BALANCE Program for Diabetes

Building Awareness
Locally And Nationally through
Community Empowerment

A COMPENDIUM

of Diabetes Self-Management and Prevention Strategies for Asian American and Pacific Islander Communities

AAPCHO | ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

ACKNOWLEDGEMENTS

We acknowledge the staff at each of the BALANCE Project Sites for their invaluable expertise, insight, dedication, and participation in the BALANCE Program for Diabetes.

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TABLE OF CONTENTS

Letter to the Readers 4

Diabetes and Asian Americans
and Pacific Islanders..............................5

The BALANCE Program
for Diabetes 7

Cultural Tailoring 8

CASE STUDIES

Asian Pacific Health Care Venture 10

Charles B. Wang Community
Health Center, Inc. 15

Family Health Center
of Worcester, Inc. 21

Kalihi-Palama Health Center 25

South Cove Community
Health Center.......................................31

Dear Reader:

As many of you already know, diabetes is a serious and costly epidemic affecting millions of people in the United States. Among the Asian American and Pacific Islander (AAPI) community, the disease's impact has been no less severe.

The Association of Asian Pacific Community Health Organizations (AAPCHO) has addressed the problem of diabetes among medically disenfranchised AAPIs through its national Building Awareness Locally and Nationally through Community Empowement (BALANCE) Program.

The BALANCE program, which is implemented through community health centers serving primarily uninsured and limited English proficient AAPIs, has helped scores of individuals learn about the seriousness of diabetes and ensured that AAPIs living with diabetes have the necessary knowledge and skills to manage the disease.

The success of these programs is largely rooted in each center's ability to develop education and outreach strategies that were culturally and linguistically appropriate, respectful, and sensitive to each individual AAPI community's culture.

AAPCHO developed this compendium as a vehicle in which to share some of these strategies. It is our hope that organizations interested in developing diabetes interventions for AAPIs will look to this guide as a resource, and view these case studies as a starting point through which to develop their own diabetes programs.

Sincerely,

Jeffrey B. Caballero, MPH
Executive Director

DIABETES AND ASIAN AMERICANS AND PACIFIC ISLANDERS

National statistics show that diabetes is the sixth leading cause of death in America, causing serious complications such as cardiovascular disease, blindness, kidney disease, and lower limb amputations. More than 18 million Americans have the disease. Diabetes in the United States has increased 61% since 1991 and is projected to double by 2050. [1]

Though research examining the impact of diabetes on Asian Americans and Pacific Islanders (AAPIs) is limited, local community studies and surveys indicate that AAPIs, such as Asian Indians, Chinese, Filipinos, Japanese, Marshallese, Native Hawaiians and Samoans, are affected at higher rates by this condition and its debilitating long-term complications than non-Hispanic whites, and their rates are significantly increasing. The prevalence of diabetes among AAPIs is estimated to be higher than that of U.S. whites, and higher than Asians in their native countries. Approximately 10% of AAPIs are diagnosed with diabetes, about 1.7 times higher than the general U.S. population (5.9%). [2]

- Rates are significantly higher in AAPI immigrant populations in the U.S. compared with rates in their native countries. [3]
- Prevalence rate for type 2 diabetes is two to three times higher among Japanese Americans in Seattle compared to non-Hispanic whites. [4]
- In the Republic of the Marshall Islands, 30% of the population over 15 years of age is living with diabetes. [5]

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[1] Centers for Disease Control and Prevention. Diabetes: Disabling, Deadly, and on the Rise 2003. CDC At-A-Glance. Atlanta: Centers for Disease Control and Prevention; 2003.

[2] Centers for Disease Control and Prevention. Health Alert: Healthier Lifestyle Can Prevent or Delay Diabetes in Children: www.cdc.gov/youthcampaign/pressroom; 2002.

[3] Carter JS, Pugh JA, Monterrosa A. Non-insulin dependent diabetes mellitus in minorities in the United States. Ann Intern Med 1996;125(3):221-32.

[4] Fujimoto, W. Diabetes in Asian and Pacific Islander Americans. In: National Institutes of Health.

[5] Feasley, J. & Lawrence, R. Pacific Partnerships for Health: Charting a Course for the 21st Century. National Academy Press, Washington, D.C., 1998.

- Age-adjusted type 2 diabetes prevalence is up to four times higher in Native Hawaiians than among non-Hispanic whites. [6]

Community surveys also indicate that information regarding the seriousness of the disease, risk factors associated with diabetes and prevention strategies, is not reaching AAPI communities, while persistent challenges ranging from poverty to lack of culturally and linguistically appropriate services, are preventing AAPIs from receiving adequate diabetes care.

The AAPI population in the United States is growing rapidly. According to the U.S. Bureau of the Census, from 1990-2000 the Asian population in the U.S. increased by 48%, while the Native Hawaiian and Pacific Islander population increased by 9%. The AAPI population is also extremely diverse and consists of at least 49 ethnic groups that speak over 100 different languages and dialects. The history and experiences and cultures of this community, among AAPIs born here and outside of the U.S., are equally diverse.

The most successful and effective diabetes interventions for AAPIs, are those interventions that acknowledge this diversity and are culturally and linguistically appropriate for the AAPI community it was created to serve. Diabetes intervention strategies, whether they include health education material or community outreach, are most effective if they are respectful of the AAPI ethnic group's culture and language.

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[6] Grandinetti, A., Mau, M., Curb, J., Kinney, E., Sagum, R., & Arakaki, R. Prevalence of glucose intolerance among Native Hawaiians in two rural communities. Diabetes Care 1998; 21:549-554.

THE BALANCE PROGRAM FOR DIABETES

The Building Awareness Locally and Nationally for Community Empowerment (BALANCE) Program for Diabetes was launched in 1999 by the Association of Asian Pacific Community Health Organizations (AAPCHO) with funding from the Centers for Disease Control and Prevention. The BALANCE Program for Diabetes was created to improve the positive outcomes of AAPIs living with diabetes, improve the understanding of diabetes in AAPI communities, improve health care providers' ability to provide culturally and linguistically appropriate services, and to increase the knowledge of policymakers and payers of health care of the impact of diabetes on AAPIs.

