

# EXPANDING HEALTH ACCESS IN THE CAMBODIAN COMMUNITY

A GUIDE TO EFFECTIVE OUTREACH STRATEGIES  
AND  
LESSONS LEARNED FROM THE  
CAMBODIAN COMMUNITY HEALTH 2010 PROGRAM



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**A Message from the Cambodian Community Health 2010  
Program Director, Sidney Liang**



*The search for improving our health and continued existence in the Cambodian community continues. Speaking as one of many Cambodians who has been here for many decades, our lives and struggles abound with the relentless pursuit to feel at ease and at home in a land from which we are still estranged. The Cambodian community in Greater Lowell, Massachusetts is still young, yet it continues to blossom in all aspects. Traditions, cultures, religion, lifestyles, but also unfortunate trauma from a ruthless regime shadow us throughout our walk of life. Along with our adjustment to basic life, the strength of those experiences with positive karma is restoring this community to look onward toward a brighter future to find peace, health, and happiness for our children and our children's children.*

*As the Cambodian Community Health 2010 Program comes to a close, we looked back at all the efforts we've accomplished to increase access to health care for the Cambodian community. Through pictures and words of wisdom, we captured and framed the contents of some of our work in this guide for everyone who walks in our road toward making life and health care access a little easier for those who do not understand the system.*

*This guide would not come to fruition without the assistance of everyone of the Cambodian Community Health 2010 Program. The enormous works left behind and the stories they interfaced could only be told by the actions remembered by our clients, participants, and our collaborative partners.*

*I hope this guide will help you in your journey of accessing resources, activity development, and building partnerships to mobilize system changes. Everyone desires to live healthy and productive lives despite the continued struggle to break down and assimilate cultural and traditional barriers.*

*Sincerely yours,*

A handwritten signature in black ink that reads "Sidney L. Liang". The signature is written in a cursive, slightly stylized font.

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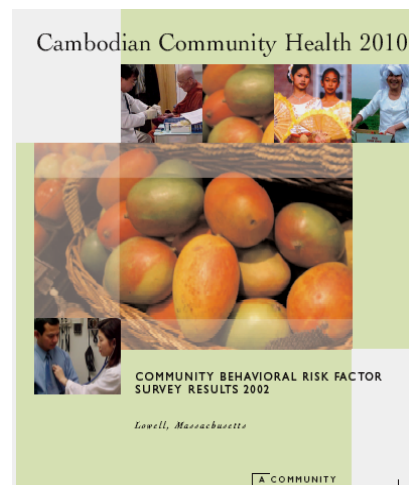
## INTRODUCTION

This document is based on best practices and lessons learned from the **Cambodian Community Health 2010 (CCH 2010)** program, one of forty Racial and Ethnic Approaches to Community Health (REACH) programs funded by the U. S. Centers for Disease Control and Prevention. The purpose of this guide is to share with the reader, examples of community driven outreach strategies, effective and sustainable interventions, and capacity building efforts that reduce health disparities in cardiovascular disease (CVD) and diabetes among adult Cambodians in Lowell, Massachusetts. The successes of CCH 2010 are directly attributed to staff, community leaders, local residents, and key coalition partners. Their knowledge and commitment to implement a broad spectrum of culturally appropriate key actions have fostered *community* mobilization efforts needed to change community conditions to enhance access to health care and reduce disparities.

## A COMMUNITY RESPONSE

### A COMMUNITY PROFILE

Lowell, Massachusetts is home to the second largest Cambodian population in the United States, but very little data is available that is directly useful for determining how to best serve the health needs of this community. According to the Massachusetts Community Health Information Profile (Mass CHIP), approximately 16% of Lowell's population of 105,000 is Asian, the majority Cambodian, making Cambodians the second largest proportion of the population. Community estimates are much higher than 16%; they are closer to 20%.



## HIGHLIGHTS OF KEY FINDINGS FOR CAMBODIAN ADULTS 25 AND OLDER

### CCH 2010 COMMUNITY BEHAVIORAL RISK FACTOR SURVEY RESULTS, 2002

From December 2001 to June 2002, trained interviewers visited a total of 610 addresses; 409 were Cambodian, 403 were eligible (at least one Cambodian in the household was 25 years of age or older), and 381 agreed to participate and completed the survey, for a response rate of 94.5%. Examples of findings among those surveyed, 25 years and older are as followed:

#### **Demographics**

- 99% were born in Cambodia, 73% were born in a rural area, and 37% were farmers prior to 1975.
- 87% reported being Buddhist.
- 85% spent time in a refugee camp.

#### **Income and Work**

- The median household income was \$21,000.
- Among those who were working, 82% worked in manufacturing.

#### **Education**

- Men received an average of 5.6 years and women 2.8 years of schooling in Cambodia.
- Among adults 25-35 years old, 43% of men and 27% of women completed high school.

#### **Language**

- 96% always spoke Khmer at home.
- 66% spoke English well enough to have a conversation.

