DEVELOPING AN ASIAN PACIFIC HEALTH AGENDA

A project submitted in partial satisfaction of the requirements for the degree of

Master of Public Health

by

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ABSTRACT

DEVELOPING AN ASIAN PACIFIC HEALTH AGENDA

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Promoting the good health of the Asian and Pacific Island communities calls for the removal of specific barriers relevant to their utilizing the full range of available health services and the development of new, more appropriate health services. Heretofore, little has been known about the health status of Asian Pacifics, residents of the United States from East Asia, Southeast Asia, South Asia, the Indian Subcontinent, and the Pacific Islands. Similarly, health education programs and the provision of health care services have been hampered by this lack of available data.

The purpose of this project was to develop an Asian Pacific health agenda, a collective gathering of health data and an outline of recommendations to be considered and acted upon, for California that could be utilized by
public health educators and administrators and public health policymakers on the federal, state, and local levels of government. The project was subdivided into four phases of development: 1) review and analysis of the pertinent literature; 2) informal meetings with leaders of Asian Pacific communities; 3) development of the health agenda; and 4) formulation of recommendations for federal, state, and local governments.

The health agenda was divided into three major areas: 1) Health Status of Asian Pacifics; 2) Health Issues and Concerns of Asian Pacifics; and 3) Recommendations for Federal, State, and Local Policymakers. The final draft of the agenda was the result of analyzing the outcome of the literature review and the information from Asian Pacific-focused services providers, summarizing the information into an outline that met with the approval of the Investigator's field supervisor, and formulating recommendations for consideration and action by health policymakers.

Findings from the literature review indicate that the lack of data on the health status of Asian Pacifics and the belief that Asian Pacifics are a model minority have hampered the provision of Asian Pacific-focused health care services. The agenda developed in this study can provide some indicators of the physical health status of Asian Pacifics and would aid policymakers in recognizing
that a major gap exists in California between the health status of Asian Pacific communities and the health services policymaking affecting these groups on all three levels of government. Awareness of this gap could result in more adequate and appropriate health care services for Asian Pacifics.
Chapter 1

INTRODUCTION

Current demographic information has shown that the Asian and Pacific Island population has more than doubled since the 1970 Census (Bureau of the Census, 1980). In Los Angeles County alone, the Asian and Pacific Island population has expanded by 150 percent (County of Los Angeles, Department of Health Service, 1982). Many factors contributing to this growth (e.g., economic crisis in many Asian and Pacific Island countries, political conflict, and expansion of business), coupled with the unique cultural and geographic idiosyncrasies of the many different Asian and Pacific Island countries, have created a complex and intricate Asian and Pacific Island community.

However, the diverse character of the Asian and Pacific Island communities goes beyond size and ethnic heterogeneity. Factors, including generational differences where a community may have a fifth, as well as a first, generation linguistic difference and dialect variation according to various regions within the homeland, culturally specific mores, racial characteristics and other aspects all affect the nature and composition of the Asian and Pacific Island communities. Whereas the Asian and Pacific Island people are viewed by the majority culture as one single community, it is actually many
different communities tied together by the commonality of
the Asian Pacific experience in America, Asian Pacific
history, culture, and philosophy.

Given the diversity of the population, where there
are no less than 20 Asian Pacific categories (Bureau of
the Census, 1980), it is not surprising that very little
is known about the health status and behaviors of Asian
Pacifies. The majority of the published data on Asian
Pacifies focus on demographics other than health (e.g.,
population growth, immigration trends, age, employment and
occupation, education, and income) and very little empha­
sis is aimed at the health issues of these groups (Bureau

Statement of the Problem

There is a lack of data concerning the health status
and behaviors of Asian Pacifies. In fact, inappropriate
health education programs and health care services reflect
this lack of data (Blane, 1979; Dana, 1981; Goldfield and
Lee, 1982; Muecke, 1983). This problem is especially
severe for newly arrived immigrants and refugees into the
United States who, until recently, were lumped into an
"other" category in most data collection efforts.

Other barriers to utilizing health care services
include the absence of bilingual/bicultural personnel and
providers (coupled with professional licensing problems
of foreign-born health providers), lack of translated
health education materials, lack of funds, the inaccessibility of services (on both physical and psychological levels), the absence of culturally relevant treatment techniques, and the lack of knowledge about available service providers.

These barriers, combined with the lack of data of Asian Pacific health issues, have resulted in public health programs that are inadequate and inappropriate. Furthermore, health care policymakers have heretofore been unaware, and therefore unresponsive, to the special needs of these groups and current health care policies reflect this neglect.

**Purpose of the Project**

The lack of data and the underutilization of services prompted the Asian Pacific Planning Council (APPCON), of which the Investigator served as a student intern for the duration of her thesis project, to propose the development of a health agenda.

The purpose of the project is:

1) To conduct a literature review and hold informal discussions with Asian Pacific-focused services providers to determine the extent of health problems within the Asian Pacific communities;

2) To utilize the results of the literature review and discussions with Asian Pacific-focused services providers in the development of a health
agenda that would serve to make health educators, health administrators, and public health policymakers aware of the existing problems of inappropriate health services as they pertain to Asian Pacifics by presenting a collective gathering of available health data and the health issues raised by these communities that reflect a major gap between the needs of Asian Pacifics and the current public health care services.

3) To formulate recommendations for federal, state, and local governments for the successful implementation of appropriate health care services within the Asian Pacific communities.

Background on APPCON

The Asian Pacific Planning Council (APPCON) was established in 1977 to promote and enhance communications between the Asian Pacific community, local, state, and federal government, and other policymakers. It exists today as a coalition of Asian Pacific human service agencies, cultural groups, and other organizations (see Appendix B) deeply concerned about the needs in the Asian Pacific community. The goals of the organization are to inform, educate, and advocate on behalf of the community with regard to human service needs and community problems.APPCON seeks to coordinate existing resources and plan for future services needed in the Asian Pacific community. It
acts as a liaison with the larger community in articulating a collective voice on social service concerns. In this facilitating, coordinating, and planning role, APPCON continuously seeks the input of the community, strives to identify obstacles to the general health and welfare of the Asian Pacific community, and formulates strategies for addressing these needs.

Limitation of the Project

This project is limited to Asians and Pacific Islanders residing in the State of California, with specific focus on those residing in Los Angeles County. It also is limited to health services and policies as they pertain to the federal, state, and local levels of government in the cities and counties of California. The project examines characteristics of the Asian Pacific communities through the analysis of data from various existing sources, published and unpublished.

Definition of Terms

The following definitions are pertinent to this project:

Asian Pacific: A generic term that groups numerous Asian and Pacific Island people, who are culturally, ethnically, and linguistically distinct populations, together. It is made up of people from Japan, China
Health Agenda: A collective gathering of Asian Pacific health data aimed at making federal, state, and local public health policymakers aware of the special needs of Asian Pacifics and that more appropriate health care services are needed for these groups. It includes recommendations for policymakers for the improvement of current health care services.
Chapter 2

REVIEW OF THE LITERATURE

The Literature Review examined five areas that are relevant to this project. They are: 1) sources of data on Asian Pacifics; 2) the Asian Pacific population in the United States and California; 3) extent of problems among Asian Pacifics; 4) major health concerns of Asian Pacifics; and 5) other barriers to health services.

Sources of Data on Asian Pacifics

The National Center for Health Statistics (NCHS), the federal agency mandated to collect, analyze, and disseminate national health statistics and epidemiological data, maintains three independent sets of records that provide information on the health of Asian Pacifics: The National Health Interview Survey (NHIS), the National Ambulatory Medical Care Survey (NAMCS), and the birth and death records for the entire United States. Data on Asian Pacifics from the birth and death files related to infant mortality (Yu, 1982) and data on adult mortality (Yu, et al., 1984) have been analyzed and published. However, with the exception of an article by Yu, Drury, and Liu (1981) and a paper by Yu and Cypress (1982), data on Asian Pacifics based on NHIS and NAMCS resources have, for the most part, remained unpublished.
The only available source for uniform data on Asian Pacifics is the United States Census. This project recognizes that due to the rapid pace of immigration, it is inevitable that data from the Census may provide a dated picture of Asian Pacifics as of 1986. Furthermore, some community leaders believe that Asian Pacifics with language problems, an inability to understand the Census, and a fear of authorities were not counted in the last Census (United Way, Inc., 1985). However, in spite of these limitations the United States Census still remains the best source of data available on the characteristics of people from Asia and the Pacific Islands.

