



The  
**State of  
Asian Americans  
& Pacific Islanders  
in Arizona**





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**A report presented by  
The APAZI Coalition,  
ASU Asian Pacific American Studies Program  
and ASU for Arizona, Office of Public Affairs**

The individuals photographed for this report represent the diversity of the Asian American and Pacific Islander communities in Arizona, including Asian Indians, Chinese Americans, Filipino Americans, Japanese Americans, Korean Americans, Laotian Americans, Maori Americans, Native Hawaiians and other Pacific Islander Americans (e.g., from the Mariana Islands), Southeast Asian Americans, Vietnamese Americans and individuals of multi-racial backgrounds.

### **Portraits**

- pg. 4, Susie Sato, historian of Asian Americans in Arizona
- pg. 6, Varen Barryman (left) and Benny Stillman, Aloha Festival board members
- pg. 15, Kalpana Batni, Asian Indian American community leader
- pg. 17, Claudia Kaercher, Pacific Islander American community leader
- pg. 24, Kelly Hsu, physician & community health advocate
- pg. 26, Leon Nguyen, pre-med student
- pg. 27, Conrad Ballacer, anesthesiologist
- pg. 30, Ken Komatsu, epidemiologist
- pg. 35, Mona Faussane, Korean American Chamber of Commerce
- pg. 37, Melissa Ho, attorney
- pg. 42, Jeannine Kuropatkin, public school teacher
- pg. 43, Subhash Mahajan, university professor
- pg. 46, Stella Faussane, student
- pg. 47, Catherine Chan, student
- pg. 51, Evita Saquilayan, nurse & translator
- pg. 53, Trinh Vu, Vietnamese American community leader
- pg. 57, Josephine Gin Morgan, Kwei Gin, and Jacque Larriva, 3 generations of one family
- pg. 65, Roxanne Song Ong, judge
- pg. 67, Jimmy Wing, police officer, and son
- pg. 68, Angela Kwan, police lieutenant
- pg. 69, Michael Somsan, attorney
- pg. 73, Ethel Luzario, Philippine Cultural Day board member
- pg. 77, Doris Asano and Ted Namba, Matsuri Festival board members

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October 2008

Congratulations to Arizona State University Asian Pacific Arizona Initiative on the publication of *The State of Asian American and Pacific Islanders in Arizona*, which documents the current diversity, population growth, health, economic footprint, educational and political participation, language and immigration issues faced by Arizona's Asian Americans and Pacific Islanders today. The report is the first to comprehensively describe the current status of the Asian American and Pacific Islander community in Arizona in all its complexities and diversity: from the Chinese-American families who have been part of Arizona history since the early 1900s to the more recent immigrant families who are still learning to speak English and every variation in between.

The publication of this report could not be more timely. The Asian American and Pacific Islander population is one of the fastest growing minority groups in Arizona, showing a 28% increase from 2000 to 2005. *The State of Asian Americans and Pacific Islanders in Arizona* report will help public policy makers in all fields better understand who Arizona's Asian American and Pacific Islander community is—one part of our "Many lands, many people, many faiths, one Arizona."

Thank you for your efforts and congratulations.

Yours very truly,

A handwritten signature in black ink that reads "Janet Napolitano".

Janet Napolitano  
Governor







Arizona State University is pleased to present the inaugural ***State of Asian Americans and Pacific Islanders in Arizona*** report.

As a public institution dedicated to the advancement of education, social embeddedness, and research that supports societal transformation, ASU is proud to provide a new resource for the people of Arizona. This report is the result of a diligent and collective effort by ASU personnel, students and community members to offer special insight into the more than 30 Asian American and Pacific Islander communities who call our state home and enrich our lives through their rich heritage and countless meaningful contributions. Through descriptions of the historical engagement of these communities, their current needs, interests and challenges, and the significant role they will play in the future of Arizona, we are afforded an opportunity to gain significant understanding and awareness.

I commend the groundbreaking work of the many individuals who inspired and guided the creation of this report, including the Asian Pacific American Studies program faculty, staff and students and the essay writers who helped to produce this valuable document.

I hope that you will find this report to be a useful and thought-provoking resource, and I thank you for your steadfast support of ASU.

