

Culture and Health Among Filipinos and Filipino-Americans in Central Los Angeles



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A Report Presented by

**The Historic Filipinotown Health Network
Los Angeles, California**

Member Organizations:

**Asian Pacific Health Care Venture (APHCV)
Filipino American Service Group, Inc. (FASGI)
Pilipino Workers' Center (PWC)
Search to Involve Pilipino Americans (SIPA)**



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EXECUTIVE SUMMARY

How does the culture of Filipino/Filipino Americans in central Los Angeles influence their health and their use of health services?

This is the question addressed by a community-focused study undertaken by a group of Filipino/Filipino American nonprofit organizations in Historic Filipinotown, located west of downtown Los Angeles, during 2006 — 07.

BACKGROUND

The study sought to understand how culturally-based experiences and perspectives of Filipino/Filipino Americans in central LA influence this population's health. Community leaders have noted persistent disparities in health and health care access for Filipino/Filipino Americans in Los Angeles. These disparities are more than statistics. They reflect real-life difficulties facing LA-based Filipino/Filipino Americans in preventing and reducing the effects of chronic disease and increasing the well-being of their households. While the factors contributing to this situation are complex, local leaders perceive that deeply held cultural beliefs, financial and time pressures associated with work, and a significant cultural distance between Filipino/Filipino Americans and LA healthcare providers have an important bearing on these health disparities. Finding ways to address *these factors effectively is widely seen as a key to reducing health disparities and improving health outcomes in LA's growing Filipino/Filipino American community.*

This report describes the study's findings regarding key cultural themes of LA-based Filipino/Filipino Americans relevant to their own health-related habits, preferences and perceptions of healthcare providers. In addition, we examine the relationship between these cultural themes and the actual health status and healthcare service use patterns of Filipino/Filipino Americans.

WHO THE SPONSORS ARE

The implementing organizations in the study were Asian Pacific Health Care Venture, Inc. (APHCV), Filipino American Service Group, Inc. (FASGI), Pilipino Workers' Center (PWC), and Search to Involve Pilipino Americans (SIPA). These organizations collaborated to collect primary data from residents, workers and health providers in Historic Filipinotown between November, 2006 and August, 2007. Together these groups represent thousands of Filipino/Filipino American households who cross the spectrum in terms of age, time in the US, family size, income, and education among other things. These organizations engaged Semics, LLC, a community research firm, to provide guidance and support in research design, implementation, analysis and presentation of results.

RESEARCH METHODS

A survey was conducted with over 300 residents/workers of Filipino/Filipino American descent in the Historic Filipinotown area, focusing on five dimensions of Filipino/Filipino American cultural life and their relationship to health and health care providers: religion; affinity-group association; family decision-making; language; and traditional medicine/healing practices. In addition, a survey was carried out with 50 healthcare providers, including 25 Filipino and Filipino American traditional healers. Lastly, 14 focus groups involving a total of more than 100 individuals were conducted in the same period, eliciting qualitative information to complement the survey data. Once collected, the data were analyzed using both quantitative and qualitative methods for central tendencies pertinent to themes in the areas of culture and health, respectively. A second step in analyzing data was to determine the strength and nature of the relationship between cultural themes on one hand, and perceptions of health and uses of health services, on the other.

LITERATURE SUMMARY IN BRIEF

Two themes in the existing literature were reviewed in relation to this study: (1) Health among Filipino/Filipino Americans in the US; and (2) The experience of acculturation among Filipino/Filipino Americans in the US.

With regard to the first theme, a survey of current literature suggests that as a group, Filipino/Filipino Americans are comparatively under-studied vis-à-vis health and health care disparities in the United States. The literature that does cover the subject suggests that Filipino/Filipino Americans (as a group) do experience disparities in health and health care. Javier *et al.* (2007) note that on a national level, Filipino/Filipino

Americans are the second largest Asian/Pacific Islander (API) population. Within this population, Filipino/Filipino American youth and adolescents in the US show disparities compared to Anglo and other API groups with regard to gestational diabetes, rates of neonatal mortality and low birth weight, malnutrition in young children, overweight, physical inactivity and fitness, tuberculosis, dental caries and substance abuse.

Within LA County, Bitler and Shi (2006) analyze disparities across groups based on health insurance, health care use and health status. While they do not focus on Filipino/Filipino Americans as a discrete subpopulation, they note that differences in the prevalence of chronic health conditions across different immigrant racial and ethnic groups were reduced after controlling for such factors as family income, net worth and neighborhood characteristics. One possible conclusion is that in neighborhoods that are co-populated densely by both Latino and Filipino/Filipino American households with similar earnings and employment characteristics (such as in Historic



Filipinotown), Filipino/Filipino Americans fare about the same as their Latino neighbors when it comes to chronic disease. This demonstrates that working class and lower-income Filipino/Filipino American households in LA County suffer from health problems more than other API populations in the County.

Taken together, these studies lend support to the perception among Filipino/Filipino American community leaders in Los Angeles that (1) persistent disparities in health and health care do exist for Filipino/Filipino Americans relative to other groups; and (2) Filipino/Filipino Americans are not adequately researched for ethnic-specific tendencies in health and health care access.

Second, a central theme that Rick Bonus uncovers in his book, *Locating Filipino Americans—Ethnicity & the Cultural Politics of Space* (1996) is the idea of nostalgia for immigrant groups. The ways in which nostalgia operates in the Filipino/Filipino American consciousness can re-make the sense of home in the US for Filipino/Filipino American immigrants, while simultaneously facilitating their acculturation. The notion of nostalgia provides a key to understanding the ways in which Filipino/Filipino Americans combine their memories and understandings of their lives in the Philippines with the need to create a sense of “home” in the US. (Espiritu, pp. 10-11) This notion also helps Filipino/Filipino Americans negotiate the challenges of socialization and acculturation in the United States.

THE FINDINGS

In attempting to discern how Filipino/Filipino American culture affects attitudes around health, health access, and health awareness, we ask the following questions:

- (1) *What are the cultural factors that bear significantly on the health status of Filipino/Filipino Americans?*
- (2) *How do they influence the perspectives and behavioral choices of Filipino/Filipino Americans vis-à-vis healthcare and healthcare providers?*

We focus on the following factors in our attempts to assess aspects of Filipino/Filipino American culture.

- Religion
- Family Decision Making and Fictive Kinship Networks
- Language

Then, we locate connections between these cultural factors and the health care access and awareness of Filipino/Filipino Americans in Central Los Angeles.

Religion

The majority of survey respondents state that they are either somewhat or deeply religious; approximately 82% are Catholic. In focus groups and the survey results, respondents could not readily separate their religious beliefs from Filipino/Filipino American cultural beliefs and/or influences. This may reflect a more general tendency among Filipino/Filipino Americans as a group. All age groups tend to share a basic belief in a God, yet have difficulty distinguishing religious practices from cultural practices. Lastly, Filipino immigrants are more likely to be religious than Filipino Americans who were born in the US.

The younger generation straddles the traditions of their parents and the more liberal attitudes of their peers in America. Youth are strongly influenced by family, especially parents, when it comes to their religious beliefs. Yet they do not seem to have a robust religious belief structure. While not religious in the traditional sense – meaning they do not necessarily have an active prayer life or go to church regularly – they still



cling to what their parents believe in defining the foundations of their own faith even while interacting with a more or less secular multicultural social environment in LA. Religious beliefs apparently are transmitted from parents, but that transmission is not always complete. For example, most youth see religion itself is seen as a “parent’s thing.”

Those working adults polled or interviewed in focus groups tend to take a practical view of religion – seeing faith as an important part, but not all, of what is needed for health and well-being. Seniors exhibit a more “institutional” view of God: Their belief structure and practice of faith are more orthodox and tradition-bound. Yet they also exhibit an ability to combine their religious beliefs with actively seeking advice, care, and treatment.

Being “somewhat” or “very” religious was consistently applicable to most respondents regardless of income or education – with one clear exception. Those with lowest incomes (\$5,000--\$10,000) per year and those with no high school education had the greatest proportion and *the largest number of deeply* or somewhat religious respondents. Also the senior citizens in the group were more religious overall than the working adults and youth.

Across all age groups is a belief that religion is closely tied to health. Younger Filipino / Filipino Americans seem to understand the importance of prayer. Among seniors, faith generally and explicitly informs healthy living. Faith takes precedence over a person’s openness to Western medicine, but does not reject it. Prayer also has a role in seniors’ understanding of health. More broadly, regardless of how religious each age group is, there is a consistent belief that God is present and, perhaps, at work in times of illness – and that prayer can somehow also contribute to healing or wellness. In the case of terminal or serious illness, Filipino / Filipino Americans tend to fall back on an acceptance of the situation and a sense that “this is God’s will.”

Language

A common assumption in the United States is that, unlike other Asian ethnic and immigrant groups, Filipino / Filipino Americans can adapt relatively easily to life in America because of the strong presence of the English language in the Philippines. However, our findings broadly demonstrate that Filipino / Filipino American immigrants often struggle with the English language, regardless of their familiarity with it. In the end, this finding makes communicating with health providers more problematic than it might appear given Filipinos’ / Filipino Americans’ general conversational proficiency in English. While our respondents reported over 40 different combinations of spoken languages (including an array of dialects spoken in different

regions of the Philippines such as Ilocano, Cebuano and Ilonggo), the top language combinations were (1) English and Tagalog, and (2) English, Tagalog, and “Other” (“other” being a local Filipino/Filipino American dialect which a person prefers to speak or speaks more fluently than both Tagalog and English).

The youth respondents demonstrate high levels of acculturation in their views and proficiency with language. English for this group is taken for granted for the most part. However, this is not necessarily true of seniors. Among working adults, understanding English well as a second language is not the same as the ability to express thought processes, which is done best in one’s native language.

There is a direct connection drawn between language facility and health. Familiarity with English does not automatically translate into a trusting, robust communication with providers. But where providers do speak Tagalog at least, patients generally manifest a rapid and willing trust that can create new possibilities for understanding, and wellness.

Influence of Affinity Groups and Family

The category of family in this context is expanded to include extended family as well as “fictive kinship” networks in addition to the nuclear family unit. The term “fictive kinship” refers to an informal web of personal relationships in which individuals are highly interdependent with family members as well as others, who may be friends or acquaintances but not necessarily blood relations. Key decisions are generally made collectively – that is, all members of a reference group of intimacy, whether nuclear family, extended family or fictive kin group – are involved.



This pattern of association and influence is a factor in families' process of making health care decisions. In terms of youth and how parents tend to the health of their children, it is apparent from the data that (1) youth depend on and are greatly influenced by their parents and (2) parents will seek treatment for their children with little regard to financial expense or other possible barriers such as language. Where the welfare of children is concerned, the key decision maker tends to be the primary female caregiver in the household.

Expectedly, young adults and seniors are more likely to rely on others compared to working adults. In regard to how much respondents said they value the advice of others, most said the advice of family and friends was either "most important" or "fairly important." Lastly, we found that the more respondents rely on others, the more they tend to value their advice.

The priority of family (broadly defined) in Filipino/Filipino American culture can occasionally create pressures on caregivers that work to their own detriment. For example, Filipino/Filipino Americans traditionally provide direct home care to sick or aging family members rather than turning to external providers of convalescent services, placing them in a position where they must juggle the daily demands and rigors of work, care-giving, and maintaining a household. This combination of obligations can be stress inducing, and is therefore a health issue in itself. Education and counseling services may need to be made available to working adults address this particular issue.

Health Awareness

Health awareness is a concern for everyone. In the case of Filipino/Filipino Americans, particularly those who are low-income and recent immigrants, health awareness may be stymied by financial and time constraints. For example, while a slight majority of our survey respondents exercise approximately two to three times a week, they also tend to eat fast food as often as they exercise. Along these same lines, income remains a major factor in the respondents' reliance on fast food, with higher amounts of fast food consumption correlating with lower income levels.

Thus, in terms of health awareness, pressures of work and lack of income and time appear to have a significant correlation with less healthy eating habits.

Notably, traditional medicine is an integral part of the health "consciousness" of Filipino/Filipino Americans, especially first-generation immigrants. It is founded on the popular belief that the human body has tremendous self-healing properties. Traditional healing methods are also passed on from one generation to another. Some examples

include touch/therapy massage; relying on services of a *hilot* (traditional healer) for selected illnesses or injuries; spiritual healing; and natural remedies including herbs, oils and spices.

Traditional medicine is regarded as a viable alternative to Western medicine especially among the uninsured and undocumented. It is generally not seen as conflicting with Western medicine among patients and traditional healers. However, Western health providers are at times skeptical about its usefulness and legitimacy. Those service providers who participated in this study concurred that among Filipino/Filipino Americans, traditional caregivers are thinning out. With them, a vast repository of knowledge about traditional medical care is at risk of being lost. Many Filipino/Filipino Americans still turn first to traditional remedies before going to the doctor or clinic for help. They do not consider such care as part of mainstream healthcare practices, but rather as part of tradition and as a contributor to their well-being.

Health Access

Filipino/Filipino American patients have difficulty in communicating effectively with health care providers. For their part, mainstream health care providers frequently are unable to offer culturally relevant services and advice. This finding is grounded in the level of comfort, or confidence, which the respondents feel, as patients, in expressing their specific health concerns in English. It also depends on the respondents' level of trust in their health care provider.

Reliance on traditional providers may stem in part from a more general reluctance on the part of many Filipino/Filipino Americans to use hospitals and doctors' services. In the Philippines, going for medical or health services is expensive and demands ready cash. The absence of sound insurance and other financial protections has created an



enormous cost to most users of health services in the Philippines, including medicine prescriptions. As a result, some patients do not seek help unless they are acutely ill. The idea of accessing health

services is thus alien to many – even when the services are available at low or no cost. This can turn into an urgent problem if and when Filipino/Filipino Americans suffer from a high incidence of chronic and/or serious illness (such as diabetes or TB).

While we received a high reported rate of insurance, providers' knowledge of the community suggests the possibility that the number of respondents who are not insured may be larger than we know. This could be partly related to residents' immigration status. In short, the restrictive environment for immigration itself creates an access barrier in regard to health services.

Implications

The findings in this study provide some implications for patients, providers and policymakers regarding health and health care. We highlight three implications here as examples of the implications discussed in the body of the report. First, many Filipino/Filipino American parents are working so hard to support their families that at times, they end up neglecting their own health (for example, by missing doctor's appointments). The burden of low-wage employment and a deeply held cultural belief about moral obligation and taking responsibility for one's family frames this reality. An implied approach for *health awareness building* is to encourage parents to take care of themselves so they are more likely to see their children in their retirement years as well, extending the experience which they value of being with family for the long term

Second, the report puts a spotlight on the hidden barrier of language, which partly explains the reluctance (especially among first-generation immigrants) to access health care or to follow doctors' recommendations. An implied response is that health care providers servicing Filipino/Filipino American patients in LA should increase the multicultural competencies of their staff, and educate especially English-dominant



providers about the cultural foundations for the particular needs, preferences and perspectives of their Filipino/Filipino American patients. English-dominant providers in some instances can present a barrier to non-English dominant patients to the degree that the providers discount the importance of culture and/or do not become culturally fluent themselves.

Third, policy makers looking to shift the attention of Filipino/Filipino Americans increasingly toward illness/injury prevention might find a helpful resource in the Filipino/Filipino American traditional healers. This is because they are a widely accepted part of the Filipino/Filipino American community and their specialty is holistic medicine. There may be unseen, synergistic opportunities available in creating partnerships with traditional healers to promote, in appropriate and sensitive ways, natural healing, health and wellness throughout the community to which they belong. In closing, the agencies that commissioned the study on culture and health in Historic Filipinotown hope that this report might become a basis for (1) Working with the Filipino/Filipino American population to develop new strategies based on their cultural strengths and assets as a people in achieving stronger health outcomes; (2) Educating health care providers regarding culture and language distinctives of Filipino/Filipino Americans as part of a larger process of increasing providers' overall competencies in addressing the needs of Los Angeles' multicultural communities; and (3) Engaging policymakers to take a more culturally informed and sensitized approach to health care reform, focusing particularly on reducing existing disparities among Filipino/Filipino Americans, improving health outcomes, and overcoming gaps and weaknesses in service coverage and service quality.

INTRODUCTION

What Is This Report About?

How does the culture of Filipino/Filipino Americans in central Los Angeles influence their health and their use of health care services?

This is the question addressed by a community-focused study undertaken by a group of Filipino/Filipino American nonprofit organizations in Historic Filipinotown, west of downtown Los Angeles, during 2006—07. This report presents the findings of the study. The intended audiences are healthcare providers, community service organizations, researchers and Filipino/Filipino Americans and other immigrant groups. The purpose of the study is to inform residents of all ages, providers, policymakers and researchers about specific ways in which culture intersects with health, and can be seen as a resource for overcoming health disparities and healthcare barriers in the interest of improving overall community health outcomes.

Background

Community leaders have noted persistent disparities in health and barriers to health care for Filipino/Filipino Americans in Los Angeles. These disparities and barriers are more than statistics. They reflect real-life difficulties facing LA-based Filipino/Filipino Americans in preventing and reducing the effects of chronic disease and increasing the overall health of their households. Local leaders perceive that financial and time pressures associated with work, and a significant cultural distance between Filipino/Filipino Americans and LA healthcare providers have an important bearing on this population's well being. Identifying and implementing strategies to effectively address these factors is therefore seen as a key to improving health outcomes in LA's growing Filipino/Filipino American community.

Of particular interest in this report is the influence of language and culture on health perspectives, health service access, and health care. Culture can affect how members of the population communicate with providers about important issues. These issues may include the types of health problems they choose to discuss with a healthcare provider,

how they are facing the ordeal of illness for themselves or in their families, what type of help they need, and whether they seek health-related assistance.

