BESAFE

A Cultural Competency Model for Asians and Pacific Islanders

National Minority AIDS Education and Training Center

Howard University College of Medicine

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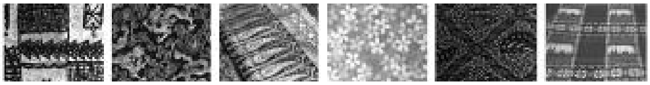

HOWARD UNIVERSITY COLLEGE OF MEDICINE

National Minority
AIDS Education and Training Center

Washington, DC

In Collaboration With

Asian & Pacific Islander Wellness Center
San Francisco, CA

Asian & Pacific Islander American Health Forum
San Francisco, CA

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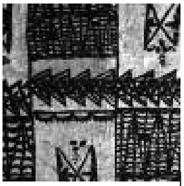
Editor



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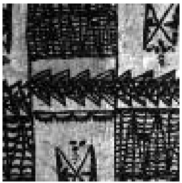


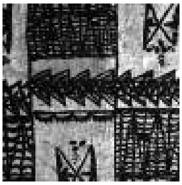
Contents

Preface

The population of Asians and Pacific Islanders (APIs) living in the United States (U.S.) is enormously diverse, comprising more than 49 ethnic groups, over 100 languages and dialects and a significant number of religious and spiritual traditions. The picture becomes even more complex when variations in terms of immigration status, level of acculturation, and education are taken into account. Some ethnic sub-groups that are more populous in the US include Chinese, Filipinos, Koreans, Indians, Japanese, Samoans, Indonesians, Vietnamese and Hawaiian. While they are concentrated mostly in large urban areas, APIs, overall, represent one of the fastest growing ethnic minorities and can be found everywhere in the continental U.S.

There are various, generally accepted abbreviated terms used for Asian and Pacific Islander communities, depending on specific social or political contexts or constructs. These include Asian and Pacific Islander (API), Asian Pacific American (APA), Asian American and Pacific Islander (AAPI), and Asian American, Native Hawaiian and Pacific Islander (AANHPI). Regardless of what abbreviation is used, it is important to understand that this is a U.S. census categorization that encompasses a diversity of cultures, languages, ethnicities, geography, and countries of origin. For this book, the abbreviation "API" will be used.

While the exact extent and nature of the HIV epidemic among APIs in the U.S. is yet to be determined, the Centers for Disease Control and Prevention (CDC) reports that infection rates are increasing rapidly and steadily. Underreporting and misreporting in surveillance data account for some of the currents challenges to better understanding the impact of the disease on this population. Although the prevalence rates seem low when compared with the ones in other populations, the sharp increases in incidence make prevention efforts with this group critical in order to keep future HIV/AIDS cases low. Compounding issues for this community related to access to care, stigma and other structural forces, is the challenging and at times insurmountable obstacle of providing truly culturally competent and linguistically accessible health care services to patients.



Undoubtedly, ensuring the highest possible level of cultural competency among providers needs to be one of the goals of a service delivery strategy addressing the needs of APIs affected by the HIV disease. This requires professionals to learn about this racial/ethnic group's worldviews, spiritual and cultural beliefs as well as becoming aware of implications for treatment of biological variations, and the existence of co-morbidities.

The National Minority AIDS Education and Training Center (NMAETC) has developed a model to assist health care providers to become culturally competent in the care of Asian and Pacific Islander patients with HIV/AIDS. The model, known as BESAFE, is a framework that uses pluralistic contents and perspectives based on six core components: barriers to care, ethics, provider sensitivity, assessment, facts, and encounters.

These components must be understood and practiced in harmony. To this end, this book discusses each core elements with the purpose of helping clinicians understand and address in a culturally responsive manner, the needs of HIV/AIDS Asian Pacific Islander patients.

The NMAETC is a collaborative network of health experts funded through the Health Resources and Services Administration (HRSA) to provide capacity building to agencies and providers serving minority patients living with the immunodeficiency virus. It is headquartered at Howard University College of Medicine in Washington, DC with seven regional performance sites across the nation.

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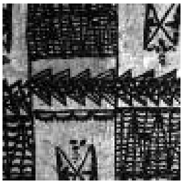
Finally, we recognize health care providers who are confronted with a myriad of basic cultural challenges presented by Asian and Pacific Islander patients and address them by focusing on affinities rather than variations. This publication has been developed in collaboration with a cadre of culturally sensitive experts and health care providers who see cultural diversity as an asset in helping reduce HIV-related health care disparities.

Introduction

Inequities and disparities continue to exist in our national healthcare system for communities of color. This leads to disproportionate incidences of illness and death for African Americans, Native Americans, Latinos/Hispanics, and Asians and Pacific Islanders (APIs) across multiple diseases. In regards to HIV/AIDS, it is critical to deepen our understanding of cultural competency so that we can continue to increase quality of care and health outcomes for persons living with HIV/AIDS, reduce HIV/AIDS incidence, and acknowledge the critical role and impact of culture on prevention and care efforts.

Building upon previous BESAFE publications for other racial/ethnic communities, this book focuses on the API community. Please note that this book does not include Native Hawaiians. Although Native Hawaiians are typically aggregated with Pacific Islanders in US Census and other federal data reports, they were included in a separate BESAFE publication entitled “A Cultural Competency Model for American Indians, Alaska Natives, and Native Hawaiians toward the Prevention and Treatment of HIV/AIDS.” There are several factors that led to the development of this BESAFE book for API communities:

- Rapid API population growth;
- Socioeconomic indicators that contribute to API health disparities;
- Cultural factors that can impact access to and quality of care for APIs living with HIV/AIDS; and
- Statistically significant increases in HIV/AIDS in API communities.



RAPID API POPULATION GROWTH

As of July 2007, there were almost 15 million Asians and Pacific Islanders in the U.S., thereby accounting for over five percent of the total population. Between 2006 and 2007, the Asian population increased by 2.9%, the highest for any racial/ethnic group. Similarly, the Native Hawaiian and Pacific populations increased by 1.7%. It is projected that by 2050, APIs will comprise eight percent of the total US population, or 40 million persons.

SOCIOECONOMIC INDICATORS

Researchers have established a strong link between factors that affect health and socioeconomic status (SES). Clear and consistent correlations have been made between poor health and poverty, low educational attainment, limited English proficiency, and other socioeconomic indicators. APIs are significantly impacted by these conditions. For example,

- APIs collectively have a lower per capita income and higher rates of poverty compared to the general population. This is particularly true for certain API subgroups.
- In the U.S., more than one out of five Chinese, Bangladeshi, Samoan, and Guamanian adults have not finished high school. Nearly half or more of Hmong, Cambodian, and
- Laotian adults have not completed high school. Ten API ethnic groups have below average rates of completing high school, and three groups have the lowest rates among the major racial and ethnic groups.

CULTURAL FACTORS

API cultures and histories trace back over many centuries. Particularly for recent API immigrants and other APIs who are not fully acculturated to the US, there are certain aspects of API cultures that can impact health-seeking behaviors as well as clinician-patient interactions. Providers must have a continuous commitment to expanding their awareness and understanding of the nuances and complexities of health care when viewed in the contexts of immigration laws and policies, histories of migration and war and internment, indigenous health care approaches and structural issues of stigma, homophobia and discrimination. For APIs, real and perceived barriers can often block access to the health care systems. Moreover, physicians need to be aware that for their API patients, healthcare rights and choices may not be implicitly assumed.

INCREASING HIV/AIDS RATES

In the U.S., the rates of HIV infection within API communities are rising steadily and rapidly. Between 2001 and 2004, APIs represented less than 1% of all U.S. HIV/AIDS cases, yet they experienced the highest (and the only statistically significant) increases in estimated annual percentage change (EAPC) in HIV diagnosis rates in comparison to all other racial/ethnic groups (8.1 for males and 14.3 for females). Moreover, from 2001 to 2006, the number of HIV/AIDS diagnoses among API men who have sex with men, aged 13-24 increased by 255.6 % (EAPC = 30.8). This is the largest increase compared to men who have sex with men, aged 13-24 years of all other racial/ethnic groups.

OVERVIEW OF CHAPTERS

The BESAFE model is based on a framework of six core elements: Barriers to care, Ethics, Sensitivity of the provider, Assessment, Facts, and Encounters. This book includes one chapter for each of the six core elements. Applying this framework to APIs, health care providers will be able to gain useful tools and relevant contextual information to increase quality of care for their patients. The following is a summary description of each chapter.

Barriers

This chapter analyzes the barriers that APIs face in accessing and utilizing HIV health care services. Specific barriers related to cultural practices, language, stigma and discrimination, and the health care system are discussed. Additionally, cultural factors that can impact the physician-patient interaction are introduced.

Ethics

This chapter presents four major guiding bioethical principles for health care and medicine: (1) autonomy, (2) beneficence, (3) non-malfeasance, and (4) justice, and applies them to provider relationships with API patients living with HIV/AIDS. Specific paradoxes that exist within each of these principles are discussed, particularly the concepts of shame and loyalty. Providers focus on accurate information and diagnosis, but various cultural attitudes at times complicate this with respect to truth-telling and decision-making on the parts of the patient and his or her family. Awareness of the many dimensions of ethical issues will prevent cultural imposition of the provider's own values, beliefs, and practices, on what is best for the patient.

Sensitivity of the Provider

This chapter provides a comprehensive presentation of demographics, followed by a discussion of practical issues related to language, family role, cultural taboos and stigma, traditional health beliefs, deference to authority and respect, indirect communication, and fatalism. Each section includes anecdotal information from patient-clinician interactions that expands understanding of these facets of culture. Ethical issues are illustrated through these examples supporting how providers must grapple with and resolve the complexities of the guiding bioethical principles from the previous chapter.

Assessment

This chapter lays out a model of culturally competent assessment developed by the National Minority AIDS Education and Training Center (NMAETC) in collaboration with Campinha-Bacote (1999), which consists of five integrated constructs: cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desires. Additionally, Kleinman's explanatory model (1980); Berlin & Fowkes' LEARN model (1983); and Chung, Nguyen & Gany's initial behavioral health assessment for Asian Americans, are integrated to ensure a comprehensive approach to evaluation and engagement (2002).

BESAFE MODEL

This framework comprises six core elements:

Barriers to care—real or perceived gaps to providing quality care that are compounded by the relationship of HIV/AIDS to ethnicity.

Ethics—science of the human condition as it applies to morality and belief systems.

Sensitivity—self-examination of one's biases and prejudices toward other cultures as well as one's own cultural background.

Assessment—ability of the health care professional to collect relevant patient health history data.

Facts—understanding of physiology, behavior, and patient's perception of his or her illness.

Encounters—necessary face-to-face interactions.

Facts

This chapter offers an overview of the many ways cultural beliefs and values can impact health practices. Information on biological variations in the manifestation of HIV disease for APIs must be understood alongside patients' worldviews, spiritual and cultural values, health beliefs, and attitudes toward health care providers.

Encounters

This chapter focuses on the impact of various cultural factors that may affect the interaction between providers and APIs living with HIV and AIDS and how providers can improve their encounters with patients. Overarching commonalities among API ethnic groups are discussed. However, it is always important to note and remember that these commonalities must not be generalized to every individual but can be used as a starting place from which to delve deeper into their unique culture, history and perceptions. Case examples are presented and discussed, followed by suggested approaches for effective, culturally competent initial encounters with API patients.

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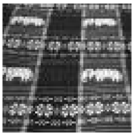

I. Barriers

Similar to other racial/ethnic groups, Asians and Pacific Islanders (APIs) can face significant barriers when attempting to access and utilize health services such as HIV testing, treatment and care and support. Only 30% of APIs have ever taken an HIV test (Centers for Disease Control and Prevention, 2008). APIs are more likely than other racial/ethnic groups to be at an advanced stage of AIDS disease and have opportunistic infections at the time of HIV diagnosis (Wong et al., 2004). APIs who are living with HIV/AIDS are also less likely to have an infectious disease specialist compared to Caucasians (Heslin et al, 2005).

The barriers presented in this chapter are based on the limited number of research studies focused on APIs. Given the diversity of the API population, however, readers are cautioned against assuming that this information universally applies to all APIs. Individual beliefs, values, and practices are impacted by ethnic subgroup, age, gender, acculturation, and many other demographic factors.

APIs are one of the fastest growing ethnic minorities as their proportion in the US population more than doubled from 1.6 percent to 4.2 percent from1980 to 2000.

