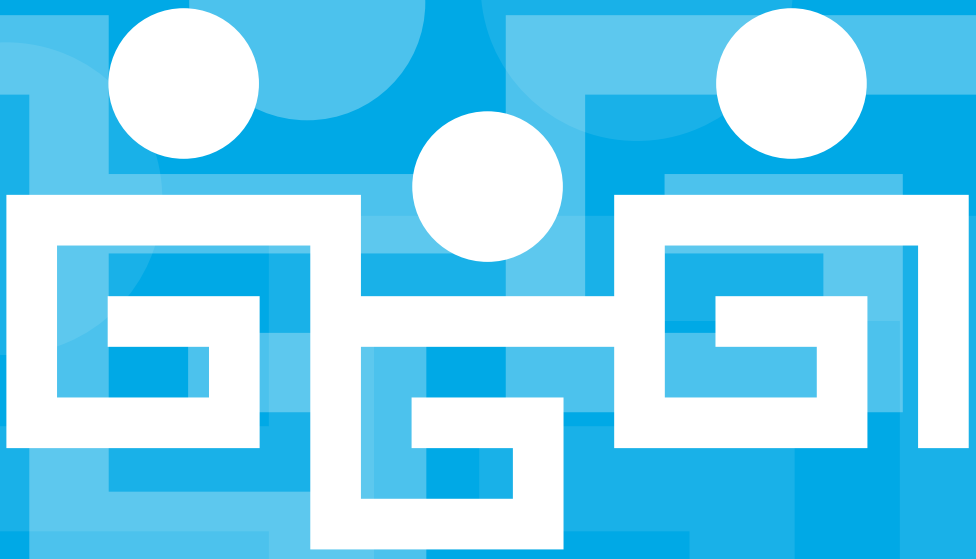
KOREAN NEEDS ASSESSMENT OF THE BAY AREA 2014-2015

POLICY BRIEF

ACHIEVING HEALTH EQUITY AMONG KOREAN AMERICAN WOMEN: CALL FOR GENDER-SENSITIVE & CULTURALLY SPECIFIC PROGRAMMING



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HEALTH RESEARCH FOR Action
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Significance

With cancer as the leading cause of death for Asian Americans (26% of overall mortality) and for Korean Americans in particular (32%), **low rates of cancer screening among Korean American women** are an area of significant concern (California Department of Public Health, 2015). Korean American women experienced an increasing incidence (4.7%) of breast cancer from 1990 to 2008, which was the highest annual increase among all Asian groups (Gomez et al., 2013). One study showed that Korean-American women have the second highest incidence and death rate from cervical cancer among six major API ethnicities in the United States (Alba, 2005). California Health Interview Survey data from 2009 indicated that Korean American women had the lowest lifetime and recent screening rates compared to other Asian American immigrant women (Ryu et al., 2013), which is consistent with a previous study conducted in California that shows only 10% of Korean American women adhered to the recommended cancer-screening guidelines for Pap smears, mammograms, and clinical breast exams in the past 2 years (Maxwell et al., 2000). In another study, only two-thirds of Korean women reported having received pap smears in the 3 years preceding the study (Alba, 2005). Furthermore, of the populations studied in a 2007 study, Korean women were found to have the second highest incidence of cervical cancer among groups of large API ethnic populations in the US (McCracken et al., 2007). Interventions that can increase Korean American women's cancer screening rates are therefore critically needed.

