PART

1

SETTING THE CONTEXT

Asian Americans and Pacific Islanders in the United States

CHAPTER

1

TOWARD A CONTEXTUAL UNDERSTANDING OF ASIAN AMERICAN HEALTH

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LEARNING OBJECTIVES

- Describe the historical development of health research in the Asian American community.
- Articulate how a focus on context can contribute to a more comprehensive understanding of Asian American health.
- Underscore the importance and relevance of this book.

INTRODUCTION

Scholars and advocates concerned with racial and ethnic disparities in health in the United States face a critical juncture. Several decades of community advocacy and health research at both local and national levels have produced an increasing number of studies and programs aimed at eliminating health disparities. Despite these efforts, racial and ethnic disparities continue to persist. A major concern is that the resources and attention allocated to addressing these health disparities are inadequate. The lack of resources for health programs and research is particularly notable in Asian American communities. The deficiency in health promotion and research funds from both foundations and government is striking and surprising given the substantive increase in Asian Americans in different geographical areas across the country (Ghosh, 2003; also see Chapter Four, this volume).

The Asian American population is growing at a faster pace than other large racial and ethnic categories in the United States. By 2050, it is projected that the Asian American population will triple in growth and represent 8 percent of the U.S. population (U.S. Census Bureau, 2007). They are also a diverse population. Asian Americans, including U.S.-born and immigrant communities, trace their diverse, ethnic heritages to numerous countries, including Bangladesh, Bhutan, Burma, Cambodia, China, Hong Kong, India, Indonesia, Japan, Korea, Laos, Malaysia, Nepal, Pakistan, Philippines, Singapore, Sri Lanka, Taiwan, Thailand, and Vietnam.[1]

Recently, important progress has been made in documenting Asian American health disparities. Advocacy groups and the health research community have placed increased attention on efforts to understand and address the causes for disease and health disparities in the Asian American population. During the past decade, there have been considerable strides and milestones in Asian American health research, as described elsewhere in this book (for example, see Chapters Four and Twenty-One). Nevertheless, many obstacles remain. Methodological issues continue to hamper the collection of data that accurately represent the Asian American community and its diverse subgroups. Existing research findings still do not translate into program and policies directed at Asian Americans.

This book examines the contextual factors affecting Asian American health. The underlying premise of the book is that a comprehensive and contextual understanding of illness and disease is essential to address health problems in diverse communities. By *context,* we mean the social, cultural, and environmental determinants, such as social institutions, neighborhoods, organizations, and policies, that are linked to different health behaviors, diseases, and well-being. A focus on different contexts allows policymakers and researchers to move beyond the medical model or a disease orientation to a framework that includes a critical investigation of the social structures that promote health and exacerbate the risk for illness.

The information presented in this book aptly demonstrates that the myth of Asian Americans as a model minority without health problems is unequivocally false. In fact, the most current national-level health data on the Asian American community indicate that when considering the tremendous ethnic diversity of Asian Americans, rates of disease morbidity and health behaviors among particular Asian American groups in some instances exceed that of the general population. For example, Barnes, Adams, and Powell-Griner (2008) recently released a report on behalf of the Centers for Disease Control and Prevention examining health characteristics of the Asian American adult population between 2004 and 2006. Figures 1.1 to 1.5 present some relevant findings on Asian American health disparities compared to the U.S. white population as reported by their study.

HISTORICAL BACKGROUND ON THE STUDY OF ASIAN AMERICAN HEALTH

Much of the early work on Asian American health issues examined the image of Asian Americans, compared to whites or other racial and ethnic minority groups, as having favorable health status and health care outcomes. This perspective is often referred to as the *model minority myth,* a term coined by sociologist William Peterson in 1966, when he argued that Asian cultures, with their emphasis on family values and strong

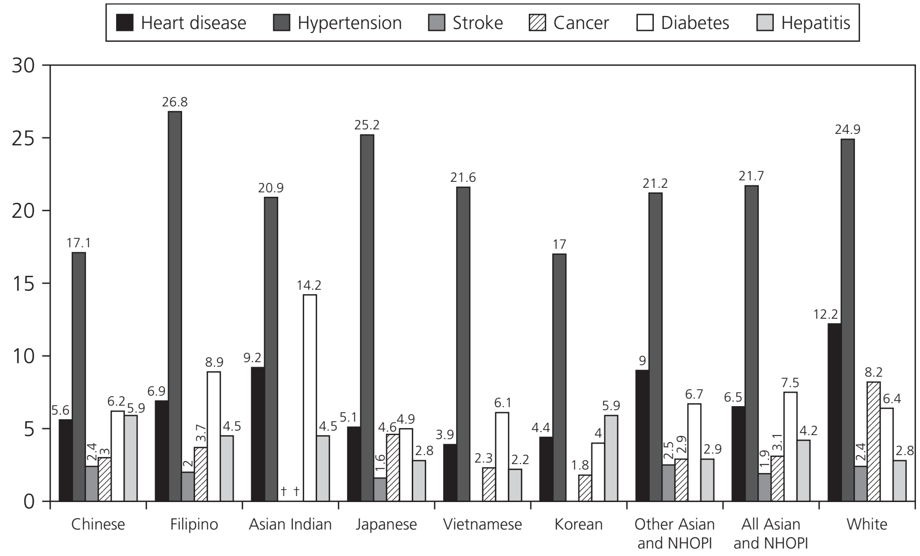

FIGURE 1.1. *Percentage of Adults Eighteen Years and Older with Selected Conditions, by Race and Ethnicity, United States, 2004–2006*

Note: NHOPI = Native Hawaiian and Other Pacific Islander.