Note that the term API encompasses over 50 different ethnic subgroups. Some researchers have focused on clusters of API ethnic subgroups based on geography. Thus, some of the following terms are used in this chapter:

- “East Asian” is used to describe individuals from or who have ancestors from China, Japan, North Korea, or South Korea.
- “Southeast Asian” is used to describe individuals from or who have ancestors from Cambodia, Indonesia, Laos, Malaysia, the Philippines, Singapore, Thailand, Vietnam, or Burma.
- “South Asian” is used to describe individuals from or who have ancestors from India, Pakistan, Sri Lanka, Bangladesh, Bhutan, or Nepal.

Additionally, Pacific Islanders ethnic subgroups are sometimes clustered based on:

- "Micronesian" is used to describe individuals from or who have ancestors from the Commonwealth of the Northern Mariana Islands, Republic of the Marshall Islands, Guam, Republic of Palau, or Federated States of Micronesia.
- "Polynesian" is used to describe individuals from or who have ancestors from New Zealand, Tonga, Tahiti, Hawaii, Samoa, and American Samoa.
- "Melanesia" is used to describe individuals from or who have ancestors from Fiji or Papua New Guinea.

BARRIERS TO ACCESSING HIV-RELATED CARE AND TREATMENT

Compared to other racial/ethnic groups, Asians are more likely to report that they had trouble obtaining medical care when they needed it (Agency for Healthcare Research and Quality, 2004). Several barriers can prevent or delay an API individual's attempts to access HIV-related care and treatment. These barriers include cultural beliefs, preferences for traditional healing methods, lack of familiarity with Western medicine and healthcare systems, competing priorities, immigration status, lack of health insurance, and limited English proficiency. Note that many of these barriers may vary based on an API individual's level of acculturation.

- ### *Lack of health insurance*

  Over two million APIs in the U.S. do not have health care coverage (DeNavas-Walt et al., 2006). Previous research has shown that health insurance affects access to health care. In particular, 52 percent of Korean Americans and 32 percent of Vietnamese Americans aged 18-64 are uninsured (Hughes, 2002). Individuals, regardless of race/ethnicity who are uninsured are four times more likely to delay or go without needed medical care compared to those who are insured (Kaiser Commission on Key Facts, 2008).

- ***Lower Usage of Public Sector Insurance Programs (e.g. Medicaid, Medicare, Ryan White Treatment Modernization Act, etc., etc.)***

  APIs often face significant difficulties in navigating these programs. Despite higher poverty rates only about 18 percent of the API population is covered by these two programs, compared with over 26% of coverage among Caucasians (Asian & Pacific Islander American Health Forum [APIAHF], 2006).

- ***Cultural beliefs***

  For some APIs, particularly immigrants who have retained the culture of their country of origin, cultural beliefs might dissuade an individual from accessing medical care or treatment. For example, some Southeast Asians believe that suffering is inevitable or that one's life span is predetermined (Uba, 1992). In some East Asian and South Asian cultures, health is based on a state of balance across various elements of nature (e.g. air, earth, fire, metal, and water) (Bhattacharya, 2004; Pachuta, 1993). Thus, in lieu of seeking out medical care, individuals may utilize non-western and more traditional strategies (such as diet changes, herbs, massage, acupuncture, etc.) to address health issues (Pachuta, 1993).

In traditional south Asian societies, women are treated as perpetual minors, requiring “protection” first by their fathers, next by their husbands and finally by their sons.

- ***Preference for traditional healing methods***

  A variety of traditional healing methods, such as traditional Chinese medicine and the Indian system of Ayurveda, have been practiced in Asia and the Pacific for many years. Traditional Chinese medicine (TCM) is based on the principle of maintaining a balance in the body (yin and yang) thereby preventing disease or fortifying and supporting the body’s own defenses. In Ayurveda, the body is made up of three primary doshas (forces). Health is determined by a state of equilibrium between the dosha. Correspondingly, disease is determined by the state of imbalance between the dosha. Some APIs prefer to utilize these traditional healing methods prior to or, in lieu of, Western medical care or treatment (Bhattacharya, 2004).

- ***Lack of familiarity with Western medicine and healthcare systems***

  For some API immigrants, the US system of healthcare is different from systems in their county of origin. For example, research has shown that some APIs are unaware of available medical services and how to access them (Uba, 1992; Families USA, 2006). Compared to Caucasians, APIs living with HIV/AIDS also have lower awareness of care related services such as mental health assistance, transportation assistance, and finding a care provider (Wong et al., 2004).

- ***Competing priorities***

  Some APIs may find it difficult to take time off from work to seek medical care. For these individuals, the importance of maintaining gainful employment overshadows the need to access medical services (Uba, 1992).

- ***Gender roles***

  In some cultures, it is seen as more appropriate for women and children to seek care (Shedlin, 2006). API women living with HIV/AIDS may also have a partner or children who may be HIV positive as well. In these circumstances, these women may prioritize their family members' health care over their own (Asian & Pacific Islander Women's HIV/AIDS National Network [API-WHANN], 2006).

- ***Undocumented immigration status***

  Undocumented immigrants who are non-citizens may be hesitant to access medical care due to fear of being reported to immigration officials (Uba, 1992; Bauer et al., 2000). These individuals believe that deportation would negatively impact their quality of life and ability to provide income for their family members (Kang et al., 2003). Thus, the risk of being deported often outweighs any medical or health concerns.

- ***Limited English proficiency***

  Limited English Proficiency (LEP) is defined as individuals who do not speak English "very well." There are over four million APIs who have LEP. This constitutes about one third of the AANHPI population (APIAHF, 2004). LEP can adversely affect a person's ability to access and utilize HIV prevention, care, and healthcare services (Chin et al., 2006).

BARRIERS THAT IMPACT PHYSICIAN-PATIENT INTERACTIONS

In one comparison study of the seven largest health plans in California, Asians were more likely than Caucasians to report believing that they would have received better medical care if they had been of a different race/ethnicity (Fernandez et al., 2007). In a separate study that examined patients' ratings of physician primary care performance, Asian patients' average scores were 12 points lower (on a 100 point scale) than Caucasian patients average scores (Taira et al., 1997). The following barriers may contribute to compromised interactions between physicians and their API patients.

- ***Limited English proficiency.***

  APIs who have LEP face barriers not only in accessing health care, but also in communicating with and understanding their physicians. LEP patients have received preventive services at reduced rates and have increased risk of non-adherence to medications (Flores, 2006).

- ***Lack of trained medical interpreters.***

  Across the US, there are only 3,398 medical interpreters (Bureau of Labor Statistics, 2009). These trained medical interpreters possess a strong knowledge of medical and lay terminology. Insurance companies usually do not reimburse for the costs of medical interpreters and only a handful of states provide reimbursement via Medicaid or the State Children's Health Insurance Program (Ku & Flores, 2005). When trained medical interpreters are not available, "ad hoc" interpreters (such as friends, family members, and even strangers) might step in to help assist. The use of ad hoc interpreters can have negative clinical consequences such as inability to accurately translate medical terms, potential breaches of confidentiality, and impact on patient's disclosure and discussion related to sensitive issues (e.g. sexually transmitted diseases, domestic violence, etc.) (Flores et al., 2003; Flores, 2005).

- ***Health literacy.***

  A health care providers' unfamiliarity with Asian cultures can interfere with communication with patients (Uba, 1992). Research has shown that even if a patient and physician can communicate in the same language, the patient might by unfamiliar with medical terminology (Loue, 1992; Kang et al., 2003). Moreover, APIs may have limited knowledge of what to ask or report to their medical provider (Kang et al., 2003).

- ***Nonverbal communication***

  Some A&PI cultures utilize indirect communication as a form of respect. Thus, instead of directly making asks or requests of their physician, these patients express that they have a need via silence or nonverbal communications (Yu, 1999). Providers who are accustomed to having patients directly ask them about symptoms and treatments may misinterpret this silence.

- ***Lack of family involvement.***

  Providers must recognize that their own personal values of including family in important life events may conflict with those of A&PI patients (Yoshioka & Schustack, 2001). APIs living with HIV/AIDS in the US are vulnerable to HIV-related stigma. In many A&PI cultures, HIV transmission is associated with activities perceived to be immoral (e.g. intravenous drug use, same-sex behavior) (Kang et al., 2005). Thus, APIs living with HIV/AIDS often choose not to disclose their HIV status to family members (Fernandez et al., 2007). For some Asian patients, the concept of disclosure to family members may feel and be “unthinkable.”

- ***Respect for authority.***

  Many A&PI cultures place value on respecting authority. In the context of clinician-patient relationships, APIs often consider the physician to be in the role of “authority.” Thus, in conversation with their physician, an API patient might smile or nod as a sign of respect, although this might be misinterpreted as a sign of understanding or agreement (Loue, 1992).

Almost 90 percent of the growth in API population in the U.S. between 1990 and 2000 was due to immigration. Thus, a sizable proportion of the population is not fully familiar with the American health care system.

Most south Asian immigrants have a tendency not to promptly seek allopathic medical treatments as they also utilize remedies based on their traditional health care systems.

- ***Physician's gender bias.***

  API women are rarely asked about their HIV risk and sexual health by their health providers (APIWHANN, 2006). Because women are often perceived to not be at risk for HIV, they may not be diagnosed until they have clinical symptoms of advanced HIV disease progression (Burdge & Money, 1996).

DISCUSSION

In light of the previously mentioned barriers that APIs often face in accessing and utilizing HIV-related health services, physicians and other healthcare service providers may benefit from cultural competency training. This may assist them in understanding the cultural contexts that impact clinician-patient relationships and help to support their API patients' adherence to medical treatment regimens.

Additional information regarding cultural factors that impact provider-patient interactions can be found in the Encounters Chapter of this manual.

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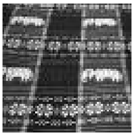

II. Ethics

This chapter introduces providers to some general Western and Asian medical ethical concepts and discusses their effects on patient care and treatment. Additionally, it will address some ethical challenges confronting the API population in accessing HIV care and support services. Issues such as truth telling, confidentiality, partner notification, the duty of health care professionals to treat HIV-infected patients, and clinical research will be discussed. A basic clinical model of ethical decision-making will be presented as well.

Ethics refers to an expectation of how individuals or groups should or ought to behave (Leininger, 1995). It could be considered as the study of right and wrong, issues that concern each person every day (Boyle & Andrews, 1989). Medical ethics guide the morality, beliefs, values, and practices of health care professionals. Thomas Percival, an English physician, published his Code of Medical Ethics in 1803, a document later adopted by the American Medical Association (American Medical Association, 2002). The majority of health care professionals in the United States is governed by this code.

Generally, ethical boundaries are defined by reason, experiences, culture and societal guidelines. However, the health care providers nowadays have to navigate the complexities of providing competent, ethical care in a multicultural, multifaith society. Are there universal medical ethics? Or, are ethics culture-specific? How might ethics relate to culturally competent care? What are some of the ethical choices to be made in the treatment of HIV/AIDS, which is a highly stigmatized disease? This chapter presents four major guiding bioethical principles which should be incorporated into any health care setting: (1) autonomy, (2) beneficence, (3) non-malfeasance and, (4) justice (Lo, 2000a).

The first principle, *autonomy,* suggests that an individual is self-governing, with the capacity to make an informed, uncoerced decision. In this context, it means giving the patient the information he or she needs, then allowing him or her to make the decision. This principle can be difficult to implement when the patient lacks the capacity or power because of age, physical or mental illness, education level or socioeconomic status.

The second principle, *beneficence*, requires that health care providers act in the best interest of their patients through the delivery of competent and timely care within clinically accepted practices.

The third principle, *non-malfeasance*, directs providers to avoid causing patients any degree of harm.

The fourth principle, *justice*, requires that health care providers treat all individuals fairly regardless of their race, ethnicity, religion, sexual orientation, or health status.

As other minority groups, APIs living with HIV may experience discrimination on multiple levels. For example, a man who engages in sex with another man may experience discrimination due to his ethnicity, sexual practices and identity, immigration status, and limited proficiency in English.

The following guidelines provide the frame of reference for the American Medical Association's nine Principles of Medical Ethics for Physicians (American Medical Association, 2002)**:**

1) A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
2) A physician shall uphold the standards of professionalism; be honest in all professional interactions; and strive to report members of the profession deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
3) A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.
4) A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
5) A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to

patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6) A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
7) A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
8) A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
9) A physician shall support access to medical care for all people.

Albert Jonsen, in his history of medical ethics, observed that eastern and western cultures shared similar ethical precepts, in contrast to the more recent perception that medical ethics is culture-specific (Jonsen, 2000). For example, in China, medical ethics predate the Confucian era, but Confucianism which emphasized ethics, actually helped to form the underpinnings for the profession in that country. Core Confucian medical ethics are about love and benevolence – doctors show love for their patients by healing them, a concept somewhat similar to western medical ethics. Confucianists believed that medicine, the purpose of which is to save lives, was the ultimate expression of saving people through love. Doctors demonstrate these feelings by neither disrespecting nor causing harm and by treating their patients equally, regardless of wealth or social status (Jingfeng, 2009).

