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Differences in nativity, age and gender may impact health behavior and perspectives among Asian Indians

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Abstract

Objective—Identify health perspectives among Asian Indians in greater Houston area, to guide a tailored community wide survey.

Design—Four focus groups of different ages, gender, and nativity were conducted at which participants were asked for their opinions about specific health topics. Key informant interviews were conducted with ten community leaders to validate focus group responses. Recordings from focus groups and key informant interviews were transcribed and analyzed.

Results—Diabetes, cancer, and hypertension were primary health concerns. Common themes were sedentary lifestyle and poor health literacy. Older participants were more accepting of having familial hypertension and high cholesterol. Women were more concerned about health of family members and dietary habits. Perspectives differed on eating habits, physical activity, use of Western medicine, and smoking based on nativity. Responses from key informant interviews validated focus group findings.

Conclusion—Perspectives on health may differ among Asian Indians depending on gender, age, and nativity.

Keywords

Asian Indians; health behaviors and health perspectives; focus groups

Introduction

The Asian Indian population in the United States grew from 1.6 million in 2000 to more than 2.8 million in 2010, an increase of almost 70%, making it one of the nation's fastest growing ethnic groups (US Census Bureau 2010,). Despite this population's rapid growth, robust data on the health-related issues affecting the Asian Indian community specifically are limited.

One potential reason for this paucity of data is the widespread practice of collecting and presenting data about Asian Indians in the United States as part of aggregated data under the Asian American Pacific Islander (AAPI) ethnic category. More than 30 distinct ethnic subgroups are included in the AAPI population, and this grouping obscures the true health profiles of specific subgroups, such as the Chinese, Vietnamese, and Asian Indian populations. National health statistics indicate that, compared with other racial or ethnic groups, the AAPI population overall is healthier, has a lower incidence of cancer, and has a lower cancer mortality rate (Howlader et al. 2016; Lin-Fu 1988). However, the limited data on Asian Indians indicate that this group has disproportionately high rates of coronary heart disease (Islam and Zojwalla 2002; Hoogeveen et al. 2001) multiple myelomas, and cancers of the stomach, liver, bile duct, gall bladder, and cervix (Jain, Mills, and Parikh-Patel 2005); increasing rates of diabetes, physical inactivity, and obesity (Misra 2004; Khowaja 2005);

and a high incidence of tobacco use, especially among men (Mukherjea and Modayil 2013). Thus, the aggregated health data of the AAPI population may present the health status of Asian Indians in a more favorable light than is factual. Therefore, it is recommended that health data of AAPI populations should be disaggregated to better understand each subgroup's specific health issues, including their risk factors for particular diseases and medical conditions (Esperat et al. 2004).

With a population of almost 250,000, the Asian Indian community in Texas is the second largest in the United States (US Census Bureau 2010, *Summary File 1. QT-P8*) and in Houston, Texas; Asian Indians are the second largest AAPI subgroup, making the city an ideal setting in which to assess this population's health issues. To improve our understanding of the health needs, beliefs, perceptions, and practices in this community, the Indian American Cancer Network (IACAN), Houston collaborated with researchers at The University of Texas MD Anderson Cancer Center to conduct the South Asian Health Needs Assessment (SAHNA) study. This paper will describe the results of focus groups and key informant interviews among diverse groups of Asian Indians to identify and characterize health perspectives and concerns in this population. This information assisted us in developing a culturally relevant survey instrument for this population. The study was reviewed and approved by the Institutional Review Board of The University of Texas MD Anderson Cancer Center and informed consent was obtained from all participants.

Methods

Participants

To gain a better understanding of the knowledge, perceptions, health beliefs, and practices of Asian Indians living in Houston, four focus groups were conducted. Based on the eligibility criteria, participants identified as Asian Indian, were 18 years of age or older, lived in Harris, Fort Bend, Brazoria, or Galveston counties, and were able to speak and understand English or Hindi. The focus groups, consisting of 9–12 participants per group, were held at an Asian Indian community center in July 2011. Participants were grouped by gender, age (18–55 years or older than 55 years) and place of birth (U.S.-born or non-U.S.-born). The four focus groups consisted of 1) non-U.S.-born women older than 55 years; 2) non-U.S.-born men older than 55 years; 3) non-U.S.-born men and women age 18–55 years; and 4) U.S.-born men and women age 18–55 years. In our discussions, we will refer to these groups as Group 1, 2, 3, and 4, respectively.

