APIAHF
HEALTH BRIEF

HMONG
IN THE UNITED STATES

HISTORY

The Hmong are an Asian ethnic group from Southeast Asia. Their presence in the U.S. is due largely to U.S. intervention in Laos and Vietnam. After the defeat of the French on the Lao-Vietnamese border in 1953, civil war raged in Laos. The U.S. provided both economic and military support to Hmong fighters in the north in what has since been called the "Secret War." In 1975, when communists took control of both Vietnam and Cambodia, the Pathet Lao took control of Laos and established a Marxist government. The government set up "reeducation camps" that were generally regarded as even more severe than those of the Vietnamese. The case for Hmong applying to come to the U.S. as refugees was especially compelling because the U.S. had reportedly promised that if Laos were lost to the communists, the U.S. would provide them with any assistance they would need. Initially, U.S. resettlement of the Lao and Hmong as refugees was substantial, but in recent years the numbers have dwindled (Southeast Asian Action Resource Center).

DEMOGRAPHICS

The U.S. Census Bureau estimates that in 2000 more than 169,000 Hmong lived in the United States, comprising 1.7% of the total API population (US Census Bureau, 2000). California is home to the largest Hmong population in the nation, followed by Minnesota, Wisconsin, North Carolina, and Michigan (SEARAC, 2004). A majority of Hmong (55.2%) are under the age of 18, more than twice the proportion of the general population.

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.

Nine-five percent of Hmong speak a language other than English at home, the highest among Asian Americans, while 58% are limited English proficient (LEP), the second highest among Asian Americans (APIAHF, 2005).

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.

For Hmong Americans, the median family income stands at $32,384 much lower than the national median figure of $50,046. Hmong Americans have the highest number (37.8%) of people living below the federal poverty level compared to the national rate of 12.4%. Hmong have the largest household size (6.14 people) of any other racial or ethnic group in the nation, compared to the national figure of 2.6 (US Census, 2000). More than 54% of Hmong families have an average of seven or more members per household (Mills et al., 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%).

Hmong Americans have the lowest level of educational attainment of any other racial or ethnic group, with only 7.5% possessing a bachelor's degree or higher compared to the national rate of 24.4% (US Census, 2000). Approximately 59% of Hmong have less than a high school level education.

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.

Fifty-six percent (56%) of Hmong are foreign-born, compared to 63% of Asians. Thirty-one percent (31%) become citizens, slightly higher than Latinos (28%).

HEALTH STATUS

It is difficult to characterize the health status of Hmong. 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 their health status.

Some documentation exists on the health beliefs or health practices of Southeast Asians, as well as how these cultural differences affect their access to care, and interactions with the U.S. health care system. For instance, healthcare strategies among the Hmong culture involves a shamanism, herbal medicines, or a combination of the two (Helsel et al., 2004).

An ethnographic study examining health beliefs and experiences of Hmong in the western health care system shows that providers need to treat Hmong with respect and understanding, while taking into account cultural beliefs and practices (Johnson, 2002). The Hmong language lacks words that are comparable to Western languages for anatomy, physiology, and many illnesses. Negative health care experiences have caused some level of mistrust and fear of Western medicine in the Hmong community.

Physicians who provide care for Hmong are advised to serve as an adviser and presenter of information rather than an authoritarian parent figure (Her & Culhane-Pera, 2004).

HEALTH INSURANCE COVERAGE

While rates of health insurance coverage do not exist nationally for the Hmong, some data exists for Southeast Asians as a whole. In 1997, 27% of Southeast Asians, ages 0-64 were uninsured in the U.S., compared to 14% of non-Hispanic Whites. Southeast Asians were much less likely to receive insurance through their jobs (49% vs. 73% in Whites), and much more likely to be covered by the Medicaid program (18% vs. 6% in Whites) (UCLA Center for Health Policy Research, 2000).

CHRONIC DISEASES

HYPERTENSION

In a study to investigate contextual factors that compromise hypertension management, in-person interviews with 323 Hmong with hypertension found a low adherence with proper medication consumption and appointment keeping (Wong et al., 2005). Sociodemographic factors (i.e. high unemployment status and limited ability to speak English), health profile (i.e. high level of psychological distress), and knowledge and beliefs about hypertension played a role in low adherence. The belief that "American medicine is too strong" also played a significant role in the compromised management.

