

CAMBODIANS IN THE UNITED STATES

HISTORY

Cambodia lies in the heart of Southeast Asia, surrounded by Laos, Vietnam, Thailand, and the Gulf of Thailand. The vast majority of Cambodian people speak Khmer and practice Buddhism. Cambodia was once a dominant force in Southeast Asia. In the late 1800s it was colonized as part of French Indochina. Cambodia gained independence in 1954 and was ruled by Prince Sihanouk. In 1970, military rulers overthrew the monarchy, and after continued fighting, Pol Pot and the Khmer Rouge came to power in 1975. The Khmer Rouge were in power for less than 5 years, overthrown by the Vietnamese army in 1979, but their legacy of genocide haunts the Cambodian people even today (Rasbridge & Kemp).

The Khmer Rouge systematically murdered all doctors, scientists, intellectuals, and other non-communists who could have been considered community leaders (Khmer Health Advocates). People were removed from cities and forced to work on agrarian communes, often separating families, and demanding absolute loyalty to the Khmer Rouge (Rasbridge & Kemp). Food shortages, malnutrition, and periods of starvation were common during this time (Kuoich et al., 1984). The experiences of survivors of the Khmer Rouge are likened to those of survivors of the Nazi concentration camps of World War II (Khmer Health Advocates). Between 1.5 and 2 million Cambodians out of a population of 7 million were killed during the Khmer Rouge regime. Refugees began fleeing to Thailand in late 1978. Between 1981 and 1985, approximately 150,000 Cambodians resettled in the United States, with lower rates of immigration and resettlement in subsequent years (Rasbridge & Kemp).

DEMOGRAPHICS

The U.S. Census Bureau estimates that in 2000 nearly 172,000 Cambodians lived in the U.S. (U.S. Census Bureau, 2000). As one of the more recent immigrant groups, Cambodians make up 1.8% of the total Asian population. The top five states where Cambodians reside include California, Massachusetts, Washington, Pennsylvania, and Texas (SEARAC, 2004).

ENGLISH LANGUAGE PROFICIENCY

The ability to speak English has a tremendous impact on access to health information, public services (i.e. Medicaid, Medicare, SCHIP), effective communication

with providers and emergency personnel, and the ability to understand and utilize medications properly.

Most Cambodians (91%) speak a language other than English at home, with 53% categorized as limited English proficient (LEP), defined as those speak English less than “very well” (APIAHF, 2005).

Most information on the Cambodian community in the U.S. comes from community agencies and local research efforts. These efforts show that the lack of trained medical interpreters has a devastating effect on access to care and quality of services provided to Cambodians. Trained bilingual outreach workers are particularly necessary and would be invaluable in increasing access and utilization of preventive services (Khmer Health Advocates).

POVERTY/INCOME

The relationship between income and health has been well established over the years. Poverty and lower income have been correlated with high rates of death and disease while higher income has been correlated with better health status. Large disparities in income have been linked to lower life expectancy in cross-national comparisons as well as higher mortality and obesity rates at the state level.

Cambodians as an ethnic group have some of the lowest socioeconomic indicators among the Asian American population. Approximately 54% live below the 200% poverty level line, which is the second highest rate after Hmong (U.S. Census, 2000). Per capita income is \$10,215 compared to \$21,587 for the general population (APIAHF, 2005).

EDUCATIONAL ATTAINMENT

According to the Institute of Medicine (IOM), the likelihood of being insured rises with higher levels of educational attainment. Having a college degree is strongly associated with multiple factors that increase the likelihood of being insured—employment in sectors that are more likely to offer coverage, higher income, and a greater likelihood of choosing employment-based coverage if offered. Previous studies of Census data have shown that adults who did not graduate from high school were almost twice as likely to be uninsured as

those with a high school diploma (38.5% compared to 19.6%).

Cambodian Americans have lower levels of educational attainment, with only 9% of individuals who possess bachelor's degree, while 53% have less than a high school education (APIAHF, 2005).

IMMIGRATION/CITIZENSHIP STATUS

Citizenship status also has significant and widespread effect on an immigrants' ability to access health services and obtain insurance coverage. While an estimated 15% of citizens lack health insurance, 42% to 51% of non-citizens lack health coverage.

Sixty-four percent of Cambodians are foreign-born with a 46% naturalization rate, higher than the U.S. average of 40%, but lower than the Asian average of 50% (APIAHF, 2005).

HEALTH STATUS

It is difficult to characterize the health status of Cambodians. Many studies do not differentiate between the various ethnicities studied. Small sample sizes make it difficult to generalize research findings. Finally, in some cases, data are just not available. For these reasons, the data contained here provide only a rough estimate of Cambodian health status.