Participants were recruited from community centers and houses of worship by IACAN volunteers and MD Anderson researchers. Recruitment information was disseminated to the community through flyers, word of mouth, and e-mail. As potential participants contacted the investigators about their interest in the study, their eligibility was confirmed and a log of their contact information was generated. The selected focus group participants were contacted by phone or by e-mail to confirm the date, time and place for the focus group sessions.

An MD Anderson faculty member experienced in qualitative research trained IACAN and MD Anderson volunteers on obtaining informed consent and facilitating focus groups.

During the 2 hour training session, volunteers observed and participated in role-playing exercises to gain proficiency and confidence in leading a group. To develop the focus group questions, a focus group discussion guide used to assess perceptions of cardiovascular risk among Filipinos, another Asian American subgroup (US Department of Health and Human Services and National Heart Lung and Blood Institute, 2003), was modified and adapted for the Asian Indian community. Content experts who were also members of IACAN and the Asian Indian community reviewed the original focus group guide. Because they thought that the original guide was too lengthy, they reduced the number of questions from 80 to 28 and shifted the emphasis to cancer instead of heart disease. The intentions for reducing the script were to streamline the discussion questions, to avoid overburdening the participants, and to minimize redundancy. They re-ordered some topics and combined sections on diet and physical activity into a category called lifestyle factors. They also deleted a section on sources of health information. The revised focus group guide included questions on community health concerns, cultural meaning of health, cancer, health care access and use of complementary and alternative medicine, body weight concerns, tobacco use, diet and physical activity, heart disease, hypertension, and hypercholesterolemia. The final version was reviewed by content experts from the South Asian and medical community who determined that it had sufficient face validity to accomplish the goals of the project.

The trained facilitators conducted the focus groups using the discussion guide to engage participants in expressing their knowledge and perceptions regarding health in their community. Each focus group session, which lasted approximately 60 minutes, was recorded and later transcribed for analysis. The participants received a \$20 gift card as a token of appreciation.

To validate and expand upon the information provided by the focus group participants, 10 key informant interviews with Asian Indians of both genders with diverse occupations and religions were conducted. Interviewers used the same set of discussion questions used for the focus group sessions. Key informants had not participated in the focus groups, so they were not subject to the influence of other community members during those discussions, therefore avoiding social desirability bias in their responses (Fisher 1993). The investigators also believed that the inclusion of key informants might contribute to the external validity of the findings, especially if their responses were similar to those of focus group members. Like the focus group discussions, the key informant interviews were recorded and transcribed by trained members of the SAHNA research team.

Measures

Recordings of the focus group sessions and key informant interviews were transcribed by persons not involved in the facilitation or interview process to reduce the possibility of systematic bias. However, to ensure completeness and quality control, transcribers discussed any uncertainties about the participants' comments with those involved in the interviews or focus groups to resolve those issues.

Analysis

The focus group transcripts were analyzed by two of the authors not involved in focus group data collection (DB and SD) using a social anthropological research paradigm (Lincoln and Guba 1985; Bernard and Ryan 2010). First, one conducted a detailed review of the transcripts to identify the common perspectives and concerns mentioned in each group. To identify preliminary codes, the repetition and similarities and differences text analysis methods were used. Preliminary codes were created, loosely based on the topics and questions in the focus group guide: these included definitions of good health, disease prevention and access to care, cancer, hypercholesterolemia, hypertension, physical activity, overweight and obesity, tobacco use, and cultural meanings of health. To ensure inter-rater reliability, the second author reviewed and confirmed the codes, discussing and resolving differences in interpretation with the first author (Bernard and Ryan 2010).