Note: Estimates with a relative standard error greater than 50% are indicated with a dagger but are not shown.

Source: Adapted from Barnes et al. (2008).

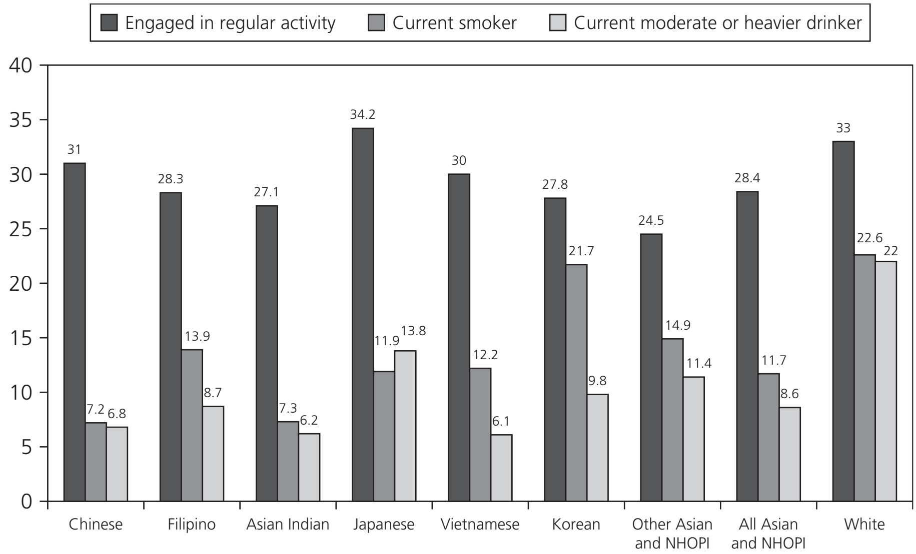

FIGURE 1.2. *Percentage of Adults Eighteen Years and Older with Selected Behaviors, by Race and Ethnicity, United States, 2004–2006*

Note: NHOPI = Native Hawaiian and Other Pacific Islander.
Source: Adapted from Barnes et al. (2008).

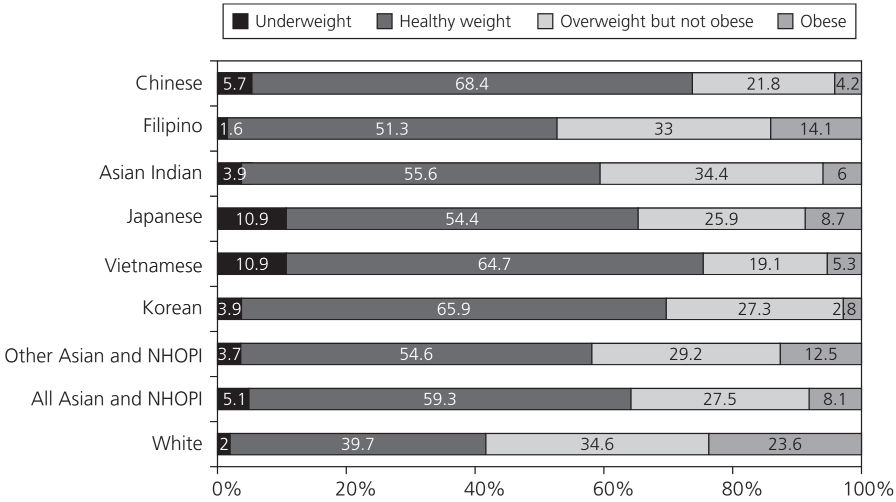

FIGURE 1.3. *Body Weight Status for Adults Eighteen Years and Older, by Race and Ethnicity, United States, 2004–2006*

Note: NHOPI = Native Hawaiian and Other Pacific Islander.
Source: Adapted from Barnes et al. (2008).

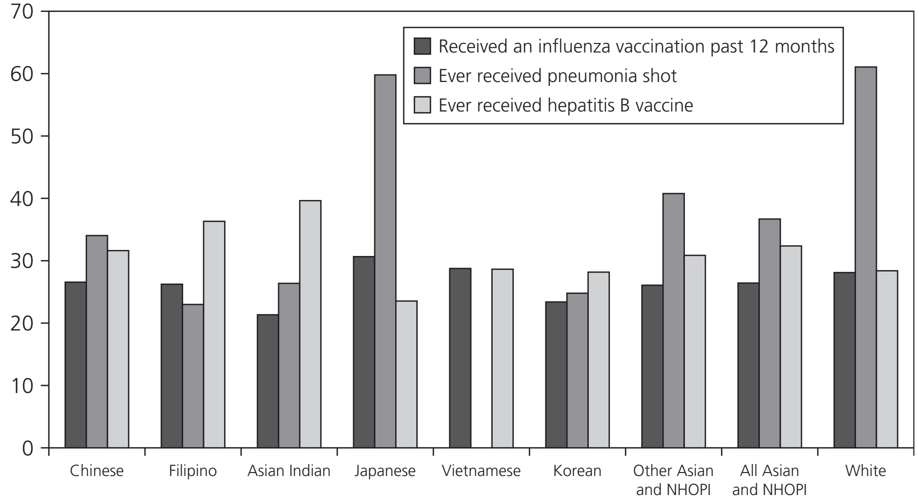

FIGURE 1.4. *Percentage of Adults Eighteen Years and Older with Selected Immunizations, by Race and Ethnicity, United States, 2004–2006*

Note: NHOPI = Native Hawaiian and Other Pacific Islander.
Source: Adapted from Barnes et al. (2008).

