Community Health Needs & Resource Assessment:

An Exploratory Study of Cambodians in the Bronx

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Note: To date, CSAAH has completed assessments in the Cambodian, Chinese, Filipino, Korean, Vietnamese, and South Asian communities. The Japanese CHNRA is forthcoming. Bilingual surveys were administered by trained staff members and volunteers at various community-based sites such as community centers, places of worship, health organizations/agencies, local businesses as well as community events like health fairs and cultural celebrations. Each assessment had a set of advisors to guide the process; which included CSAAH partnering with over 30 concerned individuals, community groups, faith based organizations, and professional associations to design, conduct, analyze, and interpret these assessments.

Background

More than one million documented and undocumented Asian Americans live in New York City (NYC). However, there is scant health research available on NYC Asian Americans. In collaboration with community-based organizations and advocates, the NYU Center for the Study of Asian American Health (CSAAH) conducted a series of community health needs and resource assessments (CHNRA) among Cambodians, Chinese, Filipinos, Japanese, Koreans, South Asians, and Vietnamese in NYC from 2004-2007. The studies were exploratory in nature, using formative research methods to identify the health concerns and needs of Asian Americans in New York City. The goals of the assessments were to determine 1) the degree to which the health issues exist in the Asian American community; (2) the resources available for Asian Americans; and (3) the best approaches to meet the needs of the Asian American community in New York City. The study activities included a review of the current state of health literature on Asian American health and the conduct of a survey on the community's perceived health status, health seeking behaviors, barriers to care, and health resources available for the community. From this, a set of health priority areas and strategies

were developed that will guide health education material development, community outreach initiatives, and future research projects for the specific Asian American communities.

The following are the results from 97 surveys of the Cambodian Community Health Needs and Resource Assessment of individuals 18 years or older living in the Bronx, New York, where the majority of the NYC's Cambodians reside. Findings of the Cambodian CHNRA are compared to national and local data to assess similarities and differences of experiences.

Who are the Cambodians in NYC?

HISTORICAL OVERVIEW

Similar to migrations from other nations in Southeast Asia, the emigration of Cambodians and their health status as refugees in the United States must be understood through their unique historical and political experiences. The history of Cambodia and its people is multi-faceted, including the rise of the Khmer Empire (9th through the 13th centuries A.D.); international relations with China, India, Thailand and Vietnam; and colonization under France (1836-1954). In 1975, the Khmer Rouge led by Pol Pot gained control over the various military groups vying for power and began to systematically restructure the face of Cambodian society by killing civil servants, educated peoples, religious leaders, critics of the Khmer Rouge, and other non-communist community leaders. Families were reorganized by the state, and much of the Cambodia's urban populations were forced to labor in agrarian communities. In addition to political killings, during the 5-year Khmer Rouge regime death resulted from food shortages, malnutrition and famine. Out of a population of 7 million, it has been estimated that 1.5 to 2 million of the population of 7 million perished under Khmer Rouge rule (Ong, 2003).