The data from the United States Census and other published documents, such as reports from the American Cancer Society, the Asian American Field Survey, and the 1982 Vital Statistics Report for the County of Los Angeles, will be reviewed in order to provide some indicators of the health status of Asian Pacifics. The unpublished data of the NCHS and a few available studies, some of which are still in progress, will also be reviewed (American Heart Association, 1983; AADAP, 1985; Kitano and Hatanaka, 1983; L.A.R.F.P.C., 1984; Los Angeles County Office of Alcohol Programs, 1984; Rokaw, 1984).
The number of Asian Pacifics in the United States has more than doubled in the past ten years, increasing from 1.5 million in 1970 to 3.5 million in 1980 (Bureau of the Census, 1980). While European immigrants established their primary entry points on the East Coast, Asian Pacifics established their communities in the West. By 1980, 36 percent of the nation's Asian Pacific population resided in California. The desire to settle in California may have been influenced by the high concentration of previous Asian Pacific immigrants and the establishment of social and cultural landmarks such as Chinatown, Little Tokyo, and Manilatown, which ease the transition of living in a foreign land (United Way, Inc., 1985).

In 1970, the Asian Pacific population comprised 2.8 percent of California's population and by 1980 it rose to 5.5 percent of the State's population. With the continuing arrival of immigrants from Asia and the Pacific Islands, it is estimated that the 1985 population of Asian Pacifics in the United States was 5,147,900, which would place California's estimate (at 36 percent of the total United States Asian Pacific population) at approximately 1,853,000 (Gardner, et al., 1985).

In Los Angeles County alone, the Asian Pacific population has expanded by 150 percent (Los Angeles County Vital Statistics Report, 1982). The 1980 Census indicates
that 434,823 Asian Pacifics, representing 5.8 percent of the total County population, resided in Los Angeles in that year. The surge in the Asian Pacific population during the 1970s exceeded that for all other ethnic groups, including persons of Hispanic origin.

Many factors contributed to this dramatic growth in population. The 1965 Immigration Act, effective as of 1968, and the 1975 Refugee Act, following the fall of South Vietnam and other parts of Indochina, made legal immigration to the United States possible. Economic crisis, as well as political conflict, also contributed to the tremendous growth (Keely, 1971). An even greater increase in the Asian Pacific population is expected by the 1990s (Yu, et al., 1984).

**Extent of Problems Among Asian Pacifics**

Despite such an increase in population numbers, the health status and behaviors of persons of Asian and Pacific Island background is perhaps the least understood (Weaver, 1976; Lieu, et al., 1976; True, 1980). Until 1976, Asian Pacifics were identified in the National Health Interview Survey as persons of "other race" (Drury, et al., 1980). Since then, efforts to improve the quality of racial classifications used in the survey have been undertaken and now respondents of Asian or Pacific Islander backgrounds may identify themselves as "Asian or Pacific Islander." This improvement in the categorical
The definition of Asian Pacifics may also account for the increase in growth documented in the 1980 Census.

Perhaps the most basic point to realize is that NHIS data cannot be separated to identify the diversity of peoples included under the term "Asian Pacific." They do not share a common language or descent and this heterogeneity is amply illustrated by the 1980 Census which included no less than 20 categories of Asian Pacifics (Bureau of the Census, 1980). The term "Asian Pacific" designates residents of the United States from the following countries and territories:

East Asia: Japan, China (including Hong Kong and Taiwan) and Korea

Southeast Asia: Cambodia, Laos, Vietnam, Thailand, Malaysia, Singapore, Indonesia, and the Philippines

South Asia or Indian Subcontinent: India, Bangladesh, Sri Lanka, Pakistan, and Burma

Pacific Islands: Hawaii, Samoa, Tonga, Guam, Fiji, and other islands of Micronesia

However, only a few of these groups (Japanese, Chinese, Korean, Filipino, and Vietnamese) are identified in federal health information systems and despite the fact that these five peoples are heterogeneous, the practice of lumping them into a single ethnic group is currently
accepted by many programs locally, statewide, and federally (Bouvier and Agresta, 1985).

Furthermore, Asian Pacifics are stereotyped as a model minority and the belief that they are a successful minority is widely held (United Way, Inc., 1985). This stereotype assumes that Asian Pacifics are model citizens who do not have significant problems such as delinquency, alcoholism, mental instability, and poverty (Kitano and Sue, 1973; United Way, Inc., 1985). One consequence of this stereotype is that it is often believed there is no need for special Asian Pacific-focused services. Another related consequence is that this stereotype perpetuates the belief that Asian Pacifics provide services within their own communities, without the need for public aid from the broader community.

Numerous articles in newspapers and magazines have promoted the image of Asian Pacifics as "model minorities." The following is a typical example taken from a 1966 article in U. S. News and World Report:

At a time when Americans are awash in worry over the plight of racial minorities--one such minority, the nation's 300,000 Chinese Americans, is winning wealth and respect by dint of its own hard work.

However, these beliefs are not supported by the facts and many Asian Pacifics argue that this stereotype misrepresents their real status by making them appear problem free (Kim, 1975; Civil Rights Commission, 1980). If a
minority group is viewed as being free of problems, it is doubtful that its members will be included in programs designed to alleviate problems they encounter as minorities. Also, if members of such a group are not represented during deliberations concerning improvement programs and policies, it is possible that the group may be excluded from such programs and policies (Kitano and Sue, 1973).

Therefore, it is vital that health educators and administrators, health providers, and health policymakers ignore the damaging stereotype of a model minority and instead focus their attention toward increasing their awareness of the present health concerns held and experienced by the Asian Pacific communities. It is important that the major gap that exists between current health status and behaviors and current, inappropriate health services be recognized in order that more appropriate and equitable, Asian Pacific-focused services be provided.

**Major Health Concerns of Asian Pacifics**

From perusal of material published and unpublished by the NHIS and from consultations with health care providers (members of APPCON), it is the position of this Investigator that the following areas reflect the major health concerns within the Asian Pacific communities today. It is by no means a comprehensive list but does
address some of the major concerns of Asian Pacifics and provides data on the existing health status of these communities.

Alcoholism

The popular stereotype that Asian Pacific communities are immune to alcoholism has been debunked by recent studies (Office of Alcohol Programs, 1984). These studies show that:

- Japanese Americans are drinking more heavily, followed by Filipino and Korean Americans, with Chinese Americans having the lowest percentage of heavy drinkers.
- there exists a serious, growing problem of alcohol misuse and abuse in the Samoan community.
- there is an increase in consumption in order to cope with cultural adjustments, loss of self-esteem, and the trauma associated with war experiences.
- increased alcohol consumption may result from the high value that the dominant culture places on alcohol consumption, acculturation, and assimilation.
- there is a stigma associated with alcoholism, therefore there is little or no discussion of it in Asian Pacific communities. Silence is often equated with the lack of the problem in these communities.
- in 1982-83, only 67 Asian Pacifics (0.4 percent) participated in the direct services county alcoholism programs, as compared to the 5.8 percent representation among the general population (Kitano and Hatanaka Alcohol Study, 1983).

**Drug Abuse**

The stereotype that Asian Pacifics are immune to alcoholism also applies to the problem of drug abuse. However, studies by the Asian American Drug Abuse Program (AADAP, 1986) show that:

- statistics for Japanese Americans of the abuse of cocaine, marijuana, and PCP have reached levels of the general population. The fact that Japanese Americans seem to acculturate faster than other Asian Pacific groups may explain this occurrence. Adults are the primary abusers and as the availability increases and the costs drop, a rise in the abuse of heroin is expected in the next few years.
- Chinese Americans also abuse cocaine, marijuana, and PCP, but not as heavily as Japanese Americans. Abusers are primarily teenagers and those in their early 20s.
- the drugs of choice of Filipino Americans are LSD, marijuana, and PCP. Abusers range in age from teenagers to those in their middle 20s.
- Samoan teenagers to those in their middle 20s are increasingly abusing marijuana and PCP.
- Indochinese immigrants, already exposed to numerous drugs during their war experiences, are abusing PCP, heroin, and cocaine.
- no extensive use of drugs has been noted in the more recent Asian Pacific newcomers but AADAP expects a rise in abuse as the children of such groups (ages 8 to 12) go through school.

