Healthcare on the Margins

The Precarious State of Physical Health for Thais in Thai Town

April 2004

Thai Community Development Center

Los Angeles, California

FOREWORD

Chanchanit Martorell, Thai CDC Executive Director

The Thai Community Development Center (Thai CDC) has been gathering data on the health care needs of Thai immigrants since our inception in 1994 but nothing as comprehensive and geographically specific as this survey. We believe the time is due for a more thorough investigation into the health needs of Thai immigrants as our population continues to grow rapidly and yet a lack of sufficient data on the community remains a problem. As long as data on our community is nonexistent, our community will continue to be invisible, marginalized and underserved. Hence, our effort to begin as accurate and precise an assessment of the community became critically important. The health care needs of economically disadvantaged Thai immigrants have always been considered of paramount concern because our initial data, observations and experience from working with this population has shown an unsettling fact – poor Thai immigrants are at great medical risk. A number of factors are contributing to their health risks. They include language and cultural barriers, religious beliefs and practices, lack of health insurance, and poor and unsafe working conditions.

To begin addressing this health crisis in our community, Thai CDC launched its ***"Campaign for Better Health"*** in 2001, which serves as the first major health education and awareness initiative in the Thai community. From our direct work on health issues in the community over the past ten years, we have seen a demonstrated need for health education, prevention awareness, and affordable health care. Our campaign seeks to address these health-related issues in a comprehensive manner focusing on the following areas of need:

- *Overall family wellness*
- *Cervical and breast cancer awareness*
- *Rights to a medical interpreter for Limited English Proficient individuals*
- *Access to quality and affordable healthcare*
- *Community health leadership development*
- *Changing unhealthy behaviors and attitudes*

To further deepen the impact of our campaign, Thai CDC commenced a landmark study of the physical health, perceived well-being, and access to health care facilities and services of the Thai population in Thai Town located in East Hollywood at the same time. This survey represents the first major health study of the Thai community, providing key insights to funders, policymakers, primary health care providers, and our own staff on the state of health among Thai immigrants in Thai Town. An enormous undertaking, the study involves a random sample survey of 220 Thai residents and/or workers in Thai Town, which provides us with the necessary baseline healthcare data.

The results of the survey will help inform us on the best strategy to improving our community's health and reducing the risk of unhealthy behaviors. While we strive to be proactive and responsive to our community's unique and broad range of needs, the results will help us establish specific goals for improved health in the next three years. To measure the success of our campaign, we will be assessing whether we met our target goals for the following health indicators three years from now:

HEALTH INDICATORS	TARGET
Specific source of ongoing primary care	80%
Survey findings: 31%	
Flu immunizations for seniors	80%
Survey findings: Not available	
Mammography screening over 40	85%
Survey findings: 71%	
Pap screening	75%
Survey findings: 64%	
Adult physical activity	40%
Survey findings: 34%	
Knowledge of right to medical interpreter	75%
Survey findings: Not available	

Ambitious as it may sound, Thai CDC believes that a significant advancement in Thai community health can be achieved as long as an integrated, comprehensive and community-based approach is taken that includes health education and screening activities, training of community health leaders, consultations on physical and mental well-being, enhancing literacy and oral communication, and development of our community members' self-awareness and personal empowerment. To begin our health promotion activities, we must rely on sound data that meaningfully sheds light on the extent to which we will need to contribute to the reversal of poor health trends and patterns now documented among low-income Thai immigrants for the very first time in this comprehensive study.

ACKNOWLEDGEMENTS

The first Thai Town Health Survey was made possible by a grant from the Los Angeles Immigrant Funders' Collaborative and The California Wellness Foundation.

The 2002 Thai Town Health Survey Working Group consisted of the following individuals:

Chanchanit Martorell, M.A.,. Mrs. Martorell is the Founder and Executive Director of Thai CDC. Ms. Martorell holds a Master of Arts degree from the University of California at Los Angeles in Urban Planning with a specialization in Urban Regional Development. She founded Thai CDC in 1994 in an effort to improve the lives of Thai immigrants through services that promote cultural adjustment and economic self-sufficiency. Her experiences leading to the founding of Thai CDC include work as a planner, as an aide to Congressman

Mel Levine and work within other local and state legislative offices. She also taught the Thai-American Experience course offered as part of UCLA's Asian-American Studies curriculum. She has written on the topics of Asian poverty, community economic development, and urban revitalization strategies.

Chanchanit initiated the ***Campaign for Better Health*** after it was clear through the implementation of Thai CDC's Family Preservation Program between 1998 through 2001 that the community was in dire need for health education and access. Consequently, she sought and secured various funding sources to launch the campaign in 2001 and assembled the team of medical professionals and consultants committed to health access issues for Thai immigrants. Chanchanit provided input on the project throughout its entirety as well as clarification of goals and objectives. She was also responsible for editing the report. At present, Thai CDC's health program component has grown dramatically and now constitutes approximately 38 percent of our overall program budget.

Jeffrey Kealing, Ph.D., is an independent management consultant who specializes in international education, communication and development. His clients include the University of Southern California, School of Public Policy, Planning and Development (SPPD), the University of Redlands, and Woodbury University. He is a former staff of the Thai Community Development Center. His understanding of Thai society stems from his work in Thailand as an international development official and field researcher for four years.

Dr. Kealing's contributions to the study were tremendous. He provided the technical assistance needed on the development of our survey methods, tools and instruments, helped us frame the context for the study as an advocacy tool, and edited the report.

Sopon Iamsirithaworn, M.D., M.P.H. Receiving his medical degree from Mahidol University in Thailand and Masters in Public Health degree from the University of California at Los Angeles, Dr. Iamsirithaworn's area of expertise is epidemiology. He has five years of formal teaching experience and a significant non-formal education experience when he coordinated an extensive village health volunteer program in Thailand. His experiences include work with the Thai Ministry of Health, the United States Center for Disease Control and Prevention, and the World Health Organization. He has also served as the lead trainer for Thai CDC's Community Health Leadership project since 2001. He is currently a doctoral candidate at UCLA's School of Public Health.

Dr. Iamsirithaworn essentially provided the key leadership on this health study. He developed the survey instruments, tools, methodology, and sampling frame and size. He translated, designed and modified the questionnaire format and was instrumental in training the Community Health Leaders and other Thai community volunteers in survey collection. He also organized the first pilot study. Responsible for the data entry, analysis, and presentation format, he also drafted the written report.

Christina Thielst, M.H.A., C.H.E. Mrs. Thielst is the principle of a health administration and management consulting business based in Santa Barbara, California. She received a Bachelors degree in Social Science/Management from Louisiana State University and a Masters of Health Administration from Tulane University, School of Public Health and Tropical Medicine.

Christina's experience includes work for several hospitals in the areas of risk and crisis management, organizational development, quality evaluation and improvement, compliance/ethics, strategic planning, medical staff affairs, safety and operations. She has over 20 years of health industry experience and her contributions have helped improve the leadership and operational performance of organizations, including acute hospitals, skilled nursing and retirement living facilities, outpatient centers, drug and alcohol programs, correctional care facilities, community based organizations, and public health programs. Christina is also on the adjunct faculty for the Health Systems Management Department of the University of La Verne, Ventura County Campus and is actively involved in efforts to improve conditions for children and families.

For the project, Christina provided valuable evaluation consultation on our survey methods and instruments. She also provided the initial analysis of our survey results. She was responsible for training the community volunteers in focus group facilitation, which was organized for the purpose of obtaining the qualitative portion of our data.

In all, the study would have not been accomplished without the collective expertise of all of the individuals involved.

SPECIAL THANKS ARE EXTENDED TO THE FOLLOWING INDIVIDUALS FOR THEIR CONTRIBUTIONS IN THE DATA COLLECTION FOR THE SURVEY:

Ms. Naree Makaratad, Ms. Amornmast Ampicaporn, Ms. Sujitra Sirithanakorn, Mr. Nikom Namprakob, Ms. Pavinee Montrichok, Ms. Boobpa Suphapvanish, Mr. Sugid Warapanyaseni, Ms. Nusaraporn Srilachai, Ms. Jenjira Meerasri, Ms. Phornphun Bhusiririt (Thai CDC Project Coordinator), Ms. Waraporn Tiaprasit, Ms. Srinapa Vasunilashorn, Mr. Sak Vasunilashorn (Thai CDC Program Director), Mr. Chirisawat Phungsunthorn (Thai CDC Project Coordinator).