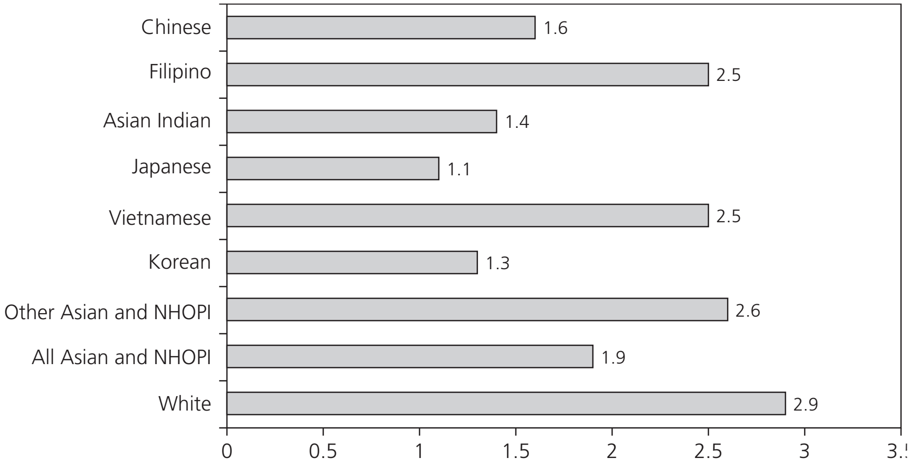

FIGURE 1.5. *Percentage of Adults Eighteen Years and Older with Feelings of Serious Psychological Distress, by Race and Ethnicity, United States, 2004–2006*

Note: NHOPI = Native Hawaiian and Other Pacific Islander.
Source: Adapted from Barnes et al. (2008).

work ethics, enabled Asian Americans to overcome prejudice and to avoid becoming a "problem minority." More than two decades later, Lin-Fu (1988) condemned the notion of Asian Americans as a model minority, particularly with regard to their health status. While other scholars had written about this topic and disputed the myth, especially on mental health issues, Lin-Fu's article, which was widely disseminated and discussed, argued that the research that had been conducted on this population was both inadequate and misleading. In fact, the majority of the data on this group was derived from epidemiological migrant studies and was limited to comparisons between native-born Japanese, Japanese in Hawaii, and the general U.S. population. As a consequence, these studies offered an incomplete perspective on the health of this diverse population (Flack, 1995). Lin-Fu (1988) cautioned that "the lack of ample data and misinterpretation of a few existing [studies], stemming from a poor understanding of the population, have caused the health problems and health care needs of this minority to be overlooked" (p. 22).

Lin-Fu's article, coupled with increasing awareness in the Asian American community that the health of its members was being ignored,[2] provided the impetus for a small group of researchers to undertake the process of dispelling the misleading notion that Asian Americans are universally "healthy, wealthy, and wise" (Chen & Hawks, 1995, p. 261). During the past two decades, researchers have documented the preventive screening practices and morbidity and mortality related to various cancers, cardiovascular disease, and mental health in the Asian American population (Chen et al., 1993; Chung & Kagawa-Singer, 1993; Kagawa-Singer, Wellisch, & Durvasula, 1997; Miller, Kolonel, Bernstein, & Young, 1996; Sue, Sue, Sue, & Takeuchi, 1995; Takeuchi et al., 1998). The early work of cancer researchers during this period was particularly influential because it illustrated that many Asian Americans are disproportionately affected by cancers of the liver, breast, cervix, and stomach compared to other groups (Miller et al., 1996; McCracken et al., 2007).

Emerging research during this period was also conducted at a local level in areas with large Asian American communities, particularly urban areas on the West Coast of the United States. The results of the research emphasized the need for community-level data in order to effectively capture the health concerns of diverse Asian groups. During the mid-1990s, researchers also began to systematically document the health needs of Asian American communities. Key among these efforts was the publication of the first textbook on Asian American health, *Confronting Critical Health Issues of Asian and Pacific Islander Americans* (Zane, Takeuchi, & Young, 1994).[3]

Corresponding with an increase in research on Asian Americans, community-based organizations (CBO) and health clinics serving large Asian American communities began to emerge in Los Angeles, San Francisco, New York, and other cities. Many of these clinics and CBOs were at the forefront in calling for social and health reform in the face of the impact and the effects of a burgeoning Asian American population. As CBOs developed, the need for resources and policy initiatives targeting the Asian American community became apparent and imperative. Organizational representatives realized the critical need for identifying, documenting, and addressing health disparities and challenges facing Asian Americans in order to advocate and secure resources for health promotion and intervention. As a result, many CBOs began to build relationships with researchers that would lead to the development of studies and interventions focusing on the health and welfare of the Asian American community. Today CBOs and health clinics continue to play an important role in advocating for locally collected, culturally relevant research and data dissemination.

With the close of the twentieth century, Asian American health concerns finally gained national momentum. This movement stems from several factors, including the growing number of researchers in the field of community-based research, an increasing number of local advocates who are striving to advance this discourse into a national forum, and recognition from local and national Asian American CBOs for combined and concerted efforts to secure federal and state support and funding. Community-based advocates and researchers have partnered to apply pressure on policymakers to deal with the unique needs and health concerns of this growing population.