**Birth Rate and Prenatal Care**

The number of Asian Pacific births in Los Angeles County has increased dramatically in recent years largely because of the great influx of immigrants from Hong Kong and Taiwan since the late 1960s, from Korea, the Philippines, India since the early 1970s, and more recently, groups from Southeast Asia. The majority of these immigrants are in their prime years and that has resulted in a birth rate increase among Asian Pacifics which has surpassed that of Hispanics and Blacks (United Way, Inc., 1985).

According to the Vital Statistics Report on births from 1982 by the County of Los Angeles, Department of Health Service, there were 138,888 births in 1982. This is the highest number since 1963 and the crude rate of 18.6 per 1,000 estimated population was the highest since 1970. Asian Pacific births rose to 9,627, or 6.9 percent
of all births, which was more than four times the number in 1970.

Despite this dramatical increase in the Asian Pacific birth rate, there are no ethnic, bilingual/bicultural community health clinics to provide adequate prenatal care to the immigrants and refugees. Chinatown Service Center in Los Angeles was the only prenatal clinic funded by the State to provide prenatal care to Asian Pacific residents in Los Angeles County during 1984-85.

Cancer

According to the statistics of the American Cancer Society (1983), the rates of most cancers for Los Angeles County Japanese and Chinese are alarmingly higher than national averages (see Table 1).

Cardiovascular Diseases

According to a 1983 study done by the UCLA School of Public Health for the American Heart Association, major cardiovascular diseases (or CVD) caused 46 percent of all deaths among Asian Pacifics in Los Angeles County in 1980. This was more than any other single cause of death in this community. It is also noteworthy that while the CVD death rate for all Los Angeles County residents decreased by 2.7 percent between 1970 and 1980, the CVD death rate among Los Angeles County Asian Pacifics increased by 1.9 percent for the same period. Among Los Angeles County Japanese
Table 1
Incidence Rates of Cancer for Los Angeles County Japanese and Chinese vs. National Averages

<table>
<thead>
<tr>
<th></th>
<th>Japanese males</th>
<th>Chinese males</th>
<th>Japanese females</th>
<th>Chinese females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon and Rectum</td>
<td>263% higher</td>
<td>230% higher</td>
<td>200% higher</td>
<td>192% higher</td>
</tr>
<tr>
<td>Stomach</td>
<td>528% higher</td>
<td>Slightly higher</td>
<td>464% higher</td>
<td>Slightly higher</td>
</tr>
<tr>
<td>Prostate</td>
<td>152% higher</td>
<td>183% higher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterus</td>
<td>373% higher</td>
<td>208% higher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>236% higher</td>
<td>177% higher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>58% of national average</td>
<td>68% of national average</td>
<td>70% of national average</td>
<td>Nearly same as national average</td>
</tr>
</tbody>
</table>
alone, major cardiovascular diseases caused 52 percent of all deaths in 1980—an increase of five percent over 1970.

Tuberculosis

According to the Tuberculosis Control Division of the Department of Health Services of Los Angeles County, the incidence rate of tuberculosis for Asian Pacifics in Los Angeles County was 74.4 per 100,000 in 1982. This is considerably higher in comparison to all other groups in the County. As a whole, Asian Pacifics have a high incidence of tuberculosis. The number of cases increased 42 percent from 1980 to 1984. In contrast, County figures declined almost ten percent in the same four-year period.

The Tuberculosis Control Division reports that the increase in the incidence of tuberculosis is directly related to the tremendous growth in Asian Pacific immigration. Although cases of tuberculosis are more prevalent among Southeast Asian refugees, statistics show that Filipinos have an increasing number of reported cases, as do Koreans. Moreover, 50 to 60 percent of all Asian Pacifics who received tuberculosis screenings turn out to be tuberculin reactive, compared to five percent of all Caucasians screened.

Family Planning

Asian Pacific communities have been historically underserved by the providers of family planning and
reproductive health. For example, according to 1982-1984 statistics, the clinics administered by the Los Angeles Region Family Planning Council have served 3.8 percent Asian Pacific clients over the past several years. This is in contrast to the estimated six percent or more Asian and Pacific Island people in the county (L.A.R.F.P.C., 1984). A large majority of Asian Pacific immigrants have a limited knowledge of family planning and may be culturally biased against it. However, the need for greater family planning awareness is necessary to prevent a high risk of unwanted pregnancies. Many immigrants who do not utilize birth control methods may be choosing to do so without being properly educated about the advantages, disadvantages, and contraindications associated with the proper usage of the various methods.

The low percentage of family planning visits does not necessarily mean a bias against family planning but only a lack of information regarding what it is and how it can be helpful in the planning, the spacing, and the number of children. Cultural factors may have created barriers among the health care providers to furnish family planning services, thereby leading to underutilization of services. Some reasons for the reluctance to provide outreach to Asian Pacifics on a wide range include:

- Limited capabilities on the part of some clinics to provide services to these groups
- Lack of cultural understanding in presenting family planning information and instructions to clients
- Language barriers
- Increased amount of time needed to provide services
- Lack of bilingual resources (e.g., information, health education materials, translators)

(L.A.R.F.P.C., 1984)

Hypertension

The preliminary findings of the California Study, conducted by the California Department of Health Services, indicate that hypertension is a major public health problem among California's Asian Pacifics, with a prevalence rate of 20 percent. The Filipino subgroup has a prevalence rate of 27 percent, Chinese, Japanese, and other Asian Pacific subgroups have rates of 18, 14, and 20 percent, respectively. Control rates are as low as four percent among some Asian Pacific subgroups. The effects of culture and acculturation on the prevalence of hypertension must be determined.

Other Barriers to Health Services

There is a need to recognize that the lack of information about the health status and behaviors of Asian Pacifics is not the sole barrier to more appropriate health services. Many social service facilities are inaccessible, both on the physical level and the
psychological level, and are not accountable to Asian Pacific communities (Dana, 1981; Lieu, et al., 1976; Muecke, 1983; True, 1980). Hospitals, clinics, and private offices are often several hours away by bus or completely inaccessible to persons without private transportation. However, for many Asian Pacifics, distance is less significant in obtaining health care services than the ethnicity of those furnishing services because they prefer to deal with bicultural, bilingual providers (Sue and Wagner, 1973). Therefore, it is no surprise that few Asian Pacifics utilize the traditional agencies.

Another barrier to obtaining available health care services is a financial one. Although there is a widespread perception that Asian Pacifics are affluent and successful minorities, the reality is that a substantial number are living under marginal circumstances. Among those, immigrants and the elderly are consistently identified as the groups most in need (U. S. Civil Rights Commission, 1980; True, 1985). Although attitudes toward health costs and the absence of health insurance does not mean that Asian Pacifics fail to secure health care services, many individuals forego regular checkups and elective procedures because of pressure on their budgets. Given the high incidence of cancer, cardiovascular disease, and other degenerative diseases among Asian Pacifics,
suffering and early death might be prevented if financial barriers were reduced or eliminated (Weaver, 1976).

In May, 1977, the United States Department of Health, Education, and Welfare's (now the Department of Health and Human Services) Division of Asian American Affairs published a document entitled "Asian American Field Survey: Summary of the Data." The survey is a study of the characteristics of selected Asian Pacific communities in low-income urban areas and those populations' need for and use of health, education, and welfare services. Supplementary data about agency services were collected in a survey of selected HEW-funded public agencies that serve these same Asian Pacific communities.

