San Francisco Bay Area

ASIAN AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER

Youth

HEALTH STATUS REPORT

Prepared for the
Asian and Pacific Islander Bay Area Health Council
by the
Asian & Pacific Islander American Health Forum

DECEMBER 2007

EXECUTIVE SUMMARY

The San Francisco Bay Area Asian American, Native Hawaiian, Pacific Islander Youth Health Status report was prepared for the Asian and Pacific Islander Bay Area Health Council ("the Council") by the Asian & Pacific Islander American Health Forum.

This report appraises the health status of Asian American, Native Hawaiian, and Pacific Islander (AA & NHPI) youth in the San Francisco Bay Area by identifying some critical health care concerns, programmatic and policy issues that affect the health needs of these youth.

Introduction

The Council offers this report as a catalyst for local community action in the San Francisco Bay Area. This study provides many illustrative findings that are difficult to obtain through the California Health Interview Survey. The qualitative nature of this study allows us to understand how youth interpret the landscape of health resources and programs available to them.

Methodology

Twenty-two AA & NHPI youth ranging in ages 14-17 were interviewed using a semi-structured interview format on subjects ranging from language access, health coverage, sexual and mental health.

Highlights from the study

Many youth cited low numbers of school counselors as a significant barrier to seeking support. As a result of the limited capacity of schools and local programs to provide necessary youth counseling services, a majority of them reported *"dealing with problems on their own."* However in terms of sexual health, many youth were exposed to some form of sex education whether it was through the school curriculum or community health workers (CHWs) actively visiting schools.

Recommendations

Program

- Promote the use of school and community based clinics among students
- Provide counseling training to program coordinators
- Increase the skills of current program counselors
- Support more peer oriented programs like Asian Pacific Islander Youth Promoting Advocacy and Leadership (AYPAL)
- Create opportunities and activities for parents and families to engage with youth

Policy

- Increase funding for local, state and national research on AA, NH & PIs
- Increase the number of community based organizations (CBOs) conducting health related education and outreach, especially for sex education
- CHIS should be advised to increase the sample of AA, NH & PIs to reflect their growing populations in the state and the Bay Area
- CHIS should continue to sample youth and maintain the sexual and mental health sections for the upcoming 2009 surveys

- Increase allocation for peer education and program coordinators in the mental health services sector like Asian Community Mental Health Services, Asian Health Services, Japanese Community Youth Council, Asian American Recovery Services, Chinatown Youth Center, Filipino American Development Foundation/Filipino Community Center, Korean Center, Inc., Samoan Community Development Center, and Vietnamese Youth Development Center.

Dissemination

The Council Report will be disseminated to member agencies, Kaiser Permanente, The California Endowment, key representatives of local and state government, AA & NHPI community based organizations and advocacy groups.

SAN FRANCISCO BAY AREA
ASIAN AMERICAN, NATIVE HAWAIIAN & PACIFIC ISLANDER YOUTH
HEALTH STATUS REPORT

Introduction

The San Francisco Bay Area Asian American, Native Hawaiian, Pacific Islander Youth Health Status report was prepared for the Asian and Pacific Islander Bay Area Health Council ("the Council") by the Asian & Pacific Islander American Health Forum. This report captures the ideas of Asian American, Native Hawaiian and Pacific Islander (AA & NHPI) youth regarding their health and well-being, using conversational interviews. The Council sought to follow up their *San Francisco Bay Area Asian and Pacific Islander: Health Status 2005* report with a *Youth Health Status report*. In line with previous methods, the Council initially sought to utilize the online database available through the California Health Information Survey (CHIS), the largest and most readily available resource for local and state health data. The Council, however, felt the CHIS data did not reflect their experiences and interactions with AA & NHPI youth, and chose instead to collect their own data.

