Community Health Needs & Resource Assessment:

An Exploratory Study of Vietnamese in NYC

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NYU School of Medicine
Institute of Community Health and Research
Center for the Study of Asian American Health
550 First Avenue, MSB-153
New York, NY 10016
www.med.nyu.edu/csaah

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Acknowledgements

Written by Christian Ngo and Douglas Nam Le

Photography credits: Noilyn Abesamis-Mendoza, Douglas Nam Le, Teresa Nguyen, Khanh Phan

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CSAAH COMMUNITY OUTREACH TEAM

- **Douglas Nam Le**
- **Noilyn Abesamis-Mendoza, MPH**
- **Henrietta Ho-Asjoe, MPS**

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For more information, please contact us at csaah@med.nyu.edu or 212-263-0485.

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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 conducted a series of community health needs and resource assessments (CHNRA) among Cambodians, Chinese, Filipinos, Koreans, Japanese, 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 health needs 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 to guide health education

material development, community outreach initiatives, and future research projects for the specific Asian American communities.

The following are the results from 100 surveys of the Vietnamese CHNRA of individuals 18 years or older. Findings of the Vietnamese CHNRA are compared to national and local data to assess similarities and differences of experiences.

Who are the Vietnamese in NYC?

HISTORICAL OVERVIEW

Although mass migration from Vietnam to the United States occurred during and after the fall of Saigon in 1975, there were in fact small numbers who chose to migrate to the U.S. before then. Refugees from Vietnam were vulnerable to violence and possible death at sea; and many were also repatriated. As political refugees, they spent upwards of 15 years at refugee camps located throughout Southeast Asia where they had to navigate the process of seeking asylum and resettlement abroad.

Prior to 1975, the number of Vietnamese choosing to migrate to the United States was very small compared to the number of immigrants who emigrated during and after the fall of Saigon in 1975. The first movement of refugees in 1975 consisted mainly of educated professionals from the South Vietnam who had military or political connections with the United States. A majority of these individuals were resettled in the United States. The second migration of refugees are referred to as the "Boat People" who escaped by boat or by land without the direct help of the U.S. military. This group consisted of people from a variety of social and economic classes and from both the north

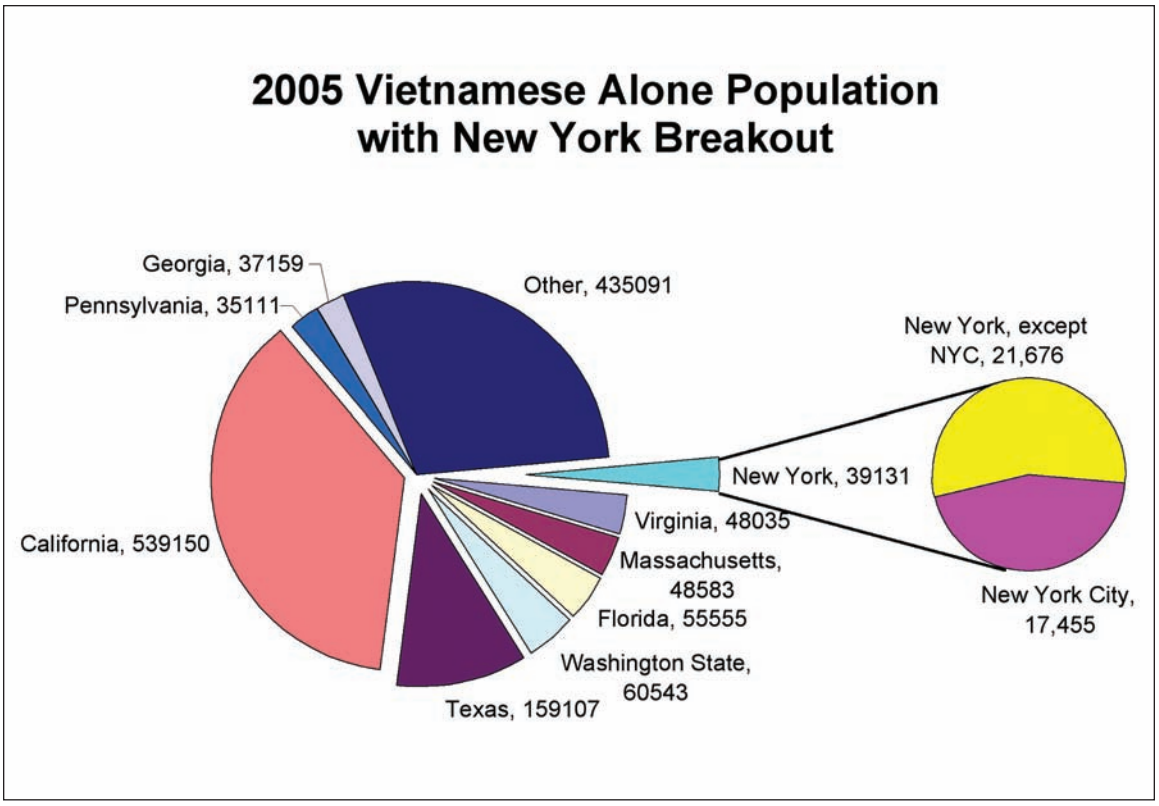

Figure 1: Vietnamese Population in the United States.

Source: American Community Survey, 2005.

and south of Vietnam. This wave lasted for over a decade until the late-1980's. The third wave of refugees included those who came to the United States through the Family Reunification and the Orderly Departure Program. Many of these individuals had family members who were already residing the United States, were former employees of government agencies, or had a relationship with the U.S. presence before the fall of Saigon (Freeman, 2005).