We also owe special thanks to Mr. Rakchai Komenkul (Thai CDC Director of Administration), Ms. Shelly Westebbe, Dr. Chalaiporn Iamsirithaworn, Mr. Sonny Inthaxay, Ms. Phornphun Bhusiririt (Thai CDC Project Coordinator), Ms. Mary Apisakkul (Thai CDC Development Associate), Ms. Sirinya Tritipeskul (Thai CDC Intern) and Ms. Lina Cosico (Thai CDC Consultant) for their contributions in either interviewing the trainees, preparing the survey materials, facilitating the focus groups, or providing logistical support.

EXECUTIVE SUMMARY

Christina Thielst, M. H. A., C. H. E., Health Administration Consultant

In 2002, Thai CDC initiated a comprehensive health needs assessment of the Thai immigrant community in the Thai Town area of East Hollywood to explore the state of individual and family wellbeing. The assessment was aimed at understanding the level of disease and infirmity, as well as, the impact of physical, mental, social, environmental and economic wellness; access to the array of preventative and treatment services; and the availability of culturally and linguistically appropriate health information and resources. This was important because of the limited, and only scattered, health data available on the Thai population.

The survey was conducted in a one-to-one format in the Thai language. The demographics of the population demonstrate that there are more females (65%) and they tend to be older than the males by 3.7 years. In addition, 40% of those surveyed are single, 40% have been in the United States less than five years, and approximately 60% of the respondents have family incomes below 100% of the federal poverty level (100%FPL). A significant majority of the respondents lack insurance (69%), because they:

- can not afford health insurance,
- do not work for employers providing a health insurance benefit, and/or
- do not qualify for medical or other public assistance programs.

The Thais surveyed are generally concerned about their health, but don't necessarily see healthcare professionals to address their needs. There are an alarming number of Thais reporting fair or poor health (49%) and a significant proportion of chronic health conditions such as allergy, hypertension and hypercholesterolemia. This is especially troublesome when combined with the facts that many Thais are:

- low income workers with long work hours,
- uninsured,
- experience communication barriers with providers, and/or
- do not have regular sources of care.

There are significant opportunities to improve cancer screening and prevention in the Thai population, especially with those that are leading causes of death: breast, colorectal and liver. For example, only 59% of the women over 40 have had a mammogram screening for breast cancer within the past two years and only 19.4% of respondents aged 50 or over have ever received colorectal cancer screening. Statistics also indicate that Thais die of cancer at a younger age than the general population.

There is currently a high prevalence of AIDS/HIV in Thailand and many of those surveyed have been in the U. S. less than five years, however, only 38.5% of respondents have ever been tested for HIV.

While Thais did not express concerns about workplace safety, we suspect that they are not aware of hazards or won't question out of a cultural deference to their employers. While we would all love to trust employers to always do what is right by their employees, we know this is not possible or realistic. We believe efforts to educate workers on workplace safety and their rights are necessary to contribute to the health of the population. This is especially important because nearly half of the respondents are working more than 40 hours a week.

The primary language spoken in the home is Thai (90%) and significant numbers of Thais experience difficulty communicating (32%) with their healthcare providers, and often rely on family and friends as interpreters (31%). Many of these interpreters are children and youth who sometimes feel uncomfortable in this role. There seems to be a shortage of professional medical interpreters for the Thai language and it is difficult to find health information and resources written in the Thai language. Language issues present special challenges because of their impact on access to care, quality of care, and patient satisfaction. Language barriers can lead to late or misdiagnosis, inappropriate medications and/or interventions.

In addition to there being limited data on the health status of Thais, there is also limited health information and education available in the Thai language. This lack of health information makes it especially difficult for Thais to know when it is important to see a health professional. For example, the relative percentage of deaths in the Thai population due to peptic ulcers and the cultural reliance on "pain medication," which has been linked to increased rates of peptic disease, is of great concern. Information available in the Thai language on peptic disease and risks associated with "pain medication" may improve the chances for diagnosis and treatment, thereby reducing morbidity and mortality.

Thai CDC hopes that healthcare providers, public policy makers, funders and community and health leaders will use this report to better understand the needs of the Thai community and their role in contributing to improved health among Thai immigrants. The following recommendations are offered as starting points:

- Communicate survey findings to key persons and leaders in the community, as well as, partners.

- Promote responsible health behavior together with occupational safety and health among Thai immigrants through tailor based health educational programs.
  - o Promote use of regular preventive health screening
  - o Smoking cessation and prevention programs
  - o Workshops on occupational safety at workplaces

- Develop strategies and measures for improving access to care.
  - o Adequate employment based low/reasonable cost health insurance
  - o Outreach and education on patient rights to qualified medical interpreters
  - o Training of Thai youths in health advocacy
  - o Expansion of Thai CDC's community health leadership training program
  - o Conduct health needs assessment surveys every 2 – 3 years
  - o More linguistically and culturally appropriate health information and education materials

TABLE OF CONTENTS

Thai Town Health Survey 2002

INTRODUCTION:

In October 1999, Thai Town was designated in the East Hollywood area by the City of Los Angeles as a result of the rigorous campaign mounted by the Thai Community Development Center that began in 1992. The fast growing Thai businesses in recent years brought an increasing number of Thai immigrants seeking employment or housing in this area. A majority of these Thai immigrants work in unskilled, low-wage jobs that provide no health insurance. The struggle to survive also forces them to ignore their health as a priority. Language and cultural barriers further compound the problem of inaccessibility of health information.

To improve their health status and the quality of life for Thai immigrants in the Thai Town area, the availability of high-quality and comprehensive health data on the Thai immigrant population is absolutely vital. Demographic and health-related data are essential for community health assessment, planning, program development, targeting health resources, and for evaluating changes in health and other factors that influence health over time. Unfortunately, the health data on the Thai immigrant subpopulation is virtually nonexistent. Therefore, the Thai Community Development Center (Thai CDC) initiated the first health survey in Thai Town and its vicinity within a 1-mile radius with the following objectives:

- ***assessing the health status and health needs of Thai immigrants in the Thai Town area;***
- ***identifying major health problems and key health indicators; and***
- ***identifying subgroups of Thai immigrants who lack health care services.***

The results will be used as baseline data, and help to guide improvements in community health. It will also be used to identify appropriate target indicators for the ***Campaign for Better Health*** program of Thai CDC. This report presents the findings and analyses of the first Thai Town health survey.

METHODOLOGY:

From March through July 2002, a total of 220 adult Thai immigrants who lived or worked in the designated Thai Town and its vicinity of a 1-mile radius were randomly sampled and interviewed using a structured questionnaire in the Thai language. The interviews were carried out at grocery stores, beauty salons, videotape rental stores, Thai restaurants and other retail businesses. In addition, houses and apartments that were known to have high concentrations of Thai immigrants were visited and Thai tenants were asked to participate in the health survey.

The development of the questionnaire was a painstaking but thorough process requiring extensive meetings by the planning team and half a dozen drafting. The questionnaire development process consumed the first year of the project. The final questionnaire was not completed until after the first pilot test was conducted which was almost at the end of the first year. The questionnaire was first designed in English and then translated into the Thai language. In the pilot study, the questionnaire was tested on 30 Thai immigrants. The final version comprised of 35 questions covering topics on demography, personal health, health-related behaviors, health access, and family wellness.

Thai speaking volunteers were recruited and trained to conduct the survey. The interviewers were provided with a survey manual and guidelines for subject selection. The training covered survey protocol for the following issues:

- ***Identifying and approaching each house;***
- ***Dealing with non-Thais who answer the door;***
- ***Dealing with uncomfortable or recalcitrant individuals who answer the door;***
- ***Noticing instances of abuse and illegal activities;***
- ***Threats or intimidation of volunteer surveyors, personal safety;***
- ***Managing data confidentially, when and how to write house address, how to address surveyee, how to find out if other Thais are in the house;***
- ***Scheduling breaks together to check in and process experience, identify problems and correct them before the next survey.***

A field test of the protocols and of the timing for the house-to-house surveys were conducted first. The Community Health Leaders served as team leaders and were assigned to each group of volunteers to assist with problem solving. After completing the training, trained interviewers conducted the health survey under the supervision of a project team staff member. Oral consents were requested from individuals before beginning the interview and they were informed that the survey will not identify the respondents and the data will be kept private and confidential. The more sensitive questions were placed on laminated cards and handed out to the respondents who pointed to the answers. This questionnaire method served as a measure of protection of the respondent's privacy especially when answering the questions in public places. Respondents were interviewed face-to-face in the Thai language.

