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HBV-related health behaviors in a socio-cultural context: Perspectives from Khmers and Koreans

Haeok Lee, RN, PhD [a,*], Peter Kiang, EdD [b], Phala Chea, EdD [c], Sonith Peou [d], Shirley S. Tang, PhD [b], JinHwang Yang, PhD [e], Jacqueline Fawcett, RN, PhD [a], Hie-Won Hann, MD [f]

[a] Department of Nursing, University of Massachusetts Boston, Boston, MA, USA
[b] Asian American Studies Program, University of Massachusetts Boston, Boston, MA, USA
[c] Community Outreach in Support of English Language Learners & Families/McKinney Vento Education Liaison, Lowell Public Schools, Lowell, MA
[d] Metta Health Center, Lowell, MA
[e] Nursing Department, Inje University, South Korea
[f] Diversion of Gastroenterology and Hepatology, Liver Disease Prevention Center, Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA

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ABSTRACT

Purpose: The aim of this study is to explore factors influencing health and health care within the sociocultural context of Cambodian Americans (CAs or Khmers) and Korean Americans (KA) and to examine intergroup similarities and differences between CAs and KAs, focusing on hepatitis B virus (HBV) and liver cancer prevention behaviors.

Methods: The study used a qualitative design guided by the revised Network Episode Model (NEM) and informed by ethnographic analysis. Focus group interviews with key informants among CA community health leaders (CHLs, $n = 14$) and individual interviews with key informants of KA CHLs ($n = 9$) were audiotaped and transcribed.

Results: Three categories that influenced HBV and liver cancer prevention emerged from both CAs and KAs: the socio-cultural, individual, and behavioral. Four additional subcategories (sub-themes) of sociocultural were identified as socio-history, socio-medicine, socio-linguistic, and socio-health resources. Both CAs and KAs, however, have low levels of knowledge and significant misunderstandings about HBV infection.

Conclusions: The study identifies and compares the social-cultural determinant for HBV and liver cancer and highlights the factors of education, intercultural communication, and interactions within socio-cultural contexts of CA and KA subgroups. In general, conceptual overlaps are apparent between Khmers (from now on, the terms, CA and Khmer, will be used interchangeably) and Koreans except for the sub-theme of socio-history. However, differences in concept-specific attributes point to the need to account for differing conceptualizations and implications of specific ethnic groups' sociocultural contexts, and to design contextually-relevant outreach and educational interventions for targeted AAPI subgroups.

1. Introduction

Despite a decrease in acute Hepatitis B virus (HBV) infections, the prevalence of chronic HBV infection remains high in the U.S.: an estimated 1.4 to 2 million people currently have chronic HBV (Centers for Disease Control & Prevention [CDC], 2008; Cohen et al., 2007; Institute of Medicine, 2010). Of those, 47 to 70% were born in other countries and approximately 50% are Asian American Pacific Islanders (AAPIs), though they comprise less than 5% of the U.S. population (Census Bureau, 2010; Pew Research Center [PRC], 2013).

The continued disparities of HBV infection among AAPIs are evident as both old and new references have shown the consistently high incidence of HBV infection among AAPIs despite implementation of universal vaccination programs for children since 1984 (CDC, 1995; Cohen et al., 2007; Kowdley et al., 2012). Kowdley et al. provided evidence of HBV infection based on systemic review of reports of HBsAg rates from 1373 articles which showed that nearly 3.5% or 1.32 million foreign-born residents in the U.S. were living with HBV infection in 2009, a rate more than 33-times higher than the prevalence of 0.11% of non-Hispanic whites (Ioannou, 2011) and with disparities that far exceed those of any of the 10 greatest health disparities based on the Healthy People 2010 (Keppel, 2007).

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* Corresponding author at: Department of Nursing, University of Massachusetts Boston; 100 Morrissey Boulevard Boston, MA 02125-3393. Tel.: +1 617 287 5061.
E-mail address: haeok.lee@umb.edu (H. Lee).

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HBV infection can result in cirrhosis, liver cancer, and death (CDC, 2008). The incidence of liver cancer is disproportionally highest among AAPIs, with almost 4 to 12 times the incidence rates for non-Hispanic whites (American Cancer Society, 2010; CDC, 2008; IOM, 2010; Kowdley et al., 2012). Given this high rate of HBV infection and liver cancer, mortality among AAPIs due to liver cancer will increase substantially in the near future without intervention.

Despite remarkable progress in recognizing the social, behavioral, and genetic components of health and disease (IOM, 2006), little research has been devoted to advancing understanding of behaviors related to prevention of HBV and liver cancer from the standpoint of assessing the associations and interactions between individuals and sociocultural factors among AAPIs with HBV infection or who are at risk for HBV infection. Understanding key factors of HBV infection prevention in a culturally relevant social context is essential to inform the development and implementation of interventions to improve HBV prevention and liver cancer prevention behavior (Lee et al., 2012).

U.S. census data show wide diversity among AAPIs: they are among both the most highly and poorly educated and both the highest and lowest income wage earners. Although the median AAPI income is higher than the national median, the poverty rates of some Southeast Asian groups, including Laotians (35%), Cambodians (43%), and Hmong (65%), are far above the national poverty rate of 13% (PRC, 2013).