Several key milestones in understanding and promoting Asian American research are described in the following paragraphs.

Importance of Disaggregated Data and Research

Advocacy efforts highlighting the problems associated with viewing Asian Americans as a monolithic group prompted the collection of disaggregated data in several national surveys and studies. Most notably, intense lobbying efforts and contributions from advisory councils consisting of Asian Americans, along with other racial and ethnic minorities, produced significant changes in racial and ethnic categories presented in the U.S. 2000 census. The 2000 census marked the first time that Asian Americans were able to indicate and be measured as belonging to one or more ethnic group categories, allowing the collection of a better demographic profile of the community.[4] In addition to changes on the census, several national health surveys, including the National Health Interview Survey, began collecting information on subgroup ethnicity.

National and Federal Awareness and Support

Researchers began working closely with federal institutions, such as the National Institutes of Health and the Centers for Disease Control and Prevention, to encourage funding for studies about Asian American and Pacific Islander communities. Researchers who had been working in these communities for the past decade were becoming more successful at securing research grants from these institutions, which facilitated the collection of long-term data on the implementation of health interventions. As a result of increased advocacy and the growing number of studies focusing on Asian Americans, the federal government began to increase support for infrastructure funding for Asian American health disparities research (for example, see Chapters Four and Seventeen in this volume). For example, as part of their Special Populations Network initiative, the National Cancer Institute funded three program projects aimed at building infrastructures to increase research, training, and outreach to reduce cancer health disparities in

Asian American communities. In 2003, the National Center on Minority Health and Health Disparities established the Excellence in Partnerships, Outreach, Research, and Training (EXPORT) Centers, which called for institutions to support health disparities research initiatives. From this mechanism, the Center for the Study of Asian American Health was established at New York University's Langone Medical Center, becoming the first, and thus far only, federally funded national center focused on promoting research on health disparities facing Asian American communities.

Value of Community-Based Participatory Research

During the late 1990s and early years of the new century, researchers working in various racial and ethnic communities began employing community-based participatory research (CBPR) as a framework for conducting research that is ethical, collaborative, and community driven. Tracing their roots back to the popular education movement made influential by Brazilian educator Paolo Freire, CBPR studies have become increasingly popular in ethnic and minority groups, particularly African American and Latino communities (Higgins & Metzler, 2001; Israel, Schurman, & House, 1989; Schulz et al., 1998). Although not reflected in the peer-reviewed literature on CBPR studies, the Asian American community has been engaged in CBPR from early on. Capturing the health needs of Asian Americans at the national or regional level has always been historically challenging; therefore, many researchers were compelled to work at the local level in order to document Asian American health disparities. For this reason, many researchers in the field were already familiar with the notion of working in conjunction with community organizations. The growing attention to participatory methods continues and has led to important implications for increased data collection, as well as to more effective and culturally relevant intervention studies in Asian American communities.

Development of Community Programs and Outreach

Corresponding with the explosion in Asian American population growth in the 1990s is the expansion of CBOs serving Asian Americans in cities throughout the United States. These organizations have facilitated the understanding of health and social welfare needs of Asian Americans through community-level outreach, programs, and research.

ISSUES CURRENTLY FACING ASIAN AMERICAN HEALTH RESEARCH

As of 2008, the Asian American health movement has added up many accomplishments. One purpose of this book is to acknowledge the significance of these achievements and, in doing so, honor and celebrate the historical impact that several decades of research and advocacy have made toward progress. Nonetheless, those in the field of Asian American health disparities research and policy are keenly aware that obstacles remain. In particular, crucial methodological challenges face Asian American health research, including the collection of accurate national and state-level data on the Asian American community.

Despite some of the advances with the 2000 census and other contemporary national data collection tools, the paucity in disaggregated data remains a challenge. Other than the 2000 census, the National Health Interview Survey, and a few state or regional surveys like the California Health Interview Survey, the majority of federally funded national and state surveys and studies continue to include relatively small Asian American sample sizes. Therefore, the data from these studies underrepresent the interests of Asian Americans and skew data outcomes. For this reason, researchers attempting to document Asian American health disparities at the national or state level are not able to effectively draw on such commonly used data sets as the Behavioral Risk Factor Surveillance Survey, the Medical Expenditure Panel Survey, and other data sets collected by the National Center for Health Statistics. Although these data sets have been used to document health disparities among Asian Americans as a whole, these findings hold limited value in providing an accurate estimate of health disparities across the board for ethnic subgroups in this diverse and growing community.

In recent decades, particularly in the 1990s, there has been increased dialogue on the idea of oversampling Asian American populations in national data sets, given that current sampling practices provide insufficient data on Asian Americans and Pacific Islanders and are inadequate for meaningful analysis for these groups. Recommendations to address this issue include additional funding for more regional and local surveys that would increase the sample size of the National Center for Health Statistics by oversampling specific Asian American and Pacific Islander subgroups in the ten U.S. states with the greatest Asian American and Pacific Islander populations. Specificity in survey methodology, taking into account Asian American populations, is critically important for measuring geographical and ethnic variations among Asian Americans (Yu & Liu, 1992; Srinivasan & Guillermo, 2000).