The 1987 Amerasian Homecoming Act brought over children of American military and civilian personnel stationed in Vietnam during the war. The intent was to reunite these children with their fathers, however only a handful were able to reconnect. It is estimated that over 30,000 Amerasians and their families were resettled in the U.S. during this time. Additionally, the Humanitarian Operations program admitted thousands of Vietnamese, mostly former South Vietnamese soldiers, political prisoners and their families who were part of re-education programs. Lastly, the Resettlement Opportunities for Vietnamese Returnees program was created in the mid-1990s. This program allowed individuals who were unable to prove their refugee status and languished in Southeast Asian camps an opportunity to be re-interviewed for possible resettlement in the United States (Lai & Arguelles, 2003). These migrations made up the fourth major wave of Vietnamese Americans.

The first four waves of refugees to the United States from Vietnam received refugee status by

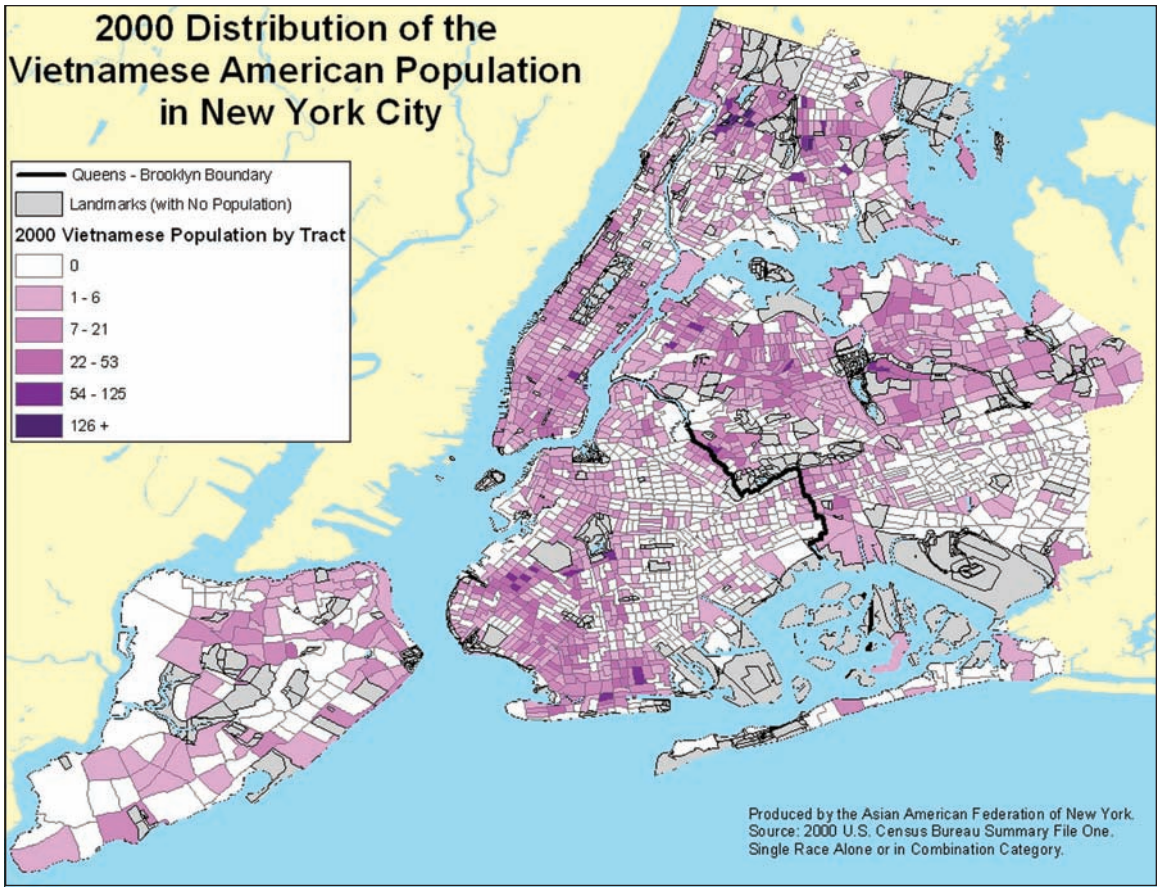

Figure 2. Geographic Distribution of Vietnamese Population in NYC. Asian American Federation of New York Census Information Center (2005).

the U.S. government and thus were able to avail of social welfare programs upon arrival in the United States. However, in more recent years, refugee status and the associated benefits were scaled back for Vietnamese coming to the United States. For example, Vietnamese immigrants under the Humanitarian Operations program received refugee status for only five years once they arrived in the United States. Many recent immigrants have not had the same level of access to public assistance as Vietnamese Americans who have settled earlier. Historically it had been the policy of the United States to scatter the resettlement of Southeast Asian refugees throughout various parts of the country in order to facilitate integration and to relieve the potential burden that newly arrived families might pose on receiving communities. Nevertheless many families migrated within the United States to follow larger enclaves of other Vietnamese, such as in California, Texas, or Massachusetts, and to pursue economic opportunities, higher standards of living, or more favorable weather.

IMMIGRATION AND SETTLEMENT IN NYC

According to the 2005 American Community Survey, there are about 1.5 million Vietnamese living in the United States. Approximately 60% of this population lives in only five states: California, Texas, Washington State, Florida, and

Massachusetts (Fig. 1) (U.S. Census, 2006). New York has the 7th largest number of Vietnamese individuals with a population of 39,131, of which 17,455 live in New York City.