In many ways, the western and eastern versions of medical ethics are not so different; the well-being of the patients is of primary concern. Similar to the principle of justice, Confucianism also dictated a universality of care; no patient should be given better or worse care on the basis of status, money, appearance, age, race, or mental ability. However, in comparison, some studies have shown western medical ethics emphasize individual autonomy while Chinese ethics are more beneficence-oriented (Tsai, 1999). The provider, however, has to be aware that Asian and Pacific Islanders come from many diverse countries, cultures, customs, values, and languages and is not represented only by the Confucian ethical and behavioral model.

ETHICAL CHALLENGES FOR HEALTH PROFESSIONALS

Although western and eastern medicine both share overarching ethical and moral guidelines, health care professionals may still face challenges when they have to choose among different options for their diverse patient populations. Questions about what constitutes autonomy, beneficence, non-malfeasance and justice may be addressed differently, depending upon how moral reasoning is influenced by religious and cultural norms. Some patients may wish to receive detailed information about their diagnosis, prognosis and treatment options while others from another culture may follow a different script, expecting family members to make important decisions and shield them from ‘bad news.’ In some cultures, autonomy may mean isolation for the individual patient, i.e., protecting the afflicted family member from painful information and not allowing the ill member to suffer alone. A study comparing Chinese and U.S. internists suggested differing medical ethical standards with Chinese doctors giving greater weight to family preferences (Feldman, Zhang & Cummings, 1999).

In many cultures, the concept of shame also plays a strong role in a patient’s life. The willingness to seek care for HIV/AIDS involves substantial personal and/or social costs for the patient, including stigma, family abandonment and shame, and possible deportation (Bhattacharya, 1999). This means the patient may never reveal his or her positive status for fear of humiliation, rejection and abandonment as well as wanting to protect the family from shame. Consequently, the patient may not receive the much needed emotional support or care and treatment (Yoshioka & Schustack, 2001). A provider must understand the background as well as the cultural values and situations in order to help the patient make the best choices.

One of the most basic issues a provider faces is deciding how to balance potential good and potential harm. There are instances when an action that benefits one person may harm another - a conflict of non-malfeasance. For example, family members may not want a health care professional to tell their relative that he or she has HIV/AIDS. This then raises the issue of truth telling related to the nature of a patient’s illness. Honoring the needs or requests of one party (in this case, the family members) may harm the interests of the other party (in this case, the patient). Yet, the health care professional may have a sense of loyalty to both parties.

It has been emphasized that the patient has the right to be informed about the risk and benefits of a particular treatment or intervention. Based on this information, the patient will exercise autonomy and decide to consent or not. Does race or ethnicity influence this practice of autonomy? One study (Blackhall, Murphy, Frank, Michel & Azen, 1995) concluded that APIs and Latinos were more likely to utilize a family-centered model of medical decision-making rather than the models favored by most African-Americans and European-Americans. Korean-Americans and Mexican-Americans were significantly less likely than European-Americans and African-Americans to believe that a patient should be told the diagnosis of metastatic cancer, or other terminal prognosis, or that the patient should make decisions about the use of life-supporting technology. Ethnicity was the primary factor related to attitudes toward truth telling and patient decision-making. This finding suggests that physicians should ask their patients if they wish to receive information to make the decisions related to their care or if they prefer that their families handle such matters (Blackhall, et al, 1995).

CONFIDENTIALITY AND TESTING

There are two types of HIV testing: *anonymous* (no name), which uses a number instead of the individual's name and *confidential (name-based)*, which requires the individual being tested to reveal his or her name to the worker administering the test. Anonymous testing allows individuals to find out about their status without worrying about the results being revealed to others. Typically administered at anonymous sites, only the individual being tested will have access to the results.

With confidential testing, the results may become part of the individual's medical file. It is the responsibility of the health care provider to inform the individual being tested as to who might access his or her test results. This information is confidential with the exception of name reporting to state or county public health departments, which is required in some, but not in all, states (Lo, 2000b).

There has been much debate about the value of anonymous versus confidential testing (Gostin, Ward, & Baker, 1997). The introduction of rapid HIV tests, which provides results within 20-60 minutes as well as increasing the opportunity for anonymous testing, has spurred some of the debate. However, the Centers for

Disease Control and Prevention (CDC) and other organizations continue to recommend that anonymous testing be offered (CDC, 1999). Research suggests that people who test anonymously are much more likely to return for the results than those who take name-based confidential tests (Hertz-Picciotto, Lee, & Hoyo, 1996). Those who support anonymous testing point to the possible negative consequences that can occur should HIV-related information be disclosed. In some states, the individual may have difficulty obtaining insurance or may suffer discrimination when seeking treatment or employment. Finally, its important to note that a positive test result will trigger partner notification procedures.

Some health officials have advocated ending anonymous testing, arguing that confidential name-based testing data provides more accurate epidemiological data, certainly important when considering the increasing rates of HIV infection and the efficacy of antiretroviral medication in delaying the onset of AIDS (Gostin et al., 1997). Some HIV/AIDS service organizations have proposed a system of testing that would satisfy the arguments of both sides, i.e., using unique identifiers that provide higher accuracy in epidemiological data yet still maintaining the privacy of the patient (San Francisco AIDS Foundation, 2008). The San Francisco AIDS Foundation re-evaluated its position on this issue after data showed that name reporting does not deter individuals from being tested. The state of California switched from code-based to name-based HIV reporting in 2007. The Foundation helped to ensure continued access to anonymous testing for those who want to learn their status without having a positive test result reported to public health authorities (San Francisco AIDS Foundation, 2008).

As long as anonymous testing is still available, the principle of autonomy requires that health care providers inform patients of the option. If the patient decides to utilize name-based testing, the provider should tell her/him the name of the governmental entity that will receive the test result and exactly what information will be disclosed (e.g., whether the patient's name will be included). As part of the informed consent process, the provider should also inform the patient about the partner notification procedures required in the state. Finally, the provider should inform patients who are considering name-based testing that when HIV-related information (such as test results) is placed in their records, that information may be included when the patient consents to disclose their medical information and the potential negative consequences of that disclosure.

CONFIDENTIALITY AND DISCRETION

There is significant stigma attached to HIV/AIDS. Confidentiality is of the utmost importance. Health care providers must understand that the patient is providing details that have the potential to be harmful, shameful, or embarrassing. It is equally important for the provider to acknowledge that the maintenance of strict confidentiality builds and facilitates trust, while maintaining the dignity and respect in the relationship. Providers must explain confidentiality, what it includes and excludes and should identify the parties that may have access to the patient's medical status and information.

PARTNER NOTIFICATION

The principle of non-malfeasance can be challenging for health care providers who are required by state law to disclose information for partner notification, in spite of the potential for harm to the patient who is HIV positive. This is a complex issue. Some argue that partner notification statutes result in patients withholding information about partners. Although the name of the infected patient is not disclosed in the process, patients know that in many cases, it may be very easy for a partner to identify the individual responsible for his or her potential infection.

Many patients may fear the reaction of their partners related to notification. In a recent study, 45 percent of health care providers serving women reported that they had patients who feared partner notification because of domestic violence. In fact, one quarter of the respondents reported knowing of female patients who had been assaulted as a result of partner notification (Rothenberg, Paskey, Reuland, Zimmerman, & North, 1995). In a survey conducted by the National Association of People with AIDS (NAPWA), patients ranked the threat of violence as a major concern (NAPWA, 1992). This has significant implication for communities where domestic violence is a serious issue. A result of patriarchal systems which favor male dominance (Nguyen, 2005) is one such instance. Many women may be infected as a result of their male partner's infidelity. However, male partners may feel threatened by involuntary partner notification because they may not want to admit to their risky behavior or their sexual orientation. Issues of sex and drug use should be discussed honestly so that the provider can assess the likelihood of violence in the relationship as well as the dangers of partner notification without patient consent (North & Rothenberg, 1993). If there is a risk of violence, the health care provider should assist the patient in the development of a safety plan.

The CDC encourages states to devise partner notification services that are “voluntary, confidential, conducted in a collegial and cooperative manner, and are sensitive to potential consequences, such as damage to relationships and violence” (CDC, 1997). However, state laws regarding partner notification differ. Health care providers should make it a point to know what the law in their state specifies and should then inform patients about the law and it’s related issues.

CLINICAL RESEARCH

The lack of accurate HIV/AIDS data and the lack of participation in clinical research by APIs, constitutes a serious ethical concern. This suggests that epidemiology may very well be inaccurate due to underreporting and a lack of accurate HIV surveillance. In addition to inaccurate API prevalence data, studies have shown that clinical research involving persons who are HIV positive has not been representative of the overall population of infected individuals living in the United States (CDC, 2003; Ponce, 1990). Data suggest that Whites are over-represented in clinical research while people of color are underrepresented (Gifford et al., 2002; Stone Mauch, Steger, Stephen, Janas & Craven, 2002). Racial and ethnic disparities in access to new treatments and clinical trial participation persist despite the National Institutes of Health’s guidelines aimed at increasing minority group participation in clinical trials (National Institutes of Health, 1994).

Clinical trials data are important because they are used to develop treatment guidelines, new treatment modalities and a host of other approaches to the therapeutic intervention for persons who are HIV positive. Current data suggest that minority patients are less likely than Whites to participate in clinical trials of new treatments. Therefore, data on minority patients, and API in particular, are lacking in the guidelines used for making treatment decisions.

To overcome racial and ethnic disparities in clinical research, providers should educate API patients with HIV/AIDS about the benefits of participation in clinical trials as well as the potential for receiving new, experimental treatments as a result of participation.

Providers should address common fears and misperceptions about clinical research in a culturally sensitive manner in order to build participation in trials by patients of color. Health care organizations and providers should also work to improve the problem of accessibility to research sites and other barriers.

Additionally, children, women, and people of color are underrepresented in clinical trials. Usually, children are restricted to protect them from the risks of unproven therapies. Women of childbearing age who can become pregnant are generally excluded to protect them and their future children from possible long-term side effects of unproven drugs. However, restricting women and children also harms them. In effect, they lack access to potentially beneficial therapies.

Clinical researchers should include a sample of participants who are representative of the population to be treated. When participants are not representative of that population and when research excludes certain groups from clinical trials, there is a risk that the treatments developed will not benefit members of the excluded groups. This violates the ethical principle of justice.

ETHICAL CLINICAL DECISION-MAKING MODEL

Anderson and Barret (2000) offer health care professionals a model for ethical clinical decision-making. They are required to consider the possible implications of various actions from multiple perspectives and to articulate the key considerations on which their actions are based. This model serves not only to improve clinical judgment but to provide a clear intention to act in accordance with the highest standards. Leininger (1995) suggests that health care professionals consider the following self-examination questions when attempting to address, reduce, or prevent ethical problems:

1) What are my ethical beliefs and practices, and how can they influence the patient's health and well-being?
2) How can health care professionals with strong ethnocentric values, biases, and actions prevent ethical dilemmas that lead to cultural imposition and conflict?
3) In what kinds of clinical contexts do health care professionals tend to impose their professional and personal ethical beliefs or values on patients, families, or groups?

4) In what ways can health care professionals prevent cultural imposition or best handle ethical or moral dilemmas?
5) What are the potential legal consequences associated with the health care professional who violates a patient's ethical values?

If health care professionals begin with these questions and try to remain nonjudgmental toward patients, Leininger (1995) asserts "many weighty ethical problems may be avoided or resolved."

CONCLUSION

Health care providers should strive to incorporate the ethical principles of autonomy, beneficence, non-malfeasance and justice into their work. Respect for the patient's right to make his or her own decisions, putting their best interests first, endeavoring to "do no harm," and ensuring that they are treated fairly are the hallmarks of good clinical practice. While it is clear that moral and ethical principles are necessary in the field of medicine, navigating the decisions and paths to action is not always a simple task. Providers may face ethical challenges when their own beliefs and values interfere with their responsibility to treat patients and/or to put their patients' interests before their own. Understanding ethical and moral values, cultural practices, as well as the law and s making appropriate health care decisions, are major challenges for health care professionals, (Leininger, 1995).