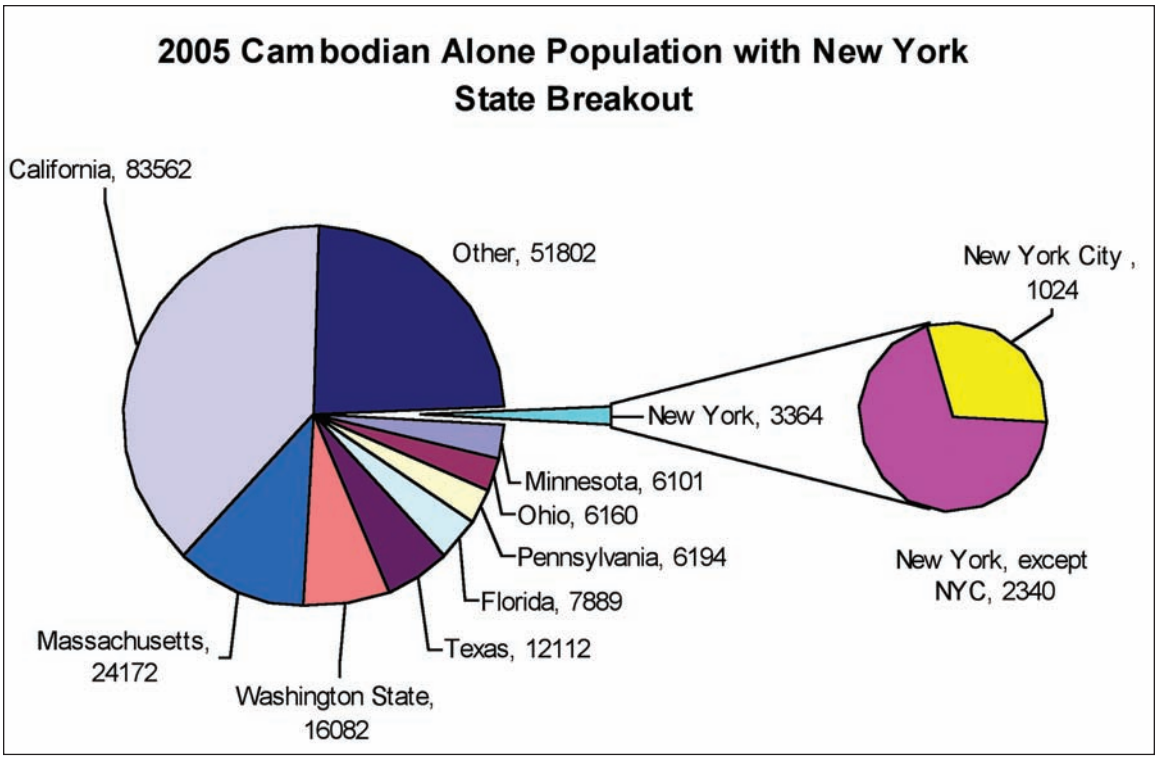

Figure 1: Cambodian Population (Alone) in the United States

Source: American Community Survey, 2005.

Cambodian refugees and their families in the United States are survivors of this history.

When Vietnam invaded Cambodia in 1979 to suppress the Khmer Rouge many Cambodians fled to the Thai border. Now as political refugees, many Cambodians spent various lengths of time at refugee camps along the Thai border where they soon had to navigate the process of seeking asylum and resettlement abroad. The Refuge Act of 1980 allowed for many Cambodians to immigrate to the United States as political refugees, and approximately 150,000 Cambodians arrived to the United States between 1981 and 1985. After this time period, Cambodian immigration and resettlement slowed to a much lower rate.

IMMIGRATION AND SETTLEMENT IN NYC

Cambodians arriving to New York City as refugees in the early 1980's were resettled primarily in neighborhoods of the Bronx and other distressed areas where housing was often sub-standard, as well as most affordable. Much of the Cambodian community in New York City today is concentrated in the northwest Bronx and areas of Brooklyn. As authorized by the Refugee Act of 1980 and subsequent legislation, Cambodians and other refugees had short-term access to welfare programs including Medicaid, housing assistance, and food stamp and cash benefits compared to voluntary migrants. However, reforms in federal welfare and immigration policy since 1996 have also had a deep impact on the security of this community. Despite more than