Unlike other parts of the U.S. such as Little Saigon in Orange County, California; Houston, Texas; or Dorchester in Boston, Massachusetts, there is no strong Vietnamese enclave in New York City. Instead, the NYC Vietnamese community is spread throughout the 5 boroughs with higher concentrations of Vietnamese residing in the neighborhoods of Queens, southern Brooklyn, and the northwest Bronx. Manhattan's Chinatown has also been a node of the Vietnamese community, particularly for refugees who are ethnic-Chinese from Vietnam. Of the 17,455 in NYC, 27% live in Queens, 27% in Brooklyn, 21% in the Bronx, 20% in Manhattan, and 6% in Staten Island (Fig. 3) (U.S. Census, 2006). The NYC Vietnamese population represents 44.6% of the total 39,131 Vietnamese population throughout New York State.

DEMOGRAPHICS

Due to the relatively smaller population of Vietnamese living in New York State, sociodemographic data for Vietnamese living in New York State and New York City were 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 Vietnamese in New York are an underestimate.

Nevertheless, it is possible to compare 2007 Vietnamese CHRNA data to the Vietnamese population nation-wide from the 2005 American Community Survey. Compared to national statistics, the sample from the CHNRA of Vietnamese in New York was more likely to be male (49% vs. 53%), foreign born (64% vs. 95%), younger, and recent immigrants. Eighty-nine percent of Vietnamese in NYC have Limited English Proficiency (speaking English less than "very well") which is also higher than the national average for Vietnamese 52% (U.S. Census, 2006). While a larger percentage of respondents to the Vietnamese CNHRA compared to national data were in the labor force (77% vs. 65%) and have larger households (3.8 vs. 3.3); household incomes tended to be lower for Vietnamese in New York and rates for receiving public benefits were higher (U.S. Census, 2006). More than half of all households in the Vietnamese CHNRA (53%) reported an annual income of $45,000 or less; while only 1 in 3 of these households receives any type of public assistance.

For Vietnamese New Yorkers who participated in the CHNRA, poverty was found to be pervasive and nuanced. The CHNRA found that poverty rates based on reported household income and size for Vietnamese in New York were twice as high as the national average (30% vs. 14%) (U.S. Census, 2006). Poverty rates for Vietnamese households in Brooklyn were slightly higher than rates city wide. In addition, the rate of poverty for Vietnamese households in the Bronx was twice as high when compared to Vietnamese households in Queens.

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

	United States	Vietnamese CHNRA
Source	U.S. Census (2006). National Data from the American Community Survey, 2005 of Vietnamese alone or in any combination.	CSAAH (2007). Vietnamese Community Health Needs & Resource Assessment
Total Population	1,521,353	100
Gender	51% Female 49% Male	47% Female 53% Male
Place of Birth	64% Born Outside U.S. 36% US-Born	95% Vietnam 5% US-Born
Length of stay in U.S.	11.6% Entered 2000 or later 41.7% Entered 1990 to 1999 46.7% Entered before 1990	27% Entered 2000 or later 37% Entered 1990 to 1999 36% Entered before 1990
Citizenship	81% US Citizens 36% Native 46% Naturalized 19% Not US Citizens	---
Working Age Adults	66% Between ages 25-55	77% Between ages 25-55
Educational attainment	28% Less than high school 23% High school graduate 18% Some college or Bachelor's degree 7% Graduate or professional degree • Population 25 years or older	23% Elementary school or less 32% Some high school or high school degree 31% Some college or college degree 13% Graduate or professional degree 1% Declined to state • Population 18 years or older
Language	52% speak English less than "very well"	89% speak English less than "very well"
Employment status	65% In labor force 35% Not in labor force	74% In labor force 26% Not in workforce
Income	$50,726 (median household income) $20,403(per capita income)	32% $25,000 or less 21% $25,001 to $45,000 13% $45,001 to $65,000 15% Over $65,000 19% Decline to state*
Household size	3.3People	3.8People
Poverty and Public Assistance	14.1% Poverty Status 3.9-13.5% Receive some type of Public Assistance	30% Poverty Status 16% Receive some type of Public Assistance

* Reported annual household incomes from the Vietnamese CHNRA.

Health Status, Information, and Health Seeking Behaviors

When asked to describe their general health, 13% of Vietnamese CHNRA respondents indicated their health was "excellent" while 55% rate their health as "fair or poor". As many community members reported excellent health status as they did poor health status. Rates of reporting poor health status are almost twice as high among individuals with public health insurance when compared to the overall rate of those reporting poor health status (62% versus 33%).

Education and health literacy have a significant impact on health status and the utilization of healthcare services. 15% of Vietnamese CHNRA respondents indicated that they have problems understanding information about their health. While 23% have an 8th grade education or less, 44% have taken college courses or obtained a college/advanced degree. Levels of educational attainment for Vietnamese also varied among boroughs. Thirty-one percent of all respondents city-wide had attained a university degree. However the rates of having a university-level education among Vietnamese residents of Brooklyn and Queens were found to be approximately 3 times higher than rates for Vietnamese living in the Bronx (38-40%

Access to Healthcare

HEALTH INSURANCE

National studies of uninsurance among Vietnamese Americans found rates as high as 18%. Results of the Vietnamese CHNRA found similar results with 17% of all respondents indicating that they had no health insurance coverage. Additionally, 1 in 3 Vietnamese (33%) received some type of public health insurance while 1 out of 2 had private or employer-based coverage.

Higher rates of health insurance coverage does not automatically translate to access to quality care that is affordable as well as culturally and linguistically responsive. The question of access to and maintenance of health insurance coverage for this community is complicated. Challenges that Vietnamese communities face include a public benefits system which may not be linguistically accessible or responsive to community needs, lack of professional support or services to help Vietnamese community members navigate the system, and problems with staying on public health insurance and sustaining other public benefits.