Despite these differences, people from all ethnicities and cultures experience health problems. Health services may fall short of reaching key segments of Los Angeles' diverse population if professionals and their patients struggle to understand each other due to language and cultural barriers. For example, even when clients have learned English as their second language, they find it easier and more comfortable to speak their primary language, particularly on subjects that are sensitive to them.

This report describes how key cultural themes particular to Filipino/Filipino Americans living in central Los Angeles are related to their own health perceptions, experiences, practices and use of health services. The estimated number of Filipino/Filipino Americans in Historic Filipinotown is about 7,000, based on the U.S. Census of 2000.

Who Participated in This Project?

Four organizations were directly involved in implementing the study: Asian Pacific Health Care Venture, Inc. (APHCV), Filipino American Service Group, Inc. (FASGI), Pilipino Workers Center (PWC), and Search to Involve Pilipino Americans (SIPA). All of these organizations are based in, or near, Historic Filipinotown. They collaborated to collect primary data from residents, workers and health providers in Historic Filipinotown between November, 2006 and August, 2007. Together these groups represent thousands of Filipino/Filipino American households who cross the spectrum in terms of age, time in the US, size, income, and education among other things. These organizations also engaged Semics, LLC, a community research firm, to provide guidance and support in the study's design, implementation, data collection, data analysis and presentation of results.



Composition of This Report

After a brief description of the research methodology and a literature summary, the core research findings are presented and analyzed. In particular, this report:

- Describes the demographics and some key cultural themes (religion, family, language) that characterize the Filipino/Filipino American community in Historic Filipinotown, taking account of the diversity within this population and the relevance of the cultural world view of the Philippines to their daily lives;
- Discusses the health awareness and health use patterns that emerged from the data; and
- Notes significant relationships between key cultural themes and health awareness and health services access in Historic Filipinotown.

A concluding section discusses the wider significance of culture for the health of the Filipino/Filipino American community, and suggests some of the study's implications for further research, future programming, best practices for health and social service providers, and possible directions for the reform of health policy in California.



METHODOLOGY

Framing and Key Questions

In attempting to discern how Filipino/Filipino American culture affects attitudes around health, health access, and health awareness, we ask the following questions:

- *What are the cultural factors that bear significantly on the health status of Filipino/Filipino Americans?*
- *How do these factors influence the perspectives and choices of Filipino/Filipino Americans vis-à-vis healthcare and healthcare providers?*

Data Collection

A survey was conducted with almost 300 residents/workers of Filipino/Filipino American descent in the Historic Filipinotown area focusing on the following dimensions of Filipino/Filipino American cultural life and their relationship to health and health care providers: religion; affinity-group and family influence; language; and traditional medicine/healing practices. In addition, a survey was carried out with 50 healthcare providers, including 25 traditional healers. Lastly, 14 focus groups were conducted in the same period as the survey with non-overlapping groups, eliciting qualitative information to complement the survey data. Once collected, the data were analyzed using both quantitative and qualitative methods for central tendencies pertinent to themes within the areas of culture and health, respectively. A critical step in aggregating data was to determine the strength and nature of the relationship between cultural themes on one hand, and perceptions and uses of health services, on the other.

The survey sample population is not a random sample. Most of the survey respondents were already receiving services from the participating agencies and may represent a more aware and cognizant population than if the respondents were randomly chosen from the population in Historic Filipinotown and the surrounding neighborhoods. This means that it may be difficult to generalize our findings to a wider segment of the Filipino/Filipino American population.

However, the large number of surveys completed and additional steps taken to triangulate survey data with focus groups gives us confidence that the findings regarding the particular population in this study are accurate.

Data Analysis

First, we examine Filipino/Filipino American culture and values in an effort to understand their implications for health awareness, and health access.¹ These lenses we use for culture are:

- Religion
- Language
- Family & Kinship Networks

Second, we examine Filipino/Filipino Americans' experiences with **health care access** and **health awareness** in Central Los Angeles, especially *with regard to different generations, and with sensitivity to place of birth. In short, we are connecting culture and health along an Acculturation and Socialization Continuum.*

Literature Review

Cultural Identify and Health Disparities

Health access for many immigrant groups has long been a main social service concern. Among other things, unequal access has been attributed to the model minority myth – a widely held view that Asian Americans are able to assimilate easily, gain access to education, and attain middle-class professional socioeconomic status in American society. (Espiritu, pp. 7-8) As a consequence, in the absence of robust data about group-specific health and other disparities, many Asian Americans have struggled to form organizations and secure funding for basic services addressing the actual needs of their populations.

This condition is aggravated by a tendency in demographic studies to lump together all Asian American populations under the umbrella category “API groups.” Contrary to mainstream perceptions, the ethnic groups that constitute the Asian American population are, in fact, quite heterogeneous. Southeast Asians, particular Cambodians and Khmer, and Pacific Islanders experience high rates of poverty and low educational attainment. While it is true that a large number of Filipino/Filipino Americans are middle-class professionals, there are also many Filipino/Filipino American immigrants

who work in low and unskilled professions. This is not to mention the unknown number of undocumented Filipino/Filipino Americans who survive in isolated and precarious circumstances.

Additionally, Abe-Kim *et al.* found that in seeking mental health services and feeling comfortable seeking these services for Asian Americans is wholly dependent on immigrant status, place of birth, and generation. They state, “Barriers identified as negatively affecting the use of mental health-related services include cultural barriers (e.g. stigma, loss of face, causal beliefs), culturally unresponsive services (e.g. lack of language match, lack of ethnic match, poor cross-cultural understanding), limited access to care (e.g. cost, lack of insurance coverage), and lack of awareness or understanding of services.” (Abe-Kim *et al.*, p. 2) Thus, on one level, Asian Americans present us with a multi-layered and complex group that is often lumped together and assumed to be doing well, obscuring the social service needs of specific Asian American ethnic groups.



While a large number of Filipino/Filipino Americans are middle-class professionals, there are also Filipino Americans and Filipino immigrants who work in low and unskilled professions. Yen Le Espiritu (2003) situates Filipino/Filipino Americans within the broader Model Minority stereotype. She states, “Overall, the post-1965 Filipino immigrants constitute a relatively affluent group: in 1990, more than half joined the ranks of managers and professionals; their median household income exceeded that of all Americans and even that of whites; and their percentage of college graduates was twice that of all Americans.” (Espiritu, p. 7) However, this stereotype belies the reality that many Filipino/Filipino Americans, especially recent immigrants, struggle economically as well as with acculturation and proficiency in the English language. They are often underemployed, relative to their education and experience. Parrenas explains how developing countries become dependent on first world nations such as the U.S. to support their weak economies. Many Filipino/Filipino Americans are subsequently forced to leave the Philippines to secure employment. These migrants are often women. (Parrenas, pp. 25-27) In terms of health, Filipino/Filipino Americans, relative to other Asian American groups, are likely to have access to health insurance, yet still claim difficulties in accessing health care for various reasons.

Our survey of current literature confirms that as a group, Filipino/Filipino Americans are comparatively under-studied vis-à-vis health and health care disparities in the United States. However, there are a few studies on the topic – especially regarding children and youth – such as Javier *et al.* (2007). The latter study indicates that on a national level, Filipino/Filipino Americans are the second largest API population in the US. Within this population, Filipino/Filipino American youth and adolescents show disparities compared to white and other API groups with regard to gestational diabetes, rates of neonatal mortality and low birth weight, malnutrition in young children, overweight, physical inactivity and fitness, tuberculosis, dental caries and substance abuse. While Javier *et al.* does not directly address the health of other age groups among Filipino/Filipino Americans, it may be inferred that such disparities may be endemic in the population as a whole, regardless of age. New studies are needed to determine the nature and extent of this possibility.

Within LA County, Bitler and Shi (2006) analyze disparities across groups based on health insurance, health care use and health status. While they do not focus on Filipino/Filipino Americans as a discrete subpopulation, they note that statistical differences in the prevalence of chronic health conditions across different immigrant racial and ethnic groups were reduced after controlling for such factors as family income, net worth and neighborhood characteristics. One possible conclusion is that in neighborhoods that are co-populated densely by both Latino and Filipino/Filipino American households with similar earnings and employment characteristics (such as Historic Filipinotown), Filipino/Filipino Americans fare about the same as their Latino neighbors when it



comes to chronic disease. This could mean also that working class and lower-income Filipino/Filipino American households in LA County suffer from health problems more than other API populations of higher socioeconomic status.

Taken together, these studies lend support to the perception among Filipino/Filipino American community leaders in Los Angeles that (1) persistent, real disparities in health and health care do exist for Filipino/Filipino Americans relative to other groups; and (2) Filipino/Filipino Americans are not adequately researched for group-specific tendencies in health and health care access.

Acculturation in American Society:

Second, with regard to Filipino/Filipino Americans, Bonus (1996) suggests the concept of nostalgia for understanding the experience of immigration. The collective experience of nostalgia can help Filipino/Filipino Americans construct a sense of belonging, or home, in the US, while simultaneously facilitating their adaptation and acculturation. For Filipino/Filipino Americans, this is a particularly interesting process in that they already know English. Combined with the resilience of Filipino/Filipino Americans while learning to adjust in a new country, the idea of nostalgia can show more clearly how Filipino/Filipino Americans negotiate the complex challenges of socialization and acculturation while nurturing an ongoing emotional connection to their own country and culture. (Bonus, pp. 62-69) Espiritu adds to this notion. "In so doing, they have created and maintained fluid and multiple identities that link them simultaneously to both countries." (Espiritu, p. 10)



For this study, Bonus' work can be applied to understanding the perspectives and experiences of Filipino/Filipino Americans regarding health/health care based on differential *degrees of acculturation*. We devote attention in this report to nuances of perspective and action regarding health based on indicators of acculturation such as differences in age, education, length of residency in the U.S. and place of birth, among other things.

Within the Filipino/Filipino American community there is a range of subgroups with their own diversity of dialects and enduring connections to sub-regions back in the Philippines. These cultural differences, although significant for several reasons, nevertheless appear less important for the subject of health and healthcare within Los Angeles compared to the experience of adjustment in the US of Filipino/Filipino Americans as a group.

Cultural Structures and Value Systems Imported from the Philippines:

"Culture" is itself a contested idea in American society where diverse traditions are constantly blending and intersecting. Although Filipino/Filipino Americans may be distinguished in the US by their own languages, traditions and other cultural factors, their interaction with people of *other* cultures can itself affect the adaptation of Filipino/

Filipino American people to mainstream US society. In addition, the second-generation typically experience a more radical change in cultural self-definition. For example, Filipino/Filipino American youth can experience a loss of cultural moorings – wanting at one time to hold on to aspects of their parents’ culture while embracing their identities as people born in and more naturally acculturated within American society. In this context of flux, what constitutes Filipino/Filipino American culture?

According to Geertz (2000), culture is a “system of meanings embodied in symbols” that provide people with a frame of reference to understand reality and animate their behavior. In addition, cultures are partly made up of “structures of plausibility” (Berger et al., 1976) that anchor and direct the ongoing shared life of a people. Based on a brief poll of informants at the beginning of the study, we identified language, religion, and family as three critical examples of core symbols and structures in the Filipino culture. While Filipinos and Filipino Americans go through various phases of acculturation to life in the US, it should be noted that generally speaking, they share a common heritage as members of a community that came to America originally from the Philippines. While the values that define their culture of origin (itself comprised of many subcultures) are fluid, they are nonetheless observable and influential.

It is also important to note where some of the defining elements of the Filipino/Filipino American culture have come from. These elements can help illuminate, or provide culture-based insight, in regard to the reported perspectives and experiences of the Filipino/Filipino American community in Los Angeles regarding health. Some elements of a worldview often associated with the Philippines are described in Appendix 2 of this report.

SUMMARY AND ANALYSIS OF FINDINGS

I. DEMOGRAPHICS

In the United States, Filipino/Filipino Americans compose the “second-largest APA (Asian/Pacific Islander American) group overall—with 2.36 million Filipino/Filipino Americans in 2000.” (Yan and Ong, pp. 124-125) According to the United States Census 2000, the Los Angeles-Riverside-Orange counties contain the largest numbers of Filipino/Filipino Americans in the country. (Yan and Ong, p. 124) On the one hand, Filipino/Filipino American immigrants composed a significant number of those who came to the U.S. due to the 1965 Immigration Act, which gave preference to middle-class, college-educated professionals, constructing the notion that all Filipino/Filipino Americans exist within this classification. On the other hand, recent trends in types of employees sought, globalization, and changes in the Philippine economy have encouraged the immigration of poorer, undocumented, and un-skilled and semi-skilled workers, the majority of whom are women. (Parrenas, pp. 24-27)

Approximately 117,657 individuals live in Historic Filipinotown. Of this population, 9,876 are under the age of 5; 86,127 are over the age of 18; and the senior citizen population, those over the age of 65, compose 9,700 of this neighborhood’s population. In Historic Filipinotown, 21,408 individuals are Asian American. Overall, those who are foreign born compose 69,145 of the population.² The estimated number of Filipino/Filipino Americans in Historic Filipinotown is approximately 7,000, based on the U.S. Census of 2000.

What does our survey respondent population look like demographically? Here we describe the population demographics based on:

- Income
- Education
- Age
- Place of Birth

Our sample population is broken down by age group in the following table. The ages of the survey respondents are relatively evenly distributed, with the largest group between the ages of 65-79.

Table I.1 — Age of Survey Population

| Age | Frequency | Percent | Cumulative Percent |
|--------------|------------|--------------|--------------------|
| 14 - 17 | 49 | 16.8 | 16.8 |
| 18 - 24 | 52 | 17.9 | 34.7 |
| 25 - 39 | 38 | 13.1 | 47.8 |
| 40 - 64 | 45 | 15.5 | 63.3 |
| 65 - 79 | 72 | 24.7 | 88.0 |
| 80+ | 32 | 11.0 | 99.0 |
| Unknown | 3 | 1.0 | 100.0 |
| Total | 291 | 100.0 | |

In terms of birthplace, our survey respondents are majority foreign-born, with approximately 84% being born in the Philippines, while only 13.1% were born in the United States. However, the majority, 51.9%, has lived in the U.S. for more than 10 years, with an additional 29.6% living here between 5-10 years.

Table I.2 — Birthplace of Survey Population

| | Frequency | Percent | Cumulative Percent |
|------------------|------------|--------------|--------------------|
| U.S born | 38 | 13.1 | 13.1 |
| Philippines born | 244 | 83.8 | 96.9 |
| Other | 2 | 0.7 | 97.6 |
| Invalid | 7 | 2.4 | 100.0 |
| Total | 291 | 100.0 | |

The gender ratio of the survey respondents is almost split evenly between females and males.

Table I.3 — Gender of Survey Population

| | Frequency | Percent | Cumulative Percent |
|--------------|------------|--------------|--------------------|
| Female | 149 | 51.2 | 51.2 |
| Male | 141 | 48.5 | 99.7 |
| Other | 1 | 0.3 | 100.0 |
| Total | 291 | 100.0 | |

A little more than the majority of the survey respondents (51.9%) have been living in the US for more than 10 years, with almost thirty percent (30%) of the respondent living in the US for between 5-10 years. Only 16.5% of the respondents have resided in the US for less than 5 years.

Table 1.4 — Length of Stay in the United States of Survey Respondents

| | Frequency | Percent | Cumulative Percent |
|--------------------|------------|--------------|--------------------|
| Less than 5 years | 48 | 17.0 | 17.0 |
| 5 - 10 years | 86 | 30.0 | 47.0 |
| More than 10 years | 151 | 53.0 | 100.0 |
| Total | 285 | 100.0 | |

In terms of income, the majority of our survey respondents fell in the bracket at or below \$24,999. We must note that the majority of our survey respondents were youth and seniors, with working adults comprising approximately one third of the respondents.

In addition, given that 59.1% have attended at least some college (with 35.4% having finished college), earnings for college-educated Filipino/Filipino Americans are generally lower than expected. The largest concentration of income, excluding retired seniors and non-employed youth, is within the \$10,000-\$34,999 range.

Table 1.5 — Income of Survey Population

| | Frequency | Percent | Cumulative Percent |
|-------------------|------------|--------------|--------------------|
| Under \$5,000 | 89 | 34.0 | 34.0 |
| \$5,000 - 9,999 | 40 | 15.0 | 49.0 |
| \$10,000 - 14,999 | 31 | 12.0 | 61.0 |
| \$15,000 - 24,999 | 36 | 14.0 | 75.0 |
| \$25,000 - 34,999 | 27 | 10.0 | 85.0 |
| \$35,000 - 49,999 | 14 | 5.0 | 91.0 |
| \$50,000 - 74,999 | 13 | 5.0 | 96.0 |
| \$75,000 - 99,999 | 9 | 3.0 | 99.0 |
| \$100,000 - over | 2 | 1.0 | 100.00 |
| Total | 261 | 100.0 | |

Table 1.6 — Levels of Educational Attainment of Survey Population

| | Frequency | Percent | Cumulative Percent |
|-------------------------------|------------|--------------|--------------------|
| Less than high school | 72 | 24.7 | 24.7 |
| High school graduate/GED | 45 | 15.5 | 40.2 |
| Some college | 69 | 23.7 | 63.9 |
| College/Graduate/Postgraduate | 103 | 35.4 | 99.3 |
| No formal education | 1 | 0.3 | 99.6 |
| Unknown | 1 | 0.3 | 100.0 |
| Total | 291 | 100.0 | |

The types of employment of the survey population are widely varied. Since approximately one-third of the respondents are youth or seniors, many of them do not have employment. Also a large number of the survey respondents are students. The next largest forms of employment include being a provider/caregiver/personal assistant, a hotel/restaurant worker or a clerical/administrative employee

Table 1.7 — Employment of Survey Population

| | Frequency | Percent | Cumulative % |
|--|------------|--------------|--------------|
| Retired | 36 | 16.0 | 16.0 |
| No Employment | 23 | 10.0 | 26.0 |
| Provider/Caregiver/Personal Assistant | 21 | 9.0 | 35.0 |
| Maintenance/Handyman | 3 | 1.0 | 36.0 |
| Student | 2 | 1.0 | 37.0 |
| Volunteer | 2 | 1.0 | 38.0 |
| Tutor | 5 | 2.0 | 40.0 |
| Hotel/Restaurant Worker | 14 | 6.0 | 46.0 |
| Intern | 5 | 2.0 | 48.0 |
| Technician/Technologist | 4 | 2.0 | 50.0 |
| Artist/Teacher | 2 | 1.0 | 51.0 |
| Warehouse Worker/Custodian | 2 | 1.0 | 52.0 |
| Bank Employee | 7 | 3.0 | 55.0 |
| Counselor/Community Organizer/Case Worker | 6 | 3.0 | 58.0 |
| Program Coordinator or Office Administrator (business/nonprofit) | 8 | 3.0 | 61.0 |
| Office Clerk/Administrative Assistant/Medical Biller/ Legal Secretary/Office Asst/Cashier | 17 | 7.0 | 68.0 |
| Student | 60 | 26.0 | 94.0 |
| CAD Draftsman | 1 | 0.0 | 94.0 |
| Quality Lab Associate/Assistant | 2 | 1.0 | 95.0 |
| Nurse/Medical Sonographer/ Pharmacist/Clinical Lab Scientist | 7 | 3.0 | 98.0 |
| Chief Technologist | 1 | 0.0 | 98.0 |
| Self-Employed | 2 | 1.0 | 99.0 |
| Driver/Mailman | 3 | 1.0 | 100.0 |
| Total | 231 | 100.0 | |

The majority of the survey participants lived in households of between two and five members.