A handwritten signature in black ink that reads "Michael Crow".

**Michael M. Crow**  
President  
Arizona State University



## Foreword



## First Steps

You are beginning to read a document that is the result of a remarkable collaboration of perspectives and people—often the source and sign of dynamic communities.

The Arizona State University Asian Pacific American Studies (APAS) program, in partnership with ASU for Arizona-Office of Public Affairs, is pleased to present *The State of Asian Americans and Pacific Islanders in Arizona*. Like many transformative documents, this report arose from a recognition that policy-makers lack adequate information. In this case, there is a dearth of information on Asian Americans and Pacific Islanders (AAPI). Given that unmet need, a coalition gathered and created the Asian Pacific Arizona Initiative—APAZI. The project represents a year-long collaboration between APAZI, APAS, ASU for Arizona, and numerous community leaders, members and professionals throughout the state. We hope this report serves as a starting point for future research on Arizona AAPI communities.

Why is this report necessary?

First, the AAPI population in Arizona is growing at a rapid rate, more than doubling over the last 30 years. Expanding numbers certainly signal expanding needs. But that is only part of the next chapter in the Arizona AAPI history.

The APAZI team saw that poorly adapted policy would flow from a failure to understand the complexity and richness of diverse communities. Although AAPIs comprise dozens of different communities in the state, these communities tend to be identified as one, under the assumption that AAPIs share similar experiences. Through this report, the APAZI team seeks to highlight the diversity of the communities and their experiences, increase awareness and visibility of AAPIs and prepare the state for their growth. We hope to educate the broader public as well as policy-makers and community leaders on the current status of AAPIs in Arizona.

The APAZI team worked with an advisory council consisting of leaders and professionals within AAPI communities. The council discussed current issues and concerns facing AAPI communities and advised the APAZI team on the areas of focus for the report. The APAZI team then condensed the issues and concerns to the five topics of health, education, public safety, immigration and business/finance. Within those five topics, common themes appeared: access, cultural competency, representation and influence at high levels of decision-making, assessment of existing programs and/or need for new programs, and opportunities that AAPIs present to the state.

Following the advisory council

“Through this report, the APAZI team seeks to highlight the diversity of the communities and their experiences, increase awareness and visibility of AAPIs and prepare the state for their growth.”

meeting, the APAZI team began collecting statistical and census data as well as focus group information. APAZI data collectors relied on a variety of data from many sources, including the U.S. Census Bureau, the Bureau of Vital Statistics, the Institute for Educational Statistics and state data from the Arizona Department of Education and the Department of Health Services. To balance the statistical and census data, the APAZI team also gathered input from many of the AAPI communities directly, conducting a survey and a series of focus group discussions.

The essays and data in this report represent the APAZI group's effort to collect a broad variety of information on the diverse AAPI communities. Such an ambitious endeavor contains its own challenges, however. Although we attempted to gather information on all AAPIs of different backgrounds, the information may be missing certain perspectives. For example, the document focuses primarily on Maricopa and Pima counties, where the core of Arizona's AAPI populations is concentrated. In addition, the survey and focus group information often reflected first-generation immigrant

experiences more than second- and third-generation concerns. Perhaps future research will be able to capture more of these perspectives.

The APAZI team will continue to gather data about Arizona's AAPI communities, and we look forward to working further with the many communities who contributed to this report. We hope that this document will educate our readers and inspire continued research on Asian Americans and Pacific Islanders throughout the state.

We also hope that you will become an active partner in our community's historic collaboration.

*The APAZI Coalition*  
*ASU Asian Pacific American*  
*Studies Program*  
*ASU for Arizona,*  
*Office of Public Affairs*

Please visit [apas.clas.asu.edu](http://apas.clas.asu.edu) for updates on the APAZI collaboration. ■



# **I. The History of Asian Americans & Pacific Islanders in Arizona**





## Diversity Out of Adversity

By Karen J. Leong

When people think about the history of Asian Americans and Pacific Islanders (AAPIs) in the United States, Arizona does not immediately come to mind, given that California and Hawaii have the largest AAPI populations in the nation. However, focusing primarily on the experiences of AAPIs in states where they are one of the larger ethnic minority groups skews the reality of the AAPI experience in states in which they are a numerical and ethnic minority. This report's focus on AAPIs in Arizona thus seeks to illuminate what it means to be AAPI neither on the West Coast nor in the Northeast, but in the rest of the nation that is not as acquainted with the history, diversity and complexity of being AAPI, and in a region where the rate of growth is projected to increase rapidly over the next few decades.