Included in this summary were data of health agencies in three Standard Metropolitan Statistical Areas (SMSAs): New York, Los Angeles, and San Francisco. Although these health agencies serve a large number of non-English speaking Asian Pacifics, the proportion of bilingual staff employed in the agencies is extremely small (see Table 2).
Table 2

Proportion of Asian Pacific Bilingual Staff in Health Agencies

<table>
<thead>
<tr>
<th>Ethnic Group Served</th>
<th>Chinese</th>
<th>Japanese</th>
<th>Korean</th>
<th>Filipino</th>
<th>Samoan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Staff</td>
<td>2603</td>
<td>2270</td>
<td>1399</td>
<td>409</td>
<td>1405</td>
</tr>
<tr>
<td>Number of Asian Pacific Bilingual Staff</td>
<td>143</td>
<td>30</td>
<td>5</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>Percentage</td>
<td>5.5</td>
<td>1.3</td>
<td>0.4</td>
<td>1.8</td>
<td>0.3</td>
</tr>
<tr>
<td>Number of Agencies Reporting</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

According to the survey, none of the health agencies in the Japanese, Korean, and Samoan neighborhoods in Los Angeles, and only a few agencies in New York and San Francisco had made any attempts to hire Asian Pacific bilingual staff (see Table 3).
Table 3
Number of Agencies with Special Programs to Hire Asian Pacific Bilingual Staff

<table>
<thead>
<tr>
<th>Ethnic Group Served (City)</th>
<th>Type of Special Effort</th>
<th>Samoan (L.A.)</th>
<th>Japanese/ Korean (L.A.)</th>
<th>Chinese (N.Y.)</th>
<th>Filipino (S.F.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Waive some job requirements</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Create special job category</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Provide educational grants</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Provide English language tutoring</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Total number of Agencies reporting</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>

Furthermore, only about a third of the hospitals and other health agencies surveyed reported having any Asian Pacific language interpreters. This is in spite of the fact that all the health agencies surveyed served Asian Pacific neighborhoods (see Table 4).
Table 4

Number of Health Agencies with Interpreters

<table>
<thead>
<tr>
<th>Ethnic Group Served</th>
<th>Chinese</th>
<th>Japanese</th>
<th>Korean</th>
<th>Filipino</th>
<th>Samoan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Agencies with Interpreters</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Number of Agencies Reporting</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

Also, only a few hospitals or health agencies have bilingual signs (see Table 5).

Table 5

Health Agencies with Bilingual Information Signs

<table>
<thead>
<tr>
<th>Ethnic Group Served</th>
<th>Chinese</th>
<th>Japanese</th>
<th>Korean</th>
<th>Filipino</th>
<th>Samoan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospitals with Signs</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total Number of Hospitals Reporting</td>
<td>5</td>
<td>10</td>
<td>6</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

Moreover, only a few hospitals or health agencies have translated materials (see Table 6).
Table 6

Number of Agencies with Translated Materials

<table>
<thead>
<tr>
<th>Ethnic Group Served</th>
<th>Chinese</th>
<th>Japanese</th>
<th>Korean</th>
<th>Filipino</th>
<th>Samoan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Agencies with Translated Publications</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Number of Agencies with Translated Applications</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of Agencies with Other Translated Forms</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total Number of Agencies Reporting</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

From the results of the survey, it is evident that response to the special needs of Asian Pacifics on the part of health care providers have been inadequate. Only a few hospitals and health agencies serving a large number of non-English speaking Asian Pacifics have made attempts to hire bilingual staff and interpreters and make bilingual signs and translated materials available.
Chapter 3

METHODOLOGY

This Chapter presents the methods which were used to plan and design the California Asian Pacific Island health agenda. The project is subdivided into four phases of development: 1) reviewing and analyzing the available pertinent literature, published and unpublished; 2) informal meetings with leaders of the Asian Pacific communities; 3) development of the health agenda; and 4) formulating recommendations for federal, state, and local governments.

Phase I: Review and Analysis of the Pertinent Literature

Several techniques were employed to gather the data necessary for the designing of the health agenda. The first procedure was an extensive review of the literature related to: 1) the immigration of Asian Pacifics and its impact on the United States population; 2) the Asian Pacific population in the United States and California; 3) the extent of health problems among Asian Pacifics; and 4) the major health concerns of Asian Pacifics.

Phase II: Meetings with Leaders of the Asian Pacific Communities

The Investigator also held informal discussions with various members of Asian Pacific-focused service organizations (see Appendix B). These individuals are also
members of the Asian Pacific Planning Council's (APPCON) Health Subcommittee, an organized council with paid memberships and voting rights on the workings of the council. They are recognized leaders in Asian Pacific affairs, as well as other arenas (e.g., political), with specific interests in Asian Pacific health.

The informal discussions were held at monthly APPCON Health Subcommittee meetings and were open-ended to permit spontaneous responses. The open-ended questions asked by the Investigator centered on the major health concerns of Asian Pacifics as identified in the literature review (e.g., the extent of alcoholism among Asian Pacifics is . . . ). Members were asked to participate on a voluntary basis and a brief oral explanation of the purpose of the discussions were provided by the Investigator at the outset. The Investigator stressed the importance of factual responses to the questions so that the project might provide an accurate basis for understanding the special needs of Asian Pacifics.

Many of the responses elicited were quite specific, incorporating statistics and supportive references. Oftentimes, they validated the findings of the literature review. The responses were duly noted by the Investigator and were included in the outcome of the literature review. The data was analyzed to determine the content of the health agenda.
Phase III: Development of the Health Agenda

On May 31, 1985, the Asian Pacific Planning Council (APPCON) sponsored a conference entitled "Asian Pacific Health Issues." This conference would serve to address the health status and health issues of the Asian Pacific communities. The keynote speakers were Dr. Samuel Lin and the Honorable Diane E. Watson.

Dr. Lin serves as Assistant Surgeon General of the United States and Deputy Assistant Secretary of Health, United States Department of Health and Human Services. He is the principal advisor to the Assistant Secretary for Health on the leadership and direction of the ten Public Health Service Regional Offices and on overall policy coordination of programs which have an impact on state and local health activities.

California State Senator Diane E. Watson currently chairs the Senate Health and Human Services Committee and is a member of various other Senate committees.

The Investigator's field supervisor, Irene Hirano, Executive Director of the T.H.E. Clinic in Los Angeles and a member of APPCON, suggested that this graduate project in some way revolve around the planned conference. (The Investigator was not a member of the planning committee). She made it clear that there is a need to focus attention on the gap between the health status of Asian
Pacifies and the health services provided to these groups and thus, the idea for this health agenda was born.

Because of the significance of the two keynote speakers, two very prominent policymakers in the area of health, it was decided that this agenda not only focus on this gap, but also incorporate recommendations for local, state, and federal governments.

Utilizing the outcome of the literature review and the APPCON Health Subcommittee discussions, the California Asian Pacific Health Agenda was developed. The Investigator's first step was to draft an outline of the project's content that met with the approval of the field supervisor. The health agenda is divided into three main topic areas: 1) Health Status of Asian Pacifics; 2) Health Issues and Concerns of Asian Pacifics; and 3) Recommendations for Federal, State, and Local Health Policymakers.

The Health Status and the Health Issues and Concerns sections included the findings of the literature review and APPCON Health Subcommittee discussions. The Investigator formulated an introduction to the project, including statistics on the growth in the population numbers of Asian Pacifics in the United States and the diversity of these groups. Information for this section was also taken from the literature review. Also included in the draft was a summary by the Investigator, a brief compendium of the agenda and its purposes, and the encouragement to
policymakers for more appropriate health care services for Asian Pacifics.

Comments and suggestions given by the field supervisor indicated that certain aspects of the draft needed further elaboration, while other aspects were favorably received. The Investigator found these comments to be helpful in refining the project.

Phase IV: Formulating Recommendations for Federal, State, and Local Policymakers

In addition to the main topics of Health Status and Health Issues and Concerns, it was decided at the outset of this project that recommendations would be formulated to aid policymakers toward increasing their awareness of the special needs of Asian Pacifics. The literature review provided a variety of approaches from existing health care providers (True, 1985; Yu, et al., 1984) and these approaches were expanded upon by the Investigator. The field supervisor, a recognized leader in the political arena of Asian Pacific Health, also offered suggestions that the Investigator expanded upon and incorporated into the project.

The final draft (see Appendix A) was accepted by the field supervisor and was included in the informational packets distributed at the May 31st health conference. The agenda was distributed under the auspices of APPCON but credit for its compilation was given to the Investigator.
Chapter 4
RESULTS AND DISCUSSION

This Chapter presents the findings of the literature review relative to the drafting of the final health agenda. The health issues and concerns of Asian Pacific-focused health care providers are discussed. Finally, recommendations are offered for federal, state, and local policymakers to assist them in bridging the gap between the special needs of Asian Pacifics and current, inappropriate health care services.