Complicating the issue of data disaggregation is the means by which Asian ethnicity is classified in national surveys. Asian Americans represent a diasporic community; as such, many Asian immigrants may trace their ethnic heritage to one country but their national origin to another.[5] For example, Lin, Clarke, O'Malley, and Le (2002) point to the substantial methodological challenges of Surveillance, Epidemiology, and End Results (SEER) data sets, an important resource for the study of cancer incidence and mortality. In this data set, information on birthplace is often used as a proxy for immigrant status and ethnic identity. This presents challenges because of the unknown accuracy of this classification, thus providing incomplete information for major pockets of the Asian American population.

Another problem related to data collection is the language in which surveys and other studies are conducted. This problem is of particular concern because no national health surveys collect data in any languages other than English or Spanish. Given the high rates of linguistic isolation and limited English proficiency in the Asian American community, the degree of error that exists in offering English- or Spanish-language-only surveys is acute. Such surveys may exclude a substantial limited-English-proficient population whose lack of comprehension of English or Spanish would automatically preclude their total or full participation in these studies. Linguistic isolation has been associated with lower socioeconomic status and poorer health status; thus, data from national surveys may be skewed and underrepresent health disparities existing in the Asian American population (Srinivasan & Guillermo, 2000).

A corresponding issue to language barriers is the data collection method of many national and state health surveys. In an effort to ensure that data are generalizable to entire groups, the most widely used data collection technique to survey households is telephone administered through random-digit-dialing methods. Such survey techniques fail to capture parts of the population without telephone access, who also tend to be underserved, or those who are unavailable at the times when the surveys are conducted, including working-class individuals in occupations with nonstandard work hours (Blumberg & Luke, 2008; Lee & Cheng, 2006).

Researchers committed to understanding Asian American health disparities face a major trade-off. By using national and state data sources, they can access data that are generalizable in the methodological sense to the general population or to English-proficient Asian Americans. But such data sets do not capture the health needs of a large segment of the Asian American population with the greatest health challenges. Consequently many researchers and advocates collect data at the local level using convenience sampling and other community-based techniques instead. Such samples may more accurately represent and provide information on the most underserved segments of the Asian American community. However, these studies are limited in their applicability to the population at large and are perceived as less scientifically rigorous or authoritative in nature.

However, recent studies have documented that the use of random samples in providing more generalizable and accurate data for the group may be overstated when it comes to particular subgroups in the Asian American community. For example, Lee and Cheng (2006) conducted a study that compared random and convenience sampling strategies in the Chinese and Korean communities in New Jersey and concluded that differences between participants based on sampling strategies were not remarkable. The authors suggest that by engaging in careful site selection, purposive or convenience sampling of the Asian American community can provide data representative of the community.

Another research challenge for researchers includes issues related to the geographical distribution of the Asian American population. Asian Americans are primarily concentrated in large urban areas of the United States, such as New York City, Los Angeles, San Francisco, and Houston. Despite this fact, national data collection efforts frequently are structured so that the geographical distributions of Asian Americans are not considered, and therefore they are not as well represented. The SEER data set provides an example of this problem. The SEER registry, the only federally funded national registry of cancer incidence in the United States, currently has sites located in a limited number of regions.[6] Although the registry has sites based in California, there are none in New York State, home to the second largest Asian American population in the country. Indeed, the only SEER registry sites on the East Coast are in Connecticut, which has a comparatively small Asian American population, and New Jersey, which was added as a SEER site in late 2001. Given this limitation, many studies that report on national rates of Asian American cancer incidence draw data and support from SEER data sets and are in reality overrepresenting data from the West Coast.

The issue of representative samples is not limited to national health and disease data on Asian Americans; it also marks the majority of peer-reviewed published literature on Asian Americans. Many of these studies are reporting on data collected from communities residing on the West Coast, particularly in California, Hawaii, and Washington. Because the social and immigration histories of Asian Americans are vastly different depending on geographical location, it is inaccurate and inappropriate to apply data assumptions and results from one region of the United States to another region that may experience its own unique set of health and community challenges and conditions.

In addition to factors related to the growth of this expanding population, researchers must take into account the geographical concentration and dispersal of this group within the United States. It is predicted that as the Asian American population continues to grow, it will also become more spread out. Over the past decade, overall immigrant growth rates have been particularly high in North Carolina (274 percent growth rate), Georgia (233 percent), Nevada (202 percent), Arkansas (196 percent), Utah (171 percent), Tennessee (169 percent), Nebraska (165 percent), Colorado (160 percent), Arizona (136 percent), and Kentucky (135 percent)—states not originally considered traditional immigrant settlement areas. Similarly, the Asian American population growth trends have been tremendous in smaller cities throughout the United States (U.S. Census Bureau, 2007). Future studies will need to consider and account for these growth trends in order to accurately measure and collect data on this group.

Another methodological challenge involves intervention studies and the recruitment of Asian Americans into clinical trials. Traditional intervention research and clinical trials in the United States do not fully represent Asian Americans. This has important implications on the applicability of evidence-based strategies or clinical practices for this community. It has often been argued that one of the reasons for the lack of Asian Americans in intervention studies and clinical trials is due to linguistic and cultural difficulties associated with recruiting Asian Americans and Pacific Islanders into these clinical trials. As later chapters in this book demonstrate (for example, see Chapter Sixteen), such claims are often unwarranted. Through the promotion of good research practices and partnerships that incorporate contextual issues within the specific community, researchers will encounter Asian American community members willing to participate in studies designed to promote community health and well-being (Nguyen et al., 2006).