In addressing ethical issues, professionals must be aware of their—and their patients'—decision-making process. This awareness will prevent cultural imposition—the tendency to impose their values, beliefs, and practices on another because they believe they have a superior value system (Leininger, 1995). It is wise for professionals to examine their values, beliefs, practices, biases, and prejudices when caring for API patients with HIV/AIDS. Ultimately, the impact of ethics is on understanding that morally good practice requires the provider to acknowledge and learn about each patient's culture and to do what is best for him or her. This is a key construct of the cultural competency model.

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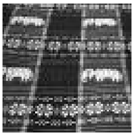

III. Sensitivity of the Provider

ASIAN AND PACIFIC ISLANDERS AND HIV

Of the estimated 40 million people living with HIV across the world, approximately eight million live in Asia and the Pacific Islands. In the U.S., although APIs account for one percent of the total number of cases, the rates of infection within the community are rising steadily and rapidly (CDC, 2006). Between 2001 and 2004, APIs represented less than one percent of all US HIV/AIDS cases, yet they had the highest estimated annual percentage increase in diagnosis rates of all race/ethnicities (8.1 percent for males and 14.3 percent for females). Additionally, from 2001 to 2006, the largest proportionate increase (255.6 percent) in incidence cases was among APIs.

CULTURAL COMPETENCY

The ethnic, cultural and linguistic diversity present in the API population also can present challenges in providing quality health care services. However, clinician's effectiveness is related to his or her ability not only to communicate but to use contextual information including the patient's ethnicity and beliefs to develop an appropriate treatment plan. This approach is known as cultural competence. The term has varying definitions in health care. Cultural competence is critical in the health and medical fields as well as in other direct service where differences in language and styles of social interaction may impede providers' ability to effectively understand the problem at hand and ultimately, deliver the most appropriate and effective treatment. These differences may also affect clients' willingness and ability to seek treatment, describe their needs, and/or apply the recommended treatment.

Delivering culturally competent care is a greater challenge when treating a diverse population such as APIs. This sensitivity is one reason why API patients often feel more comfortable with ethnic-concordant practitioners, but this is not always a feasible option for everyone. Thus, providers must figure out how to bridge the cultural divide.

LANGUAGE

Language skills contribute a great deal to an individual's ability to access and utilize health services. There are large segments of the API community, particularly those that have recently entered the U.S., that speak little to no English (Ghosh, 2003). This challenge is exacerbated by the number of API languages that are spoken in the U.S. and the fact that there are variations between individuals or groups with different acculturation experiences and literacy levels. Approximately 40 percent of APIs speak little or no English and few culturally competent intervention programs exist for them (Ghosh, 2003*)*. One study found that language is the most common barrier to receiving health care services for APIs with HIV/AIDS (Chin, Kang, Kim, Martinez, & Eckholdt, 2006). When disaggregating API data, limited English proficiency is even more pronounced and critical to take into account.

For Vietnamese, 61 percent are classified as Limited English Proficiency (LEP); Hmong, 58 percent; and Cambodian, 53 percent (Chng, 2000). Additionally, some health and HIV-related terminology can be difficult to translate into API languages because the words or concepts simply do not exist. For instance, in some languages, the term for homosexual can be translated to mean "deviant" or "transgender" (Chng, 2000). Discrepancies between API languages and English can cause confusion for both the provider and the patient.

Translating terminology around HIV is hard to do and so clients don't understand. Like saying HIV in Chinese – it isn't obvious what HIV really is. It's also hard if they have no prior knowledge of HIV.

API Wellness Center, San Francisco, CA

Having staff trained in API languages is ideal. Unfortunately, the diversity of languages makes this almost impossible. If providers are unable to speak their client's language, they are encouraged to link them to someone who is able to interpret information *(Yu, 1999)*. However, providers should be aware of several issues when using interpreters: many are not properly trained, especially with respect to API clients and HIV-related concerns; many providers are not trained in the use of interpreters; and many API clients find it hard to express themselves through an interpreter (*Chng, 2000*). It is also important to assess whether or not it is appropriate to use family members as interpreters, particularly in the context of HIV because a client may not feel comfortable fully disclosing in front of that person.

For clients who are able to speak English, providers should speak in simple language and explain concepts and terms fully. They should not overwhelm their clients with medical information and jargon, which may result in them shutting down, leaving, or feeling frustrated and isolated (*Yu, 1999*).

Many monolingual API clients may feel isolated in the larger English-speaking community and incapable of navigating the complex health care system in this country. Even individuals who are able to communicate effectively in English can become overwhelmed because of their unfamiliarity with the system (*Yep et al., 2002*).

Providers can teach their clients about the health care system so they are more equipped to advocate for themselves and feel less alienated.

Providers working through interpreters should be aware that patients may be reluctant to discuss sensitive information in the presence of friends or relatives. Certified medical interpreters may have their own culturally based biases about HIV. Interpreters trained in HIV terminology in English and API languages can learn how to discuss HIV-related "taboo" subjects in a non-judgmental manner with their API patients.- Reducing Health Disparities in Asian American and Pacific Islander Populations: A Provider's Guide to Quality & Culture Seminar – Management Sciences for Health and Office of Minority Health (2009).

COLLECTIVISM AND THE ROLE OF THE FAMILY

The cultures of Asian and Pacific Islander are collectivistic in nature where the needs of the family and social unit are typically prioritized over those of the individual, unlike in Western cultures (*Chng, 2000*). Relationships to others in the social unit are paramount and often shape the individual's sense of identity. The family is the most important social unit and has the most impact on a person's value system and behaviors. In many instances, these strong bonds are a source of positive energy and support.

> *Where I come from [the Philippines], doctors know the whole family, but here in the U.S., there are restrictions. As a psychiatrist, I'm much more involved in my patient's lives and their families. A big factor to working with APIs is working in the context of the family unit.* – Anecdotal, Psychiatrist, API Wellness Center, San Francisco, CA (2008).

However, in the context of HIV-related issues, the desire to keep the family safe from worry or social disgrace can have an adverse effect on health (*Yoshioka & Schustack, 2001*). A patient may fail to disclose his or her status or to seek care or other social services if these actions threaten the patient's role in the family (*Yu, 1999*). Also, because of the stigma around HIV, clients may ignore their disease so that the family does not experience shame (*Bhattacharya, 2004*).

Providers should assess clients' family and social dynamics to determine barriers that might arise in the course of providing health services. In some cases, the family may enable a client to adopt healthy behaviors.

> "*Sometimes involving the family helps. For example, with old couples, they won't necessarily [take care of their health] for themselves, but they'll do it for their family.*" – Anecdotal, HIV test counselor at API Wellness Center, San Francisco, CA (2008)

By understanding cultural norms, social pressures, and family expectations, providers can improve their ability to serve their client more effectively and appropriately.

CULTURAL TABOOS AND STIGMA

There are strict taboos related to the discussion of issues such as HIV, sex, homosexuality, mental health, and substance abuse. It is particularly inappropriate to discuss these types of concerns outside of the family for fear of embarrassment. The shame and guilt that is felt by individuals who violate these norms tends to be amplified among APIs because of the negative effect it could have on the entire family and its reputation within the larger community (*Yep, Merrigan, Martin, Lovaas, & Cetron, 2002; Braun & Nichols, 1997*).

> *Stigma exists in multiple layers in the API populations which contributes to a lack of HIV risk recognition, lack of access to services, and lack of ownership of HIV as a community issues. Shame is an important barrier. Some API clients may be afraid to attend and AIDS Service Organization because they do not want people to see them walking in this type of health care organization.* – Excerpted from the report,

> Breaking Through the Silence: Key Issues and Recommendations to Address HIV/AIDS among APIs in the United States; Asian Pacific Islander American Health Forum and National Alliance of State and Territorial AIDS Directors. (2009)

The stigma that surrounds these issues prevents individuals, families, and communities from openly discussing how to prevent and treat them. Even within the confines of a confidential patient-provider relationship, it is very difficult for clients to speak about them, resulting in important medical and social service needs going unmet (*Yu, 1999*).

> "*Among many API populations, there is a cultural emphasis on self-reliance, on handling problems privately. The avoidance of these topics with a provider can cause important medical and social service needs to go unmet. Continued isolation can lead to depression, inaction and decreased care seeking behavior.*" – Interview with Dr. Bhupendra Sheoran based on the publication, Clinician Guide to Working with Asians and Pacific Islanders Living with HIV – API Wellness Center – HRSA/HAB San Francisco, CA (1999)

In fact, some clients consciously choose non-API providers because this gives them more anonymity and distance from their own community. Consequently, all providers must make the effort to create a safe and open space in which patients feel comfortable enough to talk about sensitive health topics.

TRADITIONAL HEALING BELIEFS

Traditional healing methods such as acupuncture, ayurvedic medicine, qi gong, energy balancing, and shamanistic healing are used widely by APIs, even in the U.S. It is important to recognize that traditional medicine is often viewed as their primary form of health care and that many of these methods are based on a holistic view of the physical, mental, and spiritual selves. Illnesses are a result of these elements being unbalanced; in order to treat one, a provider must look at the whole (*Bhattacharya, 2004*). However, these concepts can be very foreign to providers who have been trained in Western medicine, and many are unable to effectively bridge the gap between the two spheres of thought.

> "*Some Chinese people never listen to a doctor. They have a resistance toward Western medicine. They don't like taking chemicals and medications that are unnatural*." – Anecdotal, HIV health educator at API Wellness Center, San Francisco, CA (2008)

Clients who prefer to avoid taking prescribed medication may decide to lower the dosage themselves or stop taking them altogether (*Chng, 2000*). This is a serious problem for clients who are HIV-infected and who must adhere strictly to their regimen to avoid developing resistance to medications. The tendency to rely on traditional healing may also cause patients to resort to Western medical treatment only when they have exhausted all other options and by this time, their illnesses may be far more advanced (*Bhattacharya, 2004*).

Providers can build trust with clients by showing respect for and curiosity about their belief systems. As a result, patients will be more likely to be open and to share their concerns and adhere to treatment regimens (*API Wellness Center, 1998*). Inquiring about the complementary or alternative therapy that patients might be receiving helps providers determine how best to manage their patients' care. Establishing shared basic understanding of some of the commonly used alternative systems of medicine in the API community will greatly facilitate a provider's insight into the patient's condition and planning a treatment strategy that complements their beliefs.

DEFERENCE TO AUTHORITY AND RESPECT

In many API cultures, physicians and health care providers are viewed as authority figures due to their higher education and status within the community. As a result, clients are more likely to defer to their opinions and less likely to openly question them about specific health concerns.

> *In most API cultures value deference to authority they may show by smiling or nodding. They may appear to be compliant just to please the provider, even if they disagree with what the provider is saying. This can prevent patients from self-advocating, raising concerns, or fully examining their options, thus resulting in non-adher-*

> *ence. Reducing Health Disparities in Asian American and Pacific Islander Populations: A Provider's Guide to Quality & Culture Seminar* – Management Sciences for Health and Office of Minority Health (2009).

The display of deference can be a challenge for providers who misinterpret it to mean that the client understands the information that he or she has been given. It also leads to missed opportunities for clients to advocate for their care or to raise concerns about the care they are receiving (*API Wellness Center, 1998*).

Providers can avoid these missed opportunities by actively engaging their clients and encouraging them to ask questions about their health. A key component of empowering clients in this way is to build trust with them. Providers should take care to be respectful and attentive, and refrain from asking questions in a judgmental or accusatory way.

> "*I've met residents that are completely insensitive. They don't introduce themselves, they don't make eye contact, they don't respect these clients…you need to be very respectful, especially of elders in API cultures"* – Anecdotal, case manager at API Wellness Center, San Francisco, CA (2008)

> *"[With mental health], there is a lot more hesitation, so providers need to engage [API clients] more and allow for a trusting relationship. They must take the time to build a relationship.*" – Anecdotal, psychiatrist at API Wellness Center, San Francisco, CA (2008)

Spending a few extra minutes to build rapport with clients can have a tremendous effect on the way they communicate with their providers and adhere to treatment.

INDIRECT COMMUNICATION

Providers may find that API clients do not directly communicate how they feel or what they are experiencing. Chng & Collins (2000) describe APIs as a "high context culture that relies less on verbal communication than on understanding through shared experience, history, and implicit messages." For example, API cultures will use body language and non-verbal cues to convey their thoughts. For instance, in South Asian communities, depending on the context, a horizontal head movement may express agreement, understanding, or approval.

Besides paying attention to non-verbal cues, providers can encourage their patients to communicate more directly by asking specific questions, as well as questions that are open-ended. Again, this is a process that will require time and patience because of the trust-building that is involved (*Yu, 1999*).