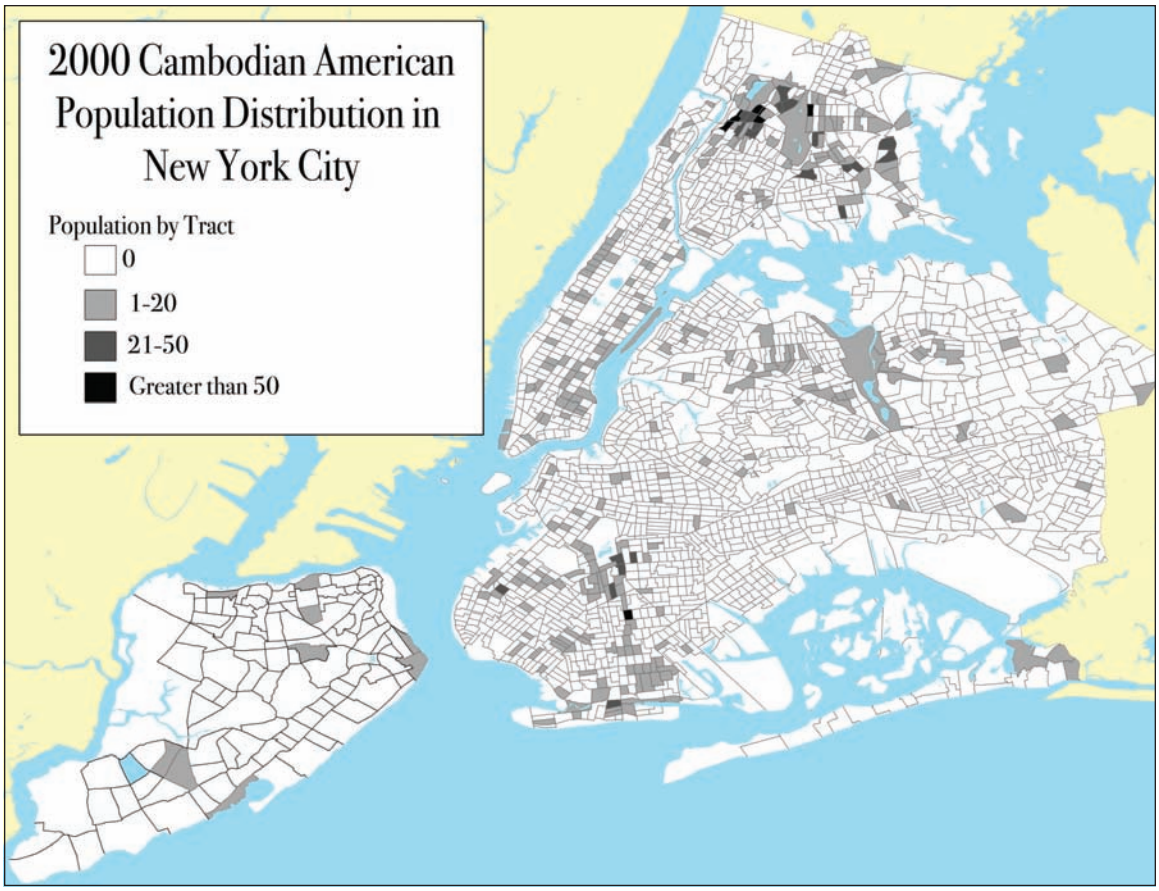

Figure 2: Geographic Distribution of Cambodians in NYC

Source: United States Census Bureau (2001).

20 years of history in New York City, poverty is persistent, educational opportunities and English proficiency remain limited for many, and lower levels of citizenship also keep community members vulnerable to the United States criminal justice and immigration systems.

Due to the relatively smaller population of Cambodians living in New York State, sociodemographic data for Cambodian New Yorkers was not available from the 2005 American Community Survey, which analyzes populations numbering 65,000 or greater. Population size for Southeast Asians in New York State and City are only available for populations that are "alone" and not in "combination with any other race." Therefore population size data from the 2005 American Community Survey presented here for Cambodians in New York are an underestimate, and do not count those of mixed race and ethnicity.

According to the 2005 American Community Survey (ACS), the states with the largest populations of Cambodians are California, Massachusetts, Washington, and Texas, which account for more than 60% of the Cambodian population in America. New York State's Cambodian community is smaller than those mentioned above but sizable with a population of 3,364 reported to be Cambodian alone in the 2005 American Community Survey.