HEALTH INSURANCE COVERAGE

In 1997, 27% of Southeast Asians in the U.S. were uninsured. Approximately 20% of Southeast Asians received Medicaid or other public health care coverage, 49% had job-based coverage, and 4% purchased private insurance (UCLA Center for Health Policy and Research & Henry J. Kaiser Family Foundation, 2000).

Cambodians are at a structural disadvantage when it comes to access to health care. They have a significantly much lower physician representation than the general population, 40 physicians compared to 257 per 100,000 for whites (U.S. Census, 2000). Moreover, CDC's REACH 2010 survey found that Cambodians were at least three times more likely to report not visiting a physician due to cost issues than were all Asians or the general U.S. population.

CHRONIC DISEASES

HEART DISEASE & STROKE

Cambodians in California had four times the rate of stroke as the white population in the state (107 vs. 28 per 100,000) (Dumbauld et al., 1994). Some researchers

believe that the high cardiovascular morbidity is possibly due to the physiological effects of starvation (Eitinger & Strom, 1973).

CANCER

Liver cancer is the second leading cause of cancer death for Cambodian American men (Asian Liver Center, Stanford University). The chewing of betel nut, especially among middle age to elderly women has also been associated with cancer of the mouth (Khmer Health Advocates).

Jackson and colleagues (2005) developed a cervical cancer control intervention program for Cambodian American women in Seattle by employing a variety of strategies to address barriers to screening. Prior to designing the intervention, researchers conducted an ethnographic study in addition to a community-based survey in order to use the findings to influence the content of the intervention program. The intervention program included home visits, presentations, and small group meetings led by bicultural outreach workers, barrier-specific counseling, tailored logistic assistance, and the use of a Khmer-language video. The intervention was used to conduct a randomized trial to evaluate its effectiveness, which was subsequently reported in another peer-reviewed publication.

The cervical cancer control program designed by Jackson and colleagues aforementioned was implemented using a group-randomized controlled trial targeting Seattle's Cambodian refugee community to evaluate its effectiveness (Taylor et al., 2002). Seventeen neighborhoods served as the unit of randomization with a total of 370 participants. Interestingly, results showed a significant increase in the number of Cambodian women reporting Pap testing in both intervention and control neighborhoods. Researchers suggested that perhaps a general awareness regarding the project among women and their health care providers, along with other ongoing educational efforts may all have contributed to increases in Pap testing rates. This is an example of a unique circumstance whereby contamination in the study served as a powerful tool resulting in positive outcomes.

Tu and colleagues (2002) conducted a cross-sectional survey to examine breast cancer screening among Cambodian women in Seattle using the trans-theoretical model of change to assess stages of adoption. Results indicated that only 26% of Cambodian American women were in the maintenance stage for clinical breast exam (CBE), which was operationally defined as having

received a CBE less than a year ago and planning to have another CBE in the next 12 months. Physician characteristic, namely women with an Asian American female physician reported statistically significant associations with higher stages of screening adoption as compared to women with physicians who were male or who were non-Asian.

The Seattle region Asian American Network for Cancer Awareness, Research, and Training (AANCART) has developed a partnership with the Fred Hutchinson Cancer Research Center and the county hospital to improve cancer awareness programs for Cambodian Americans in the area (Seng et al., 2005). Through collaboration with community leaders and Cambodian service organizations, they have successfully implemented a community-based cancer education program that was guided by a community assessment and provided grass-roots health education programs along with development of culturally appropriate Khmer language materials.

INFECTIOUS DISEASES

HEPATITIS B

It is estimated that of the 1.4 million Americans who are chronically infected with Hepatitis B (HBV), over half are API (Asian Liver Center, Stanford University). Cambodians have a hepatitis carrier rate that is three times higher than the general population.

Taylor and colleagues (2002) conducted a survey to assess Hepatitis B knowledge and practices among Cambodian women in Seattle, Washington, in both Khmer and English. Results indicated low levels of knowledge about HBV infection with approximately half having never heard about the infection. Among those sampled, only 38% had indicated having ever been serologically tested for HBV, while two-thirds of those tested had not been vaccinated.

DOMESTIC VIOLENCE

In a study conducted by the Asian Task Force Against Domestic Violence in Boston, using a self-administered questionnaire at ethnic fairs, 44–47% of Cambodians interviewed said they knew a woman who experienced domestic violence (Yoshioko & Dang, 2000). Youth gangs have become increasingly common and violent during the last decade, and have been described as a continuation of the Khmer Rouge influence (Khmer Health Advocates).

Violence has been a serious issue for the Cambodian community, and may be related to the violence and

terror experienced during the Khmer Rouge period (Khmer Health Advocates).

MATERNAL AND CHILD HEALTH

Cambodian women are thought to have a high rate of gestational diabetes (Khmer Health Advocates). The California Department of Health Services found that Khmer women were less likely to receive proper prenatal care, with only 64% receiving care in the first trimester. Cambodian women in California were also more likely to give birth to low birth weight infants than white women (7% vs. 5%).