Statistical analysis of the data was performed by using the EpiInfo 2000 and Stata 7.0 programs. The survey findings are presented in tabular and graphical formats. Specific health outcomes were explored and compared with the corresponding variables from the findings of the 2001 California Health Interview Survey and the Los Angeles County Health Survey 2002 – 2003.

RESULTS:

1. DEMOGRAPHIC CHARACTERISTICS

From March through July 2002, a total of 220 Thai immigrants were surveyed in the Thai Town area and its vicinity. Among those surveyed, 143 (65%) were female and 77 (35%) were male. The respondents' age ranged from 20 – 71 years. Mean age of females (42.5 years) was 3.7 years significantly greater than males (38.8 years). As can be seen in Figure 1 and Table 1, the number of female respondents was greater than male respondents in all age groups, in particular the middle age groups. The elderly group aged 60 and older was substantially smaller than other age groups.

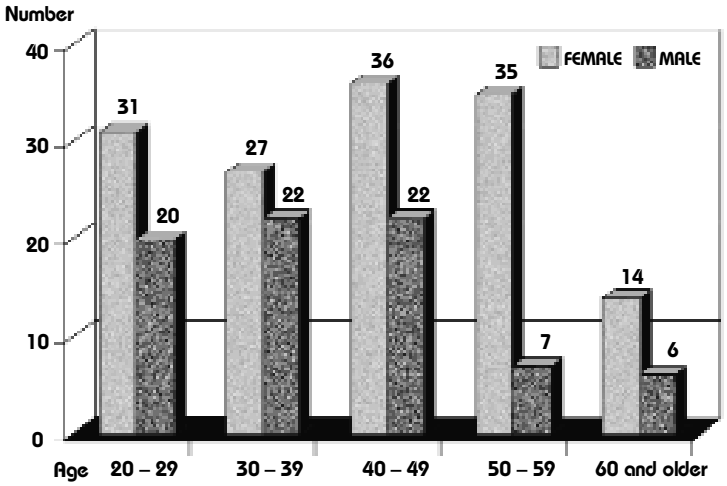

Figure 1.
Age and gender of respondents

Table 1 presents the demographic characteristics of respondents in the 2002 Thai Town Health Survey. Regarding the marital status, forty percent of surveyed Thais were single, followed by married individuals who live with their spouse in the United States (35%). Twelve percent of interviewees reported they are married, but their spouses live in Thailand during the time of the interview. Widowed Thais were 4%, and divorced/separated were 10%. Interestingly, among those 76 married Thais who live with their spouse in the United States, it is estimated that 15% of them are married to non-Thais.

Table 1.
Characteristics of respondents,
Thai Town Health Survey 2002 (N = 220)

CHARACTERISTICS	NUMBER	%
GENDER		
Male	77	35.0
Female	143	65.0
AGE (YEARS)		
20-29	51	23.2
30-39	49	22.3
40-49	58	26.4
50-59	42	19.1
60 or older	20	9.1
MARITAL STATUS		
Single	88	40.0
Married, with spouse in USA	76	34.5
Married, with spouse in Thailand	27	12.3
Widowed	8	3.6
Divorced/Separated	21	9.6
EDUCATIONAL ATTAINMENT		
Below high school	57	25.9
High school graduate	46	20.9
Some college	28	12.7
College/Bachelor degree	71	32.3
Post-graduate	18	8.2
OCCUPATION		
Restaurant worker	89	40.5
Company employee	33	15.0
Student	13	5.9
Self-employed	13	5.9
Business	12	5.5
Restaurant owner	12	5.5
Housewife	11	5.0
Others	10	4.5
Garment worker	8	3.6
Beauty-salon	7	3.2
Salesman	6	2.7
Retired	6	2.7
FAMILY INCOME		
Less than $10,000	83	37.7

$10,000 – $19,999	80	36.4
$20,000 – $29,999	26	11.8
$30,000 and over	31	14.1
RESIDENCY STATUS		
Permanent resident/Naturalized citizen	93	42.3
Non-resident	127	57.7
YEARS IN USA		
Less than 1 year	25	11.3
1 – 4 years	64	29.1
5 – 9 years	40	18.2
10 – 19 years	60	27.3
20 years or more	31	14.1

- **NEARLY SIXTY PERCENT OF THE RESPONDENTS DIDN'T COMPLETE COLLEGE.**

Only one-third of the respondents had completed a college/bachelors degree and 21% had a high school diploma. However, a quarter of the respondents had less than a high school education. This group is comprised mostly of people aged 50 years or older who have only completed 4th grade (primary school) as a result of a four-year mandatory education policy in Thailand instituted before the 1970s.

- **A MAJORITY OF THE RESPONDENTS (80%) REPORTED WORKING ONE JOB, BUT THE AVERAGE HOURS WORKED EXCEEDED FIFTY HOURS PER WEEK.**

However, 12% reported working two or more jobs. The remaining 8% were unemployed, senior citizens, housewives or students. The majority of the respondents were restaurant workers (41%) followed by self-employed/small business owners (16.9%) and company employees (15%). Among the 26 people who reported working 2 or more jobs, sixteen (62%) worked in restaurants. Other occupations such as restaurant owner, self-employed, salesman, beautician, and garment worker were relatively small (<6%).

- **NEARLY THREE IN FOUR RESPONDENTS HAVE A FAMILY INCOME OF LESS THAN $20,000 PER YEAR.**

Eighty-three respondents (38%) reported having an annual family income of less than $10,000, while 36% had incomes between $10,000 and $19,999. Based on the 2002 federal poverty guideline, approximately 60% of the respondents have family incomes below 100% of the federal poverty level (100% FPL).

- **MORE THAN HALF OF THE RESPONDENTS (58%) ARE NON-PERMANENT RESIDENTS IN THE UNITED STATES.**

It is likely that they are without legal status. However, 93 interviewees (42%) were either permanent residents or naturalized citizens. Approximately 40% of respondents have resided in the USA less than 5 years. Similarly, 41% have lived here 10 or more years. The remaining 18% were in the country between 5 to 9 years.

2. HEALTH STATUS OF THAI IMMIGRANTS

To assess the health status of Thai immigrants in the Thai Town/East Hollywood area, many key health indicators such as self-perceived health status, chronic health condition, serious illness/health emergency in the past year and self-perceived stress were included in the survey questionnaire.

2.1 SELF-PERCEIVED HEALTH STATUS

How people view their own health is an important indicator of health status. Self-perceived health has been widely used as a major health indicator in many local and national health surveys. Although a perception of health status is a subjective judgment, strong correlations between subjective health and the presence of health problems have been observed. Studies have found that individuals who perceive their health to be poor or fair have higher mortality rates than those who consider their health as good or very good or excellent, when other factors are controlled.

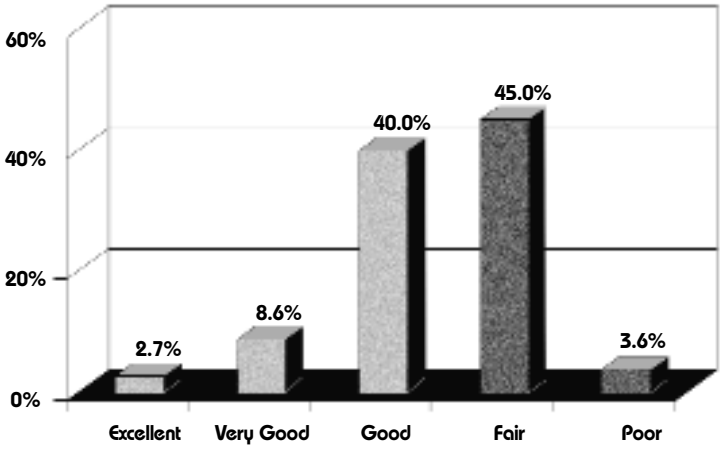

Figure 2.
Self-perceived health status of Thai Immigrants (N = 220)

In this survey, ninety-nine respondents (45%) perceived fair health, and eight (4%) perceived poor health (Figure 2). On the other hand, the proportion of respondents who considered their health to be good, very good and excellent were 40%, 9% and 3%, respectively.

A comparison of the gender responses in Figure 3 shows that more males perceived themselves healthier than females. A majority of females (51%) perceived themselves to be in fair health whereas a majority of the males (44%) perceived themselves to be in good health. This observed difference becomes more marked when comparing the percentage of respondents who perceived fair or poor health: females – 56% and males – 35%. The cumulative percentage of females and males who perceived very good or excellent health were 6% and 21% respectively.