Table 7. Cancer Screening

	Valid %
Female Respondents only	
Received Pap smear (no, **n=185**)	30
More than 21 years old (no, n=185)	30
Received Mammogram (no, **n=190**)	27
More than 40 years old (no, n=153)	18
Doctor examination of lumps (no, **n=189**)	58
Familiar with benefits of Mammogram (Not too familiar/ Not at all familiar, **n=187**)	13
Familiar with benefits of Pap Smear (Not too familiar/ Not at all familiar, **n=185**)	20

Along with the low rates of cancer screening seen among Korean American women, **high secondhand smoke exposure** rates are also important health issues in this community and may contribute to cancer. In a study conducted in Pennsylvania and New Jersey, Korean Americans reported the highest rate of exposure to second-hand smoke (57.9%) compared to other Asian Americans (Ma et al., 2005). In the California Health Interview Survey (CHIS, 2011-2012), Korean American women reported the highest rate of second-hand smoke exposure (CHIS, 2011). Among non-smoking Korean women with limited English proficiency (LEP), 23% reported having an adult smoking at their home a much higher rate than that reported by all Asian women or all racial groups combined (4%). Given that women are affected the most in terms of deaths caused by second-hand smoke (Öberg et al., 2011), Korean American women remain particularly vulnerable.

Korean American women also report low rates of self-reported health status (SRH), a strong predictor of an individual's mortality and morbidity (Walsh, 2010). Previous studies showed that Korean American women were more likely to report poorer

SRH, than did Korean American men (Lee et al., 2000).

Although the female sex is the most prominent factor that is associated with low cancer screening rates, poor SRH, high rates of exposure to second-hand smoke, and **limited English proficiency (LEP)** are also an important contributing factors to these health issues. The close association between limited English proficiency (LEP) and access to health resources is a large barrier that affects Korean women's health (Yi et al., 2012). In a 2003 study, limited English proficiency was shown to be a significant factor for lower rates of regular cervical cancer screening because of difficulties understanding information and interacting with healthcare professionals (Juon et al., 2003). In addition to the language barrier, a more complex issue is the perceived lack of cultural understanding by American doctors and Korean Americans' tendencies towards placing higher credibility in health resources obtained from trusted family and community members (Yi et al., 2011).

Korean Community Center of the East Bay (KCCEB) and Health Research for Action at UC Berkley School of Public Health conducted a survey in the San Francisco Bay Area, which corroborates the serious problems associated with women's health among Koreans living in the region. 342 Korean American adults participated via phone, in-person interviews, and online between July 2014 and February 2015 in the San Francisco Bay Area. The following are results of the survey and recommendations to improve health equity among Korean American women.

Discussions

Bay Area Korean women were less likely to receive cancer screening than Korean women in California and all women in California. Our study found that the Pap smear screening rate in the local group was substantially lower than the state average. 30% of participants in this sample reported never receiving a Pap smear compared with only 5% of all Californians and 18% of Korean women in California reporting never having received a Pap smear (CHIS, 2001-2009). Breast cancer screening rate in our sample was also lower than the state average; among those 40 years or more who are recommended to receive mammograms (American Cancer Society, 2015), 18% in our Korean sample never received a mammogram, but rates for never received mammogram in this age group was 7% for the California overall state average (CHIS, 2011). Furthermore, almost 60% of women in our sample replied that they never had a doctor examine their breasts for lumps, compared with only 23% of all Californian women and 48% of Korean American women in California having reported never having received this screening (CHIS, 2001-2009).

Table 13. Comparison of KoNA Bay Area data with CHIS Data

	Bay Area Korean	CHIS Korean	CHIS All Asian	CHIS Entire CA
Cancer Screening: Pap Smear (21 years and older)				
21 years and older (NEVER), % *CHIS (2011 – 2012; age 21-85)*	30.0	18.0	14.0	5.0
Cancer Screening: Mammography				
Overall (NEVER), %	27.0	27.0	27.0	23.0
40 years and older (NEVER), % *CHIS (2007; age 21-85)*	18.7	34.6	11.9	7.4

Bay Area Korean women are at risk of second-hand smoke exposure, and feel no control over this exposure. Our Bay Area needs assessment shows smoking prevalence among Korean males is higher than among women. The disparity between male and female is consistent with CHIS data - men smoke at over 3 times the rate of women. Among 71 female Korean respondents in our survey, 57% reported SHS exposure and 71% reported not having complete control of SHS avoidance, including 32% of the female respondents reporting they "never/rarely" have any control over SHS exposure. Findings underscore the need for interventions for smoke-free environments, including for the non-smoking Korean population, and empowering women to speak up for smoke-free homes.