Although APIs have the lowest teen pregnancy rates compared to all other major ethnic groups, Southeast Asians have disproportionately much higher rates. In California, although less than 6% of births to APIs are teen births, for Cambodians 11% of births are to teen mothers (Weitz et al., 2001). Qualitative data derived from focus groups with Southeast Asian youth revealed issues of low esteem and lack of power as young API women as some issues related to teen pregnancy.

Qin and Gould (2006) conducted the first study ever to examine maternal risk factors and birth outcomes of major Asian ethnic subgroups in California, including Filipino, Chinese, Vietnamese, Korean, Cambodian/Laotian, and Japanese. Overall results indicated that Japanese and Chinese had the lowest mortality rates, while Cambodians/Laotians had the highest total mortality rates across the spectrum: neonatal, post-neonatal, and infant. Medi-Cal, the federal Medicaid program in California, was the payer for delivery for nearly three out of four Cambodian/Lao births. Approximately 14% of births among this ethnic subgroup were preterm deliveries, defined as less than 37 weeks. Other significant predictors of maternal risk factors on neonatal and post-neonatal deaths include maternal age, late or no prenatal care, maternal education, and parity (the number of viable previous pregnancies).

MENTAL HEALTH

A number of studies have described mental health problems in the Khmer population in the U.S. Cambodians who were in Cambodia from 1970-1980 were found to have experienced 8-16 major trauma experiences during this time, including torture, long periods of malnutrition, slave labor, imprisonment, and witnessing atrocities (Kinzie et al., 1984; Realmuto et al., 1992; Mollica et al., 1990). A study of Cambodians who had lived in Cambodia from 1975-79 found very high incidence of headache, dizziness, and weakness (Mollica et al., 1985), all symptoms of Concentration

Camp Syndrome found in survivors of the Holocaust (Eitinger, 1961).

Marshall et al. (2005) conducted a cross-sectional, face-to-face interview with 482 Cambodian refugees residing in Long Beach, California, the largest such community in the U.S., to assess their mental health status two decades after resettlement in this country. Results indicated high rates of past-year PTSD (62%) and depression (51%). Such elevated rates raise questions about the adequacy of mental health resources for this community, as well as larger public health policy issues concerning refugee resettlement.

Using secondary data, Blair (2000) examined risk factors associated with PTSD and major depression among Cambodian refugees in Utah. Risk factors including experiencing a greater number of war traumas and a greater number of resettlement stressors were identified with PTSD and major depression. Financial stress was also found to increase the risk of major depression

For many Asian Americans, standard mental health service may not be the first choice of treatment. Daley (2005), however, found contrary results to past findings through his study using a mixed-methods design among second-generation Cambodian children and their parents. The study sought to examine beliefs about treatment of two specific emotional and behavioral problems that are common to the Cambodian American community: depression and gang involvement. Qualitative analyses revealed that the use of formal services and informal guidance (such as with a family member or friend) were the most common preferences for treatments. Findings indicated that both children and parents generally endorsed the use of mental health services, and that children are asking for more involvement and attention from their parents.

Healthcare providers in the U.S. do not have much experience treating conditions associated with war trauma or starvation, and few providers ask their patients any trauma they may have experienced (Khmer Health Advocates). This type of dialog is particularly unlikely given the tremendous cultural and language barriers faced by the Cambodian community (Uba, 1992).

SEXUAL HEALTH

Le and Kato (2006) conducted one of the first studies to investigate the role of age, gender, peer, family, and culture on the risky sexual behavior of Cambodian and Lao/Mien adolescents. The study's results revealed that peer delinquency and older age were significant

predictors of risky sexual behavior for both ethnic groups studied. Interestingly though, acculturation was found not to be a significant predictor, which perhaps may be explained by the fact that the sample studied consisted primarily of second-generation adolescents.

TOBACCO USE

Prevalence data for tobacco use among Cambodian Americans, though scarce, vary widely. CDC REACH 2010 survey results reported a significantly higher smoking prevalence for Cambodian men (50.4%), compared to the national aggregate data for Asians (14.7%) and the U.S. general population (24.9%)(CDC, 2004).

A recent study using focus group interviews was conducted to examine the socio-cultural determinants of tobacco use among Cambodian Americans residing in Long Beach, California (Friis et al., 2006). Results showed a very high smoking prevalence, with men smoking four times higher than women at 79.3% and 20.7%, respectively. Socio-cultural factors that were identified to influence Cambodians to smoke include traditions and practices that integrate smoking with Cambodian American social environment (i.e. funeral ceremonies, religious practices), and smoking being used for coping practices and medicinal purposes. Given that physicians are held in high regard and credibility among the Cambodian community, researchers suggested that physicians may have the most influence in both smoking prevention and cessation efforts, and that prevention programs should be cross generational.