Table 1.8 — Household Size of Survey Participants

| Household Members | Frequency | Percent | Cumulative Percent |
|-------------------|------------|--------------|--------------------|
| 1 | 24 | 9.1 | 9.1 |
| 2 | 53 | 20.2 | 29.3 |
| 3 | 50 | 19.0 | 48.3 |
| 4 | 48 | 18.3 | 66.5 |
| 5 | 34 | 12.9 | 79.5 |
| 6 | 17 | 6.5 | 85.9 |
| 7 | 17 | 6.5 | 92.4 |
| 8 | 14 | 5.3 | 97.7 |
| 9 | 3 | 1.1 | 98.9 |
| 13 | 1 | 0.4 | 99.2 |
| 16 | 1 | 0.4 | 99.6 |
| 20 | 1 | 0.4 | 100.0 |
| Total | 263 | 100.0 | |

2. RELIGION

The majority of the survey respondents state that they are somewhat to deeply religious.

Table 2.1 — Respondents’ Measure of Their Levels of Religiosity

| | Frequency | Percent | Cumulative Percent |
|----------------------|------------|--------------|--------------------|
| Not religious at all | 32 | 11.0 | 11.0 |
| Somewhat Religious | 121 | 41.6 | 52.6 |
| Deeply Religious | 131 | 45.0 | 97.6 |
| Unknown | 7 | 2.4 | 100.0 |
| Total | 291 | 100.0 | |

Religion’s role in the lives of Filipino/Filipino Americans is inextricably intertwined with culture. This makes our treatment of religion as a “part” of culture problematic. Generally speaking, religion is analytically distinct from culture and has its own influence on people’s views regarding health and healthcare. The subject of this study is not the influence of religion on the health of Filipino/Filipino Americans. However, because of the intertwined character of religion with culture in the Filipino/Filipino American community, we do not treat religion separately but rather as a discrete factor in understanding the overall influence of culture with regard to health in this population. Staff members at one of the sponsor agencies in this study confirm the observation that religion and culture are closely intertwined:

Another example is looking at culture and religion. Catholicism – what is cultural and what is religion? Look at the novena, and women doing it - how much is that religious or cultural? We put things in boxes and it’s not easy [to keep them apart in reality].

(Focus Group, SIPA, 24 May 2007)

In the context of this study, both the survey respondents and focus group participants find it difficult to disentangle religious from cultural factors and/or influences. In effect, for them the two are seen as virtually inseparable.

Approximately 82% are Catholic. In light of over 300 years of Spanish colonialism in the Philippines, in which one of the ways that the Filipino natives were “civilized” involved massive conversions to Catholicism, the intertwining of religion and culture should perhaps not be surprising.

Table 2.2 — Religions Practiced

| | Frequency | Percent | Cumulative Percent |
|---------------|------------|--------------|--------------------|
| Protestantsim | 18 | 6.2 | 6.2 |
| Catholicism | 216 | 74.2 | 80.4 |
| Islam | 2 | 0.7 | 81.1 |
| Other | 55 | 18.9 | 100.0 |
| Total | 291 | 100.0 | |

Religion and Demographic Factors

Table 2.3 — Levels of Religiosity Based on Income Brackets

| | Religious | | | | Total |
|-----------------|-----------|----------------------|--------------------|------------------|------------|
| | Other | Not religious at all | Somewhat religious | Deeply religious | |
| Under 5,000 | 0 | 7 | 44 | 38 | 89 |
| 5,000 - 9,999 | 0 | 2 | 11 | 27 | 40 |
| 10,000 -14,999 | 0 | 5 | 15 | 11 | 31 |
| 15,000 - 24,999 | 2 | 3 | 14 | 17 | 36 |
| 25,000 - 34,999 | 1 | 5 | 12 | 9 | 27 |
| 25,000 - 34,999 | 0 | 3 | 5 | 6 | 14 |
| 35,000 - 49,999 | 0 | 4 | 4 | 5 | 13 |
| 50,000 - 74,999 | 0 | 0 | 3 | 6 | 9 |
| 75,000 - 99,999 | 0 | 0 | 0 | 2 | 2 |
| Total | 3 | 29 | 108 | 121 | 269 |

The preceding table suggests that with regard to the population in this study, the more income one makes, the less religious s/he is. However, most survey respondents are in the low-income range. (The U.S. Department of Health and Human Services defines poverty at or below \$20,650 for a family of four as of 2007.) It could be inferred from this information that for most persons on lower incomes, such as seniors on fixed incomes, religious faith is a decisive influence on the way they see, and act on, both illness and wellness. Thus understanding the variety of faith perspectives, especially among patients on low incomes, may be important if providers want to understand health through their patients' eyes.

Religion and Place of Birth

Table 2.4 — Levels of Religiosity Based on Place of Birth

| Birthplace | Religious | | | | Total |
|------------------|-----------|----------------------|--------------------|------------------|------------|
| | Other | Not Religious at all | Somewhat religious | Deeply religious | |
| U.S. born | 0 | 9 | 16 | 13 | 38 |
| Philippines-born | 5 | 22 | 103 | 114 | 244 |
| Unknown | 2 | 1 | 1 | 3 | 7 |
| Total | 7 | 32 | 120 | 130 | 289 |

The strong tie between religion and Filipino/Filipino American culture can be viewed also through the lens of the place of birth of survey respondents. Respondents born in the Philippines were more likely to be deeply religious.

Religion and Age

Table 2.5 — Levels of Religiosity Based on Age

| Age | Religious Commitment | | | Total |
|--------------|----------------------|--------------------|------------------|------------|
| | Not religious at all | Somewhat religious | Deeply religious | |
| 14 - 17 | 5 | 26 | 18 | 49 |
| 18 - 24 | 11 | 36 | 5 | 52 |
| 25 - 39 | 8 | 19 | 11 | 38 |
| 40 - 64 | 3 | 17 | 24 | 44 |
| 65 - 79 | 2 | 19 | 48 | 69 |
| 80+ | 2 | 4 | 23 | 29 |
| Unknown | 1 | 0 | 2 | 3 |
| Total | 32 | 121 | 131 | 284 |

Religion definitely influences attitudes regarding health for Filipino/Filipino Americans. Additional factors such as income, age and education influence how much religion is intertwined in the minds of people with health, especially when it comes to crises, serious conditions and disease. God is seen as the protector and/or giver of good health. What is surprising is the diversity of perspectives shown here. A good number of respondents in all age categories are “not religious at all”. However, there also are many more who are “deeply religious.”

For each age group – youth, working adults, and senior citizens – religion and religious practices differ. Additionally, each group’s way of connecting religion to health is different. The nuances in perspectives are described further below.

Youth and Religion

Family influences the youth, especially parents, when it comes to their religious beliefs. For the youth survey respondents, the level of religiosity appears related significantly to the youths' respective levels of *acculturation* as well as income and education. The religious understanding of the young is a good example of inter-generational cultural transmission. The comments from youth below demonstrate how their families influence them in regard to their religious beliefs.

For me, I was influenced by my mom. When my mom goes to church, I didn't really feel like going.

Since birth, my *kapatids* [relatives] and I don't really practice religion, but we believe in God.

For me, my parents are really religious. We have to read the Bible every night. (Do you feel obligated?) No, not really. I feel that it's for the family.

(Focus Group, PWC, 7 June 2007)

These young people do not seem to be "religious," yet they still generally hold onto a basic belief in God and view it to some extent as part of their familial obligations. Religious beliefs are only partly transmitted from parents and religion itself is seen as a "parent's thing." The link from "God" to health, however, is clear to them vis-à-vis their parents' beliefs. Parents are also seen by youth implicitly as role models in the area of religion, which serves as a significant factor in their upbringing and faith perspectives.

Maybe your parents wanted to pass on that tradition. Or even your church, to encourage you to pray. But I still don't understand why [*the novena*] just keeps repeating.

(Focus Group, SIPA, 24 May 2007)

The sentiments expressed by the youth partly demonstrate that religion also serves as a moral marker, for example Catholicism's negative views around pre-marital sex. This affects health and health care access because sexually active teens may not be able to communicate with their parents on these issues even while needing health care education and services for conditions associated with their sexual habits.

Working Adults and Religion

The working adults are the largest age group in our survey sample that claimed to be “somewhat religious.” In light of the comments below, it appears that they have had mixed experiences in the intertwining of health and religion.

One of my aunts had lupus. Instead of going to a clinical specialist for treatment she opted to attend prayer meetings where people “pray over” her believing that in doing so, she will be healed (“pray over” involves laying down the hands of all those participating over the head of the subject while praying) . Now, she is terminally ill and in severe pain.

My mother was a diabetic. At first, she was going to the doctor. Then, she completely changed her mind about medical treatment. She was enticed to join the El Shaddai (religious movement). She stopped taking her medicine. Whatever money she had that was supposed to be used to buy medicine was given to this religious group. Her condition became worse. The family decided to take her to the hospital. This was the time when she was too weak to have control over her situation. It was too late.

(Focus Group, PWC, 19 January 2007)

The comments above demonstrate that some focus group interviewees experienced a loss of control when an individual for whom they cared relied too heavily on religion to cure disease, and it failed them. The thrust of these observations is that religious practices alone are not enough to address a person’s health needs. These working adults hold a pragmatic view of religion: Religion has a place, but it cannot replace going to the doctor or taking medicine prescribed by a doctor to take care of an illness or injury. However, our survey respondents, particularly the working adults in the sample, utilize religious coping mechanisms (along with traditional healing) to cope with health problems and disease. These specifically include praying the novena and engaging in the services of a *hilot* (traditional healer who utilizes massage).

Both healthcare and service providers noted that Filipino/Filipino American clients utilize prayer as a coping mechanism in order to deal with health problems.

Filipino/Filipino Americans are good with prayer and socialization so find ways to cope even if they do not overcome their problems.

(Focus Group, APHCV, 26 January 2007)

It is common to hear that as Filipino/Filipino Americans are informed of good laboratory results by their healthcare providers, they will say “Thank God” not as a form of expression but as a form of prayer and an additional remark, “ I prayed for that.” While Filipino/Filipino Americans seek a certain level of care, they, at the same time, believe in divine intervention.

(Focus Group, APHCV, 15 May 2007)

The above quote indicates that Filipino/Filipino American working adults tend to place a premium on prayer, helping each other, and trusting God while also going to the doctor when needed.

Seniors and Religion

Overall, the senior citizens exhibited comparatively deep levels of religiosity. But with this depth, many still placed a premium on seeking and receiving mainstream healthcare. Seniors actively combine prayer, seeking treatment and financial resources, and a strong belief in God.

For physical health, we have to feed the body with food; for spiritual health, the food is the word of God.

Prayer is for divine healing.

(Focus Group, FASGI, 25 May 2007)

We heard some accounts of “faith healings,” in which seniors cited religion as the source of their regaining physical health, a phenomenon which they believed to be miraculous:

In 1999, as I was waiting for my US immigration petition to be approved, I was diagnosed with a gall bladder stone as shown in ultrasound results. I was advised by doctors that surgery was needed. Worse, I am a diabetic. I also did not have the money for surgery. Around this time, my petition was approved but my situation became more complicated as I was thinking that it could be more difficult if I left for the US without being treated. In a strange land, I wouldn't know what to do. I prayed hard for divine guidance. I approached the office of the governor of my hometown who generously provided financial assistance for my surgery. I was then referred to the Philippine General Hospital for surgery. Prior to surgery, I was made to go through one final ultrasound test and results would show that the gall bladder stone disappeared. I considered it to be a miracle of the Lord. Prayers heal but you also have to go to the doctor.

(Focus Group, FASGI, 25 May 2007)

But at the same time, for some seniors, belief in God does not replace modern medicine. Rather, like prayer, the hand of a trained doctor is seen as a means by which a person can be healed:

The doctor serves as an instrument of the Lord who happens to be the ultimate doctor.

(Focus Group, FASGI, 25 May 2007)

Seniors also turn to their faith to make sense of their mortality, and the mortality of their loved ones and neighbors. Seniors seek treatment for themselves or loved ones – including use of modern medical services. Yet, in situations where they have exhausted all efforts, they are able then to turn over their fate to a higher power. The following personal account by one elderly Filipina regarding her own son's illness reflects this combination of personal faith, treatment of illness, and ultimate acceptance of mortality.

My son, who was then 5 years old, had [what I believed at the time to be] chicken pox. I was too young then to deal with this kind of a situation. I was advised by an elderly neighbor to give him a bath of tea with plant seeds after 3 days. I exactly did what I was told. Soon afterwards, sores developed all over his body. I couldn't understand why. He never played outside that would expose him to the elements. I took him to the doctor at the hospital of the Philippine Iron Mines which was the company where my husband worked. The doctor said that it was just a case of lymph nodes. After a year, I took my son to my hometown in Bicol (southern part of Luzon, the biggest island in the Philippines) and there we were referred to a specialist on TB (tuberculosis). His diagnosis was that my son had TB of the glands. This doctor gave him an injection. My son complained of pain.

With this doctor, the condition of my son did not change. Finally, I decided to take him to our family doctor who gave out the diagnosis that my son had lymphosarcoma; a very rare disease at that time. In fact, the doctor explained that this particular illness belonged to the family of cancer and in his experience as a doctor, my son's case was just the second he encountered in his years of medical practice. He advised me to take son immediately to one of the big hospitals in Manila.

As soon as I was able to raise money, I brought him to Manila for treatment. Biopsy results were even sent to the United States for analysis. Although doctors explained as to what they were doing to my son, I couldn't understand them fully. The results of medical tests confirmed the earlier diagnosis of lympho-sarcoma. The next thing to worry about was the prescription for medication which according to the doctors would have to be procured from the United States. My husband at that time was

earning Php 4.00/day but the medication cost Php 7.00 (during the early 60's when this story happened, exchange rate was \$1: Php 2). Fortunately, medication was given free. He also underwent cobalt treatment which again was given free. Because of the fact that he received the proper treatment, his condition improved. I thanked the Lord for everything.

When it was time for me to go back to my hometown where I was attending college, my son insisted on going with me. Since he was already outside of the hospital, his medication stopped as I had no money to support him. His condition worsened and so what I did was to write to the President of the Philippines to ask for medical assistance. An ambulance came to take my son to the provincial hospital. The doctor's prognosis was that if my son would survive, there's a one in a million chance that in five years he could be cured of his cancer but if he could not make it, he would go within a year and indeed, within that year, he died. Because of my experience with my son, I get traumatized when I feel the nodes in anyone's body. According to the doctor, the illness is not hereditary but viral. My son was the only one in the family to have been afflicted by that kind of illness.

(Focus Group, FASGI, Female Participant, age 70+, 18 January 2007)

Clearly, among seniors religion is a means of attaining good health. The doctor does not replace God, nor does God take the place of the doctor. The doctor, like prayer, is used by God to preserve or restore health. In the end, however, religion gives seniors hope even when health fails.

Conclusions on Religion and Health

Despite varied understandings of religion, across all age groups there is a consistent belief that religion is closely tied to health and illness. It is a coping mechanism — a source of reassurance and an explanation of perplexing experiences. In some cases, it is a source of healing and provides motivation to take care of one's health and the health of loved ones.

Table 2.6 — Views of God’s Role in Human Health Based on Age

| Age | It’s God’s will | It’s God’s will/it’s not God’s will | It’s God’s will/God plays no role | It’s God’s will/I don’t know | It’s not God’s will | God plays no role | I don’t know | Total |
|--------------|-----------------|-------------------------------------|-----------------------------------|------------------------------|---------------------|-------------------|--------------|------------|
| 14 -17 | 29 | 0 | 1 | 0 | 3 | 3 | 13 | 49 |
| 18 - 24 | 24 | 0 | 0 | 0 | 3 | 8 | 17 | 52 |
| 25 - 39 | 17 | 0 | 0 | 0 | 4 | 5 | 12 | 38 |
| 40 - 64 | 21 | 0 | 0 | 0 | 6 | 6 | 10 | 43 |
| 65 - 79 | 53 | 1 | 0 | 1 | 8 | 3 | 2 | 68 |
| 80+ | 22 | 0 | 2 | 1 | 1 | 1 | 3 | 30 |
| Total | 166 | 1 | 3 | 2 | 25 | 26 | 57 | 280 |

The table above confirms that Filipino/Filipino Americans tend to lean on their religious traditions or seek traditional healing when faced with an illness or injury. They most frequently pray the novena, seek the services of a hilot, or a combination of the two. (Of all the survey respondents across religion, Catholics composed 22.5% of those who pray the novena and 10.8% of those who seek the services of a hilot.) Thus, there is a definite correlation between cultural tradition, religion, and seeking healing. Moreover, the ways in which Filipino/Filipino Americans cope with health problems include a mixture of religious practices and reliance on and assistance to others, while also seeking mainstream healthcare.