### Historical Background

To understand the rapid expansion of AAPI communities in Arizona beginning in the 1970s, one must understand the historical context of AAPI immigration to Arizona. Although the current U.S. Census classification of Asian Americans is quite broad, this historical background focuses on those popularly considered Asian at the time—those from what Americans consider East Asia, South Asia and Southeast Asia. Immigrants from the Philippines, China and India traveled from the West Coast states

to work in Arizona's agricultural industry beginning in the late 19<sup>th</sup> century. The construction of railroad lines to Prescott and Tucson, and the mining industry in Williams, also provided employment for Chinese and Japanese workers at the turn of the 20<sup>th</sup> century.

Within the following two decades, however, the majority of Asian American communities would settle in Maricopa County. Chinese American-owned businesses were located in downtown Phoenix. In the first decade of the 20<sup>th</sup> century, Japanese and Punjabi families were cultivating farms in Maricopa County or working in the seed or shipping businesses. There also exist records of Koreans and Filipinos living in Arizona from that decade. This early migration resulted in the eventual settlement of some families in Arizona who today can boast at least four to five generations as Arizonans. Pacific Islanders, in contrast, experienced the United States coming to their own lands during the 19<sup>th</sup> century, creating a series of political, economic and personal relationships between the islands and their new home in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries that facilitated migration from the Pacific Islands to the United States.

Racial antagonism combined with economic duress in the 1870s resulted in anti-Asian sentiment and mobilization. Hence, during the

periods of the highest ratio of immigration to the United States, Asians were denied entry on the basis of their race. The U.S. Congress passed subsequent restrictions on immigration from any Asian country beginning with the Page Law of 1875—the first restrictions on the basis of nationality, race, and gender enacted in United States history. This was followed by the 1882 Chinese Exclusion Law, extended indefinitely in 1902, which restricted most Chinese immigrant workers from entering the United States. After restricting Japanese migration in 1907, Congress barred migration from the Asian subcontinent in 1917. Several Punjabi immigrants farmed in Maricopa County during the first decades of the 20<sup>th</sup> century, but all of these families fled Arizona after the anti-alien movement that seized the county from 1934 to 1935 as a result of the nation's economic downturn. Because the Philippines was under U.S. governance, Filipinos were able to immigrate during the 1910s and 20s, and they found work in Arizona's agricultural and hotel industries. However, their immigration was restricted in 1934.

Only after 1943 were very limited numbers of Asian immigrants able to become naturalized citizens. After the passage of the 1965 Immigration and Naturalization Act, Asian immigrants finally gained unrestricted access to entry into the United States.

The relatively recent lifting of restrictions in 1965 explains why there has been such a dramatic increase

in migration from Asian nations to the United States in the past 40 years, and why the majority of Asian Americans currently are foreign-born. These restrictions on Asian immigration to the United States also explain the longstanding stereotype of Asian Americans (including those born in the United States) as “perpetual foreigners” who are assumed to neither share American values nor desire U.S. citizenship.