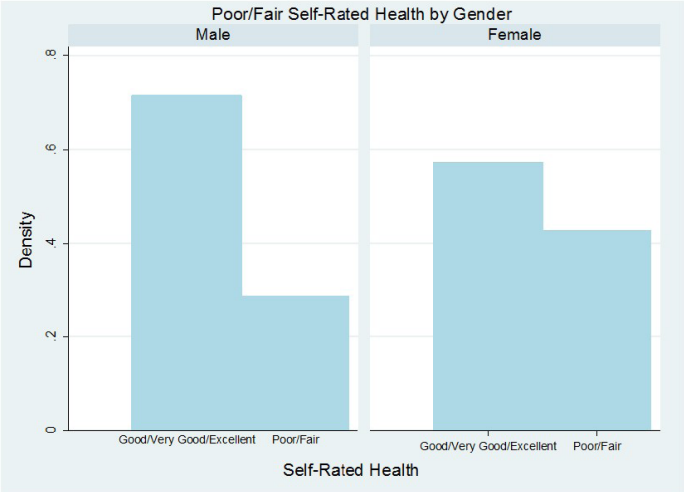
Table 12. Secondhand Smoking by Sex

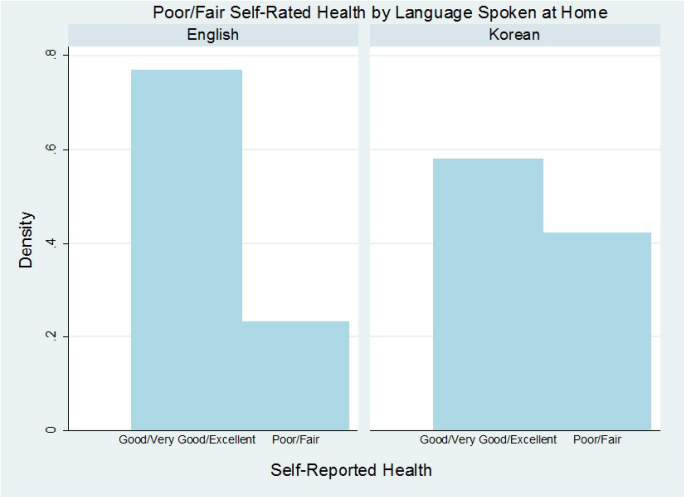
	Male	Female
Secondhand Smoking (n=110, *respondents can choose more than one option*)	%	%
Not exposed	20	44
Home	8	10
Car	3	3
Work (indoor)	6	11
Work (outdoor)	27	18
Other person's home or car	8	18
Outdoor	35	42
Restaurant	15	15
Casino	3	4
Other	15	7
	Male	**Female**
Complete control to avoid tobacco smoke **(n=105)**		%
All the time	29	29
Most or fair amount of time	21	21
About half of the time	12	10
Less than half of the time	6	9
Rarely/Never	32	32

Bay Area Korean women have significantly lower self-rated health than do "All California" Koreans and other minority groups. In our sample, nearly 40% of the participants perceived themselves as having fair/poor health. This percentage is higher than CHIS Korean (27%), other Asian American groups (Chinese: 16%; Filipino: 10%) and the state average (15%) (CHIS, 2001-2009). When stratified by sex, more women (43%) perceived their health as fair/poor than men (29%). This trend is similar to CHIS's Korean sample in that more women (26%) perceived their health as fair/poor than did men (12%), but in our sample, the percentage of participants who regarded their health as unhealthy was significantly higher. Findings from this study confirm results from other studies of SRH among minority groups.