Between 2002 and 2004, five community health centers (project sites) across the country partnered with the BALANCE Program for Diabetes in the following AAPI communities:

- Asian Pacific Health Care Venture, Inc. (Los Angeles, CA) – Filipino and Thai
- Charles B. Wang Community Health Center (New York, NY) – Chinese
- Family Health Center (Worcester, MA) – Cambodian and Vietnamese
- Kalihi Palama Health Center (Honolulu, HI) – Chuukese and Filipino
- South Cove Community Health Center (Boston, MA) – Chinese

AAPCHO staff worked with each community health center to strengthen its capacity in the following areas: partnerships, community outreach and education, diabetes self-management and prevention education and evaluation.

Each of these community health centers has a long history of providing comprehensive health care services to lower income and uninsured patients. Project site activities were tailored based on their organizational and staffing capacities, as well as the community served. All project sites conducted activities that were culturally and linguistically appropriate to ensure that interventions would ultimately reach AAPI communities. Each project site conducted its activities with the overall goal of increasing its target population's awareness of diabetes, prevention and self-management strategies.

AAPCHO staff also worked extensively with project sites to establish baseline data collection instruments and methods that would allow the sites to determine if an intervention was adequate and effective.

CULTURAL TAILORING

Due to the diversity of the AAPI population, it was apparent that a single model of intervention for diabetes education, outreach and management, would be ineffective if applied to all BALANCE project sites. Therefore, staff worked with each project site to individually develop programs that would more adequately meet the needs of each AAPI population. Though project site programs differed widely, they all shared common themes: (1) incorporating culturally and linguistically appropriate materials and interventions; (2) outreach with bilingual/bicultural health outreach workers; and (3) partnerships with key individuals/organizations in the AAPI community. These common patterns represented key elements contributing to the success of each project site's diabetes efforts.

Integrating cultural aspects of each specific AAPI group was critical to ensuring that the program's messages regarding prevention and self-management were understood and well-received. For instance, many sites translated necessary education materials and conducted diabetes workshops strictly in the language spoken by their target audiences. This type of cultural tailoring enabled sites to communicate program messages effectively among AAPIs who were monolingual or limited English proficient. In other instances, using outreach workers familiar with the audience's culture and language was also very important to sites' outreach efforts. For some project sites, bilingual/bicultural health outreach workers were critical in building trust with community members and were vital to the recruitment of participants for diabetes education activities.

BALANCE Program project sites also developed partnerships with community organizations, media sources and community leaders to increase the community's awareness of diabetes in AAPI communites. For instance some project sites collaborated closely with local ethnic media outlets. Through radio programs, press releases, and the dissemination of health education messages in the audience's native language, the project sites reached an even larger audience than originally anticipated. This type of outreach encouraged community members to visit their health care provider and participate in diabetes education workshops.

Although all project sites had unique challenges and differences in carrying out their program activities, each site tailored their interventions to meet the needs of the community they served, not only through the translation of diabetes materials, but through multi-faceted approaches that involved forging critical partnerships with the AAPI community as a whole.

CASE STUDIES

Asian Pacific Health Care Venture 10

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Family Health Center of Worcester, Inc. 21

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South Cove Community Health Center.. 31

ASIAN PACIFIC HEALTH CARE VENTURE

BY JOCELYN ESTIANDAN

Asian Pacific Health Care Venture, Inc. (APHCV) was founded in 1986 by providers concerned about the lack of bilingual and bicultural primary health care services for the growing Asian American and Pacific Islander (AAPI) community in Los Angeles. The mission of APHCV is to advocate for and provide quality health care services in a culturally competent manner. The organization offers its services with a strong focus on low-income families and underserved Asians and Pacific Islanders and health education and community economic development programs. APHCV's services currently include prenatal, pediatric, adolescent, adult, and geriatric care, family planning, as well as HIV testing and counseling.

APHCV provides bilingual and bicultural health care for appointments, clinical language translation and interpretation, health education, and follow up. APHCV offers linguistic and cultural care and outreach in many AAPI languages – Chinese, Ilocano, Japanese, Korean, Lao, Thai, Vietnamese, Khmer (Cambodian), Tagalog, and Tongan. These services are also offered in Spanish.

Through these programs, APHCV has forged working relationships with community leaders, local businesses, churches, temples, schools, media, and other community based organizations within AAPI communities across Los Angeles. APHCV's philosophy is that health care is a right, not a privilege. With this fundamental belief, APHCV continues to deliver holistic, quality, and effective primary health care services that meets its communities' needs.

LIFESTYLE EDUCATION ABOUT DIABETES (LEAD) PROJECT

APHCV's Lifestyle Education About Diabetes (LEAD) Project goal is to improve the quality of life among AAPIs who are at-risk or living with diabetes via lifestyle education on preventive measures and self-management strategies. The LEAD program sought to increase awareness and understanding of diabetes, including recognition of symptoms and associated risk factors and preventive measures developed by the National Diabetes Education Program (NDEP) and the BALANCE Program. LEAD also provided culturally and linguistically sensitive education through diabetes self-management classes that aimed to reduce com-

plications associated with the disease. Lastly, LEAD focused on developing and establishing partnerships with diabetes control entities for collaboration, resource sharing, and information exchange.

The LEAD staff consisted of a project director, coordinator, and three health educators, one of whom was a registered nurse. The project director and coordinator were in charge of the supervision, implementation, and evaluation of project goals and objectives. The registered nurse used her medical background to explain the curriculum and train other health educators. She also utilized APHCV staff members that were fluent in Thai and Filipino languages and skilled in the cultural tailoring of health education, when implementing the diabetes curriculum.

APHCV's two class curriculums, one for Filipino and one for Thai clients, were adapted from the National Diabetes Education Program's "7 Principles for

THE LACK OF LANGUAGE AND CULTURAL BARRIERS PROVIDED A MORE RELAXING AND INTERACTIVE LEARNING ENVIRONMENT.

