and utilization of quality health care services by maximizing the use of existing programs and resources and by working with the community and provider groups to enhance health literacy.

> *Concerted efforts are needed to maximize access to existing health care and to ensure receipt of appropriate health services. This will include minimizing barriers to care, providing access to culturally and linguistically appropriate resources, and investing in enhancing the health literacy of the populations.*

Recommendation: Enhance collaborations and partnerships with community-based and faith-based organizations, working with them to develop and expand new and existing programs, and empowering them to sustain effective health programs and to address health disparities.

> *There are many Asian community-based and faith-based organizations in the county that provide cultural insight and direct access to specific Asian American populations. As a critical component in addressing health disparities and implementing programs, AAHI's collaborations with community and faith-based organizations should be further cultivated to provide the fullest extent of programs.*

Recommendation: Enhance the capacity to obtain, analyze, and monitor health and related data on an ongoing basis for overall AAHI planning and for program development and evaluation purposes.

The populations that are covered by AAHI in the county are numerous and continue to grow in number and diversity. Mechanisms are needed to obtain, analyze, and monitor health and related data on an on-going basis. These data are essential to the decision-making process needed to determine how best to direct available resources to meet the needs of these populations and address the previous recommendations.

NEXT STEPS

The main goal of these recommendations is to improve the health and well-being of all Asian Americans in Montgomery County regardless of their country of origin, age or socioeconomic status. This report provides a comprehensive list of recommendations developed from collecting information on the perceived health needs of this population using qualitative methods along with data from available literature. As it relates to its mission and goals, AAHI will incorporate the recommendations from this report and develop a plan to implement them. Under the guidance of Montgomery County's Department of Health and Human Services, AAHI will continue to support efforts for reducing and/or eliminating health disparities to improve the health and well-being of the Asian American population in Montgomery County. Together, AAHI and its partners can build a healthy community.

The Asian American Health Initiative

RICE FIELD IN ASIA

ANGKOR WAT IN LOTUS POND, CAMBODIA

THE ASIAN AMERICAN HEALTH INITIATIVE

The Asian American Health Initiative (AAHI) was established and funded in fiscal year 2005 with the support of the County Executive, County Council, Director of the Department of Health and Human Services, and Asian American community leaders to help eliminate health disparities that exist between Asian Americans and their non-Asian counterparts. Part of the Montgomery County, Maryland, Department of Health and Human Services, AAHI is the first health-related program that directly addresses the Asian American community in Montgomery County. Since its inception, AAHI has partnered with numerous community- and faith-based organizations within the county to improve the health and well-being of the Asian American population. AAHI's Steering Committee, composed of stakeholders from various ethnic groups in the Asian American community, assists in further developing AAHI to better serve the diverse Asian American community by making recommendations to and advocating on behalf of AAHI.

AAHI STEERING COMMITTEE

Hoan Dang (Chair)	President, Maryland Vietnamese Mutual Association
Meng K. Lee (Vice Chair)	Director of Community Service Division, Chinese Culture and Community Service Center
Anis Ahmed	Commissioner, Governor's Commission on Asian Pacific American Affairs, Maryland
Julia Chang	Former Project Manager, Korean Community Service Center of Greater Washington, DC
Walter Engelen	Montgomery County community member, Indonesian Community
Nerita Estampador, MD	Physician, Montgomery County DHHS
Wilbur Friedman	Treasurer, Organization of Chinese Americans, Greater Washington, DC Chapter
Paul Han, MD, MPH	Medical Officer, National Institutes of Health (NIH)
Harry Kwon, PhD, MPH	Montgomery County community member, Public Health Expert
Felicitas Lacbawan, MD	Clinician, NIH; Lab Director, State University New York Downstate Medical Center
Michael Lin, PhD	President, Asian American Political Alliance
Alvin Madarang, MD	President, Philippine Medical Association-Metropolitan Washington, DC
Sam Mukherjee, PhD	General Secretary, Asian Indians for Community Service, Inc
Kim Dung Nguyen	Former Branch Manager, Boat People SOS Inc.
Anthony Tran, MPH, MT	Global Health Program Manager, Association of Public Health Laboratories
Sovan Tun, PhD	President, Cambodian Buddhist Society, Inc.

AAHI MISSION

The mission of AAHI is to identify the health care needs of Asian American communities, to develop culturally competent health care services, and to implement health education programs that are accessible and available to all Asian Americans in Montgomery County, Maryland.

AAHI GOALS

The goals of AAHI are:

- To conduct in-depth data collection, analysis, and reporting of the health status for the different ethnic groups in the Asian American community.
- To expand and improve the existing health services available to Asian Americans.
- To ensure the availability of quality health care directed to the specific needs of the different ethnic groups in the community.
- To provide outreach programs to inform and educate the different ethnic groups about the accessibility and the availability of health care services.
- To ensure that all ethnic groups in the Asian American community have their fair share of health care by eliminating barriers.

AAHI PROGRAMS

To address health disparities that disproportionately affect Asian Americans and utilizing input from the community and the scientific literature, AAHI put into place the following programs/projects.

> AAHI focuses on increasing the community's awareness of determinants of health and preventive actions for conditions that are prevalent among Asian American populations through educational and screening programs.

Cancer Program

AAHI's Cancer Program increases awareness about targeted cancers (breast, cervical, colorectal, and prostate cancers) by providing culturally competent cancer education and screening services to Asian American residents in Montgomery County. The Cancer Program fosters public awareness that, if properly screened, detected, and found early, cancer can be prevented and treated. Working in conjunction with the Montgomery County Cancer Crusade, AAHI provides free screenings for targeted cancers to eligible Montgomery County Asian American residents.

Hepatitis B Program

AAHI's Hepatitis B Program is in place to increase awareness and knowledge about hepatitis B and to improve access to hepatitis B preventative measures. In addition, education and awareness are provided to health care professionals to advocate for improved health care procedures and policies to prevent hepatitis B. To further increase the understanding of hepatitis B, AAHI has also created educational brochures and posters in multiple Asian languages.

Osteoporosis Education and Screening Program

Through AAHI's Osteoporosis Education and Screening Program, the community is able to learn more about this silent disease and take part in free bone density screenings. At the different outreach events, AAHI provides education, screenings, explanations of results, and recommendations for improvement. AAHI also has developed its own educational postcard in multiple languages to assist community members in understanding the effects of osteoporosis and the importance of preventing this debilitating disease.

Diabetes Education Program

Diabetes, currently the fifth-leading cause of death for Asian Americans, is a major concern[6] (note: citation numbers throughout the document refer to works cited in the list of References, and therefore may not be sequential). AAHI's Diabetes Education Program provides diabetes prevention information to reduce the number of Asian Americans with risk factors for diabetes and raise awareness about the growing risk of type 2 diabetes. Collaborating with community partners to provide glucose screenings at outreach events also helps community members detect the disease early to receive appropriate treatment.

Tobacco Control Program

AAHI's Tobacco Control Program aims to decrease morbidity and mortality associated with the use of tobacco and exposure to environmental tobacco smoke among Asian Americans. To achieve its mission, AAHI educates the community about tobacco use and secondhand smoke prevention at different outreach events. AAHI also collaborates with the Montgomery County Cancer and Tobacco Initiative to provide smoking cessation counseling for Asian Americans.

AAHI works to develop innovative workforce models to facilitate access to health care for our populations.

Health Promoters Program

The Health Promoters Program aims to help reduce language and cultural barriers and assist AAHI in reaching out to and educating the diverse Asian American groups. As the minority population has increased over the last few years, Montgomery County has become more ethnically diverse with a wider variety of cultures and languages; hence, more linguistically and culturally appropriate services are needed for the county's changing population. AAHI trains bilingual health promoters so that they, in turn, are able to become health educators in their communities.

Patient Navigators Program

To assist Asian Americans in Montgomery County access health care services and overcome cultural and language barriers between medical providers and non-English-speaking county residents, AAHI implemented the Patient Navigators Program. This program includes a telephone health information line for non-English-speaking Asian Americans and provides trained medical interpreters who can translate into variety of Asian languages for patients.

AAHI gathers data, networks with organizations and health leaders, and strategically disseminates targeted health education messages.

Asian American Health Conference

In 2006, AAHI sponsored its first conference—"Commitment to Change: Exploring Health Disparities in the Asian American Community"—that addressed the many challenges and barriers Asian Americans face in obtaining quality health care. More than 250 national, state, and local health organizational leaders—including health care professionals, community-based organization leaders, and health care policy makers—convened to discuss research and other information on a broad spectrum of topics, ranging from cancer and osteoporosis to mental health and domestic violence in the Asian American community. It also was an opportunity to network with others involved in Asian American health issues.

Web Site

AAHI maintains a Web site with valuable health information and resources at *www.AAHIinfo.org*. This site provides details on each of AAHI's programs as well as educational material regarding targeted health disparities. It is also a valuable asset for finding county resources and contacts for local Asian American community-based organizations and faith-based organizations. The Web site is available in English, Chinese, Hindi, Korean, and Vietnamese.

www.AAHIinfo.org

Media Campaigns

Periodically, AAHI conducts media campaigns in local Asian American newspapers. Educational messages are published about various Asian American health disparities, focusing on issues such as hepatitis B, various cancers and mental health. Each message is tailored to a specific community and incorporates their particular language. Media campaigns assist AAHI in gaining exposure in the community and spreading health messages on a wider scale.

Health Educational Material Development

The need is apparent for more culturally and linguistically appropriate education materials for the Asian American community. AAHI makes continuous efforts to develop and disseminate multilingual educational materials to the diverse Asian American population. Currently, AAHI has made available a brochure and poster about the hepatitis B virus, postcards on Osteoporosis, a comprehensive medical guide for limited English proficient patients, and a cancer information booklet detailing four cancers that affect this population.

The current programs and projects reflect input from our review of national statistics and the scientific literature as well as findings from an initial community-based needs assessment conducted in 2005 (see Appendix A: Summary of 2005 Health Needs Assessment). This report is the result of a second needs assessment and provides more detailed guidance for our future directions and programs. The findings of this report will assist AAHI in tailoring its programs to reduce health disparities and improve the health and well-being of a broader range of Asian Americans across the county. The report presents national statistics and a review of literature to compare findings from this report to national trends. Equally important, this report includes program recommendations for action plans .

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Samples of AAHI's Health Education Materials

1 | *Cancer Facts*
Translated into Chinese, Hindi, Korean, and Vietnamese.

2 | *Good Health in Your Hands: Improving Communication between Patient and Provider*
Translated into Chinese, Hindi, Korean, and Vietnamese.

3 | *Hepatitis B in the Asian American Community*
Translated into Chinese, Hindi, Korean, and Vietnamese.

4 | *Hepatitis B Awareness Poster*
Translated into Chinese, Hindi, Korean, Tagalog, and Vietnamese

5 | *Osteoporosis Education Postcard*
Translated into Chinese, Hindi, Korean, and Vietnamese.

PART I | Who Are We?

GREAT WALL IN BEIJING, CHINA

TAJ MAHAL IN AGRA, INDIA

A DEMOGRAPHIC: AN OVERVIEW OF ASIAN AMERICANS

We learn from the scientific literature and surveys about our demographics, health status, and health risks.