The next step of analysis was data reduction which was accomplished by identifying transcribed text, usually comprised of two or three sentences that referred to or described a particular concept. These blocks of text were assigned one of the preliminary codes. Codes for concepts not included among the preliminary codes, such as chronic disease and community health concerns, were added as needed. The next step in data reduction consisted of clustering the codes based on patterns of their occurrence in the text. Data was further reduced by conducting cross group comparisons to identify patterns resulting in a set of emerging themes and sub-themes among the clustered codes of text. A “theme” was defined as a major thought or idea expressed by a majority of the group and “subthemes” were related ideas, perhaps not mentioned as frequently by the focus group participants, or not by the majority of participants (Bernard and Ryan 2010).

Results

Focus Group Session Findings

The first question asked in all focus group sessions was, “what do you feel are the top health problems in the Asian Indian community?” A tally of all the groups’ responses identified diabetes, cancer, and hypertension as the top three community health concerns. However, the identification and ranking of the most important health conditions in the Asian Indian community differed slightly among the groups (Figure 1). Of note is that all Group 1 participants ranked cancer as the number one health concern.

To gain insights about cultural perspectives on health, we asked “what does good health mean to you?”. Some examples of responses were: “healthy people are self-dependent”, “healthy people use less health care”, and “unhealthy people are unhappy.” Overall, participants associated good health with wellness and a positive state of being as opposed to the absence of disease. We probed for cultural folk tales or sayings or symbols about health that are unique to the Indian culture and responses included: “a fat person is considered healthy which is a myth”, “if a person is lean he is sickly”, “eating more and becoming fat is healthy” and “if you see a doctor or go to a doctor you are not healthy”.

The ways in which the focus groups’ perceptions of health and health behaviors varied are shown in Figure 2. To gauge perceptions about cancer, we asked, “How concerned are

people in the Asian Indian community about cancer?” It was notable that Group 1 mentioned media over exposure and fear related to cancer, and Group 2 commented on the mystery, fears and myths surrounding cancer incidence and risk factors.

When the topics of health care access and complementary and alternative medicine were introduced, Groups 1, 3 and 4 brought up the theme of health literacy, with Groups 1 and 4 referring to “poor health literacy” in the Asian Indian community. We asked, “When people in the Asian Indian community get sick, what do they tend to do?” Themes arising from Group 1 were avoidance of doctor visits, hiding of illnesses, stigma attached to illness, and not seeking mental health assistance. Members of Group 2 noted that the Asian Indian community exhibits denial of health problems and gender differences in decision making power with males in the Asian Indian community having greater decision making power over females especially when it comes to health or medical decisions. Because of a lack of understanding of how to navigate the US health care system, many continue to call the family doctor in India for medical advice. Group 3 participants also noted that Asian Indians tend to rely on their family doctor in India even after moving to the US.

We asked “Do you think members of the Asian Indian community use complementary and alternative medicine? If so, what kinds of services do Asian Indians use the most?” Group 1 reported the use of alternative medicine, including acupuncture, chiropractic, herbal remedies, homeopathy, spirituality and prayer. Group 2 noted frequent use of alternative medicine such as acupuncture, ayurvedic, chiropractic and home remedies, spirituality and prayer, but also mentioned ineffective coping strategies. Group 4 mentioned dependence among community members on spiritual healers and lay persons for medical advice and use of natural remedies.

To assess lifestyle behaviors in this community, we asked about the meaning of “overweight” in the Asian Indian culture. Members of Group 2 noted that it was a social norm for individuals to gain weight as they age. We asked “how does the Asian Indian community view tobacco use?” Members of group 2 mentioned the implicit acceptance of smoking with growing rates of smoking among young women being prevalent in India. They also added that alternative forms of tobacco are commonly used.

We also asked “What kind of food do you think the majority of Asian Indians eat? Do you think the Asian Indian community has difficulty in obtaining and eating healthy foods?” Both Groups 1 and 4 characterized their community as having poor dietary habits. To assess physical activity, we asked, “When you look around the Asian Indian community here in Houston, how physically active are the people in the community?” A common theme noted by all groups was sedentary lifestyle in their community, and Group 4 brought up the theme of poor role modeling by parents regarding exercise.