Findings of the Literature Review

The lack of current, published data on Asian Pacifics is a blatant example of the problem that these communities face in securing appropriate health care services. Public health policymakers are unaware of the special needs of the Asian Pacific communities and have, therefore, neglected to address their concerns. The lack of data has been interpreted by public health policymakers to mean that Asian Pacifics have no problems. Without a clear picture of the needs of Asian Pacifics, it is little wonder that federal, state, and local policymakers have been hampered by such a lack of accurate, concrete data in the decision making process affecting these groups.
Health Issues and Concerns of Asian Pacific-Focused Health Care Providers

Although many of the Asian Pacific health care services initiated during the past several years have been successful in overcoming a number of barriers to utilization, these programs (e.g., Chinatown Health Clinic, Asian Health Services, Northeast Health Center) indicated in the True study (1985) their concerns about a variety of additional obstacles:

- While the number of Asian Pacific immigrants continues to grow, increasing the number and size of ethnic groups represented, the governmental resource allocation has not shifted according to the changing nature of the population. Governmental policies and program funding are often inflexible and outdated. Therefore, the programs are forced to overextend their resources to meet the needs of the new populations, or will be unable to service those needs.

- The current system of funding and reimbursement, which is leaning more toward a capitation system, does not allow for the cost of translation or outreach to work with the difficult, multi-problem population.

- Current Immigration and Naturalization Service regulations penalize immigrants from seeking any kind of public assistance, including medical care,
and therefore compound the dilemma of the struggling immigrant groups.

- While it is more feasible to develop bilingual services for the more dominant, larger Asian Pacific groups, it is more difficult to develop resources for smaller Asian Pacific groups whose individual needs may be just as great.

- Although there is a definite trend toward a prepaid health care system in the health care industry, the specialized ethnic services are lost in the process by larger organizations. At the same time, because of their small sizes, it is difficult for most Asian Pacific health care organizations to develop a competitive prepaid system. This is a major issue for community-based programs which must address the cultural needs of the Asian Pacific populations. What will be the roles of such programs and how will they survive?

- While many of the existing Asian Pacific health care providers are finding the advantages of preventive programs in the reduction rate of more expensive services, the reimbursement policies of private industries and the government are to eliminate such funding of preventive programs.

- While there is a significant concentration of bilingual Asian Pacific health care providers in
certain metropolitan areas, it is extremely difficult to recruit such personnel in areas with less amenities and fewer Asian Pacific residents. While a service area may have an adequate number of non-Asian Pacific physicians, the area may lack appropriate bilingual physicians. Because of the simplistic application of the federal regulations, the non-English speaking patient groups are underserved.

It has been found that when there are appropriate programs, there is use (Weaver, 1976). For example, Little Tokyo Towers in Los Angeles, a housing project for the elderly Japanese, is filled and has a long waiting list. The counseling program funded by the Los Angeles Chamber of Commerce using bicultural and bilingual social workers also has a steady stream of clients. Asian Pacifics enrolled in voluntary hospital plans, such as Kaiser, provide models (e.g., bilingual staff, geographically accessible) upon which successful programs can be delivered to Asian Pacifics. The Chinese Community Health Plan is the result of Chinese health care leaders establishing a Health Maintenance Organization (HMO) of their own (True, 1985).

**Recommendations for Federal, State, and Local Policymakers**

Asian Pacifics have special health care needs and current policies governing health care service delivery
do not reflect this need. Much support is needed from federal, state, and local policymakers to reverse this situation. Because the following recommendations have not been addressed by these public health policymakers, existing health care providers (True, 1985; Yu, et al., 1984) and the Investigator offer them for consideration and action.

Federal Level

- Collection of data on bilingual and bicultural needs is essential in order to have greater statistical documentation of Asian Pacifics and to eliminate the invisibility of health needs that exists today.

- Federal funds should be allocated to implement Asian Pacific health services which are culturally and linguistically relevant to the Asian Pacific communities.

- For incentive purposes, Medicaid should establish reimbursement policies for interpreters and service providers who have a bilingual staff.

- The federal government, particularly the Department of Health and Human Services, must provide support and incentive to the Asian Pacific community-based programs currently utilized in the Asian Pacific communities.

- The federal government should develop mandates to the state so that federal funds being administered
by the state be appropriately allocated for program development in the Asian Pacific communities.

- Federal funding intended for overall refugee allocations should not be limited to job seeking purposes for refugees, but should also be specifically targeted for health care.

- Federal grant support should be provided to conduct research, with respect to specific problems of each ethnic group within the Asian Pacific communities, into the feasibility of culturally sensitive Asian Pacific health services. Also, funds should be allocated for research of diseases more prevalent in the Asian and Pacific Island communities.

- In the development of prepaid health plans, issues relating to the needs of the Asian Pacific communities should be addressed.

- On the federal level, representatives of the Asian Pacific communities should be placed in top level staffing positions, as well as on special commissions, in order to ensure appropriate advisement relating to health care issues.

- Federal support should be provided to encourage medical curriculum to stress culturally sensitive issues relative to health care delivery techniques.

- Demonstration Centers should be established by federal funds to provide technical assistance to
- The federal government should inform Asian Pacific communities of the available training and fellowship opportunities funded by the National Institute of Health and the Department of Health and Human Services.

- Federal regulations should be revised in order to allow flexibility for the special needs of the Asian and Pacific Island population (e.g., MUA description criteria, reimbursement rates, and allowable service modalities).

State Level

- Collection of data on bilingual/bicultural needs by ethnicities is essential in order to have greater statistical documentation of Asian Pacific and to eliminate the invisibility of health needs that now exists.

- A commission composed of representatives from the Asian and Pacific Island communities should be established to advise the state administration on regulations, policies, problems, and areas of concern with regard to appropriate and adequate provision of health care services.

- Representatives of the Asian and Pacific Island communities should be placed in top management level
staffing positions to ensure appropriate advisement and follow-up relating to health care issues.
- State licensing of foreign-trained medical providers should be examined and revised.
- State funding should be provided for the implementation of culturally sensitive health care services. Bilingual staffing and translated materials are imperative.
- As federal funding for refugee service is reduced, state agencies should assume the responsibility for the continuation of such services.

The lack of access to health care services is, in effect, denial of such services. The following, which the state should be responsible for funding, are proposed to remedy or alleviate the problem of access to services:
- Bilingual and bicultural staffing should be made available.
- Interpreters and health education materials in primary languages (culturally sensitive materials) are vital.
- Community-based facilities and mobile clinics should be established in order to provide direct services to Asian Pacific communities, with designated service sites, a primary health care team, and bilingual and bicultural health providers.
- Culturally relevant treatment modalities and health care delivery techniques should be explored and implemented.
- Initiation and expansion of community education outreach efforts through vernacular (language native to particular ethnicities) media should be undertaken.
- The state should require and monitor funded programs located in or near Asian Pacific communities to ensure adequate services and the provision of bilingual staffing.

Local Level
- In order to have greater statistical documentation and to eliminate the invisibility of health needs that exists today, it is essential that data be collected, by ethnicities, on the health status and needs of Asian Pacifics.
- A commission, comprised of representatives of the Asian and Pacific Island communities, should be established to advise the County administration on regulations, policies, problems, and areas of concern with regard to appropriate and adequate provision of health care services.
- Representatives of the Asian and Pacific Island communities should be placed in top management
level staffing positions to ensure appropriate advisement and follow-up relating to health care issues.

- Local mandates must require the staffing of bilingual/bicultural personnel and translated materials in health care agencies serving Asian and Pacific Island clients with limited English skills.

- As federal funding for refugee services is reduced, County agencies should assume the responsibility for the continuation of such services.

- Local agencies must take the initiative in informing the Asian and Pacific Island communities about the availability of health care services, how to gain access to such services, and how to pay for them.

Public and private health providers located in or near Asian Pacific communities should provide the following:

- Bilingual and bicultural staffing.

- Interpreters and health education materials that are culturally sensitive and available in the primary ethnic languages of the Asian Pacific communities.

- Community-based facilities and mobile clinics to provide direct services, with designated service sites, a primary health care team, and bilingual/bicultural health providers.