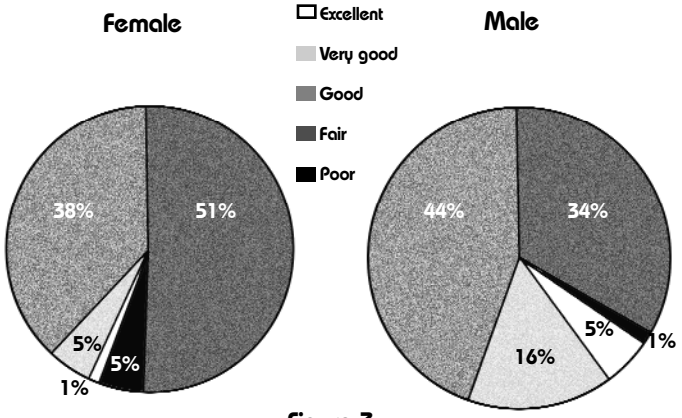

Figure 3.
Self-perceived health status of Thai immigrants by gender

2.2 CHRONIC HEALTH CONDITIONS

Chronic health conditions can affect quality of life and ability to work. Several chronic diseases are expected in the late middle-aged and elderly populations.

Of the 215 respondents with complete data, 135 respondents (63%) reported suffering with at least one chronic disease diagnosed by healthcare professionals (Table 2). Females and males had about the same percentage at 62% and 64%, respectively. However, a significantly greater number of people aged 40 years and older had chronic health than those less than 40 years (75% vs. 48%, $p<0.001$).

Table 2.
Reported any type of chronic health conditions diagnosed by health professionals

Chronic Health Conditions	Total Respondents		Aged < 40 years		Aged 40 years and older	
	Number	%	Number	%	Number	%
Yes	135	62.8	47	48.0	88	75.2
No	80	37.2	51	52.0	29	24.8
Total	215	100.0	100	100.0	120	100.0

As shown in Figure 4, allergy was the most prevalent chronic disease among respondents (27%), followed by hyperlipidemia and hypertension (20% and 19%, respectively). Other common chronic diseases included peptic disease (11%), muscle and bone disease (11%), and diabetes (9%).

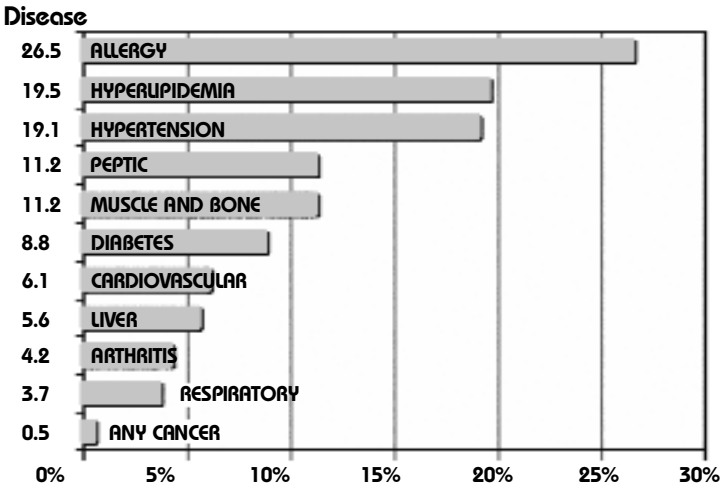

Figure 4.
Percentage of Reported Chronic Disease (N = 215)

2.3 SERIOUS ILLNESS AND HEALTH EMERGENCY

Twenty-eight respondents (13%) experienced either serious illness or health emergency in the past 12 months (Figure 5). Of those 28 people, 25 (89%) received treatment for their health problems. Examples of health problems included bone fracture of the leg, heart attack, stroke, back pain, flu, food poisoning and headache. Three respondents did not get treatment and their reasons were: "had no money," "did not know where to get treatment" and "symptoms were not so severe."

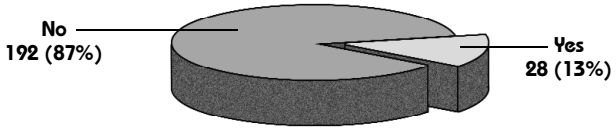

Figure 5.
Percentage of Thai immigrants who have experienced serious illness or health emergencies in past 12 months

2.4 SELF-PERCEIVED STRESS

Stress is an unavoidable consequence of life. Chronically high stress level leads to many adverse health effects such as hypertension, depression, peptic ulcers, immune dysfunction, and the worsening of diabetes. As shown in Figure 6, ninety-seven respondents (44%) reported their situation during the month of the interview as "not very stressful" followed by "a bit stressful," "not at all stressful," "quite a bit stressful" and "extremely stressful" (24%, 21%, 8% and 3%, respectively).

For the simplicity of further analysis, the new binary variable was generated by classifying "not at all stressful" together with "not very stressful" as "low stress level" while the other 3 groups were classified as "high stress level." As a result, interviewees with high stress level accounted for 10.9% (24/220).

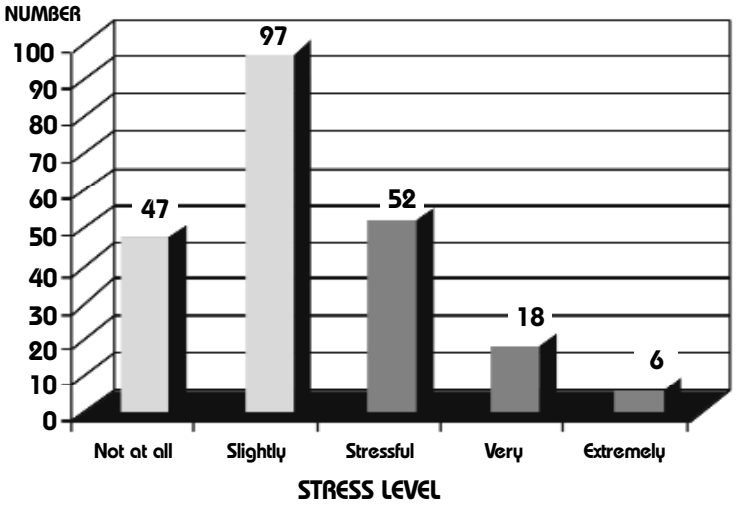

Figure 6.
Self-perceived stress level of Thai immigrants (N = 220)

When stratified by chronic disease status (Figure 7), individuals with chronic disease were more likely to have high stress level compared to those without chronic disease (37% vs. 26%, $p=0.1$).

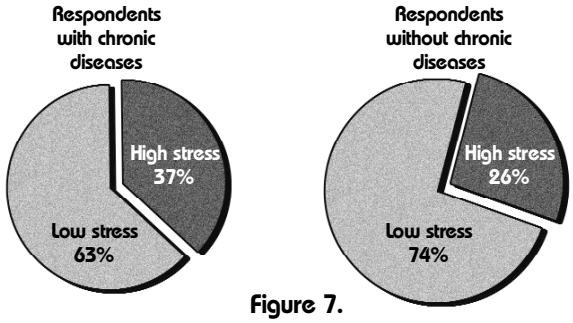

Figure 7.
Chronic disease and level of stress

3. ACCESS TO HEALTH CARE

Access to quality health care is an important determinant of health and influences one's quality of life. Immigrant populations tend to have limited health care access. Strong predictors of access to quality health care include having health insurance, a higher income level, and a regular primary care provider. Availability of health insurance and a regular source of health care make it easier to access timely and effective care when needed.

3.1 HEALTH INSURANCE COVERAGE

Health insurance provides access to health care. Individuals with health insurance are more likely to have a primary care provider for the treatment of diseases and to have received appropriate preventive health services such as serum cholesterol checkup, Pap test, mammogram and necessary immunizations.

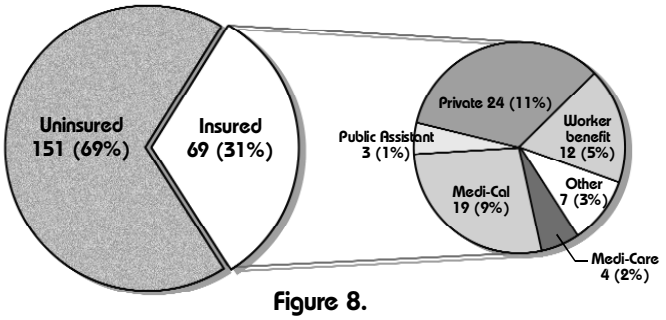

Figure 8.
Health insurance status of Thai Immigrants and type of insurance (N = 220)

As shown in Figure 8, a majority (69%) of respondents were uninsured at the time of the survey. Only 31% reported having health insurance coverage. Private health insurance shared the largest proportion (11%), followed by Medi-Cal (9%), worker benefit (5%), other (3%), Medi-Care (2%) and public assistant program (1%).

