Cultural Competence: Strengthening the Clinician's Role in Delivering Quality HIV Care within ASIAN PACIFIC ISLANDER (API) Communities (Burmese)

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Learning Objectives

1. Describe the impact of HIV in Asian Pacific Islander (API) communities, including Burmese immigrants.
2. Identify at least 3 barriers to accessing and utilizing health services for APIs.
3. Identify 3 strategies for providing more effective and culturally appropriate services to APIs.
4. Identify 3 important priorities for maintaining the health and wellness of Burmese immigrants with HIV.

Profile of APIs

The term **"Asian"** includes persons having origins in any of the original peoples Of the Far East, Southeast Asia, or the Indian subcontinent (e.g. India, China, Philippines, Korea, Japan, Malaysia, Vietnam, Burma, and Pakistan.
"**Pacific Islander**" refers to those having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- Fastest growing racial or ethnic population in U.S.

  (2000-10: 43% increase) with 17.3 million Asian Americans
- Distinct ethnic groups, speak more than 100 different languages/dialects
- Diversity of economic, educational successes/challenges
- Distinct histories, cultures, religions

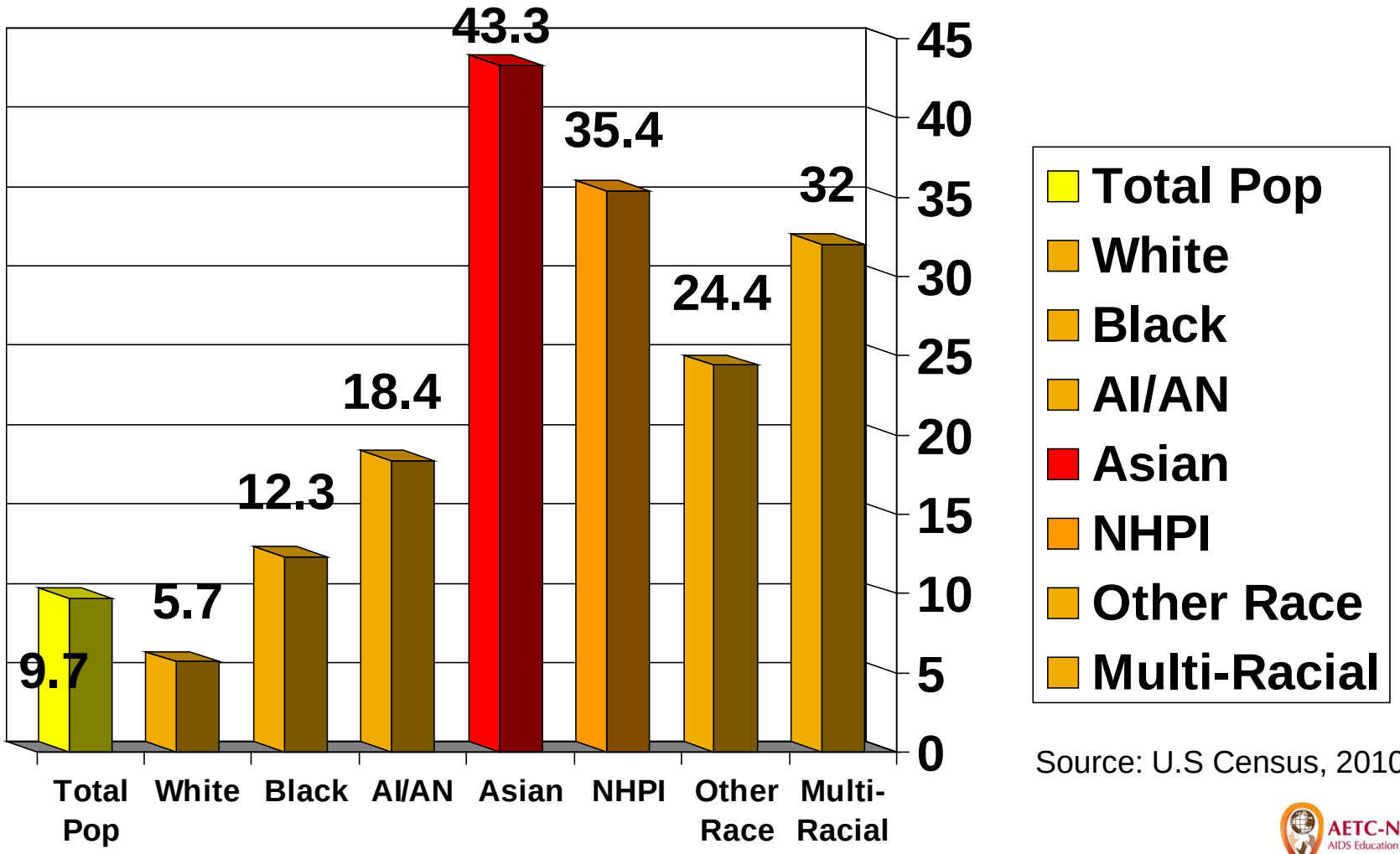
Source: U.S. Census 2010; Office of Management and Budget (1997). Revisions to the standards for the classification of Federal data on race and ethnicity. Federal Register 62FR58781-58790. [online] www.whitehouse.gov/ omb/fedreg/1997Standards.html; Asian American, MEDLINE.