- Initiation and expansion of community education outreach efforts through vernacular media.

- Culturally relevant treatment modalities.
Chapter 5
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this project was to develop an Asian Pacific Health Agenda for California that could be utilized by public health educators, public health administrators, and federal, state, and local public health policymakers in recognizing that a gap exists between current Asian Pacific health policymaking and the health status of Asian Pacifics. It is vital that this problem be addressed in order that more appropriate and equitable health care services be provided for Asian Pacifics.

The methodological steps used to carry out this project were organized into four phases:

I. Review and Analysis of the Pertinent Literature
II. Meetings with Leaders of the Asian Pacific Communities
III. Development of the California Asian Pacific Health Agenda
IV. Formulation of Recommendations for Federal, State, and Local Governments

The California Asian Pacific Health Agenda was developed by utilizing the results of a literature review and from information provided by members of the Asian Pacific Planning Council (APPCON). It was critiqued and
debated upon by these members for its appropriateness and its validity. Revisions were made on the basis of this input. The final version of the agenda included the following three major areas of focus:

I. Health Status of Asian Pacifics
II. Health Issues and Concerns of Asian Pacifics
III. Recommendations for Federal, State, and Local Policymakers

The agenda was developed under the auspices of the Asian Pacific Planning Council and distributed at a May 31, 1985 health conference (sponsored by APPCON) entitled "Asian Pacific Health Issues." Like the conference, this project has been an attempt to review the health status and the health care concerns held by the Asian Pacific communities and to explore strategies for the improvement of health services to these diverse minority groups. Legislators, government agencies, and funding sources have a responsibility to be involved in working toward a change of the unfortunate situation that exists at this time, that of inadequate and inappropriate health care for Asian Pacifics.

Conclusions

Based on the literature review and information provided by members of APPCON, the following conclusions were reached by the Investigator:
1. There is an invisibility of data on Asian Pacifics despite the growing numbers of immigrants since 1970. Census figures do not appropriately document Asian Pacifics.

2. Asian Pacifics are stereotyped as being a "model minority" and therefore viewed as being problem free. This has caused them to be overlooked in program planning and policymaking.

3. Asian Pacifics are viewed as homogeneous and are treated as such.

4. Available data shows that Asian Pacifics have major health concerns. They include alcoholism, birth rate and prenatal care, cardiovascular disease, drug abuse, family planning, hypertension, and tuberculosis.

5. Asian Pacifics face many other barriers to health care besides being overlooked in health data. They include the lack of translated signs and materials, the absence of culturally relevant treatment techniques, lack of funds, the inaccessibility of services, the lack of knowledge about available service providers, and the absence of bilingual/bicultural personnel and health care providers.

6. Foreign-born health providers are prevented from practicing their specialties because of
professional licensing problems and English language limitations.

7. In view of the above, it is clear that the Asian Pacific communities are severely underserved. The conclusions support the need for improvement of health services to these groups.

The following are additional conclusions reached by the Investigator:

1. Heretofore, only a few studies have focused on the health status of Asian Pacifics. This lack of data have historically resulted in inappropriate health care services to these groups.

2. The current lack of appropriate health care for Asian Pacifics reinforces the importance of public health policymakers of becoming more aware of the special needs of Asian Pacifics.

3. In order for public health policymakers to make informed decisions regarding the special needs of Asian Pacifics, it is vital that information provided to them on the health status of Asian Pacifics be current, accurate, and easily understood.

4. As health issues and concerns in the Asian Pacific communities change, it is essential that information provided to public health policymakers be updated.
Recommendations

Based upon the outcome of the project, the following recommendations are offered by the Investigator:

1. The United States Bureau of the Census should expedite a special census of all Asian and Pacific Island peoples.

2. Federal agencies which fund service programs should endeavor to generate more accurate data measuring the needs of Asian and Pacific Island communities. Needs-demands assessments can be carried out by community health workers at these service programs by surveying the clients of such programs. Furthermore, designated leaders and/or representatives of Asian Pacific communities can push for such action by voicing their concerns at special hearings specific to Asian Pacific affairs and to the State Committee on Human Relations. Moreover, grants for research can be channeled for the undertaking of such assessments.

3. The Asian Pacific communities are not homogeneous and, therefore, agencies should assess the needs of each group in order to be truly responsive. These assessments can be done in Asian Pacific service delivery areas by determining what the numbers of a specific population are and surveying for their needs. County facilities are
available for referrals of smaller ethnic groups and recent immigrants. Such facilities can encourage an appointment system with these groups instead of a walk-in system so that providers can plan ahead to meet any special needs (e.g., securing translators). Also Asian Pacific community centers, churches, associations, and community health workers can be valuable sources of information on the needs of these groups.

4. Following a reassessment of community needs, all California agencies with service responsibilities should determine the extent of underutilization and underrepresentation of Asian Pacifics in their programs. This can be accomplished by determining the number in their target populations in a particular area (e.g., through the Census) and comparing it to the amount of clients served. A standard (e.g., five percent or less) can be used to determine underutilization.

5. There is a need to identify potential as well as existing Asian Pacific leadership and a need for representation from a variety of ethnic communities, both American and foreign-born. Local Asian Pacific community centers, churches, and associations are sources where such leaders and representatives may be identified. In Los
Angeles, there is a two-year training program ("Leadership for Asian Pacifics") for potential leaders to become well-versed in many areas, including health.

6. The progress of programs and policies for improving health care services to Asian Pacifics should be monitored and evaluated for relevancy and validity. In-house surveys can be conducted (verbally or written) to determine what clients would like to see in terms of special services and their levels of satisfaction with existing services. A high return rate of clients and the completion of total treatments are good indicators of satisfaction with the appropriateness of health care services.

7. The recommendations set forth in the California Asian Pacific Health Agenda for federal, state, and local public health policymakers should be addressed and acted upon immediately in order that the problem of inadequate and inappropriate health care for Asian Pacifics can be reversed. Asian Pacific health conferences, with public health policymaker participation, and community input at hearings by community leaders and community health workers can aid in making the
special needs of Asian Pacifics more evident to public health policymakers.

8. The Asian Pacific Health Agenda should be revised and updated as the concerns of Asian Pacifics change or grow. Designated members of APPCON and/or Asian Pacific Commissions can utilize needs assessments and Census data to replace outdated information so policymakers may act upon current, accurate data.


Fitzpatrick-Nietschmann, Judith, Ph.D. "Pacific Islanders--Migration and Health," The Western Journal of Medicine, 139(6), December, 1983.


Office of Alcohol Programs, Evaluation Management Services, Los Angeles County, 1984.


Rokaw, Bill, Epidemiologist, Tuberculosis Control Division, Los Angeles County, 1984.


Yu, Elena, S.H., Ph.D. and Beulah K. Cypress, Ph.D. "Visits to Physicians by Asian/Pacific Americans." Medical Care, 20(8), August, 1982.


APPENDIX A
AN ASIAN/PACIFIC ISLANDER HEALTH AGENDA
FOR CALIFORNIA - 1985

Developed by
ASIAN PACIFIC PLANNING COUNCIL
HEALTH TASK FORCE

May 1985
INTRODUCTION

Recent sources and statistics have shown that the Asian/Pacific Islander population has more than doubled since the 1970 census. In Los Angeles County alone the Asian/Pacific Islander population has expanded by 150%. Many factors contributing to this growth (e.g., economic crisis in many Asian and Pacific Island countries, political conflicts, and expansion of business), coupled with the unique cultural and geographic particularities of the many different Asian and Pacific Island countries, have created a complex and intricate Asian/Pacific Islander community.

However, the diverse character of the Asian/Pacific Islander community goes beyond size and ethnic heterogeneity. Factors, including generational differences where a community may have a fifth, as well as a first, generation linguistic difference and dialect variation according to various regions within the homeland, culturally specific mores, racial characteristics and other aspects all affect the nature and make-up of the Asian/Pacific Islander communities. Whereas the Asian/Pacific Islander people are viewed by the majority culture as one single community, it is actually many different communities tied together by the commonality of the Asian/Pacific Islander experience in America, Asian/Pacific Islander history, culture, and philosophy.