Controlling Your Diabetes for Life!" brochure. APHCV created "6 Steps to Control Your Diabetes for Life" which were: 1) healthy diet, 2) regular exercise, 3) taking medicine correctly, 4) regular medical visits, 5) regular glucose testing, and 6) daily foot care. Each class was taught using various aids and PowerPoint presentations, and an oral quiz was conducted after the lecture to help emphasize the main points. Participants received a copy of the lecture, a blood glucose record keeper and flyers on hyper- and hypoglycemia, as well as a goody bag full of diabetic-friendly snacks, supplies, and pamphlets of information.

In both classes, participants expressed a specific interest in nutrition, with many inquiring about how much they could eat since they believed having diabetes required you to eat less. They were told that the quantity of food they consumed was not as important as the types of food they ate and how frequently they ate them. Some participants had two meals a day, and often with plenty of rice. Instead, educators recommended participants eat three meals a day with healthy snacks between each meal. Participants were also informed of the importance of portion size, especially for rice given

An outreach worker in Thai Town gets the contact information of a woman interested in learning more about diabetes control and management.

its high amount of carbohydrates. Educators also addressed participants' concerns about appropriate blood sugar levels. The health educators went over the symptoms of hyper- and hypoglycemia and recommended participants check their blood sugar levels often, or as prescribed by their doctor. Participants later informed health educators that the most helpful information they received was regarding nutrition. Since much of mainstream diabetes education is based on typical "American" diet standards, participants felt it was relevant to receive nutritional information on Asian foods. For example, educators instructed Filipinos and Thais to limit their use of fish sauce when cooking and to eat smaller servings of rice during meals.

Outreach workers were critical in providing and promoting diabetes education through the LEAD program. APHCV's outreach program differed from mainstream diabetes programs in that the interaction between outreach workers and community members was one-on-one and personalized. Outreach workers were of the same ethnic background as the population they served; therefore patients could culturally identify with staff and felt comfortable discussing their concerns and providing feedback. The lack of language and cultural barriers provided a more relaxing and interactive learning environment.

To date, over 960 AAPIs were educated about diabetes at one-to-one outreach venues including Filipino, Cambodian, Thai, and Vietnamese eth-

nic restaurants, newspaper offices, bookstores, beauty salons, supermarkets, video rental stores, employment agencies, preschools, temples, and churches. In most settings the outreach workers approached community members leaving the store premises, although sometimes outreach workers interacted with patrons on-site as they were waiting in line. At schools, where staff was familiar with APHCV, outreach workers approached mothers who were waiting to pick up their children. In the cases of beauty salons and newspaper offices, outreach workers interacted with employees, especially during breaks or when salon workers were waiting for clients. At a typical outreach site, the outreach workers explained APHCV's mission and objectives, discussed an individual's needs, provided health information and materials, and most importantly, referred them to the appropriate services. Outreach workers that were well known in the community were allowed to conduct more formal presentations in large group settings such as religious congregations or ethnic community organization meetings.

APHCV extended its outreach efforts to various community events such as the Festival of Philippine Arts and Culture, the LA County Commission on Aging Senior Health Festival, the Thai Traditional New Year Festival and the AAPI Lotus Festival. Over 103 AAPIs scheduled medical appointments at APHCV as a result of these activities. On average, APHCV outreached to 100 sites per month with five outreach workers. Outreach workers typically stayed at each venue from 20 minutes to 2.5 hours, depending on the number of people present and questions asked. Outreach workers kept a log of names and demographic data for individuals they interacted with.

The most difficult challenge for most outreach workers was approaching a venue for the first time. All outreach workers acquainted themselves with the owner or shopkeeper to gain that individual's trust and develop a working relationship. Some outreach workers initiated contact as a customer eating at the restaurant or shopping at the store. As the owner became familiar with the outreach worker and APHCV, they felt more comfortable allowing that individual to interact with their customers and employees. Some successful outreach workers have built such strong relationships with these businesses that many owners referred their friends and family to the outreach workers and APHCV.

FUTURE PLANS

Through a grant with Kaiser Permanente, APHCV will expand its Project LEAD activities. The funds will sustain the center's self-management classes, and extend its case management, community outreach, and education efforts.

APHCV will also continue its work with the California Primary Care Association's Quality Improvement Collaborative for diabetes. The electronic diabetes registry allows APHCV to track patients' clinical measures such as HbA1c levels, and track class participants' progress.

LESSONS LEARNED

- **Incorporate ethnic-specific foods into nutrition discussion** – When discussing nutrition, incorporate the types of foods that are consumed by the community you are working with.
- **Utilize the expertise of community outreach workers** – The cultural and linguistic fluency of outreach workers enables them to effectively engage community members.
- **Build trust via community business partnerships** – Outreach workers must develop relationships with ethnic business owners to make deeper and lasting connections with the AAPI community.

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CHARLES B. WANG COMMUNITY HEALTH CENTER, INC.

BY BRENDA WAN

Charles B. Wang Community Health Center (CBWCHC) is a non-profit community based health care facility established in 1971 to provide health care services to New York City AAPI communities. The center emphasizes health promotion and disease prevention with health education and advocacy for increased access to health care services. CBWCHC seeks to provide access to quality and culturally sensitive health care and health education services as well as advocate on behalf of the AAPI communities who face cultural, language, educational or financial barriers in accessing basic health care services.

In addition to bicultural and bilingual clinical services, the center seeks to recruit and train future Asian-American health care workers, develop their understanding of Asian community needs and problems, and encourage an interest in community involvement upon completion of their training. As a result of these efforts, CBWCHC has nurtured a generation of health, social services and other professionals for community service through their unique training and internship programs. Many of these graduates now work in Asian American community based organizations throughout the country, further spreading the impact of those volunteers who first came together in 1971 to create CBWCHC.

CHINESE-AMERICAN DIABETES EDUCATION AND AWARENESS CAMPAIGN

CBWCHC created the Chinese-American Diabetes Education and Awareness Campaign to increase diabetes knowledge and awareness among New York City's Chinese American community. The overall program focused on education, early detection and diagnosis, and diabetes self-management. A major component of the program included community awareness, which involved ethnic specific media and outreach activities aimed at increasing public awareness of diabetes and emphasizing the importance of early detection and intervention to prevent and delay diabetes complications. In addition, CBWCHC provided diabetes management workshops to improve diabetes knowledge and self-management among patients and family members.