An Asian American is a person of Asian ancestry who was born in or immigrated to the United States. Composed of diverse ethnic groups, Asian Americans come from more than 50 countries, speak more than 100 different languages and dialects, practice a variety of religions and have wide range of lifestyles.[1] They descend from the Far East, Southeast Asia, and the Indian subcontinent.[i]

One of the fastest-growing minority groups in the United States, the Asian American population grew by an annual rate of 3% between 2004 and 2005. As of July 2006, there are 14.4 million U.S. residents who identify themselves as Asian or Asian in combination with one or more other races, comprising about 5% of the total population. By 2050, the number of Asian Americans is expected to grow to 33.4 million—a 213% projected increase between 2000 and 2050, compared with a 49% increase in the population as a whole over the same time period.[2]

In Montgomery County, Maryland, the Asian American population has been increasing rapidly, growing at a rate of 62% from 1990 to 2006 (Figure 1). In 2006, 124,605 of the county's residents identified themselves as Asian American, accounting for 13.3% of the population.[3] Asian Americans in the county are highly heterogeneous with six main groups representing 87% of the Asian American population. These groups are Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese. Approximately 13% belong to "additional" Asian American groups, such as Indonesian, Taiwanese, and Thai, among others. These "additional" Asian American groups are referred to as "underrepresented Asian American communities" throughout this report. Figure 2 illustrates the breakdown of all the Asian American groups in the county.

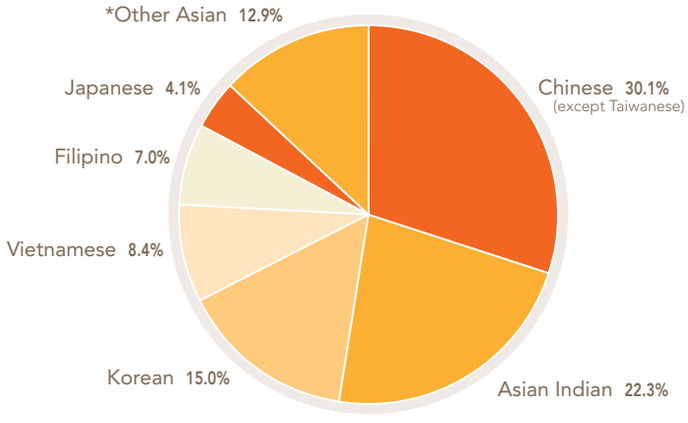
FIGURE 1
Population Trends in Montgomery County

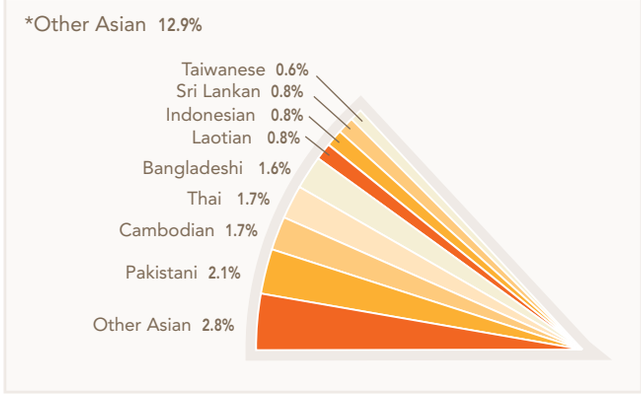
Sources: 2006 American Community Survey; 2000 Census, 1990 Census, U.S. Census Bureau.

[i] The Far East is as a region comprising the countries of East Asia, namely China, Japan, North Korea, South Korea, Mongolia, and Taiwan. The region of Southeast Asia is bounded on the west by the Indian subcontinent, China on the north and the Pacific Ocean on the east; it includes Myanmar, Thailand, Cambodia, Laos, Vietnam, Malaysia, Singapore, Indonesia, Brunei, and the Philippines. The Indian subcontinent is a large section of the Asian continent consisting of countries lying substantially on the Indian tectonic plate. This includes India, Pakistan, Bangladesh and parts of Afghanistan, Nepal, Bhutan, and Sri Lanka.

FIGURE 2

Asian American Subgroups in Montgomery County

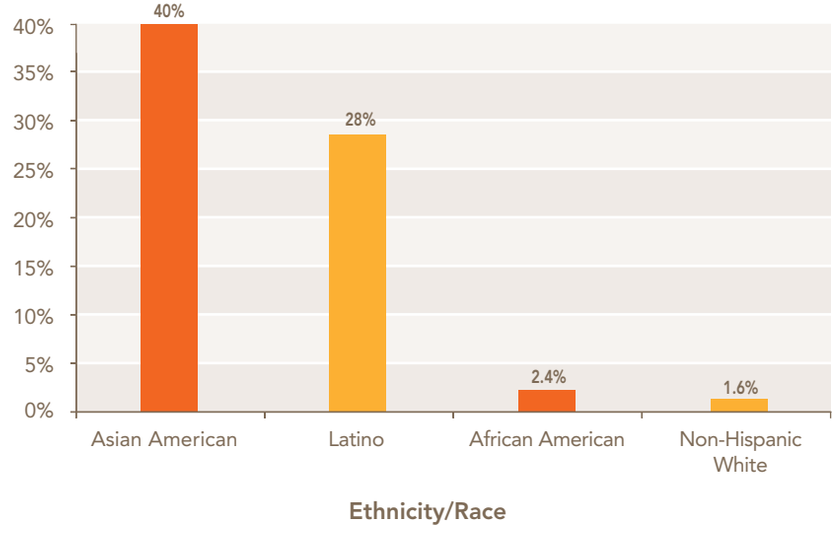




Asian Americans are often stereotyped as the "model minority." They are perceived as having more successfully adapted to American life—having higher income and higher education levels than other minority groups. This is an erroneous notion and this stereotype prevents their important concerns from being heard. A significant number of Asian Americans do not have high socioeconomic status, and, in fact, they do have problems and needs. Asian Americans represent both extremes of socioeconomic and health indices—more than a million Asian Americans live at or below the federal poverty level. Low socioeconomic status is a major barrier to attaining good health for Asian Americans. Beyond lacking necessary skills, many Asian Americans live in linguistic isolation (Figure 3), which further compounds the difficulty of finding jobs that offer health insurance.

FIGURE 3

Linguistic Isolation* in Montgomery County, 2000 Census



*Linguistic isolation is defined by the U.S. Census Bureau as living in a household in which all members aged 14 years and older speak a non-English language while speaking English less than "very well." [4] Additionally, 17.9% of Asian Americans do not have health insurance (compared with 11.3% of non-Hispanic Whites) according to 2005 data from the U.S. Census Bureau.[5]

B | HEALTH BACKGROUND: WHAT ARE OUR HEALTH RISKS?

(see Appendix B: Glossary of Selected Diseases and Conditions)

Cancer is the leading cause of death for both Asian American and Pacific Islander (AAPI) men and women according to 2004 Centers for Disease Control and Prevention (CDC) data (Table 1). Heart disease and stroke follow cancer for both men and women. Diabetes is the fourth-leading cause of death for women and the sixth for men.[6] Asian Americans have a 60% higher prevalence of diabetes compared with non-Hispanic Whites.[7] Accidents, influenza and pneumonia, chronic obstructive pulmonary disease, suicide, kidney disease, and Alzheimer's disease are other leading causes of death for AAPIs according to CDC data.[6]

TABLE 1

Leading Causes of Death for Asian Americans and Pacific Islanders, CDC 2004

	MALES	FEMALES	OVERALL
1	Cancer	Cancer	Cancer
2	Heart disease	Heart disease	Heart disease
3	Stroke	Stroke	Stroke
4	Accidents	Diabetes	Accidents
5	Chronic lower respiratory diseases	Accidents	Diabetes
6	Diabetes	Influenza and pneumonia	Influenza and pneumonia
7	Influenza and pneumonia	Chronic lower respiratory disease	Chronic lower respiratory disease
8	Suicide	Alzheimer's disease	Suicide
9	Kidney disease	Kidney disease	Kidney disease
10	Homicide	Hypertension	Alzheimer's disease

Source: CDC, Health, United States 2006.

Maryland state data suggest that there is a high prevalence of tuberculosis and hepatitis B and that these diseases pose a serious threat to some Asian American communities.[8] Additionally, mental health issues are prevalent among the elderly and adolescents, while mental health services are often inadequate. At the national level, according to a 2001 study, only 17% of AAPIs experiencing mental health problems seek care.[9]

CANCER IS THE LEADING CAUSE OF DEATH FOR ASIAN AMERICANS AND PACIFIC ISLANDERS

As specified in Table 1, national-level statistical data indicate that cancer is the leading cause of death in Asian Americans.[6] In particular, Asian Americans have higher rates of liver and stomach cancers compared with other racial and ethnic groups (Table 2).[10]

TABLE 2

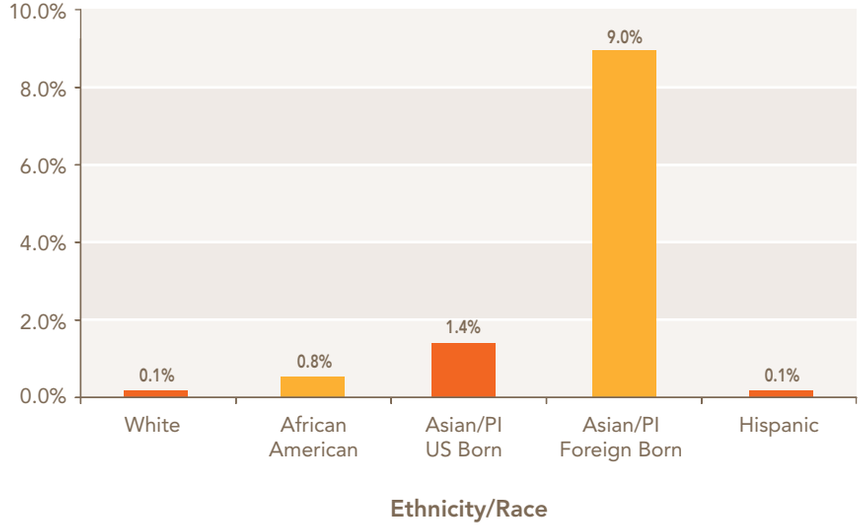
Incidence of Liver and Stomach Cancers across Different Races and Ethnicities 1998–2002 (incidence per 100,000)

ETHNICITY/RACE	LIVER CANCER	STOMACH CANCER
Asian Americans/Pacific Islanders	**14.0**	**15.9**
Whites	5.0	7.4
African Americans	7.3	12.9
Hispanics	9.7	13.0
American Indians/Alaskan Natives	6.7	12.0

Source: NCI, Cancer Health Disparities: Fact Sheet, 2005.

According to a report by the President's Advisory Commission on Asian Americans and Pacific Islanders, breast cancer is the most common cancer among Chinese, Filipino, Japanese, and Korean women. Cervical cancer is the most common cancer in Vietnamese women, and lung cancer is the most common cancer among Chinese, Korean, and Vietnamese men and women.[11] National statistics indicate that Asian American women tend to have low screening rates and are usually diagnosed in the later stages of cancer.[10] Another study on the effects of immigration on the risk of breast cancer among Chinese, Japanese, and Filipino women living in California showed that Asian Americans born in the United States had a 60% higher breast cancer rate than those born in their country of origin. It also reported that immigrants' risk of breast cancer doubled after residing in the United States for a decade.[12]

FIGURE 4
Chronic HBV Infection Rates, 2003



Source: Standford Asian Liver Center.