BARRIERS TO HEALTHCARE

English language proficiency is among the most important indicators to understanding the health care challenges facing immigrant communities. Also relevant are poverty and income, education, and immigration status, as these factors may determine the likelihood of immigrants to seek medical attention (Fig. 3). Consistent with U.S. Census data on Vietnamese in NYC, 84% of Vietnamese CHNRA respondents reported that they felt most comfortable speaking Vietnamese or another Asian language. Eighty-nine percent of survey respondents were Limited English Proficient, and nearly 1 in 4 spoke English "Poorly" or "Not at All".

Although 63% of survey respondents indicated that they had a provider that spoke a language in which they were comfortable communicating in, 27% identified language barriers when communicating with their healthcare provider. One in four respondents need an interpreter when going to a hospital or health clinic. The majority of those that need language assistance (96%) do not have any interpreter available to them when they seek healthcare services. Sixty-eight percent of those who reported needing language assistance relied on a child or other family member to interpret, while only 32% percent actually received assistance from professional interpreters. Vietnamese that needed language assistance were twice as likely to be uninsured compared to those that didn't need language assistance.

Besides language and communication barriers, the largest barrier that respondents faced was the ability to afford healthcare services (26%). This is not surprising considering that a CDC REACH 2010 survey found that Vietnamese were at least three times more likely to report not visiting a physician due to cost issues than were all Asians or the general US population (APIAHF, 2006). Additional challenges in accessing healthcare for Vietnamese in NYC were time (19%), knowledge of services (12%), transportation barriers (9%), and cultural barriers (8%).

ROUTINE CHECKUPS

Within the arena of preventive health care, studies have highlighted the importance of maintaining healthy eating habits, stopping to smoke, reducing the intake of alcohol, drinking

Figure 4. Comparison of Health Indicators and Language Access Needs

Source: CSAAH (2007). Vietnamese American Community Health Needs and Resource Assessment.

Key Indicators for Access to Healthcare	**Rates for respondents who do not require language assistance in healthcare (N=75)**	**Rates for respondents who do require language assistance in healthcare (N=25)**
Having no formal education	5%	20%
Reporting Fair or Poor Health Status	50%	76%
No health insurance coverage	13%	28%
No regular healthcare provider	15%	20%
Having a healthcare provider who speaks the same language	47%	33%

sufficient water, adhering to a regular exercise regimen; and getting regular screenings or examinations (Cornelius, 2002). By doing so, the likelihood of developing many diseases and conditions such as certain types of cancers, cardiovascular problems, asthma, diabetes, and infectious diseases is decreased.

Among respondents of the Vietnamese CHNRA, 95% reported having a regular doctor, 78% saw their doctor for a routine checkup within the past year, and 65% see a dentist regularly. These findings are likely the result of the relatively high rates of health insurance coverage for Vietnamese in NYC. Anecdotally, it is know that the majority of community members go to a number of Vietnamese-speaking physicians in private, community-based practice throughout NYC for their primary care whether or not they are insured or pay out of pocket. It is promising that community members access primary care regularly, and outreach and health education initiatives targeting this community should engage with primary care physicians as well. However, the community still faces barriers to healthcare including language, transportation, and knowledge of available services when they access hospital-based health screenings, diagnostic services, and treatment.

Figure 5. Community Health Profile

Population	**All NYC Residents**	**All NYC Asian Residents**	**Vietnamese 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). Vietnamese 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	13% Excellent 30% Good 42% Fair 13% Poor 2% Declined to state
Health Insurance	34% Public Insurance 59% Private 17% Uninsured	38% Public Insurance 41% Private 21% Uninsured	33% Public Insurance 49% Private 17% Uninsured
Have a Regular Healthcare Provider	80% Have a regular provider	79% Have a regular provider	95% Have a regular provider
Blood Pressure Screening	96% Yes* 4% No*	91% Yes* 9% No*	70% Yes 30% No
Cholesterol Screening	80% Yes 20% No	75% Yes 25% No	57% Yes 43% No
HIV Test	58% Yes 42% No	40% Yes 61% No	26% Yes 74% No
Colonoscopy (50 years or older)	55% Yes 45% No	50% Yes 50% No	29% Yes 71% No
Mammogram	73% Yes 28% No	65% Yes 35% No	63% Yes 37% No
Pap Test	80% Yes 20% No	64% Yes 36% No	55% Yes 45% No
Current Smoker	19%	13%	17%
Heavy Smoker (more than 10 cigarettes a day)	Among current smokers, 44% Yes 56% No	Among current smokers, 41% Yes 59% No	Among current smokers, 31% Yes 69% No

*Data drawn from 2002 New York City Community Health Survey

Health Conditions

CARDIOVASCULAR DISEASE AND NUTRITION

In 1994, the National Vital Statistics System reported that 1 in 5 Vietnamese Americans (20%) die from cardiovascular disease (CDC, NCHS, 1994). Furthermore, in a study of Vietnamese living in a Gulf Coast community, 44% of those surveyed were found to be hypertensive (Duong, 2001). However, compared to the overall population, Vietnamese Americans have much lower rates of being overweight or obese. However, data from the CDC's REACH 2010 survey shows that when compared to the general population and the Asian American population, Vietnamese are less likely to meet physical activity recommendations or eat the recommended daily amount of fruits and vegetables (APIAHF, 2006).