Profile of APIs

- Different migrations patterns: Chinese Americans/Japanese Americans vs. Southeast Asian refugees
- Live in linguistically isolated households
- Have multiple cultural beliefs on health
- 18% of API were uninsured, as compared to 11.7% non-Hispanic White Americans

Source: U.S. Census 2010; Asian American, MEDLINE; Office of Minority Health, Asian American Profile, 2012; HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention; Am J Public Health. 2001 June; 91(6): 915–921;KClements-Nolle, RMarx, and M Katz.

Demographics: 2000-2010



Source: U.S Census, 2010

Geographic Distribution of APIs

States with the Highest Proportion of Asians
Hawaii (38.6 percent)
California (13.0 percent)
New Jersey (8.3 percent)
New York (7.3 percent)
Nevada (7.2 percent)
States with the Highest Proportion of NHPIs
Hawaii (26.2 percent)
Alaska (1.6 percent)
Utah (1.3 percent)
Nevada (1.2 percent)
Washington (1.0 percent)

Top 10 States with the Highest Increases of Asians
Nevada (116.5%)
Arizona (91.6%)
North Dakota (91.6%)
North Carolina (83.8%)
Georgia (81.6%)
Arkansas (78.5%)
Delaware (75.6%)
South Dakota (73.8%)
Indiana (73.3%)
Texas (71.5%)