The wide dissemination of study findings poses another problem for Asian American disparities researchers. Although there have been recent strides in the number of studies published on Asian American health disparities, the proportion of these studies pales in comparison to the size of the population (Ghosh, 2003). In fact, researchers reporting on studies conducted in Asian American communities often experience difficulties in publishing their findings in peer-reviewed journals. Many reviewers and editorial boards are dismissive of Asian American health studies, arguing that they are limited in their generalizability due to sampling methods or small sample sizes.

A final challenge confronting Asian American health research is the underuse of theoretical frameworks and constructs to guide the research design and analysis. This challenge is certainly not new to the field and is frequently highlighted in influential works on Asian American health (Zane et al., 1994). The documentation of trends in morbidity, mortality, and risk factors for disease is based primarily on epidemiological research that may not be theoretically guided. Health statistics, often generated from government-sponsored national surveys and registries and clinical research, drive national policies regarding health planning and allocation of resources (Lin-Fu, 1988). For that reason, the importance of improving data collection efforts in the Asian American population is particularly salient. Without that information, Asian American health issues are often overlooked or ignored. Thus, the need for theoretically relevant research must be balanced with the need for empirical data on the Asian American community.

FOCUS ON CONTEXT: A NEW LENS TO UNDERSTAND ASIAN AMERICAN HEALTH

A large proportion of the literature regarding Asian American health has focused on individual-level risk factors of health. The premise of the book is to shift focus away from individual-level factors and place attention on the overall context that these individual-level factors play in the larger landscape. By *context,* we mean the set of interrelated conditions in which something exists or occurs. For all populations, health and illness occur in a number of contexts:

- Structural—for example, social policies and political systems
- Institutional—for example, workforces, religious institutions, and schools
- Historical—for example, immigration histories or the political and social histories of home countries
- Community and family—for example, family structures
- Geographical—for example, neighborhoods and environments
- Cultural—for example, systems of beliefs and practices

By putting these conditions into proper perspective, researchers can view the role that context plays in Asian American health and better understand how health disparities develop and evolve. Health, programmatic, and policy interventions can be developed that target particular contexts and concerns in order to maximize effectiveness and efficacy in the communities being served (National Institutes of Health, 2001).

As described in greater detail in the following chapters, considerable strides have been made in research, programs, and policy for the Asian American population. However, much more work remains to fully address, reduce, and finally eliminate disparities in health status and access to care for many Asian American communities. The Asian American health movement is at a pivotal point. Although much epidemiological research is being collected, there also needs to be a transition to a more holistic approach and understanding of health. This can be accomplished by integrating an understanding of context into all aspects of future research, programmatic, and policy efforts dedicated to addressing Asian American health disparities.

RELEVANCE OF *ASIAN AMERICAN COMMUNITIES AND HEALTH*

For researchers, health providers, advocates, and community members who have been working in the field of Asian American health and disparities, the need for this book may seem obvious. For individuals who are interested in careers related to Asian American health, this book may shed light on what has been done and what challenges and gaps remain. By examining Asian American health through the lens of context, this book is both timely and relevant for several reasons.

The first, and perhaps most compelling, reason is that the demographic shifts and explosive growth of the Asian American population necessitate a different and much more comprehensive approach to address the health needs of this population. In order to ensure that disparities that Asian Americans face are not exacerbated as the population continues to expand, it is increasingly imperative that programs and policies place stronger emphasis on understanding the diversity of this community. With an aging Asian American population, changes in migration and immigration patterns within the United States, and changes in immigration trends to the United States, understanding the impact of local contexts is critical to developing and implementing effective health programming and policies tailored to these communities.

Second, this book seeks to address social justice and equity concerns facing the Asian American community. Demographic realities should not be the deciding factor in the distribution and dissemination of health resources to particular groups or communities. Health equity and social justice frameworks (Castells, 2000; Chen & Berlinguer, 2001) call for a democratization of health and are based on moral values such as universality and social solidarity. In many ways, the promotion of Asian Americans as model minorities lends itself to the misperceptions of Asian Americans as devoid of health problems, which leads to the Asian American community's receiving limited access to resources, power, and funding for health programs. The positive image of a model minority undercuts and marginalizes the needs and concerns of the very group it praises. One of the goals of this book is to invalidate this myth and then embrace the diversity of Asian Americans and other racial and ethnic minority communities in America. This book serves as a stepping-stone in the larger movement to democratize health in America.

By contextualizing Asian American health, this book uses an interdisciplinary approach. The transition from simply documenting morbidity and mortality among Asian Americans toward promoting a holistic understanding of the group's health and well-being demands attracting a larger and more interdisciplinary workforce to the field of Asian American health research. Therefore, social epidemiologists, community advocates, social service providers, social workers, government officials, physicians, nurses, economists, sociologists, psychologists, and anthropologists are major contributors to this book. The collaboration among these diverse and varied professions is the foundation of the future of public health.

Finally, the emphasis on understanding health in context is not a limited viewpoint of the editors and chapter authors of this book. Researchers, government officials, and funding agencies also realize that an integrated approach is essential to understanding health and illness (National Institutes of Health, 2001).

STRUCTURE OF *ASIAN AMERICAN COMMUNITIES AND HEALTH*

Asian American Communities and Health is designed to serve as a dynamic and critical reflection on the current state of Asian American health disparities in the United States. It also aims to be a comprehensive resource for health researchers, health professional students, community advocates and service providers, and policy and other decision makers wishing to better understand the unique health challenges facing the Asian American community.