Approximately one third of the Vietnamese CHNRA respondents indicated that cardiovascular disease (CVD) was a major concern for themselves or their families. These included CVD-related conditions such as hypertension, coronary heart disease, and stroke. In terms of receiving CVD-related screenings, 57% of Vietnamese CHNRA respondents have had their cholesterol checked, 70% were

screened for high blood pressure, and 27% for diabetes. The majority have received these screenings during the past year. The rate of cholesterol screening for Vietnamese in NYC remains low when compared to rates for NYC Asian Americans (75%) and all New Yorkers (80%) (NYC DOHMH, 2005). Diet and nutrition was also identified as a major health concern for 19% of respondents. An emphasis should be placed on culturally appropriate cardiovascular and nutritional health information to ensure that health programs targeted at the Vietnamese population are effective in combating chronic disease.

CANCER

Different cancers affect Vietnamese Americans at a disproportionate rate. For men, the highest cancer mortality rates were from lung cancer, followed by liver cancer, stomach cancer, colorectal cancer, and leukemia. For women, the highest cancer mortality rates were also found in lung cancer, followed by liver cancer, colorectal cancer, breast cancer, and stomach cancer (McCracken, 2007).

Thirty percent of Vietnamese CHNRA respondents indicated that cancer was an important health concern for themselves or their families. Several of the cancers that disproportionately affect Vietnamese Americans are detectable at early stages by standard tests. However, it has been found that Vietnamese have low rates of preventative testing. A 2007 study of Surveillance Epidemiology and End Results (SEER) data found that only 27% of Vietnamese men have had a PSA screening, one of the early detection tests for prostate cancer, in the past year (McCracken, 2007). This rate is the lowest of all ethnic and racial groups examined in the survey.

Colonoscopy and Prostate Cancer

Among Vietnamese CHNRA respondents who were 45 years or older, 29% received a colonoscopy and men represent 73% of those receiving screening. Fifty-seven percent of male respondents over the age of 50 years received screening for prostate cancer.

Lung Cancer.

The incidence of lung cancer is highest for Vietnamese among all Asian American ethnic groups at 72.8 per 100,000 for males and 37.8 per 100,000 for females (McCracken, 2007). In addition, the highest cancer mortality rate for Vietnamese men and women was that of lung cancer (Chu, 2005). With smoking being the number one cause of lung cancer, the CHNRA examined current smoking rates. Seventeen percent of CHNRA respondents reported they were current smokers, and 69% of smokers smoke less than half a pack (≤10) per day. This rate of smoking is higher compared to Asian American current smokers city-wide (13%). Additionally, 76.5% of Vietnamese CHNRA males were current smokers, while only 23.5% of female respondents were current smokers. While lung cancer remains one of the most prevalent cancers in the Vietnamese community, there is a dearth of information available in the literature. Future research should attempt to elucidate the cultural and social factors that contribute to the high rate of smoking among Vietnamese Americans.

Cervical Cancer.

A 2007 study showed that Vietnamese women have the highest incidence of cervical cancer compared to all other Asian ethnic groups studied (McCracken, 2007). Pap testing lowers the risks involved with cervical cancer by allowing

for early diagnosis and treatment. However, pap testing within the Vietnamese community is relatively low. Two studies of Vietnamese in Seattle and California showed that 66% and 69.8%, respectively, of those surveyed had had a pap test (Taylor, 2004; McCracken, 2007). This rate is even lower among Vietnamese CHNRA female respondents (55%); which is also a lower rate compared to Asian American women in NYC (64%) and women city-wide (80%). One factor that is contributing to this low rate of pap testing is physician practices. Studies have shown that a Vietnamese woman is less likely to receive a pap test if her doctor is also Vietnamese (Taylor, 2004). Furthermore, according to a study performed in 2004, many Vietnamese doctors are unaware of the treatment for abnormal pap test results (Taylor, 2004). Many Vietnamese physicians were also found to be unaware that Vietnamese are at heightened risk for cervical cancer and of the survival rates at each stage of diagnosis.

Breast Cancer.

Breast cancer incidence for Vietnamese women is low compared to other ethnic groups but high when compared to other cancer sites (McCracken, 2007). However, Vietnamese women are more likely to be diagnosed with poorly or undifferentiated tumors than non-Hispanic White women. These types of tumors are more malignant than those that are fully differentiated (Lin, 2002). Vietnamese women also have a relatively low frequency of breast cancer screening. In a California survey, more than 40% of Vietnamese women had not had a mammogram in the past year (McCracken, 2007). This rate parallels the rate of Vietnamese CHNRA female respondents in NYC who have not received a mammogram (37%) and a clinical breast exam (45%). However the CHNRA respondents still received mammograms less frequently than all female New Yorkers (73%). A separate study targeting low income women showed that the most common reason cited for not having had a mammogram was that their physician had not recommended one (McGarvey, 2003). Future research and interventions in this area should focus on the roles that a physician plays in obtaining mammograms rather than solely targeting the Vietnamese women themselves.

HEPATITIS B

Hepatitis B virus is a large public health issue for all people of Southeast Asian descent, and particularly Vietnamese. The rate of chronic hepatitis B infection for Vietnamese is 10% compared to less than one percent for the general population (Taylor, 2004). Individuals who are chronically infected with hepatitis B are both potentially infectious to those around them and are at an increased risk of cirrhosis, liver failure, and liver cancer (Choe, 2006). In fact, carriers of hepatitis B are 200 times more likely to contract liver cancer than those who are not infected (APIAHF, 2006). While hepatitis B infection rates for Vietnamese are some of the highest, serological screening is lower than desired as illustrated by a Seattle study showing 66% of the Vietnamese population having been screened (Taylor, 2004). Higher rates of screening are correlated with older age, increased education, private health insurance, and having a regular medical provider (Choe, 2006). A study of low income Vietnamese in the Delaware Valley area of Pennsylvania and New Jersey showed a much lower rate of screening with 92% never having been screened for hepatitis (Ma, 2007). Among Vietnamese

CHNRA survey respondents, 45% have been screened for hepatitis B and 35% for hepatitis C. Considering the significant disparity of hepatitis B in Southeast Asian populations, communities must promote education, screening and vaccination efforts for hepatitis B and facilitate access to treatment for people who are chronically infected with the virus.