As Asian/Pacific Islander health administrators, physicians, and other practitioners and consumers involved in the provision of basic medical services to our communities, we must stress the importance of being aware of the major gap that exists in this (state, county, city) concerning health status. As previously stated, each of the various Asian/Pacific Islander groups residing in California have unique needs according to their respective culture, tradition, and lifestyle. Their needs vary according to the recency of their immigration to this country and among the various generations within a given ethnic group. The gap reflected does not recognize these respective differences and displays various incorrect assumptions regarding health status.
HEALTH STATUS

It is our position that the following areas reflect the major health concerns within the Asian/Pacific Islander communities today. It is not a comprehensive list but does address some of the major concerns and provides data and information which depict an alarming condition for us all.

Alcoholism

Alcohol related studies have shown that:

- Japanese Americans are drinking more heavily, followed by Filipino and Korean Americans, with Chinese Americans having the lowest percentage of heavy drinkers.

- there exists a serious growing problem of alcohol misuse and abuse in the Samoan community.

- there is an increase in consumption to cope with cultural adjustments, loss of self-esteem, and the trauma associated with war experiences.

- increased alcohol consumption may result from the high value that the dominant culture places on alcohol consumption, acculturation, and assimilation.

- there is a stigma associated with alcoholism, therefore there is little or no discussion of it in Asian/Pacific Islander communities. Silence is often equated with the lack of the problem in these communities.

- in 1982-83, only 67 Asian/Pacific Islanders (0.4%) participated in the direct services county alcoholism programs, as compared to the 5.8% representation among the general population. (Kitano and Hatanaka Alcohol Study, 1983).

In view of the research cited above, showing that Asian/Pacific Islander groups have significant alcohol related problems, it is clear that these groups are severely underserved.

Birth Rate and Prenatal Care

The number of Asian/Pacific Islander births in Los Angeles County has increased dramatically in recent years
largely because of the great influx of immigrants from Hong Kong and Taiwan since the late 1960s, from Korea, the Philippines, and India since the early 1970s, and more recently, groups from Southeast Asia. According to the Vital Statistics Report on births for 1982 by the County of Los Angeles Department of Health Service, Public Health Programs, there were 138,888 births in 1982. This is the highest number since 1963 and the crude rate of 18.6 per 1,000 estimated population was the highest since 1970. Asian/Pacific births rose to 9,627, or 6.9% of all births, which was more than four times the number in 1970. Even though there was such a dramatical increase in the Asian/Pacific birth rate, there is no ethnic community health clinic to provide adequate prenatal care to the Asian/Pacific bilingual and bicultural immigrants. Chinatown Service Center in Los Angeles is the only prenatal clinic funded by the State to provide prenatal care to Asian/Pacific residents in Los Angeles County during the year of 1984-85.

Cancer

According to the 1976-77 statistics of the American Cancer Society, the rates for cancer for Los Angeles County Japanese and Chinese vary greatly, depending on the type of cancer. However, the rates of most cancer for both these groups were alarmingly higher than national averages:

<table>
<thead>
<tr>
<th></th>
<th>Chinese males</th>
<th>230% higher (than national</th>
<th>Japanese males</th>
<th>263% higher male average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon and Rectum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chinese females</td>
<td>192% higher (than national</td>
<td>Japanese females</td>
<td>200% higher female average</td>
</tr>
<tr>
<td></td>
<td>Japanese males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Japanese males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach</td>
<td></td>
<td>Slightly higher than national male average</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chinese males</td>
<td></td>
<td>Japanese males</td>
<td>528% higher</td>
</tr>
<tr>
<td></td>
<td>Chinese females</td>
<td>Slightly higher than national female average</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Japanese females</td>
<td></td>
<td></td>
<td>464% higher</td>
</tr>
<tr>
<td>Prostate</td>
<td></td>
<td>Slightly higher than national male average</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chinese males</td>
<td>183% higher (than national</td>
<td>Japanese males</td>
<td>152% higher male average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Chinese females</td>
<td>Japanese females</td>
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<tr>
<td>Uterus</td>
<td>208% higher (than national female average)</td>
<td>373% higher female average</td>
<td></td>
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</tr>
<tr>
<td>Breast</td>
<td>177% higher (than national female average)</td>
<td>236% higher female average</td>
<td></td>
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</tr>
<tr>
<td>Lung</td>
<td>Chinese males 68% of national male average</td>
<td>Japanese males 58% of national male average</td>
<td></td>
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<tr>
<td></td>
<td>Chinese females Nearly same as national female average</td>
<td>Japanese females 70% of national female average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td>Rates slightly less than national averages for both Chinese and Japanese males and females.</td>
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**Cardiovascular Diseases**

According to a 1983 study done by the UCLA School of Public Health for the American Heart Association, major cardiovascular diseases (or CVD) caused 46% of all deaths among Asian/Pacifies in Los Angeles County in 1980 -- more than any other single cause of death in this community. It is also noteworthy that while the CVD death rate for all Los Angeles County residents decreased by 2.7% between 1970 and 1980, the CVD death rate among Los Angeles County Asian/Pacifies increased by 1.9% for the same period. Among Los Angeles County Japanese alone, major cardiovascular diseases caused 52% of all deaths in 1980 -- an increase of five percent over 1970.

**Drug Abuse**

The dilemma of the Asian/Pacific Islander drug abuser is paradoxically manifested in the general lack of visibility of its symptomology. The invisibility of the Asian/Pacific addict both within the ethnic community and by the society at large, has, historically, and currently, operated to reinforce the illusion equating lack of visibility with lack of problem. As far back as the late 1960s, early 1970s, the Japanese community in Los Angeles experienced a large number of deaths among its youth population. The obituary column in the ethnic vernacular identified causes of death in phrases such as respiratory
collapse, pneumonia, and heart failure. However, when one examines the records, one will find that the majority of these deaths were directly drug related. Since then, reported cases of drug usage has increased, particularly amongst the youth population. The use of quaaludes and cocaine has been seen on the increase, especially amongst those Asian/Pacific youth attending Senior High Schools within the L.A. Unified School District.

**Family Planning**

Asian/Pacific Islander communities have been historically underserved by the providers of family planning and reproductive health. For example, according to 1982-84 statistics, the clinics administered by the L.A.R.F.P.C. have served 3.8% Asian/Pacific clients over the past several years. This is in contrast to the estimated six percent or more Asian and Pacific people in the county. A large majority of Asian/Pacific immigrants have a limited knowledge of family planning and may have cultural biases against it. However, the need for greater family planning awareness is necessary to prevent a high risk of unwanted pregnancies. Many immigrants who do not utilize birth control methods may be choosing to do so without being properly educated about the advantages, disadvantages, and contraindications associated with the proper usage of the various methods.

The low percentage of family planning visits does not necessarily mean a bias against family planning but only a lack of information regarding what it is and how it can be helpful in the planning, the spacing, and the number of children. Cultural factors may have created barriers among the health care providers to furnish family planning services, thereby leading to underutilization of services. Some reasons for the reluctance to provide outreach to Asian/Pacifics on a wide range include:

- Limited capabilities on the part of some clinics to provide services to these groups
- Lack of cultural understanding in presenting family planning information and instructions to clients
- Language barriers
- Increased amount of time needed to provide services
- Lack of bilingual resources (e.g., information, health education materials, translators)
Hypertension

The preliminary findings of the California Study conducted by the California Department of Health Services indicate that hypertension is a major public health problem among California's Asian/Pacific Islanders, with a prevalence rate of 20% and a low overall control rate of 21% in the Black population. The Filipino subgroup has a prevalence rate of 27%, Chinese, Japanese, and other Asian/Pacific Islander subgroup have rates of 18%, 14%, and 20%, respectively. Control rates are as low as four percent among some Asian subgroups. The effects of culture and acculturation on the prevalence of hypertension must be determined.

Tuberculosis

According to the Tuberculosis Control Division of Los Angeles County, the incidence rate of tuberculosis for Asians/Pacific Islanders in Los Angeles County was 74.4 per 100,000 in 1982. This is considerably higher in comparison to all other groups in the county. Statistics show that Filipinos have an increasing number of reported cases, as do Koreans and Indochinese. Moreover, 50-60% of all Asians/Pacific Islanders who received tuberculosis screenings turn out to be tuberculin reactive, compared to five percent of all Caucasians screened.
Promoting the good health of Asian/Pacific Islander communities also calls for the removal of the barriers there are to utilizing the full range of health services available. Heretofore, little has been known about the health status of Asian/Pacifics. Similarly, health education programs and the provision of health care services have been hampered by this lack of visible data. This problem is especially severe for newly arrived immigrants and refugees. Other barriers to utilizing services include the absence of bilingual/bicultural personnel and providers, lack of translated health education materials, lack of funds, the inaccessibility of services (on both physical and psychological levels), the absence of culturally relevant treatment techniques, and the lack of knowledge about available service providers.