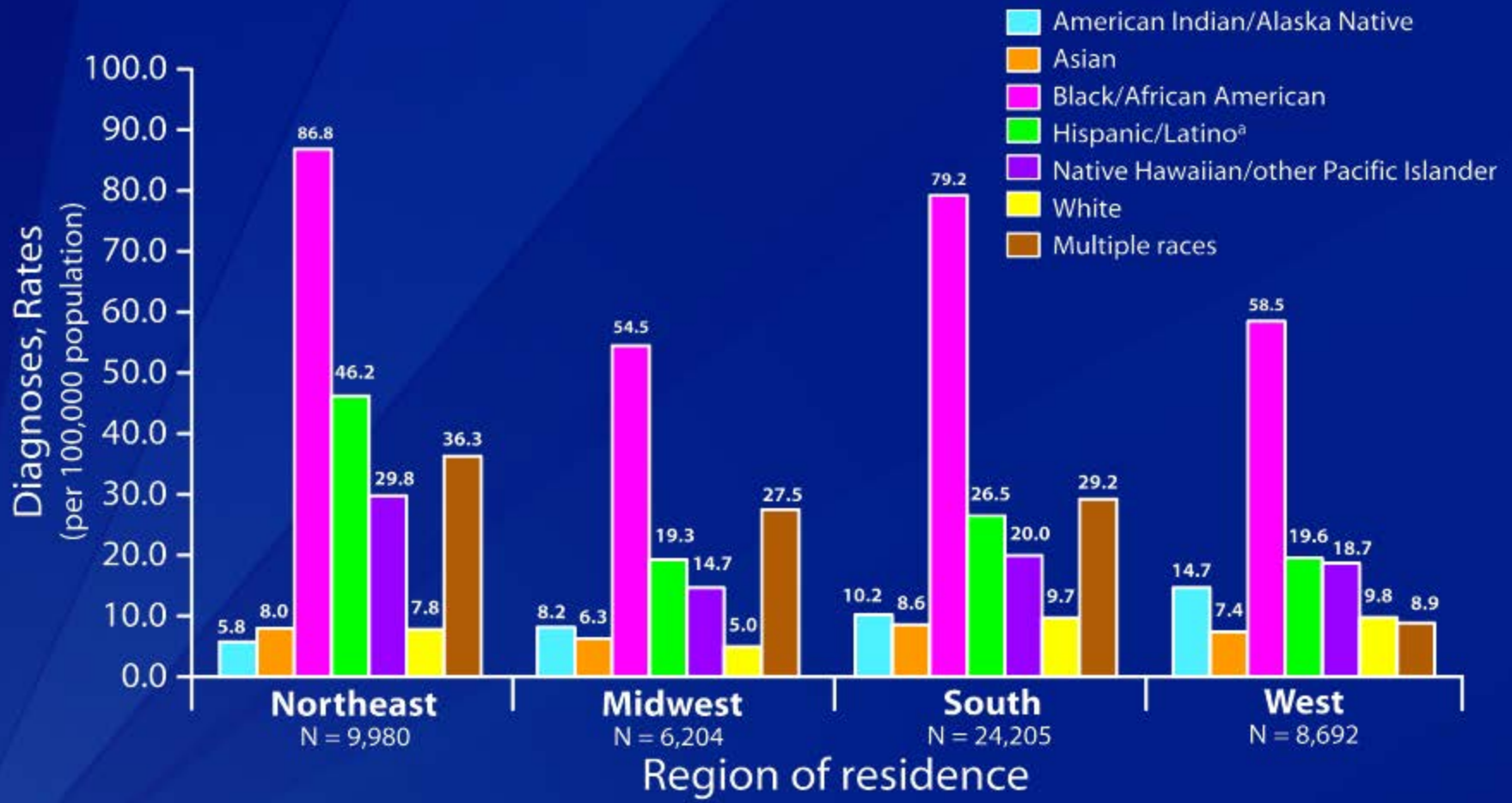
Source: US Census Bureau 2010 Census

APIs and HIV

- Account for 1.1% of HIV/AIDS cases in U.S.
- Have the highest rate of increase (4.4%)in new HIV infections in the nation
- 2/3 have never been tested for HIV (lowest testing rates of all races and ethnicities)
- 1 in 3 APIs living with HIV is unaware
- 70% of cumulative reported AIDS cases among API men are among men who have sex with men
- Gay men (MSM) and transgenders are highest risk group
- Infection rates in women are increasing

Source: A&PI Wellness Center 2011. HIV and Asians & Pacific Islanders: National Epidemic Fact Sheet. [online] *http://www.apiwellness.org/extras/2011/USA_factsheet_REV2011.pdf [NCHSTP, 2001]*