3.2 USUAL SOURCE OF HEALTH CARE

As shown in Figure 9, sixty-two percent reported having a usual source of health care whereas 27% have no usual source of care. Interestingly, 11% of respondents never visit a doctor to obtain medical care and health service in the United States. They are mainly new immigrants in the country.

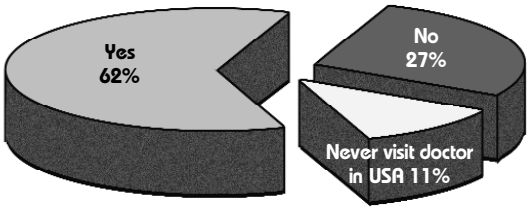

Figure 9.
Having usual source of health care (N = 220)

Among 135 respondents who reported having a usual source of care, 81 persons (60%) have health care providers that they can communicate with in the Thai language. As can be seen in Table 3, of those 135 respondents with usual source of health care, fifty-seven percent have utilized health services from community clinics such as the clinic of the Asian Health Project and Asian Pacific Health Care Venture, followed by a doctor's office (21%) and an HMO clinic (12%).

Table 3.
Types of regular source of health care (N = 135)

Usual Source of Health Care	Number	%
Community clinic	77	57.0
Doctor's office	28	20.7
HMO clinic	16	11.9
County/City clinic	9	6.7
School health clinic	2	1.5
Private Hospital OPD	3	2.2

3.3 BARRIER TO HEALTH CARE ACCESS

There are many common factors such as language barrier, cultural differences, religious beliefs and practices, and financial constraints that can limit access to health care. In the present study we assessed language barrier and cost of medications as factors that prevent Thai immigrants from obtaining needed health care.

A. COST OF MEDICATIONS

Overall, fourteen percent of respondents reported that cost prevented them from obtaining medications (Table 4). The proportion was substantially higher among people with any chronic diseases (19%) than those without chronic diseases (6%).

Table 4.
Incidence of non-medication due to cost (N = 215)

Cost prevented obtaining medications	All Respondents		With Chronic Diseases (N = 135)		No Chronic Diseases (N = 80)	
	Number	%	Number	%	Number	%
Yes	30	14.0	25	18.5	5	6.3
No	185	86.0	110	81.5	75	93.7

B. ENGLISH-LANGUAGE BARRIER

Of 162 respondents, fifty-two (32%) reported having difficulties in communicating with their health care providers. This finding supports the fact that the majority of respondents with usual source of health care have visited Thai-speaking care providers.

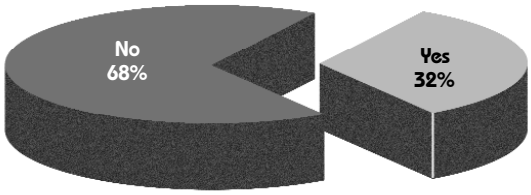

Figure 10.
Difficulty in communicating with health care provider (N = 162)

3.4 USE OF MEDICAL INTERPRETER

Nearly fifty percent of respondents (55/111) reported that they used an interpreter during their doctor visits. Clinic personnel were the most common source of medical interpretation (67%). However, thirty-one percent relied on family members or friends to communicate with the health care providers. Only one person (2%) used a professional medical interpreter.

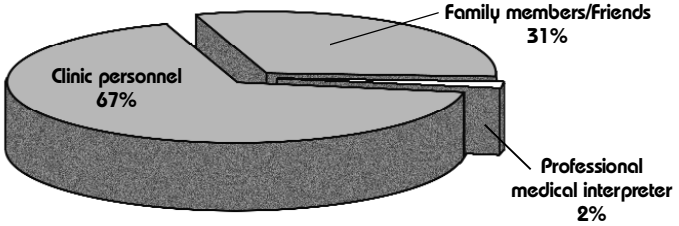

Figure 11.
Use of interpreter in communicating with health care providers (N = 55)

3.5 USE OF ALTERNATIVE HEALTH CARE

Use of alternative health care is common among immigrant populations. People may use alternative health care for preventive purposes, while some use them for treatments.

Of 161 respondents, ninety-four (58%) reported taking supplemental vitamins. Other alternative medicines that are commonly used by Thai immigrants were Thai massage (27%) and herbal medicines (23%).

Table 5.
Percentage and types of alternative care practice * (N = 161)

Alternative care practice	Number	%
Vitamins	94	58.4
Thai massage	44	27.3
Herbal medicine	37	23.0
Acupuncture	15	9.3
Chiropractor	10	6.2
Acupressure	7	4.4
Yoga	6	3.7

* Overall percents exceeds 100% due to multiple responses

3.6 HEALTH SCREENING PRACTICE

Health screening is essential for early detection of diseases at asymptomatic stage, as well as, identifying risk factors for developing certain diseases. Appropriate treatments and interventions can be provided promptly to achieve better health outcomes. In addition, regular screenings can motivate individuals to modify their current activities and behaviors to improve their overall health.

Table 6.
Health screening practice among respondents*

Health Screening	Number	%
Blood pressure checked within the past 2 years	164	78.1
Blood sugar checked within the past 2 years	124	59.6
Cholesterol checked within the past 2 years	105	50.2
Dental visit within the past 2 years	122	58.7
Vision examined within the past 5 years	107	51.2
Hearing tested within the past 5 years	40	19.2
Ever been tested for HIV	62	38.5
Ever had STD screening	42	26.6

*** Denominators of individual types of screening are not equal due to missing value**

As shown in table 6, the most common health screening is blood pressure checked within the past two years (78%), followed by blood sugar (60%), and cholesterol (50%). Dental visit within the past 2 years is only 59% and vision exam within the past 5 years is 51%. Hearing test is relatively rare (19%). Interestingly, less than half of the respondents have had HIV test (39%) and STD screening (27%) in their lifetime.

4. CANCER SCREENING

According to the American Cancer Society, cancer is the second leading cause of death in the United States. Regular screening examinations by a health care professional can result in the early detection of many common cancers when treatment is more likely to be successful. The leading cancers, i.e., breast, cervical, prostate and colorectal cancer were included in the survey.

4.1 BREAST AND CERVICAL CANCER

Breast cancer is the most common malignancy among females in the United States. It is interesting to know what proportion of Thai immigrant women are obtaining breast and cervical cancer screening compared to the recommendation guideline of the American Cancer Society.

As can be seen in Table 7, less than half (45%) of Thai adult females perform regular breast self-exam, and only fifty-seven percent reported experience with clinical breast exam. The percentages of having breast self-exam and clinical breast exam were significantly higher among women aged 40 and older. According to the recommendation of the American Cancer Society, women age 40 years and older should have an annual mammogram for early breast cancer detection. In this survey, seventy-one percent (60/85) of women aged 40 years and older reported that they have had a mammogram at least once in their life time. And only fifty-nine percent (50/85) had mammogram screening for breast cancer within the past two years.

Table 7.
Breast cancer screening practices of Thai females (N = 143)

Type of Screening	All Ages		Aged < 40 years (n = 58)		Aged 40 years and older (n = 85)	
	Number	%	Number	%	Number	%
Breast self-exam	64	44.8	19	32.8	45	53.0
Clinical breast exam	81	56.6	15	25.9	66	77.7
Mammogram	67	46.9	7	12.1	60	70.6
Pap test	92	64.3	23	39.7	69	81.2

All women who are or have been sexually active or who are 18 and older should have an annual Pap test. Of the 143 female respondents, sixty-four percent have had Pap test for cervical cancer screening. Nevertheless, fifty-five percent (79) had Pap test within the past two years. Interestingly, the screening rate was significantly lower in females aged below 40 years (40%) compared to females 40 years and older (81%).

4.2 PROSTATE CANCER

Prostate cancer is the most common cancer among males in the United States. The annual screening for prostate cancer by digital rectal examination and the Prostate Specific Antigen (PSA) test is recommended for men age 50 years and older. Among 13 male respondents aged 50 years and older, six (46%) had PSA tested in the past 12 months (Figure 12).