A question provoked by this finding is: How do providers take into consideration the importance for a majority of Filipino/Filipino Americans of their religious beliefs and traditional health practices while addressing the needs of this population? In our research, health providers noted the importance of these traditions for many of their Filipino/Filipino American patients.

An implication of this observation might be that health providers of all kinds – not just hospitals – consider providing on-call religious chaplaincy services, referrals to traditional healers, or prayer rooms within their facilities.

3. LANGUAGE

Within mainstream American culture, it is widely assumed that Filipino/Filipino Americans can assimilate easily because the Philippines used to be a US territory, with a consistent presence of Americans in the Philippines. It is often further assumed that Filipino/Filipino Americans, unlike most other Asian American ethnic and immigrant groups, can adapt relatively easily to life in America because of the presence of the English language in the Philippines. However, our findings broadly demonstrate that Filipino/Filipino American immigrants struggle with the English language, regardless of their familiarity with it. This, in the end, makes access to healthcare, and specifically, communicating with health providers much more problematic than is typically assumed.

Despite the fact that becoming proficient in English is part of the immigrant acculturation process, many Filipino/Filipino Americans still struggle with English. This is especially problematic for working adults and seniors who are more likely to be immigrants.

[W]hile many ... Filipinos are comfortable speaking in English, they may not be proficient in communicating their medical problems in English. In one provider's experience, he'd say approximately 70% of his Filipino patients can speak English well enough to express their health problem to him, while about 30% prefer having an interpreter in the exam room.... Many "new arrival" Filipinos ... have difficulty adjusting to their new environment. They are often sad or homesick. They miss their family, especially those who do not speak English well and have a hard time communicating. While the majority of Filipinos do speak English, there are some that are often embarrassed to speak English because they are afraid that they will speak it "wrong" and are more comfortable speaking in their native language.

(Focus Group, APHCV, 26 January 2007)

In this study, most respondents that were not English-dominant spoke Tagalog, Cebuano or Ilocano (or some combination of these). Underlying difficulties with speaking English within the Filipino/Filipino American population means many immigrants do not feel comfortable enough to seek healthcare or communicate openly with their providers. How long one has lived in the US is significantly associated with how much one uses health services.

For example in the following table, survey respondents felt more comfortable with their doctor the longer they had lived in the US.

Table 3.1 — Comfort Level with Doctor Based on Length of Stay in the US

| Stay in US | Level of comfort with the doctor | | | | | | Total |
|--------------------|----------------------------------|------------------|----------------------|--|------------------------|--------------------|------------|
| | Unknown | Very Comfortable | Somewhat Comfortable | Sometimes Comfortable Sometimes Uncomfortable | Somewhat Uncomfortable | Very Uncomfortable | |
| Less than 5 years | 3 | 12 | 12 | 12 | 2 | 1 | 42 |
| 5 - 10 years | 4 | 24 | 21 | 21 | 3 | 0 | 73 |
| More than 10 years | 4 | 50 | 22 | 20 | 3 | 3 | 102 |
| Total | 11 | 86 | 55 | 53 | 8 | 4 | 217 |

Additionally, when given a prescription, most respondents claim to not seek methods of treatment beyond the prescription itself.³ Yet it is also the case that many respondents regularly turn to alternative medicine or traditional remedies. It is possible that they see traditional methods as having no relation to the use of medical prescription drugs and other forms of treatment, and trust these methods based on past experience.

Youth and Language

Youth respondents demonstrate high levels of competency and confidence in the English language as demonstrated in the following quotes.

Since you're here in the US, you have to speak English.

For me, it's a privilege that people know another language. But there are [people who will tease me and] speak with an accent when I speak English. Like yesterday, I had a classmate in homeroom that was telling me "you sound so immigrant." It was a negative. They make me feel different. But I feel that's the way I am. It's hard. All my life, it's been [this way]. Even in the Philippines, I learn the subject English in Tagalog.

(Focus Group, SIPA, 24 May 2007)

The youth (particularly US-born but also most that were Philippines-born) tend to not experience language as a barrier to acculturation even when pressured by their peers. The people quoted above take English for granted even if they don't speak with an American accent. An implication is that language barriers to health are not significant for a majority of young Filipino/ Filipino Americans. At the same time, language may be a barrier in a different direction: between youth and their grandparents. To the extent that this barrier is present (and our population suggests that it is), the youth may miss out on gaining knowledge of their Filipino elders, including knowledge about health.

Working Adults and Language

For a majority of respondents in this age group, understanding English as a second language is not the same as the ability to express thought processes and feelings, which are usually done best in one's native language. There is a direct connection drawn to health as well.

Most Filipinos can understand the English language but understanding is completely different from expressing oneself in English. As Filipinos, our thought process is in the native language, so expressing ourselves in English does not come out naturally. When we go see a doctor, usually the first question that is asked is "what's wrong with you?" and if the doctor happens to be non-Filipino, the Filipino patient struggles to express him/herself in English.

(Focus Group, PWC, 19 January 2007)

This sentiment demonstrates that language proficiency, or lack of confidence with the English language, can act as a barrier to healthcare. In addition:

One provider brought up the fact that Filipino patients do not all speak the same language. There are many dialects within the Filipino community, which also make it challenging to provide care to them.

(Focus Group, APHCV, 26 January 2007)

Seniors and Language

The language barrier for working adults is also felt by seniors in our sample – most of whom are first-generation immigrants from the Philippines. Seniors mostly are comfortable speaking English, but they are even more comfortable when speaking with other Filipinos in their own language:

Most Filipinos can speak/understand English so they can easily adjust but they are more comfortable when talking to fellow Filipinos.

(Focus Group, FASGI, 8 June 2007)

In addressing the subject of health and illness in a society that does not share their primary spoken language, seniors tend to rely more on their peers for support and advice.

It is not unusual to hear from the elderly that they are better off with their friends rather than their families because [their friends] can speak the language.

(Focus Group, APHCV, 12 June 2007)

The survey data suggest that seniors are not uncomfortable with their healthcare providers compared to other age groups polled, including young people. However, the sample taken of seniors included primarily individuals who very likely had access to Filipino or culturally competent caregivers.

Additional data may be needed to ascertain whether, as a group, seniors are uncomfortable communicating with non-Filipino or non-Tagalog speaking providers. The focus groups we held with seniors suggests the following conclusion: Language is problematic for seniors inasmuch as it may act as a barrier in communicating with healthcare providers because they are more comfortable speaking with a provider who is Filipino/Filipino American and can speak their primary language.

Communication with Providers

The table below demonstrates that, regardless of primary language(s), the majority of survey respondents felt either “Somewhat comfortable” or “sometimes comfortable, sometimes uncomfortable” when communicating with their doctor.

Table 3.2 — Level of Comfort with Doctor Based on Language(s) Spoken

| | Very Comfortable | Somewhat Comfortable | Sometimes Comfortable | Somewhat Uncomfortable | Very Uncomfortable | Total |
|-------------------------------------|------------------|----------------------|-----------------------|------------------------|--------------------|------------|
| English | 8 | 6 | 9 | 2 | 2 | 27 |
| Tagalog | 25 | 25 | 19 | 4 | 1 | 74 |
| English, Tagalog | 45 | 39 | 25 | 3 | 3 | 115 |
| Ilocano with English and/or Tagalog | 19 | 1 | 2 | 0 | 0 | 17 |
| Visayan with English and/or Tagalog | 5 | 5 | 6 | 1 | 1 | 18 |
| Other Primary Languages | 6 | 3 | 1 | 0 | 1 | 11 |
| Total | 108 | 79 | 62 | 10 | 8 | 267 |

The above finding correlates with the table below, in that the majority of survey respondents, regardless of primary language(s), found it either “somewhat easy” or “neither easy nor difficult” to communicate with their providers.

Table 3.3 — Ability to communicate with Provider Based on Language(s) Spoken

| | Ability to communicate with Provider | | | | | Total |
|-------------------------------------|--------------------------------------|---------------|----------------------------|--------------------|----------------|------------|
| | Very Easy | Somewhat Easy | Neither Easy nor Difficult | Somewhat Difficult | Very Difficult | |
| English | 1 | 5 | 4 | 2 | 1 | 13 |
| Tagalog | 4 | 15 | 20 | 11 | 6 | 56 |
| Visayan | 3 | 39 | 48 | 21 | 8 | 119 |
| Tagalog with English and/or Spanish | 1 | 6 | 12 | 6 | 3 | 28 |
| Ilocano with Tagalog and/or English | 3 | 14 | 10 | 0 | 3 | 30 |
| Other Primary Languages | 1 | 10 | 2 | 3 | 0 | 16 |
| Total | 13 | 89 | 96 | 43 | 21 | 262 |

While the majority of survey respondents appeared to have minor difficulties in communicating with their providers, the majority of survey respondents overwhelmingly preferred either “a doctor born in the Philippines” or “a Pilipino American doctor.” This finding shows that in our survey population, there is a strong overall preference for healthcare that they feel is culturally sensitive. This point was confirmed by the following focus group with healthcare providers:

When asked why patients like to come to them, one provider responded that they liked coming to him because they feel he listens to them. “They appreciate when you take the time to really listen to their problems. For example, there was a patient who was abused by her husband, and by law, she had to report it to the authorities. The patient subsequently left her husband and later came back to thank the provider for his involvement in her situation.” He stated that it is important to give them a chance to tell their story. He personally feels lucky to be able to hear what no one else – often the patient’s own family and friends – hear. It is a blessing to be able to be kind to them, and once that happens they are “yours forever.” You form a bond and trust with that patient that will last.

(Focus Group, APHCV, 26 January 2007)

Table 3.4 — Type of Doctor More Likely to Understand Health Concerns Based on Language(s) Spoken by the Client

| | Doctor discuss | | | | | | Total |
|-------------------------|--------------------------------------|--------------------------------|----------------|--|------------------|----------------------|------------|
| | A doctor born in the Philippines (a) | A Filipino-American doctor (b) | Both (a) & (b) | A doctor who is neither Filipino nor Filipino-American | Any of the above | Neither of the above | |
| English | 3 | 1 | 5 | 1 | 0 | 2 | 12 |
| Tagalog (Filipino) | 11 | 2 | 6 | 2 | 1 | 0 | 22 |
| English, Tagalog | 6 | 4 | 10 | 0 | 2 | 5 | 27 |
| Ilocano | 10 | 4 | 7 | 2 | 1 | 2 | 26 |
| Visayan (Cebuano) | 30 | 7 | 49 | 15 | 6 | 16 | 123 |
| Other Primary Languages | 5 | 0 | 6 | 1 | 1 | 2 | 15 |
| Total | 65 | 18 | 83 | 21 | 11 | 27 | 225 |

Conclusions on Language and Health

First, in the context of accessing health services, building a sense of comfort and trust with patients requires language and cultural competency on the part of providers. Language in particular can be a sensitive issue for Filipino/Filipino Americans. This is not only because health issues are seen as personal, but also because misunderstandings resulting from language barriers can themselves make a patient feel ashamed or embarrassed. This situation highlights the importance for providers of mastering the patients' primary language.

...[P]roviders stated that speaking the patients' language is so important to them. They have an instant comfort with you when they discover you speak their language. It gives them the sense that you truly care about them.

(Focus Group, APHCV, 26 January 2007)

Second, the particular community that is the focus of this study is located in a multi-generational, multi-cultural neighborhood that historically served as a meeting place for the first generation of Filipino/Filipino American immigrants arriving in Southern California, many of whom were agricultural workers. Language was preserved through this enclave while immigrants simultaneously became acculturated.

Such enclaves in general can be viewed as sites in which health providers can focus their energies and set up convenient locations with services that can address the particular language and acculturation needs of specific ethnic communities. However, the process of language maintenance appears to be broken in the case of the youth.

This may result in a generation gap and communication issues between youth, and adults and seniors. In this situation, the inter-generational transfer of cultural knowledge and traditions may be stymied – including culture-based knowledge in the area of traditional health care.



4. FAMILY AND KINSHIP NETWORKS

The category of family in this context can and does often include extended family and “fictive kinship” networks. (Fordham, p. 71) This term refers to an informal web of personal relationships in which individuals are highly interdependent not only with family members but others as well. These “others” may be friends or acquaintances but not blood relations. Key decisions are generally made collectively – that is, all members of a reference group of intimacy, whether nuclear family, extended family or fictive kin group – are involved. Such a collective approach to decision making is at the same time embedded in a tradition of honoring senior members, respecting the wisdom and authority of parents and placing a high value on sustaining and promoting harmony in the relationships one has with members of this primary reference group.

The primacy and deep influence of “family” is observable in our sample population, and in the context of making health care decisions. For example, it is apparent from the data that (1) youth depend on and are greatly influenced by their parents; and (2) parents will seek treatment for their children with little regard for cost or other possible barriers such as language. Where the welfare of children is concerned, the key decision maker of the household tends to be the primary female caregiver. Most often this is the mother. In many other instances, and as a practical matter, the authority for making healthcare decisions rests with the family member who is paying the medical bills.

The priority of family in Filipino/Filipino American culture can in some cases create pressures on caregivers that work to their own detriment. For example, Filipino/Filipino Americans traditionally provide direct home care to sick or aging family members rather than turning to external providers of convalescent services. This preference can put them in a position of working in their jobs, taking care of ailing family members, and maintaining a household all at one time. This situation may pose risks to the caregiving family members’ own health and wellbeing. Education and counseling services may need to be made available to address this particular issue.

Health and health access are affected by the structure of “fictive kinship.” Filipino/Filipino Americans tend to rely on others close to them on advice related to health.

Table 4.1 — Level of Reliance on Others for Health Related Advice Based on Age

| Age | Rely on others | | | | | Total |
|--------------|----------------|------------------|--------------|----------------------|-----------|------------|
| | All the time | Most of the time | Occasionally | Only once in a while | Never | |
| 14 - 17 | 11 | 23 | 8 | 5 | 2 | 49 |
| 18 - 24 | 8 | 19 | 15 | 6 | 3 | 50 |
| 25 - 39 | 4 | 9 | 16 | 5 | 4 | 38 |
| 40 - 64 | 6 | 7 | 20 | 7 | 2 | 39 |
| 65 - 79 | 16 | 11 | 16 | 20 | 4 | 62 |
| 80+ | 5 | 7 | 14 | 2 | 1 | 26 |
| Unknown | 0 | 0 | 0 | 1 | 0 | 1 |
| Total | 50 | 76 | 90 | 46 | 16 | 265 |

Notably, members of all age groups tend to rely on each other to some extent. Expectedly, youth and seniors are likely to rely on others more than working adults.

Table 4.2 — The Importance of the Advice from Others Regarding Health Related Matters Based on Age

| Age | Advice from others | | | | | | Total |
|--------------|--------------------|----------------------------------|------------------|-----------|---------------|-----------|------------|
| | Most important | Major factor but not only factor | Fairly important | Minor | Not important | Depends | |
| 14 - 17 | 13 | 19 | 7 | 6 | 4 | 0 | 49 |
| 18 - 24 | 5 | 23 | 15 | 4 | 4 | 0 | 51 |
| 25 - 39 | 6 | 14 | 6 | 6 | 5 | 1 | 38 |
| 40 - 64 | 11 | 10 | 10 | 6 | 2 | 3 | 42 |
| 65 - 79 | 25 | 12 | 11 | 1 | 4 | 14 | 67 |
| 80+ | 17 | 2 | 5 | 2 | 1 | 2 | 29 |
| unknown | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Total | 77 | 80 | 54 | 25 | 20 | 21 | 277 |

In contrast to relying on others for money or things, our sample population appears to rely on others for advice. The sample population's responses pertaining to the extent to which they value and rely on practical advice from others range from answering "most important" to "fairly important."

Similarly, regarding a tendency to rely on others for guidance in health care decisions, most respondents were either "completely" or "somewhat" influenced by others. Others indicated that they rely significantly on others.⁴

Focus group participants emphasized that when it comes to health, many Filipino/ Filipino Americans are influenced as much by their close friends as by family members:

When coming in for medical care, the [provider] participants felt that most consulted with their family, of course depending on the issue...[But] when asked whether or not Filipino patients to go to family first before seeking a medical provider, the majority response was that they actually go to their friends first, then family...Many patients compare with their friends what worked for them. Their friends are full of health advice in what works, what doesn't work, etc. They come to the clinic to compare; they want to see if we have the same remedies...

(Focus Group, APHCV, 26 January 2007)

In light of the tables and focus group information above, it appears that our sample population does rely quite extensively on the advice and influence of others, whether friends or family, regarding health decisions. In general, young adults and seniors are more likely to rely on others compared to working adults.

Furthermore, the survey reveals that among members of this population, the more you rely on others, the more you will value their advice. It can be inferred from this general tendency that when it comes to matters of health, those receiving advice from friends and loved ones do value this type of advice and may well be expected to follow it. The more a respondent relies on others, as is the case for most seniors and youth, the more they value the advice of others.⁵

Parents place a premium on their children's health, which they tend to view more urgently than their own health at times. While parents take primary responsibility for caring for a sick child and seeking the medical attention which their children need, approximately 10% of the survey respondents say they rely on "others" to seek this treatment for children.