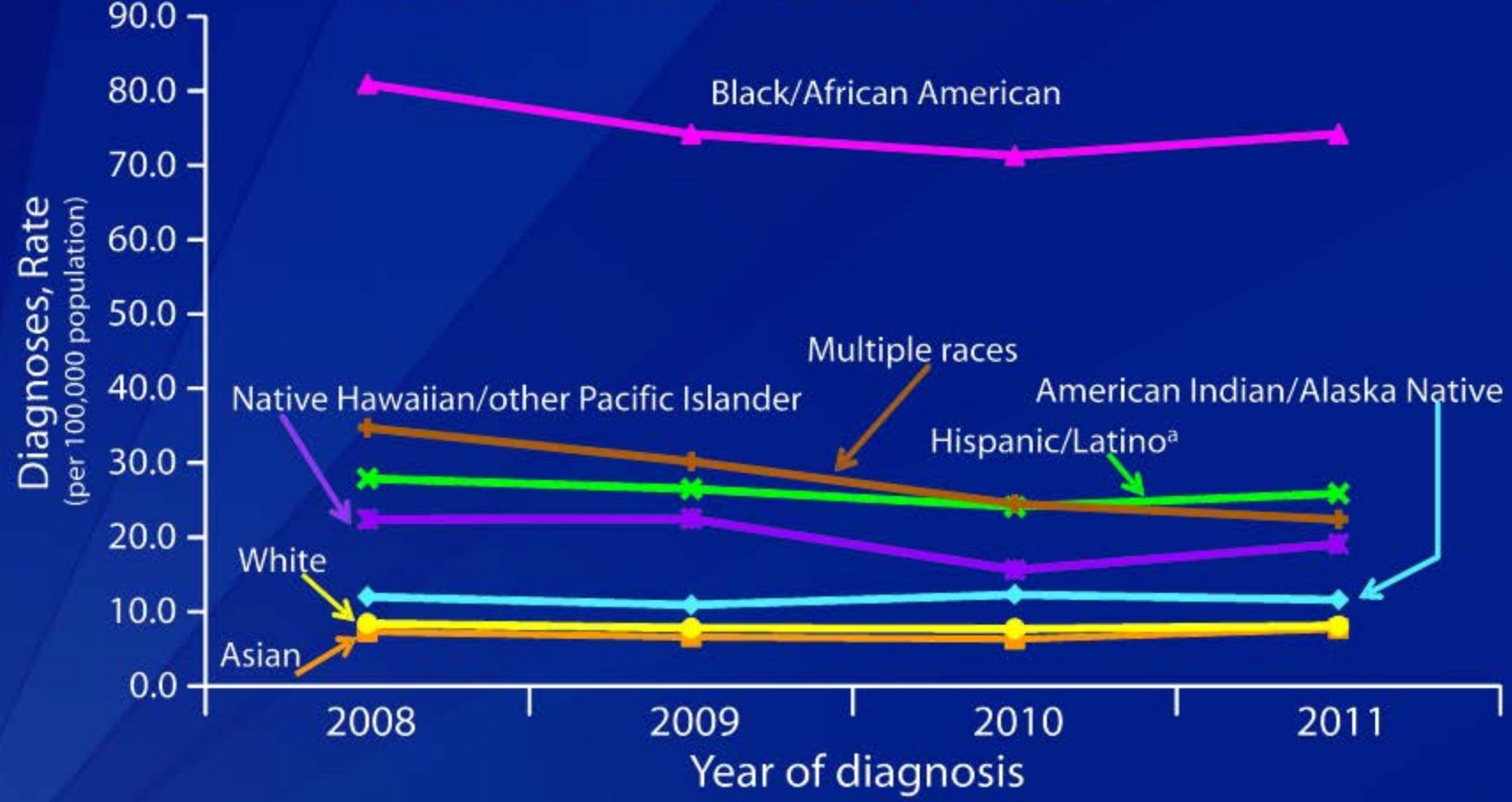
Diagnoses of HIV Infection among Adults and Adolescents, by Region and Race/Ethnicity 2011—United States



Note. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

[a] Hispanics/Latinos can be of any race.