In addition to health and well-being during and after pregnancy, an important factor in child health is vaccination. For Vietnamese, the high prevalence of chronic hepatitis B in the community predisposes youth to infection. However, current vaccination rates against hepatitis B are lower than optimal. A 2000 study found that those who were born before 1993 had very low rates of vaccination and that children with Vietnamese physicians were less likely to have been fully vaccinated than those with a non-Vietnamese physician (Jenkins, 2000). This suggests that Vietnamese physicians and those physicians with large numbers of Vietnamese American clients should be educated on the endemic status of hepatitis B in the Vietnamese community and the importance of vaccination in preventing horizontal transmission.

MENTAL HEALTH

Vietnamese mental health is influenced by both the history of immigration and war and the present situation of refugees in America. Factors such as trauma related to surviving war and torture, migration, separation from family members, trouble adjusting to American lifestyles, intergenerational conflict, downward occupational mobility, and reestablishing social networks contribute to an increasingly complex picture of Vietnamese American mental health (Ong, 2002). In addition to these factors, the Vietnamese refugee experience and the traumas experienced during the war, while escaping from Vietnam, and during stays in refugee camps play a large role in the mental health of Vietnamese individuals. In a 2002 study, Vietnamese American students showed higher rates of depression than Whites. In addition, Vietnamese American students' goals were less likely to be pursued for autonomous reasons (Ong, 2002).

Mental health services are highly underutilized by the Asian American population and the Vietnamese show these same trends. A 2005 study conducted on Vietnamese Americans who had been living in the United States for more than eight years showed that none of the respondents had visited a psychiatrist and less than 3% had visited a psychologist. While this study found that most Vietnamese had positive attitudes towards mental health services, it also found that most Vietnamese would not utilize mental health services or recommend their friends use mental health services unless the situation was very severe (Nguyen, 2005).

The two-point Patient Health Questionnaire which is used as a screening tool for depression was incorporated into the CHNRA survey. Among Vietnamese respondents more than 1 in 4 (27%) were identified to be significantly at-risk for depression. Two-thirds of community members identified to be significantly at-risk for depression also reported fair or poor health status. Additionally rates of depression risk varied significantly based on New York City borough of residence. Vietnamese respondents living in the Bronx reported symptoms of depression twice as often as Vietnamese living in Queens (41% versus 19%); and these rates

were found to intermediate among Vietnamese Brooklyn residents (30%). Despite this, only 18% of all survey respondents indicate that mental health is an important health concern.

The process of rebuilding lives in the United States and the potential changes social status, household economics, gender roles, and family structure have a significant impact on mental health of Vietnamese Americans. Family violence can be one outcome of changes in family dynamics and related stressors. Traditionally, Vietnamese households have a strong gender based hierarchy with males being in positions of power where they are earning for the household and women taking on the tasks of nurturing the children and taking care of the household. These roles are disturbed by the disproportionate employment opportunities, affording women more jobs and leaving many men at home in positions that they are not used to. These social issues as well as economic pressures and the strain of acculturation can increase stress and frustration and may lead to instances of family violence. In a small survey of Vietnamese women in Boston, 47% reported intimate partner violence ever, and 30% reported intimate partner violence in the past year (Tran, 1997).

The CHNRA documented health behaviors and somatic symptoms related to mental health status and refugee experience among Vietnamese. Thirty five percent report drinking alcohol, and the majority of those who do drink (71%) consume 1-3 drinks per week. Twenty-three percent of men smoke, while only 12% or women reported smoking. Drinking alcohol as well as smoking are likely to be underreported by respondents. Chronic fatigue was common among 29% of community members; and respondents also reported headaches (25%) and sleep disturbances (24%) to be frequent.

MATERNAL AND CHILD HEALTH

Breastfeeding is an important part of infant health. It provides immunological protection and proper nutrition for the infant and promotes mother-child bonding. However, a 1994 study of Southeast Asian mothers in northern California showed that breastfeeding was uncommon in the Vietnamese community. In addition, the study showed that most Vietnamese women thought that formula feeding was more popular in the United States and that it was healthier than breastfeeding (APIAHF, 2006).

Studies also show that there is a disparity in birth outcomes and prenatal healthcare between Vietnamese mothers and mothers of other Asian descent. A study of Asian American mothers in California showed that Vietnamese mothers had the second highest rates of neonatal, post-neonatal, and infant mortality as well as the second highest rate of low birth weight babies. Vietnamese mothers were also the second least likely to have a private insurance company pay for their delivery (Qin, 2006). Another similar study conducted in 2006 found that Vietnamese women had the highest rate of preterm delivery at 12.4% (Rao, 2006). A study of Asian American mothers in California showed that Vietnamese women had the highest rate of no prenatal care.

Literature Gaps and Recommendations

Though there is some data available on the health disparities that face Asian Americans, a majority of this data is not disaggregated by ethnic group. Thus, the differences that exist in education, socioeconomic status and health among the diverse Asian American community are often masked. As the Vietnamese population in New York grows to a more substantial percentage of the city's population, researchers should aim to investigate the health of the Vietnamese in New York City and the possible differences that exist between the Vietnamese in the northeast and the Vietnamese living in other sectors of the United States.