Outreach workers administer the Diabetes Awareness Quiz at local community fairs.

When staffing this program, CBWCHC ensured that the program team was bilingual and bi-cultural, and therefore cognizant of the AAPI cultural beliefs and barriers to diabetes management. The program team members included a health educator, nutritionist, and other support staff such as an outreach specialist, program assistants and volunteers. Each staff member is fluent in different Chinese dialects to accommodate the diverse Chinese populations in the area. In addition, CBWCHC partnered with a registered nurse from NYU Downtown Hospital Chinese Community Partnership for Health, who had an extensive background in patient education and interactive teaching methods, to help motivate workshop participants to make lifestyle changes necessary for diabetes management.

COMMUNITY AWARENESS CAMPAIGN

When developing its Community Awareness Campaign, CBWCHC knew that the success of its media outreach strategy was dependent on its knowledge of its target population. For instance, CBWCHC was well aware that newer immigrants not proficient in English face social, economic, and language barriers when accessing diabetes education through mainstream channels, such as websites, magazines, the internet, and health fairs. To counter these barriers, the health center conducted mass media awareness campaigns via ethnic, in-language media outlets. CBWCHC made this decision knowing that many limited English proficient Chinese Americans are literate in Chinese and that in-language newspapers served as their primary source of information.

Media is considered the most widely used means in which Chinese immigrants obtain health information. Chinese newspapers are widely sold at newsstands, supermarkets, bakeries, and other businesses located in areas with highly concentrated Chinese populations. Through its previous work with local media, CBWCHC found that Chinese newspaper reporters had a strong interest in health issues. With that in mind, staff invited journalists responsible for covering heath issues to attend various events. The resulting print articles provided publicity for CBWCHC's workshops and lectures, and promoted various health events, such as the program's diabetes management workshops and health fairs. According to the center's Diabetes HealthLine, a phone line providing information on diabetes and related services, 76% of callers learned about diabetes workshops through newspaper articles. (The phone line was promoted through media, health education materials and flyers.) In addition these stories, which provided information on the overall content of CBWCHC's workshops, informed readers of important diabetes self-management and prevention information.

In order to reach an even broader audience, CBWCHC also deployed a media outreach strategy targeted at radio listeners. The health center, in partnership with local radio stations, developed an in-language program featuring a Chinese physician. During the program, listeners could call-in and get their diabetes-related questions answered by a health care professional who spoke their language. This format enabled radio audiences with diverse age, educational and occupational backgrounds to listen and conveniently obtain medical information while keeping their daily routine.

CBWCHC also utilized health fairs to conduct its community outreach. One activity the center found to be successful was its Diabetes Awareness Quiz. The quiz, which was also administered at health fairs, represented a fun and interactive way that participants could learn about diabetes. The center found this method to be more effective than distributing diabetes brochures. Participants were recruited randomly on-site by inviting them to play a "quiz game" with a promise of prizes at the end. Through the quiz, many participants learned for the first time that AAPIs were at a higher risk for type 2 diabetes. Participants also became familiar with some of the common myths associated with the disease such as "People have diabetes because they eat too much sugar," and "Only the elderly have diabetes". Moreover, program staff also became aware of education gaps that existed for community members, such as the lack of diabetes information and services that actually exist for the community. For the two-year project, 261 Diabetes Awareness quizzes were administered at six outreach activities.

Despite the clear success of the interactive "quiz game", CBWCHC was challenged by the different responses from participants, given the varying levels of understanding and interest in diabetes as a serious health issue. In addition, staff manning the health fair booth found it difficult to obtain valid and complete surveys from community members, both due to hot summer weather, and competing attractions/health fair events, such as loud music, gift giveaways at different booths, as well as other health and social interests. The most challenging aspect of the project was the phone follow-up staff conducted for the post-event questionnaire. The questionnaire gauged whether participants retained the knowledge they obtained from the health fair, or if their knowledge improved after reading the educational material they received. Staff often found that many of the target participants were not at home. (The project staff stopped calling after 3 attempts on different days, especially on the weekend.) However, it was rewarding when staff reached participants and discovered they had increased or retained their

MEDIA IS CONSIDERED THE MOST WIDELY USED MEANS IN WHICH CHINESE IMMIGRANTS OBTAIN HEALTH INFORMATION.

diabetes knowledge, were happy to learn more about the disease and recognized CBWCHC as a venue through which they could participate in other health education activities. Additionally, staff learned through these calls that participants wanted more educational workshops, including a class in Mandarin.

DIABETES SELF-MANAGEMENT CLASSES

CBWCHC's diabetes self-management classes represented the second tier of its education and awareness campaign. Each session was facilitated by a program staff member and often included a health care specialist as a guest speaker. The weekend morning classes, which were conducted primarily in Cantonese, were divided into two sessions that were held one month apart from one another. This scheduling strategy enabled the 15 participants (and family members) to review the education materials from the first session and then implement what they learned to manage their diabetes shortly thereafter. The second class focused on nutrition and addressing participants'

questions. Though the classes were scheduled for approximately two hours, participants often stayed beyond that time period to address additional concerns and questions with program staff.

The goal of these classes was to provide education and self-management techniques for patients, family members, and friends. The program's health care specialist used PowerPoint slides and discussed the symptoms and complications of diabetes as well as the importance of adopting a healthy diet and engaging in physical activity. Participants identified proper diet and regular exercise most frequently as concerns in diabetes self-management. Food models, measuring cups and spoons, and practical Chinese diabetes food recipes were also utilized in the class. The specialist also recommended forms of physical activity that participants could easily incorporate into their daily lives, such as walking and indoor stretching.

The well-attended classes reflected a strong desire on behalf of patients and family members to learn about diabetes self-management. CBWCHC believes that culturally relevant, interactive educational classes conducted by bilingual professionals have been extremely effective. People who registered for the workshops were very involved through their participation and eagerness to learn new tools.