Table 4.3 — Caregiver Responsible for Taking a Sick Child to the Doctor

| Caregiver(s) | Frequency | Percent | Cumulative Percent |
|---------------------------------------|------------|--------------|--------------------|
| Mother | 71 | 34.80 | 40.1 |
| Father or both parents | 101 | 49.51 | 85.6 |
| Grandparents | 5 | 2.45 | 87.8 |
| Friends | 1 | 0.49 | 88.3 |
| Neighbors | 1 | 0.49 | 88.7 |
| Other | 21 | 10.29 | 98.2 |
| Child does not go to doctor when sick | 4 | 1.96 | 100.0 |
| Total | 204 | 100.0 | |

The vast majority of parents reported that they will take their sick child to the doctor within three days regardless of their comfort level with the doctor.⁶

Family and Barriers to Healthcare

The intimacy of relationships within Filipino/Filipino American families can also act a barrier to healthcare. This can be traced to not wanting to be a burden, lack of understanding, and generation gaps.

There are different issues with the different age groups of Filipinos. Many youth hide what they are going through from their parents. Adult Filipinos may hide a medical condition because they don't want to worry their loved ones. Some patients will not tell their elderly parents that they have certain health conditions because they feel that they have enough to deal with and don't want to burden them with any more. The same is true of elderly patients who will not tell their adult children what conditions they have...

(Focus Group, APHCV, 26 January 2007)

The importance to health of family and kinship network support and care should not be underestimated; however, where present, these barriers tend to form around generational differences and misunderstandings.

Parents are seen by youth as caregivers in health matters, yet may also be viewed by youth as judgmental and strict, especially in matters of pre-marital sex. The majority of survey respondents believe that teen pregnancy and pre-marital sex are an issue in the community. Apparently, both the young and their parents see a problem here, but possibly for different reasons.⁷

Table 4.4 — Frequency of Those Who Believe that Pre-marital Sex Is an Issue in the Community

| | Frequency | Percent | Cumulative Percent |
|--------------|------------|--------------|--------------------|
| Yes | 168 | 57.7 | 57.7 |
| No | 105 | 36.1 | 93.8 |
| Unknown | 18 | 6.2 | 100.0 |
| Total | 291 | 100.0 | |

The statement below by APHCV staff about access barriers due to concern about keeping use of services out of parents' view suggests that some youth are divided within themselves between respecting the tradition of their parents and attending to their own health needs.

On the part of the youth, the barrier is defined as concern with confidentiality. The youth would like to be assured that their parents would not have a way of finding out what services they are accessing. This concern is mainly rooted [in] the traditional orientation of Filipino/Filipino American families, in particular, Catholic families who regard certain health practices [such as] having a pap smear or birth control as taboo.

(Focus Group, APHCV, 24 May 2007)

Youth may find it difficult communicating with parents around matters related to sexual activity and health. While this finding is relevant to some extent for all teens and their parents, there exists a pronounced need to educate first-generation immigrants (youth and parents) around these health matters.

Like the young people in our sample, the seniors also experience unseen barriers to healthcare in the context of relying on family members. Traditionally, Filipino/Filipino American families are expected to care for their elderly as the statement below demonstrates.

Strong family ties specifically in the aspect of taking care of the elderly; the family will always want to keep them; Filipinos don't want to send them to nursing homes.

(Focus Group, PWC, 18 May 2007)

This cultural belief, however, from the perspective of healthcare providers is complicated. They believe that seniors who are cared for solely at home and by family members may need additional treatment and care.

I work in the home healthcare sector. We do follow-up care for those who have been discharged from the hospital. Most of our clients are the elderly. We are situated in the valley. We get Filipino clients like for every 10 patients, around three or four are Filipino. I think it is ingrained in the Filipino culture to still keep their elderly at home.

(Focus Group, APHCV, 24 May 2007)

Additionally, senior citizens appear to have a difficult time with their families for various reasons. They may have immigrated to the United States later in their lives, at a relatively older age, but they are still forced to cope with all the changes associated with immigration. This situation is compounded for seniors because they often live on a fixed income and are, therefore, dependent on their adult children for housing and other necessities. However, their adult children are often still in the workforce and have little time to care or spend time with their parents. Moreover, seniors are often expected to provide childcare for their grandchildren. A sense of alienation or neglect can be engendered by the demands of work and lack of affordability of life here. Sometimes seniors even can become paid babysitters for their grandchildren and others. From one perspective, this may take time away from seniors' efforts to build their own peer support networks.

The problem is that seniors rely heavily on their peer networks to assist them in all aspects of their lives, e.g. medical referrals, support, and social ties – even while they are meeting demands to baby-sit at home. A generation gap is likely to increase, as seniors may feel closer to their peers than their families, a situation ironically fueled by possible language and lifestyle differences. These findings imply that while honoring and caring for senior members is a core familial value, it imposes costs on old and young alike in practice. The quote below from a service provider illustrates how it can become problematic for seniors to live with their adult children.

Stress among the elderly starts to develop with ... high expectations as their adult children petition them to come over here in the US. The images of America that are formed in their minds are those of Disneyland, Universal Studios, Hollywood etc. only to find out that when they reach the US, they will only stay at the homes of their children's families to take care of their English-speaking grandchildren. Oftentimes, they are hired by other families to become baby-sitters as the parents are so busy with making money. On the part of the elderly, baby-sitting becomes an alternative source of income. Thus, they find themselves working instead of enjoying their stay in the US.

These are the conditions that may trigger stress and ultimately plunge the elderly into depression. Things can even be worse for women who are already in their menopause... I met a Filipino/Filipino American elderly in a convalescent home who shared with me that in order for her to talk to her daughter even just on the phone, she has to make an appointment with her given her busy work schedule.

(Focus Group, APHCV, 24 May 2007)

Conclusions About Family/Social Networks and Health

Overall, the familial and fictive kin networks in the Filipino/Filipino American community work to foster support for individuals' health care. Care and advice are readily given to others. These work to ensure that members' health is attended to, and also to educate newly arrived immigrants or those with little resources for accessing healthcare. However, the intertwining of tradition and expectations for youth and seniors also work to erect barriers to care.



5. HEALTH AWARENESS: PREVENTION AND HEALTHY HABITS

Health awareness and prevention of illness are a major concern for almost any community, but especially for a diverse community such as Los Angeles. Those members most heavily impacted by health disparities are low-income, minority populations. As discussed in the introduction to this report, Asian Americans as a group are often overlooked because they are assumed to fit the stereotype of a Model Minority, a stereotype aggravated by an improper conflation of subgroups in the Asian American community which are in reality quite diverse. Filipino/Filipino Americans are one clear example of a group that is diverse internally, and different in many respects from other API groups in the US.

This study examined health awareness among Filipino/Filipino Americans as one way of mapping the group-specific conditions they are facing with regard to health in general. Participants in this study were asked about their own health and nutrition habits in an effort to better understand the extent and nature of their own awareness, approaches, and activities focused on increasing their well-being.

Physical Exercise

Table 5.1 — Frequency of Engaging in Exercise by Income Level

| Income | How often do you exercise? | | | | Total |
|-----------------|----------------------------|-------------|--------------|--------------------|------------|
| | 2x-3x per week | 1x per week | 1x per month | Never/Almost Never | |
| Under 5,000 | 57 | 19 | 8 | 5 | 89 |
| 5,000 - 9,999 | 26 | 9 | 1 | 4 | 40 |
| 10,000 - 14,999 | 17 | 4 | 3 | 5 | 29 |
| 15,000 - 24,999 | 17 | 12 | 3 | 2 | 34 |
| 25,000 - 34,999 | 10 | 9 | 2 | 6 | 27 |
| 35,000 - 49,999 | 4 | 3 | 2 | 5 | 14 |
| 50,000 - 74,999 | 5 | 4 | 0 | 4 | 13 |
| 75,000 - 99,999 | 4 | 1 | 1 | 3 | 9 |
| 75,000 - 99,999 | 2 | 0 | 0 | 0 | 2 |
| Total | 142 | 61 | 20 | 34 | 257 |

In regard to having ready access to a place for exercise, our findings were counter-intuitive. The lower the income, the more likely the group had access to a place for physical activity. If the sample population had fit the tendency observed among the population of LA as a whole, access to physical activity venues would have correlated with higher incomes.

However, since approximately one-third of our sample is composed of youth, then it is likely that they are able to exercise at school. Additionally, seniors are more likely to have planned activities at senior centers in which they are also able to participate in programmed physical fitness activities.

Table 5.2 — Respondents’ Frequency in Getting Physical Exercise, by Age Group

| Age | Exercise | | | | Total |
|--------------|----------------|-------------|--------------|--------------------|------------|
| | 2x-3x per week | 1x per week | 1x per month | Never/Almost Never | |
| 14 -17 | 37 | 6 | 4 | 2 | 49 |
| 18 - 24 | 25 | 11 | 5 | 11 | 52 |
| 25 - 39 | 13 | 13 | 3 | 9 | 38 |
| 40 - 64 | 13 | 14 | 5 | 11 | 43 |
| 65 - 79 | 46 | 17 | 3 | 1 | 67 |
| 80+ | 23 | 6 | 1 | 2 | 32 |
| Total | 157 | 67 | 21 | 36 | 281 |

Working adults, who bear a dual burden of earning income and running the household, may not lack access to a place, but rather to time, for getting the exercise they need.

Table 5.3 — Respondents’ Access to Local Venue For Regular Exercise Based on Income Level

| Income | Exercise place | | Total |
|-----------------|----------------|-----------|------------|
| | Yes | No | |
| Under 5,000 | 69 | 18 | 87 |
| 5,000 - 9,999 | 28 | 10 | 38 |
| 10,000 - 14,999 | 16 | 13 | 29 |
| 15,000 - 24,999 | 23 | 11 | 34 |
| 25,000 - 34,999 | 14 | 12 | 26 |
| 25,000 - 34,999 | 8 | 6 | 14 |
| 35,000 - 49,999 | 12 | 1 | 13 |
| 50,000 - 74,999 | 8 | 1 | 9 |
| 75,000 - 99,999 | 2 | 0 | 2 |
| Total | 180 | 72 | 252 |

While it appears from the two tables above that the majority of respondents in the sample are aware of the importance of keeping healthy habits,⁸ in reality, they do not consistently practice these habits when it comes to nutrition and healthy eating.

Table 5.4 — Frequency of Respondents Eating Fastfood Based on Income Level

| Income | How often do you eat Fastfood? | | | | | Total |
|-----------------|--------------------------------|----------------|-----------------|---------------------------------------|------------------------|------------|
| | 2x - 3x per week | 1x per week | 1x per month | 1x per month Never/Almost never | Never/ Almost never | |
| Under 5,000 | 25 | 27 | 23 | 1 | 12 | 88 |
| 5,000 - 9,999 | 9 | 11 | 8 | 0 | 9 | 37 |
| 10,000 - 14,999 | 7 | 9 | 8 | 0 | 5 | 29 |
| 15,000- 24,999 | 7 | 13 | 13 | 0 | 3 | 36 |
| 25,000 - 34,999 | 11 | 9 | 1 | 0 | 4 | 25 |
| 25,000 - 34,999 | 7 | 5 | 2 | 0 | 0 | 14 |
| 35,000 - 49,999 | 2 | 11 | 0 | 0 | 0 | 13 |
| 50,000 - 74,999 | 2 | 4 | 2 | 0 | 1 | 9 |
| 75,000 -99,999 | 0 | 0 | 0 | 0 | 2 | 2 |
| Total | 70 | 89 | 57 | 1 | 36 | 253 |

Healthy Eating

In regard to healthy eating, we note from respondents a problem with access to fresh, healthy food. The working adults, who are often busy and strapped for time, may find it difficult to shop for groceries and provide home cooked meals on a regular basis. Moreover, affordable supermarket retail chains are not always easy to get to for some who live in Historic Filipinotown. Adding to this is a different way of seeing fast food:

The youth don't consider it fast food . . . they don't have concern about health in the food they eat – (because they are) victims of fast food ads. It is the cheapest and most accessible food. When you are young, you don't think about illness or diet. Also, it's cheap. Their parents don't have time to cook. . . . [Apart from fast food restaurants] [w]hat do you see in family [fridges]? Quick and easy foods. Cup o' noodles. Canned goods (e.g. spam, corned beef). Microwaveable foods. And when you want vegetables, the preparation takes long. So (they) just go to Bahay Kubo (restaurants serving Filipino food) or fast food. In the Philippines, you can't go to McDonald's since it's expensive. The other alternative – karinderia or turo-turo places.

(Focus Group, SIPA, 24 May 2007)

There also is a perception in the Filipino/Filipino American community that eating out, whether healthy or not, is a status symbol. Many people in the Philippines cannot afford to eat at MacDonal'd's.

Overall, across age and income, our sample is generally aware of healthy eating habits. However, it is not clear that this awareness translates into people actively seeking out and accessing healthy foods, usually due to time constraints and cost.

Nutrition, Health and Traditional Medicine

But this discrepancy may be rooted in a deeper cultural gap – in this instance, Filipino/Filipino Americans tend to have a different understanding of sickness, health and wellness. This wider divergence of perspectives is partly a function of the generation to which one belongs, and also of how much one retains of traditional cultural understandings of health and health care.

For example, we have observed a diversity of opinion and practice regarding health and well-being among respondents that goes well beyond issues of nutrition and fitness. Those Filipino/Filipino Americans who are assimilated in Los Angeles tend to see health through the lens of the West. From this perspective, most health problems can be clinically diagnosed, and treatments prescribed, based on knowledge acquired through the mainstream medical sciences. Even participants who observed that many Filipino/Filipino Americans' health problems can be addressed through better nutrition and exercise are using a Western lens on public health.

On the other side from those who subscribe to Western medicine are those who embrace *traditional cultural views* of health and medicine. Traditional medicine assumes that illness and health have a metaphysical dimension, and that this dimension should be addressed along with the physical dimension in the maintenance of health and treatment of illnesses. In the arena of health, Filipino/Filipino Americans historically believed that spirits brought illness and healing to people in different situations. Some still do believe this. Remedies sought to address these phenomena went beyond incantations or exorcism and included herbs and plants with medicinal properties.

In their experience, many patients try many things before coming to them for help, or do it in conjunction with seeing them. Patients use "salampas," or "efficacious oil" (the "green" oil). They try "tiger balm" or "white flower" or different kinds of vitamins. They try herbs for asthma. They drink juices said to having healing powers, such as "noni juice," "mangosteen," and "xango." They wear bracelets said to have healing powers. Many of the herbs and juices are sold in the community out of peoples' homes or cars. Just like "Tupperware" parties, some people are known in the community to sell these "natural" healing items. Many are claimed to reduce blood pressure, have

antioxidants (which is heard to be “good for you”). Filipino patients tell them that they eat garlic and eat vinegar with their foods to lower blood pressure.

(Focus Group, APHCV Providers, 26 January 2007).

For most Filipino/Filipino Americans, traditional medicine is not regarded as antiquated and strange, but rather provides encouragement to embrace natural remedies and holistic medicine in much the same way that other groups in America now do.

To return to eating habits: traditional medicine does not leave Filipino/Filipino Americans to minimize the importance of good nutrition. Rather, it sees nutrition as one part of a wholistic response to risk factors to health that modern medicine does not sufficiently acknowledge or address including stress in the American way of life and influences of unseen spirits.

Mental Health

When discussing causes of illness in the Filipino/Filipino American community, traditional providers point to stress created by the pressures of living in America:

I think it is stress brought about by our lifestyle. Driving is a source of stress.

(Focus Group, APHCV, 24 May 2007)

Working adults may experience stress brought on by stoicism:

Filipinos [sometimes deny it] when they feel something wrong about their physical condition. The common reaction is “I can handle this;” or “this is nothing.”

(Focus Group, PWC, 18 May 2007)

But our findings further point to stress as a cause of problems with mental health for this population. For example, health providers noted the following tendency particular to Filipino/Filipino Americans:

...[w]hen comparing their Filipino patients with other ethnic communities, most of the participants agreed that the rate of stress, anxiety, depression, relationship issues with children is higher in the Filipino community ... Many Filipino patients feel like they are “slaving away” in this country. Many are caregivers. Many have emotional problems, for example dealing with spousal abuse. They are afraid to talk about it because it is an embarrassment to their family. It may have started in the Philippines but it continues here ... Some providers have to come to the realization of to what

extent the stress in Filipino patients' lives affect their health. Their stress lends itself to other health problems. Stress causes them to lose sleep, which makes them more tired and fatigued and more prone to get other illnesses and less likely to engage in healthy behaviors, like physical activity...

(Focus Group, APHCV Staff, 26 January 2007)

Participants in focus groups corroborated the claim that depression and mental health challenges are common:

[T]here are many students who have *utang*. They have a different way of thinking. You are talking more about disabilities.

In my case, I am dealing with that kind of thing. It was three weeks ago when I started seeing a psychologist, I needed guidance mentally... It's hard when I deal with different kinds of people with different age and thinking. Even in my family, there are dramatic things. I feel depressed thinking about it. I feel confused too. I can't decide straight. When I talk to the psychologist, everything started to make sense. It's been 3 weeks since I see him, every Monday and Friday. This therapist I started talking to, he said that I was clinically depressed. He didn't tell me to take anti-depressants, but I told my mom if I should. She said, I might get addicted, and I shouldn't take it.

When I first came to the States, the doctor prescribed me anti-depressants. I felt lonely. I didn't have any friends. I didn't know the community. Every year, I kept moving to a different school, so it was hard for me.

"In the place I work, they check up on us if we are ok – if we are violent, or whatever. I feel lazy ... to share my stories. I feel that they were private. They keep insisting whether something bad happened to me, and they were evaluating me after that. They kept telling me that it wasn't my fault after I finally told them what happened. I almost felt like crying. The pain in your chest, you can't ignore it. It's better if you share it, and open up."