Although many of the Asian/Pacific Islander health care services initiated during the past several years have been successful in overcoming a number of barriers to utilization, these programs have indicated their concerns about a variety of additional obstacles:

1. While the number of Asian/Pacific immigrants continue to grow, increasing the number and size of ethnic groups represented, the governmental resource allocation has not shifted according to the changing nature of the population. Governmental policies and program funding are often inflexible and outdated. Therefore, the programs are forced to overextend their resources to meet the needs of the new populations, or will be unable to service those needs.

2. The current system of funding and reimbursement, which is leaning more toward a capitated system, does not allow for the cost of translation or outreach to work with the difficult, multi-problem population.

3. Current Immigration and Naturalization Service regulations penalizing immigrants from seeking any kind of public assistance, including medical care, are compounding the dilemma of the struggling immigrant groups.

4. While it is more feasible to develop bilingual services for the more dominant, larger Asian/Pacific groups, it is more difficult to develop resources for smaller Asian/Pacific groups whose individual needs may be just as great.
5. Although there is a definite trend toward a prepaid health care system in the health care industry, the specialized ethnic services are lost in the process by larger organizations. At the same time, because of their small sizes, it is difficult for most Asian/Pacific health care organizations to develop a competitive prepaid system. This is a major issue for community-based programs which must address the cultural needs of the Asian/Pacific populations. What will be the roles of such programs and how will they survive?

6. While many of the existing Asian/Pacific health care providers are finding the advantages of preventive programs in the reduction rate of more expensive services, the reimbursement policies of private industries and the government are to eliminate such funding of preventive programs.

7. While there is a significant concentration of bilingual Asian/Pacific health care providers in certain metropolitan areas, it is extremely difficult to recruit such personnel in areas with less amenities and fewer Asian/Pacific residents.

8. While a service area may have an adequate number of non-Asian/Pacific physicians, the area may lack appropriate bilingual physicians. Because of the simplistic application of the federal regulations, the non-English speaking patient groups are underserved.
RECOMMENDATIONS

Based on the experience gained from various Asian/Pacific Islander communities, we are now beginning to understand some of the essential ingredients for the successful implementation of health services within our communities. Because of the limited resources available in the Asian/Pacific Islander community, much support is still needed from federal, state, and local governments.

Federal Level

1. Collection of data on bilingual/bicultural needs is essential in order to have greater statistical documentation of Asian/Pacifics and to eliminate the invisibility of health needs that exists today.

2. Federal funds should be allocated to implement Asian/Pacific health services which are culturally and linguistically relevant to the community.

3. For incentive purposes, Medicaid should establish reimbursement policies for interpreters and service providers who have a bilingual staff.

4. The Federal government, particularly the Department of Health and Human Services, must provide support and incentive to the Asian/Pacific community based programs currently utilized in the Asian/Pacific community.

5. The Federal government should develop mandates to the states so that federal funds being administered by the states be appropriately allocated for program development in the Asian/Pacific community.

6. Federal funding intended for overall Refugee allocations should not be limited to job promotion purposes, but should also be specifically targeted for health care.

7. Federal grant support should be provided to conduct researches, with respect to specific problems of each ethnic group, into the feasibility of culturally sensitive Asian/Pacific health services. Also, funds should be allocated for research of diseases more prevalent in the Asian/Pacific community.
8. In the development of prepaid health plans, issues relating to the needs of the Asian/Pacific community should be addressed.

9. On the Federal level, representatives of the Asian/Pacific community should be placed in top level staffing positions, as well as on special commissions, in order to ensure appropriate advisement relating to health care issues.

10. Federal support should be provided to encourage medical curriculum to stress culturally sensitive issues relative to health care delivery.

11. Demonstration Centers should be established by federal funds to provide technical assistance to communities with underdeveloped Asian/Pacific health resources.

12. The Federal government should inform Asian/Pacific communities of the available training and fellowship opportunities funded by the National Institute of Health and the Department of Health and Human Services.

13. Federal regulations should be revised to allow flexibility for the special needs of the Asian/Pacific Islander population (e.g., MUA description criteria, reimbursement rates, and allowable service modalities).

State Level

1. Collection of data on bilingual and bicultural needs by ethnicities is essential in order to have greater statistical documentation of Asian/Pacifics and to eliminate the invisibility of health needs that now exists.

2. A commission composed of representatives of Asian/Pacific Islander communities would advise the State administration on regulations, policies, problems, and areas of concern with regard to appropriate and adequate provision of health care services.

3. Representatives of the Asian/Pacific communities should be placed in management level staffing positions to ensure appropriate advisement and follow-up relating to health care issues.
4. State licensing of foreign trained medical providers should be examined and revised.

5. State funding should be provided for the implementation of culturally sensitive health care services. Bilingual staffing and translated materials are imperative.

6. As federal funding for Refugee services is reduced, State agencies should assume responsibility for the continuation of such services.

The lack of access to health care services is, in effect, denial of such services. The following, which the State should be responsible for funding, are proposed to remedy or alleviate the problem of access to services:

7. Availability of bilingual/bicultural staffing

8. Availability of interpreters and health education materials in primary languages (culturally sensitive materials)

9. Community-based facilities and mobile clinics to provide direct services, with designated service sites, a primary health care team, and bilingual and bicultural health providers

10. Initiation and expansion of community education outreach efforts through vernacular (language native to particular ethnicities) media

11. Culturally relevant treatment modalities

12. The State should require and monitor funded programs located in or near Asian/Pacific communities to ensure adequate services and the provision of bilingual staffing.

Local Level

1. In order to have greater statistical documentation and to eliminate the invisibility of health needs that exists today, it is essential that data be collected, by ethnicities, on the bilingual/bicultural needs of Asian/Pacifics.

2. A commission, comprised of representatives of Asian/Pacific communities, would advise the County administration on regulations, policies, problems, and areas of concern with regard to
appropriate and adequate provision of health care services.

3. Representatives of the Asian/Pacific communities should be placed in top management level staffing positions to ensure appropriate advisement and follow-up relating to health care issues.

4. Local mandates must require staffing of bilingual personnel and translated materials in health care agencies serving Asian/Pacific clients with limited English language skills.

5. As federal funding for Refugee services is reduced, County agencies should assume the responsibility for the continuation of such services.

6. Local agencies must take the initiative to inform the Asian/Pacific communities about the availability of health care services, how to gain access to such services, and how to pay for them.

Public and private health providers located in or near Asian/Pacific communities should provide the following:

7. Bilingual and bicultural staffing

8. Interpreters and health education materials that are culturally sensitive and available in the primary ethnic languages of the Asian/Pacific communities.

9. Community-based facilities and mobile clinics, with designated service sites, a primary health care team, and bilingual/bicultural health providers, to provide direct services

10. Initiation and expansion of community education outreach efforts through vernacular media

11. Culturally relevant treatment modalities
SUMMARY

This paper has been an attempt to review the health care concerns faced by the Asian/Pacific Islander community and to explore strategies for the improvement of health services to this diverse minority group. Legislators, government agencies, and funding sources have a responsibility to be involved in working toward a change of the unfortunate situation that exists at this time, that of inadequate and inappropriate health care for Asian/Pacifics.

The Asian/Pacific Islander community must be assured of their fair share in the budget allocation and distribution of resources of Federal agencies serving the total population. Federal minority programs must reach out to place Asian/Pacifics in administrative and policymaking positions to help assure equitable representation in programs.

We feel that the major thrust which Asian/Pacific Islander people must undertake during the 1980s is to assume greater responsibility for our own health care. We must stress the need for specialized services and hold our political and administrative officials responsible to respond to our particular needs. Therefore, we urge the private and public health providers to adopt an action plan for the improvement of the health status of Asian/Pacific Islander people.
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