Focus group facilitators led discussions about the community’s concerns about heart disease, high blood pressure and cholesterol. Groups 2 and 3 noted that there was acceptance of the likelihood of having high blood pressure and high cholesterol due to family history. To conclude the sessions, facilitators asked for any other comments from the group. Additional

discussion topics were the generation gap and the empowerment of women by Group 1, and the use of online sources of health information by Groups 2 and 3.

Key Informant Interview Findings

The findings of our analysis of the transcribed 10 key informant interviews largely validated the focus group responses. In general, the key informants and focus group participants provided similar responses regarding the health of Asian Indians. In addition to identifying the same health concerns of the focus groups, the key informants also identified geriatric, neo-natal, and women's health concerns in the Asian Indian community. Some responses of the participants regarding women's health were ".....they do not know that you should have mammogram every year or we should get this tested you know, so many people have had one Pap smear or never. You find a lot of people in the Indian community who never had a Pap smear and they do not understand why they should have a Pap smear. They do not even understand what is Pap smear, so education is very important with them." and "Women have apathy and the tendency to overlook their need like going for regular checkups and doing exercise."

Like the focus group participants, the key informants discussed the lack of health-related awareness and knowledge among Asian Indians. The key informants also reported perceiving social stigmas associated with cancer, which was in line with the responses of the focus group participants.

Discussion

Common themes

Common themes identified from the focus group transcripts included poor health literacy, cultural norms of accepting increased weight as one ages, being fat implies that the person is healthy, the inevitability of high cholesterol and high blood pressure, acceptability of a sedentary lifestyle; poor dietary habits, gender differences in decision-making power and use of alternate forms of tobacco, such as betel leaf. The sub-themes that emerged included a lack of awareness regarding the types and benefits of preventative and screening behavior. Additional sub-themes were ineffective coping strategies, which were associated with denial of health problems and apathy. Mental illness, which was attributed to a lack of knowledge about mental health issues and seeking mental health services was also one of the sub-themes.

Health literacy

Health literacy was a major theme for all groups. Older immigrant groups reported on the lack of understanding of navigating the US health care system, avoiding preventive screenings, denying health problems, and continuing to rely on health professionals in India. The difference in responses based on age with regard to regular preventive screenings reported in our study was different from a similar study (Mehrotra, Gaur, and Petrova 2012), where the participants' compliance with regular medical examination was noted to be associated with income level and not with other demographic or socio-economic characteristics, such as gender, age, health coverage, education and duration of stay in the

US. Additionally, the older immigrant groups in our study reported greater use of alternative therapies, such as Ayurveda and herbal remedies. Again, this points out the need for targeted outreach efforts to this segment of the Asian Indian community. The barriers and practices they identified could lead to delayed diagnosis of health problem and incurring greater healthcare costs.

Differences based on age, gender and place of birth

Responses regarding several health behaviors and beliefs differed based on participants' age, gender, and nativity.

Cancer—Regarding cancer, two of the non-US born groups, Groups 1 and 2, expressed that there was fear and lack of information (“mystery,” “myths” “over exposure in the media”) about cancer. They said they had difficulty in sorting through what they characterized as an overwhelming amount of information about cancer in the media. This may demonstrate a greater need to provide health education on this topic to immigrant Asian Indians to minimize fear, address misconceptions, and encourage screening to reduce anxieties about the disease. The need for more health education, specifically for cancer, was also identified in studies in which Asian Indian women reported that their knowledge of breast cancer was inadequate and that there was a need for increased awareness and education (Boxwala et al. 2010; Sadler et al. 2000).

Weight gain and chronic disease—Immigrant and older participants, Groups 1, 2, and 3 had greater acceptance of weight gain and chronic disease and considered these as a normal part of getting older. They felt that these conditions were inevitable and may be resistant to lifestyle changes that could prevent or delay heart disease, hypercholesterolemia and high blood pressure. On the other hand, the younger US born participants reported greater participation in physical activity and awareness of the importance of good nutrition. Compared with their older counterparts, individuals age 18–55 years (both US- and non-US-born) indicated having a healthier lifestyle in terms of exercise and diet. These results were similar to those found by Jonnalagadda and Diwan (2005) in which younger Asian Indians and those with longer length of residence in US reported greater participation in physical activity.