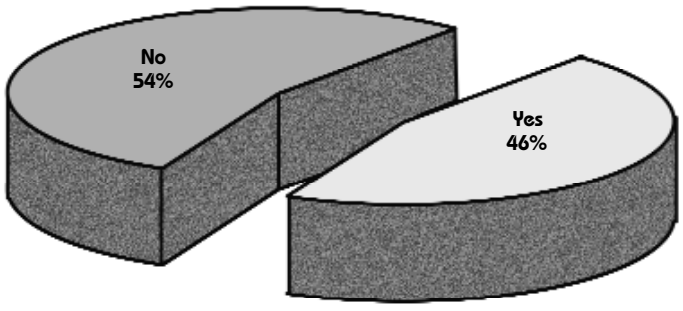

Figure 12.
Prostate cancer screening rate (N = 13)

4.3 COLORECTAL CANCER

In the United States, colorectal cancer is the third common malignancy in male and women. Early detection of colorectal cancer is recommended for men and women age 50 and older through an annual fecal occult blood test (FOBT) and flexible sigmoidoscopy every five years. Overall, 19.4% (12/62) of respondents aged 50 year and older have ever received colorectal cancer screening (Figure 13). However, 14.5% (9/62) received the screening within the past 2 years.

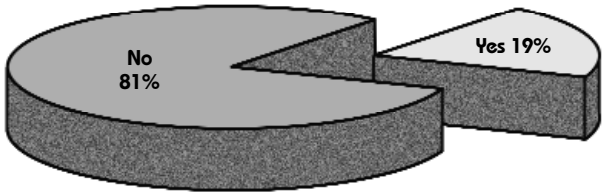

Figure 13.
Colorectal cancer screening rate (N = 62)

5. HEALTH RISK BEHAVIORS

Health risk behaviors and lifestyle factors are important determinants of health in the population.

Cigarette smoking, alcohol use, diet and sedentary life style are key risk factors of many leading causes of death and diseases such as heart disease, stroke and certain cancers.

5.1 CIGARETTE SMOKING

As shown in Table 8, the percentage of current cigarette smoking among Thai immigrants was 15% and ex-smoker was 9%. However, the prevalence of current smoking among males was about 3 times higher than those among females (26% vs. 8%). Similarly, the proportion of ex-smokers was also higher among males than females (16% vs. 5%).

Table 8.
Percentage of cigarette smoking among respondents by gender

Smoking Status	Both Genders		Male		Female	
	Number	%	Number	%	Number	%
Current smoker	32	14.6	20	26.0	12	8.4
Ex-smoker	19	8.6	12	15.6	7	4.9
Never smoker	169	76.8	45	58.4	124	86.7

5.2 ALCOHOL USE

Fifty-nine percent reported not having drunk alcohol in the past 12 months (Table 9). The percentage of Thais who drink at least once a month was 29%, at least once a week was 17 % and that drink everyday was 4%. Thai men were 3 times as women to drink at least once a week (31% vs. 9%).

Table 9.
Frequency of alcohol use in the past 12 months (N = 220)

Alternative Health Care	Number	%	Cumulative %
Everyday	9	4.1	4.1
4-6 times a week	6	2.7	6.8
2-3 times a week	5	2.3	9.1
Once a week	17	7.7	16.8
2-3 times a month	12	5.5	22.3
Once a month	14	6.4	28.7
Less than once a month	27	12.3	41.0
Do not drink	130	59.1	100.0

5.3 PHYSICAL ACTIVITY

As can be seen in Figure 14, thirty-four percent of interviewees (74/217) reported engaging in physical activity at the level of increasing breathing/heart rate at least 3 times a week. Males were more likely to engage in such physical activities than females (45.5% vs. 27.3%, p=0.006).

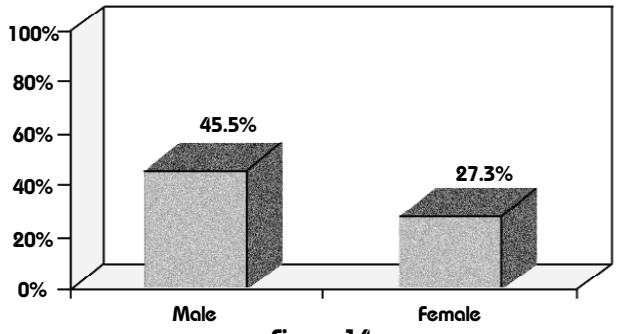

Figure 14.
Percentage of Thai immigrants who engage in moderate to vigorous physical activity for at least 3 times a week by gender

5.4 DIET STYLE

Majority (89%) of Thai immigrants described their diet as mostly Thai food (Figure 15). However, 11% reported consuming half-Thai, half-American food.

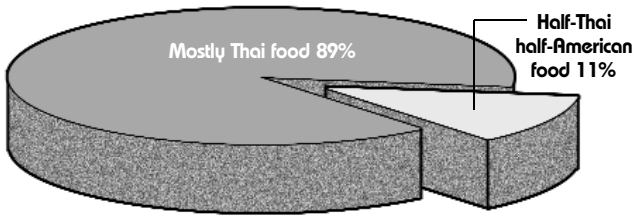

Figure 15.
Diet style of Thai immigrants (N = 163)

5.5 SLEEP HOURS

The amount of sleep each person needs depends on many factors, including age. For most adults, 7 to 8 hours a night appears to be the best amount of sleep, although some people may need as few as 5 hours or as many as 10 hours of sleep each day.

In this survey, about half of the respondents reported sleeping 7 – 8 hours a day while forty-one percent slept less than 7 hours (Figure 16).

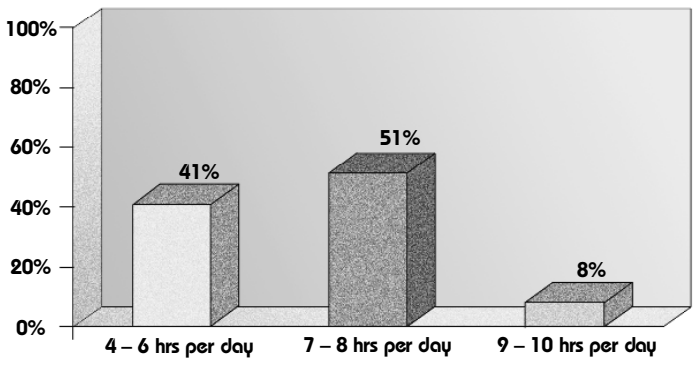

Figure 16.
Sleep hours of Thai immigrants (N = 214)

6. OCCUPATIONAL SAFETY AND HEALTH

Occupation and working conditions may have a direct effect on people's health in a variety of ways. For example long working hours may increase stress level due to reduced sleep hours. Working with hazardous substances and/or in poor sanitary conditions can cause work-related illnesses.

6.1 WORK HOURS

As shown in table 10, nearly half (48.2%) of working Thai immigrants worked more than 40 hours per week. Those who work more than 60 hours a week accounted for 15.5%. Long working hours is a common practice among Thai restaurant workers in Thai Town.

Table 10.
Work Hours of Respondents (N = 199)

Number of Work Hours	Number	%	Cumulative %
1 – 20	22	11.1	11.1
21 – 40	81	40.7	51.8
41 – 60	65	32.7	84.5
Over 60	31	15.5	100.0

6.2 LIMITATION OF WORK/LIFE ACTIVITY

Nineteen respondents (9%) had been limited work/life activity due to impairment or health problem in the past 12 months (Figure 17). Approximately 50% of the causes of the limitation were related to muscle and bone problems. Other causes included flu, headache, allergy, anemia, stroke, and faintness.

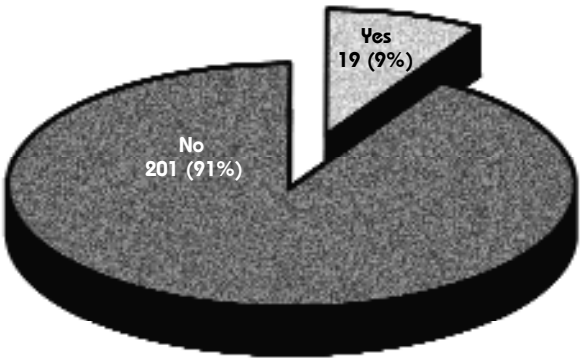

Figure 17.
Percentage of Thai immigrants who have experienced work/life activity limitation by an impairment or health problem in past 12 months (N = 220)

6.3 CONCERNS OF WORKPLACE SAFETY

As shown in Figure 18, back injury was the leading concern of the respondents (14.9%), followed by noise, repetitive motion injuries and accidents in the workplace (13%, 11% and 10% respectively). Percentages of interviewees with fire safety (5.1%) and ventilation (9.3%) concerns were relatively low even among restaurant workers who comprised 40% of survey respondents.