#### **Health Status**

- A quarter were symptomatic for depression; among women 50+, 43%.
- 73% had used traditional healing treatments (such as coining) in the past year.

#### **Health Care Access**

- 68% wanted an interpreter when talking to a non-Khmer speaking doctor.

**The Cambodian Community Health 2010 Community Behavioral Risk Factor Survey Results, 2002 is available on the CCH 2010 website: [www.CCH2010.info](http://www.CCH2010.info).**

## THE NEED

A review of Lowell-specific data reveals poor health status in relation to CVD and diabetes, including disproportionate risk for morbidity and mortality from CVD and diabetes. Among Lowell Cambodians, a disproportionate share of adult ( $\geq 45$  years) deaths are attributable to stroke (15.9%) and diabetes (13.4%) when compared to all stroke and diabetes related deaths for Massachusetts adults 45 years or older (6.5% and 2.5% respectively). When heart disease, stroke, and diabetes are combined, the proportion of deaths attributable to these diseases is 48.9% for Cambodians and 42.1% for all Massachusetts adults.<sup>1</sup>

From 1975-1979, as a result of the Khmer Rouge regime, between one million and three million Cambodians were killed through starvation, murder, disease, and unspeakable brutality. The Khmer Rouge produced misery and repression on a massive scale and caused the Cambodian people to live in hopelessness and prolonged fear. One study published in JAMA found that 62% of Cambodian refugees living in Long Beach, CA (home to the largest U.S. Cambodian population) suffer from Post-Traumatic Stress Disorder (PTSD).<sup>2</sup> According to the Cambodian Community Health 2010 Community Behavioral Risk Factor Survey Results 2002, among Lowell Cambodian adults 25 and older, a quarter was symptomatic for depression, and the rate rose to 43% among women 50 and older. According to the National Institute of Mental Health, depression often co-occurs with other serious illnesses such as stroke, diabetes, and heart disease, but most people with depressive illness do not seek treatment. Furthermore, depression is associated with an increased risk of coronary heart disease in both men and women, but men suffer a high death rate.<sup>3</sup>

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<sup>1</sup> Massachusetts Department of Public Health, Massachusetts Community Health Information Profile (Mass CHIP):Mortality, ICD-9 based. <http://masschip.state.ma.us>.

<sup>2</sup> Marshall GN, Schell TL, Elliott MN, Berthold SM, Chun C. Mental health of Cambodian refugees 2 decades after resettlement in the United States. *JAMA*, 2005; 294:571-579.

<sup>3</sup> Ferketick AK, Schwartzbaum JA, Frid DJ, Moeschberger ML. Depression as an antecedent to heart disease among women and men in the NHANES I study. National Health and Nutrition Survey, *Archive of Internal Medicine*, 2000; 160 (9): 1261-8.

Cambodians have low awareness about hypertension, and have low medication treatment levels, control rates, and rates of contact with primary care physicians.<sup>4</sup> Diets high in sodium and fat are typical. The smoking rate among Cambodian males is extremely high (71%), even in comparison to other Asian groups.<sup>5</sup> According to the CCH 2010 Community Behavioral Risk Factor Survey Results 2002, Cambodian men between the ages of 36-49 smoke at a much higher rate than the general Massachusetts population (33% vs. 18% respectively).<sup>6</sup>



**PHASE I** of the CCH 2010 program (the planning phase) focused on collecting qualitative and quantitative data to better understand health issues among Cambodians and their association with health care access. During this period, CCH 2010 staff conducted fourteen community focus groups, held four Cambodian Advisory Group meetings, and collected data from peer reviewed literature and local, state, and national research data sets. Also during this period, the CCH 2010 Steering Committee (made up of key coalition partners) met eleven times and a community forum entitled *Cambodian Community Health 2010: Eliminating Health Disparities in the Cambodian Community* was held in 2000. These collective efforts resulted in the development of a framework for action which became the Community Action Plan for the CCH 2010 program.

CCH 2010 implements a broad spectrum of key actions that involve the Cambodian community, health and human service agencies, teaching institutions, government agencies, medical providers, and institutions of higher education to address issues of disparities in cardiovascular disease and diabetes among adult Cambodians in the

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<sup>4</sup> Stavig, SR, et. al. Hypertension and related health issues among Asians and Pacific Islanders in California. *Public Health Reports*. 1998; 103:28-37.

<sup>5</sup> Fact Sheet on Asian Americans and Pacific Islanders and Cancer. Published in *Asian American and Pacific Islander Journal of Health*. 1997;5:74.

<sup>6</sup> *Cambodian Community Health 2010*. (2002). *Community Behavior Risk Factor Survey, 2002*. Lowell, MA.

greater Lowell area. These strategies, interventions, and capacity building efforts encompass multiple approaches which are rooted in a community action plan and address the following four primary goals:

1. Increase access to the health care system for Cambodians.
2. Increase awareness among health care providers about Cambodian health care beliefs, practices, and needs relating to CVD, diabetes, and access to health care.
3. Increase knowledge and awareness in the Cambodian community about diabetes and CVD; increase involvement in active participation in decision making related to healthier lifestyles and/or disease management; and decrease risk factors and behaviors associated with CVD and diabetes.
4. Increase capacity of public health researchers to conduct community research in the Cambodian community in order to increase available data about CVD and diabetes; and increase the capacity of practitioners and health professionals to implement culturally appropriate community level interventions.