CANCER

Compared to all races combined, Hmong were found to have higher rates of cancer in the following sites: nasopharynx, stomach, liver, pancreas, leukemia, and non-Hodgkin's lymphoma. Cervical cancer, and in particular, invasive cervical cancer, were much higher in Hmong women. In addition to cervical cancer, diagnosis of many cancer sites occurred at the advanced stage and grade of the disease, indicating avoidance of Western medicine and low participation in screening programs (Mills & Yang, 1997; Mills et al., 2005).

Cancer incidence reports from Minnesota showed that the Hmong population had increased proportional incidence ratios for nasopharyngeal, hepatic, and cervical caner, while decreased ratios for prostate and breast cancer, Hodgkin disease, and melanoma during the period from 1988-1999 (Ross et al., 2003).

Data from the California Cancer Registry revealed a number of health disparities among Hmong women. Incidence and mortality were three and four times higher among Hmong women than the Asian/Pacific Islander and white women (Yang et al., 2004). Approximately half (51%) of Hmong women chose no treatment options, compared to API women (5.8%) and white women (4.8%). This preference may in part be explained by the idea that it is culturally unacceptable to surgically remove body parts, hence affecting diagnosis and treatment related decisions of cervical cancer. Traditional Hmong health beliefs and practices center on spiritual rather than biological etiologies and thus Hmong tend to distrust physicians and Western medicines.

Cancer occurrence in Southeast Asian children may not reveal as any patterns. One study found race/ethnic misclassification of many Hmong children in the California Cancer Registry database, with many

classified as Laotian, probably because most were born in Laos. Researchers call for a more accurate classification system of Southeast Asian subgroups in order to conduct more accurate studies (Ducore et al., 2004).

A culturally and linguistically appropriate intervention to improve breast cancer screening rates among Hmong women in California led to increased knowledge and more positive attitudes among participants (Tanjasiri et al., 2006). A unique aspect of this intervention was that it targeted men as well in an effort to secure their support for their wives' breast cancer screenings. For Asian American women, women's health and the decisions surrounding health care is family matter. Intent to seek clinical breast exams and mammograms among women and support for such exams among men also increased from baseline data.

DIABETES

National disaggregated prevalence data for diabetes among Asian Americans or Pacific Islanders ethnic groups is not available (American Diabetes Association), although Asians in general have similar rates of diabetes as non-Hispanic Whites. Asians are 20% less likely than non-Hispanic whites to die from diabetes (Office of Minority Health). "Sweet blood" is the term Hmong use to describe diabetes (Her & Mundt, 2005). One estimation, however, is that the Hmong community in Fresno, CA, has double the rate of diabetes than the general US population (Helsel et al., 2005). A cross-sectional survey conducted among adult Hmong in Wisconsin found that 41% of the sample were potentially at risk for developing the disease, based on waist-to-hip ratio as a strong predictor of the disease (Her & Mundt, 2005)

Culhane-Pera and colleagues (2005) conducted a study using group visits among 39 Hmong adults with type 2 diabetes recruited from three community health clinics in Minnesota. Results did not reveal significantly improved clinical outcomes, although participants received quality medical services and improved their mental health. Researchers suggest that perhaps addressing mental health among this population may be necessary before instituting behavioral changes to improve diabetes management.

Focus groups with African Americans, Native Americans, Hispanics and Hmong with diabetes were conducted in the Minneapolis and St. Paul areas. Recommendations from participants centered on improvements in the areas of health care, diabetes education, social support, and community action in a culturally responsive manner (Devlin et al., 2006).

INFECTIOUS DISEASES

HEPATITIS B

A study at a clinic in St. Paul, Minnesota found that 18% of the Hmong patients had acute or chronic Hepatitis B infection (HBV), with the rate of infection highest in the 15-19 age group (Gjerdingen, 1997).

MATERNAL AND CHILD HEALTH

The practice of breastfeeding, which provides immunological protection to infants, is uncommon among Hmong and many other Southeast Asian women. Targeted breastfeeding promotion is needed to address attitudes regarding the popularity and convenience of formula-feeding, and discouraging hospital practices that may hinder breastfeeding (Tuttle & Dewey, 1994).

In a descriptive correlational study examining maternal sensitivity (as measured by the mother's sensitivity to her child's communication), posttraumatic stress, and acculturation among 30 Hmong and Vietnamese mothers, results revealed that almost half (43%) were clinically depressed or anxious (Foss, 2001). Less acculturated mothers tended to be more anxious and depressed, while one third of the sample had considered suicide in the previous week. Clinical implications from this study suggest that nurses should incorporate screening for depression and anxiety into routine assessments or discharge planning for foreign-born mothers and make appropriate referrals for stressed mothers.