HEPATITIS B INFECTION RATES ARE THE HIGHEST AMONG ASIAN AMERICANS

National-level statistics indicate that AAPIs account for over half of the 1.3 million chronic hepatitis B cases and half of the deaths resulting from chronic hepatitis B virus (HBV) infection in the United States.[11] Foreign-born AAPIs account for 9% of HBV infection rates, according to the Stanford Asian Liver Center, which is significantly higher than other race and ethnic groups (Figure 4). In many Asian countries, about 10% of the population are HBV carriers.[13]

HEART DISEASE IS THE SECOND-LEADING CAUSE OF DEATH FOR ASIAN AMERICANS[6]

Cardiovascular disease accounts for 35% of all deaths for AAPI men and 36% of AAPI women.[11] There is, however, a lack of data on cardiovascular morbidity patterns among Asian American groups. Limited population-based studies and anecdotal evidence suggest that cardiovascular risks vary greatly among Asian American subpopulations.[11] In a longitudinal study among health plan members in California, the risk of hospitalization for coronary artery disease (CAD) among Asian Indians was more than three times the risk for non-Hispanic Whites.[14] Additionally, a recent study mentioned that CAD was an emerging risk for South Asians.[15]

Another study found that mean cholesterol levels were highest among Japanese men and women compared with other AAPI populations.[16] Moreover, other studies reported that many Asian Americans were unaware that high cholesterol increases the risk of developing heart disease.[17, 18] In addition, according to the California Hypertension Survey, blood pressure levels vary among Asian American groups, as well as by age and gender. The prevalence of hypertension for Japanese women ages 50 and older was less than half of the corresponding rate for women of any other ethnic group in the same age bracket. However, the same study found that Filipino men and women ages 50 and older had

hypertension prevalence rates of 60% and 65%, respectively, compared with 47% of the U.S. general population in the same age group.[19]

DIABETES IS PREVALENT AMONG ASIAN AMERICANS

A national study found that Asian Americans have a 60% higher prevalence of diabetes compared with non-Hispanic Whites.[7] In addition, a study on Asian Indians age 20 years and older living in Atlanta reported an 18.3% overall prevalence of diabetes, which was higher than in Hispanics (9.3%), Blacks (8.2%), and non-Hispanic Whites (4.8%).[20] Moreover, another study reported that diabetes prevalence among Asians grew by 68% from 1994 to 2001 in Medicare beneficiaries ages 67 or older, increasing faster than in Hispanics, Blacks, and non-Hispanic Whites.[21]

Compelling scientific evidence indicates that lifestyle changes (e.g., diet, smoking, physical activity, etc.) prevent or delay the occurrence of Type 2 diabetes in high-risk groups.[22] However, it has been found that diabetes management varies by the level of acculturation (for new immigrants). Patients who have recently emigrated from their home countries, and those who have been residing in the United States for a long time but have not acculturated to mainstream society, may need health care providers with a higher level of cultural competency.[23]

MENTAL HEALTH CARE MAY BE A CHALLENGE FOR ASIAN AMERICANS

A national survey showed that Asian American children age 18 years and younger were less likely than non-Hispanic Whites, Blacks, and Hispanics to receive mental health care.[24] Other national surveys have shown that 30% of Asian American girls in grades 5 through 12 reported more depression symptoms than non-Hispanic White, Black or Hispanic girls.[25] According to a report of the Surgeon General on mental health, approximately 70 AAPI providers are available for every 100,000 AAPIs in the United States, compared with 173 non-Hispanic White providers per 100,000 non-Hispanic Whites. The Surgeon General's report also indicates that only 17% of AAPIs experiencing mental health problems sought care.[9]

OSTEOPOROSIS IN AAPI WOMEN IS COMPARABLE TO THAT OF WHITE WOMEN

TABLE 3

Prevalence of Osteoporosis, Low Bone Mass, and Lactose Intolerance among Different Populations

	ASIAN AMERICAN	AFRICAN AMERICAN	CAUCASIAN	LATIN AMERICAN
Osteoporosis (women ages 50 and older)	**20%**	5%	20%	10%
Low bone mass (women ages 50 and older)	**52%**	35%	52%	50%
Lactose intolerance	**90%**	70%	15%	N/A

Source: National Osteoporosis Foundation.

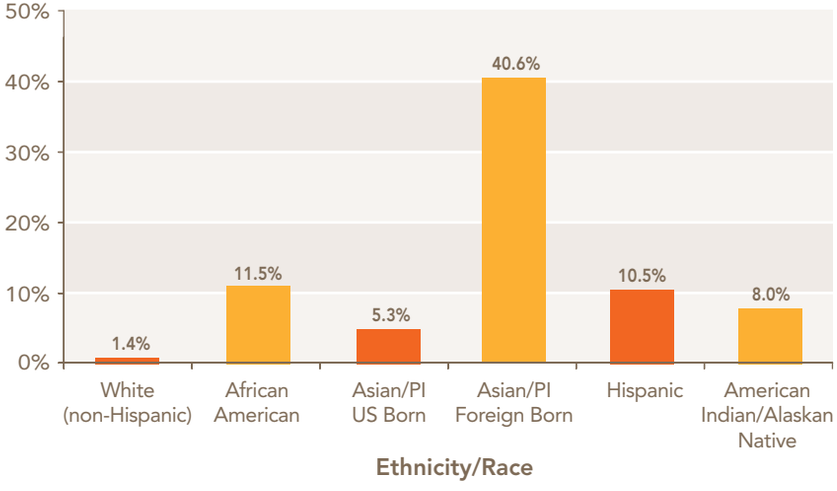
A widely held misconception is that only Caucasian women develop osteoporosis. However, 52% of Asian women age 50 years and older are estimated to have low bone mass, which is equal to the risk for Caucasian women.[26] Furthermore, 20% of Asian women age 50 years and older are estimated to have low bone mass, which is equal to the risk for Caucasian women.[26] Furthermore, 20% of Asian women ages 50 and older are estimated to have osteoporosis, which is the same as that of non-Hispanic White women (Table 3).[27] However, some reports are showing even higher numbers of osteoporosis in Asian American women. One epidemiologic study indicated that the prevalence of osteoporosis is much higher in Asian people than in White European or North American populations.[28] Another study reported that bone mineral density was lower in Asian women compared with Caucasian women.[29] A review on lactose intolerance, calcium intake, and osteoporosis indicates that the highest prevalence of lactose intolerance is observed in Asians compared to other racial/ethnic groups.[30] It states that lactose intolerance is a cause of milk avoidance and decreased calcium intake may lead to osteoporosis.

TUBERCULOSIS RATES ARE HIGHEST AMONG ASIAN AMERICANS

CDC data from 2003 indicate that tuberculosis (TB) incidence rates are highest for AAPIs compared with all other race and ethnic groups (Figure 5).[31] This is particularly true for foreign-born AAPIs. In a study based in San Francisco, the number of active TB cases among Asian Americans in 1999 was more than 60 people per 100,000—the highest rate among all ethnicities in San Francisco—compared with African Americans (40 per 100,000) and Latinos (20 per 100,000).[32]

FIGURE 5

Prevalence of TB in the US Population, 2003



Sources: *MMWR*, March 19, 2004, CDC

WHILE DOCUMENTED HIV/AIDS IS RELATIVELY LOW IN ASIAN AMERICANS, THEY HAVE LOW TESTING RATES AND THERE IS A LACK OF DATA ON RISK BEHAVIORS

According to the CDC, 417 AAPIs were diagnosed as having HIV/AIDS in 2005, which was 1.1% of the 37,331 cases diagnosed that year. Of the 475,220 U.S. persons living with HIV/AIDS as of 2005, 2,996 (0.6%) were AAPIs.[33] Lower diagnoses or prevalence of HIV/AIDS may be due to low testing rates for AAPIs. Data from an HIV testing survey in Seattle indicated that of the AAPIs surveyed, 90% perceived themselves at some risk for HIV infection, yet only 47% had been tested during the past year.[34] Low HIV testing rates also affect the stage at which a diagnosis is made. CDC surveillance shows that for many AAPIs the diagnosis of HIV infection is made late in the course of the disease. In 2004, 44% of AAPIs received an AIDS diagnosis within one year after their HIV infection was diagnosed, compared with 37% of Whites, 40% of Blacks, 41% of American Indians/Alaskan Natives, and 43% of Hispanics.[35]

WHILE NATIONAL DATA ARE NOT AVAILABLE FOR ORAL HEALTH, COMMUNITY AND STATE DATA REVEAL THAT UNTREATED DENTAL DISEASES ARE HIGH IN AAPI CHILDREN

A California study of six to eight-year-olds found that 71% of California's AAPI children had untreated dental caries, with a significant portion of this group requiring urgent dental treatment.[62] Early childhood caries are defined as "the presence of one or more decayed (cavitated or not cavitated lesions), missing (due to caries) or filled tooth surfaces in any primary tooth in a child 71 months of age or younger." By comparison, the National Health and Nutrition Examination Survey (NHANES) III data indicate that from 1988 to 1994, 29% of children in the United States between six and eight years of age had untreated dental decay.[36] Moreover, the 1993–1994 *California Oral Health Needs Assessment of Children* reported that the estimated risk for early childhood caries was more than three times higher in Head Start (HS) Asian Americans compared with HS Whites and non-HS Whites, controlling for socioeconomic status variables.[37]

Oral health status varies among groups of AAPI children. The prevalence of early childhood caries among AAPI children ranged from a low of 8% among Japanese children to a high of 25% among Filipino children. The prevalence of untreated dental caries in six- to eight-year-old AAPI children ranged from a low of 16% among Japanese children to a high of 48% among Southeast Asians.[36]

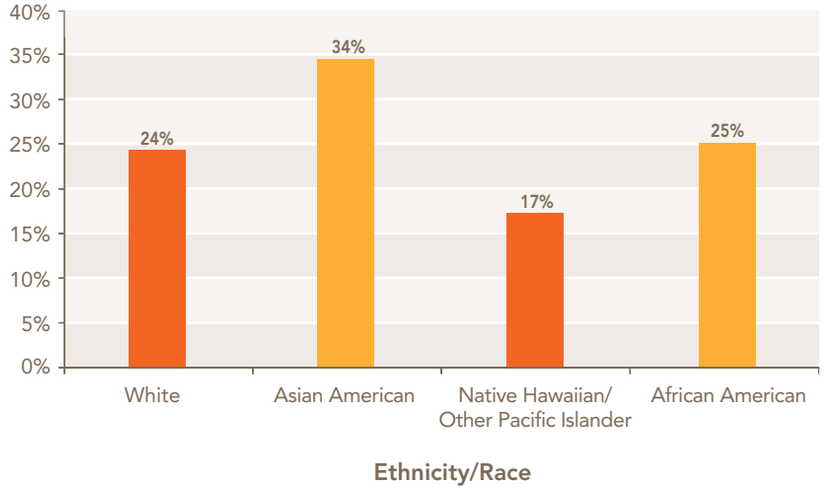
LIFESTYLE BEHAVIORS VARY AMONG ASIAN AMERICANS

- **Physical Activity:** Only limited national-level data are available on the physical activity of Asian Americans. According to a CDC report published in 2004, 41% of AAPI men and 35.8% of AAPI women reported that they participated in physical activity that met or exceeded recommended levels of physical activity. These values were lower than overall estimates of U.S. men and women in 2003 (48.4% for men and 43.3% for women).[38] A few California-based studies also reported that Asian Americans exercised less than the average U.S. population. One study from California showed that 40% of Vietnamese males and 50% of Vietnamese females did not exercise, compared with 24% of males and 28% of females in the U.S. population.[39] Another study found that 31% of Korean Americans in Alameda County, California, did not exercise, compared with 21% of the total California population.[40]