All CCH 2010 efforts are intended to influence risky/protective behaviors through learning about the underlying causes of health disparities and transforming community conditions and systems so that a supportive context exists to sustain health promoting behavior over time. The next section provides an overview of key activities, interventions, and capacity building efforts of the Cambodian Community Health 2010 Program.



# HIGHLIGHTS OF CCH 2010 INTERVENTIONS

The following examples of interventions were the results of collaborations among key partners such as the Cambodian Mutual Assistance Association of Greater Lowell, Southeast Asian Bilingual Advocates Inc., Visiting Nurse Association of Greater Lowell, Merrimack Valley Area Health Education Center of the Greater Lawrence Family Health Center, and the City of Lowell Senior Center.

## CAPACITY BUILDING EFFORTS

- Cultural competency training provided at the Lowell Community Health Center, the University of Massachusetts Lowell, and local hospitals.
- Professional development courses such as interpreter training, Khmer medical terminology, coalition development and sustainability, and developing lesson plans and presentations.
- Health advocacy and case management services.
- The first Cambodian Cultural Health Conference held in Lowell, MA on 9/28/2005.
- Numerous local and national presentations about CCH 2010.
- Development and implementation of an Outreach Tracking Information System (OTIS) for evaluation purposes, which is used by staff as well as subcontractors.
- Massachusetts Association of Registered Nurses (MARN) approved 1 contact hour for an educational workshop called, Overview of Cambodian Community Health 2010: Cambodian Health Practices, Beliefs, and Culture and Selected Results of the Community Behavioral Risk Factor Survey, 2002 and the NORC REACH 2010 Risk Factor Survey. These presentations, coordinated and presented by the Program Director, Sidney Liang, and a Clinical Liaison from the Visiting Nurse Association of Greater Lowell, have been well received in the community. Examples of locations where presentations are conducted include institutions of higher education (nursing programs and other medical and health related programs of study), private practices, long-term care facilities, in-patient rehabilitation facilities, and other health care organizations.





## TARGETED ACTIONS

- Peer support groups at the Lowell Senior Center and three housing developments.
- Stress reduction sessions which include information about massage therapy, acupuncture, anger management, walking programs, music and dance, and field trips.
- Community screenings for blood glucose and blood pressure.
- Health education groups about diabetes, heart disease, and stroke at the Adult Basic Education Center, Saint Julie Asian Center, Cambodian Mutual Assistance Association ESL classes, and Casey Family Services.
- Cardiovascular exercise programs at the Lowell Senior Center, tai chi, river walking programs, and harvesting trips to local farms.
- A recipe booklet, with over twenty traditional Cambodian foods that can be used as a shopping, preparation, or cooking guide to make nutritional changes to traditional Cambodian recipes by reducing saturated fat, cholesterol, and sodium, and increasing fiber. Cooking demonstrations and food tests are also provided in community settings.
- Implementation of the Massachusetts Department of Public Health's Stroke Heroes Act FAST educational program.
- Learning tours to local hospitals, Lowell Community Health Center, Lowell Police Department's 9-1-1 emergency response systems, Lowell Regional Transit Authority's public transportation routes, and Road Runner services for elders.
- Content for over 100 one-hour TV shows for Jivit Thmey, a Khmer language cable television program aired twice a week.
- The Voice of Cambodian Children weekly radio program on health topics related to diabetes, cardiovascular disease, and other health areas such as Avian Influenza (Bird Flu).
- Education tools to assist adult Cambodians to better manage their disease, such as identity badges and pocket-size vital sign cards to record blood pressure.



## LESSONS LEARNED ABOUT INFRASTRUCTURE

Paramount to the success of any of the above interventions is the on-going development of and investment in a strong infrastructure that represents the community, is capable of mobilizing prevention efforts, provides continuing support at all levels, becomes the voice for needed environmental changes, provides continual opportunities for improvement, and encourages the development of change agents necessary for community-wide behavior and system changes that lead to reducing disparities and barriers to health care. An equally important element in developing effective interventions is the provision of innovative community outreach practices to not only promote health and self-advocacy, but to sustain community-wide behavior change.

Infrastructure for the CCH 2010 program includes several distinct yet equally valuable elements: 1) a coalition of community leaders, health care providers, and residents; 2) staff; 3) subcontractors; 4) a lead agency; and 5) evaluators who understand the role of community approaches and partnerships in sustaining community-wide change. The following are helpful thoughts for developing this infrastructure:

► **Community partners** (a coalition) representing diverse spheres of influence need to be actively engaged in decision making processes around how to define and best address community needs prior to seeking and securing funding sources. They should share leadership roles to present, implement, and continuously evaluate solutions. Evaluation is important to measure effectiveness of interventions, but also to ensure continuous quality improvement.