LESSONS LEARNED

- **Know the demographics of your participants** - It is important to identify key characteristics of participants, such as: socio-economic status, immigration history, education level, health literacy level and support systems to tailor classes and materials to meet their needs.
  - i.e. – A Cantonese-speaking group may exhibit different characteristics, such as diet and communication styles, from a Mandarin-speaking group in another part of the city. Therefore classes may be specifically tailored by dialect.
  - Individuals with low health literacy or educational levels may require simple instructions on what to eat and not to eat, while other community members may be able to comprehend instructions regarding serving sizes, as well as a scientific discussion on diabetes as a chronic disease.
- **Build multi-level partnerships with media and the community** - It is crucial to build relationships with local partners, such as community based organizations, media outlets, and consumers. They can stimulate creative ideas to approaching and educating community members. Recruitment of community volunteers is also helpful to build your program's manpower.

- i.e. – Partnerships with different community based organizations helped diversify CBWCHC's health fair locations, as well as target age groups, and health topic areas.
- Media, including newspapers and radio programs, helped widely distribute diabetes knowledge and announced the schedule of upcoming educational activities.

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FAMILY HEALTH CENTER OF WORCESTER, INC.

BY TAM LE

Family Health Center of Worcester (FHC), founded in 1970, is situated in the densely populated and predominantly low-income community of Worcester, and is one of the largest medically underserved areas in central Massachusetts. A large percentage of FHC's more than 16,000 patients are recently arrived refugees, public assistance recipients, uninsured working families, and homeless persons.

FHC provides bilingual/bicultural services to individuals and families through the "family practice" model of care, which ensures continuity of care for both adults and children. At FHC, the traditional idea of "the family doctor" has evolved with 21st century medical practice and responded to the diversity of American culture. In addition to providing quality primary care, FHC also offers dental care, an on site pharmacy, and a wide range of support services on mental health, HIV, hepatitis B and C, tuberculosis, substance abuse, teen pregnancy and infant mortality prevention. FHC also operates school-based health centers at 4 schools to provide further outreach to clients. FHC provides services to its diverse patient base in English, Spanish, Vietnamese, Chinese, Albanian, Cambodian, Portuguese, and African dialects.

SOUTHEAST ASIAN HEALTH PROGRAM

FHC's diabetes program, which was implemented through the center's Southeast Asian Health Program (SEAHP), was designed overall to improve patient understanding of diabetes and positive outcomes with respect to the disease.

The program targeted Worcester's Southeast Asian community, most of which are refugees from formerly war torn countries. Many of these individuals, upon coming to the U.S., discovered that they had settled into a society that was culturally very different from their own. Currently, community members are still unfamiliar with the public health care system, uncomfortable attending conventional meetings, and are even shameful of going to clinics.

With this in mind, SEAHP created a program that was led by a Vietnamese and Cambodian bilingual, bicultural health educator; individuals that were

not only fluent in the languages spoken by the community, but familiar with cultural nuances. The primary responsibility of the health educators was to provide outreach and in-language diabetes education to 80-100 clients per quarter. Through the program, the educators set out to accomplish a number of specific goals: to increase diabetes awareness and knowledge among Vietnamese and Cambodians; to help patients living with diabetes acquire self-management skills; and to promote diabetes prevention through physical activity and healthy eating.

HEALTH EDUCATION: HOUSE PARTY

A critical component of SEAHP's diabetes education efforts was its "house parties", an innovative and culturally relevant method developed by the center to conduct targeted community outreach.

Through the center's house parties, Vietnamese and Cambodian community members could learn about diabetes in an informal setting.

House parties, which were conducted in Vietnamese and Khmer by SEAHP health educators, were social gatherings held in a community member's

HOUSE PARTIES WERE ALSO AN EFFECTIVE METHOD OF OUTREACH SINCE HEALTH-RELATED INFORMATION IS OFTEN SPREAD BY WORD OF MOUTH.

home and attended by 3-6 of the host's family members and/or friends. The parties usually occurred on the weekends or in the evening to accommodate participants' schedules, and lasted from one to two hours. Food and drink were always provided for participants.

Each house party was organized through an SEAHP educator who, through his/her consistent contact with community members, either responds to a request to lead a session at a client's home, or asks a client to host an education session. After this request is made, the host invites family members and friends to attend the party.

During these in-language sessions, some of which were conducted with the Worcester Senior Center and the Massachusetts College of Pharmacy, participants received information about the nature of diabetes, symptoms and

Vietnamese senior citizens participate in a FHC physical exercise session held in local collaboration with the Worcester Senior Center.

consequences, early detection methods such as blood sugar screenings, as well as prevention strategies such as diet and physical activity. Participants, through videos and flip charts, learned that they could also effectively manage diabetes by visiting the doctor, receiving foot and eye exams, and taking medication if necessary. Staff also demonstrated how to use glucometers and pedometers.

To evaluate the effectiveness of each session, the health educator administered a pre-test questionnaire on diabetes prior to the presentation, and an identical post-test following the presentation. Staff noted an overall increase of 35% in diabetes self-management knowledge from pre-test to post-test.

SEAHP held 30 house parties for 115 Cambodian clients, and 55 house parties for 225 Vietnamese clients.

This type of outreach was culturally appropriate since informal gatherings of this nature occurred regularly among community members' family and friends. In the Cambodian community in particular, women felt uneasy inviting strangers into their homes to discuss topics related to the body. However, because these sessions were attended by a small number of friends and family members, participants were more comfortable engaging in candid dialogue. House parties were also an effective method of outreach since health-related information is often spread by word of mouth in these two communities. The house parties overall were a familiar and comfortable setting in which family and friends could gather to share food and information.

The house party format, despite its effectiveness, presented SEAHP educators with its own set of challenges. For one, concurrent house parties were

difficult to manage between two health educators. Second, house parties held during the winter season, when subzero temperatures are common, made travel difficult for participants and resulted in session cancellations. Thirdly, educators found that transportation, both in cost and availability, were huge considerations influencing a participant's decision to attend a session. Though these challenges were often daunting, SEAHP educators were personally rewarded in knowing that each house party increased participants' knowledge about diabetes. Moreover, the program allowed educators to continue to build strong relationships with local Southeast Asians, and increase community members' level of trust in the program.