(Focus Group, SIPA, 24 May 2007)

Filipino/Filipino American culture has potentially cross-cutting effects on mental health. On one hand, the desire to avoid a sense of shame, or embarrassment (*hiya*) in the family could lead to stigmatizing mental illness, creating a potential barrier to appropriate health care. On the other hand, the intimacy of the family and kin networks can provide a robust network of support for members with mental illnesses, once a family has come to accept a member's condition for what it is.

The finding that mental health is an issue does not diminish the fact that resilience and adaptability are among the qualities for which Filipino/Filipino Americans are well-known. It does appear to be a possible outcome of living with unacknowledged stress for a long time.

The link between stress, mental health and physical health in the Filipino/Filipino American community has barely been touched in recent literature, with some notable exceptions. (See, for example, Takeuchi *et al.* (2007)). The quotes above are given by youth, but mental health needs cross generations, afflicting working adults and the elderly as well. The apparent prevalence of stress and depression in the population suggests that the mental health challenges and needs of Filipino/Filipino Americans deserve greater attention and culturally sensitive care.



6. HEALTH ACCESS

The responses around insurance and access to healthcare pose a conundrum. Based on their responses (see the table below), survey respondents appear to have either little or no problems in accessing healthcare.

Table 5.5 — Respondents’ Type of Insurance Coverage Based on Income Level

| Income | Employment based HMO or PPO | Privately purchased HMO or PPO | Medi-Cal | Medi-Medi or dual eligible | Uninsured | Medi-Care | Other | Total |
|-----------------|-----------------------------|--------------------------------|-----------|----------------------------|-----------|-----------|-----------|------------|
| Under 5,000 | 16 | 4 | 19 | 14 | 7 | 7 | 17 | 84 |
| 5,000-9,999 | 2 | 1 | 10 | 14 | 5 | 1 | 2 | 35 |
| 10,000- 14,999 | 4 | 2 | 4 | 8 | 7 | 1 | 4 | 30 |
| 15,000 - 24,999 | 16 | 1 | 3 | 5 | 7 | 1 | 2 | 35 |
| 25,000 - 34,999 | 14 | 2 | 1 | 2 | 4 | 0 | 1 | 24 |
| 25,000 - 34,999 | 9 | 2 | 1 | 0 | 0 | 1 | 1 | 14 |
| 35,000 - 49,999 | 11 | 0 | 0 | 0 | 0 | 0 | 1 | 12 |
| 50,000 - 74,999 | 5 | 2 | 0 | 1 | 0 | 0 | 1 | 9 |
| 75,000 - 99,999 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Total | 77 | 14 | 38 | 44 | 32 | 11 | 29 | 245 |

The majority of respondents here claim to have health insurance and feel comfortable communicating with their providers, which stands in contrast to their issues with language proficiency and other issues of acculturation.

Across educational levels, the majority of the survey respondents appear to report that it is “very easy” to “somewhat easy” to communicate with their healthcare providers.⁹ Also when correlating place of birth with degree of comfort with a doctor, the majority of survey respondents, regardless of birthplace, reported that it is “somewhat easy” to “very easy” to communicate with their provider.¹⁰

These survey findings contradict the responses of participants in focus groups in this study. The focus groups highlighted several reasons that Filipino / Filipino Americans are in fact uncomfortable with doctors and health providers. For example, according to seniors and working adults, there is a fear around the legal status of many immigrants. Although actual numbers were not sought in this study, the undocumented are afraid of their status being discovered and of the possible threat of deportation. The focus group participants also described a lack of understanding around how to navigate the healthcare system and access services or insurance that is low-cost. Further, they

described negative experiences with County health facilities and of not wanting to repeat past bad experiences when utilizing the healthcare system. Lastly, senior and working adults also discussed their need for healthcare providers to offer culturally and linguistically appropriate services. The quotes below are all from working adults or seniors who are first-generation immigrants. The number of years they have been in the U.S. varies.

(The issue of) no insurance coverage [is such that] in case of emergency, the only option for them is to go to county hospitals but not knowing how to navigate the system, they end up being charged with thousands of dollars in medical bills.

(Focus Group, PWC, 18 May 2007)

For myself, I have no faith in the doctors here in the US. I had this experience of having to go through a medical examination and a lesion in one of my lungs appeared. I explained to my doctor that it was a result of my involvement in a brawl during my younger years. He did not want to believe me. Instead he ordered a lot of tests like CT Scan to determine the cause. After going through a circuitous route he came up with a conclusion which is the same as what I had explained to him.

(Focus Group, PWC, 19 January 2007)

When my husband suffered a stroke, we called up 911 but they decided that my husband's case was not an emergency. We, the family members ended up taking him to the hospital. In the hospital we were made to wait which worsened his condition to the point of being paralyzed. We brought this to the attention of the authorities but [all they did was] reprimand the emergency staff.

(Focus Group, PWC, 18 May 2007)

There are people who believe that prescription drugs have side effects in the sense that if one takes a particular drug for one type of illness, another type comes up.

(Focus Group, FASGI, 25 May 2007)

The *survey* responses about being comfortable communicating with doctors are perplexing not only when seen in light of the quotes above, but also when triangulated with our findings around *language* described earlier in this report. Our best explanation is that the particular sample of residents in this survey appears to have already found healthcare providers that address their needs, and issues may only arise when they are referred to a specialist. Because this is a not a random sample and the respondents were receiving services from the participating agencies, they may be aware of where and how to address their healthcare needs without culture-based communication problems.

Notwithstanding the survey finding above, the barriers we heard about in focus groups and the language-related problems reported across all respondents suggests that most Philippines-born Filipino / Filipino Americans are not at ease with their health providers. Additional research on the “health access” question should be pursued in order to better understand the complexity of results in this study.



CONCLUSIONS

In light of our findings, our conclusion is that Filipino/Filipino Americans are an ethnic group that faces challenges in the experience of immigration and acculturation in Los Angeles that at once help its members address their health needs and can pose barriers to healthcare access. These include language, length of stay in the US, and income. However, these barriers are complex and multi-layered. For example, language is a complex issue because Filipino/Filipino Americans, especially those who are immigrants prove to have a familiarity with the English language, which should theoretically reduce barriers to communicating with healthcare providers. Our survey respondents and focus group participants stated that while they are familiar with English, they are not always confident and/or comfortable speaking it.

Another cultural factor that influences healthcare decisions and access is religion. The reliance of many members of the population on prayer and other rituals theoretically could lead them to use religion as an alternative to conventional health care. However, the seniors appear to integrate their strong religious beliefs with a trust in mainstream healthcare. For example, seniors seek treatment and advice in addition to praying and utilizing traditional medicine. More broadly, levels of acculturation, as measured by length of stay in the US, also serve to affect how much this population accesses healthcare and how comfortable its members feel within the mainstream healthcare system. Beyond cultural factors, Filipino/Filipino Americans in our sample are affected by low-income levels, which often lead to lack of exercise and lack of attention paid to preventative healthcare, mostly among working adults.

Generational Differences

Overall, our original approach of examining levels of acculturation in order to elicit connections between culture and health appears to have revealed hidden complications. While levels of acculturation generally do have a tangible effect on people's ability to access healthcare, this is not as large an issue as we first thought. The specific ways in which each age group's degree of acculturation intersects with their income and other resources (time, knowledge, care/advice from others and income) are important factors in creating or limiting access.

For example, the youth are very adaptive. They are cognizant of cultural differences, yet do not view these differences as an issue or a limitation vis-à-vis their life options. Their challenges are different: They revolve around a need to be more educated about healthcare, specifically when it comes to sexual activity, and negotiating the traditional values of their parents and the proscriptions of the community at large on premarital sex.

Working adults prove to have the greatest difficulty in accessing health care and maintaining healthy habits in their daily lives, such as nutritious eating and exercise. While they place high importance on caring for their children and their elders, this often occurs to the detriment of caring for themselves. Among other things, this could mean that they need access to childcare, senior day care or a program in which they can exercise and bring their children at the same time. Future research could examine the types of jobs that working adults are holding and how they can find time and resources to access healthcare and preventative health measures for themselves.

The seniors in our sample represent the group most keenly aware of healthy habits, such as eating nutritiously and regularly participating in exercise activities. They also appear to value and utilize social networks for advice and support and often turn to traditional medicine.

The enclave of Historic Filipinotown provides a unique window on the needs of a discrete culture group in Los Angeles. This study explores the complexity of their experience with health. We have seen how on the surface, Filipino/Filipino Americans report that they have no problem accessing healthcare, yet in reality face many problems that are in fact barriers to care. Much of this complexity can be traced back to the way in which Filipino/Filipino Americans deal with acculturation vis-à-vis mainstream American society. (Bonus, 167) Filipino/Filipino Americans tend to create a culture that is neither fully assimilated into the American mainstream nor isolated from it.

While the resulting barriers can be addressed through more culturally relevant care and outreach, these cannot be as simplistic as having a healthcare provider who is proficient in Tagalog – essential though this may be. Other, less tangible but still crucial dimensions of care need to be considered as well. For example, along these same lines, healthcare providers must also be cognizant of the importance of prayer, the reliance of many members on traditional approaches to medicine, and the importance of advice of those included in the kinship networks in the Filipino/Filipino American community.

Implications for Healthcare and Social Service Providers

The findings in this study provide some implications for patients, providers and policymakers regarding health and health care. The following are four examples of possible “next steps.”

First, many Filipino/Filipino American parents work extremely hard to support their families – to the point that they end up neglecting their own health (for example, by missing doctor’s appointments). This practice is anchored in a deeply held cultural belief about moral obligation and taking responsibility for one’s household. An implied approach for *health awareness building* is to encourage working adults to take care of themselves so they are more likely to see their children in their adult years as well, extending the experience which they value of being family.

Subsequent projects can also focus on defining options to promote a healthy lifestyle among Filipino/Filipino Americans in Historic Filipinotown despite the socio-economic pressures with which they are confronted. One example might be educating working parents around healthy meals that are easy and quick to prepare.

Second, the report puts a spotlight on the hidden barrier of language, which partly explains the reluctance (especially among first-generation immigrants) to access health care or to follow doctors’ recommendations. An implied response is that health care providers servicing Filipino/Filipino American patients in LA should expand the number of Tagalog-fluent medical practitioners (including nurses) on their staff, and educate English-speaking providers about the cultural foundations for the particular needs, preferences and behavior of their Filipino/Filipino American patients. For example, many Filipino/Filipino Americans appreciate, and embrace, group-based activities. They also tend to respect the advice of friends as much as doctors on health questions; targeting education to natural social groupings within this community might be an effective way to work through existing channels of influence.

Third, policy makers looking to shift the attention of Filipino/Filipino Americans increasingly toward illness/injury prevention might find a helpful resource in the Filipino/Filipino American traditional healers, due to their acceptance within the Filipino/Filipino American community. There may be unseen, synergistic opportunities available in creating partnerships with traditional healers to promote, in appropriate and sensitive ways, natural healing, health and wellness throughout the community to which they belong.

Fourth, researchers could focus on the health situation of undocumented Filipino/ Filipino Americans and determine, in more depth the relationship between immigration status and health.

In closing, the agencies that commissioned this report hope that it might become a basis for (1) Working with the Filipino/ Filipino American population regarding ways they can build on their core strengths and assets as a people in achieving stronger health outcomes; (2) Engaging health care providers regarding culture and language distinctives of Filipino/ Filipino Americans as part of a larger process of increasing providers' overall competencies in addressing the needs of Los Angeles' multicultural communities; and (3) Engaging policymakers to take a more culturally informed and sensitized approach to health care reform, focusing particularly on reducing existing disparities among Filipino/ Filipino Americans vis-à-vis other groups, improving health outcomes, and overcoming gaps and weaknesses in service coverage and service quality.

ENDNOTES

1. Descriptive and cross-tabulation data are presented in tables throughout the findings summary section of this report. While the total number of resident survey respondents (n) was 291, in a few cases, n was less than 291. This occurred for answers that had been recorded erroneously by respondents in the original survey form (such as unclear markings or double responses). These responses could not be entered in the SPSS database for analysis.
2. Census 2000. These demographics were based on an analysis of the 90026 and the 90057 zip codes.
3. Respondents' Likelihood of Taking a Prescription Based on Length of Stay in the US

| Frequency of patients' compliance | | | | | | | |
|-----------------------------------|-----------|--------------|-----------|--------------|-----------|-----------|------------|
| Stay in US | Unknown | All the time | Often | Occasionally | Rarely | Never | Total |
| Less than 5 years | 6 | 3 | 3 | 10 | 9 | 11 | 42 |
| 5 - 10 years | 4 | 2 | 14 | 13 | 14 | 26 | 73 |
| More than 10 years | 5 | 8 | 11 | 14 | 22 | 42 | 102 |
| Unknown | 1 | 0 | 0 | 0 | 0 | 4 | 5 |
| Total | 16 | 13 | 28 | 37 | 45 | 83 | 222 |

4. The Impact of the Influence of Others on Matters Related to Health on the Respondents, by Age Group

| How much respondent are influenced by others | | | | | | | |
|--|------------|---------------|-----------|---------------|------------|-----------|------------|
| Age: | Completely | Significantly | Somewhat | Only slightly | Not at all | Depends | Total |
| 14 - 17 | 7 | 22 | 12 | 2 | 5 | 0 | 48 |
| 18 - 24 | 5 | 18 | 14 | 10 | 4 | 0 | 51 |
| 25 - 39 | 2 | 15 | 8 | 4 | 8 | 1 | 38 |
| 40 - 64 | 8 | 6 | 10 | 14 | 2 | 1 | 41 |
| 65 - 79 | 16 | 15 | 9 | 14 | 5 | 6 | 65 |
| 80+ | 6 | 9 | 5 | 3 | 2 | 3 | 28 |
| Unknown | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Total | 45 | 85 | 58 | 47 | 27 | 11 | 272 |

5. Respondents' Reliance on Others vs. Importance of Others' Advice

| Reliance on others | Importance of advice from others | | | | | | Total |
|--------------------|----------------------------------|----------------------------------|------------------|-----------|---------------|-----------|------------|
| | Most important | Major factor but not only factor | Fairly important | Minor | Not important | Depends | |
| All the time | 33 | 13 | 2 | 0 | 0 | 2 | 50 |
| Most of the time | 19 | 44 | 11 | 0 | 1 | 1 | 76 |
| Occasionally | 18 | 20 | 30 | 14 | 2 | 6 | 90 |
| Once in a while | 7 | 2 | 11 | 9 | 5 | 12 | 46 |
| Never | 1 | 1 | 0 | 2 | 12 | 0 | 16 |
| Total | 78 | 80 | 54 | 25 | 20 | 21 | 278 |

6. The Length of Time Elapsed Before a Sick Child is Taken for Medical Care vs. Parents' Comfort Level with the Doctor

| Comfort level with doctors: | When child is taken to doctor | | | | | Total |
|-----------------------------|-------------------------------|-------------------|-------------------|------------------------|-----------|------------|
| | Same day | 2 or 3 days later | 4 or 5 days later | 1 week later or longer | Other | |
| Very Comfortable | 65 | 25 | 2 | 2 | 14 | 108 |
| Somewhat comfortable | 36 | 23 | 2 | 2 | 9 | 72 |
| Sometimes un/comfortable | 17 | 24 | 5 | 1 | 7 | 54 |
| Somewhat uncomfortable | 4 | 3 | 1 | 0 | 2 | 10 |
| Very Uncomfortable | 2 | 1 | 1 | 1 | 2 | 7 |
| Total | 124 | 76 | 11 | 6 | 34 | 277 |

7. These findings may be based on the moral and religious beliefs of the survey respondents, in light of the relative high levels of religiosity within this community. However, from a broader social context, this finding should also be understood in relation to other factors, particularly income, immigrant status, and identity struggles among immigrant and second-generation youth, and not be understood solely from a moral/religious viewpoint.