► **The Project Director** must be a leader in the community, and staff should have knowledge about the community, cultural viewpoints, diversity of values, practices, beliefs, and problem solving strategies, as well as a good understanding of the U.S. and local health care system.

► **Understanding** Cambodian immigration history, including political, societal, historical, and religious influences is essential to developing interventions.

► **Capacity building** efforts for staff such as professional development opportunities and leadership training should be continually integrated into all aspects of program development and activities. Examples of staff development training provided by CCH 2010 included:



- How to conduct focus groups.
- How to administer community surveys, including interviewing techniques.
- Trainings about health conditions such as heart disease, diabetes, and stroke and health behavior such as smoking cessation.
- CPR and First Aid training.
- Training about community outreach and health promotion.
- Extended learning opportunities through access and participation in state and national workshops, conferences, and seminars sponsored by the CDC, MDPH, and APHA.
- How to develop lesson plans and presentations.
- Team and leadership training.
- Evaluation and developing measurable outcomes.
- Massachusetts League of Community Health Centers and Suffolk University Certificate Program in Community Health and Community Health Center Management.

► **Write** clear, concise, and mutually agreed upon contracts or memoranda of agreements between the lead agency and all partners. These subcontracts should state deliverable services with clear outcomes that meet not only the program's goals and

objectives, but also reasonable outcomes for people who benefit from interventions. Establishing effective contract administration systems assures performance of contractual obligations. Contract monitoring further ensures contractor program performance, continuous quality improvement, and compliance with the terms and conditions set forth by the funding agency. Key elements in contract administration include:

- Regular communication and meetings between contractors and the lead agency.
- Continuous technical assistance, support, and feedback among all partners.
- Annual written contracts or memoranda of agreements.
- Implementation of monitoring systems such as desk reviews, fiscal reviews, site-visits, participant evaluations, and performance monitoring/evaluation of outcomes for subcontractors and program activities.
- Contracts should include a description of the overall purpose, a clear description of services that will be provided to meet goals and objectives, the time they will be delivered, expected performance or outcome measures for objectives, terms of payment, methods of evaluation and reporting requirements, and other terms, conditions, and clauses.

► **Evaluation:** The primary evaluator for the CCH 2010 program is the University of Massachusetts Lowell, Center for Family, Work, and Community. Several forms of evaluation should be considered which utilize process, impact, and outcome evaluation methods to measure change and the project's ability to meet project objectives. Methods of evaluation for CCH 2010 included community surveys, chart



reviews, activity logs and evaluations, process evaluation, and observation at all levels. In addition, an overarching Logic Model of evaluation, which encapsulates key goals and objectives for CCH 2010, ensures progress toward process and outcome measures. A system called Outreach Tracking Information System (OTIS) was also developed and

used by staff and subcontractors to track number and type of activities, number of people reached per activity, and educational materials distributed through outreach. Finally, an internet-based information network system tool called REACH IN was used for handling data and reporting purposes. Key points to consider regarding evaluation specific to the CCH 2010 program include:

- Language and literacy levels when developing any type of written evaluation.
- Limited exposure to use of scales (such as 1-5 on 'most liked' to 'least liked').
- The IRB process can be time consuming because extra time is needed for translation and back translation. Communication is also important between IRB reviewers and staff about translation discrepancies.
- Staff need to develop evaluation tools in collaboration with evaluators. Some words are lost in translation or are not translated word for word.
- At least two Khmer speaking staff need to be present when evaluating an activity to help participants who may need assistance with reading or writing in Khmer and/or English.
- The use of visual aids (such as PowerPoint or an overhead) can assist Khmer evaluators for larger groups. Participants can see the evaluation questions while the evaluator reads it in Khmer.
- Focus groups with staff who speak Khmer and English can be used to follow up about written evaluation results. For example, the evaluation question may read, "Please explain two ways peer support group sessions help you better manage your disease." A frequent answer may be "I learn" or "I'm very happy." A focus group may provide further information about what someone learned or how attending the groups makes someone happy.



# COMMUNITY OUTREACH STRATEGIES AND LESSONS LEARNED

**COMMUNITY OUTREACH** for the Cambodian Community Health 2010 program is carried out in a number of ways and include reaching out to the community, meeting new people, developing partnerships with advocacy organizations, and interacting with a person or group as it pertains to health issues that may impact their overall well-being or ability to access health care.

## **WHAT IS THE GOAL OF COMMUNITY OUTREACH?**

The goal of community outreach is sustained, community-wide positive behavior change. Its purpose is to promote health and wellness, and reduce diseases, social ills, and health disparities through information, resources, referrals, and advocacy. Community outreach provides access to health and social service resources as well as support for individual, family, and community life.