- **Tobacco Use:** National data show the percent of current smokers in Asian American males (34%) is substantially higher than in other races (24% of Whites, 25% of African Americans, and 17% of Native Hawaiians or other Pacific Islanders; Figure 6).[11] Moreover, according to a recent report based on interviews conducted with more than 1,300 Asian Americans, nearly half of them were exposed to secondhand smoke at home or at work.[41] It also has been found that Asian American youths (in 7th to 12th grades) have the highest increase in smoking rates of any racial and ethnic group.[42]

FIGURE 6

Male Smokers, 2003



Source: President's Advisory Commission on Asian Americans and Pacific Islanders. Report to the President and the Nation. *Asian Americans and Pacific Islanders Addressing Health Disparities: Opportunities for Building a Healthier America 2003.*

- **Alcohol Use:** Although Asian Americans are known to have generally low drinking rates, drinking behaviors vary substantially among different groups and with different study designs. For example, in a study that compared drinkers and abstainers among four Asian ethnic groups in Los Angeles, there were more drinkers than abstainers among Japanese Americans and Chinese Americans and more abstainers than drinkers among Filipino Americans and Korean Americans.[43] Another study that examined heavy drinking suggested that the rates of heavy drinking differed greatly among groups, with the highest proportions of heavy drinkers found among Japanese Americans, followed by Filipino Americans, Korean Americans, and Chinese Americans.[44, 45] In addition, a study of Southeast Asian refugees found that approximately 45% of

respondents reported having problems with alcohol use, and a large proportion of the sample considered alcohol use an acceptable way to cope with stressful situations.[45] Although data on the quantity of alcohol consumed by Asian American adolescents were not available, a study indicated that alcohol use by Asian American adolescents was increasing significantly. [46]

- **Substance Abuse:** Drug use among Asian Americans is generally lower than that of other racial and ethnic groups. The rate of current illicit drug use among Asian Americans was 2.8%, compared with 6.8% for non-Hispanic whites, 6.9% for Blacks, and 11.2% for American Indian/Alaskan natives. However, there were variations among the Asian groups. For persons aged 12 or older, the rates were 1.3% for Chinese, 2.2% for Asian Indians, 3.0% for Vietnamese, 4.5% for Japanese, and 5.0% for Koreans.[47] Drug use statistics for adolescents are not available because they are combined with adult data (e.g., most national-level statistics on drug use are on individuals ages 12 years or older).

- **Sexual Behaviors:** National statistics also indicated that 2004 birth rates for teenage girls (15–19 years old) were lower in AAPIs (17.3 per 1,000) compared with non-Hispanic Whites (26.7 per 1,000), Blacks (63.1 per 1,000), and Hispanics (82.6 per 1,000).[48] Similarly, Asian American adolescents were less likely to have sexual intercourse than other racial groups.[49] However, this may be influenced by under-reporting to some degree due to cultural taboos in the Asian American community.

ASIAN AMERICANS FACE MULTIPLE HEALTH CARE ACCESS BARRIERS

Many Asian Americans lack access to health insurance. It is estimated that Asian Americans are less likely than non-Hispanic Whites to receive health insurance through their employers (64% versus 73%, respectively).[50] Of the Asian Americans who do not receive health insurance through their employers, 9% directly purchase private health insurance.[50] Moreover, the proportion of uninsured Asian Americans increased from 16.5% in 2004 to 17.9% in 2005.[5]

According to the Kaiser Commission on Medicaid and the Uninsured report, only 63% of Asian Americans benefit from employer-sponsored insurance.[50] Among Asian Americans, 55% of Korean Americans are most likely to be uninsured, followed by 37% of Vietnamese, 18% of Asian Indians, 16% of Chinese, 15% of Filipinos, and 4% of Japanese.[51]

Another barrier to health care access is lack of knowledge of the American health care system. Oftentimes, Asian Americans may not know the right questions to ask—or even whom to ask—concerning their health care needs. They do not have a clear understanding of how to assess their medical problems and symptoms in the new cultural context. Compounding this issue is a lack of English-language proficiency, particularly given the difficulty of remembering and understanding rarely used medical terms.

Finally, something as basic as lack of transportation can present a barrier to health care access—particularly for seniors. Many seniors are too old to drive, or have not obtained a driver's license given the challenges and inconvenience this often entails. Moreover, seniors may not have an understanding of the public transportation options available to them. Quite often, seniors forgo medical care because they do not want to burden working family members who would have to take time off to provide transportation.

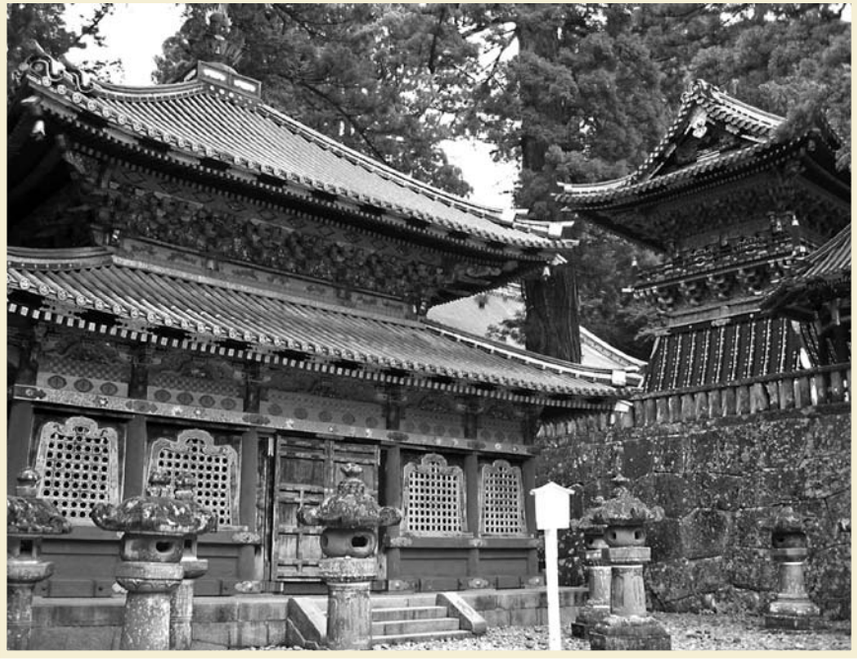
Regarding Asian American health, a lack of data poses significant problems. Oftentimes, health data are reported only in terms of non-Hispanic Whites, Blacks, and Hispanics. In many cases Asian Americans are combined with Pacific Islanders or American Indians. Since these three groups have very different characteristics, this mixing of data may lead to misleading results. It is important to collect data specific to Asian Americans and report it in a disaggregated format.

AAHI recognizes the importance of collecting health information to develop appropriate interventions to reduce health disparities and improve the health of Asian Americans in Montgomery County, Maryland. To enhance the available data, AAHI took action to gather input from our many communities.

PART II | What Are Our Concerns?

BALI THEATRE, INDONESIA

TOSHOGU TEMPLE IN NIKKO, JAPAN



A | HEALTH NEEDS ASSESSMENTS: WE ASKED AND LISTENED

BACKGROUND

As AAHI expands its programs and continuously reaches out to the Asian American population, it has become even more apparent to identify specific health disparities among the increasingly diverse Asian American groups. The lack of available data on health disparities affecting the county's Asian Americans has been a challenge especially in assessing the current health status. To address this need, AAHI has conducted two health needs assessments. AAHI worked with the University of Maryland to conduct a health needs assessment of seven major Asian American groups living in Montgomery County as one of its first projects in 2005. This needs assessment was the initial step in gathering relevant and essential information to address Asian American health needs and the results were instrumental in helping AAHI implement and further refine a plan of action to respond to meeting those needs. Appendix A provides a summary of the 2005 assessment.

Although the 2005 needs assessment report provided a good in-depth understanding of the needs of the county's major Asian American groups, limitations (which are, perhaps, intrinsic in the study of diverse communities with small population sizes) became apparent that might have constrained the applicability of the first needs assessment results. Realizing the need for health information of the smaller underrepresented Asian Americans in the county, AAHI commissioned a second needs assessment in 2007 to identify the health needs of both the major communities as well as the underrepresented, or isolated, Asian American communities in Montgomery County and to update the findings from the 2005 needs assessment.

This *Asian American Health Priorities: Strengths, Needs, and Opportunities for Action* report is the result of findings from the second health needs assessment and includes significant updates to the first needs assessment. The second assessment was conducted in Montgomery County in a total of 13 Asian American communities: Asian Indian, Burmese, Cambodian, Chinese, Filipino, Indonesian, Japanese, Korean, Nepali, Pakistani, Taiwanese, Thai, and Vietnamese.

APPROACH TO THE 2007 HEALTH NEEDS ASSESSMENT

In 2007, AAHI commissioned the development of the second health needs assessment to identify the unique needs of smaller underrepresented Asian American communities residing in Montgomery County. AAHI worked with the research team from the Maryland Asian American Health Solutions at the University of Maryland School of Public Health to conduct this second needs assessment.

A total of 174 individuals belonging to 13 Asian American communities (Table 4), including 17 young adults (18-30 years old), participated in 19 focus groups and two interviews. Two of the focus groups were devoted to young adults representing eight communities (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese). Participants were asked to discuss a variety of health issues affecting their communities based on their observation or communication with members from their own communities. Specific topics included: common illnesses among adults and vulnerable populations; utilization, access and preferences of health services and providers; complementary and alternative medical practices; and health and information needs, as well as dissemination channels. In-depth information was gathered about their perceptions of priority health issues and barriers to accessing health services, as well as their recommendations on how to improve their community's health. At the conclusion of each focus group, women's health issues were discussed separately from the main focus group with only female researchers and participants. Focus groups were composed of community members representing various age groups, genders, socioeconomic status (i.e., diverse education, income, and occupational backgrounds), religions, and health insurance status.

TABLE 4

Participants in the Second Health Needs Assessment, 2007

COMMUNITY	METHOD	NO. OF PARTICIPANTS	DESCRIPTION OF PARTICIPANTS
Asian Indian	1 focus group	5	Physicians and health professionals
Burmese	1 focus group	7	Community leaders and community members
Cambodian	1 focus group 1 interview	11	Community leaders, community members, and health professionals
Chinese	1 focus group	11	Physicians, health professionals, and community leaders
Filipino	1 focus group	8	Physicians
Indonesian	2 focus groups 1 interview	20	Community leaders, community members, and a physician
Japanese	1 focus group	7	Community members
Korean	1 focus group	8	Physicians and community leaders
Nepali	1 focus group	9	Community members
Pakistani	2 focus groups	17	Community leaders and community members
Taiwanese	2 focus groups	24	Community leaders, community members, and physicians
Thai	2 focus groups	21	Community leaders and community members
Vietnamese	1 focus groups	9	Community leader and community members
Young Adults	2 focus groups	17	Young adults from eight communities
Total	**19 focus groups 2 interviews**	**174**	

Data from all 19 focus groups were analyzed, and the findings are summarized in this report. Individual community reports are enclosed as a CD and also are available from the AAHI Web site (www.AAHIinfo.org). These reports are useful for obtaining detailed information on unique health issues of specific Asian American communities. Findings from this report are based on results from qualitative studies (i.e., focus groups and interviews). Although qualitative studies are credited for being able to uncover in-depth information on certain topics, due to their smaller sample size, the findings from this report are not intended to be generalized to all Asian Americans. Furthermore, since each focus group was diverse and different in terms of the educational level and health-related expertise of the participants, the findings do not provide compatible data that allow for cross-group comparisons.