This book is divided into six parts. Part One sets the stage to explore Asian American health in context. In Chapter Two, Winston Tseng provides an overview of the social history of Asian immigration to the United States, as well as the current demographic realities of this diverse community. Tseng's chapter is significant in that it illustrates the first examples of racism and discrimination toward Asian American communities and the impact that led to adverse economic and health inequities for this population. In Chapter Three, Sela Panapasa gives a similar overview of the complex history and current situations of Pacific Islanders in the United States and affiliated jurisdictions. Panapasa demonstrates the tremendous diversity of the Pacific Islander community and underscores the need to separate the health issues that affect Asian American from Pacific Islander communities. Chapter Four, by Chandak Ghosh, examines baseline data and funding for the Asian American and Pacific Islander community by exploring gaps in research funding by public and private agencies.

Part Two examines health across the life span and for special populations. Chapter Five, by Stella Yu and Amita Vyas, and Chapter Eight, by Tazuko Shibusawa and Irene Chung, address important health issues by life stages, along with unique cultural and social challenges facing Asian American youth and the elderly. Chapter Six, by Sora Park Tanjasiri and Tu-Uyen Nguyen; Chapter Seven, by John Choe; and Chapter Nine, by Sel Hwahng and Alison Lin, examine health issues through the dimensions of gender and sexual identity. These chapters focus on health priority areas that are particularly relevant to minority communities: rates of immunization, cancer, cardiovascular disease, diabetes, infant mortality, HIV/AIDS, other infectious diseases like hepatitis B, and mental health. These chapters are framed by social and cultural issues relevant to the life span and special populations.

Part Three addresses cross-cutting issues that are increasingly relevant to the health of Asian Americans. In Chapter Ten, Darshan Mehta and Ellen McCarthy examine the historical, cultural, and social significance of complementary and alternative medicine in Asian American communities. Chapter Eleven, by Marguerite Ro, Jinny Jihyun Park, and Deeana Jang, and Chapter Twelve, by Ninez Ponce, explore the complex and multifaceted issues of access to health care for Asian Americans. Gilbert Gee and Annie Ro explore the impact of racism and discrimination on the health of Asian Americans in Chapter Thirteen. And in Chapter Fourteen, Pam Tau Lee examines occupational and environmental health issues faced by segments of the Asian American community in disenfranchised workplaces and geographical areas.

Part Four offers a comprehensive examination of the process, benefits, and challenges of community-based research efforts in the Asian American community. Grace Ma and Gem Daus appraise the current state of knowledge on health interventions in the Asian American community in Chapter Fifteen. In Chapter Sixteen, Darius Tandon and Simona Kwon give an overview of CBPR efforts in the Asian American community, highlighting successful models and considerations for future research. Chapter Seventeen by Chau Trinh-Shevrin, Nadia Shilpi Islam, and Mariano Jose Rey explore the promotion of CBPR at the institutional level and implications for the Asian American community. Chapter Eighteen, by Traci Inouye, explores an innovative model for evaluating interventions in Asian American and other minority communities.

Part Five offers chapters on challenges and promising solutions to ameliorate the health of the Asian American community. In Chapter Nineteen, Marguerite Ro argues that particular Asian American subgroups are underrepresented in various health fields and explores important implications on leadership development in the field. In Chapter Twenty, Thomas Tsang, Kevin Lo, and Jeffrey Caballero underscore the important role of community health centers for the Asian American community. In Chapter Twenty-One, Deeana Jang and Ho Tran examine health policy and advocacy in the Asian American community, offering recommendations to systematically influence policy to promote the well-being of Asian Americans.

The final part of the book offers chapter briefs on issues of importance to the Asian American community where the state of knowledge is still nascent. The topics addressed are disability (Chapter Twenty-Two, by Peter Wong and Lois Takahashi), oral health (Chapter Twenty-Three, by Kavita Ahluwalia), gambling addiction (Chapter Twenty-Four, by Timothy Fong), and the burgeoning area of genetic testing and profiling (Chapter Twenty-Five, by Joon-Ho Yu) in the Asian American community.

USING *ASIAN AMERICAN COMMUNITIES AND HEALTH* AS A TEACHING AND EDUCATIONAL TOOL

This book has also been designed to serve as a dynamic overview of Asian American health that can be used to facilitate thought-provoking discussions, lectures, and brainstorming sessions on how to effectively address the health of this population. The book has integrated several key features that can be used to this end:

- Each chapter begins with learning objectives that readers should walk away with as a result of reading the chapter. Chapters conclude with discussion questions that can be used to facilitate dialogue on themes and issues highlighted in the chapters.

- Case studies present fictional or real-life situations that are of particular relevance to the topic of the chapter. They may be especially useful in encouraging groups to work together as a team to think through problems or challenges in the field.
- "Communities taking action" vignettes honor the theme of understanding local context that is central to this work. These stories and vignettes of Asian American CBOs taking action on particular issues in their communities have been integrated into chapters.

TERMINOLOGY AND PRESENTATION OF DATA IN *ASIAN AMERICAN COMMUNITIES AND HEALTH*

Given the diversity of the Asian American community and a changing history of how racial and ethnic groups have been categorized by the U.S. government, the use of consistent terminology regarding the Asian American community presents a challenge. In this book, Asian Americans are defined using the U.S. Census 2000 classification of "individual people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent." Asian Americans are a race as defined by the 2000 census. Within the umbrella term of *Asian American* are various ethnicities described in the first part of this chapter. Much has been written regarding the problematic use of the term *Asian American.* In particular, scholars have noted that the term tends to conflate race, culture, and ethnicity (Kagawa-Singer, 2006).