Bivariate Analysis of Self-Rated Health

	OR (95% CI)
Sex (Female)	1.86 (1.16, 2.98)**
Age (45 years old)	1.64 (1.18, 2.27)**
Employment (not working)	2.24 (1.38, 3.63)***
Government assistance (yes)	2.28 (1.21, 4.28)**
Speak English (not proficient)	4.72 (2.81, 7.92)***
Languages spoken at home (Korean)	2.40 (1.36, 4.26)***
Education	
< 12 years	5.13 (1.33, 19.7)***
> 12 years	0.44 (0.24, 0.81)***
Income (less than $50K)	3.75 (2.18, 6.43)***
Health Insurance (yes)	0.71 (0.38, 1.35)
Smoking (yes)	0.82 (0.21, 1.71)
Smoking inside home (yes)	0.60 (0.35, 1.87)
Walk at least 10 minutes (no)	1.54 (0.89, 2.69)
Physical activity guideline (inactive)	1.09 (0.68, 1.76)





Having a language barrier and larger share of burden from immigration widens the health disparity gap for Korean women. Immigrant women face a large burden of health disparities (Alba, 2005; Echeverria et al., 2006; Tillman, 2009). In the process of acculturation, Korean immigrant women are faced with compounded risk factors in all areas of life, including family, work, and society at large (Lee et al., 2012). Their struggles to integrate family and work roles were shown to impact quality of life and put them at greater risk for depression (Kim et al., 1994). In abusive relationships, immigrant women are more vulnerable to violence through their partners' abuse of legal status and culture (Raj et al., 2002). There is a lack of services that can simultaneously address cultural issues and language barriers, and this narrows the range of assistance that women may perceive as fitting for their needs.

Critical call for gender-sensitive and culturally specific programming. With the higher likelihood that Korean women will not receive adequate information from health facilities or physicians due to language and cultural barriers, the matter of increased health information access will require an awareness of trusted sources within the local community, as well as a means by which to understand women's current understanding of various health issues. A call for greater gender equity in health and the need for gender-specific health care programs have been put forth for some time now. Rather than aiming to standardize health outcomes for two different groups, the purpose of promoting gender equity is to "ensure that the two groups have equal access to those resources which they need to realize their potential for health" (Doyal, 2000). Gender/sex disparities and differences in health and health care are well-documented generally. At the same time, the issue of minority women's health and health care disparities is a more complex topic from the general concept of women's health, if only for the fact that the perception and context of "women's health" across cultures are varied; for example, socioeconomic factors create diverging views of medical practices as empowering or stigmatizing (Kumanyika et al., 2001). It follows, then, that the challenges of promoting health equity and health care access within the Korean American community are unique.

Call for Gender-Sensitive & Culturally Specific Programming:

- ***Low Screening Rates***
- ***High Second-Hand Smoke Exposure***
- ***Low Self-Rated Health***

Recommendations

Achieve health equity among Korean American women by:

- Investing in community and capacity building in operationalizing culturally competent and gender sensitive programs; use evidence to guide decision-making, and evidence-based data to model best practices for educating

and empowering Korean women;

- Identifying and supporting effective and culturally appropriate women's empowerment programs and practices to lower women's exposure to second-hand smoke, to increase cancer screening rates, and to improve self-rated health status of Korean women;
- Integrating social norm change and population-based approaches and interventions in program efforts and design; diversify and innovate community engagement strategies to create supportive community environments;
- Reducing disparities by collecting disaggregated data to accurately capture the needs of minority women populations, by supporting culturally appropriate gender specific outcome measurements, and by providing continuous resources to validate culturally appropriate programs;
- Investing in creating opportunities for participation in diverse workforce development including Community Health Workers, capitalizing on the inherent roles and talent of minority women in their culture as a caretaker; providing leadership development and technical assistance;
- Ensuring API women in the community are represented at decision-making processes locally;
- Incorporating health equity, language access, cultural competency and women/gender sensitivity standards in all public and private healthcare practices and personnel policy.

References

All references cited in the text are available in the on-line. [http://kcceb.org/konabayarea/]

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