8. Respondents' Frequency in Checking Food Nutrition Labels, by Income Level

| Income: | Frequency of checking food labels | | | | Total |
|-----------------|-----------------------------------|-----------|----------------|-----------|------------|
| | All the time | Often | Not very often | Never | |
| Under 5,000 | 18 | 26 | 25 | 20 | 89 |
| 5,000 - 9,999 | 18 | 14 | 3 | 5 | 40 |
| 10,000 - 14,999 | 9 | 8 | 9 | 5 | 31 |
| 15,000 - 24,999 | 9 | 11 | 12 | 3 | 35 |
| 25,000 - 34,999 | 5 | 5 | 9 | 8 | 27 |
| 35,000 - 49,999 | 2 | 3 | 7 | 2 | 14 |
| 50,000 - 74,999 | 1 | 1 | 5 | 1 | 8 |
| 75,000 - 99,999 | 0 | 0 | 2 | 0 | 2 |
| Total | 64 | 73 | 76 | 46 | 259 |

9. Respondents' Level of Comfort in Communicating with a Healthcare Provider, by Education Level

| Education | Comfort level communicating with provider | | | | | | Total |
|--------------------------------|---|------------|---------------|----------------------------|--------------------|----------------|------------|
| | Unknown | Very easy | Somewhat easy | Neither easy nor difficult | Somewhat difficult | Very difficult | |
| Less than high school | 2 | 22 | 27 | 15 | 5 | 1 | 72 |
| High School Graduate/ GED | 2 | 17 | 12 | 11 | 3 | 0 | 45 |
| Some College | 5 | 21 | 26 | 12 | 4 | 1 | 69 |
| College/Graduate/ Postgraduate | 4 | 41 | 36 | 13 | 8 | 1 | 103 |
| No formal education | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Total | 13 | 101 | 101 | 53 | 20 | 3 | 291 |

10. Respondents' Level of Comfort in Communicating with a Healthcare Provider, by Place of Birth

| Birthplace | Comfort level communicating with provider | | | | | | Total |
|------------------|---|-----------|---------------|----------------------------|--------------------|----------------|------------|
| | Unknown | Very easy | Somewhat easy | Neither easy nor difficult | Somewhat difficult | Very difficult | |
| US born | 0 | 8 | 4 | 6 | 3 | 1 | 22 |
| Philippines born | 11 | 64 | 67 | 35 | 15 | 1 | 193 |
| Total | 11 | 72 | 71 | 41 | 18 | 2 | 215 |



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APPENDICES

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APPENDIX I

SURVEY FORM FOR RESIDENTS AND WORKERS IN HISTORIC FILIPINOTOWN, LOS ANGELES

Improving Healthcare Access and Utilization in Historic Filipinotown

SURVEY

March, 2007

Administered By:

*Thank you for taking part in this study, which seeks to improve access and utilization of healthcare services for Pilipinos in Historic Filipinotown. The Search to Involve Pilipino Americans (SIPA) has engaged Semics, LLC to assist in doing research to learn about how culture can influence healthcare decisions among Pilipinos and Pilipino Americans. Your answers will help a great deal in our continuing efforts to improve the health and well-being of our communities and families. For privacy purposes, we assure you that all survey responses will remain **confidential** and **anonymous**. Please try to answer each question in the survey.*

I. Demographic Information

1) **Gender**

- Female
 Male
 Other: _____

2) **Zip Code:** If you live in Historic Filipinotown, please select your zip code

- 90057
 90026
 Other: _____

3) **Zip Code:** If you do not live in, but you work in Historic Filipinotown, please provide your work zip code

4) **Age**

- 14-17
 18-24
 25-39
 40-64
 65-79
 80+

5) **Marital Status**

- Married
 Single
 Divorced
 Widowed
 Living with partner

6) **PART 1: Type of Residency**

- Citizen/Permanent Resident
 Non-Citizen

PART 2: Place of Birth

- US-born
 Philippines-born

7) **Length of Stay in the US**

- Less than 5 years
 5-10 years
 More than 10 years

8) **Household Size:** Please state how many people currently live in your place of residence.

9) If you are receiving an income, how much is your **individual income** per year?

- Under \$5,000
 \$5,000-\$9,999
 \$10,000-\$14,999
 \$15,000-\$24,999
 \$25,000-\$34,999
 \$35,000-\$49,999
 \$50,000-\$74,999
 \$75,000-\$99,999
 \$100,000 and over

SURVEY FORM FOR RESIDENTS AND WORKERS IN HISTORIC FILIPINOTOWN, LOS ANGELES

Improving Healthcare Access and Utilization in Historic Filipinotown

SURVEY

March, 2007
Administered by:

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10) **Education:** Please select the highest education level you have completed.

- Less than high school
- High school graduate/GED
- Some college
- College/Graduate/Postgraduate
- No formal education

11) **Employment:** Please state your current job, or employment?

(Note: You may also write "student" or "retiree" in the space above if applicable.)

II. Prevention and Healthy Habits

1) How often do you exercise or take part in healthy, physical activity?

- At least two or three times a week
- Once a week
- Once a month
- Never/Almost Never

2) Is there a place in your neighborhood for you to exercise or take part in healthy, physical activity?

- Yes
- No

Please explain: _____

3) How often do you eat food from a fast food restaurant (such as *Jollibee, McDonald's, etc.*)?

- At least two or three times a week
- Once a week
- Once a month
- Never/Almost Never

4) When buying groceries, how often do you check the nutrition facts label before purchasing a product?

- All the time
- Often
- Not very often
- Never

5) Please list any barriers to eating and/or purchasing fresh foods.

6) In your own words, please describe the neighborhood in which you live.

SURVEY FORM FOR RESIDENTS AND WORKERS IN HISTORIC FILIPINOTOWN, LOS ANGELES

| | | | |
|---|---------------|---------------------------------|----------|
| Improving Healthcare Access and Utilization in Historic Filipinotown | SURVEY | March, 2007 Administered by: | 3 |
|---|---------------|---------------------------------|----------|

III. Religion and Spirituality

- | | |
|---|--|
| <p>1) Please rate how religious you feel you are.</p> <p><input type="checkbox"/> Not religious at all</p> <p><input type="checkbox"/> Somewhat religious</p> <p><input type="checkbox"/> Deeply religious</p> <p>2) Which religion do you believe in and/or practice?</p> <p><input type="checkbox"/> Protestantism</p> <p><input type="checkbox"/> Catholicism</p> <p><input type="checkbox"/> Islam</p> <p><input type="checkbox"/> Other: Please specify: _____</p> <p>3) How often do you attend religious services?</p> <p><input type="checkbox"/> Two or three times a week</p> <p><input type="checkbox"/> Once a week</p> <p><input type="checkbox"/> Once a month</p> <p><input type="checkbox"/> Hardly ever</p> <p><input type="checkbox"/> Never</p> <p>4) Do you believe that there is a God who will take care of your health and your family's health?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Please explain: _____</p> | <p>5) What do you see as your God's role in the situation if ever you or someone in your family has an illness? Circle all that apply.</p> <p><input type="checkbox"/> It's God's will</p> <p><input type="checkbox"/> It's not God's will</p> <p><input type="checkbox"/> God plays no role</p> <p><input type="checkbox"/> I don't know what I think about God's role in this situation</p> <p>6) When I go to the hospital or take a family member to the hospital to have an illness or injury treated, I prefer to go to a Catholic hospital.</p> <p><input type="checkbox"/> True</p> <p><input type="checkbox"/> False</p> <p>7) God provides care and/or healing through doctors and other health providers</p> <p><input type="checkbox"/> True</p> <p><input type="checkbox"/> False</p> <p>8) When I or a family member becomes sick, it is just as important, or even more important, to pray for healing than go to the doctor for medical help.</p> <p><input type="checkbox"/> True</p> <p><input type="checkbox"/> False</p> |
|---|--|

IV. Language

- | | |
|--|---|
| <p>1) What dialect(s)/language(s) do you speak at home?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>2) What dialect(s)/language(s) do you feel most comfortable speaking?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|--|---|

SURVEY FORM FOR RESIDENTS AND WORKERS IN HISTORIC FILIPINOTOWN, LOS ANGELES

Improving Healthcare Access and Utilization in Historic Filipinotown

SURVEY

March, 2007
Administered by:

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3) What dialect(s)/language(s) do you use when speaking to a doctor/nurse/ clinician? Please indicate as many languages as apply.

4) How long have you been a patient with your doctor/clinician?

- Less than 1 year
- 1-3 years
- 4-5 years
- 5 or more years
- Other (Please specify): _____

5) On a scale from 1-5, how comfortable do you feel when visiting your doctor/clinician?

- 1 - Very Comfortable
- 2 - Somewhat Comfortable
- 3 - Sometimes Comfortable, Sometimes Uncomfortable
- 4 - Somewhat Uncomfortable
- 5 - Very Uncomfortable

6) On a scale from 1-5, how easy or difficult is communicating with healthcare providers (doctors, nurses, therapists, etc.)?

- 1 - Very Easy
- 2 - Somewhat Easy
- 3 - Neither easy nor difficult
- 4 - Somewhat difficult
- 5 - Very Difficult

7) When discussing your health, which doctor are you likely to understand better?

- A doctor born in the Philippines
- A Pilipino American doctor (US born)
- Both (a) and (b) equally well
- A doctor who is neither Pilipino nor Pilipino American
- None of the above. Explain _____

- Any of the above. Explain _____
- _____
- _____
- _____

V. Healthcare Access and Utilization

1) PART 1: How many times have you visited a doctor/clinic provider in the last year?

- 0 times (a)
- 1-3 times (b)
- 4-7 times (c)
- 8-9 times (d)
- 10+ times (e)

PART 2: If you answered (a), why did you not visit a doctor/clinic provider in the last year? Check all that apply.

- Could not get time off from work
- No insurance

- Rather see a Pilipino healer
 - Other (Please specify): _____
- _____
- _____

PART 3: If you answered (b), (c), (d), or (e), please select the reason/concern for visiting a doctor/clinic provider. (Check all that apply.)

- Check up/follow-up
 - Feeling sick
 - Other: Please specify: _____
- _____
- _____

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2) If you have visited a doctor/clinic provider, where did you go for those services? Circle all that apply.

- Private or independent health care provider
- Community clinic
- Emergency room
- Community healer
- Asian Pacific Health Care Venture
- Kaiser
- Other: _____

3) Have you ever talked about preventing illnesses with your doctor?

- All the time
- Often
- Occasionally
- Rarely
- Never

4) While on a doctor visit, when the doctor tells you about your health condition or your diagnosis, do you believe what s/he says?

- All the time
- Often
- Occasionally
- Rarely
- Never

Please explain: _____

5) Was there a time when you sought a second opinion about a condition or diagnosis?

- Yes
- No

Please describe: _____

6) PART 1: Do you follow through with everything the doctor tells you to do?

- Always (a)
- Often (b)
- Occasionally (c)
- Rarely (d)
- Never (e)

PART 2: If you answered (c), (d), or (e) please explain why below:

7) On a scale of 1 to 5, how much would you say you can trust what the doctor tells you about your health?

- 1 - Completely
- 2 - Somewhat
- 3 - Not sure
- 4 - Not much
- 5 - Not at all

8) PART 1: If your doctor gives you a prescription, how willing are you to follow his/her advice and take the prescribed medicine?

- Very willing
- Somewhat willing
- Not very willing
- Not willing at all

Please explain: _____

PART 2: What are some of the reasons you choose NOT to take prescription drugs? Please select as many as apply.

- Cost
- Don't trust prescription drugs

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Other - Please explain: _____

9) If you are taking prescriptions drugs, do you ever do or take something else as well in order to treat the same problem —something that the doctor didn't tell you?

- All the time
- Often
- Occasionally
- Rarely
- Never

PART 2: Please explain your answer: _____

10) PART 1: Has a doctor ever referred you to a specialist?

- Yes
- No

If so, what kind of specialist(s) have you seen? (Circle all that apply.)

- Medical doctor
- Psychiatrist
- Chiropractor
- Acupuncturist
- Other (Please specify): _____

PART 2: Would you trust a specialist as much as your doctor, or not?

- Yes
- No

Please explain: _____

11) PART 1: How many times have you gone to the emergency room in the last year?

- 0 times
- 1-3 times
- 4-6 times
- 7-9 times
- 10+ times

PART 2:

Please describe why you chose to go to the emergency room as often/seldom as you did:

12) Please select which type of medical insurance you have currently:

- Employment-based (HMO or PPO)
- Privately purchased (HMO or PPO)
- Medi-Cal
- Medi-Medi, or dual-eligible
- Uninsured
- Medi-Care
- Other: _____

13) Have you ever made an appointment to see a doctor and did not end up going to the appointment after all?

- Yes
- No

If so, why?

- Could not get time off from work
- Family responsibilities
- Other: Please specify: _____

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VI. Traditional, Cultural Medicine

1) Have you ever used remedies for health problems that are different from Western medicine? Yes No

a) If so, what were they?

b) How often did you use them?

c) For what reasons/concerns?

2) PART 1: Do you practice any traditions to *prevent* sickness that are different from Western medicine? Yes No

PART 2: If so, what do you do? _____

PART 3: Rate on a scale from 1-5 the overall effectiveness of these traditions for you in *preventing* sickness:

- 1 - Helped a lot
- 2 - Helped somewhat
- 3 - Helped but only a little
- 4 - Made no difference
- 5 - Made me sick

3) PART 1: Do you practice any traditions to *treat* sickness (yours and/or a relative's) that are different from Western medicine?

Yes No

PART 2: If so, what do you do?

PART 3: Rate on a scale from 1-5 how effective you have found these traditions in *treating* illness:

- 1 - Very Successful
- 2 - Somewhat Successful
- 3 - Only Mildly Successful
- 4 - No Effect
- 5 - Made Things Worse

4) Do you practice any of the following traditions? Circle all that apply.

- Praying a Novena (Praying to Our Lady of Perpetual Health)
- Tawas (Rituals of candles, hot water)
- Usog (Attacking negative energy, esp. with regard to children)
- Kulam (Witchcraft)
- Hilot (Therapy through massage, touch)
- Others: Please describe.

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VII. Family Decision Making

1) If you are feeling sick, when do you decide to go to the doctor?

- The same day
- Two or three days after
- Four or five days after
- One week later or longer
- Other- Please specify: _____

2) If there is a child or teenager in your family, who takes him/her to the doctor when s/he is sick?

- Mother
- Father or Both Parents
- Grandparents or Other Relatives
- Friends
- Neighbors
- Other: _____
- My child generally does not go to the doctor when s/he is sick.

3) If there is a sick child or sick teenager in your family, when is s/he taken to the doctor?

- The same day
- Two or three days after
- Four or five days after
- One week later or longer
- Other-Please specify: _____

4) If there is a child or a teenager in your family, who takes him/her to get a regular check up?

- Mother
- Father or Both Parents
- Grandparents or Other Relatives
- Friends

- Neighbors
- Other: _____
- The child/teenager does not see a doctor for a regular check up

5) If your parents become very sick or injured, when do they tell you/your siblings?

- Right away
- They tell me as soon as they get home with symptoms or doctor's diagnosis
- They tell me when they need help financially or need advice
- They don't tell me when they get sick so I will not worry

6) If older, senior members of the family become sick or injured, who is the first person informed of the situation?

- A spouse (if still living or together)
- The eldest child
- The child or relative who could help financially
- Other- Please Specify: _____

7) If you are married or are living with a partner, when does your spouse or partner tell you that he/she is sick or injured?

- Immediately
- They tell you as soon as they get home with symptoms or doctor's diagnosis
- They tell you when making a decision on treatment/finances
- They don't tell me when they get sick or injured so I won't worry

8) Do you consider pre-marital sex and/or teen pregnancy to be a problem for families in the Filipino community? Yes No

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Please explain: _____

9) Whether or not you are a parent, would you allow your children to:

a) Receive birth control such as condoms?

Yes No

Why or why not? Please explain: _____

b) Receive education from school or an agency outside the home about HIV/AIDS?

Yes No

Why or why not? Please explain: _____

10) How often do you rely on your relatives and friends for advice on matters related to your health?

- All the time
- Most of the time
- Occasionally
- Only once in a while
- Never

11) How important is the advice of your relatives or friends for you in deciding how to care for yourself or your family's health?

- Most important of all
- A major factor but not the only factor
- Fairly important but not more important than other factors
- Minor; other factors are more important
- Not important at all
- It depends on the type of decision. (Please explain): _____

12) On a scale of 1—5, how much does what your relatives or friends DO for their own health influence what you decide to DO for yourself and your family's health?

- 5 - Completely
- 4 - Significantly
- 3 - Somewhat
- 2 - Only slightly
- 1 - Not at all
- It depends on what type of health-related practices we are talking about. (Please explain): _____

SURVEY FORM FOR RESIDENTS AND WORKERS IN HISTORIC FILIPINOTOWN, LOS ANGELES

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SURVEY

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VIII. Community Health Concerns

- 1) On a scale from 1-5, please rate whether you consider drug addiction a problem in Historic Filipinotown?
- 1 - Not a problem at all
 - 2 - Only a minor problem
 - 3 - Somewhat of a problem
 - 4 - A major problem
 - 5 - The number one problem
- 2) On a scale from 1-5, please rate whether you consider *alcohol addiction* a problem for people in Historic Filipinotown?
- 1 - Not a problem at all
 - 2 - Only a minor problem
 - 3 - Somewhat of a problem
 - 4 - A major problem
 - 5 - The number one problem
- 3) PART 1: On a scale from 1-5, please rate whether you consider *mental health issues* to be a problem for Filipinos?
- 1 - Not a problem at all
 - 2 - Only a minor problem
 - 3 - Somewhat of a problem
 - 4 - A major problem
 - 5 - The number one problem
- PART 2: If you answered 2 - 5, what specifically do you believe are the primary mental health issues affecting Filipinos in Historic Filipinotown? (Circle all that apply.)
- Depression
 - Dementia
 - Stress
 - Other- Please specify: _____
- _____
- _____
- _____
- _____

- 4) **(For seniors)**
- a) Do you participate in the programs or services of an Adult Day Healthcare Center on a regular basis?
- Yes
 - No
- b) How often do you go? _____
- _____
- c) How many hours per week do you estimate that you spend there? _____
- _____
- d) What two or three things do you find most helpful about the Center you go to?
- _____
- _____
- _____
- _____
- _____
- _____
- _____

APPENDIX 2

Filipino/Filipino American Cultural Values Related to Health

(Much of this material was adapted from F J Jocano, *Filipino Value System: A Cultural Definition*)

Filipino Worldview. Jocano (1997) articulates several core elements of a Filipino/Filipino American cultural worldview which, appear pertinent to understanding Filipino/Filipino Americans' culture and also their perspectives on health and health care. Historically, people of the Philippines have embraced a worldview based on the primacy of *human relationships in community*. These relationships are built on respect for the wisdom of elders.

Intertwined with this vision is a *group consciousness*: the identity of the individual is almost inseparable from the community or kinship group of which s/he is a part. Members of a group do not see themselves as individuals related to other individuals. Rather, they often see other individuals as extensions of their own being. In this context, Filipino/Filipino Americans have created and sustained a highly refined system of values to maintain and uphold the stability and integrity of "the group." This system is built on principles of *harmony* (smooth relationships) and reciprocity (mutual concern among members for each individual's well being and sense of belonging). The primacy of group identity and relational harmony is itself grounded in a vision of the universe that sees life ultimately as harmonious and grounded in relationships between living beings. Three key cultural concepts that reflect this worldview are "bahala na," "hiya," and "kapwa."