FATALISM

Many API beliefs around illness are rooted in spiritual and religious ideas that are fatalistic and can impact health-seeking behaviors. Concepts such as karma and destiny can lead individuals to believe that contracting HIV in this lifetime may be a result of sins in a previous life and therefore, it is necessary to endure the suffering (Bhattacharya, 2004). Among Catholic APIs, including many Filipinos, HIV infection may be viewed as “God’s will” and therefore, they are powerless to change their circumstances. These beliefs can cause clients to remain passive about their health status and prevent them from accessing necessary care and treatment (Yu, 1999). Providers should work with clients to take control of their health and to empower them. Providing them with options that will fit into their cultural framework can increase their hope and optimism around their HIV-related problems.

ADDITIONAL INFORMATION FOR THE PROVIDER

Providers should recognize that a multitude of cultural factors come into play when caring for an API patient that differ from the factors relevant to a non-API patient. These social and cultural elements affect the strength and longevity of the patient-provider relationship, and in turn affect health outcomes. Previous research highlights that APIs are more likely to get a delayed HIV diagnosis or avoid getting appropriate treatment compared to other ethnic groups (*Bhattacharya, 2004*). Provision of culturally-appropriate care in private and public health care settings is one of the first steps in helping APIs stay healthy.

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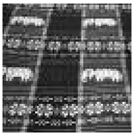

IV. Assessment

Cultural sensitivity to Asian and Pacific Islander (API) patients' needs in regards to HIV/AIDS care is a must for communicating prevention and treatment options to individuals who represent the fastest-growing minority population in the United States. Given the diversity and complexity of the population, how can health care providers conduct culturally appropriate assessments of their clients? The model of cultural competence developed by Campinha-Bacote (1998, 1999) offers a firm foundation for effectively assessing API clients as well as others from other communities of color. The model consists of five integrated constructs: cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desires. In addition to Campinha-Bacote's model, Kleinman (1980) provides a tool based on the explanatory model approach for understanding a patient's condition as well as his or her perception of that condition.

Cultural Awareness is the process of becoming sensitive to the customs, traditions, beliefs, and values of a client's culture. In order to do so, providers must recognize and acknowledge their own beliefs, prejudices, and assumptions about the culture in question. Realistically, providers will be unable to become culturally aware of every API community because of the diversity within this population. It is recommended, however, that providers make the effort to become familiar with the cultures from which a majority of their clients come.

Cultural Knowledge is the process of learning about the experiences of others that are bounded by the realities of culture and specific belief systems. In order to become knowledgeable about their clients' culture, providers should be cognizant of their beliefs about health, HIV/AIDS and other diseases prevalent in their communities as well as viable treatment options. Furthermore, it is helpful for providers to understand the historical context of API subgroups and their varying experiences in the U.S., including migration patterns, experiences with racism, political strife in home countries, and histories of being colonized.

The sum of these experiences affects the manner in which patients perceive and access providers, government organizations, and other health care entities as well as how they perceive options for treatment and care.

Linda S. Beeber, a Professor at the University of North Carolina at Chapel Hill, suggests that providers should look at each patient individually, even when they share their ethnic background and are familiar with the culture. This is because familiarity could lead to labeling and making assumptions. “It could perpetuate biases. It is a step away from stereotyping,” says Beeber. “It does not take into account the powerful process of acculturation.”

Cultural Skills is the ability to collect relevant and meaningful data from a client about their condition. This represents an ongoing challenge with API clients because of language barriers, lack of emphasis placed on direct communication and a traditional deference to providers as authority figures. Kleinman’s explanatory model provides a good start to eliciting important information from patients with eight open-ended questions:

1) What do you think caused your condition?
2) Why do you think it started when it did?
3) What do you think your HIV status does to you?
4) How severe is your sickness?
5) What kind of treatment do you think you should receive?
6) What are the most important results you hope to achieve?
7) What are the chief problems your sickness has caused?
8) What do you fear most about your sickness?

In addition to asking these questions, providers must be attuned to non-verbal cues that may indicate reluctance, embarrassment, or discomfort on the part of the patient to disclose information. Providers may also want to ask about traditional healing methods that are in use, family support, and access to other social services.

The LEARN (***listen, explain, acknowledge, recommend and negotiate***) model (Berlin & Fowkes, 1983) is also a helpful tool for allowing the patient to lead the discussion of his/her symptoms. Gayle Tang, a registered nurse and director of national linguistic and cultural programs at Kaiser Permanente in San Francisco, in an interview with Margaret Burnette, says “It is an easy-to-remember model that reminds nurses to not only explain a situation but to also take time to understand how their patient sees a problem. The nurse will **listen** to how the patient sees their own problem, and then **explain** his or her own perception of the problem. At that point, the nurse **acknowledges** the differences and similarities between the two viewpoints while being nonjudgmental. The nurse would then **recommend** treatment or behavior change and then try to **negotiate** the best way to get the patient to follow through" (Burnette, 2001). Although the above comments reference nurses, the approach is recommended for other clinicians as well.

Another important consideration in treating APIs, is recognizing and addressing mental health issues. According to the book A *Provider's Handbook on Culturally Competent Care: Asian and Pacific Islander Population*, second edition, published by Kaiser Permanente, APIs represent a relatively small number of patients admitted to psychiatric hospitals compared with other racial and ethnic groups. This has led to the misconception that they have fewer mental health problems. Research also indicates that many APIs receive inadequate mental health care because they commonly practice what is known in psychiatry as somatization, where patients express their feelings through physical complaints, which may result in a misdiagnosis (Burnette, 2001).

Cultural Encounters are interactions in which health care providers engage directly with people from diverse backgrounds, according to Campinha-Bacote (1999). These encounters help to change and affirm providers' beliefs about their API clients and the cultures from which they come. These are opportunities for providers to increase their awareness and knowledge of API communities. For instance, a provider may use an encounter to learn about the roles that religion and spirituality play in a client's life and how it may impact health outcomes. The provider may also use an encounter to discover more about the role of the family, including the stigma and/or support that may stem from certain familial interactions.

Cultural Desires is the final construct in Campinha-Bacote's model. It is defined as a provider's own motivation to engage in the process of becoming culturally competent (1999). In order to be successful, providers must genuinely want to increase their own awareness and knowledge, acquire skills and connect with their clients in a sensitive and appropriate manner.

This will result in better rapport and communication with API clients and therefore, increase the effectiveness of any health intervention. The following are some key principles to observe while conducting a behavioral health assessment of Asian and Pacific Islanders (APIs).[1]

- In the initial assessment, put your patient at ease, clarify his/her goals in seeking help, and communicate concepts in simple and clear terms
- During history taking, ask about use of traditional medicines and pharmaceutical products
- Be aware that patients with psychiatric disorders may exhibit "stoicism," denying sadness or depressed mood, or other symptoms
- Reassure patients that what they discuss with you remains confidential
- Tailor explanations in a way that is appropriate to the client's culture; giving a bio-psychosocial explanation will resonate with the API "mind-body" view of illness

Clinicians should ask patients about their use of traditional treatments and herbal medications while taking the history of the present illness. Some patients resort to western medicine only if traditional healing fails; others use both traditional and western medicine, and others, only Western medicine (Jin, XW. Slomka *2002)*

Patients who hold culturally rooted health beliefs and practices may not seek out preventive screening, diagnostic testing, and treatment. In traditional Chinese culture, for example, if a person feels well, there is no need to see a doctor. Also, since blood is considered a nonrenewable vital energy for the body, patients may not seek preventive care and may resist having blood tests to check such things as cholesterol and glucose levels (Spector**,** 1985).

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[1] The following principles are based on *Initial behavioral health assessment of Asian Americans. Part 1. Henry Chung,[1] Dustin Nguyen,[2] and Francesca Gany[3]*, 2002

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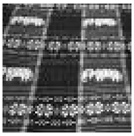

V. Facts

Providing culturally responsive health care to APIs with HIV/AIDS requires providers to learn about the many worldviews and biological variations of the diverse racial/ethnic groups under this umbrella.

Worldviews are explanations and beliefs used by a group of individuals to explain life events. Health care providers must take into consideration variations in national origin, language, immigration and acculturation status, and generational differences. Since there is no single worldview among API communities, the following statements are broad generalizations of beliefs and facts that give providers an overview of cultural influences.

RELIGIOUS AND SPIRITUAL BELIEFS

The API communities belong to a variety of faiths, including Hinduism, Buddhism, Christianity, Islam, Catholicism, and native religions. These religions may influence beliefs about the origins of health and illness, as well as influence interactions with the health-care system. For example, Hindus believe in the principle of *karma* — that actions in past lives affect the circumstances in this life- so illness is caused by circumstances out of one's control; pain and illness are result of fate or god's will (Ananth, 1984; Bunghalia, Kelly, Van De Keift & Young, 2007). This karmic law of cause and effect can accrue over many lifetimes; hence, an illness may be seen as a result of actions in this life or a past life (Rasbridge, 2003).

Hindus also believe that illness occurs when *dosha*, forces in the body, are out of balance. Conversely, gaining balance of *dosha* is health. They believe in taking on the sick role when one is not well and being stoic even in the face of pain (Bunghalia, et al, 2007). Since there is stigma attached to seeking help for disease, many Hindus might not seek help from the health care system. However, Ayurvedic or traditional Indian health practices, may be used (Muecke, 1983a; Muecke, 1983b).

Similarly, although many APIs are Christians, they still may adhere to traditional spiritual beliefs (McGrath, 1999; Parsons, 1995). For some APIs, the concept of health is four-fold: the spiritual, the physical, the psychological, and the social, particularly the relationship with family. Most APIs believe in *mana*, a life force or special power, and feel that valuable tools or chiefs and warriors possessed *mana*. Illness and disease are regarded as the loss of, or imbalance of *mana*. Illness and disease mean a lack of internal balance and the objective of treatment is to restore spiritual, physical, and emotional balance (Macpherson, 1990). Also, APIs use storytelling for teaching and healing, along with medicine. Specifically, Hawaiians may use *ho'oponopono*, a form of family counseling and conflict resolution therapy (Hurdle, 2002).

The Confucian and Buddhist traditions also stress the importance of saving "face" or dignity, so illness, especially one like HIV, may bring shame upon the family. Providers need to be ready and able to discuss these issues if they arise (Yu, 1999).

Confronting HIV and AIDS means a person has to deal with spiritual issues such as guilt, loss, and a search for meaning. Guilt that stems from a feeling of being punished by God may result in hopelessness and resignation. Fatalism is the belief that one must accept the unfortunate events in one's life and that one has little control over negative health outcomes. This is sometimes found among APIs particularly among immigrants who have suffered hardship (Kemp, 1985; McLaughlin & Braun, 1998). To address fatalism, professionals need to work with patients to empower them and create opportunities for participation in treatment and wellness behaviors, thus enabling a sense of control over the disease and its progression (Huff & Kline, 1999; Yu, 1999).

KINSHIP AND FAMILY TIES

Strong kinship and family ties are the basic characteristics of the API family structure (Hsu, 1973). Many of them embrace hard work and they place particular value on family, elders, privacy and respect. There is a strong belief in collective welfare, and the needs of the family and society are placed above that of the individual's (Yee, 1990). There is deep respect for authority; a doctor is highly regarded, for example, and there may be less of a perception of patient-physician partnership (Beller, Pinker, Snapka & Van Dusen, 2007).

Since there tends to be cultural avoidance when it comes to discussing issues related to sexual behavior, alcohol or drug use, API individuals diagnosed with HIV/AIDS are less likely to share personal information with their families and communities because of the behaviors associated with its transmission. Because sexuality and illness are not always openly discussed, providers need to encourage patients to communicate with trusted family members and loved ones based on the patient's readiness. Having a strong family support system can lead to a more successful treatment and HIV management process (Frye, 1995).

BELIEFS ABOUT HEALTH

These are ideas about the cause and onset of illness and symptoms, patho-physiology of the disease, natural history of the illness and treatment methods. These can have significant influence on health status and health seeking behaviors. Asian and Pacific Islanders usually view health holistically, linking the mind, body and soul or a balance of life energies – a combination of the spiritual and the scientific. Many of them use complementary and alternative medicine (CAM) and folk medicine (Buchwald, Panwala & Hooton, 1992; Kaczmarcyzk & Burke, 2003; Lu, 1986; Rasbridge, 2003). These treatments are often used before or concurrently with western health care. Many APIs practice both Asian and western healing methods, viewing the latter as more powerful for acute illness but using eastern practices for regulating daily health. In general, however, many APIs believe that taking too much western medicine can cause irreparable damage to the liver or kidneys. They tend to be reluctant to have blood drawn because they believe blood is not replenished once it is removed.