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

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

- Build the cultural and linguistic competence of programs, healthcare providers and local healthcare facilities serving Vietnamese in

New York to better understand community dynamics, their historical experiences and healthcare needs;

- Ensure the quality of healthcare services and community members' access to the continuum of healthcare—from the doctor's office to hospital—by making available appropriate language assistance and enhanced supportive services;

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

- Despite a long history of organizing and community-based service for Vietnamese living in New York City, there are currently few organizations and resources to support the health, social well-being and economic development of this community. Collaborative mobilization and advocacy from within the community is needed to improve this situation.

References

Asian & Pacific Islander American Health Forum. (2005). *Diverse Communities, Diverse Experiences: The Status of Asian Americans & Pacific Islanders in the U.S.*

Asian & Pacific Islander American Health Forum. (2006). *Health Brief: Vietnamese in the United States.*

Asian American Federation of New York Census Information Center. (2005). *Census Profile: New York City's Vietnamese American Population.* New York: Asian American Federation of New York.

Center for Disease Control and Prevention, National Center for Health Statistics. (1994). *National Vital Statistics System*.

Choe, J. H., Taylor, V. M., Yasui, Y., Burke, N., Nguyen, T., Acorda, E., et al. (2006). Health Care Access and Sociodemographic Factors Associated with Hepatitis B Testing in Vietnamese American Men. *Journal of Immigrant and Minority Health , 8* (3), 193-201.

Chu, K. C., & Chu, K. T. (2005). 1999-2001 Cancer Mortality Rates for Asian and Pacific Islander Ethnic Groups with Comparisons to Their 1988-1992 Rates. *Cancer , 104* (12 Suppl), 2989-2998.

Cornelius, L.J., Smith P.L., & Simpson, G.M. (2002). What factors hinder women of color from obtaining preventive health care. *American Journal of Public Health,* 92(4), 535-539.

Gee, G. C., Spencer, M. S., Chen, J., & Takeuchi, D. (2007). A Nationwide Examination of Discrimination and Chronic Health Conditions Among Asian Americans. *American Journal of Public Health , 97* (7), 1275-1282.

Jenkins, C. N., McPhee, S. J., Wong, C., Nguyen, T., & Euler, G. L. (2000). Hepatitis B Immunization Coverage Among Vietnamese-American Children 3 to 18 Years Old. *Pediatrics, 106* (6).

Kim, S. S., Ziedonis, D., & Chen, K. W. (2007). Tobacco use and dependence in Asian Americans: A review of the literature. *Nicotine & Tobacco Research , 9* (2), 169-184.

Lai, E., & Arguelles, D. (2003). *The New Face of Asian Pacific American: Numebers, Diversity, & Change in the 21st Century.* Berkeley, California: Consolidated Printers, Inc.

Lai, K. Q., Nguyen, T. T., Mock, J., McPhee, S. J., Doan, H. T., & Pham, T. H. (2004). Increasing Vietnamese-American Physicians' Knowledge of Cervical Cancer and Pap Testing: Impact of Continuing Medical Education Programs. *Ethnicity & Disease , 14*, 124-128.

Lam, T. K., McPhee, S. J., Mock, J., Wong, C., Doan, H. T., Nguyen, T., et al. (2003). Encouraging Vietnamese-American Women to Obtain Pap Tests Through Lay Health Worker Outreach and Media Education. *Journal of General Internal Medicine , 18*, 516-524.

Le, G. M., Gomez, S. L., Clarke, C. A., Glaser, S. L., & West, D. W. (2002). Cancer Incidence Patterns Among Vietnamese in the United States and Ha Noi, Vietnam. *International Journal of Cancer, 102*, 412-417.

Lin, S. S., Phan, J. C., & Lin, A. Y. (2002). Breast Cancer Characteristics of Vietnamese Women in the Greater San Francisco Bay Area. *The Western Journal of Medicine , 176* (March), 87-91.

Ma, G. X., Fang, C. Y., Shive, S. E., Toubbeh, J., Tan, Y., & Siu, P. (2007). Risk Perceptions and Barriers to Hepatitis B Screening and Vaccination among Vietnamese Immigrants. *Journal of Immigrant and Minority Health*, 213-220.

Ma, G. X., Shive, S. E., Fang, C. Y., Feng, Z., Parameswaran, L., Pham, A., et al. (2007). Knowledge, Attitudes, and Behaviors of Hepatitis B Screening and Vaccination and Liver CAncer Risks Among Vietnamese Americans. *Journal of Health Care for the Poor and Underserved, 18*, 62-73.

Ma, G. X., Tan, Y., Toubbeh, J. I., Su, X., Shive, S. E., & Lan, Y. (2004). Acculturation and smoking behavior in Asian-American populations. *Health Education Research, 19* (6), 615-625.

McCracken, M., Olsen, M., Chen, M. S., Jemal, A., Thun, M., Cokkinides, V., et al. (2007). Cancer Incidence, Mortality, and Associated Risk Factors Among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese Ethnicities. *CA: A Cancer Journal for Clinicians, 57*, 190-205.

McGarvey, E. L., Clavet, G. J., Johnson, J. B., Butler, A., Cook, K. O., & Pennino, B. (2003). Cancer Screening Practices and Attitudes: Comparison of Low-income Women in Three Ethnic Groups. *Ethnicity & Health, 8*, 71-82.

McPhee, S. J., Nguyen, T., Euler, G. L., Mock, J., Wong, C., Lam, T., et al. (2003). Succesful Promotion of Hepatitis B Vaccinations Among Vietnamese-American Children Ages 3 to 18: Results of a Controlled Trial. *Pediatrics, 111*, 1278-1288.

Moechberger, M. L., Anderson, J., Kuo, Y.-F., Chen, M. S., Wewers, M. E., & Guthrie, R. (1997). Mutlivariate Profile of Smoking in Southeast Asian Men: A Biochemically Verified Analysis. *Preventive Medicine, 26*, 53-58.