For CCH 2010, outreach includes community educational groups, workshops, talking to people one-on-one or in a group, door-to-door outreach, business outreach to pharmacies, markets, and restaurants distributing educational materials, organizing special events, wellness programs such as peer support and stress management sessions, exercise programs, health screenings, cooking demonstrations, radio programs, cable television programs, presentations for providers and schools of higher education about culture and the importance of cultural competence in the delivery of health care, and participation in local and state boards, committees, and subcommittees. These activities can take place anywhere, at a community agency, organization, school, university, someone's home, a temple or a church.

Effective outreach can only take place once we have gained enough knowledge about the community we are targeting. We need to become aware of cultural viewpoints and take into account the diversity in values, beliefs, practices, lifestyles, and problem-solving strategies. In addition, we need to gain knowledge about the differences in the community's historical, societal, political, and religious influences that affect the worldview of community members or patients. For immigrant and refugee communities, such as the Cambodian community, learning their immigration history is an essential part of creating a successful outreach strategy.<sup>7</sup> It is also essential to how the community accesses preventive health care services, and in the delivery of culturally appropriate health care.



<sup>7</sup> “Cultural Competence in Health Care” by the Cross Cultural Health Care Program, June 2002.

## BACKGROUND ON CAMBODIA

Cambodia is located in the southeastern part of Asia, surrounded by Thailand, Laos, and Vietnam. Prior to 1970, Cambodia was rich in natural and agricultural resources. The majority of the people lived in small villages and worked in agriculture. In 1975, the Khmer Rouge, a small movement of revolutionaries, overthrew the government and began a new regime. The regime began to eliminate the Cambodian population in a reign of terror lasting from 1975 to 1979. This new movement killed millions of Cambodians. During this time period, many Cambodians escaped across the Thai border. Those refugees who made it to the camps in Thailand and Malaysia found starvation, disease, overcrowding, and violence.<sup>8</sup> Most Cambodians who came to the U.S. are from rural Cambodia, have had limited educational opportunities and have very low literacy levels in their own language. Khmer, also known as Cambodian, is the official language of Cambodia. The written language is complex, including 66 consonant symbols, 35 vowel symbols, 33 superscripts, and 33 subscripts.<sup>9</sup>



## ON TRANSLATION

**When translating a document, follow these steps:**

1. Review the intent and target audience of the document with the translator.
2. Translate from English to Khmer (or other language).
3. Revise the document by a second translator.
4. Back-translate the document from Khmer to English and ask yourself, does the content say what you want it to say? If not, restart the process.
5. When the final document is ready, one last proof reading by at least two people fluent in the language should occur prior to reproduction.

It is important to keep in mind that when some materials are translated, some of the original texts (words) are lost. In fact, most effective translations are not word-for-word. What matters most is that the idea and concept is the same, that is, that you are giving out the right message.

<sup>8</sup> “Cambodian Cultural Profile” by Linda Wetzel, RN, [www.ethnomed.org](http://www.ethnomed.org).

<sup>9</sup> Center for Applied Linguistics, 1981.

## CAMBODIAN HEALTH BELIEFS

Cambodians generally seek assistance from a health care provider after traditional practices have been tried and have not worked. Herbal remedies, dermal techniques, maintenance of hot-cold balance, and other rituals are the main forms of medical treatment.

**Cupping, pinching, or rubbing** (known as coining or Koh Kyol) are the most common forms of treatment.<sup>10</sup> Coining is used to treat a variety of ailments, including fever, upper respiratory infections, nausea, weak heart, and malaise. Coining involves firmly rubbing the skin with a spoon or a coin in order to bring the toxic “air” to the surface of the body. Pinching is used to treat headaches and malaise. Pinching is usually done at the base of the nose, between the eyes, on the neck, chest, or back. In cupping, a cup is heated and then placed on the forehead or abdomen. Cupping is believed to draw excess energy or “air” into the cup.

Advice is often sought from Buddhist monks, Kru Khmer (traditional healers), or elder family members. It is important to recognize that there is no real concept of ‘preventive care’ in the Cambodian community. This is due in part to the fact that this concept did not really exist in Cambodia.<sup>11</sup>



<sup>10</sup> “Cambodian Culture Profile” by Linda Wetzel, RN, [www.ethnoMed.org](http://www.ethnoMed.org)

<sup>11</sup> “People Profile: Cambodian”, VNA Care Network, Inc. Cultural Competency Program.

## A WORD ON COMMUNITY TRUST

*“...we need to be willing to listen, to learn... in order to build the bridge between the community and us.” -CCH 2010 outreach worker*

Due to the long decades of turmoil in Cambodia, the Cambodian community has lost its trust in the outside world, even when the outside world is the fellow Cambodian. The process of rebuilding trust in this community is a long and tedious road. Often, community members isolate themselves from the surrounding communities, neighbors, friends, and most importantly, from available resources.

## RECRUITING IS NOT ALWAYS SO EASY

**Trust** in this community is one of the most important outreach techniques because word of mouth travels exceptionally well. Relationships are built on trust. Staff exhibit leadership behaviors that show compassion and respect. Explaining each activity and how it involves the community can reduce unexpected surprises and is one way to build trust.