The Chinese regard health as a balance of positive (yang) and negative (yin) energy in the body. Yin-yang are opposing forces with yin being female, negative, cold and yang being male, positive and hot. Taoism emphasizes balancing natural processes so the person is treated as a whole using methods like acupuncture, acupressure and herbs (Ma, 1999). Natural processes and energies are restored also through food and diet. It is believed that certain foods are either 'cold' or 'hot,' and when the body is out of balance or during certain conditions such as childbirth, specific foods are prescribed and others avoided. "Hot foods" include meat, eggs, nuts, herbs and spices while milk products, fruits and vegetables are considered "cold" (Lu, 1986).

Like Hindus, the Chinese believe that illness may be a result of bad *karma*. Therefore talking about or discussing negative subjects like illness or death, could actually bring about these realities (McLaughlin & Braun, 1998). Additionally, the Chinese believe in a psychosomatic model of health— that certain organs are associated with emotions and symbolic functions, and illness may result from a dysfunction of those organs (Shih, 1996).

In Japanese culture, the body is as holy as the mind, and the mind and body are one. Therefore, it is important to heal both body and mind. Illness is considered beyond human control. Since their culture discourages individualism, the Japanese patient will listen but may not often ask questions and will appreciate and want guidance from providers rather than make individual choices. In a health care situation, Japanese prefer formal and structured interventions with roles clearly defined (Chen et al, 1993).

For Koreans, illness is a matter of fate and a disharmony in natural forces, similar to Chinese concepts of yin and yang. Hospitalization of a patient might be regarded as a sign of impending death. Patient care is often provided by family members. The physician is a powerful and trustworthy authority figure and his or her advice is well respected and heeded (Chen et al, 1993; Do, 1988).

Indians practice Ayurvedic medicine, a model that views health as a relationship between the universe and the body (Bunghalia, et al, 2007; Panganamala & Plummer, 1998; SenGupta, 1996). The aim of Ayurveda is to integrate and balance the body, mind, and spirit. This is believed to help prevent illness and promote wellness. In Ayurvedic philosophy, people, their health, and the universe are all thought to be related. It is believed that health problems can result when these relationships are out of balance. Ayurveda mixes religion with medicine and views health as a holistic system with emphasis on prevention. When *dosha*, forces in the body, are in balance, then it is healthy. Ayurvedic treatments often employ medicinal plants and herbs, specific 'hot' and 'cold' foods, metals, massage, and other products and techniques are used to cleanse the body and restore balance. Indians also believe illness is due to *karma*, even when the patient understands that it has biological causes.

Because Indians have strong family ties, they may resist using long-term care facilities, preferring to rely instead on care and support provided by the immediate family. Similar to the

Chinese, Indians also tend to save “face” by keeping stigmatized illnesses private. They tend to use meditation and prayer and many practice vegetarianism as part of their health management and religious lifestyles (Bunghalia, et al, 2007).

The Southeast Asian cultures (Vietnamese, Hmong, Cambodians, Laotians, etc.) consider illness and disease as shifts in environmental forces. Some practice animism, a form of religion that sees human beings, animals and inanimate objects as possessing souls. Illness is punishment from gods, demons, spirits, or curses from evil or malevolent spirits. They may use religious and spiritual leaders and healers as part of their medical car and often use cupping and coining (Buchwald, et al, 1992; Frye, 1994; Frye & D’Avanzo, 1994; Kemp, 1985; Keovilay & Kemp, 2007; Muecke, 1983a; Muecke, 1983b).Cupping involves the use of a cup that is filled with warm air and placed open end down on the part of the body that is experiencing distress. This therapy is thought to restore the flow of the life force to a proper and working state (Buchwald, et al, 1992). Coining is the rubbing of a coin over body surfaces to expel “bad winds” that cause illness (Buchwald, et al, 1992).

The *Vietnamese* attribute illness to a spiritual imbalance of *Ama* and *Duong* (yin and yang), even if they also respect and understand Western concepts of disease. They believe Western prescriptions cure illness immediately and that dosages of medicine are too strong for Asian bodies. Consequently, they may save half-used prescriptions instead of taking the entire dosage once symptoms disappear. They also have great respect for doctors as expert (Rasbridge, 2003).

For *Cambodians*, illness is caused by an imbalance of natural forces or changes in the environment. Cambodians are comfortable with both western and traditional healing practices and often use both. They might try the traditional methods first, utilizing medicinal practices with a spiritual component or magic with a medicinal component before they employ conventional treatments. Also, they tend to focus on the symptoms rather than the cause of an illness or disease and may stop using medicines once symptoms disappear (Frye & D’Avanzo, 1994; Kemp, 1985; Mattson, 1993; Rasbridge & Kemp, 2007; Wetzel & Huong, 1996).

Laotians believe illness is the loss of one of 32 spirits and may first practice traditional treatments, such as performing a ceremony to regain or appease the lost spirit. Western medicine is usually a last resort. Laotians are reluctant to volunteer information because there is great value placed on privacy in their culture. They believe it is important to prescribe dosages of medication according to the individual's needs (Keovilay & Kemp, 2007).

ATTITUDES TOWARD WESTERN HEALTH CARE

Asian and Pacific Islanders tend to seek primary care in hospital outpatient clinics, and because of distinct gender roles they often request and feel more comfortable with a doctor who is of the same sex (Yee, 1990). Some APIs are used to accessing care in their home countries without having to make an appointment and cannot understand the need to do so in the US. Providers should also know that API interactions between social equals tend to be characterized by politeness and concern for the other person (Chin & Bigby, 2003). As a result, patients may often nod their heads in agreement and say "yes" when they really do not understand or intend to follow instructions. Apparent acquiescence is merely a display of politeness and respect for the providers.

Some APIs, especially immigrant populations, may have had less experience with Western medical systems and will seek out CAM and folk medicine (Kaczmarczyk & Burke, 2003). Practitioners and vendors of Asian medicine and homeopathic remedies, such as herbalists and acupuncturists, exist in ethnic and immigrant enclaves (e.g., Chinatowns) throughout the U.S., making these medicines and treatments easily accessible. Patients may not disclose them on their own, either because they fear negative reactions from western doctors or they do not understand the importance of the possible interactions with conventional treatments. Thus, the provider is tasked with finding out what treatments patients are receiving elsewhere (Kaczmarczyk & Burke, 2003). Providers who are knowledgeable about the many ethnomedical and traditional practices used within the community can improve the patient's level of trust in the provider and adherence to health care regimens. A provider who discourages or demonstrates bias toward CAM practices may further isolate a patient and actually have a negative impact on his or her ability to access care (Ahn, 2006: Chen et al, 1993).

Integration of safe ethnomedical practices with Western medicine may result in positive and beneficial outcomes. Integration may provide a sense of social and psychological support and comfort to an immigrant who is HIV-infected and who is struggling to adapt to the United States. It is advantageous for the provider to be aware of the patient's folk medicine practices so that he or she may integrate harmless practices into the patient's treatment regimen (Bigby & American College of Physicians, 2003).

Although most practices appear to be safe or beneficial it is important that the provider has knowledge of those that have been proven harmful, such as those that contain lead or mercury. The provider may also advise the patient of any harmful consequences that could result from some dangerous practices that are known to exist. Further, some products may be harmful when used on their own or when used with western medicines. Health care providers must be sure to gather as much information as possible and then consider the impact of the treatment in which the patient is engaged.

RACIAL/ETHNIC GROUP'S BIOLOGICAL VARIATIONS

Understanding biological variations also is critical to the culturally sensitive treatment of APIs with HIV/AIDS. Global travel and migration patterns, especially among immigrants, affect the variations of the disease and may introduce subtypes not typical for a particular region. It is important to consider the ethnic origins of patients and their contacts. Ethnic and cultural background, migratory patterns, and intercultural contacts could have profound implications in the diagnosis, management and treatment of HIV infection.

If an API patient knows that she or he was infected in North America, they most likely have subtype B HIV. Dependent on background and immigration patterns, API patients theoretically can be dually infected with HIV-1 subtype B and non-B and with HIV-1 and HIV-2. Providers should be mindful of the API patient's ethnic origins and their contacts so as to provide optimal diagnostic and treatment services. For example, if an API patient is from another country or travels often to their home countries, providers should be aware that historically, subtype B has been the most common subtype/CRF in Europe, the Americas, Japan and Australia. Subtype C is predominant in Southern and East Africa, India and Nepal, and has caused the world's worst HIV epidemics. It is also responsible for around half of all infections in these regions. The CRF A/E is prevalent in South-East Asia, even though it originated in Central Africa. In general, in Southeast Asia (primarily Thailand and Vietnam), subtype E is the most prevalent, while in China and India subtype C is the most prevalent.

SIMULTANEOUS INFECTION OF TUBERCULOSIS (TB) AND HIV

The numbers of HIV/TB co-infections are increasing (Corbett, 2003; Sharma, 2005). In patients dually infected with TB and HIV, clinicians are challenged with a number of unique issues related to TB diagnosis, pathogenesis and treatment (Wei, 2005). Individuals born in other countries may already be infected with TB or may have been vaccinated. Providers should be aware that many Asian countries use the BCG vaccine, which may result in a positive TB screen. Nonetheless, a person who has a positive skin test, and who was previously given BCG vaccine, should be treated the same as a person who has not received BCG; both should be treated as if they have TB. Overall, clinical guidelines require a chest x-ray and complete clinical assessment to determine if TB is active and which antibiotic regimens are appropriate. As noted above, this may necessitate altering or terminating HIV medications due to interaction with certain TB medications.

CONCLUSION

There are many ways API cultural beliefs and values can impact upon health practices. By working with culturally and linguistically appropriate materials, providers can improve the nature and content of their communication with APIs diagnosed with HIV (Bigby & American College of Physicians, 2003; Chin & Bigby, 2003; Lassiter, 1995; Lee, 1997; Waxler-Morrison, 2005). Providers should strive to have and/or be able to elicit effectively from their patients an overview of their worldview as well as understand the biological variations in the manifestation of the HIV disease in the population in order to ensure the delivery of culturally competent quality care (Betancourt, 2003; Kaiser Permanente, 1999; Yee & Weaver, 1994).

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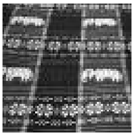

VI. Encounters

This chapter focuses on the impact of various cultural factors that may affect the interaction between healthcare providers and APIs living with HIV/AIDS. This chapter also focuses on how providers can improve their encounters with the patient who is HIV positive. It also highlights some of the overarching commonalities among these ethnic groups. It is always important to note and remember that these commonalities must not be generalized to every API individual but can be used as a starting place from which to delve deeper into the patient's unique culture, history and perceptions.

Specifically, the chapter addresses three key questions relevant to the encounter process:

1) What cultural factors facilitate the patient-provider encounter process?
2) What are the barriers or challenges that patients face in accessing services?
3) What can providers do to help patients overcome these barriers and learn how to navigate the complex medical system to obtain quality care?

BACKGROUND

Among APIs diagnosed with HIV/AIDS, approximately 78 percent were men, 21 percent were women and one percent, children under the age of 13. Among males living with HIV/AIDS, 67 percent of cases were due to male to male sexual contact, 16 percent to high risk heterosexual contact, 11 percent to injection drug use and four percent to a combination of male to male sexual contact and injection drugs use (Chin et al., 2006; Zaidi, I.F., Crepaz, N., Song, R., 2005). Among females living with HIV/AIDS, the majority of cases were attributable to high risk heterosexual contact followed by 16 percent due to injection drug use (Chin et al., 2006; Zaidi, I.F., Crepaz, N., Song, R., 2005).

Providers who work with API clients need to be sensitive to the taboos regarding sexual practices and drug use associated with HIV/AIDS that prevent many from seeking HIV testing or care (Zaidi et al. 2005). For women, domestic violence and lack of knowledge about the disease are also significant concerns that require special consideration and services.

The initial encounters, thus, present an extremely important opportunity for providers to better understand the cultural experiences of APIs and how they can influence the health attitudes, beliefs and behaviors of their clients. The initial encounters also offer a good opportunity to forge a strong provider-patient alliance that can impact patient satisfaction and positive treatment adherence and outcomes. Furthermore, providers can use the initial encounter as a valuable opportunity to provide not only vital treatment-related information, but also learn about the patients' relationships with their family and the communities in which they are embedded.

The percentage of overall AIDS diagnoses is low among APIs compared to other racial or ethnic groups in the United States.

STIGMA AND SHAME

For APIs, the fear of social rejection and discrimination may determine whether the client discloses his or her serostatus and receives timely care (Herek & Glunt, 1988; Yep, 1993). For many, disclosure not only brings dishonor to the individual, but can bring shame to family and friends because of the association of HIV/AIDS with various cultural taboos including drug use, homosexuality, illness and death (Kang, E., et al., 2005).