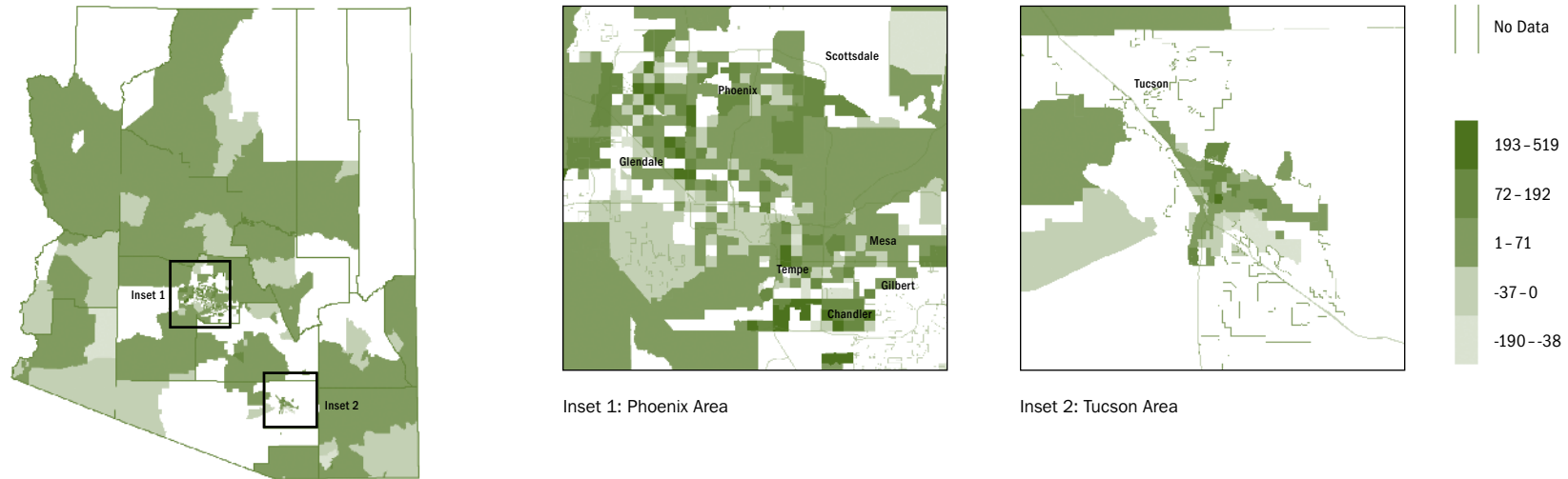
AAPI migration to Arizona thrived in the 1960s, with the prospect of employment in service industries such as landscaping and hotel service. Filipino and Pacific Islanders have in more recent decades worked in the hospitality industry that is so vital to the state's economy. Since the 1980s, Asian Americans of Filipino, Chinese, Asian Indian and Pakistani heritage have contributed to the knowledge economy in Arizona. These workers developed communities that attracted further migration. The growth in the AAPI community was rapid; from 1980-2006 the rate of growth for Asian Americans was 599% with the Native Hawaiian or other Pacific Islander rate at 738.6%. Figure 1-1 shows growth in these populations throughout the state from 1990–2000. Population growth was centered in the Phoenix and Tucson areas, with AAPIs comprising more than 10% of the population in some pockets of the Phoenix Valley (see Figure 1-2).

United States military involvement in Southeast Asia also further diversified Arizona. Refugees from Vietnam