The results of the CHIS data sets correspond to the AA & NHPI "model minority" stereotype as the most thriving and self-sufficient minority group in the U.S. These images are harmful because it obscures not only the heterogeneity of the AA & NHPI population but also their real tangible needs. The myth randomly assigns certain "truths" about the socioeconomic success of these minority groups and therefore diverts essential resources away from community investments in these underserved populations. So it follows that many of the stories in this report run counter to narratives in the mainstream media and the CHIS data. Our interviews with working class youth in the San Francisco Bay Area reveal life experiences that effectively highlight significant discrepancies with the CHIS data and the model minority myth. We seek to give voice to the struggles of AA & NHPI youth who often remain unheard in light of the nonexistent or inadequate documentation of the needs, experiences and perceptions of this diverse community.

Purpose

The purpose of this report is to:

- Capture the current health and well being among San Francisco Bay Area AA & NHPI youth ages 14-17
- Inform program planning and policy development
- Develop opportunities for youth development and health promotion among the San Francisco Bay Area AA & NHPI youth

This report is unlike mass surveys in that it examines the quality and character of the challenges facing our constituency. In fact, it is clear that the twenty-two youth from which we gathered our report represent twenty-two unique experiences of AA & NHPI youth in the San Francisco Bay Area. The qualitative nature of the study allows us to understand how these young people interpret the landscape of health resources and programs available to them. Significantly, it sparks knowledge and insight around sensitive topic areas that

are difficult to capture in depth with quantitative data. Their stories help contextualize some of the realities facing AA & NHPI youth in this region — and to guide current and future conversations to address these challenges. In fact, concrete issues arose during interviews, concerning the availability of social and health services for the mental and sexual health of youth.

Challenges

One of the major challenges that has emerged in public health within the last twenty years is how to address the diversity of health concerns within the AA & NHPI population, which is often masked under the aggregate label "Asian American" or "Asian Pacific Islander (API)." Even under these aggregate categories, few studies or projects are funded that address the health issues in this community. From 1986 to 2000, only 0.2% (342) of 150,369 National Institute of Health grants corresponded to AA & NHPI populations. Only 0.01% of studies found on MEDLINE even mention AAPI as a studied group. Even fewer targeted the challenges of AA & NHPI youth. This demonstrates the limited pool from which AA & NHPI baseline data can be gathered. (Ghosh, 2003)

The lack of funding directed towards national research also trickles down to the availability of state and local data on AA & NHPI's. The CHIS has been the forerunner in the attempt to collect disaggregated data on AA & NHPI communities, collecting data on the following Asian subgroups: Cambodian, Chinese, Filipino, South Asian, Korean, Japanese, Vietnamese, and Other single/multiple Asian type. However, these categories still do not adequately represent the over 30 ethnicities that fall under "API."

The CHIS methodology runs into limitations when surveying youth. The majority of households sampled through the CHIS are surveyed using Random Digit Dialing (RDD), limiting the sample population to those living in households with landlines, and skewing the data to only capture youth of certain socioeconomic levels. This methodology does not recognize that many youth use cell phones as their main source of telecommunication and very few are accessible via home phones.

The CHIS also has limitations with the validity of answers because although the interviewers can guarantee respondents confidentiality, it is unlikely youth are always free to answer all the questions honestly. This is especially true when the interviewer must first receive verbal consent from an adult in the household, who may likely remain within hearing range of the young person during the interview. How many young men or young women will easily disclose information about their sexual activity over the phone? The large survey methodology of CHIS does not lend itself to accurately capture sensitive topics such as the sexual and mental health status of youth.