The emphasis on collectivism may also explain the lower rates of service utilization among APIs compared to other racial and ethnic groups. Further, many APIs feel that they do not deserve to receive treatment because of the dishonor they have brought to their family. This perhaps explains the reason why APIs are more likely than all other ethnic groups to be diagnosed with AIDS at the time of HIV testing. Approximately 45 percent of those with AIDS cite illness as their initial reason for seeking testing and care compared to 38 percent for whites (Wong, Campsmith, Nakamura, Crepaz, & Begley, 2004). For example, APIs are more likely to have AIDS-defining *Pneumocystis carinii pneumonia* (PCP) diagnosis upon first learning of their HIV infection, and to have later entry into AIDS care than other groups (Eckholdt & Chin, 1997; Eckholdt, Chin, Manzon-Santos, & Kim, 1997).

In addition, research findings indicate that APIs are more likely to use hospital-based HIV clinics, and to utilize ancillary services, such as HIV case management, housing assistance, day or respite care, food/nutrition, substance abuse treatment, and health education, far less frequently (Pounds et. al., 2002). This characteristic regarding care-seeking behaviors and service utilization is evident in many API groups, regardless of gender, age, and geographic location. These findings highlight the need for health providers to address language, economic and cultural barriers early in the initial encounters in order to help patients get tested early and receive more timely care.

VERBAL COMMUNICATION & USE OF INTERPRETERS

Improving communication between patients and health professionals is an essential component of the health care encounter since, for many APIs, language is one of the most common barriers to accessing HIV/AIDS services (Chin et. al, 2006). However, because of the diversity of languages spoken, verbal communication can become a challenge to service providers. Providers receiving Federal financial assistance are obligated to ensure that people with limited English proficiency have meaningful and equal access to services according to the 1964 Civil Rights Act (Federal Register, 2000).

If the health care provider does not speak the patient's language, a trained medical interpreter should be utilized. Asking a patient's relative or friend to interpret should be discouraged because of the sensitivity of the issues that are likely to be raised during the course of assessment and treatment. It is also critical to have an interpreter who not only speaks the language but is familiar with the patient's cultural perspective and understands the subtle nuances of nonverbal cues. The provider and the interpreter should work closely during the first encounter as this will likely set the basis for provider-patient trust in future encounters.

Another issue that can pose barriers to open communication is the pressure to remain stoic and refrain from expressing any negative feelings or concerns about one's self. Among APIs, discussing one's feelings, particularly fears or anxieties is considered a sign of weakness and an inability to cope. Thus, APIs may smile to hide a range of emotions that reflect worries about their medical status. Often individuals have been taught not to ask for help since it draws attention to their needs rather than focusing on those of the group. Consequently, patients may minimize their physical symptoms or their level of concern regarding their HIV status.

Providers who have limited prior experience working with API cultures should be sensitive to the attitudes, beliefs and perceptions that patients have regarding their illness and the stigma associated with HIV/AIDS. Using open-ended inquiries will allow patients to discuss matters that are sensitive to them without feeling forced to divulge information that they might consider inappropriate. Thus, it is critical during the initial encounters to listen closely and to ensure a sense of security and trust so that patients can discuss their medical and psychological needs openly.

Patients who are considering disclosing their status may also need assistance with providing HIV/AIDS education to family members and friends who have little knowledge in this area and also have language limitations. To aid in these efforts, the health care provider may need to identify materials that have been translated in the patient's language or to identify an interpreter who is sensitive to his or her culture.

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NONVERBAL COMMUNICATION

In western cultures, individualism is emphasized and communicating directly to achieve one's goals is reinforced. In contrast, in API cultures, self discipline and self control are emphasized. Individuals are discouraged from expressing their emotions directly and are taught to tolerate discomfort and difficulties in life. They are also taught from a young age to speak only when spoken to, to speak only if one has something important to say, and to have stamina and strength to tolerate crises. There are also pressures to direct attention away from the self and focus on the needs of the family, group and community.

Further, the culture values stoicism and complaining about one's symptoms or asking for help are not positively viewed. By extension, silence is valued as a sign of politeness and it is considered rude to interrupt others, particularly authority figures. Consequently, for many APIs, personal needs are often expressed through nonverbal communication. Thus, providers are faced with the challenge of interpreting their patients' silence and nonverbal cues and asking questions in order to identify their problems. It is important for providers to interact with clients in a non-judgmental manner and to provide HIV information clearly and simply.

EYE CONTACT

Although western cultures emphasize direct eye contact as a sign of respect and confidence, in most API cultures it may be perceived as rudeness, a sign of aggression or having sexual connotations. Providers are trained to make direct eye contact with the patient as a way to engage with the patient and show their concern and sensitivity. However, patients from API cultures are taught not to look directly at individuals. Making direct eye contact with health professionals in many API cultures is viewed as a sign of disrespect for the provider's status or as questioning his/her expertise.

RESPECT FOR HEALTH PROFESSIONALS

The concepts of filial piety or respect for one's parents or elders, and patriarchal authority are highly valued in the API culture. Individuals are taught to be loyal and trustworthy, to respect those who lead and never to question authority. Thus, physicians and health care providers in general are highly respected. This can become a barrier if it inhibits the patient from expressing their needs and symptoms directly and clearly. For example, APIs may nod or smile to please the authority figure but may not really understand the information that is provided about their treatment. Deferring to the provider can also inhibit the patient from advocating for their health or questioning the provider about the course of treatment or the availability of alternative or more appropriate treatment. It is important for the provider to put patients at ease by asking open-ended questions about their health in a respectful and none threatening manner. The provider should also listen to the patient carefully and be observant of nonverbal and subtle cues that might be exhibited during the interaction. During the conversation, providers need to be especially careful about interrupting since it may prevent patients from feeling free to express their concerns and worries. Given the deference and respect accorded health professionals, providers should seize the opportunity to teach patients about their medical conditions and help them navigate the complex structure of the medical care system. For many patients, the first encounters with health care providers can be overwhelming. As such, pacing the amount of information is important as well as avoiding the use of jargon.

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CONFIDENTIALITY

For APIs, disclosure of their HIV status is a major concern because of multiple taboos associated with sexuality and drug use. Therefore, during initial encounters, it is vital to assure patients of confidentiality and privacy protections, while taking into consideration that the meaning of confidentiality may vary by culture (Westermeyer & Janca, 1997). In the U.S., there are typically laws and state mechanisms mandating the confidentiality of the provider-patient encounter and patient's medical records. In other countries, however, information conveyed to the provider may be discussed with the family, community leaders, or elders without the patient's consent.

In the API culture, the family is the critical societal unit, and many patients will be extremely cautious about what they disclose if they anticipate that the information regarding their status will be relayed to their family and friends. Therefore, it is important for providers to have an open and clear discussion may about the meaning of confidentiality for patients since their beliefs and attitudes regarding confidentiality affect what they disclose to the providers and impact treatment progress.

CASE STUDY #1

The patient is a 22 year old Chinese American male who is gay and has had multiple partners over the last several years. He recently graduated from college and has found a position as an engineer in a prestigious firm. As the only male child, his parents are very proud of his accomplishments. He has been experiencing flu-like symptoms for several weeks and upon the urging of his friends, has visited a clinic outside of his community. He has not yet disclosed his sexual orientation to his family because of their traditional values and expectations regarding the role of the male child. His older sister is the only member of his family to whom he has disclosed his sexual orientation. Although they are not close, she is accepting of his lifestyle. Although the patient's father speaks some English, his mother speaks primarily Chinese. The patient reports that he has been "dating" but currently there is no one special that he is seeing.

Discussion

In this case, there are a number of cultural issues that are important to consider in providing the most effective care. The patient's sexual orientation, the traditional views and values of his culture, the language barriers within his family, and the patient's limited social support are factors that can impact treatment adherence and outcomes. Acknowledging and reinforcing his decision to seek care would help to ease the tension, establish trust and empower the individual.

In many cultures, seeking help is considered a sign of weakness and the patient may even feel that he does not deserve care because of the shame he has brought not only upon himself but his family. The patient's position in his family as the only male child cannot be emphasized enough. The obligations attached to this role must be fully understood from the patient's perspective when making recommendations and referrals. To address the many issues presented here, the provider could link the patient to a peer group living with HIV/AIDS for support and information that will help him to maintain a positive attitude. The provider could also be helpful in preparing and empowering the patient to begin the process of disclosing his sexual orientation and possible serostatus to his family. This may entail identifying a culturally competent interpreter to be part of the patient's process of disclosure.

CASE STUDY #2

The patient is a 26 year old Filipino woman who got tested at a community based clinic after reading about the multicultural staff in a local newspaper. She reported that her husband has been seeing commercial sex workers for several years, has been in and out of drug treatment programs, and has been physically abusive toward her while intoxicated. The patient speaks minimal English and is concerned that she is HIV positive. She reports that she has no job, no close friends and all of her family is in the Philippines.

Discussion

In this case, the patient's traditional views, the language barriers, and limited social support are significant factors that need to be addressed since they can impact treatment adherence and prognosis. Seeking to obtain testing and disclosing her status, if found to be positive for HIV, may be further complicated by gender and sexual restrictions that are placed on API women (Gock, 1994). These restrictions could also make it difficult for her to discuss her situation since they emphasize sexual modesty and remaining stoic in the face of domestic violence. Thus, acknowledging and reinforcing the individual's decision to seek care and testing is vital in establishing trust and empowering the individual. The provider could refer the patient to a peer group of women who are also living in similar situations. She should also be linked to a social worker, case manager or peer counselor who speaks his or her native tongue and can first conduct a safety assessment and identify any immediate risks for harm and then provide information about HIV treatment and support and domestic violence services that are available in the community.

Below are some suggested approaches for effective, culturally competent initial encounters with API patients:

- Introduce yourself professionally and appropriately. For example say, *good morning Ms. Wong how are you feeling today?* Be sure to ask the patient how they wish to be addressed. It is usually appropriate to express a lack of knowledge about the culture and concern that the interaction be meaningful.
- If language is an issue, do not use a family or friend to interpret for the patient; work closely with a professional interpreter who is both linguistically and knowledge-

able about the needs of the patient population.

- Bow slightly as a gesture of respect.
- Avoid prolonged eye contact; most API cultures consider direct eye contact rude and may elicit discomfort.
- Do not use any medical jargon or terminology; speak clearly, slowly and simply.
- Speak in a respectful manner and do not talk “down” to the patient.
- Pace the delivery of information. For many patients the first encounter can be overwhelming since a significant amount of complex medical information will need to be provided. Also the patient may be trying to accept and to adjust to his/her HIV status.
- Do not interact or question the patient in an aggressive manner.
- Interact and approach the patient using a non-judgmental stance. This may be their first attempt at seeking testing, care and/or disclosing their HIV status.
- Do not rush through the encounter but make time for each patient. Since APIs see health professionals as authority figures, the initial interaction can be a prime opportunity to establish trust and a positive relationship that will impact treatment adherence and outcomes.
- Empower the patient. He or she may feel that they have brought shame to their families and friends and as such, do not deserve good care. Assist him or her in navigating the complex medical care system and encourage them to utilize multiple services.
- Assure patients that confidentiality will be maintained and that you are committed to helping them get the best care.

The following questions from the Assessment chapter can be helpful to remember during the initial encounter with an API patient:

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to achieve?
- What are the chief problems your sickness has caused?
- What do you fear most about your illness?

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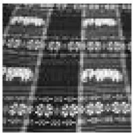
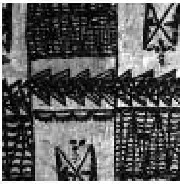


VII. Conclusion

This book is essential to the goal of culturally competent and linguistically accessible health care. As new data on HIV incidence indicates a continued raise in API communities, elimination of disparities and inequities must involve a commitment to culturally competent care. This book offers a perspective on cultural competency and includes tools and guidance to:

1) address overt and covert barriers to care
2) assess the level of awareness and sensitivity toward API patients living with HIV/AIDS
3) conduct culturally competent assessments
4) obtain cultural knowledge about API communities
5) increase effectiveness of clinical encounters with APIs.

The application of the BESAFE model must be accompanied by an openness, awareness, and consciousness of structural disparities, inclusive of poverty, discrimination, stigma, and homophobia. These social determinants have a direct impact on health status for communities of color. For providers who have API clients, this book offers a broad overview of the unique histories, beliefs, values, and spiritual and cultural factors that come into play when providing health care services. Finally, the BESAFE model will hopefully inspire providers to continue to learn and educate themselves about API cultures and communities in order to improve the quality of care for APIs.