FUTURE PLANS

SEAHP looks forward to continued collaboration with the Massachusetts Statewide Comprehensive Diabetes Control and Prevention Task Force. SEAHP hopes this partnership will help the program sustain its diabetes program. The program will also continue its partnership with BALANCE to distribute diabetes education materials.

LESSONS LEARNED

- **Develop trust and strong relationships with the community** – Aside from addressing health issues, a health educator builds trust with community members in such a way that the community becomes more receptive to health education. The health educator often demonstrates a willingness to listen to an individual's concerns, and a desire to ensure that the individual's needs are being met by a particular program or service.
- **Utilize and build community networks** – FHC's ability to find community members that were willing to open up their homes to health educators, stemmed from the center's ability to establish relationships and networks of patients, family members, and trusted community leaders.
- **Develop partnerships with other local health organizations** - Partnering with other organizations helped the center build a social support network, and allowed other health care professionals to build critical relationships with community members.

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KALIHI-PALAMA HEALTH CENTER

BY CRISTINA VOCALAN AND ANNE LEAKE

Kalihi-Palama Health Center (KPHC), a community health center located in urban Honolulu, Hawaii, primarily serves the community of Kalihi-Palama, a low-income community designated as a medical and dental Health Personnel Shortage Area (HPSA) and a medically underserved population (MUP). The mission of KPHC is to provide quality, integrated health services to the community and all others in need of healthcare. The community health center's focus is to provide preventive and primary health care in a respectful, caring and culturally sensitive environment.

In 1975, Reverend Richard Wong and other concerned community members recognized an urgent need for quality medical services among Kalihi-Palama residents. In response to the community's concerns, Hale Ho`ola Hou (House of Life) opened that year at Kaumakapili Church to provide medical services to the poor, elderly, homeless, and newly arrived immigrants in Kalihi-Palama and the surrounding community. In 1994, the health center moved to a larger and more modern facility to accommodate its community's increasing needs.

Today, KPHC offers comprehensive services in adult and pediatric primary care, family planning, health education, dental and optometry services, behavioral health, and case management. KPHC also provides women, infant and children (WIC) programs that offer breastfeeding and nutrition counseling and serves the homeless population through its Healthcare for the Homeless Project. KPHC offers its bilingual and bicultural services in Mandarin, Cantonese, Ilocano, Tagalog, Chuukese, Marshallese, Pohnpeian, Korean, Laotian, Samoan, Spanish, and Vietnamese to accommodate its extremely diverse patient population.

DIABETES IN HAWAII: FILIPINOS AND CHUUKESE

KPHC focused its diabetes project on two important populations served by the health center: Filipinos and Chuukese. For Filipinos in Hawaii, the prevalence of diabetes is significantly higher than the national average.[1] Filipinos

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[1] National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System. http://www.cdc.gov/brfss/
Hawaii State Department of Health, Community Health Division, Chronic Disease Management and Control Branch, Diabetes Prevention and Control Program, Hawaii Diabetes Report 2004.

at KPHC account for 23% of the patient population. Filipinos are the third largest AAPI population in Hawaii, behind Japanese Americans and Native Hawaiians, and the fastest growing ethnic minority in the state.[2]

In the past few years, KPHC recognized a large influx of migrants from the Federated States of Micronesia coming to Hawaii and the health center. Specifically, the numbers of Chuukese migrants from Micronesia seeking care at the health center have grown rapidly. Many of the Chuukese go to KPHC seeking better diabetes care and management. Even though the prevalence of diabetes among Hawaii's Chuukese community has been difficult to obtain, KPHC, in everyday clinical practice, recognizes this as a group requiring a more focused diabetes intervention.

The growing needs of the Filipinos and Chuukese and the dearth of in-language diabetes programs for these two groups prompted KPHC to focus on diabetes awareness and education. Specifically, the project sought to increase diabetes awareness and improve diabetes knowledge, attitudes and beliefs through culturally appropriate materials and interventions.

IN-LANGUAGE DIABETES SELF MANAGEMENT EDUCATION CLASSES

KPHC held in-language diabetes self-management classes in Tagalog (Filipino), Ilocano (Filipino), and Chuukese. Staffing program activities with educators knowledgeable in the cultures and fluent in the languages and dialects spoken was vital to the success of the program. These bilingual and bicultural educators were a necessary component to the program as many participants did not speak English or felt uncomfortable doing so.

In order to effectively reach its participants, KPHC specifically tailored classes and activities to the needs and learning styles of each community. For the Filipino classes, KPHC called on either a Tagalog or Ilocano speaker to teach the class in tandem with a registered nurse. The Filipino classes focused on the individual's active role in self-managing and controlling his/her diabetes within the supportive network of family. KPHC noted that many Filipinos in the area lived in multigenerational households or had loved ones actively involved in their care; therefore it was important to discuss the role of family in the class. In fact, a significant number of participants attended the classes with their spouse or their adult children.

The classes were highly interactive and strongly encouraged group participation. Each class was held on Saturday mornings for three hours, serving

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[2] University of Hawaii at Manoa, Center for Philippine Studies. http://www.hawaii.edu/cps/fill-community.html

Class participants show their goodie bags as gifts for completing the session.

both as a review of diabetes and as an empowerment session. There was great interest and enthusiasm demonstrated by class participants. At each class, facilitators also administered a pre-test and post-test on diabetes knowledge and self-management as an internal evaluation tool to measure diabetes knowledge of participants before taking the class and knowledge gained by participants at the end of the class. Some participants returned more than once to review the diabetes information, while others returned to review their post-test scores, even though the tests were for internal evaluation purposes only. Participants also expressed their interest in additional diabetes sessions, which led to the formation of a diabetes support group at KPHC called HodgePodge.