Tobacco use—Mukerjea and Modayil (2013) reported that the use of smokeless, cultural tobacco products, such as paan masala, betel leaf and supari, is pervasive in the South Asian population. Use of these substances is frequently not captured in national health surveys. We found that practices such as use of alternative forms of tobacco, consumption of betel leaf were reported to be higher among the older immigrant focus group members as compared to the US-born participants. In fact, younger community members felt that their parents were not good role models for health practices.

Mental health—The younger groups also mentioned mental health issues and depression, whereas the older groups did not. Mental health issues often carry a stigma that is especially pronounced in the Asian community (Liang 2004). These findings further support the need for tailored programs aimed at older, immigrant Asian Indians, to educate them to seek help

for mental health concerns and developing lifestyle intervention programs that are culturally appropriate.

Limitations of the study

Although we believe that this study generated important insights into the health beliefs and perspectives of the rapidly growing Asian Indian community, we acknowledge its limitations. The small number of focus groups may not have captured the variations in responses of individuals from diverse regions of India. Additionally, saturation resulting from a large number of focus groups may not have been achieved.

On the other hand, well thought out steps were taken to engage the community's input in recruiting participants, developing a relevant set of questions, and in validating the opinions expressed in the focus groups by key informant interviews with individuals who were intentionally selected to represent diversity in gender, occupation, and religion.

Although the focus group guide included an opportunity for discussion of topics not on the guide, time constraints may have limited the discussion of additional health topics of concern. Focus group facilitators were instructed to encourage participation from all focus group members, but more talkative members may have prevented some from fully expressing their perspectives.

Implications for future research

Asian Indians are a rapidly growing population that is widely dispersed in the U.S. with large concentrations residing in several regions. Because of different reasons for and patterns of immigration, varying levels of acculturation and English proficiency, these communities may not all be the same, and may have diverse perspectives on health and health care, as some of our findings were in contrast to those with other Asian Indian communities. Therefore, we believe it is important to assess the health needs of local populations in order to understand their specific health concerns.

Our study showed that public health professionals in communities with large Asian Indian populations should also be aware of the unique differences in health perspectives depending on gender, age, and nativity. The health-related attitudes, practices, and beliefs identified from the focus group sessions and key informant interviews informed the design of the SAHNA survey which was later administered to a representative sample of Asian Indians in the greater Houston area. We incorporated this new understanding into the design of the SAHNA survey in order to collect data on the health needs and health status of Asian Indians living in the greater Houston area. We believe that the findings of this study and the methodology used may help in understanding and addressing the health disparities of Asian Indians living in the U.S.

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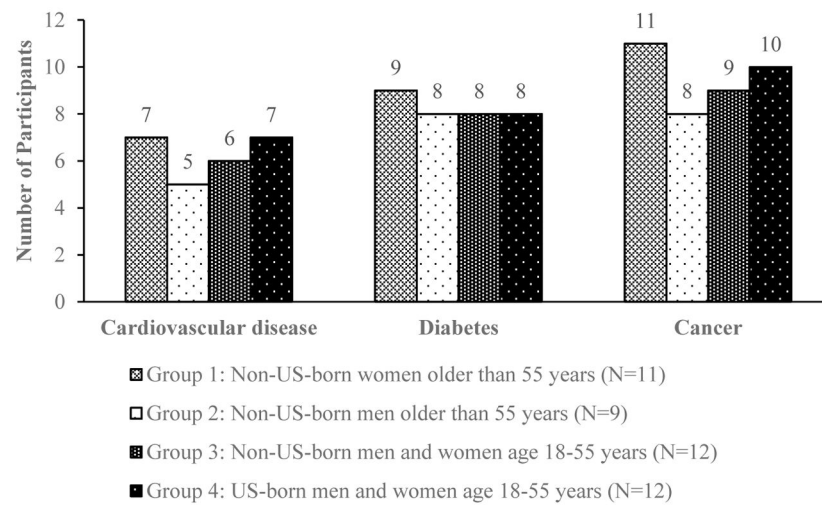