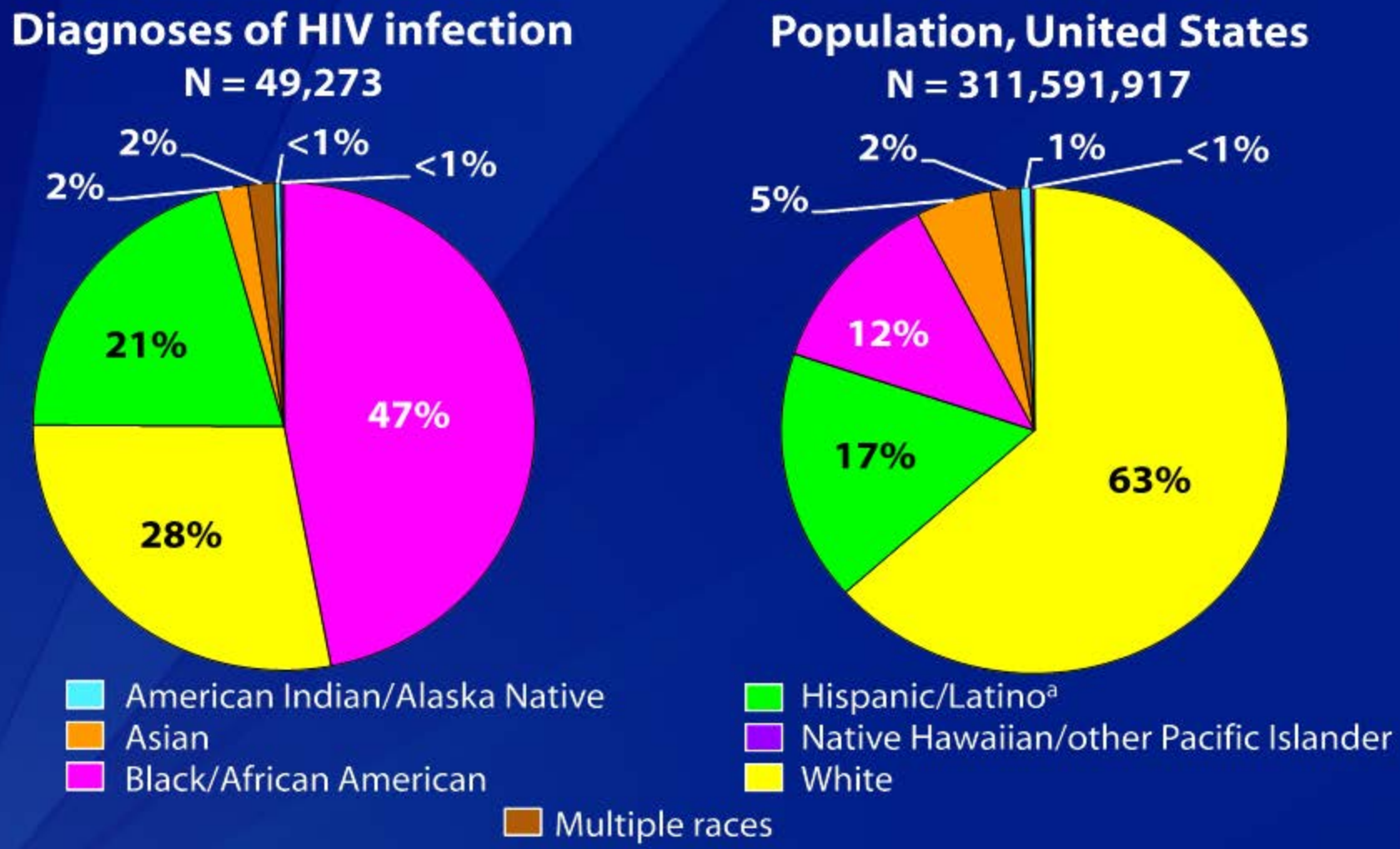
Rates of Diagnoses of HIV Infection among Adults and Adolescents, by Race/Ethnicity 2008–2011—United States



Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

[a] Hispanics/Latinos can be of any race.

Diagnoses of HIV Infection and Population by Race/Ethnicity, 2011—United States



Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.

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APIs Comorbidities

- APIs have high rates of tuberculosis (NCHSTP, 1998)
- APIs have the highest rates of Hepatitis B (NCID, 1997)
- Depression/mental health issues are risk factors in API Community
- Co-morbidities puts APIs at higher risks for HIV/AIDs

Source: U.S. Census 2010; Asian American, MEDLINE; Office of Minority Health, Asian American Profile, 2012; HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention; Am J Public Health. 2001 June; 91(6): 915–921;KClements-Nolle, RMarx, and MKatz.