**Transportation** seems to be one of the biggest barriers to getting to medical appointments and many program activities. Instead of “how do *we* get them *here*,” the question needs to be “how do *we* get *there*?” It is always good practice to have a plan for transportation that engages representatives from



existing local transportation services, such as the Regional Transit Authority or Lowell’s Road Runner Services for elders. A plan is also important for sustainability efforts and to enhance community system changes. The idea of appointments and expectation of arriving exactly on time is still new to this community, which leads to appointments not being met, lateness, or lack of preparedness for appointments. For some elders, public transportation is frightening because of language differences and low literacy levels.


Many Cambodians would rather walk or not go to their appointments than take public transportation or a taxi. For some activities, CCH 2010 utilizes a van and picks up participants who have requested transportation. Providing bus route tours and utilizing mentors help community members become better acquainted with existing services, promote confidence, and enhance access and utilization of both transportation and health services.

**Literacy and language** play very important roles in educating, providing resources, and recruiting new participants to the program. According to our CCH 2010 Survey, Cambodians in the Lowell community had very little schooling in Cambodia, and the majority did not receive a formal education after arrival in the United States. The majority of the Cambodian population in Lowell, MA speak Khmer (Cambodian language) at home. Most of the education acquired by the older Cambodian population was from temples, as they were the central education system for low-income farmers. Since literacy and language are the focal points for understanding health related materials, educators need to find other venues (such as visual aids, audio cassettes and CDs, and Khmer cable television programs) in order to provide resources to this population.



## PLANNING OUTREACH EFFORTS IN THE CAMBODIAN COMMUNITY

Organizing any kind of outreach takes time, effort, and advanced planning. The following is a list of things to do when planning outreach and health promotion efforts:

- First and foremost, determine the needs of the community and the appropriate ways to address those needs. Use forums that promote community conversations, conduct literature reviews, and develop tools that gather data. Engage community members and elder council members in program planning.
- 
- Consider the customs and traditional practices related to the topic that you will be addressing, e.g. the use of traditional herbs and treatments is widespread in the Cambodian community. Much homework must be done before addressing and finding solutions to the outlined needs.
  - Identify organizations, agencies, and individuals who can collaborate with your program efforts. A team approach shows solidarity.
  - Always plan ahead; time is needed for preparation, implementation, and evaluation. List everything that needs to be done and make sure someone is in charge of following the checklist.
  - When conducting a group, remember to book the location and equipment well in advance.
  - Pictures and images of your presentation enhance the content, especially for those with limited literacy.
  - Determine costs and available resources.
  - Prepare all materials to be handed out well in advance – translation always takes longer than expected. Make sure all the translated materials go through the review of more than one inspector.
  - Evaluate efforts. Always analyze what **you** felt was successful, your challenges, and consider what can be done differently in the future in addition to the participant's evaluation and feedback. Always leave time for process evaluation.

## CCH 2010 ACTIVITIES

### OUTREACH

**Team Outreach** consists of going door-to-door in a particular neighborhood and having conversations with people about accessing health services and health education topics. In most



instances, a group of 2 or 3 health educators go together, hence “team” outreach. Our motto in these conversations is *equal education*. Outreach is maximized by targeting different streets in a particular neighborhood. It is always a good idea to plan months ahead and to have tentative back-up dates in the event of inclement weather. In New England for example, team outreach is best suited for the spring, summer, and early fall months, as it is very dependent on weather conditions.

**Business Outreach** consists of going to local businesses and distributing educational materials and talking to employees about the program or health topics. It may also include working with restaurant owners to consider providing “healthier” menu options. Business owners are permanent hands in the community for future referrals to your program. Educate them to educate their clients about available programs and services.

**The Jivit Thmei** television program is an important media venue for health promotion and outreach among adult Cambodians who speak Khmer in Lowell. The program focuses on healthcare issues utilizing hosts from the health center and professionals from the medical community. On average, one show is produced weekly which is aired twice a week. Examples of topics include diabetes, heart disease, stress, depression, stroke, high blood pressure, and kidney disease. Resources needed to provide this service are staff time (at least 20 hours per week for production and editing), equipment, and a partnership or collaboration with the local community access cable TV, such as Lowell Telecommunications, for training and technical assistance. Community members also listen

to local Khmer radio programs. The Program Director of the CCH 2010 Program hosts a volunteer radio program, The Voice of Cambodian Children, on WUML 91.5 FM.