Appendix: Case Scenarios

CASE SCENARIO 1

Mrs. V is a 40 year old, first-generation Vietnamese woman with AIDS, who has been under your care for three years. You met Mrs. V while treating her husband. Mrs. V had presented for treatment a late-stage HIV infection.{Should this not be AIDS diagnosis} Soon after meeting them, you suggested that Mrs. V also be tested for HIV. Mr. V died soon after your initial contact with them. Mrs. V only speaks Vietnamese, therefore you refer her to a bilingual Vietnamese-speaking case manager at a local HIV service organization. Throughout her treatment, Mrs. V has refused to use hospital interpreter services, saying she prefers to rely on her sister and the case manager for help in communicating with you, because she is afraid that people from the Vietnamese community will find out about her diagnosis. Recently, Mrs. V's condition has deteriorated dramatically and you propose treatment that would hospitalize her for at least 72 hours. It would be required that she be monitored continuously in case any potential-life-threatening side effects occur. The hospital however states that they cannot provide continuous interpretation services. Mrs. V initially refuses, again stating that she does is fearful someone in the community will find out.

Discussion:

Here the patient is more concerned about the community's perception than of her own health. The patient fears her confidentiality will be compromised simply because people outside her level of comfort will know about her information. In Asian and Pacific Islander cultures, indirect communication avoids drawing attention to another's personal life styles (Yu, 1999). The patient may hide his/ her HIV diagnosis, fail to seek or adhere to treatments, or even outright reject social services if these actions threaten the patient's role being compromised in the community (Yu, 1999). Mrs. V demonstrates fear and value importance of the communities' impression of finding out her diagnosis, rather than on herself and her health (Yu, 1999). In Asian and Pacific

Islander cultures, shame is used to remind individuals of their obligation to their family and their community, and any sense that they have disappointed their family brings about a feeling of unworthiness, which will impact receiving care, treatment and support (YU, 1999). Thus acknowledging and respecting Mrs. V's cultural and traditional beliefs demonstrates respect, sensitivity and understanding for her concerns (APA, 2002). While providers do not necessarily have to indicate sharing common beliefs, taking time to understand Mrs. V's perspective will surely build rapport and trust in the care and treatment system you will provide for her. Educating and reiterating issues of confidentiality by health professionals to her will help Mrs. V place trust in the system of care and treatment she will continue to receive. While language barriers and cultural alienation are bound to always interfere with the patients motivation to seek and adhere to treatment and care, providers should always be sensitive to personal family member biases that might occur with communication of information (Krisberg, 2005).

Suggested approaches for effective, culturally competent affirmation about care and treatment should include:

- Linguistic and Culturally Sensitive Care
- Awareness of personal family biases to communicating information
- Teaching patients about the hospital structure and care system
- Enforcement of Confidentiality of the patients information among within the hospital structure
- Help facilitate communication between case managers and the hospital system
- Help the patient maintain a sense of control
- Continual Assessing of the patients understanding and seriousness of their condition with the benefits of care and treatment
- Importance of adhering to care and treatment to improving their health

CASE SCENARIO 2

A recent Chinese immigrant is fearful of being tested, because she claims the health department will expose her status if she turns out to be positive. Fears stem from Chinese newspapers where a woman who tested HIV positive in China's Fujian province testified that the government exposed her so that they could prevent the spread of the epidemic. She is fearful that once her identity is revealed, she would not be able to gain access to care and treatment, as her picture and name will be sent to all government clinics to make sure she does not continue to infect others. She therefore refuses to test or know her status for fear of being exposed to the community and throughout the government clinics.

Discussion:

Here the patient demonstrates why API immigrants may be reluctant to test and know their status, for fear of being exposed throughout the community and government. The patient fears their medical information will be released about the care, treatment and results of their health. They therefore do not trust the health care system fearing this belief. Since most immigrants do not meet eligibility requirements for Medicaid, Social Security and other federally funded programs, accessing government facilities could be seen as being exposed to deportation as a result of their legal status within the country (Maki, & Kitaono, 2002). Despite the availability of free HIV testing services, many uninsured APIs do not get tested suggesting other significant issues play a role in hindering them from gaining access to care and treatment. This fear along with Language barriers, keeps them from gaining access, as they are linguistically isolated from the general population. Confidentiality about personal information and the fear of stigma and discrimination is a reality within the API community, especially due to cultural and traditional intolerance against the status quo. Most APIs thus do not seek services, until they are already very sick and forced into mandatory screening. Most often secondary infections and or opportunistic infections which are co-factors to HIV are most often how HIV testing will be conducted. Thus APIs living with HIV/AIDS are not diagnosed until the later stages of the infection, where most times life-prolonging treatment and protocols are no longer available or effective (Eckholdt & Chin, 1997).

The patient's fears of the health system, and stigma and discrimination will greatly impact seeking testing and care and treatment. Outright reject social services thus occurs anytime the patient feels threatened and or their role in the community will be compromised (Yu, 1999). Misconceptions of access and care to services, including confidentiality within the health system varies depending on the level of importance APIs give the disease. Being ostracized by the community and one's family impacts greatly whether APIs will seek care (YU, 1999). While these barriers to care area reality for APIs, providers must acknowledge, respect, and understand the cultural and traditional beliefs that can greatly hinder care and access to care for APIs. Helping APIs trust in the health system is not an easy task, given their long history of fear and distrust, especially of the government (Kim, Atkinson, & Umemoto, 2001).

Suggested approaches for engaging APIs to accessing care and treatment services includes:

- Linguistic and Culturally Sensitive Care
- Teaching patients about the hospital structure and care system
- Linking patients to social services
- Being aware patients may defer to you without fully understanding their options
- Enforcement of Confidentiality of the patients information among within the hospital structure
- Re-emphasize Trust in the health care system
- Show respect for traditional and cultural beliefs to care and treatment
- Pace the delivery of information
- Refrain from appearing frustrated or being judgmental
- Help the patient maintain a sense of control
- Verify patients understanding and seriousness of their condition and importance to adhere to treatment

CASE SCENARIO 3

Ramesh is a 38 year-old male Indian man diagnosed with AIDS. He was diagnosed after coming down with flu like symptoms he was forced to seek medical care for constant coughing and serious chest pains. He was initially diagnosed with PCP and has been on treatment at home for the past three weeks. Ramesh returns with problems indicating difficulty breathing and seems somewhat disoriented (Yu, 1999). Diagnosis finds that he has not been taking his medication as his mother has been treating him with traditional Aryuveda methods (Barnes, Bloom, & Nahin, 2008). His mother is unaware of his status and the necessary treatment he is supposed to be taking. She believes that with continued prayer and treatment she and the family will help Ramesh get better soon.

Discussion:

Treatment of illnesses by traditional methods is common in Indian culture and society, and has shown to be effective for certain illnesses. However, treatments of HIV with traditional methods are not effective, and with other opportunistic infections increase the risk of Rameshs' health deteriorating (Mundewadi, 2008). While Ramesh is keen on seeking care and treatment, tradition places him in a difficult situation between his mom and western treatment. Ramesh too is fearful that his family does not know about his condition, and would rather not conflict with their traditional methods of care and treatment. His reluctance to inform his family is causing the HIV to destroy his health further, even though he refuses to compromise his parents trust and care. Ramesh's situation is common in traditional Indian societies, where shame to the family will result in him and his family being ostracized in the community.

Suggested approaches include:

- Being culturally sensitive , and showing respect for the family's approach
- Spend time explaining the positives and negatives and as it relates to HIV/AIDS.
- Link the patient to HIV support groups
- Verify patients understanding and seriousness of their condition, and the importance to adhere to treatment
- Discuss the importance of gaining family support in the care and treatment process

- Talk with the patient and the family about the importance of care and treatment in addition to traditional methods being used
- Link patients to social services
- Enforcement of Confidentiality of the patients information among within the hospital structure
- Re-emphasize Trust in the health care system
- Show respect for traditional and cultural beliefs to care and treatment
- Help the patient maintain a sense of control

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Resources

Below is a list of resources that providers serving APIs can access to gain better understanding of the factors that influence their health seeking behaviors and enable them to provide services that are sensitive to their specific needs.

http://www.nmaetc.org

http://www.casanet.org/library/culture/culture-aware.htm

http://wiche.edu/MentalHealth/Cultural_Comp/ccslist.htm: Standards, guidelines and cultural competencies for managed behavioral health services for racial/ethnic populations

http://ncadi.samhsa.gov/govpubs/MS701/: Communicating Appropriately With Asian and Pacific Islander Audiences

http://www.apiahf.org/programs/hivcba/resources/facts/apiahf_hiv-fact2.pdf: Asian Americans and Pacific Islanders and HIV/AIDS

http://www.aids-ed.org/pdf/p02-et/et-09-00/nmaetc_AsianPacificIslander.pdf: Asian & Pacific Islander Americans Fact Sheet, NMAETC.

http://www.apiwellness.org/pdf/clinicianguide.pdf: Clinician's Guide To Working With Asians & Pacific Islanders Living With HIV

OTHER RESOURCES

Downer, G A. (2009). HIV in Communities of Color: The Compendium of Culturally Competent Promising Practices. National Minority AIDS Education and Training Center (NMAETC), Howard University College of Medicine

National Alliance of State & Territorial AIDS Directors (NASTAD). (2008). Breaking through the Silence: Key issues & Recommendations to Address HIV/AIDS among Asian Americans, Native Hawaiians, & Pacific Islanders in the United States. San Francisco, CA: Asian & Pacific Islander American Health Forum.

Lee, Z. (2005). HIV/AIDS among Asian & Pacific Islanders in Washington, Alaska, Montana, Idaho & Oregon: A Needs Assessment. North Western AIDS Education & Training Center (NWAETC).

Yu, D. (1999). Clinician's Guide to Working with Asians and Pacific Islanders Living with HIV. San Francisco, CA: Asians and Pacific Islanders Wellness Center.

Glossary

AIDS: Acquired Immunodeficiency Syndrome. This disorder is caused by the human immunodeficiency virus (HIV) type-1 or type-2.

API- the term **“**Asian & Pacific Islander” is used throughout this book to refer to a set of communities that include over 50 distinct ethnic subgroups and who speak more than 100 different languages and dialects.

Ayurvedic medicine- is a model that views health as a relationship between the universe and the body. Its aim is to integrate and balance the body, mind, and spirit. This is believed to help prevent illness and promote wellness. In Ayurvedic philosophy, people, their health, and the universe are all thought to be related.

CAM – Complementary and Alternative Medicine-are a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.

Coining, cupping – these are folk medicine practices commonly used by some Asian communities. In the cupping, a cup is attached to the skin surface to create a vacuum with the purpose of increasing heat and stimulate local blood flow to draw out fever or pain. Coining is the scrapping a coin over a sick individual’s body to treat headache, cold, vomiting, and other minor illnesses.

Cultural competence – “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.”

Culture – is a shared, learned, symbolic system of values, beliefs, communication, and attitudes that shapes and influences perceptions and behaviors that characterizes a social group, institution or organization.

Diaspora – a historical dispersion of a group of people deriving from similar origins (i.e. the Asian diaspora, the African diaspora, the Latino diaspora).

Dosha – the belief that illness occurs when forces in the body, are out of balance. Thus gaining balance of *dosha* is health. Taking on the sick role when one is not well and being stoic even in the face of pain

Filial Piety – refers to the moral obligation an individual feels towards their parents. It can cause individuals to hide or ignore their diagnosis and isolate themselves from their families.

Ho'oponopono – Specific to Hawaiian culture, it is a form of family counseling and conflict resolution therapy.

Karma – The belief that actions in past lives affect the circumstances in this life- so illness is caused by circumstances out of one's control; pain and illness are result of fate or god's will

Linguistic competence – refers to the ability to provide readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) speakers through such means as bilingual/ bicultural staff, trained medical interpreters, and qualified translators.

Mana – Is a life force or special power, and feeling that valuable tools or chiefs and warriors possessed mana. Illness and disease are regarded as the loss of, or imbalance of mana. Illness and disease mean a lack of internal balance and the objective of treatment is to restore spiritual, physical, and emotional balance.

Taoism – is the emphasis of balancing natural processes so the person is treated as a whole using methods like acupuncture, acupressure and herbs

Yin-Yang – The Chinese regard of health as a balance of positive (yang) and negative (yin) energy in the body. Yin-yang are opposing forces with yin being female, negative, cold and yang being male, positive and hot.

NMAETC
National Minority
AIDS Education and
Training Center

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For other information on other programs and offerings
please visit out website: http://www.NMAETC.org