Some data suggest that there are disparities in health and health-related behaviors among AAPI subgroups, such as earlier cohorts of immigrants from East Asia and their descendants, including Japanese Americans, Chinese Americans, and Korean Americans, compared with more recently settled Southeast Asians who came to the U.S. as refugees following traumatic experiences of war and forced migration (Asian American Legal Center [AALC], 2011; PRC, 2013). Thus, disease-specific as well as ethnic-specific studies are necessary to capture the sociocultural experiences of individual ethnic groups and to explore the similarities and differences in factors that influence the health and health-related behaviors of AAPI subgroups. Therefore, the purpose of this article is to explore factors influencing health and health behavior within the sociocultural context of CAs and KAs, and to examine intergroup similarities and differences, focusing on HBV and liver cancer prevention behaviors.

2. Conceptual framework

The revised Network Episode Model (NEM) was used to guide these studies. The NEM explains how individuals come to recognize and respond to health problems and use healthcare services (Pescosolido, 1992). The revised NEM conceptualizes that health care decisions are made within social context of interactive social process that is influenced by the factors of sociocultural and individual level factors rather than by a deterministic response (Lee, et al., 2012).

3. Literature review

Our interest in the ethnic specific social contexts of two AAPI subgroups—CAs and KAs—was catalyzed due to the high prevalence of HBV infection and liver cancer and the diversity of the socio-demographic characteristics of these two groups. In keeping with the NEM, our study began with a review of literature about CA and KA sociocultural contexts.

3.1. Sociocultural contexts of Cambodian Americans

The 2010 U.S. census counted 241,520 CAs, more than 90% of whom came to the U.S. during the past three decades (Table 1). CAs began arriving in the U.S. as refugees after surviving the brutal rule of the Khmer Rouge in Cambodia from 1975 to 1979 when 1.7 million people—close to 30% of the country's population—died from starvation, execution, torture, forced labor, and illness. Many Cambodians lived in refugee camps in Thailand and other countries for several years before resettling in the U.S. Many suffered starvation, witnessed killings, and experienced torture and sexual assault during the Khmer Rouge era; those who escaped to refugee campus often faced further starvation, diseases, and violence (Berthold, 2000; Chan, 2003; Wright, 2010). These experiences led to a high rate of post-traumatic stress disorder and depression that continue to influence current CA health and health behaviors (Marshall et al., 2005).

Table 1
Socio-cultural characteristics of Cambodian, Korean, and AAPIs, 1980–2010.

Variables	Cambodians	Koreans	AAPIs	U.S. total
Population				
1980	16,044	357,393	3,726,440	226,545,805
1990	149,047	797,304	7,226,986	248,709,873
2000	206,052	1,228,428	11,898,828	281,421,906
2010	264,080	1,456,076	17,242,278	309,349,689
Median age				
1980	22.4	5.9	28.4	30.0
1990	19.4	29.1	30.1	33
2000	23	32	31.1	35.3
2010	29.3	36.7	33.3	37.2
Education				
College completed				
1990	2.6%	37.1%	37.9%	20.3%
2000	9.2%	43.8%	42.7%	24.4%
2010	15.7%	52.9%	48.9%	28.2%
Income				
Median household income				
1980	$ 9,306	$18,145	$14,400	$17,710
1990	$18,837	$30,184	$41,251	$30,056
2000	$36,155	$40,037	$51,045	$41,994
2010	$48,585	$50,316	$18,145	$50,046
Foreign born				
1980	93.9%	81.9%	58.6%	6.2%
1990	79.1%	72.7%	63.1%	7.9%
2000	68.1%	77.4%	62.7%	11.1%
2010	59.4%	74.4%	59.3%	12.9%

Source: Barnes andBennett (2002); Census Bureau (1993); and Census Bureau (2010). In 1990 census data, Asian or Pacific Islander group was included as a category. However, beginning in 2000 census, the Asian and Pacific Islander group was divided and created Pacific Islander group as a separate category.

The 2000 U.S. Census indicated that CAs had the highest poverty rate of all AAPIs and the highest proportion of those who were linguistically isolated, with over 90% speaking Khmer at home (Tang, 2008). A majority of CAs lives in three locales—Long Beach, California; Lowell and Lynn, Massachusetts; and Seattle, Washington. CAs are relatively more socioeconomically and socioculturally homogeneous than other AAPIs (Chan, 2003; Marshall et al., 2005; PRC, 2013).

A report about the Racial and Ethnic Approaches to Community Health (REACH) 2010 program revealed that CAs were three times more likely than other Asians not to visit a doctor in the past year due to financial reasons (CDC, 2004). Compared with other AAPIs, CAs experience greater poverty, have more limited education, and experience more health disparities in HBV and liver cancer-related risk factors and mental health (PRC, 2013).

3.2. Sociocultural contexts of Korean Americans

The history and socio-demographic characteristics of Korean immigration frames the sociocultural context of KAs, the majority of whom were not born in the U.S. (Min, 2011). This profile differs from Japanese and Chinese Americans who have longer histories of immigration, settlement, and multi-generational acculturation.

According to the 2010 Census, KAs increased from 11,000 in 1960 to 1,076,872 in 2000 and to over 1.4 million in 2010, an increase of 78% since 1990. Immigration to the U.S. peaked in 1987, but has