Bahala na refers to an act of letting go of one's situation and putting it in the hands of a more knowledgeable party or in the hands of God. The use of *bahala na* in some situations can be confused with resignation or complacency. *Hiya* (roughly translated as shame, shyness, hesitation or reluctance) refers to a deep impulse to protect against a loss of face, especially if there are differences of opinion in a group on a sensitive matter. Such protection can be for one's own sake (against embarrassment in front of others from being personally exposed, not knowing or doing something wrong); or for another person (to prevent him/her from humiliation in front of a group). While *hiya* may bring about inhibitions in terms of disclosing health information to a doctor, it is intended to

protect the dignity of oneself, one's family and friends and keep intact the harmony of interpersonal relationships.

Kapwa refers to a neighbor or close friend. It suggests "togetherness" and equality of status regardless of class or race. It is grounded in a harmonious, respectful standard for relationships. It stems from a deep-seated value in belonging to a group, and is guided by moral principles of humility, empathy and mutual support.

Broadly speaking, these worldview concepts can help us understand why members of the Filipino/Filipino American community – in varying degrees and different ways – may think and act as they do in the area of health/healthcare. Jocano's vision of Filipino/Filipino American culture has been critiqued for being overly static. The reality of life in the US – and increasingly in the Philippines also – makes the definition of culture more fluid, dynamic and ambiguous than Jocano's analysis suggests. Keeping this in mind, for purposes of this study, Jocano still is helpful in that he corrects a common notion in the West that traditional cultures are an obstacle to good health. Jocano's work reveals culture as a powerful resource, one that provides a decisive basis for Filipino/Filipino Americans' individual and collective well being if applied appropriately.

Supporting Good Health, Responding to Illness. Filipino/Filipino Americans have an unusual ability to accept things as they are. This acceptance is sometimes expressed through the saying, *bahala na*. As noted earlier, *bahala na* basically means "whatever will be, will be." It is a way of moving on in the face of an enduring and perhaps unchangeable hardship. This position enables many Filipino/Filipino Americans to accept, and endure, great suffering including suffering from illness or injury.

Pakikipagkapwa-tao. Historically, health care for Filipino/Filipino Americans was inseparable from "people care." Put simply, cultural norms energized Filipino/Filipino Americans to care for others in every sense, as fellow human beings. Acting with care toward others as fellow humans is roughly translated *pakikipagkapwa-tao* in Filipino. Since "feeling well" is a desired state by most everyone, health care is a natural extension of care for people in general. However, in practice the idea of showing care for others – as a means of sustaining and supporting one's social group – has sometimes been emphasized more than care of self. This has been the case even though Filipino/Filipino American culture has always contained within it the important ingredient of valuing and caring for self as well. (Jocano 1997: 77)

A *kapwa* is a person with whom one shares a relational bond of deep respect, if not intimacy. This type of relationship supports a structure of familism (tight-knit extended family structures) among Filipino/Filipino Americans. Caring for the health of each member within one's family or kinship network is thus a top priority. An example from our survey is the reported willingness of parents to take their children to the doctor for medical care in times of illness/injury and persist in getting the help they need even when they feel very uncomfortable (culturally speaking) in talking to health care providers. A second example from the data is the preference among families to provide direct care to their aging parents at home, regardless of the sacrifices required, rather than moving them into a convalescent facility.

The sense of obligation to one's kin based on "shared being" is reflected in the study in other ways as well. One example is the propensity among Filipino/Filipino Americans to give *moral and practical advice* to their loved ones. Typically such advice flows from the older generation to the younger, but not always. It can also be given by a middle-age adult to an elderly member of the household who is sick. The term "advice" in English does not quite convey the authority of the act of giving advice among Filipino/Filipino Americans (*pagpapayo* in Filipino). The emotional impact of taking advice in the traditional Filipino/Filipino American family is authoritative. *Who gives the advice* is just as important – sometimes *more* important – than the technical correctness of the advice being given. Our findings confirm the significance of *pagpapayo* among Filipino/Filipino Americans in Los Angeles with regard to health. Most survey respondents reported that they take seriously the advice of family members – and, in many cases, actually change their behavior in response to such advice – on how to prevent, or treat, illness.

In practical terms, this translates into a personal commitment to protecting and nurturing others (*pagkabahala* in Filipino), especially those in one's household or kin group. In America, this same commitment is extended by Filipino/Filipino Americans beyond their kinship groups to neighbors, friends and even strangers. The tradition of putting the group first and looking out for other group members has helped make Filipino/Filipino Americans world-class caregivers in the marketplace. This is one reason why Filipino/Filipino Americans have such a prominent presence as recognized professionals and workers in the U.S. healthcare sector.

Traditional Medicine. The cultural perspectives described above lend insight to the use of traditional medicine in the Philippines and, to a lesser degree, among Filipino/Filipino Americans in the US. The crux of traditional medicine in the Philippines is seen in the following quote from a focus group participant in explaining how she diagnoses a patient:

Ask the person how he feels. Then observe the patient, especially look into the eyes because illness manifests itself through a person's eyes. Then, touch the person, try to identify bumps, bruises, or ... a dislocated joint. The patient must have trust in the healer.

(Focus Group, APHCV, 24 May 2007, Translated from Tagalog in focus group discussion)

Similarly, remedies often include the use of incantations, religious rituals, dance, prayers and candles. Traditional practitioners view health problems as a result of "imbalance" in the human body brought about by stress. For treatment of illnesses, they favor the use of natural herbs, oils and other ingredients to maintain or restore balance to the body. For prevention of illness, they emphasize adopting a different *lifestyle* and "downshifting" to reduce stress, such as working fewer hours, driving less and spending more time that is just quiet and meditative. This line of thinking draws attention to the overall health effects of a Western lifestyle driven by pressure to compete and succeed in a stress-ridden marketplace. This is not very different from a wider movement in the US to, for example, embrace forms of mysticism, slow down, practice meditation, cook food with natural ingredients and visit an acupuncturist.

'Hiya' and Culturally Appropriate Care. As noted in the body of this report, *hiya* is a group-affirming norm among Filipino/Filipino Americans. It refers to feelings of shame or losing face. The social function of *hiya* is to protect the honor, or dignity, of persons in situations of conflict or when problems arise in a group. In this study, it can pose a barrier to accessing health care. It comes up especially when an individual feels violated or exposed to embarrassment or shame in the context of seeking, and using, healthcare services. One example is misunderstandings due to language barriers. Some patients may not express it openly, but feel shamed or embarrassed in front of health care providers when they cannot understand or be understood properly. However, this situation must be seen in wider context. Filipino/Filipino American tradition actually affirms members going for check-ups, whatever this entails, in order to ensure the longevity and well-being of each member. What seems to matter is that families have an established working relationship with their health provider and feel they can trust the individual provider to take care of them in ways they understand and can accept as beneficial and necessary.

APPENDIX 3

PROTOCOL AND SCHEDULE OF FOCUS GROUP DISCUSSIONS

Culture and Health Among Filipinos and Filipino Americans in Historic Filipinotown

Schedule of Completed Focus Group Discussions, January — June, 2007

| Participants | Venue | Date(s) |
|----------------|-------|------------|
| Youth | SIPA | 01-25-2007 |
| | " | 05-24-2007 |
| | PWC | 06-07-2007 |
| Working Adults | PWC | 01-19-2007 |
| Seniors | FASGI | 01-18-2007 |
| | " | 06-08-2007 |
| Agency Staff | SIPA | 01-29-2007 |
| | PWC | 05-18-2007 |
| | FASGI | 05-25-2007 |
| | APHCV | 01-26-2007 |
| | | 05-15-2007 |
| Providers | APHCV | 01-26-2007 |
| | " | 05-24-2007 |
| | " | 06-12-2007 |

Improving Access to Healthcare in Historic Filipinotown

Focus Group Protocol
January 9, 2007

Overall Research Question

What cultural factors influence healthcare access and utilization among Pilipinos and Pilipino Americans in Historic Filipinotown?

Set-up and Materials Needed

- Chairs for participants
 - Table for refreshments
 - Drinking water for facilitators
 - Chair and table for facilitator and note taker
 - Nametags and Thick black magic markers to write on name tags
 - Focus group recording equipment – audio and /or laptop?
 - Pad and pen or laptop for note taker
 - Small alarm clock (digital) for facilitator to glance at
 - 2 clipboards
 - Copies of JLP Background document (brief demographic survey for participants)
-

Focus Group Site Preparation (20 minutes)

1. Arrange chairs in circular formation for participants, one facilitator and one note taker.
2. Setup snacks.
3. Have name tags and thick black magic markers available for people to write their first names only.
4. Have pens ready.
5. Test tape recording equipment and place in center of the circle.
6. Warmly greet focus group participants as they enter the room. Encourage them to take some snacks.
7. Distribute JLP Background document, which will be collected at the end of the discussion.
8. Ask participants to turn off cell phones.
9. Inform participants where bathrooms are and encourage their use before focus group gets started.

INTRODUCTION (5 minutes)

1. Welcome and Facilitator Introduction

“Good morning/ afternoon and welcome to our discussion. I want to thank you for taking the time to join us to talk about. My name is FACILITATOR’S NAME and assisting me is my co-worker, NOTETAKER’S NAME. We both work for Semics, an evaluation organization in L.A.”

2. Background and Purpose of Focus Group

“I’m going to tell you a little bit about our project and what you can expect today. Semics is assisting the SIPA, PWC, FASGI and APHCV on a project to gather information about healthcare access and utilization of healthcare among Pilipino Americans in Historic Filipinotown. We are going to use what we learn from you today to find out what is needed to help Pilipino Americans access and use the healthcare we need and help improve the health and well-being of our communities and families.”

“Our focus group discussion is going to last about one hour. I am going to ask you questions, and you are going to share your thoughts and opinions. You’ll do most of the talking. Remember we want to learn from you.”

HOW TODAY’S FOCUS GROUP WILL WORK (5 minutes)

1. No “Right” or “Wrong” Answers and Participation

“I want to assure you that there are no “right” or “wrong” answers but rather different points of view. I encourage you to share your point of view, even if it is different from what others have said.”

“In fact, it’s really important for us to hear all the different points of view in the room. If you want to follow-up on something someone said, or if you want to agree or disagree, or give an example, feel free to do that. Don’t feel like you have to respond to me all the time. Feel free to have a conversation with one another about these questions. We want everyone to have a chance to share ideas. We may need to interrupt or call on people to make sure this happens. Please do not feel offended if we do this.”

2. Tape Recording and Confidentiality

“Before we get started, I want to remind you that we will be tape recording the session because we don’t want to miss any of your comments. People often say things in these sessions, and we can’t write fast enough to write them all down.”

“Although we will be on a first name basis today, we will not use your real names in our report. You can be assured of complete confidentiality. No one will be able to link your name back to what you said, and we are the only ones who will listen to the tape.”

“Also you do not have to answer any question that makes you feel uncomfortable. I would also like to ask that if you talk about your focus group experience with family or friends, do not attach anyone’s name here with the stories they share. Can I get everyone to agree to that by nodding their heads?” Make eye contact with each person in the group and wait for him/her to nod affirmatively.

3. Timing

“We expect to be here until _____. We appreciate you taking this time with us so we want to make sure we end on time. I will be watching the clock and may need to break off the discussion at times to be sure we have time to discuss all topics. I may also ask you some questions or remind me of something I missed.”

ICEBREAKER (5 minutes)

“Let’s begin. We have asked you to wear a nametag with your first name on it to help us remember each other’s name. Let’s go around the room for introductions. Please give your first name. Let’s start with you.”

QUESTIONS

Questions for the focus groups

1. Share with the group your actual experience with yourself or someone in the family who is sick.

- a. When did it occur to you / family member was sick?
 - i. What are the signs? For example, someone is not eating well, someone is unusually quiet, someone is complaining of pain / fever, etc.
 - b. What was the first thing you / family member / your family did?
 - i. Did you go to the family medicine cabinet? What is usually in your family's medicine cabinet?
 - ii. What else did you do?
 - c. Then, afterwards, what did you / family member / your family do / does? What happened?
 - d. At what point would you say the family decides to bring you / family member to a doctor? For example, are there signs like high fever, convulsions, vomiting, bleeding, etc?
 - e. What were the results? Did you expect them to happen?
 - f. Were there any unexpected outcomes? Why?
 - g. When you are talking to the doctor about yourself or a family member, does he / she explain to you and the family the condition of the person who is sick?
 - i. How does the doctor explain?
 - ii. What have you liked about your / family member's doctor?
 - iii. What problems have you / your family had with doctors?
 - iv. Has it ever been difficult to understand the doctor? In what ways?
2. What about preventive health? Would you share with the group how you or someone in the family takes care of their health to prevent sickness? For example, eating healthy foods, exercising regularly, managing their stress
- a. What kinds of things do you / family do to prevent sickness?
 - b. How is your / your family's doctor involved in preventing sickness?
 - i. Does your / your family's doctor explain prevention?
 - 1) How does the doctor explain?
 - 2) What have you liked about your / family member's doctor?
 - 3) What problems have you / your family had with doctors?
 - 4) Has it ever been difficult to understand the doctor? In what ways?
3. *(Transition/introduction to new topic – religion and spirituality)* At what point do you think of turning to God for help?
- a. Why?
 - b. How did you do it? For example, doing the novena during one's confinement in the hospital.

Throughout these questions, probe for the roles of: a) Traditional medicine practices, b) Language usage, c) Familial decision making processes, d) Religion and spirituality, and e) Health insurance and healthcare utilization patterns



PROFILE OF SPONSOR ORGANIZATIONS



Asian Pacific Health Care Venture, Inc.

APHCV is a 501(c)(3) nonprofit community health center established in 1986. Our mission is to advocate for and provide quality health care services to all persons in a culturally competent manner. We offer services with a particular focus on low-income families and underserved Asians and Pacific Islanders (APIs). We also offer programs of health education and community economic development within our catchment area and other regions of Los Angeles County. APHCV provides full lifecycle health care services including pediatric, prenatal, adolescent, women's health (prenatal and gynecology), men's health, adult and geriatric care, family planning, integrated mental health, disease management, and HIV testing and counseling. APHCV provides on-site bilingual and bicultural health care support—language translation, interpretation, and ethnic specific health education—in multiple Asian languages (Bangladeshi, Cambodian, Chinese, Indonesian, Japanese, Tagalog, Thai and Vietnamese) as well as English and Spanish. APHCV is a Medi-Cal, Medicare and Family Planning provider as well as a provider for California's Cancer Detection Program: Every Woman Counts. APHCV operates a dispensary in which more than 300 prescriptions are filled daily. In addition, APHCV provides health outreach and education in the communities including temples, schools, and markets, and works closely with ethnic media. APHCV also operates youth clinic and youth programs including various after-school activities.

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Kazue Shibata

Chief Executive Officer



Filipino American Service Group, Incorporated

FASGI is a private, nonprofit, neighborhood-based health and human care provider. Incorporated in 1981, FASGI has grown into one of the leading independent providers of health and social services for low-income underserved Filipino American seniors in Los Angeles County. From its inception, FASGI's mission has been to empower the underserved through culturally-competent care, advocacy, social services, education, social action, research and leadership. During over two decades of providing culturally-competent geriatric services, FASGI has helped prevent unnecessary or early institutionalization of thousands of target elderly. FASGI's philosophy is grounded on the power of personal responsibility and community empowerment in promoting the quality of life. As such, FASGI combines independent living skills training and human services in promoting physical and behavioral health – thus providing a balanced medical home for its target clientele. FASGI is a critical component of the health care 'safety net' in Los Angeles County and is integrated in the California Partnership for Access and Treatment network, linked with Temple Community Hospital, UCLA's Jonsson Comprehensive Cancer Center, as well as neighboring schools, local shelters, and community based organizations. Although FASGI serves the entire Los Angeles County, we maintain a special focus on Historic Filipinotown near downtown Los Angeles.

Filipino American Service Group Inc (FASGI)

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Susan E. Dilkes

Executive Director



Pilipino Workers Center of Southern California

PWC was formed in 1997, on the idea that all individuals deserve a high quality of life. This means that we are entitled to safe working conditions, living wages, decent living conditions, access to quality healthcare and basic human dignity. We provide services and resources that help meet the immediate needs of Pilipino workers and their families while organizing for long-term change.

Pilipino Workers Center of Southern California

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Contact: Strela Cervas

Aquilina Soriano-Versoza

Executive Director



Search to Involve Pilipino Americans

SIPA was founded in 1972 and provides health and human services as well as community economic development and arts/cultural programs for youth and families in multi-ethnic Historic Filipinotown and the greater Los Angeles Pilipino American community. SIPA envisions becoming a premiere advocate of Pilipino American health, welfare, and political and cultural empowerment. Our mission is to enhance the quality of life for Pilipino Americans and other communities through youth development, health, economic, and social services. SIPA also develops affordable housing and other projects that promote cultural identity, economic stability, self-sufficiency, and civic participation. SIPA's innovative programs and services are facilitated through community-based, collaborative relationships.

The ultimate goal is to provide innovative programs that inspire and empower youth to make smart choices, bring families together, and ultimately, revitalize the community. SIPA's health and human services department features two divisions: case management and counseling and afterschool enrichment and community outreach and education. Our community economic development department also features two divisions: affordable family housing and small business development. All told, SIPA provides a myriad of programs and services to over 7,000 clients annually. This makes SIPA the largest social services provider and community development corporation primarily serving the Pilipino American community in the United States. .

Search to Involve Pilipino Americans (SIPA)

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Joel F. Jacinto

Executive Director



Semics LLC

Semics LLC is a community-focused research and evaluation company based in Los Angeles. Semics' mission is to provide clients in the private, public and independent sectors with a multidimensional understanding of the populations they serve.

Semics specializes in social research and program evaluation. We combine quantitative and qualitative methods with client-focused consultative processes to produce useful, relevant and penetrating analyses and productive information for decision making.

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Culture and Health Among Filipinos and Filipino Americans in Central Los Angeles

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