Cultural attitudes towards health care

We don't just visit the doctor [for preventative care]. There has to be something wrong—it has to be extreme. (Nepali woman)

B | FINDINGS: WE LEARNED

All groups expressed concerns about general health conditions. Awareness of the prevalence and risk for some conditions varied among community groups and among age and gender-specific groups. Participants also discussed lifestyle behaviors such as diet practices, physical activity, tobacco use, alcohol and substance abuse, and sexual practice. This information was collected from adults, young adults, and seniors, and lifestyle behaviors differed by age groups. Lastly, discussion included the topic of accessing and receiving health care. Participants brought up barriers that hinder access to health care, preferences for physicians, and effective communication channels for receiving health information.

GENERAL HEALTH KNOWLEDGE AND CONCERNS

Participants from 13 Asian American communities identified and prioritized health issues that were prevalent among community members. The research team also inquired about health concerns for specific populations: seniors, children and adolescents, and women. Mental health emerged as a significant health concern, particularly for young adults, adolescents and seniors. Other frequently mentioned health concerns were cardiovascular diseases and conditions (e.g., heart attacks, hypertension, and high cholesterol), diabetes, and cancer. Most communities perceived that a combination of lifestyle factors, such as poor diet, lack of physical activity, and high stress increased their risk for these common chronic diseases. Hepatitis B also posed a risk in some communities in addition to the aforementioned conditions (that are prevalent across most groups).

[ii] Refer to Appendix B for more information on specific diseases and conditions.

1 | GENERAL HEALTH CONDITIONS[ii]

Cancer

TABLE 5

Perceived Prevalent Cancers in Asian American Communities in Montgomery County, MD

ASIAN AMERICAN COMMUNITY	CANCER IS AN IMPORTANT CONCERN	TYPE OF CANCER
Asian Indian	Yes	No particular type of cancer mentioned
Burmese	Yes	Breast, cervical, gastric, lung
Chinese	Yes	Breast, liver, nasopharyngeal, stomach
Filipino	Yes	Colon, liver
Japanese	Yes	Colorectal, intestinal, liver
Korean	Yes	Breast, colorectal, lung, pancreatic, prostate, stomach
Taiwanese	Yes	Colon, esophageal, liver, lung, nasopharyngeal, prostate, stomach
Thai	Yes	Breast
Vietnamese	Yes	Cervical
Cambodian	No	Not applicable
Indonesian	No	Not applicable
Nepali	No	Not applicable
Pakistani	No	Not applicable

In this health needs assessment, nine out of 13 communities believed cancer was an important health problem. Eight of these specified a particular type of

cancer (Table 5). The type of cancer differed across groups and included breast, colorectal, cervical, liver, lung, prostate, and stomach cancers. Participants from Filipino, Japanese, Korean, and Taiwanese communities felt that colorectal cancer was increasing due to changing from a more traditional Asian diet to a more Westernized diet. A physician from the Taiwanese community stated that younger women were experiencing an increased incidence of breast cancer. In addition, nasal pharyngeal cancer was mentioned as an important concern in the Chinese and Taiwanese communities.

Hepatitis B

According to the focus group results, four communities—Cambodian, Filipino, Korean, and Vietnamese—perceived hepatitis B as an important health issue. Furthermore, Chinese, Filipino, Japanese, and Taiwanese communities perceived liver cancer as a prevalent cancer in their community. A recent AAHI-supported study of more than 800 Montgomery County residents on hepatitis B screening found that several groups are at particular high risk of hepatitis B infection. These include Chinese, Korean, descendants from southeast Asia, first-generation Asian immigrants, groups with low immunization rates, and those aged 36–45.[52]

Heart Disease, High Cholesterol and Hypertension

According to the 13 Asian American communities, cardiovascular diseases or related conditions (hypertension, high cholesterol, and heart disease) were their most pressing physical health concerns. All 13 groups identified hypertension as highly prevalent among community members, and eight groups considered heart disease and high cholesterol as their main health concerns. A few communities reported that a combination of symptoms relating to cardiovascular disease, known as metabolic syndrome, were of concern to them.

Disease Prevention

> We don't have information to prevent chronic illness. That's why we have diabetes, high blood pressure, and all kinds of disease.
>
> (Thai Participant)

Diabetes

All 13 Asian American communities identified diabetes as a very serious health concern, as well as one of the most frequently mentioned health problems. These findings are consistent with national statistics. Maryland state data (2001–2004) also supports that Asian Americans have a significantly higher prevalence of diagnosed diabetes compared with non-Hispanic Whites. In the 18–44 age group, 2.4% of Asian Americans have diagnosed diabetes compared with 1.8% of non-Hispanic Whites, and 11.3% of Asian Americans in the 45–64 age group have diabetes compared with 7.8% of non-Hispanic Whites.[8]

Mental Health

Mental health problems were one of the most important and frequently mentioned health concerns among almost all the Asian American groups in this health needs assessment. This study began in the months following the recent Virginia Tech shooting tragedy;[iii] therefore, it is likely that there has been an increase in mental health awareness since that event. The most common conditions mentioned were depression and anxiety. However, many communities perceived that their "immigrant status" significantly affected their mental well-being. It was a strong contributor of stress in their lives. Most groups expressed that they would not seek professional help even if they felt that they needed it. Some of the reasons mentioned in the focus groups included the stigma associated with mental illness, lack of awareness, and a shortage of mental health professionals who can offer linguistically and culturally appropriate care. The biggest mental health challenge expressed was that it is oftentimes taboo to discuss it openly in many Asian cultures; thus, people tend to hide, neglect or deny symptoms rather than seek help.

Comments from the focus groups identified potential sources of stress that affect the mental health of each age group:

Adolescents and Young Adults:
Parental pressure to succeed academically, strive for certain career paths and fulfill expectations; difficulty balancing two different cultures; providing family care based on the strong family values; and discrimination or isolation at school due to different racial or cultural backgrounds;

Adults:
Adjusting to a different work environment than that of their home country; acculturation and language barriers; difficulty communicating with their children due to lack of time and language barriers; Post-Traumatic Stress Disorder (PTSD); and women with multiple roles;

Seniors:
Isolation and loneliness.

Osteoporosis

A few Asian American communities indicated that osteoporosis is a serious health concern.

Tuberculosis

Many participants in the focus groups reported that they had received the Bacille Calmette-Guerin (BCG) vaccination as children and constantly test positive on TB tests. They mentioned that this positive finding creates a burden since it often requires extensive testing and chest x-rays, and even taking medications.

Arthritis and Joint Problems

Joint discomfort was frequently mentioned as a health concern among young and senior participants alike by seven communities in this health needs assessment (Asian Indian, Chinese, Filipino, Indonesian, Pakistani, Taiwanese, and Thai). Some explained that the nature of certain jobs typically held by immigrants (e.g., standing for long periods of time at stores or restaurants) may contribute to a high prevalence of arthritis among Asian Americans.

[iii] The Virginia Tech tragedy was a school shooting that took place on April 16, 2007 at the campus of Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg, Virginia. Seung-Hui Cho, who had been diagnosed with and was treated for a severe anxiety disorder, killed 32 people and wounded many others before committing suicide. See http://www.nytimes.com/2007/04/16/us/16cnd-shooting.html.

General health concerns also were obtained from women participants separately from the full focus group. In addition, comments regarding health concerns for seniors were obtained from participants.

Comments by Women

Major Health Concerns:

Female participants mentioned that breast cancer, cervical cancer, osteoporosis, prenatal care, and infertility were the main health issues affecting women. Moreover, because most of the Asian American women tend to have multiple roles—working outside the home, household chores, and family caregiving (e.g., raising children and looking after older parents)—oftentimes, the women were under stress. Women who had not worked in their home countries often found themselves working low-income jobs to contribute to the family's income after immigrating to the United States.

Domestic Violence:

Four groups out of 13 discussed domestic violence as an important issue. Similar to mental illness, it is considered taboo in most Asian cultures to talk openly about domestic violence. It is unclear whether the other nine groups did not have this problem, or whether they were simply unaware of it. Participants who spoke about this topic suspected that incidences of domestic violence may go unreported in Asian American groups.

Comments about Seniors

Major Health Concerns:

Participating communities indicated that diabetes, cardiovascular disease, arthritis, dental health, and aging-induced eye diseases were the most common health issues affecting seniors. These problems may be further complicated or exacerbated because many do not go to annual check-ups or follow-up appointments. Care related to dental or eye health becomes difficult because these services are not covered under some health insurance policies. Consequently, it was mentioned that seniors suffering from poor dental health have difficulties eating and may develop digestive problems.

Isolation and Depression:

Many seniors reported feeling lonely and depressed at home. Focus group participants felt this situation could lead to serious depression or could increase the risks of cognitive impairment. The discussion revealed that many Asian American seniors also experience isolation due to cultural, language, and transportation barriers. Seniors frequently live with their children when they are no longer independent. They tend to stay at home by themselves or have childcare responsibilities. Significant language and cultural barriers hinder social relationships with neighbors or the surrounding community. Additionally, due to their lack of transportation, they may be unable to attend religious services or community gatherings to meet with friends.

Chronic illness

> When the immigrant lifestyle changes and the immigrant diet changes, the incidence of coronary heart disease also increases. (Taiwanese physician)

2 | LIFESTYLE BEHAVIORS

Focus group participants were asked about a range of lifestyle behaviors. In some cases participants made comments about their perception of these behaviors in children, adolescents, and seniors. In addition, two distinct focus groups were held exclusively for young Asian Americans (ages 18–30) from eight communities (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese) who are mostly part of the 1.5 generation (people who immigrated to a new country before or during their early teens) and the 2nd generation (those born in the United States). They bring with them characteristics from their home country, but experience an assimilation and socialization process in the new country. Because their health concerns are vastly different from those of adults or seniors, separate focus groups were held to discuss their particular health issues. The following tables highlight their comments by focus group category.

Diet Practices and Related Effects

There was overall concern with the effects of traditional and Western diets on health for youth and adults, and an interest in learning about healthy food preparation.

Focus Group Comments:

General Focus Groups

Some communities acknowledged their traditional foods and cooking styles were not conducive to a healthful diet. *Asian American communities reportedly consume high amounts of sodium (in soy and other cooking sauces and in pickled vegetables), simple carbohydrates (white rice, added sugar and sweets), and fat (fried food or coconut milk).*

Most communities mentioned that chronic illnesses, such as hypertension, heart disease, and diabetes might be attributable to poor eating habits.

Many communities expressed an interest in learning how to prepare their traditional foods in more healthful ways.

Ten out of 13 Asian American communities reported that they were concerned about weight. Most participants felt that their communities currently do not have serious problems with obesity, but they are concerned that it might become a threat to their health in the future.

General Focus Groups' Comment on Children and Adolescents

Focus group participants were concerned about their children's possible weight problems. They foresee that the younger generation may have more problems with weight as they tend to consume a more Westernized diet (i.e., a diet high in fat and sugar) than the first generation (defined as people not born in the United States, also known as "foreign born") and tend to be less active.