Cultural Factors that Affect Health Care Access and Utilization

- Communal vs. Individual Identity "Saving Face"
- Indirect Communication Methods
- Language barriers
- Deference to Authority
- Taboo Topics (sex/gay issues)
- Stigma associated with HIV/AIDs
- Traditional Healing vs. Western Medicine

Source: NMAETC BESAFE Guide, A Cultural Competency Model for Asians and Pacific Islanders, 2009, Disclosure of HIV Infection Among Asian/Pacific Islander American Women: Cultural Stigma and Support, http://www.cdc.gov/hiv/resources/factsheets/pdf/api.pdf, revised 2008.

Alternative Medicine/Traditional Healers

- Based on family traditions, various religions, and the balance of nature.
- Common illnesses are usually treated by, or at the advice of family, a family caregiver or traditional healer
- Spirituality/faith practices
- Use of herbal medicines/remedies
- Acupuncture

Source: A Cultural Competency Model for Asians and Pacific Islanders, 2009

General Barriers to Prevention and Treatment

- Distrust of providers due to cultural/language barriers/differences
- Lack of provider concordance
- Health literacy
- Cultural misunderstanding about HIV/AIDs
- Lack of health insurance
- Low socio-economic status
- Limited access to facilities (transportation, hours)
- Immigration Status – undocumented, refugee, asylee

Source: A&PI Wellness Center, 2000. [online] http://www.apiwellness.org/articletgissues.html, http://www.cdc.gov/hiv/resources/factsheets/pdf/api.pdf, revised 2008, , NMAETC BE SAFE Guide, A Cultural Competency Model for Asians and Pacific Islanders, 2009.

Cultural Competency and HIV Care

- Awareness and acceptance of differences
- Awareness of your own cultural values
- Awareness of dynamics of differences
- Development of cultural knowledge
- Ability to work within other's cultural context
- Healthy self-concept
- Free from ethnocentric judgment

Source: Donini- Lenhoff FG et al. Increasing awareness and implementation of cultural competence principles in health education professions education. J. Allied Health. 2000;29:241-245.; 2. Robins LS et al. Improving cultural awareness and sensitivity training in medical school. Academic Med. 1998;73 (10 suppl): S31-S34.

Culturally Competent HIV Care

- Identify the patient's core health belief issues
- Explore the meaning of the illness to the patient & patient to provider
- Explore the patient's social context
  - Life control/stigma
  - Change in environment
  - Literacy and language
  - Support systems
- Negotiate across patient-physician culture to develop a treatment plan that is mutually agreeable/build trust

Source: AIDS in U.S.Communities of Color. Springer; New York, NY: 2009,Carrillo JE, et al. Ann Intern Med. 1999;130:829-834.Stone VE. ClinInfect Dis. 2004;38:400-404, NMAETC BE SAFE Guide, A Cultural Competency Model for Asians and Pacific Islanders, 2009.

Summary (1)

- APIs are a heterogeneous group.
- Cultural beliefs may affect one's risk for HIV infection and one's choices for health care if infected.
- Migration and immigration can be an isolating experience and may lead to HIV risk behavior.

Source: Bennet M. Modes of cross-cultural training. Intl J Intercultural Relations. 1986:10(2): 117-134; NMAETC BE SAFE Guide, A Cultural Competency Model for Asians and Pacific Islanders, 2009.

Summary (2)

- APIs experience a unique set of cultural challenges when faced with HIV.
- Barriers to care may not be apparent. Open up a discussion about fears or challenges associated with HIV care.
- Traditional medicine can be a complement or a determent to HIV care.
- Need to appreciate family traditions centered around health and healing.

Source: Bennet M. Modes of cross-cultural training. Intl J Intercultural Relations. 1986:10(2): 117-134; NMAETC BE SAFE Guide, A Cultural Competency Model for Asians and Pacific Islanders, 2009.