**Figure 1-1**  
**Change in Asian Americans and Pacific Islanders Total Population by Census Tract, 1990–2000**

Data source: Census 2000 Summary File 1 (SF 1) 100-Percent Data

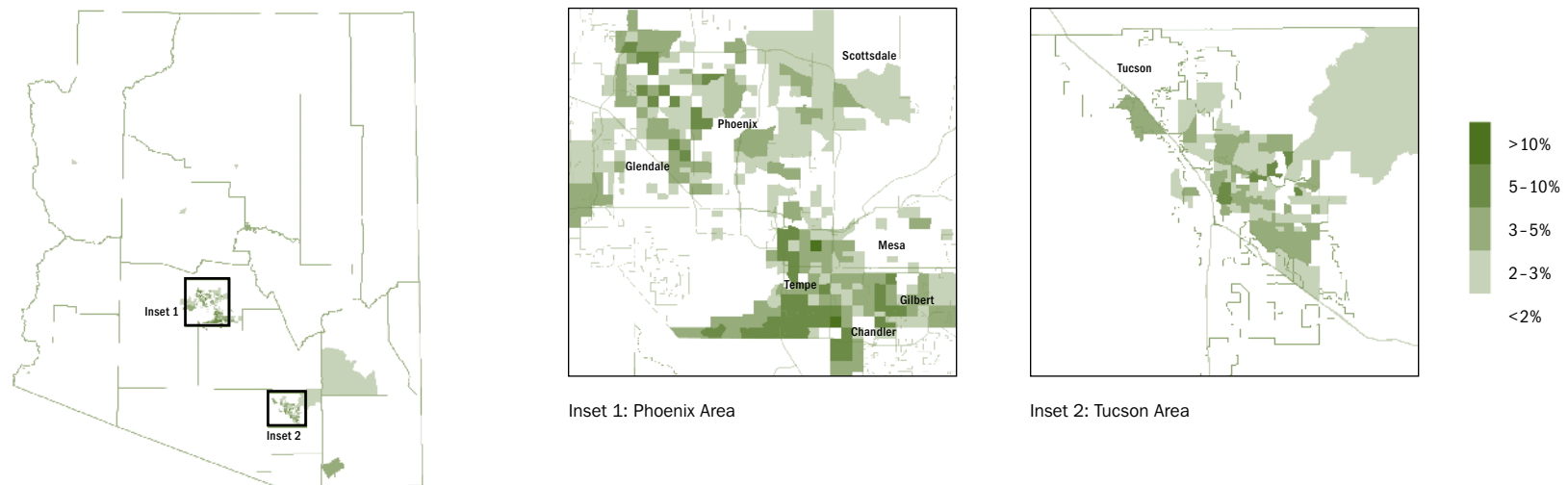


Inset 1: Phoenix Area

Inset 2: Tucson Area

**Figure 1-2**  
**Percentages of Asian Americans and Pacific Islanders in Total Population by Census Tract, 2000**

Data source: Census 2000 Summary File 1 (SF 1) 100-Percent Data



Inset 1: Phoenix Area

Inset 2: Tucson Area



were relocated to more than 800 ZIP codes throughout the United States, and a strong community developed in north Phoenix during the 1980s. The Vietnamese American community enjoyed the largest rate of growth of any Asian ethnic group between 2000 and 2006 (U.S. Census, 2000; ACS, 2006). A snapshot of the diversity of the AAPI population in Arizona is provided in Figure 1-3. Chinese Americans, Filipino Americans and Asian Indian Americans comprise more than 50% of the AAPI population in Arizona.

**The “Perpetual Foreigner” Stereotype**

The tendency to lump all persons of Asian and Pacific Islander heritage together within a simplistic category is a historical tradition that continues even today and has implications for policy and socioeconomic mobility (as will be seen in the subsequent sections of this report). A continual frustration for fourth- or fifth-generation Asian American Arizonans is that they often are assumed to be foreign-born by virtue of their ancestry and physical appearance. The stereotype of a “perpetual foreigner” can result in the exclusion of Asian Americans from discussions of local, state, regional and national policy.

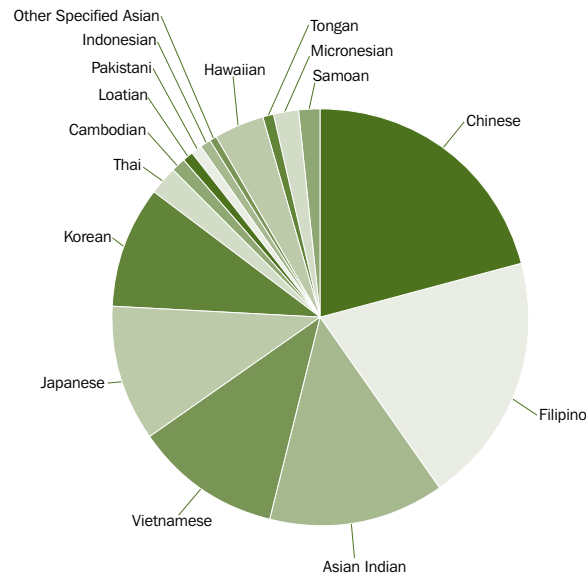
Despite the fact that close to 50% of Asian immigrants will become naturalized U.S. citizens (although distinct differences in naturalization rates exist depending on ethnic group), Asian Americans continue to be linked in the U.S. popular imagination to Asian nations. Thus, shifts in U.S.–Asian relations can have a profound impact on Asian American communities. The most obvious example is the removal of Japanese Americans (two-thirds of whom were American-born citizens) from the West Coast into internment camps after the government of Japan bombed Pearl Harbor in December 1941. Arizona’s American Indian communities at Gila River and the Colorado River reservations were sites of the two largest internment camps.