The second series of diabetes self-management classes, for Chuukese participants, was less structured than the Filipino classes and served as a "talk story" session about diabetes. "Talk story" is a cultural practice of Pacific Islanders, in particular Native Hawaiians, where people informally converse with one another and share stories, ideas, and more personal information about themselves. It was in these group sessions that a Micronesian community outreach worker fluent in Chuukese, created a comfortable environment that encouraged the approximately 10 participants to discuss issues such as diabetes control and self-management. Although this was a small, less structured setting, it was an appropriate way to teach diabetes self-management given the group-oriented nature of the culture. Seating was arranged in a circle with a table placed in the center of this formation. The outreach worker noted that some Chuukese participants found an open circle intimidating,

therefore a table was placed in the middle to fill in the center. In addition, the outreach worker recognized that the Chuukese felt most comfortable when everyone sat as equals without a designated "head" of the table. In order to not single out any one Chuukese participant, educators avoided extended eye contact with individuals when soliciting responses from the group. Educators were also sensitive in their teaching styles and avoided standing and lecturing, as a teacher would with students. Moreover, staff found that many Chuukese participants were uncomfortable discussing private matters involving their bodies with members of the opposite sex. Therefore, staff found it more culturally appropriate to divide men and women into two separate groups, or by couples, when discussing diabetes education.

The content for most classes, which were held in Chuukese, was determined by participants' interests as well as through questions that arose during class. Formal presentations were rarely utilized during classes. Each session allowed participants to ask personal questions and fostered a relaxed environment where myths about diabetes were dispelled. Chuukese patients openly

THE FOCUS IS TO PROVIDE PREVENTIVE AND PRIMARY HEALTH CARE IN A RESPECTFUL, CARING AND CULTURALLY SENSITIVE ENVIRONMENT.

shared their thoughts on diabetes, and enthusiastically discussed their diets with other participants. A registered nurse was present throughout the session to answer additional questions.

As a result of these classes, KPHC noticed that more members of the Chuukese community were involved in health center activities. Members of both the Chuukese and Filipino communities currently participate in HodgePodge, the ongoing diabetes support group for health center patients. The outreach worker begins each session with an introduction of participants, and with an ice breaker-type of game such as Simon Says, musical chairs, and dancing. A dietitian attends these sessions to provide both diabetes education and tips on diabetes control. Other class topics involved heart disease and stroke, as well as information on kidney disease. At the end of the meeting, participants are asked what they learned, and if they would recom-

mend the sessions to others. Many Chuukese patients found that attending HodgePodge gave them hope, since many participants were unaware of the steps they could take toward diabetes control and self-management; they assumed that diabetes led to inevitable amputations. The Chuukese patients also recognized the importance of eating vegetables and fruit. Incorporating these types of foods into their meals required a significant adjustment for some participants since a typical Chuukese diet often consisted of meat and foods high in starches such as potatoes, taro, and rice. Additionally, exercise was also demystified. Prior to the sessions, walking was not perceived as a form of exercise by Chuukese patients. HodgePodge has successfully given the Chuukese and Filipino participants diabetes knowledge and self-management skills, as well as an opportunity to give and receive support while living with diabetes.

The success of the classes for both Filipino and Chuukese communities was due in large part to KPHC's recognition that community members want to learn, and will effectively do so when they are in a learning environment that is comfortable and supportive. Though it had its share of successes, one of the challenges of the program was sustainability; an issue that staff members believed could be addressed through cross-training staff in the event of staff turnover, as well as through the development of strategic partnerships, and capitalizing on development opportunities.

MEDIA

The major media activity for the program was the development of a diabetes Public Service Annoucement (PSA) in "Taglish" (Tagalog and English). The public service announcement which featured a Filipino family and a registered nurse, aired daily during Filipino broadcasting on local public station KIKU-TV. The PSA continues to be aired today. Anecdotally, many patients, friends and relatives of the family and nurse portrayed in the PSA gave positive feedback about the authenticity and messages of the PSA. The PSA was shared at one of the National Diabetes Education Program meetings and was offered to organizations interested in using or replicating the video.

FUTURE PLANS

A two-year grant from the Hawaii EXPORT Project will provide diabetes self-management education in Ilocano, and will be taught by the same Filipino registered nurse. Furthermore, the diabetes support group "HodgePodge" continues for all health center patients and is mainly attended by Filipinos and Chuukese.

KPHC also received a service expansion grant from the Bureau of Primary Health Care that focuses on in-language diabetes self-management education to Chuukese, Filipino, Samoan communities. This additional funding will help to continue the work of the Chuukese community health worker. KPHC also plans to apply for funding from the Hawaii Community Foundation to partner with Mayor Wright Public Housing and Kaumakapili Church for continued outreach.

LESSONS LEARNED

- **Utilize strategies and methods that your target population is comfortable with** – In-language "talk story" sessions were a less structured, interactive method used with the Chuukese community. This outreach worker determined that this method would be better received by the group than formal presentations and handouts. Strong consideration should be given to the configuration of chairs and tables to be culturally sensitive to the learning styles of each AAPI community. In addition, using questions and comments brought up by participants is a well-practiced technique to facilitate an interactive dialogue on diabetes self-management.

- **Recruit bilingual, bicultural health educators** – The outreach worker's fluency with Chuukese and Micronesian languages was vital to the success of the Chuukese diabetes education classes. The same held true for the Filipino classes. Many in AAPI communities are either not fluent in English or are uncomfortable in their ability to speak English. Health educators have strongly noted that patients are more comfortable and receptive to diabetes education and self-management strategies when educators and providers are fluent in patients' native languages.

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SOUTH COVE COMMUNITY HEALTH CENTER

BY ESTHER LEE

Founded in 1972, South Cove Community Health Center (SCCHC) provides medical and behavioral health services to approximately 17,000 clients annually in the greater Boston area. SCCHC's mission is to improve the health and well-being of Asian Americans in Massachusetts, with a special focus on the medically underserved by providing bilingual, community-based health care and programs that are accessible and linguistically and culturally competent for these populations.

The center accomplishes its mission in large part through the delivery of primary and preventive health care services including: adult medicine, neurology, obstetrics, gynecology, pediatrics, health education, dental, podiatry, and behavioral and family health services. SCCHC also supplements its service offering to meet the growing needs of its patients. For instance, the center recently added mammography to its range of services so it could better offer breast cancer screening detection for its female patients.

Today, South Cove has four sites with over 170 employees who provide a range of services in Chinese (Cantonese, Mandarin, Toisanese, Taiwanese), Vietnamese, and Khmer.