## WELLNESS PROGRAMS

**Peer support groups** provide a supportive environment for community members to discuss better ways to manage their disease and share experiences. These groups should be organized by community health advocates. Special sessions to address specific health issues can be facilitated by health professionals with an interpreter if



needed. The goal is for members to gain the knowledge, skills, and resources necessary to sustain self-advocacy and disease management. Sharing information in this format creates friendship and trust among often isolated community members. The primary objective is to increase a client's involvement in active participation and decision-making related to his/her disease management. Health advocates provide additional assistance and resources for participants. On average there are four peer support groups per month with an average attendance of 17 per group. These groups are provided on-site at different locations in the city, such as the Senior Center and the Flanagan Community Center. Support groups may include speakers from Lowell Community Health Center's Metta Health Center who address the cultural and institutional barriers to health care for Southeast Asians, alternative therapies (such as massage and acupuncture), mental health treatment, primary medical care, or the role of specialists (e.g. eye care, nutrition). Process evaluations revealed that 86% of participants attended peer support groups regularly; 100% of participants felt that attending peer support groups was very important to them; and 98% of participants felt that attending peer support groups help them to manage their disease.

**Sustained physical activity** has a benefit of reducing risks of cardiovascular disease and diabetes, according to the National Heart, Lung and Blood Institute. People want to exercise more than we think. Find an exercise that is in common agreement with participants and then a location, such as walking along a river, in a park, or at a mall, or engaging in exercise activities at local community agencies such as the Senior Center or Boys and Girls Club. This will create a suitable and comfortable zone within trusted friends. For CCH 2010, 83% of participants were able to identify a way that participating in regular exercise helped them improve their overall health, and 100% of participants indicated that they would recommend exercise activity to other people.

**Community educational workshops** about heart disease, diabetes, high blood pressure, and stroke are conducted in community settings to increase basic knowledge about these diseases, risk and protective factors, and disease management. Community settings may include organizations such as the Saint Julie Asian Center, Cambodian Mutual Assistance Association, Adult Basic Education Center, and Casey Family Services, a non-profit licensed and accredited child welfare agency that provides a broad range of programs to meet the changing needs of vulnerable children and families. Participation in community educational workshops ranges from small groups of 10 to larger groups of over 25. Presentations are usually between 1-2 hours long. Extra time is needed for evaluation, and more staff are needed for larger groups.



**Stress reduction sessions** aim to reduce risk factors associated with diabetes and cardiovascular disease while enhancing protective factors and behaviors. Sessions may include demonstrations about alternative therapies such as acupuncture and massage therapy, mental health counseling, field trips to Buddhist temples, and harvesting trips to local farms.

**Meditation:** The Cambodian community has gone through so much in their lives. With decades of war in their country and the human tragedy that resulted from the Khmer Rouge regime, many Cambodians are traumatized and suffer from Post-Traumatic Stress Disorder. Meditation is a way for folks to come and find a peaceful time and space to be alone and relax. This activity was coordinated by a monk from a local temple in Lowell, Massachusetts, and community members sustained the activity by going on weekends.



A **recipe booklet** was developed which is intended to be used as a shopping, preparation, and cooking guide that makes nutritional changes to traditional Cambodian recipes by reducing saturated fat, cholesterol, and sodium and increasing fiber. An introductory section focuses on food shopping, preparation, and cooking methods that can be applied to any dish. This section includes nutrition information about fat, saturated fat, carbohydrates, and cholesterol in foods commonly consumed by Cambodians. It also includes a section on calcium. The second section of the booklet has recipes with illustrations. Each recipe has information on ingredients, measurement, preparation, nutrition information from the USDA nutrient database



SR17, a photograph, and information about health promoting modifications. This booklet intends to be used as an additional resource for patients who already receive care from a dietician. It is not intended to provide individualized dietary information. Cooking and tasting demonstrations have been conducted in community forums using some of the booklet's recipes.

## REFLECTIONS

“We started from scratch. . . prior to the start of the program, we never identified what are the needs of the community.” – CCH 2010 Staff

“Our community asks a lot of questions. They want to learn so much. This takes a lot more time than expected.” – CCH 2010 Community Health Worker

“It’s a commitment...the community expects things if we say we are doing it.”  
– CCH 2010 Outreach Worker

## ONE OF MANY STORIES

“I first came to the United States in 1985. I worked three years in the U.S. before I ended up in the hospital really sick. The doctors told me that I had blood in my brain. I had surgery and stayed one week in the hospital. One day in 1990, I couldn't lift up my arms and couldn't move my legs. My doctors told me I had a stroke. I stayed at Lowell General Hospital for a week. A few years later, I had a heart attack. They put a tube into my leg [catheter] to unclog my heart.

After I joined CCH 2010, I attended peer support groups and met with the advocates. They taught me how to cut down on cholesterol and how to use the blood sugar monitor. They taught me to eat less red meat, to eat more vegetables, and to exercise. I listened to them by joining exercise programs, eating less fatty meat, and cutting down on sugar and salt. They’ve also helped me take my medicines on time and taught me how to take public transportation to see my doctor. Since I joined CCH 2010, I feel much better. I have more control over my arms and legs now too. My goal was to be able to advocate for myself. Now, I am eating healthy, exercising, taking medicine on time, and I am comfortable asking my doctors questions. CCH 2010 helped me to reach my goal. The doctor was the one that gave me my medicine, but CCH 2010 saved my life.”