Strengthening the Clinician's Role in Delivering Quality HIV Care within the *BURMESE* Community

Definition of Burmese Refugees

- Burmese is defined by a combination of religion, State of origin, within Burma & ethnic group
- Burmese people prefer their homeland to be called Burma
- Many ethnicities among Burmese
- Karen, Chin, Karenni, Shan, & Burmese (most numerous in U.S)

Source: Ranard, D.A. & Barron, S. (2007)Refugees from Buram: Their backgrounds and refugee experiences. Washington, DC.:Center for Applied Linguistics; Neiman, A., Soh,E., & Sutan, P. (2008). Karen cultural profile. EthnoMed., Scarlis, C.A. (2010). Chin cultural profile. EthnoMed.

Demographics of Burmese Refugees

- Burmese account for 100,200 of U.S. population, but growing number due to migration refugee status
- Population increase of 499% (16,720) from previous US census (2000-2010)
- Majority of Burmese refugees are comprised of people between the ages of 20-40 years of age
- Burmese settlement areas by State: California, Indiana, Iowa, New York, North Carolina, and Vermont
- Burmese settlements by cities: Albany, Chicago, Des Moines, Los Angeles, New York City, San Francisco, and Washington, DC
- Many ethnicities among Burmese

Source: 2010 U.S. Census

Languages/Religions of Burmese Refugees: Cultural Competency Implications

- Burmese is the national language; some Burmese speak another ethnic language as well
- Diversity of languages among ethnic groups
- Karen people speak their own Karen language, but subgroups speak their own distinct languages
- Chin speak Chin language
- Burmese are mixed religions, Buddhist, Muslim & Christian groups
- More Sgaw Karen in Burma than Po Karen, more Karen Buddhist than Christian Karen
- Po Karen people are mostly Christian
- Karen & Karenni share similar culture/customs/religions

Source: Ranard, D.A. & Barron, S. (2007)Refugees from Burma: Their backgrounds and refugee experiences. Washington, DC.:Center for Applied Linguistics, Karen cultural profile. EthnoMed., Scarlis, C.A. (2010). Chin cultural profile. EthnoMed.

Co-morbidity Factors for HIV Infection Among Burmese Refugees: Cultural Competency Implications

- High rates of TB (CDC,2008a)—TB is a leading cause of death worldwide among people who are HIV-positive
- Hepatitis B: 15% prevalence rate of chronic hepatitis among Burmese in the U.S. (U.S. DHHS, 2008)
- Substance Use of Betel nut, known as Kunya in Burmese, a stimulant that contains high levels of psychoactive alkaloids and produces a euphoric effect
- Sexual health: awareness of prevention and treatment of STDs is low

Source: Ranard, D.A. & Barron, S. (2007) Refugees from Burma: Their backgrounds and refugee experiences. Washington, DC.:Center for Applied Linguistics; Neiman, A., Soh,E., & Sutan, P. (2008). Karen cultural profile. EthnoMed., Scarlis, C.A. (2010). Chin cultural profile. EthnoMed., CDC, American Refugee Committee, & Medecins Sans Frontieres (2002). An assessment of reproductive health issues among Karen and Burmese refugees living in Thailand.

Barriers to Care for Burmese with HIV

- Limited knowledge of U.S. health care system, especially medication usage
- Health literacy—due to limited English skills, unable to read and understand medical instructions
- Lack of awareness among health professionals of traditional medicine used by Burmese
- Under-representation of Burmese health professional providers
- Lack of qualified medical interpreters who can act as not only interpreters but cultural brokers
- Lack of culturally appropriate outreach strategies to promote prevention/treatment
- Issues of stigma/confidentiality, Burmese perspective

Source: Refugees from Burma Considerations for Health Providers, Refugee Health Technical Center, Boston, MA, 2012.: Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs Providing Services to Karen Person from Burma, CDC, 2010.

Shared Decision-Making Strategy (SDM)

SDM is an approach that values the contribution of the patient and provider equally when it comes to making decisions about medical treatment, including to:

- Develop a partnership with the patient.
- Establish or review the patient's preference for information, e.g. amount and format.
- Establish or review the patient's preferences for role in decision-making.
- Ascertain and respond to patients' ideas, concerns, and expectations.