Approximately 30% of this population was living in New York City. With a population of about 1,024 reported in 2005, the New York City Cambodian population is spread out over all 5 boroughs with higher concentrations residing in areas of Brooklyn and the Bronx.

Data from the U.S. Census shows significant shifts in this population over the past two decades (U.S. Census Bureau, 1990, 2000, 2006). Between 1990 and 2000 the Cambodian population "alone or in combination with any other race" in New York State decreased 20.6% (3,746 to 2,973). The updated, though underestimated, population data for Cambodians "alone" from 2005 shows a growth of at least 13.2% increase (2,973 to 3,364) throughout New York State.

Nevertheless, it is possible to compare 2007 Cambodian CHRNA data to the Cambodian population nation-wide from the 2005 American Community Survey. Compared to national statistics, the sample from the CHNRA of Cambodian in New York had a larger proportion of respondents who were female (51% vs. 68%) and foreign-born (58% vs. 79%); however the lengths of United States residence reported for both samples are similar. Rates of limited English-proficiency were found to be much higher among Cambodians in the Bronx (79%) when compared to the national rate (44.2%).

Levels of educational attainment are also significantly lower among Bronx Cambodians compared to Cambodians nation-wide. Forty-one percent of Cambodians in the United States in 2005 had less than a high school degree, while in the Bronx 32% reported some high school or a high school degree (between 9-12 years)[1], 21.6% had only attended some elementary school (between 1-8 years), and 26.8% had received no formal education during their lifetime. Levels of educational attainment for Cambodians nationally and Cambodians in New York City are significantly lower when compared to the general population. For example, the 2000 U.S. Census reported that 47.3% of NYC Cambodians have a high school degree or higher, which is lower than the overall New York City rate of 72.3%. (U.S. Census, 2000). Historically there was limited access to formal education in Cambodia, particularly in rural areas where illiteracy is common. Furthermore, the Khmer Rouge regime systemically killed educated members of Cambodia's society and Cambodians in the United States today are the survivors of this history (Ong, 2003).

Considering the low levels of educational attainment reported for Cambodians in the United States and locally, and their history as refugees, it is not surprising that the Cambodian CHNRA documented significantly high levels of unemployment, poverty and utilization of public benefits for this community in the Bronx. Based on the 2005 American Community Survey 39% of Cambodian nationally are not in the labor force, and 21% experience poverty. In the Bronx, approximately 55.7% are not in the labor force. While income data from the Cambodian CHNRA is incomplete, the rate of public assistance utilization can be

[1] Comparison of data indicating levels of education between the U.S. Census Bureau and Cambodian CHNRA is limited because different measures were used. While the U.S. Census measures those who have attained a high school degree compared to those who have not, the CHNRA asked for total years of education in specific categories, e.g. 9-12 years equivalent to some high school or a high school degree.

used as an indicator for poverty and 57.7% of respondents live in households that receive at least one type of public assistance, excluding government health insurance (e.g. Medicaid, Medicare). Twice as many Bronx Cambodians received means-tested public benefits than Cambodians nationally: 30% vs. 14.4% receiving Supplemental Security Income (disability benefits); and 36.1% vs. 18.6% receiving Food Stamps. An additional indicator of poverty, 54% of Cambodians in the Bronx receive government health insurance compared to 34% among all New York City residents.