Methods

Asian Pacific Islander Youth Promoting Advocacy and Leadership (AYPAL) is a 300-member youth organizing group based in the Bay Area that exposes people to community based programs. AYPAL enables underserved youth in grades 9-12 to become community leaders and to work cooperatively with their peers, families, and neighbors to advocate for positive changes. AYPAL includes ACMHS (Asian Community Mental Health Services), FAA (Filipinos for Affirmative Action), OASES (Oakland Asian Students Educational Services), KCCEB (Korean Community Center of the East Bay), LIMCA (Lao Iu Mien Culture Association), and PIKA (Pacific Islander Kie Association). Each site hosts a youth leadership organization (YLO), with 20-50 youth members. There have been many positive development outcomes among

members such as decrease in youth drug use, fewer violent incidents, and an increase in ability to lead groups and build inclusion. Participants for this study were recruited from these YLOs and given parental and adolescent consent forms. Twenty-two Asian American, Native Hawaiian, and Pacific Islander youth ranging from age 14 to 17 years were interviewed using a semi-structured interview format on subjects that included language access, health coverage, sexual and mental health.

Survey Demographics

Age	
14-15	8
16-17	14
Ethnicity	
Chinese	5
Vietnamese	3
Cambodian	4
Filipino	2
Samoan	2
Tongan	3
Korean	1
Laotian	1
Mien	1
Sex	
Male	8
Female	14

Discussion

Language

Almost all of the youth surveyed translate for family members; most frequently, they translate for their mothers, followed by their fathers. They translate in school, hospital/medical facilities, and retail settings. It appears to be a commonplace experience among AA & NHPI youth to have to translate for their parents for essential interactions.

Health Coverage

This topic did not generate useful findings because the majority of respondents did not know what type of insurance they had, or if they even had health insurance.

Sexual Health

All the youth seem to have had some form of sex education class, and most are aware of sexually transmitted diseases (STDs) and community-based health clinics. Sex education courses occur predominantly in high schools, where community health workers (CHWs) from these clinics conduct continuous outreach to schools. The presentations run approximately two weeks, the standard time allotted to sex education in the curriculum during the school year. Youth ages 16-17 have a clear idea of where to obtain sexual health resources, whereas youth ages 14-15 could not pinpoint where to access these resources. Therefore, one recommendation is to increase sex education classes and workshops during this crucial period of 14-15 years.

Since the respondents were recruited from youth programs, many of them have been exposed to sex education and resources through those programs. Some community health clinics conduct youth centered health programs, and collaborate with APIAHF and the Council. One seventeen-year-old Laotian male from Alameda County recalls his clinic tour:

"They'll talk about disease and stuff. Like why we should come see the clinic and you know, being healthy. They gave us advice on what you should do. I didn't know about this one pill called Plan B. If you were to be pregnant or whatever, you have like three days to get the pill and wash it out…to get it out of your system."

He says that, because Asian Health Services (AHS) is located in the same building as his youth program, this gave him the opportunity to take a tour of AHS. He says he not only learned the location of a community clinic, but also how to protect himself and his partner from STDs. That he remembers this piece of information about emergency contraception, points to his level of responsibility. Because of his awareness, he is also able to offer support to protect his partner. He clearly views AHS as a safe and accessible resource for himself and his peers to minimize the unwanted consequences of high risk health behaviors.

Peer education programs such as AYPAL provide participants with important information and resources and increase their ability to be proactive about their own health. These programs in turn allow them to educate and empower their peers in the community to also be aware of their own health. This fifteen-year-old Cambodian female states,

"I used to work for the youth program, the clinic. So they'd tell us about all the STDs and how to fix your body, so I know all about that. They show us how to present and teach other youth about sex and stuff and then we go over to middle schools and present it at schools."

She says that her friends confide in her because her participation in this youth program makes her knowledgeable about sexual health. Her friends feel free to discuss their sexual behaviors with her and ask about the consequences of these behaviors. This young woman feels,

"... good that I'm able to help my friend about it. Instead of just being shy and just having the situation get worse and instead of talking it out."