Shared Decision-Making Strategy (SDM)

- Identify choices and evaluate the research evidence in relation to the individual patient.
- Present (or direct to) evidence, taking into account the above steps, and help the patient reflect upon and assess the impact of alternative decisions with regard to their values and lifestyles.
- Make or negotiate a decision in partnership, manage conflict.
- Agree upon an action plan and complete arrangements for follow-up.

Strategies to Promote HIV Prevention/Testing & Care to Burmese Immigrants

- Develop workshops that educate Burmese on the HIV/AIDs health care models
- Develop HIV prevention, testing, and treatment education workshops for each ethnic group
- Organize HIV prevention education workshops around locally organized activities (cultural gatherings and events)
- Establish partnerships with other API community-based organizations to conduct outreach strategies on HIV/AIDs
- Create linkages with existing heath care providers to provide case management, advocacy services, & cultural competency training for health professionals and staff

Source: Refugees from Burma Considerations for Health Providers, Refugee Health Technical Center, Boston, MA, 2012.
Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs Providing Services to Karen Person from Burma, CDC, 2010.

Case Study

Kim, a Burmese young man worked at an agency in California. Kim in the past has had multiple male and female sex partners in Thailand before resettling in the U.S. Upon his resettlement, he tested positive for HIV. He was immediately put on HAART but stop taking the medication after two weeks.

At the small agency where he works, Kim started dating and eventually married Cho, the secretary on staff. Cho is anxious to start a family. She goes to the clinic to begin prenatal care and completes a physical. The nurse calls two weeks later and asks that she come in right away. Kim accompanies Cho. Dr. Smith reports that she is 8 weeks pregnant and that she is also HIV+. Cho asks Dr. Smith, "What does that mean?" "Am I pregnant or not?" She turns to Kim and asks, "What is this HIV?" Kim answers, "I don't know; let Dr. Smith explain."

Case Study

A month later, Cho has left Kim and is living with her family. Understanding about HIV and its implication for her baby, she is too embarrassed to go back to the clinic and has resigned from her job. She is depressed, ashamed and is suicidal.

Kim is also depressed. He is ashamed and regrets giving the disease to his wife and baby. He is unwilling to risk the relationship with his family by divulging his status; he now has AIDS. He has returned to the clinic and is now taking his meds religiously. He too is suicidal. In Burmese culture, it is assumed that if you have HIV you either were a prostitute or you slept with one. He has never slept with a prostitute.

Case Study: Kim

What, if any are the primary cultural competency issues of this case study?

Case Study: Kim

SYSTEM FAILURE

- Lack of responsiveness of the health care system to Kim's treatment for HIV

STIGMA

- Stigma/shame/depression of both partners and of the family

Case Study: Kim

CLINICAL COMPLICATIONS

- Kim's conversion from HIV to AIDS
- Cho's pregnancy (Mother-to-Child Transmission)

INTERVENTION STRATEGIES

- Behavioral health interventions for the family
- Potential use of cultural brokers to bridge cultural/treatment

IMPACT of Cultural Competency on HIV Disparity among APIs

- Reduction of new infections
- Increased access to care and improved health outcomes for people living with HIV
- Reduction of HIV-related disparities and health inequities

Resources

- BESAFE: A Cultural Competency Model for Asians and Pacific Islanders
  National Minority AIDS Education and Training Center, Howard Unversity College of Medicine,
  www.NMAETC.org
- Asian & Pacific Islander Wellness Center
  www.apiwellness.org
- Life Foundation
  www.lifefoundation.org
- The EthnoMed site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent refugees to the United States.
  http://ethnomed.org/
- *Burmese*
  http://www.globalhealth.gov/refugee/refugees_health_burmese.html
  USCRI patient information toolkit for Burmese (Karen) patients
- http://www.refugees.org/article.aspx?id=1848&subm=113&ssm=129&are
  Cultural profile for Burmese (Karen) patients
- http://ethnomed.org/ethnomed/cultures/karen/karen_cp.htm
  http://www.rhin.org/
- Refugees from Burma: www.refugeehealthta.org

AETC-NMC

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