New York City Department of Health & Mental Hygiene (2005). Selected results from *The Community Health Survey* 2005. New York, NY: NYC Department of Health & Mental Hygiene, Division of Epidemiology, Bureau of Epidemiology Services.

Nguyen, Q. C., & Anderson, L. P. (2005). Vietnamese Americans' Attitudes Toward Seeking Mental Health Services: Relation to Cultural Variables. *Journal of Community Psychology , 33* (2), 213-231.

Nguyen, T. T., McPhee, S. J., Bui-Tong, N., Luong, T.-N., Ha-Iaconis, T., Nguyen, T., et al. (2006). Community-Based Participatory Research Increases Cervical Cancer Screening among Vietnamese-Americans. *Journal of Health Care for the Poor and Underserved, 17*, 31-54.

O'Malley, C. D., Shema, S. J., Clarke, L. S., Clarke, C. A., & Perkins, C. I. (2006). Medicaid Status and Stage at Diagnosis of Cervical Cancer. *American Journal of Public Health, 96* (12), 2179-2185.

Ong, A. D., & Phinney, J. S. (2002). Personal Goals and Depression Among Vietnamese American and European American Young Adults: A Mediational Analysis. *The Journal of Social Psychology , 142* (1), 97-108.

Qin, C., & Gould, J. B. (2006). The Asian Birth Outcome Gap. *Paediatric and Perinatal Epidemiology , 20*, 279-289.

Rao, A. K., Daniels, K., El-Sayed, Y. Y., Moshesh, M. K., & Caughey, A. B. (2006). Perinatal Outcomes among Asian American and Pacific Islander Women. *American Journal of Obstetrics and Gynecology , 195*, 834-838.

Segal, U. A. (2000). A Pilot Exploration of Family Violence Among Nonclinical Vietnamese. *Journal of Interpersonal Violence , 15*, 523-533.

Taylor, V. M., Schwartz, S. M., Yasui, Y., Burke, N., Shu, J., Lam, D. H., et al. (2004). Pap Testing Among Vietnamese Women: Health Care System and Phsyician Factors. *Journal of Community Health , 29* (6), 437-450.

Taylor, V. M., Yasui, Y., Burke, N., Nguyen, T., Acorda, E., Thai, H., et al. (2004). Pap Testing Adherence Among Vietnamese American Women. *Cancer Epidemiology, Biomarkers & Prevention , 13* (4), 613-619.

Taylor, V. M., Yasui, Y., Burke, N., Nguyen, T., Chen, A., Acorda, E., et al. (2004). Hepatitis B Testing among Vietnamese American Men. *Cancer Detection and Prevention , 28* (3), 170-177.

Yoshioka, M. R., DiNoia, J., & Ullah, K. (2001). Attitudes Toward Marital Violence: An Examination of Four Asian Communities. *Violence Against Women , 7*, 900-926.

Yu, S. M., Alexander, G. R., Schwalberg, R., & Kogan, M. D. (2001). Prenatal Care Use Among Selected Asian American Groups. *American Journal of Public Health , 91* (11), 1865-1868.

Appendix

RESOURCES FOR VIETNAMESE IN NYC

Health Related

ASIAN & PACIFIC ISLANDER COALITION ON HIV/AIDS, INC.
400 Broadway
New York, NY 10013
phone: (212) 334-7940
www.apicha.org

ASIAN FAMILY SERVICES
1921 Park Street
Hartford, CT 06106
phone: (860) 951-8770 x.24
www.asianfamilyservices.org

ASIAN-AMERICAN CONSULTING SERVICES / NEW LAND COMMUNITY CENTER
677 Seneca Avenue
Ridgewood, NY 11385
phone: (718) 381-3607

CHARLES B. WANG COMMUNITY HEALTH CENTER
268 Canal Street
New York, NY 10013
phone: (212) 379-6986
www.cbwchc.org

HAMILTON-MADISON HOUSE, INC.
50 Madison Street
New York, NY 10038
phone: (212) 349-3724
www.hmhonline.org

INDOCHINA SINO-AMERICAN COMMUNITY CENTER
170 Forsyth Street, 2nd Floor
New York, NY 10002
phone: (212) 226-0317

NEW YORK ASSOCIATION FOR NEW AMERICANS, INC.
17 Battery Place
New York, NY 10004
phone: (212) 425-2900
www.nyana.org

SAINT VINCENT'S CATHOLIC MEDICAL CENTER
170 West 12th Street
New York, NY 10011
phone: (212) 604-7000
www.svcmc.org/body.cfm?id=32

VIETNAMESE COMMUNITY HEALTH INITIATIVE

NYU Center for the Study
of Asian American Health
550 First Avenue, MSB-153
New York, NY 10016
Phone: (212) 263-0485

Other Resources

CAAAV: ORGANIZING ASIAN COMMUNITIES

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

CHINESE-AMERICAN PLANNING COUNCIL

150 Elizabeth Street
New York, NY 10012
phone: (212) 941-0920
www.cpc-nyc.org

GAY ASIAN & PACIFIC ISLANDER MEN OF NEW YORK

P.O. Box 1608
Old Chelsea Station
New York, NY 10113
phone: (212) 802-RICE (7423)
www.gapimny.org

INTERNATIONAL RESCUE COMMITTEE - NEW YORK CITY REFUGEE EMPLOYMENT PROJECT

122 East 42nd Street, Suite 1100
New York, NY 10168
phone: (212) 551-3150
www.theirc.org

NEW YORK ASIAN WOMEN'S CENTER

39 Bowery, PMB 375
New York, NY 10002
phone: (212) 732-0054;
(888) 888-7702 (24-hour hotline)
www.nyawc.org

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

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