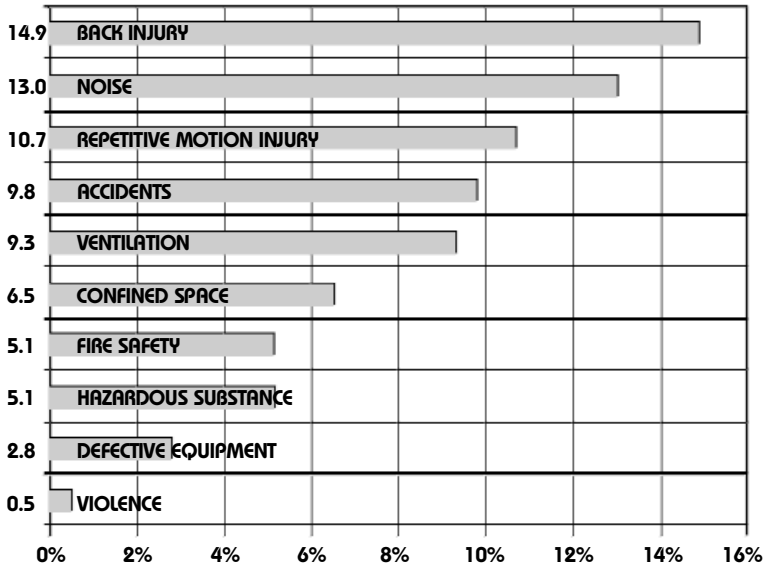

Figure 18.
Concerns of Workplace Safety Among Respondents

6.4 EXPERIENCE OF RESTRICTION OF MOVEMENT BY EMPLOYERS

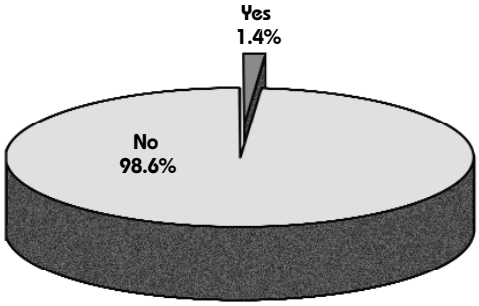

Figure 19.
Experience of restriction of movement by employer (N = 216)

A very small proportion (1.4%) of surveyed Thais reported experiencing restriction of movement by employers, either physically or through fear or financial obligation (Figure 19).

7. FAMILY WELLNESS

7.1 LANGUAGE SPOKEN AT HOME

As can be seen in Figure 20, the language spoken at home is mainly Thai (90%). Only 5% speak English, while 5% speak both Thai and English at home.

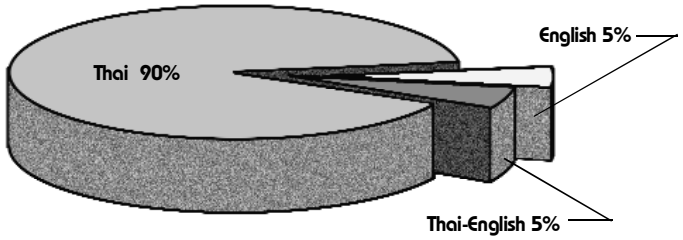

Figure 20.
Main language spoken at home of Thai immigrants

7.2 FAMILY MEMBER DEPENDING ON FAMILY INCOME

The number of family members depending on the family's income in the United States reflects the family size of Thai immigrants. As can be seen in Table 11, approximately 43% of respondents earned income for self-support. The percentage of Thais with family size of 2, 3 to 4 and 5 or more were 25%, 27% and 5%, respectively. Over one-third (37%) of respondents provided financial support to their family members in Thailand.

Table 11.
Number of family members in USA and Thailand depending on family income

Number of Family Members	USA (n = 213)*		Thailand (n = 203)**	
	Number	%	Number	%
0.....	–	–	128	63.1
1.....	91	42.7	18	8.9
2.....	54	25.4	28	13.8
3 – 4.....	57	26.8	23	11.3
5 or more.....	11	5.2	6	3.0

*** Missing data in 7 respondents**
**** Missing data in 17 respondents**

7.3 RISKY BEHAVIORS IN FAMILY

Overall, nineteen respondents (13.3%) reported having at least one risky behavior among family members (Figure 21). The leading risky behaviors included drunk driving, fire arm possession, excessive/compulsive gambling, drug use and multiple sex partners.

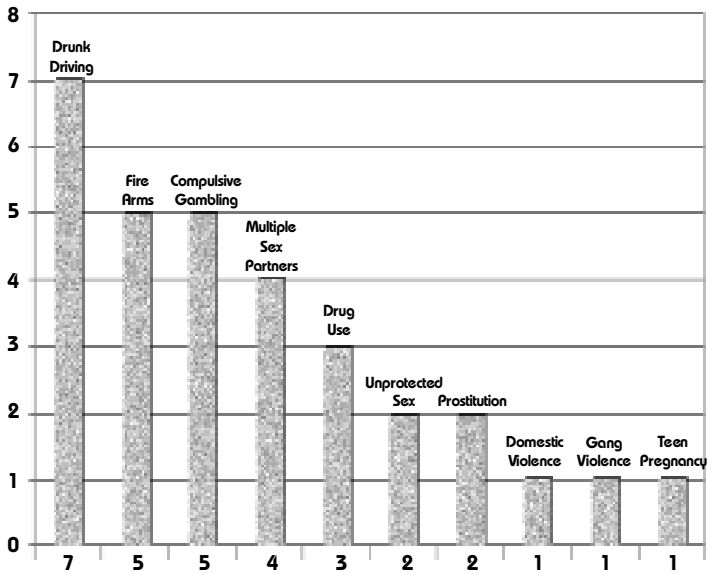

Figure 21.
Risky behaviors in family members of Thai immigrants.

8. DISPARITIES BETWEEN GENDERS

Table 12 shows selected variables stratified by gender. As observed before, Thai immigrant women tend to be older than men, but the numbers of years in the United States are not different. This reflects the fact that Thai men came to the United States at a younger age than women. Men were more likely to have higher education and work longer hours than women, but have similar sleep hours. The health risky behaviors, i.e., smoking, alcohol use were more prevalent among men than women. However, men were more likely to be physically active than women.

Table 12.
Comparison of female to male by selected variables

Variables	Male	Female	p-value
Age in years	38.8	42.5	0.04*
Years in US	9.0	8.9	0.98
Years of school attained	13.5	11.6	0.003*
Work hours per week	46.6	39.3	0.02*
Sleep hours per day	7.1	6.8	0.15
Married with spouse in Thailand	13.0%	11.9%	0.16
Permanent resident	41.6%	42.7%	0.88
Alcohol use at least once a week	31.2%	9.1%	<0.001*
Current smoker	26.0%	8.4%	<0.001*
Active physical activity	45.5%	27.3%	0.006*
Health insurance	35.1%	29.4%	0.39
Perceived fair or poor health	35.1%	55.9%	0.003*
Perceived high stress	27.3%	38.5%	0.096
Experienced medical emergency	9.1%	15.7%	0.24
Any chronic disease	64.0%	62.1%	0.79
Hypertension	14.7%	21.4%	0.23
Diabetes	6.7%	10.0%	0.41
Hyperlipidemia	21.3%	18.6%	0.63
Peptic disease	10.7%	11.4%	0.87
HIV testing	52.5%	30.4%	0.007*

*** p-value < 0.05**

Over half (56%) of females considered their health as fair or poor compared to only 35% of males. In addition, females also had a significantly higher stress level compared to males (39% vs. 27%). The percentage of males with HIV testing is about half, while only 30% of females have ever been tested.

9.FACTORS RELATED TO SELF-PERCEIVED HEALTH STATUS OF THAI IMMIGRANTS

As shown in Table 13, Thai immigrants who perceived fair to poor health were older than those who perceived good, very good to excellent health (44.4 vs. 38.2 years). In contrast, the number of years of education attained is less for people who reported fair or poor health (11.3 vs. 13.2 years).

Table 13.
Comparison of Thais who perceived fair/poor health to good/very good/excellent health by selected variables.