Youth Focus Groups

Young adults mentioned that eating habits were mainly based on convenience and parental food preferences or cooking routines. They also mentioned a tendency to eat a more Westernized diet, with fewer vegetables and more fat.

Physical Activity

Participants reported increased sedentary time after immigrating to the United States. Youth pointed out that the cultural influences which emphasize academic performance rather than physical activity as children affect their activity level in adulthood.

Focus Group Comments:

General Focus Groups

A few communities mentioned that they had become more sedentary since they immigrated to the United States.

The level of physical activity differed among individuals. Some pointed out that participation in sports as a young adult may have been related to how often the individual had played sports during childhood.

Youth Focus Groups

In some Asian American families, sports often was not a preferred extracurricular activity that parents encouraged. Instead, parents tend to concentrate their child's activities on academic or musical pursuits.

Tobacco Use

Some groups mentioned smoking as an important health issue for men. Since many Asian countries have high smoking rates, immigrants tend to bring that habit to the United States. Smoking is also prevalent among Asian American youths.

Focus Group Comments:

General Focus Groups

Five communities out of 13 identified smoking as an important issue.

They thought this was a problem for men, but not for women.

Participants reported that Asian American men often bring their smoking habit from their home countries, where the smoking rate is very high.

Some mentioned that they changed their smoking behavior after coming to the United States due to high cigarette prices or environmental influences, which makes it difficult to smoke (e.g., smoking is prohibited in restaurants, public places, etc.).

Youth Focus Groups

Many college-aged individuals were identified as a group that smoked, with some smoking about a pack a day.

Some participants mentioned that if their parents smoked, it was easier to develop and maintain the habit as well.

Alcohol and Substance Abuse

Adult participants mentioned alcohol and substance abuse were not problems in their community. However, youths stated that drinking and drug use were common in some communities.

Focus Group Comments:

General Focus Groups

A majority of the groups that participated in this health needs assessment mentioned that alcohol and drug use were not problems in their communities. They believed that most alcohol was consumed in social

situations and that it did not tend to go to extremes, such as binge drinking and/or drunk driving.

General Focus Groups' Comment about Children and Adolescents
A difference of opinion was noted among different groups for substance abuse in adolescents. Some communities thought it was a problem and others did not. Many parents believed that their cultural or religious values would prevent their adolescents from engaging in substance abuse. However, most groups agreed that substance abuse may become a problem in the near future as their children are increasingly exposed to these pressures at school, or through their peers or the media.

Youth Focus Groups
Participants mentioned that drinking was common within the current generation.

Social drinking is present as well as drinking with the intention of getting drunk.

The groups mentioned that ecstasy and cocaine were also used.

Sexual Practices

Adult participants and youth participants had different opinions on sexual practice. Although adult participants thought Asian American youths believed in abstinence until marriage, youth participants mentioned that sexual activity among unmarried youths was common.

Focus Group Comments:

General Focus Groups' Comment about Adolescents
For most Asian American communities, sexual intimacy before marriage was strongly discouraged. Parents in many communities believed that their cultural or religious values prevented their adolescents from engaging in sexual behavior. Therefore, none of the communities thought that either mistimed pregnancies or sexually transmitted infections (STIs) were problems.

Youth Focus Groups
Contrary to adults' belief in abstinence until marriage, young Asian Americans mentioned that sexual activity among unmarried young adults was very common. However, they were not particularly concerned about sexually transmitted infections (STIs).

Teenage pregnancy among young Asian American women was considered rare in comparison with other racial or ethnic groups.

3 | ACCESSING AND RECEIVING HEALTH CARE

A key component of enjoying physical and mental health and well-being is the ability to access and use appropriate health resources as needs arise. A number of issues related to cultural attitudes toward health care and knowledge of preventive care were raised. In addition many Asian Americans commented on issues that highlight financial, physical, and communication barriers to health care. These barriers also hinder access to important screenings to prevent common chronic illnesses. When in need of health care, many Asian Americans prefer an Asian health care provider who can speak their language and is cultur-

ally sensitive. Furthermore, many reported using different complementary and alternative medicine for their health needs. Communities have a strong desire for health information that would help them address some of the barriers to accessing preventive and curative health services. The communication channels and formats suggested in this report may help disseminate health information effectively to this community.

Issues Related to Appropriate and Timely Health Care Access

a | Attitudes and Knowledge

Cultural Attitudes toward Health:

According to many communities, their members are accustomed to going to a physician only when they are very ill. This was seen in part due to a reported general lack of awareness of the importance of preventive care among community members. They tend to hide, neglect, or deny health problems rather than actively seek help.

Knowledge about Preventive Health Care:

Communities reported that there is lack of general knowledge about what preventive care is and what screenings are recommended. However, many communities perceived that once educated, many would become more proactive regarding disease prevention.

b | Financial Access to Health Care Services

Lack of Health Insurance:

The inability of community members to afford health insurance or obtain it through their employment was mentioned as the main barrier to health care access. According to the respondents, individuals with health insurance might have more contact with a physician who regularly schedules screenings and stresses the importance of preventive care. However, those without health insurance do not receive such reminders and essential information from their physicians. More importantly, many are not able to afford expensive screenings. From the small groups of people interviewed in each community, it was observed that individuals who reported a lack of health insurance often had lower education levels and lower incomes.

Expensive Out-of-Pocket Care:

Due to the high cost of quality health care, many reported that they did not go to a health clinic until they felt very ill. Some communities were aware of the volunteer clinics supported by Montgomery County and often used them. However, many underrepresented Asian American community members did not know about these clinics. A few communities reported that traveling to their home countries was not uncommon for health care—such as dental work, surgery, or a checkup with a physician there.

Expensive Prescription Medications:

Some community members have resorted to using traditional medicine, such as Chinese medicine or home remedies (see pages 39 for more detail). Others "self-medicate" by using over-the-counter medications or purchasing prescription medications from their home countries.

c | Physical Access to Health Care Services

Lack of Transportation:

Many participants mentioned people have difficulty getting to a physician's office. The main obstacle communities mentioned was a lack of transportation, particularly for seniors. Communities reported that seniors often relied on family members to take them to medical appointments as well as to be language interpreters. Many are not able to take public transportation due to an inability to decipher bus routes, the fear of getting lost, and a lack of ability to communicate in English when problems arise. Many seniors also cannot drive and have no alternative means of transportation.

Time Conflict with Medical Appointments:

The second physical obstacle for accessing health care services mentioned was finding a convenient time to visit a physician. Some communities indicated that many Asian Americans were unable to schedule appointments during the day, preferring night or after-hour appointments. Many communities mentioned that people were discouraged when they were unable to see a physician immediately and had to wait several weeks for a consultation. Communities also reported that long waiting lines in free or low-cost health clinics could be important deterrents.

d | Patient-Provider Communication

Language Barrier:

Limited English proficiency posed a significant barrier in accessing health services from a private or public provider for many in Asian American communities. Communities reported that translation services are often available in some major Asian languages such as Chinese, Korean, and Vietnamese. However, given the diversity of Asian languages, these services might not exist for many underrepresented Asian American groups in some locations. Communities found that many first-generation and newly arrived immigrants and seniors often encountered language difficulties. They mentioned the difficulty of sufficiently explaining their symptoms to physicians and being unable to understand doctors' instructions.

Low Levels of Health Literacy:

Communities reported that health literacy was a challenge. Many Asian Americans, particularly seniors, may have trouble interpreting test results and understanding the basis of their diagnoses. Even those who reported good English skills still had difficulty understanding medical terminology and physician's explanations. Many individuals had problems accurately describing their symptoms in English. This may result in poor disease management, misuse of prescription medication or a reluctance to go to a medical follow-up appointment.

e | Preferences in Health Care Providers and Alternative Health Options

Physician Preference:

Almost all communities studied regarded Western medicine and physicians as essential components of the health care system. However, many Asian Americans preferred physicians who were originally from their home country, or from Asian countries of a similar culture. Moreover, women consistently reported feeling more comfortable with female physicians for women's health care issues, such as sexual and reproductive health.

- Asian Physicians Provide Care in Their Own Language: Communities reported that they felt more comfortable when talking to physicians in their native language. They were more confident in accurately explaining their symptoms and understanding physicians' instructions.

- Asian Physicians Provide More Culturally Appropriate Care: Some communities mentioned that Asian American physicians might be able to provide more culturally appropriate care. Some perceived that Asian American physicians understood Asian health issues better than non-Asian physicians. Moreover, individuals who prefer Chinese medicine perceive that many Asian physicians, particularly those trained in Asia, understand better and may combine traditional Chinese medicine and Western medicine.

- Female Physicians Are Preferred by Women for Women's Health Care: Most female participants responded that they preferred going to a female physician for treatments or health care considered for women's health. These include mammography, gynecological exams and Pap smears, and any other care relating to sexual or reproductive issues.

Alternative or Complementary Health Options:

Most Asian American communities use alternative or complementary therapies (Table 6), Chinese medicine, or home remedies in lieu of or in addition to West-

ern medicine. Most respondents reported that these medicines were taken, on average, for three days, and they would consult a physician if symptoms did not subside. The most often used alternative and complementary therapies are listed below in order of the frequency with which they were mentioned.

TABLE 6

Commonly Used Alternative and Complementary Therapies

THERAPY	DESCRIPTION	COMMUNITY RESPONSE
Tiger Balm	Topical ointment marketed as a pain reliever.	Tiger balm was the single-most mentioned alternative medicine used by most communities. Most communities reported that they often used tiger balm for muscle and joint aches.
Chinese Medicine and Herbs	Consists of a variety of treatments, including herbal remedies, acupuncture and massage, among others. Herbal remedies, also called phytotherapy, refer to the use of plants for their scent, flavor or therapeutic properties.	Use of Chinese medicine and herbs was also frequently mentioned as home remedies. The communities did not elaborate on what herbs or Chinese medicinal remedies they frequently used.
Meditation	Meditation is a discipline in which the mind is focused on an object of thought or awareness. It usually involves turning attention to a single point of reference. Meditation is recognized as a component of almost all religions.	A few communities, particularly Buddhists, mentioned that meditation was a common practice to alleviate stress. Buddhist monks frequently recommended meditation to individuals who approached them with mental health concerns. Some attributed meditation to the low prevalence of mental illness, stress, and anxiety among their community members.
Homeopathic Medicine	Consists of treating symptoms with highly diluted substances that cause similar symptoms as the disease. It uses many animal, plant, mineral and synthetic substances in remedies. Examples include sodium chloride, the venom of the bushmaster snake, opium, and thyroid hormone.[53] Some modern homeopaths consider more esoteric substances, such as X-rays, sunlight, and electricity.[54]	A few communities use homeopathic medicine. These communities mentioned that homeopathy was widely used in their home countries and was a preferred health care method.
Ayurvedic Medicine	Ayurveda translates into the "knowledge of life." It operates on the precept that various materials of vegetable, animal and mineral origin have some medicinal value. Ayurvedic medicines are made from herbs or mixtures of herbs, either alone or in combination with minerals, metals, and other ingredients of animal origin.[55]	Some Asian American communities also widely use Ayurvedic medicine, an ancient system of health care native to the Indian subcontinent.
Acupuncture	A Chinese medicine procedure that involves inserting thin needles in the skin in specific parts of the body to improve well-being, e.g., treating pain and diseases. Some research has found good evidence that acupuncture is effective in treating nausea[56] and chronic low back pain,[57] and moderate evidence that it alleviates neck pain[58] and headache.[59] There is general agreement that acupuncture is safe when administered by well-trained practitioners.	Acupuncture is used by some communities not only for curative purposes, but also for prevention, such as smoking cessation.
Coining	Coining, or "gua sha," consists of stroking highly lubricated skin with a smooth edge, such as a coin or spoon. It is used to alleviate symptoms of muscle discomfort, headaches and fever, among others. Its effectiveness is attributed to improved blood circulation in the treated area. However, some respondents reported that school staff often confused red marks left by coining with child abuse.	One community mentioned that coining was a very popular pain relief method in their community.