In *Asian American Communities and Health,* this classification has been used in order to present study results and analyses consistent with existing federal efforts and scientific literature. It is important to note, however, that the continent of Asia is home to numerous countries that are not included in the definition of *Asian American.* Recent decades have seen increased migration to the United States from countries in the Middle East and parts of western Asia such as Uzbekistan and Afghanistan. Immigrants from these countries share many commonalities with other Asian American immigrants. For example, many Middle Eastern immigrants are Muslim, as are many immigrants from Pakistan, Bangladesh, Malaysia, and Indonesia. Indeed, many CBOs serving Asian Americans have begun reaching out to Middle Eastern and other immigrants who hail from countries in Asia that are not currently included in the census-defined *Asian American* term. Going forward, the federally recognized definition of *Asian Americans* may be expanded to include groups that come from other parts of the continent of Asia.

Another challenge related to terminology is the aggregation of Asian Americans and Pacific Islanders in many studies. In 1997, the Office of Management and Budget (OMB) recognized the need to measure Pacific Islanders as a distinct group and revised OMB Directive 15, splitting the broad "Asian and/or Pacific Islander" category into two separate groups, "Asians" and "Native Hawaiian and Other Pacific Islander." This directive stipulated that federal agencies collect and present information on these racial populations separately by the year 2003. Thus, federal agencies classify and present data on Asian Americans and "Native Hawaiians and Other Pacific Islander" apart from each other (Ingram et al., 2003). However, the majority of studies targeting the Asian American population were conducted prior to 2003, and these studies collected data from both communities (Asian Americans and Pacific Islanders) as an aggregated group. Today in many areas of the country (most notably California), CBOs and researchers reach out to both Asian American and Pacific Islander communities to gain more insight and knowledge of their needs. Thus, many of those efforts and studies are summarized and highlighted in this text.

The editors of this book acknowledge the tremendous diversity that exists within the Pacific Islander population. Chapter Three explores this diversity by documenting the social, demographic, and cultural characteristics of U.S. Pacific Islanders. It is important to recognize current political realities regarding classification of racial and ethnic groups and the reasons for disaggregating Native Hawaiians and Other Pacific Islanders from Asian Americans. Native Hawaiians and Other Pacific Islanders experience large disparities that are masked when the Pacific Islander population is aggregated with the Asian American population. The editors of this book contend that the issues of Native Hawaiians and Other Pacific Islanders warrant exclusive attention, including the publication of a future text on the health of this population.

Asian American Communities and Health seeks to highlight the challenges that exist in the Asian American population. In addition, the book illustrates the inherent struggle for researchers to distinguish the health concerns for Asian Americans from those of the Pacific Islander community. For example, various chapters in this book also include study findings and programmatic efforts that target Pacific Islander communities. In addition, chapters include findings from studies that present aggregated data on Asian American and/or Pacific Islander. In general, the book attempts to present disaggregated data by ethnic subgroup wherever possible (for example, as Asian Indian, Vietnamese, or Tongan). However, studies that have collected aggregated data combining several Asian American subgroups (for example, South Asian or Southeast Asian) are also included where applicable. In presenting demographic information, particularly from the 2000 census, the book provides data that include Asian Americans who self-identified as belonging to more than one race in order to better reflect the breadth of this growing community.

The use of terminology and acronyms to describe Asian Americans and Native Hawaiians and Other Pacific Islanders has been made as consistent as possible and is summarized below:

- For studies including aggregated data on Asian Americans only, *Asian American* is used.
- For studies including aggregated data on Asian Americans and/or Pacific Islanders (for example, studies conducted prior to 2003), the term *Asian American and Pacific Islander* is used. For studies including data on Native Hawaiians and Other Pacific Islanders, we use *Native Hawaiians and Other Pacific Islander* or *Pacific Islander*. Although the phrase *Native Hawaiians and Other Pacific Islander* is

in accordance with OMB Directive 15, controversy exists among community advocates and scholars regarding the use of the term *other* in this phrase. For this reason, some authors have chosen to use the phrase *Pacific Islanders.* The acronym used for *Native Hawaiians and Other Pacific Islanders* is NHOPI; that for *Pacific Islanders* is PI.

NOTES

1. See Chapter Two for a further explication of Asian Americans in the United States.
2. For example, in 1985, the U.S. Department of Health and Human Services released the *Report of the Secretary's Task Force on Black and Minority Health* (see Chapters Four, Twenty, and Twenty-One in this volume).
3. Other textbooks relevant to Asian American health disparities were also published during this time (Hayashi, 2003; Lee, 1997; Ma, 1999; Zhan, 1999; Zhan, 2003).
4. In addition, the U.S. Census Bureau worked with community agencies and employed thousands of bilingual census administrators so that individuals were able to complete the census in their native language.
5. For example, many Asian Indians are born in parts of East Africa, and Chinese are born in Vietnam.
6. Current SEER sites are in Connecticut, Iowa, New Mexico, Utah, Louisiana, New Jersey, Puerto Rico, and Hawaii and the metropolitan areas of Detroit, San Francisco–Oakland, Atlanta, Seattle–Puget Sound, Los Angeles County, and four counties in the San Jose–Monterey area south of San Francisco.

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