Many youth from Alameda County mentioned a mandatory, one semester class called *Current Life*. One seventeen-year-old Filipina describes the curriculum:

"*They teach you about STDs and situations that go on in our community and how we can make the place better... just for people to know what's out there and then they let you tell your family background and stuff, and tell people about your life... like what you go through, so you get to know people in the class and mix with different types of people. And they just teach you about STDs and you know, peer pressure and how you can help other people. And you know - it just makes people closer."*

The impact of a required class such as *Current Life* is difficult to gauge for the entire student population, but this young woman plainly acknowledges the value of this program in addressing issues she and other youth face —sexual health, peer pressure, diversity. The sex education program offers resources and builds a sense of community among youth, from which to draw when faced with difficult issues outside the *Current Life* class.

School-based clinics, play a critical role in providing free or low-cost primary health care. They are located on campus, staffed with medical personnel and counselors, and equipped with health service facilities, such as STD or pregnancy testing. They are also accessible, safe, and offer immediate, confidential answers to questions young people have around sex, birth control options, and health in general. One sixteen-year-old Korean female was better able to understand the consequences of the Pill and,

"...found out more information about it. I didn't think it was safe... I though that it didn't work 'cause it's just a pill and it would affect my health and stuff and I asked doctors... I found out it wasn't true."

She learned more about birth control options, thereby broadening the scope of ways to protect herself. Furthermore, the school clinic staff made her feel comfortable, making it clear that they are non-judgmental of the students they administer to, regardless of their level of knowledge or level of sexual activity. Students see that the school clinics exist to aid youth to act safely and reduce risk-taking behaviors. The student's perception is that the clinic staff is approachable and trustworthy. This indicates similar reasons other students would have to make it more likely for them to utilize services at school clinics.

A problem is that students still may not know about the resources and services available to them, even though school clinics are located on campus, One seventeen-year-old Samoan male, also from Alameda County, sums it up succinctly:

"We got that at our school. I didn't see that. I didn't know. If I don't know, then other people might not know where to get [STD and HIV testing] if they wanted to."

Another drawback to school clinics is that students fear the lack of privacy and confidentiality in accessing clinic services, and not because the youth do not trust the staff. They anticipate a possible breech in confidentiality based purely on the clinic's location on-campus, and fear that students/faculty may overhear or have access to their personal records. A fifteen-year-old Cambodian female from Alameda County knows she can get tested at school, but states,

"I don't really trust the school 'cause like stuff goes around. And like only I want me and that person to know about it."

She does not feel comfortable seeking help at school simply because of a perceived threat of exposure in that setting. It is unlikely that these two youth are in the minority when describing such sentiments toward school clinics. These factors lend support to the necessity of community clinics, which offer a possible solution to addressing these concerns.

Fortunately, all the youth respondents could recall a **community clinic** or knew how they could find one, and AHS was the one most frequently mentioned. Community clinics offer to youth a high degree of approachability and confidentiality, and communicate little to no stigmatization towards them. They also provide youth with the support, resources, and services they need to stay healthy and safe from STD's, HIV, teen pregnancy and youth violence. A fifteen-year-old Cambodian female states:

"I had an accident a few months ago and didn't know what to do, but found out what to do because I went upstairs [to the clinic] and they told me..."(She) *"...got an abortion at the Jack London place. ' Cause Stanley*, upstairs ... he's hecka nice to me and I just told him what happened. And he helped me set up the appointment and get the emergency Medi-Cal, so it could be free and gave me the address."*

Her story vividly describes the vital role a community clinic and its staff played during her crisis by providing her with options and resources to address her unplanned pregnancy. On a milder note, a seventeen-year-old Chinese female believes,

"It's really easy because I could just come by and get some [condoms]. And there'll be no questions asked about why am I getting it."

Findings

The 2005 CHIS data showed that 92.7% of AA & NHPI youth ages 14-17 in the San Francisco Bay Area answered as "has not had sex." However, nine of the twenty-two youth in our study (41%) answered yes, when asked "if they had ever been sexually active." Of the nine youth who had ever been sexually active, seven were young women, two were young men. All, except one of the nine, used some method of birth control, mostly condoms. One young woman used the rhythm method, monitoring her menstrual cycle to avoid pregnancy.