f | Disseminating Information to the Community

Asian American communities reported that obtaining current and accurate health education information, as well as information on health care resources, is critical in improving their members' overall health. Many Asian Americans reported that they were unaware of some of the health services that Montgomery County has to offer. In addition, they found it difficult to access information about the county's health services. To communicate effectively, they expressed strong preferences for health information delivered in culturally and linguistically appropriate formats provided through channels that are friendly to them. They suggested that health-related information, including information about health resources and services, could be disseminated more effectively through various media and community channels. This includes:

Community-Based and Faith-Based Interventions:
Almost all communities preferred receiving health education information through their temples or churches or in social gatherings. These interventions could come in the form of health fairs, presentations, or lectures conducted in common gathering places. Most mentioned that the best way of accessing communities was through community and religious leaders. They showed great interest in working closely with the county and strengthening the relationship between their leaders and county staff. Additionally, community organizations and religious establishments (e.g., temples, churches, and mosques) also served as clearinghouses for disseminating information through posting bulletins, periodical publications, and word of mouth.

Culturally Appropriate and Relevant Information:
Although many communities have a good command of the English language, their most vulnerable members feel more comfortable reading materials written in their native language.

Print Media:
Focus group participants indicated that one of their main sources for health-related information came from community ethnic papers written in their own language.

Television:
Some communities have their own television programming at the national or local level. They suggested using television as a medium to disseminate announcements about health services and health-related activities.

PART III | What Will We Do?

A TRADITIONAL TEMPLE IN KOREA

SHWEDAGON PAGODA IN YANGOON, MYANMAR

A | RECOMMENDATIONS AND ACTION PLANS

Asian American communities are confronting unprecedented challenges characterized by, among other things, a rapid population growth, which outpaces many other minority groups, and being at-risk of widening health disparities due to health care access barriers discussed throughout this report. Nevertheless, the present report affords a snapshot of the health needs of more than a dozen Asian American communities, and opportunities to improve the health and well-being of the Asian American populations.

After completing the focus groups and the data collection, the UMD research team presented preliminary results of the analysis to the AAHI Steering Committee and two Asian American health experts, who served as consultants to the project, in August 2007. The following recommendations reflect the research results and incorporate comments from the committee members and consultants at the meeting. In addition, it includes a review of the literature, input from the communities participated in focus groups, discussion drawn from the research team and AAHI staff, and Montgomery County's strategic plan to achieve its overarching goals. These recommendations are intended to provide the Montgomery County Department of Health and Human Services and AAHI with action plans to address Asian American health needs. The main goal of these recommendations is to improve the health and well-being of all Asian American individuals in Montgomery County regardless of their country of origin, age, or socioeconomic status.

The following recommendations address the three major themes that evolved from the analysis of the focus groups, the scientific literature, and selected available data on health status. The fourth recommendation area, focused on data collection and reporting, serves to provide the essential infrastructure foundation for AAHI's programs. Action steps are provided for each recommendation area. In addition, the focus group design and analyses provided insight into needs for youth, women, and seniors across population groups. Selected aspects of these needs have been integrated into the action steps.

B | THEME I: INCREASE KNOWLEDGE AND RAISE AWARENESS OF HEALTH PROMOTION AND DISEASE PREVENTION MEASURES

RECOMMENDATION

Expand health promotion and disease prevention programs to raise awareness and level of knowledge of health issues that disproportionately affect Asian Americans.

RATIONALE

Implementing health education programs is a part of the mission of the Asian American Health Initiative. A major finding from this needs assessment is that a lack of knowledge or awareness continues to exist regarding the diseases and conditions that disproportionately affect Asian Americans and their risk and protective factors. In addition, issues surrounding mental health were significantly reported by several of the Asian groups participating in this needs assessment. As the only county health program that specifically addresses the Asian American community in Montgomery County, it is imperative that health promotion and disease prevention programs not only continue, but expand to provide additional information on health issues that disproportionately affect Asian Americans.

ACTION STEPS

Action steps to raise awareness and knowledge of health issues that disproportionately affect Asian Americans:

1 | Expand current health promotion and disease prevention/control efforts on chronic diseases (diabetes, cardiovascular disease, cancer, etc.).

- Provide health education to maintain healthy lifestyles.
- Increase awareness of the importance of regular screening for prevalent diseases and conditions with a special emphasis on women.
- Provide health education on the importance of blood glucose screening to detect diabetes for Asian Americans who are at risk.
- Raise awareness of regular screening for cardiovascular-related diseases or conditions.
- Provide linguistically and culturally appropriate informational materials on management of hypertension, high cholesterol, or other cardiovascular diseases.
- Expand AAHI's current cancer and bone density screening programs to underrepresented communities that have not yet benefited from these services.

2 | Expand current health promotion and disease prevention/control efforts on infectious diseases including hepatitis B.

- Provide hepatitis B screening and vaccination.

3 | Create a health promotion program focusing on mental health with a special emphasis on targeting the senior and adolescent populations.

- Plan for the provision of mental health education programs to raise awareness.
- Identify potential mental health problems in vulnerable or at-risk populations, including adolescents and young adults.
- Provide resources for isolated seniors to meet with their peers to prevent depression from isolation.

- Create a directory of mental health professionals who are Asian American or who are familiar with the cultures and/or speak an Asian language.

- Involve community-based and/or faith-based organizations in the implementation of mental health programs.

4 | Increase awareness of the detrimental effects of lifestyle behaviors, such as use of tobacco and alcohol and lack of exercise, on health status.

Action steps to continue health promotion and prevention programs:

1 | Expand the existing Health Promoters Program to Asian American communities.

- Recruit community members from each Asian American community who are interested in participating in the Health Promoters Program.

- Strengthen partnerships among health promoters and community/ faith leaders.

2 | Increase support for existing community-based health initiatives and programs.

- Initiate community-based health-related activities to promote preventive services and disease screenings with the assistance of lay heath promoters.

- Continue to support community-based health fairs by providing County services, such as AAHI staff, health promoters, etc. Actively use health fairs as a gateway into the formal health care system, particularly for those who do not seek curative or preventive health services.

- Provide technical assistance to set up health fairs in the underrepresented Asian American communities.

C | THEME II: CONTINUE TO EXPAND ACCESS TO QUALITY HEALTH CARE SERVICES

RECOMMENDATION

Strengthen access to and utilization of quality health care services by maximizing the use of existing programs and resources and by working with the community and provider groups to enhance health literacy.

RATIONALE

Our health care delivery systems and the third party payor reimbursement programs are complex. Seeking health care services and obtaining reimbursement can be a daunting task, especially to populations who are used to a different health care system and who have used professional health services primarily for acute care needs. Concerted efforts are needed to maximize access to existing health care and to ensure receipt of appropriate health services. This will include minimizing barriers to care, providing access to cultural and linguistically appropriate resources, and investing in enhancing the health literacy of the populations. Health literacy is defined as the ability to obtain, understand, and appropriately use health information in order to improve overall health. To achieve optimum health, literacy efforts need to be directed to health care providers, health promoters, patient navigators, and to the populations.

ACTION STEPS

Action steps for minimizing barriers to care:

1 | Provide technical assistance to the Asian American community about the importance of health insurance and explore opportunities to provide low cost insurance or access through pilot partnerships or government programs.

2 | Explore and implement programs and/or methods to reduce barriers to health care including improving transportation options and access to voluntary clinics by working with county and state agencies.

3 | Increase the use of community-based lay health promoters.

Action steps for providing access to cultural and linguistically appropriate resources:

1 | Provide training for health care professionals to enhance their understanding of the diverse cultures and health care practices.

2 | Continue to improve and provide culturally and linguistically appropriate health resources including health education materials relevant and appropriate for Asian American communities.

3 | Further develop use of patient navigator program.

Action steps to enhance health literacy:

1 | Review existing health information materials to determine whether they are clear and written in plain language.

2 | Provide technical assistance to support programs aimed at improving health literacy.

3 | Improve the access to these health information materials through familiar channels such as the community-based organizations, faith-based organizations and lay health promoters.

4 | Provide community education for health care providers in the community clinics to increase their effectiveness in listening and communicating health information.

5 | Integrate health literacy efforts into existing programs.

D | THEME III: INVIGORATE AND EXPAND PARTNERSHIPS AND COLLABORATIONS

RECOMMENDATION

Enhance collaborations and partnerships with community-based and faith-based organizations, working with them to develop and expand new and existing programs, and empowering them to sustain effective health programs and address health disparities.

RATIONALE

There are many Asian community-based and faith-based organizations in the county that provide cultural insight and direct access to specific Asian populations. Collaborating with these organizations is essential to engage in program planning and implementation efforts to meet the health education needs of these populations. These collaborations also serve to promote community empowerment and community partnership with the county. AAHI has partnered with several of the Asian community/faith-based organizations to carry out health education activities. As a critical component in addressing health disparities and implementing programs, collaborations with community and faith-based organizations should be further cultivated to provide the fullest extent of programs despite limited resources.

ACTION STEPS

Action steps to enhance collaborations with community and faith-based organizations to develop and expand health programs and to address health disparities:

1 | Establish new and strengthen existing partnerships with community and faith-based organizations from each Asian American community.

2 | Encourage county-community partnerships in addressing health disparities.

3 | Design approaches to gain input to AAHI from all communities by serving as a convening forum for all organizations.

4 | Encourage participation of community members/leaders in program planning and development and for health professionals to volunteer services.

Action steps to enhance collaborations with community and faith-based organizations to sustain health programs and to address health disparities:

1 | Continue to provide technical assistance for underserved or under-represented Asian communities, so that their community and faith-based organizations will be empowered to eventually take ownership of their health promotion programs.

2 | Provide education and training for partner institutions on approaches used to sustain programs.

E | THEME IV: DATA COLLECTION AND REPORTING

RECOMMENDATION

Enhance the capacity to obtain, analyze, and monitor health and related data on an ongoing basis for overall AAHI planning and for program development and evaluation purposes.

RATIONALE

The populations that are covered by AAHI in the county are numerous and continue to grow in number and diversity. Establishing mechanisms to obtain, analyze, and monitor health and related data on an on-going basis is essential to the decision-making process needed to determine how best to direct available resources to meet the needs of these populations and address the previous recommendations. These data will allow AAHI to stay in the forefront of emerging health issues and also will contribute to the tailoring of existing and development of new programs and initiatives. Routine reports of the findings of the collected data will give visibility to the public, health care providers, and policy makers (among others) of the issues that warrant action and of the outcomes of AAHI programs.

ACTION STEPS

Action steps for establishing an ongoing data collection program:

1 | Allocate sufficient funding to secure expertise, instrumentation and analytic capacity for the collection and reporting of quantitative and qualitative population-based health data.