In an effort to address the growing problem of diabetes in its local AAPI communities, SCCHC developed a comprehensive diabetes program. Through this program, SCCHC sought to increase awareness of risks, prevention, and treatment of diabetes and related cardiovascular diseases among Asian immigrant and refugees in Boston. The program utilized and distributed National Diabetes Education Program (NDEP) media campaign materials, and partnered with local media to promote diabetes awareness and access to SCCHC's self-management diabetes education classes. In addition, SCCHC conducted self-management diabetes education workshops for patients with diabetes, and committed itself to providing culturally and linguistically appropriate outreach in all of its events.

DIABETES SELF-MANAGEMENT CLASSES SERIES

SCCHC's diabetes self-management class series, which targeted the Chinese population in greater Boston, consisted of 3 different components: (1)

Exercise and communication (support group), (2) Nutrition and diabetes self management, and (3) Control A1c and prevent diabetes complications.

The program's classes, which were overseen by both a nurse practitioner with extensive knowledge in diabetes, and a health educator, were held over a two month timeframe. The decision to conduct a series of classes allowed for program staff to reinforce diabetes knowledge with participants over time, and allowed for more time to be devoted to different topics. Approximately 8-12 participants attended the weekend sessions.

At each session participants had the opportunity to learn about a broad range of diabetes information, often from guest speakers, which included physicians and nutritionists from the health center as well as other agencies. In one session, a nutritionist utilized a food chart to illustrate the differences found in Western and Asian food products, such as the calories found in bread versus rice, pastas versus noodles, and butter and margarine versus various cooking oils (i.e. peanut and sesame). The session also focused on educating participants about the nutrients found in different foods, and helping participants make positive adjustments and modifications to their diet. For

THE CULTURAL COMPETENCY OF THE STAFF ALLOWED PARTICIPANTS TO MORE OPENLY VOICE THEIR CONCERNS...

example, educators noted that a piece of bread and a bowl of rice were not equivalent with respect to sugar content and carbohydrates. Educators also provided information on the sugar content found in whole fruits that were commonly consumed by participants.

Central to the success of SCCHC's classes was its commitment to implementing a culturally competent program that ensured that language was not a barrier to diabetes education. All program staff was bilingual. In addition, health educators, doctors, nurses as well as outside speakers were either fluent in Cantonese and/or Mandarin. An interpreter was also on hand to translate for both Cantonese and Mandarin-speaking participants. To supplement the cultural competency of its staff, all educational material, such as brochures, were also either bilingual or translated into the language spoken by the tar-

Community members attend local health fairs to learn more about diabetes.

get audience. SCCHC's efforts to make the program and materials culturally competent and language appropriate paid off — participants seemed much more willing to express their opinions and needs with staff that was fluent in their home language. Participants were also more candid when expressing their concerns and frustration with, for example, maintaining a rigid and strict diet. The cultural competency of the staff and speakers allowed participants to more openly voice their concerns, raise questions, and most importantly, express their fears of the disease. Program staff noticed participants were most comfortable when communicating directly with healthcare providers, rather than through an interpreter.

Despite its successes, SCCHC did face some cultural challenges. For example, staff found that participants were more receptive to information when "professionals" such as physicians, nurses and nutritionists led the class, as opposed to when health educators facilitated a session. This was the case even when the information presented was essentially the same. Typically, Asian cultures have a strong tradition of respect for authority figures, including elders, teachers, and doctors. Since AAPI communities are relatively unfamiliar with the role of health educators, program members addressed this issue by providing both diabetes self-management education, as well as information on the significant role health educators have in the primary health care system.

Another challenge involved the staff's ability to equally engage participants of vastly diverse social, economic, educational, and linguistic backgrounds. For example, participants' different education levels made it difficult for staff to design a class tailored to their varying needs. Classes that concentrated heavily on the medical aspects of diabetes prevented some participants from easily following along, while classes that offered more general and basic information proved far from stimulating for other participants. In addition, the different levels of literacy and dialects spoken within the class often led to participants misunderstanding information they received in a class session. To resolve these differences, educators provided general diabetes knowledge in each session, and addressed more sophisticated questions and literacy needs in side conversations with participants either before or after class. Moreover, educators encouraged participants with higher literacy levels to befriend those less literate for added support.

LESSONS LEARNED

- **Effective outreach is dependent on consistent follow-up:** Staff found that low-income community members often had other priorities that superceded their own preventive health efforts. Staff surveyed community members and found that the key to effective outreach was grounded in the program coordinator and outreach workers' efforts to consistently conduct follow-up phone calls, and implement multiple methods of outreach.

- **Utilize multiple community outreach strategies:** Staff used a variety of means to recruit community members to its diabetes self-management classes. Staff utilized bilingual media such as newspapers, local TV announcements, radio and the distribution of flyers in other education/outreach classes at SCCHC. Program staff also partnered with Joslin Diabetes Center to co-host workshops and seminars at the clinic. Moreover, staff held diabetes education workshops at churches, malls, community centers, housing projects, frequented by its target audience.

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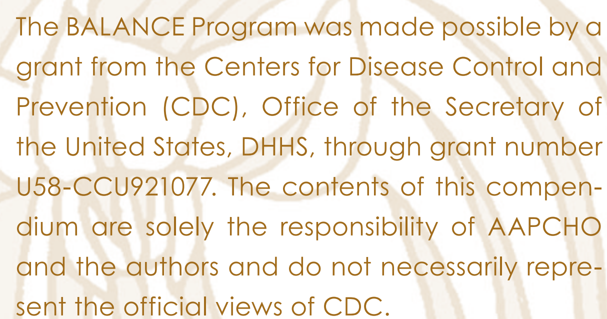

The BALANCE Program was made possible by a grant from the Centers for Disease Control and Prevention (CDC), Office of the Secretary of the United States, DHHS, through grant number U58-CCU921077. The contents of this compendium are solely the responsibility of AAPCHO and the authors and do not necessarily represent the official views of CDC.

Suggested Citation: *Association of Asian Pacific Community Health Organizations (AAPCHO), BALANCE Program for Diabetes, A Compendium of Diabetes Self-Management and Prevention Education Strategies for Asian American and Pacific Islander Communities. Oakland, California 2005.*

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