We found that there were high rates of birth control usage, however they reported alarmingly low rates of STD and HIV testing. Only two of the nine (22%) youth who had ever been sexually active, have been tested. Many of them believe that since they practice safe sex, in accord with what they learned from sexual education classes, the *Current Life* class, and clinics, they do not have to worry about contracting STDs or HIV. A seventeen-year-old Cambodian male candidly reveals a common attitude:

> *"It seems like if you don't have it, if there's no immediate danger, you don't really need it. I know that sounds bad, but that's just the way it is."*

While a majority of the AA & NHPI youth from our study who have been sexually active engage in safe sexual practices, and are also aware of the risks and of the available resources, very few are taking the extra precaution to assure that they have not contracted any STDs or HIV. One hopeful exception came from a fifteen year old Cambodian female who speaks about her experience when going to get tested,

> *"You'll just get nervous a little bit, but then like I know I didn't do anything crazy or whatever, I just did it just to make sure I'm safe."*

A large part of the problem stems from the stigma associated with getting tested. Almost all reported feeling "nervous" or "ashamed" when asked, "How do you feel about getting tested for STDs/HIV?" In order to better protect the health of young people, public health institutions and organizations must conduct better outreach and engage young people in these diagnostic screenings as well as investigate how to reduce the stigmatization and fear that are attached to these tests.

Mental Health

The psychological health of minority youth, in particular AA & NHPI youth is poorly understood. What is known even less is their utilization of mental health support services. In the 2004 Services and Advocacy for Asian Youth [SAAY] Consortium Report, mental health was the top issue, and it remains so 3 years later.

Many of the youth interviewed describe situations at home, at school, or with friends that typically call for a supportive counselor. Yet only five out of the 22 reported that they had ever seen one. What is even more alarming is that when asked "Could you see a counselor if you wanted to?" sixteen of the twenty-two answered no. It seems youth feel more comfortable with a program coordinator whose primary role is not that of an official school counselor.

Many youth cited the limited number of counselors as a barrier to seeking them out for support. One seventeen-year-old Vietnamese male describes his experience when he tried to see his counselor:

> *"I tried to talk to a counselor, but at times, I don't think she has time… it's like, whenever I get there, she's either at lunch or at break or, she does talk to me, it's only about educational things. Never about any of this stuff."*

Another fifteen-year-old Tongan male speaks about the time he was able to see a counselor:

"The only time I met with a counselor is when I get in trouble in class. That's the only time I see a counselor. Or when I need to transfer. But when I talk about stuff like this, they don't give a crap."

These youth are proactively seeking, or at least know they want, support from counselors, yet schools severely lack the staff capacity to offer guidance beyond academic-related issues. Students clearly understand that school counselors are always busy and extremely understaffed, and this deters many from trying to see them.

Youth also need early exposure to counseling to increase their receptivity to the idea of utilizing these services throughout the school years. Increasing counselor availability for freshmen can help address this need. A fifteen-year-old Tongan male cites his high school as only having four counselors for the entire student body of 2,000, and this is why he does not try to talk to one. He articulates:

"That's why when I talk to them, they don't worry about me, they worry about the seniors… To me, the freshmen need more attention than what the seniors do 'cause if the freshmen don't get any attention from the counselors during their freshman year, then all sophomore, junior year, they're not gonna really care about going to see them . And in their senior year, 'cause they're used to their counselors not seeing them."

The school system needs to address the issue of providing mental health support to its youth because they clearly need it and the lack of staff will continue to deter youth from seeking needed help in the future.

Youth seem to find support in other ways, from coaches, youth program coordinators, or counselors at school clinics. One seventeen-year-old Cambodian male realizes that even if he has to force himself to talk, having his coach or his program coordinator to speak to is imperative to maintain a sense of balance:

"I think it's like I just gotta get myself out there 'cause if you keep things to yourself for so long, it messes with you. And so didn't want that to happen to me… I don't want to share my life story with everybody, but I'm just saying I gotta express myself sometimes, if I can't talk to anybody."