Figure 3: The Cambodian American Demographic Profile At-A-Glance

	United States	**Cambodian CHNRA**
Source	U.S. Census (2006). National Data from the American Community Survey, 2005 of Cambodian alone or in any combination.	CSAAH (2007). Cambodian Community Health Needs & Resource Assessment.
Total Population	241,025	97
Gender	51% Female 49% Male	68% Female 31% Male 1% Declined to state
Place of Birth	58% Born Outside U.S. 42% US-Born	79% Born Outside U.S. 21% U.S.-Born
Length of stay in U.S.	10% Entered 2000 or later 13% Entered 1990 to 1999 77% Entered before 1990	3.4% Entered 2000 or later 13% Entered 1990 to 1999 75.3% Entered before 1990 8.3% Decline to state
Citizenship	73% US Citizens 42% Native 31.5% Naturalized 27% Not US Citizens	---
Age	35% Ages 18 -34 28% Ages 35 – 54 11% Ages 55 and older	44% Ages 18-34 35% Ages 35-54 21% Ages 55 and older
Educational attainment	41% Less than high school 25% High school graduate 31% Some college or Bachelor's degree 3% Graduate or professional degree • Population 25 years or older	27% No formal education 22% Elementary school or less 32% Some high school or high school degree 28% Some college or college degree 1% Graduate or professional degree 8.2% Declined to state • Population 18 years or older
Language	44.2% speak English less than "very well"	70% speak English less than "very well"
Employment status	61% In labor force 39% Not in labor force	42% In labor force 56% Not in workforce 2% Declined to state

* Figure 3 continues on the next page

Income	$44,955 (median household income) $13,267 (per capita income)	---
Poverty and Public Assistance Benefits	21% Poverty Status 13% Social Security Income 14% Supplemental Security Income 19% Food Stamps	58% Receive some form of Public Assistance 13% Social Security Income* 30% Supplemental Security Income* 36% Food Stamps

* The Cambodian CHNRA Survey asked respondents if they received "SSI" (interpreted as Social Security Income) and "Disability" (interpreted as Supplemental Security Income). Upon analyzing the data, the ambiguity of responses was noted and as a result, the data represented here may be an underestimate of those receiving "Supplemental Security Income" or disability benefits.

Health Status and Access to Healthcare

HEALTH STATUS

When asked to describe their general health, 52% of Cambodian survey respondents rated their health as "Good" or "Excellent." Individuals with less education reported being in poor health more often than others. Additionally, over 60% of respondents who were not working described their health as "poor."

Findings from the CHNRA also characterize key indicators for potential poor health outcomes. Community members born outside the United States reported "poor" health status twice as often as respondents born in the U.S. Likewise, those receiving public benefits reported "poor" health status twice more often than those who were not. Respondents who require language assistance when receiving healthcare services reported to have "poor" health three times more often than those who do not need language assistance.

Feedback from community partners suggests that the sample from the Cambodian CHNRA is relatively young compared to the actual make-up of this community. Thus, there should be special consideration when interpreting data from older Cambodian respondents. For

instance, it was found that older Cambodian adults are more likely than working-age and young adults to have indicators for poor health status such as foreign birth, limited English-proficiency, lower educational attainment, low-income and receiving public benefits. For example, "chronic fatigue" was only reported by respondents who were not working or who were receiving public benefits. Furthermore "chronic pain" was reported by 80% of respondents who were not working or who were receiving public benefits. For older adults (55 years or older) representing 21% of the CHNRA sample, 53% reported chronic fatigue and 60% reported chronic pain.

ROUTINE CHECKUPS

The Cambodian respondents were knowledgeable about where to go for healthcare services (85%). Sixty-seven percent have seen their doctors within the past 12 months. Additionally, only 6% of Cambodian CHNRA respondents do not have a regular healthcare provider compared to 20% for all New York City residents (NYC DOHMH, 2005).

HEALTH INSURANCE

Results of the Cambodian CHNRA found that only 7% of all respondents have no health insurance coverage. Fifty-four percent of Cambodian CHNRA respondents receive public health insurance such as Medicaid, Medicare, Family Health Plus, or the Prenatal Care Assistance Program. However, the question of access to and maintenance of health insurance coverage for this community is complicated. Staying on public health insurance and sustaining other public benefits is a constant challenge that Cambodian families face. Reasons include low levels of English-proficiency and education, public benefits systems which may not be linguistically accessible or responsive to community needs, and a lack of professional support or services to help Cambodian community members navigate the system.