Figure 1.
Top Community Health Concerns of Focus Group Participants

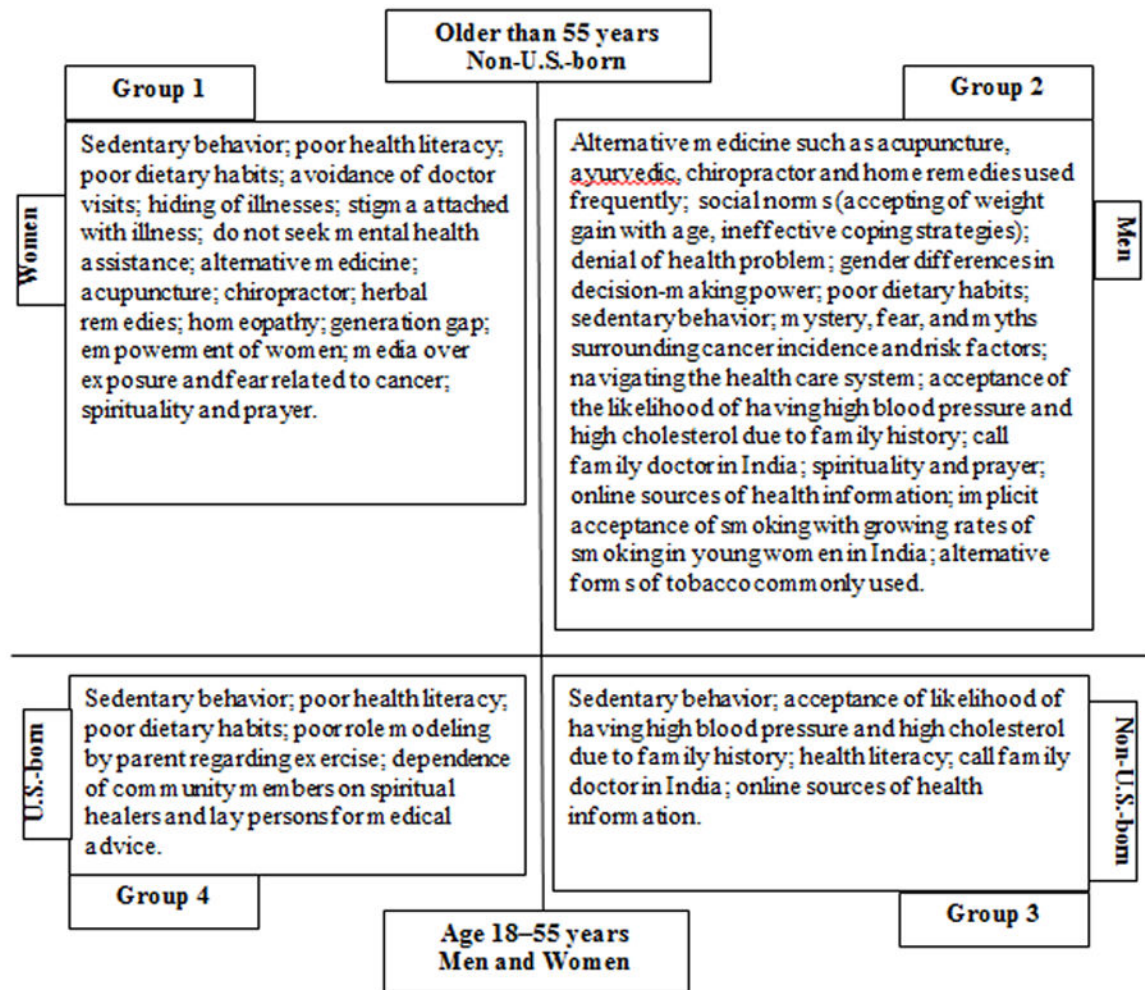


Figure 2.
Similarities and Differences in Coded Responses from the Four Focus Group