Another seventeen-year-old Filipina acknowledges the positive impact of talking with counselors at school clinics:

"… they're just there to help you 'cause some people don't really have people there for them… Like you know how sometimes you talk to your friends, but they can't really understand you? Like counselors, you can talk to them 'cause that's what they're trained and that's what they get paid for. And sometimes they go through the same experience, and then you can relate to them."

Youth who have successfully sought support from individuals who play a counselor role clearly value the direct impact these individuals have had on them. The youth in our study affirm a need and desire to foster these proactive attitudes, and emphasize the importance of expanding programs outside the academic setting to serve in these support roles, i.e. youth programs, school clinics, and sports programs.

Findings

In light of the severe lack of infrastructure to support youth with their struggle to address life challenges, it comes as no surprise that a majority of them reported *"dealing with problems on their own."* Some coping mechanisms they reported include: writing poetry, listening to music, ignoring problems, being alone, and dancing. While these mechanisms are relatively harmless or even positive ways to cope, other mechanisms can potentially lead to other negative consequences and have the potential to become self-destructive. Such coping mechanisms include running away, leaving in the middle of the night to "tag" (vandalize) and "cutting" school. The last response mechanism is of particular concern because ten of the twenty-two youth answered "Yes" when asked, "Have you ever felt so sad you cut school?"

As public health planners, we should work to expand counseling availability by either increasing the numbers of direct counselors or providing additional counseling training to those who interact with youth. Community based organizations (CBO's) should also provide support by providing counseling or providing mental health services. The likelihood of Asian youth accepting and utilizing mental health services will significantly increase if it is provided in a safe and comfortable environment. School districts, as well as other institutions and community service providers in the San Francisco Bay Area should acquire or develop the tools and resources necessary to properly identify and assess the mental health needs of young people. Youth development and educational workshops on positive coping strategies for youth and parents also need to be provided. Lastly, the 2004 California Mental Health Services Act funds should be allocated for mental health services to finance and support more counseling programs for youth.

Recommendations

The following policy and program changes are recommended to strengthen the San Francisco Bay Area's overall capacity to support health and wellness programs for AA & NHPI youth, and ensure the development of youth development and health promotion that includes families and communities.

Policy:

- Increase funding for local, state and national research on AA, NH, and PIs
- Increase the number of CBO's conducting health related education and outreach, especially for sex education
- CHIS should be advised to increase the sample of Asian Americans and Pacific Islanders to reflect the growing populations in the state and the Bay Area
- CHIS should continue sampling youth and keep the sexual and mental health sections for the upcoming 2009 surveys
- Increase allocation for peer education and program coordinators in the mental health services sector like Asian Community Mental Health Services, Asian Health Services, Japanese Community Youth Council's, Asian American Recovery Services, Chinatown Youth Center, Filipino American Development Foundation/Filipino Community Center, Korean Center, Inc., Samoan Community Development Center, and Vietnamese Youth Development Center.

Program:

- Create opportunities and activities for parents and families to engage with youth
- In addition to school clinics, increase the range of resources for students

- Provide training on counseling for program coordinators
- Increase the skills of current program counselors
- Support more peer oriented programs like Asian Pacific Islander Youth Promoting Advocacy and Leadership (AYPAL)

References

Bernard, H.R. Research Methods in Anthropology: Qualitative and Quantitative Approaches. 4th Edition, 2006. AltaMira Press.

UCLA Center for Health Policy Research. California Health Interview Survey (CHIS) 2005.

Ghosh, C. Healthy People 2010 and Asian Americans/Pacific Islanders: Defining a baseline of information. American Journal of Public Health 2003; (93)12: 2093-2098.

The Services and Advocacy for Asian Youth Consortium. Moving Beyond Exclusion: Focusing on the Needs of Asian/Pacific Islander Youth in San Francisco. March 2004 report.

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