VARIABLES	Fair/Poor health	Good/ very good/ excellent health	p-value
Age in years	44.4	38.2	<0.001*
Years in US	9.9	8.1	0.097
Years of school attained	11.3	13.2	0.002*
Work hours per week	39.2	44.4	0.068
Sleep hours per day	6.7	7.1	0.058
Annual income below $10,000	43.0%	32.7%	0.117
Permanent resident	44.9%	39.8%	0.450
Alcohol use at least once a week	20.6%	13.3%	0.149
Current smoker	12.2%	16.8%	0.327
Active physical activity	32.7%	34.5%	0.777
Health insurance	27.1%	35.4%	0.185
Perceived high stress	41.1%	28.3%	0.046*
Experienced medical emergency	19.6%	6.2%	0.003*
Any chronic disease	72.4%	53.6%	0.004*
Hypertension	25.7%	12.7%	0.015*
Diabetes	3.6%	14.3%	0.006*
Hyperlipidemia	12.7%	26.7%	0.010*

*** p-value < 0.05**

Thais who perceived fair to poor health were more likely to have annual income below $10,000 compared to those who perceived good, very good to excellent health (43% vs. 33%); however, the association is not statistically significant.

Thais who considered themselves as having fair to poor health were more likely to experience medical emergency in the past 12 months and to have chronic disease such as hypertension, diabetes and hyperlipidemia. They were also more stressed than those who considered themselves to be in in good, very good or excellent health (41% vs. 28%).

SUMMARY OF KEY FINDINGS

1. STUDY POPULATION

In the current survey, the surveyed population is Thai adults aged 18 and older who live and/or work in the Thai Town area. We have found that the female population is predominant. Explanations for the significant disproportion in gender include 1) preference of female workers in the restaurant business; 2) reflection of the real population structure of Thai immigrants in the County of Los Angeles; and 3) the premature death or lower life expectancy of Thai males after middle-age. According to the Census 2000 data, Thais in the middle age category who migrated to the United States were predominantly females (56%).[1] Approximately 12% of the married respondents had spouses who lived in Thailand at the time of the interview. In addition, many Thai immigrants support their family members and/or relatives in Thailand. This evidence corresponds to the fact that 40% of the respondents have resided in the USA less than 5 years.

2. HEALTH STATUS

It appears Thai immigrants are not healthy because of a high percentage of fair/poor health status in the survey. The percentage of adults who considered their health as fair/poor is more than 2 times higher among Thai immigrants than the general population of the Los Angeles County (49% vs. 22%).[2] The factors associated with perceived fair/poor health were low education, older age of respondents and chronic diseases.

3. CHRONIC DISEASES

The percentage of adults diagnosed with hypertension in the 2002 Thai Town Health Survey and the 1999 – 2000 Los Angeles County Health Survey are both the same (19%). The percentage of Thai immigrants diagnosed with diabetes (9%) and heart disease (6%) were close to the CHIS 2001 data (7% and 7%, respectively). The high prevalence of allergy (27%) and peptic disease (11%) are of concern. Statistics from the Los Angeles County Department of Health Services showed that peptic disease is the number 4 leading cause of death among Thai immigrants in the County of Los Angeles in 1999.[3]

4. HEALTH CARE ACCESS

- The percentage of currently uninsured Thai immigrants was nearly 3 times higher than the general adult population in Los Angeles County in the 2001 CHIS (69% vs. 26%).[2] This result may be skewed because a majority of the respondents were restaurant workers who work long hours receiving low wage and provided minimal to no health benefits.

- Nearly 40% of Thai immigrants did not have a regular source of care compared to 19% of the general population in Los Angeles County. Thus, it would be difficult for Thais to obtain critically needed health information and preventive services. The real concern here is the lack of coordinated care, if there is any care at all.

- Cost of medication and limited English proficiency were barriers to health care access among Thai immigrants

- Use of non-professional medical interpreters is a concern. Many Thai immigrants' lack of English communication skills and reliance on family members, especially their children, to communicate with health care providers may put them medically at risk.

- Use of vitamin supplements is common among Thai immigrants. Thai herbal medicine and Thai massage play important roles on Thais' health.

Combining these factors, i.e., language barrier, low income, lack of health insurance and lack of regular source of health care, it appears that lack of access to health care is a major problem for Thai immigrants. Community clinics are the main health resource for many Thai immigrants.

5. HEALTH SCREENING

- The rates of common health screenings were low, such as blood sugar check, dental visit and HIV test. Thai immigrants tend to overlook the importance of health screenings. For example, only 78% of adult Thai immigrants have had their blood pressure measured within the past 2 years, compared to 91% of adults in the 1999 – 2000 Los Angeles County Health Survey.[4] One

explanation for this problem is the lack of health insurance. Uninsured Thai immigrants were less likely to have their blood pressure checked within the past 2 years compared to those with any health insurance (73% vs. 90%).

- The percentage of Thai immigrants who have been HIV-tested in their lifetime is 39% while the 1999 – 2000 Los Angeles County Health Survey reported 37% of adults in Los Angeles County were tested for HIV in the past 2 years.[5] Although these two figures cannot be directly compared, it suggested that Thai immigrants and the general adult population in Los Angeles County may have contrasting levels of awareness of HIV status (unless Angelenos were tested prior to 2 years ago).

- Regarding screening for cancer, the percentage of Thais who were screened for breast, cervical or colorectal cancer (except prostate cancer) was lower than the general population in Los Angeles County and California.[2,6] Screening rates of cervical and breast cancers were moderate, even though cervical and breast cancer early detection programs have been implemented in the Thai community for years. Colorectal cancer screening rate is substantially low and language appropriate health education on colorectal cancer is needed.

6. HEALTH RISK BEHAVIORS

- Cigarette smoking is a major risk factor for many leading causes of deaths, e.g., heart disease, stroke and lung cancer. Although smoking prevalence was relatively low among females (8%), a high prevalence (26%) among males was observed. According to the Healthy People 2010 project, the objective for cigarette smoking is to reduce the percent of cigarette smoking in adults to 12%. Therefore, efforts to reduce tobacco smoking should target Thai men.

- Almost 30% of Thai immigrants reported alcohol use at least once a month. Based on Thai CDC's experience in serving Thai clients, alcohol use among Thai men is one of the major health problems in the community.

- The low percentage (34%) of Thai immigrants with active physical activity provides room for improvement. On the other hand, nearly 90% consumed mainly Thai food that is generally perceived as a nutritious diet. However, the longer they live in a western environment, the higher chance there is of changing their eating habit from consuming Thai food to consuming American fast food. Therefore, promoting regular exercise and preserving Thai diet styles are necessary for long-term health and fitness especially among Thai youths who tend to eat more fast foods.

- Overall, the concerns of work hazards and work-related health problems were relatively low in this surveyed population. For example, fire safety was not a big concern although 40% of respondents work in restaurants that can be susceptible to fire. It can also be assumed that Thai workers are not aware of work hazards or may not question hazards out of a cultural deference to their employers.

RECOMMENDATIONS:

1. COMMUNICATE KEY FINDINGS TO KEY PERSONS/LEADERS IN THE COMMUNITY AND PARTNERS.

2. PROMOTE RESPONSIBLE HEALTH BEHAVIORS TOGETHER WITH OCCUPATIONAL SAFETY AMONG THAI IMMIGRANTS THROUGH TAILOR BASED HEALTH EDUCATIONAL PROGRAMS

- Promote use of regular preventive health screenings
- Initiate smoking cessation program and program for preventing new smokers
- Conduct outreach workshops on occupational safety and health at workplaces

3. STRATEGIES AND MEASURES FOR IMPROVING ACCESS TO HEALTH CARE

- Adequate employment based low/reasonable cost health insurance
- Outreach and education on the right to sufficiently qualified medical interpreter
- Training of Thai youths in health advocacy
- Expansion of Thai CDC's community health leadership training program
- Adequate care for people with chronic diseases
- Conduct Thai Town health surveys every 2 years
- More linguistically and culturally appropriate health information and education materials

4. RECOMMENDATIONS FOR IMPROVING FUTURE SURVEY IN THIS POPULATION

a. Questions that should be removed:

- Number and relationship of dependents in Thailand
- Certain chronic diseases, e.g., allergy should be replaced with specific disease such as allergic rhinitis or asthma in order to get insight and comparison to other population

b. Questions that should be added:

- Linguistic isolation in addition to the question "Language spoken at home"
- Body mass index (BMI): add questions of self-report height and weight in order to calculate BMI and determine obesity status
- Details of diet, for example how often do you eat fast food?
- Influenza vaccine coverage
- Treatment and follow-up care for individuals with chronic disease

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