BARRIERS TO HEALTHCARE

Results from the CHNRA indicate that the Cambodian community faces a host of challenges when accessing healthcare services. Limited English language proficiency is among the most important indicators to understanding the health care challenges facing immigrant communities. Also relevant are poverty and income, educational attainment, and immigration status, as these factors may determine the likelihood of immigrants to seek medical attention. Having limited English proficiency greatly impacts the ability to access public services, read published health information and forms, and comply with providers' instructions. According to the Cambodian CHNRA, 70% have limited English-proficiency; and 30% speak English fluently.

Sixty-one percent of Cambodian respondents indicated that they do not have a healthcare provider who speaks in a language that they are comfortable communicating in. Seventy-two percent have problems understanding their healthcare providers—whether or not their provider speaks their language. Forty-one percent of Cambodian respondents need an interpreter during their medical appointment. Most often, their interpreters are their children or family members. Additionally, 26% of respondents have difficulty understanding health information and 23% report difficulties paying for healthcare services.

Health Conditions

CANCER

In a study of cancer rates in the Cambodian communities of California, Seattle, and Washington between 1998 and 2002, the top five cancer incidence rates for males were lung and bronchus, liver, prostate colorectal, and stomach cancers. The top five incidence rates for females were breast, lung, colorectal, cervical, and thyroid cancers. In addition, this study compared the cancer incidence rates of Cambodians to those of non-Hispanic Whites in the same regions and found that for men, the cancer sites with the largest disparities between these two populations were found to be nasopharyngeal cancer, liver and intrahepatic bile duct cancer, stomach cancer, and myeloma. For females, the largest disparities between Cambodians and non-Hispanic Whites were found in nasopharyngeal cancer, liver and intrahepatic bile duct cancer, stomach cancer, and cervical cancer (Kem and Chu, 2007).

Studies conducted in California have shown that cervical cancer is a disease that disproportionately affects immigrants from Southeast Asia. Between 1998 and 2002, Southeast Asians had an incidence rate of cervical cancer that was five times that of the

Figure 4. Community Health Profile

Population	All NYC Residents	All NYC Asian Residents	Cambodian CHNRA Sample
Source	NYC Department of Health & Mental Hygiene (2005). Community Health Survey.	NYC Department of Health & Mental Hygiene (2005). Community Health Survey.	CSAAH (2007). Cambodian Community Health Needs & Resource Assessment.
Health Status	19% Excellent 25% Very Good 34% Good 23% Fair or Poor	13% Excellent 26% Very Good 32% Good 30% Fair or Poor	7% Excellent 44% Good 36% Fair 12% Poor
Health Insurance	34% Public Insurance 59% Private 17% Uninsured	38% Public Insurance 41% Private 21% Uninsured	54% Public Insurance 39% Private 7% Uninsured
Have a Regular Healthcare Provider	80% Have a regular provider	79% Have a regular provider	94% Have a regular provider
Have High Cholesterol	26% Yes* 74% No*	26% Yes* 74% No*	20% Yes 80% No
Have High Blood Pressure	58% Yes* 42% No*	40% Yes* 61% No*	22% Yes 78% No
Current Smoker	19%	13%	23%

* Data drawn from 2002 NYC Community Health Survey.

non-Hispanic White population (Kem et al,. 2007). These high rates could be explained by very low rates of PAP smears, which screen for pre-cancerous abnormal cells of the cervix, reported in the Cambodian community as illustrated by studies in Minnesota and Texas (Taylor, 2002). Efforts should be made to educate Cambodian women as well as their healthcare providers of the elevated risk of cervical cancer for Southeast Asian women and the importance of pap tests in the early detection and treatment of this cancer. With the recent opportunity of vaccination for the types of human papillomavirus (HPV) which can cause cervical cancer, culturally and linguistically appropriate efforts must be made to educate the community on availing of this vaccine.