# CCH 2010 COALITION CONTACT INFORMATION

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Lowell, MA 01852  
(978) 746-7829  
[www.cch2010.info](http://www.cch2010.info)

UMASS LOWELL CENTER FOR FAMILY,  
WORK, AND COMMUNITY  
[www.uml.edu/centers/CFWC](http://www.uml.edu/centers/CFWC)

MASSACHUSETTS DEPARTMENT OF PUBLIC  
HEALTH: REFUGEE AND IMMIGRANT  
HEALTH PROGRAM  
[www.mass.gov/dph/cdc/rhip/wwwrihp.htm](http://www.mass.gov/dph/cdc/rhip/wwwrihp.htm)

MASSACHUSETTS DEPARTMENT OF PUBLIC  
HEALTH DIVISION OF COMMUNITY HEALTH  
PROMOTION  
[www.mass.gov/dph/fch/dchp.htm](http://www.mass.gov/dph/fch/dchp.htm)

LOWELL GENERAL HOSPITAL  
[www.lowellgeneral.org](http://www.lowellgeneral.org)

SAINTS MEMORIAL MEDICAL CENTER  
[www.saintsmedicalcenter.com](http://www.saintsmedicalcenter.com)

LOWELL DEPARTMENT OF PUBLIC HEALTH  
[www.lowellma.gov/depts/health](http://www.lowellma.gov/depts/health)

GREATER LAWRENCE FAMILY HEALTH  
CENTER, MVAHEC  
[www.glfhc.org](http://www.glfhc.org)

CAMBODIAN MUTUAL ASSISTANCE  
ASSOCIATION  
[www.cmaalowell.org](http://www.cmaalowell.org)

UMASS LOWELL SCHOOL OF HEALTH AND  
ENVIRONMENT  
Center for Public Health Research and  
Health Promotion  
[www.uml.edu/College/she](http://www.uml.edu/College/she)

KHMER HEALTH ADVOCATES, INC.  
[www.hartnet.org/khmer](http://www.hartnet.org/khmer)

SAINT JULIE ASIAN CENTER  
[www.saintjulia.org](http://www.saintjulia.org) (closed in 2006)


VISITING NURSE ASSOCIATION OF GREATER  
LOWELL  
[www.vnalowell.org](http://www.vnalowell.org)

U.S. CENTERS FOR DISEASE CONTROL AND  
PREVENTION  
[www.cdc.gov](http://www.cdc.gov)

LOWELL COUNCIL ON AGING  
[www.lowellma.gov/depts/coa](http://www.lowellma.gov/depts/coa)

LOWELL POLICE DEPARTMENT  
[www.lowellpolice.com](http://www.lowellpolice.com)

**EXPANDING HEALTH ACCESS IN THE CAMBODIAN COMMUNITY**  
A GUIDE TO EFFECTIVE OUTREACH STRATEGIES  
AND  
LESSONS LEARNED FROM THE  
CAMBODIAN COMMUNITY HEALTH 2010 PROGRAM



**Cambodian Community Health 2010**


Our goal is to reduce disparities in cardiovascular disease (CVD) and diabetes in the second-largest Cambodian community in the United States, Lowell, Massachusetts.

Title: Disease Management and Health Promotion

CCH 2010 has increased access to the health care system for Cambodians; increased participants' engagement in wellness programs; increased awareness among health care providers and researchers about Cambodian culture, health care beliefs and needs; increased knowledge and awareness about CVD and diabetes in the Cambodian community; and enhanced the ability of participants to better manage their disease.

- Peer Support Groups at Casey Family Services, the Flanagan Center, Lowell Senior Center and South St.
- Exercise programs at Lowell Senior Center and the Boys and Girls Club of Greater Lowell
- Stress Reduction Program
- Health Advocacy Services
- Jivit Thmey television program – CCH 2010 has provided content for over 85 1-hour TV shows
- *A Guide to Healthy Eating* by Jerusha Nelson Peterman, CMAA

"Before, my cholesterol level was close to 400. But after I exercise and ate healthier, my cholesterol level right now is at 160. I am extremely happy with this improvement." Cambodian senior in the Lowell Senior Center exercise program.



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**CAMBODIAN COMMUNITY HEALTH 2010**

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**Coordinating agency: Lowell Community Health Center**

**Coalition partners:** Cambodian Mutual Assistance Association of Greater Lowell; University of Massachusetts Lowell, Center for Family, Work and Community, and School of Health and Environment; Visiting Nurse Association of Greater Lowell; Southeast Asian Bilingual Advocates, Inc.; Saints Medical Center; Lowell General Hospital; City of Lowell Senior Center; Greater Lawrence Family Health Center- Merrimack Valley Area Health Education Center; Saint Julie Asian Center; Massachusetts Department of Public Health, Division of Community Health Promotion and Refugee and Immigrant Health Program; Khmer Health Advocates; Lowell Police Department; Lowell Telecommunications; and Trinity EMS.