A cross-sectional study was conducted in seven counties of Pennsylvania and New Jersey (also known as the Delaware Valley region) to examine the role of social influences on smoking behaviors among four Asian American subgroups: Chinese, Korean, Vietnamese, and Cambodian (Ma et al., 2003). Among the participants sampled, Cambodians reported a smoking rate of 42.4%, figures comparable to the CDC REACH 2010 survey. Family influences, as measured by having a father or brother who are smokers, played a significant role in smoking behavior. Cambodians (53.5%) were more likely to have a current smoking father or brother than Koreans (38.5%), Chinese (38.4%), and Vietnamese (27.8%) in the sample. Social influence was found to have a stronger influence on men than women, as Cambodians were three times more likely to smoke if more of their friends smoke, a figure higher than the other three ethnic groups. The study underscores the importance of taking into consideration

male parental tobacco use when designing prevention and cessation programs, as such social influences represents the primary source of learned behavior.

NUTRITION, WEIGHT AND PHYSICAL ACTIVITY

Survey results showed that Cambodians were less likely (16.4%) to report consuming the daily recommended 5 servings of fruits and vegetables a day, compared to the Asian population (32.1%) and the general U.S. population (24.4%) (CDC, 2004).

Vision and hearing problems have also been associated with starvation conditions (Gill & Bell, 1981).

TRADITIONAL MEDICINE

Many Cambodians are very committed to traditional medicine and healers. They will often use traditional medicine first and then go to a Western practitioner if necessary for further treatment. Sometimes, both traditional medicine and Western medicine are used simultaneously (Rasbridge & Kemp).

Traditional healers are called *Kruu Khmer*, and base their treatments on either a spiritual or magical system. Illness may be attributed to an imbalance in natural forces, such as the influence of “wind” or *kchall* on circulation. *Koo’ kchall*, or “coining” may be used to treat fever, nausea, and heart problems, and involves dipping a coin in medicine and rubbing it on the body in a symmetric pattern. *Jup kchall*, or “cupping” is used to treat headaches and depression, and is performed by heating a cupped object against the skin to create a vacuum. Traditional healers also use massage, a variety of natural plants and herbs, amulets, strings, and tattoos as therapeutic treatments and for protection against harm or illness (Rasbridge & Kemp).

RESOURCES

The following agencies and websites are able to provide additional information regarding the Cambodian community:

- Khmer Health Advocates
860-561-3345
<http://www.hartnet.org/khmer/>
- Ethnomed Cambodian Culture and Health
<http://ethnomed.org/ethnomed/cultures/cambodian/cambodian.html>
- Cambodian Association of America
562-988-1863
<http://www.cambodian.com/caa/>

- Southeast Asian Resource Action Center
202-667-6449
<http://www.searac.org/>
- Baylor website
http://www.baylor.edu/~Charles_Kemp/cambodian_health.html
- Cambodian Community Health 2010
<http://www.cch2010.info/>

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ABOUT THIS SERIES

This health brief is part of a series of that includes Cambodian, Chamorro, Chinese, Filipino, Hmong, Japanese, Korean, Native Hawaiian, Samoan, South Asian, and Vietnamese. All are available for download at www.apiahf.org.

Purpose

The purpose of the series is to summarize published research findings of disparities in the health and healthcare of the selected group. The data presented is meant for community health advocates, grant writers, evaluators and students as a tool to raise awareness, guide program development and spark future research for the well-being of Asian American and Pacific Islander populations.

Methods

This brief was updated after a PubMed literature review. In order to find the latest information, the Pubmed literature search focused on the years 2000-present and each ethnic group was cross referenced with these focus areas: access to quality health services, arthritis, osteoporosis, and chronic back conditions, cancer, chronic kidney disease, diabetes, disability and secondary conditions, education & community-based programs, environmental health, family planning, food safety, health communication, heart disease and stroke, HIV, immunization, infectious disease, injury & violence prevention, maternal, infant & child health, medical product safety, mental health & mental disorder, nutrition & overweight, occupational safety & health, oral health, physical activity & fitness, public health infrastructure, respiratory disease, sexually transmitted disease, substance abuse, tobacco use, and miscellaneous topics. For the Cambodian health brief, the search cross-referenced the term Cambodia and Cambodian with the aforementioned areas.

Limitations

It is difficult to characterize the health status of specific Asian American or Pacific Islander ethnic populations. Many studies do not differentiate between the various ethnicities studied. Small sample sizes make it difficult to generalize research findings and in some cases, data are just not available. For these reasons, the data contained here provide only a rough estimate of health status and are not an exhaustive presentation of the findings, nor are they meant for medical decision-making.

Contributors

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