CARDIOVASCULAR DISEASE, DIABETES, AND NUTRITION

In California, Cambodians have a rate of stroke four times that of the non-Hispanic White population in the same state (APIAHF, 2006). Some postulate that the high rate of cardiovascular morbidity in Cambodians can be attributed to the long-term effects of starvation under the Pol Pot regime and during escape from Cambodia (National Diabetes Education Project, 2006). In a Minnesota study of students, Cambodian girls were twice as likely of having hypertension when compared to white and black children from the same sample. This elevation of blood pressure is likely to persist into adulthood and can have health implications later in life (Munger, 1991). Among Cambodian CHNRA respondents, 20% indicated that they are hypertensive (high blood pressure), but only 1 out of 3 hypertensives had received counseling or education on how to manage the condition.

In addition to these elevated cardiovascular disease rates, a REACH 2010 survey of Cambodians reported they are less likely than the general population to eat the daily recommended amounts of fruits and vegetables.

Less than half of those surveyed reported ever having their blood cholesterol checked (CDC, 2004). For Cambodians in the Bronx, 13% of survey respondents reported they had high cholesterol with only half of these individuals indicating that they received cholesterol counseling or education.

Diabetes is a known issue for Cambodians. In a 2005 study of Cambodians in Cambodia, a quarter of all adults sampled had some degree of glucose intolerance. War-time experiences such as food deprivation and malnutrition have been associated with elevated risk for adult diabetes (National Diabetes Education Project, 2006). This trend is most likely mimicked in the Cambodian American population and possibly exacerbated by the acculturation effects of changing diets and lifestyles. While there is a dearth of data on the prevalence and health outcomes of diabetes for Cambodians in the United States, national health collaboratives and numerous local organizations throughout the United States recognize diabetes as a health crisis in the Cambodian community (National Diabetes Education Project, 2006). While only 3% of Cambodian CHNRA respondents reported having diabetes, over one-third (34%) know someone in the community with diabetes.

HEPATITIS B

The chronic hepatitis B infection rate for Cambodians is at three times the rate of the general population (APIAHF, 2006). While infection rates are very high, Cambodians have a very low rate of serological screening for hepatitis. A study of Cambodian women in Seattle, Washington showed that only 38% had ever been tested for the hepatitis B virus. This study also showed that the Cambodian women surveyed had low levels of knowledge of how the disease is transmitted and the trajectory of chronic hepatitis B infection. Furthermore, chronic hepatitis B infection and liver disease are intimately entwined. Individuals who are chronically infected with hepatitis B are potentially infectious to intimate and cohabitating contacts; in addition they are at an increased risk of cirrhosis, liver failure, and liver cancer (Choe, 2006). Considering the significant incidence of hepatitis B in Southeast Asian populations, healthcare providers and community leaders must promote education, screening and vaccination efforts for hepatitis B and facilitate access to treatment for people who are chronically infected with the virus.

MENTAL HEALTH & SUBSTANCE ABUSE

The history of Cambodians as survivors of war and refugees has a huge impact on the mental health of this population. Cambodian immigrants who had lived in Cambodia between 1970 and 1980 were found to have experienced between 8 and 16 major trauma experiences including torture, long periods of malnutrition, slave labor, imprisonment, and witnessing atrocities (APIAHF, 2006). A recent study reported that Cambodians who have experienced past trauma had high rates of PTSD at 62% and high rates of major depression at 51% (Marshall, 2005). High rates of psychiatric disorders due to trauma continue even 20 years after immigration from Cambodia. While it is known that Asian Americans tend to underutilize mental health services, further research is required to investigate if the same trend exists in Cambodian populations and if it does exist, ways in which to address this underutilization.