2 | Facilitate data capture design by adapting items from Centers for Disease Control and Prevention funded surveys, such as the National Health Interview Survey and Behavioral Risk Factor Surveillance System.

3 | Explore ability to extend state health surveys to the populations served by AAHI.

4 | Collect and report on initial surveillance data on convenience populations in clinics, CBOs, and FBOs for major health conditions; knowledge, attitudes, and practices related to those conditions; and data on health services utilization.

Action steps for data related to program planning and evaluation:

1 | Assess modifications to existing programs (such as expansion of services or extension to new populations), in addition to the existing program planning and evaluation activities for AAHI initiatives.

2 | Develop criteria for determining need for new programs versus modifying existing programs.

F | NEXT STEPS

Asian American Health Priorities: Strengths, Needs, and Opportunities for Action provides valuable insight into the diverse Asian American community of Montgomery County, Maryland. This report provides a comprehensive list of recommendations developed from collecting information on the perceived health needs of this population using qualitative methods along with data from available literature. As it relates to its mission and goals, AAHI will incorporate the recommendations from this report and develop a plan to implement them. In addition, we plan to evaluate our current programs and projects to identify areas for improvement and expansion.

Under the guidance of Montgomery County's Department of Health and Human Services, AAHI will continue to support efforts at reducing and/or eliminating health disparities to improve the health and well-being of the Asian American population in Montgomery County. We will expand and improve current programs as detailed in the action plan to ensure that any existing barriers to receiving culturally and linguistically competent services are eliminated. AAHI will continue to work on providing limited English residents in the county full access to services available to them. Through our various programs, residents will be able to successfully navigate their way through county health services with confidence. To address the needs for health promotion and to improve health literacy, AAHI will continue to educate the community about health issues that are important to them and create innovative ways to share this information. As the Asian American Health Initiative grows and obtains necessary resources, we intend to take all the required steps to fulfill the recommended actions of this report and to work towards improving the health of all Asian Americans.

Once again, thank you to all who have contributed to this report. Through our collaborative efforts, we are moving toward a day when members of the Asian American communities of Montgomery County will possess a far greater understanding of the health concerns they face, and the resources available to them. We will provide Asian American residents with the confidence, resources, and understanding they need to engage with the American health system. AAHI is enthusiastically, energetically and optimistically committed to this important endeavor.

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PRAYING WHEELS AND FLAGS IN MANANG, ANNAPURNA, NEPAL

CHOCOLATE HILLS IN BOHOL, PHILIPPINES

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Appendices

FLOATING MARKET, THAILAND

TEMPLE OF LITERATURE IN HANOI, VIETNAM

APPENDIX A: SUMMARY OF 2005 HEALTH NEEDS ASSESSMENT

The lack of data on the health disparities affecting Asian Americans in Montgomery County has made it difficult to assess the current health status of the Asian American population. As one of the initial projects, in 2005, AAHI worked with a research team from the University of Maryland (UMD) Department of Public and Community Health to conduct a health needs assessment of Asian American groups in Montgomery County. AAHI's focus was to develop an initial health needs assessment and database to explore the health-related issues of the county's Asian American population, especially those who are low income and uninsured, and establish approaches to reduce or eliminate barriers to health care access. This assessment was the first attempt to collect health data on the Asian American community in Montgomery County.

The first health needs assessment established baseline health data on the major Asian American communities in Montgomery County. A significant part of the initial assessment included the development of a database to record the health-related needs of the county's Asian American residents, particularly those with low incomes and/or without health insurance. Findings from the first needs assessment were used to explore alternative approaches to alleviate barriers to health care access.

The needs assessment included focus groups and individual interviews involving 61 local Asian American constituents and stakeholders within seven major Asian American communities (Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, and Vietnamese). Interview questions asked about community health matters, group-specific issues (involving, for example, seniors and children), disease-specific concerns (such as cancer and hepatitis B) and the availability of community resources. In addition, approximately 50–59 Asian Americans were surveyed from each community among the seven groups mentioned above. The purpose of the survey was to determine the health status, health care access (by using the proxy of health insurance status), language barriers, and available community health resources for the Asian American community.

The study identified both opportunities and challenges for improving the health of Asian Americans. Various health conditions and barriers to health care access accounted for health disparities, and the lack of health data reporting in the past might have undermined efforts to reduce health disparities. On the other hand, the study showed that community assets abound, and many community and faith-based organizations were eager to participate in the county government's effort to provide better health care services for their respective communities.

Please note that a full version of the 2005 Health Needs Assessment can be downloaded from our Web site by visiting www.AAHIinfo.org.

APPENDIX B: GLOSSARY OF SELECTED DISEASES AND CONDITIONS

Arthritis: Arthritis is a group of more than 100 rheumatic diseases and conditions that affect joints, the tissues surrounding the joint or other connective tissue. Arthritis is a very common health condition. It has been estimated that as many as 47 million Americans have some form of arthritis or joint pain.[60] There are many different forms of arthritis. The most common form is osteoarthritis, which occurs following trauma to a joint, infection of a joint or simply as a result of aging. Other forms are rheumatoid arthritis and psoriatic arthritis, which are autoimmune diseases in which the body attacks itself. Risk factors for arthritis include female gender, older age, obesity, and work factors (e.g., jobs that require repetitive movements or heavy lifting). People who are overweight or obese report more doctor-diagnosed arthritis than thinner people. Additionally, people with arthritis tend to be less physically active: 44% of adults with doctor-diagnosed arthritis report no leisure-time physical activity compared with 36% of adults without arthritis.[61]

Cancer: Cancer is an abnormal growth of cells that tend to proliferate in an uncontrolled way. These abnormalities can be due to the effects of carcinogens, such as tobacco smoke, radiation, chemicals or infectious agents. Other cancer-promoting genetic abnormalities may be inherited or randomly acquired through errors in DNA replication. Cancer may affect people at all ages, but the risk of the more common cancers tends to increase with age.

Diabetes: Diabetes is a metabolic disorder characterized by hyperglycemia (high blood sugar). There are two types of diabetes. Type 1 diabetes is an autoimmune disease that results in the permanent destruction of the insulin-producing cells of the pancreas. It is a lifelong condition that usually begins before the age of 30. There is no known preventive measure that can be taken against Type 1 diabetes, and diet and exercise cannot reverse or prevent it. Type 2 diabetes is a metabolic disorder that is primarily characterized by insulin resistance, relative insulin deficiency, and high blood sugar. It is often managed by exercising and modifying one's diet. Its presence is rapidly increasing in the developed world. The characteristic symptoms are polyuria (excessive urine production), polydipsia (thirst and increased fluid intake), and blurred vision; these symptoms may be absent if the blood sugar is only mildly elevated.

Hepatitis B: The hepatitis B virus (HBV) causes an inflammation of the liver. Studies suggest that about 80% of liver cancers are etiologically associated with HBV infection.[13]

HIV/AIDS: Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms and infections resulting from specific damage to the immune system caused by the Human Immunodeficiency Virus (HIV).

Metabolic Syndrome: Metabolic syndrome is a cluster of conditions that often occur together, including obesity, increased blood sugar, high blood pressure, and elevated triglycerides (the chemical form in which most fat exists in food and the body), which can lead to cardiovascular disease.

Osteoporosis: Osteoporosis is a disease that weakens bones, increasing the risk of unexpected fractures. It results in an increased loss of bone mass and strength. Osteoporosis is often called the "silent disease" because bone loss occurs without symptoms.[26]

Tuberculosis: Tuberculosis, commonly referred to as TB, is a bacterial infection that can spread through the lymph nodes and bloodstream to any organ in the body, but it is usually found in the lungs. Most people who are exposed to TB never actually develop symptoms. The bacteria can live in an inactive form in the body.

The enclosed CD is intended to provide a convenient, electronic means for health care professionals, policy makers, community leaders, and individual members of the Asian American community of Montgomery County, Maryland to access the data and conclusions associated with this project. The CD contains the complete contents of this publication; the 14 summary reports of the individual community focus groups; and the focus group guide. The contents of this CD are also available online at www.AAHIinfo.org. For additional copies of this CD, or for any questions related to its use or distribution, please contact the AAHI directly.

CD Contents

Instructions and FAQ

How do I start the CD?

Insert the disk into the CD-ROM drive. If it does not start automatically, go to Start/Run/Browse, select the drive, and double click the "Home" file.

How do I search for information about a subject?

Click the search icon at the top of the screen. Type your search phrase into the field. Select "All PDF Documents in," choose CD-ROM from the field, and click on the "Search" button.

What is the list of titles in the left margin?

These links (or bookmarks) will take you to individual pages or documents on this CD.

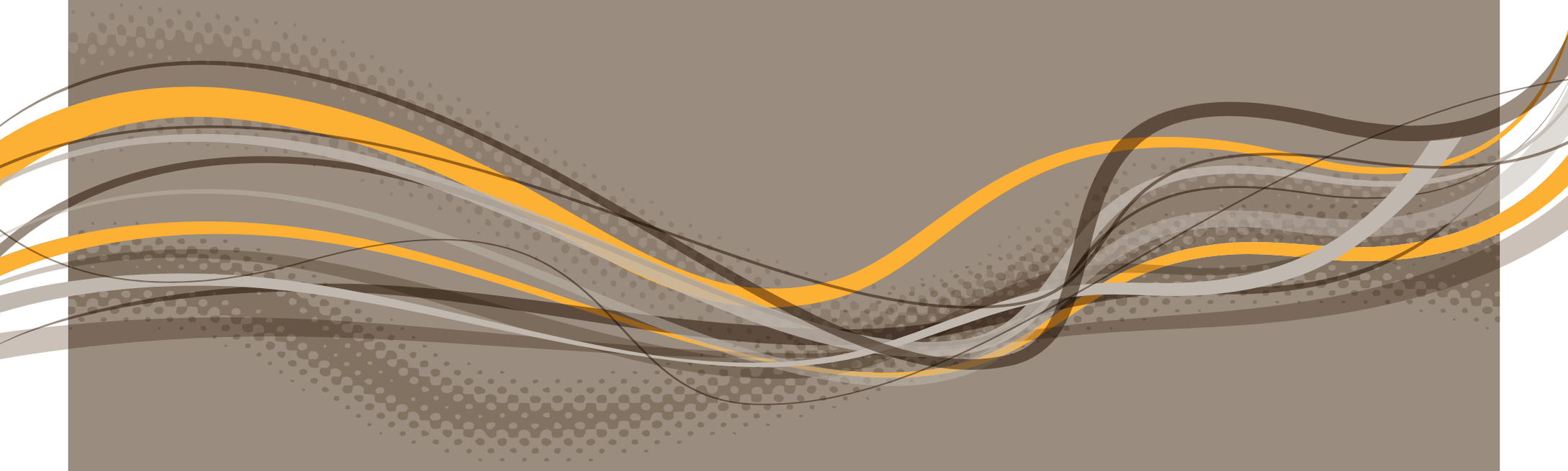
These publications are formatted in print friendly PDF files and require Adobe® Acrobat Reader.

Montgomery County
Department of Health and Human Services
ASIAN AMERICAN HEALTH INITIATIVE

1335 Piccard Drive
Rockville, MD 20850

Phone 240.777.4517
Fax 240.777.4564

www.AAHIinfo.org



Asian American Health Initiative

Together To Build A Healthy Community