Delays in obtaining care have also been documented with regards to prenatal visits. Interviews with pregnant Hmong women living in Wisconsin found that fear of miscarriage caused by the touch of a doctor or nurse resulted in delayed care (Jambunathan & Stewart, 1995).

Efforts to improve the quality and access of care have received positive feedback. One clinic implemented successful reforms such as hiring a nurse-midwife, reducing the number of pelvic exams, expanding hours of operation, creating a direct telephone line to Hmong interpreters and producing a Hmong-language prenatal health care education videotape (Spring et al., 1995).

A literature review identifying beliefs, knowledge, attitudes, and practices related to the care of children with acute illness among mothers from rural areas of developing Asian countries and Hmong mothers in the

U.S. found many similarities (Jintrawet & Harrigan, 2003). For example, causes of diarrhea, measles, and acute respiratory illness are derived from traditional and cultural beliefs and hot-cold reasoning, and primary treatment is either a home remedy or traditional practice.

A study of Hmong children who underwent appendectomies has suggested that Hmong children experience longer delays before arriving at the emergency room, longer delays between arriving at the hospital and arriving at the operating room for surgery, and longer mean hospital stays. They also experienced more invasive surgeries. Social and cultural barriers and communication difficulties largely compromised the health care of Hmong children (Hu, 2001).

MENTAL HEALTH

Mental health providers in the U.S. have encountered numerous challenges in serving the Southeast Asian population. Many Vietnamese, Cambodian, Laotian, and Chinese refugees are diagnosed with post-traumatic stress disorder (PTSD). This condition is rooted in traumatic etiologies from being victims of wars, such as political refugees, concentration camp prisoners, victims of rape, and from suffering severe personal losses (property or human lives) (Ton-That, 1998).

SUBSTANCE USE

Due to the combined effects of mental health disorders and acculturation pressures, substance abuse problems among Southeast Asian immigrants may be significantly increasing O'Hare & Van Tran, 1998).

NUTRITION, WEIGHT AND PHYSICAL ACTIVITY

Evidence suggests that Southeast Asian refugees (Cambodian, Vietnamese, Hmong) who have been in the United States for five years or less maintained strong ties to their native foods and traditional meal patterns (Story & Harris, 1998).

California is home to a successful nutrition education campaign, *Five A Day,* a program that encourages consumption of five servings of fruits and vegetables a day. Recent additions to the program include campaigns that are directed towards Latinos and African Americans. At the time of this writing, there currently is no program in place that specifically targets Asian Americans. The state health department and UCLA researchers have, however, recently convened a group of low-income Chinese, Vietnamese, and Hmong Americans to explore knowledge, attitudes, dietary practices, and physical activity levels (Harrison et al., 2005). Results of the focus groups indicate that the maintenance of healthy traditional diets, education on mainstream U.S. foods, and promoting active lifestyles are strategies to include in the creation of such a campaign.

Programs which provide culturally competent nutrition education are likely to be successful in reducing risks for diabetes and heart disease, as they have among other populations (Hughes, 1998). Valuing traditional culture and using it to complement Western health practices will help reduce barriers to health care and improve the health of the community.

SUDDEN DEATH

Numbers of seemingly healthy Hmong immigrants have died mysteriously and without warning from what has come to be known as Sudden Unexpected Nocturnal Death Syndrome (SUNDS). The disorder tends to strike young Southeast Asian men during sleep. While breathing disorders, and heart conditions have been suspected of causing SUNDS, to date medical research has provided no adequate explanation for these deaths (Adler, 1994).

RESOURCES

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

- Southeast Asia Resource Action Center (SEARAC)
  www.searac.org
  (202) 667-6449
- Hmong National Development, Inc.
  http://www.hndlink.org
  (202) 463-2118
- Ethnic Specific Health Care Beliefs and Practices
  http://www.baylor.edu/~Charles_Kemp/asian_health.html
- Hmong Cultural and Resource Center
  www.hmongcenter.org
- Hmong Health website
  www.hmonghealth.org

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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 Hmong health brief, the search cross-referenced the term Hmong 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
This series was revised in 2006 by Gem P. Daus, MA, Mona Bormet, MPH, and Sang Leng Trieu, MPH, with research assistance from Doris Chen. You may send comments and questions to healthinfo@apiahf.org.