Among Cambodian CHNRA respondents, 20% reported having emotional difficulties and consistently having poor mental health. Many respondents indicated that they "rarely or never" receive emotional or social support (56%). Consistent with previous studies on Cambodians, results of the CHNRA show that depression is a major problem for the community. Almost half of survey respondents (47%) are significantly at risk for depression, most of these individuals have less than an 8th grade education. Eighty percent of elder Cambodian CHNRA respondents were found to be significantly at-risk for depression, compared to the rates at 63% for persons ages 35-54 and 40% for ages 18-34.

The CHNRA documented health behaviors and somatic symptoms related to mental health status and refugee experience among Cambodians. Only 8% report drinking alcohol, usually 1-3 drinks per week. Twenty-three percent smoke cigarettes and all smoke less than 10 cigarettes—or half a pack—per day. These behaviors are likely to be underreported by respondents. Sleep disturbance were common among 53% of community members, and chronic pain, fatigue and other physical difficulties were also frequent (between 16-27%).

TRADITIONAL MEDICINE

Culture plays a large role in the health practices of Cambodians. Traditional medicine and healers are an integral part of Cambodian culture. As such, many Cambodians will use traditional medicine before seeking treatment with a Western practitioner. However, sometimes both traditional and Western medicines are used simultaneously (APIAHF, 2006). Among respondents to the CHNRA, 31% percent utilize alternative and complementary medicine and therapies.

Figure 5. Cambodians in the Bronx are significantly at-risk for depression

Source: Cambodian Community Health Needs and Resource Assessment (2007).

2 out of 3 Cambodians at-risk for depression are:	4 out of 5 Cambodians at-risk for depression are:
• Born outside of the U.S. • Living in poverty and receiving public benefits • A woman	• Limited English-proficient and require interpretation services in healthcare settings • Over the age of 55 years

Literature Gaps and Recommendations

The experiences of Cambodians in New York City are among the most under-documented. Due to the lack of research, little is known about the community's particular health needs and resources available. The development of the Cambodian Community Health Needs and Resource Assessment was one of the first attempts to capture a story of the health experience of Cambodians living in the Bronx.

The Cambodian CHNRA clearly documents unmet needs with regard to healthcare and social services for Cambodians living in New York. Additional recommendations include:

- Improve the quality of healthcare by providing medical interpretation, staff educational materials, and access to phone medical systems in Khmer and other Southeast Asian languages;

- Ensure the quality of healthcare services and community members' access to the continuum of healthcare, including the integration of complementary and alternative healthcare practices such as acupuncture, cupping, massage, and horticultural therapy;

- Develop education on health promotion and disease prevention that is culturally and linguistically appropriate targeting Cambodians in New York;

- Increase the awareness of healthcare providers and supportive staff about the Cambodian community's history, culture, and experiences as refugees;

- Understand health disparities in the Cambodian community to be the complex sequelae of being refugees and trauma survivors;

- Utilize a holistic approach to provide comprehensive medical care in conjunction with supportive and informational social services;

- Improve the economic conditions for Cambodians living in New York City in order to enhance their quality of life and facilitate access to healthcare services;

- Leverage community resources to build the capacity of local healthcare systems in providing linguistically and culturally accessible healthcare by actively recruiting and training community members to staff healthcare facilities.

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Appendix

RESOURCES FOR THE CAMBODIAN COMMUNITY IN NYC

INDOCHINA SINO-AMERICAN COMMUNITY CENTER

170 Forsyth Street, 2nd Floor
New York, NY 10002
phone: (212) 226-0317

KHMER HEALTH ADVOCATES

29 Shadow Lane
West Hartford, CT 06110
phone: (860) 561-3345
www.khmerhealthadvocates.org

CAAAV: ORGANIZING ASIAN COMMUNITIES

2473 Valentine Avenue
Bronx, NY 10458
phone: (718) 220-7391
www.caaav.org

TOLENTINE-ZEISER / ST. RITA'S CENTER FOR IMMIGRANT AND REFUGEE SERVICES

2342 Andrews Avenue
Bronx, NY 10468
phone: (718) 365-4390