Pacific Islanders, on the other hand, because of their relatively smaller numbers, are often entirely ignored when it comes to understanding issues facing their communities. Understanding the differences between native Hawaiians, Chamorro, and Tongans, and between Pacific Islanders and Asian Americans, is critical. Pacific Islanders have a different political and economic relationship with the United States. Pacific Islander migration to the United States is documented to have occurred as early as the 1850s, but migration particularly surged during the postwar era. The dominance of the U.S. military in the Pacific over Guam, Micronesia, part of Samoa, and Hawaii resulted in economic, social and political ties

that influenced the movement of Pacific Islanders to the 48 contiguous states. The legacies of militarization of the economy and the islands themselves have resulted in unique challenges for the Pacific Islander community in areas of educational opportunities, socioeconomic mobility and health. Arizona is seventh among the states with the largest Pacific Islander population. It thus is important for Arizonans—including Asian Americans—to be aware of these distinctions when it comes to interactions and policy-making.

The desire of U.S.-born Asian Americans to be recognized as American may result in the exclusion of or distancing from those Asian Americans who are foreign-born, yet who are just as committed to participating in U.S. society and Asian American communities. Moreover, many Asian Americans embrace their Asian heritage, sometimes maintaining global ties with their families and communities, while also identifying as American and participating in American institutions. Although the smaller size of communities in states like Arizona may serve to promote pan-Asian American collaboration, the relatively smaller size may also heighten socioeconomic, political, religious and other cultural differences within and among these communities. National Asian American and Pacific Islander advocacy organizations are only now coming into their own, but most of their advocacy relies on and focuses on AAPI experiences in California, New York and other very

**Figure 1-3**  
**AAPI Population Distribution in Arizona**  
(Source: 2006 ACS)



large urban populations. These organizations are only beginning to address the distinctive experiences of smaller concentrations of Asian Americans in the interior west or southern states. (Asian Pacific Legal Center, 2004).

What is at stake in educating Arizonans about the diversity of Asian Americans and Pacific Islanders, and repudiating the stereotype of the “perpetual foreigner,” is perhaps most strikingly exemplified by the post-9/11 harassment and violence against persons of Persian, Asian Indian and Pakistani descent or Islamic faith. Despite President George W. Bush’s public statement urging that Americans of Arabic ancestry not face “retaliation” after the 9/11 terrorist attacks, Sikh immigrant and Mesa gas station owner Balbir Singh Sodhi was shot to death on Sept. 15, 2001. His attacker assumed that, because Sodhi wore a turban and had a beard, he somehow must be associated with terrorist leader Osama bin Laden. Sodhi, however, was of the Sikh faith and from India. The prompt and proactive response of the local community and Mesa city officials in addressing and mourning this tragic event and embracing the Sikh community as fellow Americans and Arizonans was an important part of the healing process.

### **Asian American National and State Legacies**

The historical record, moreover, shows that Asian Americans have demonstrated a deep commitment to the fundamental tenets of U.S.

democracy and freedom expressed in the Constitution. During what is called “the exclusion era” (1875–1965), Chinese immigrants contributed to the development of U.S. civil rights law with a series of 1868 court cases that helped to define the Constitution’s 14<sup>th</sup> Amendment “equal protection under the law.” Although unsuccessful, challenges in the 1920s by Asian Indian Americans and Japanese Americans to the Naturalization Laws, which excluded persons of Asian ancestry from

naturalized citizenship, laid bare how racial prejudice shaped definitions of U.S. citizenship. During World War II, Japanese American court challenges to the constitutionality of detaining U.S. citizens without formal charges or a trial of their peers were rejected by the Supreme Court, only to be reversed at the end of the war. This series of cases further developed civil rights and constitutional law for all Americans.

Asian Americans in Arizona also actively participated in these efforts

to secure their rights and create positive change in the state. Chinese immigrant Wing F. Ong successfully ran for election to Arizona’s House of Representatives in 1946. Judge Thomas Tang challenged the politicized appointment of judges, resulting in his being the first Asian American elected to the bench in the 1963; he was the first Asian American appointed to the federal courts in 1977. His wife, Dr. Pearl Tang, worked in public health to dramatically lower the infant mortality rate in Arizona.



Victory Day Parade, 1945. Copyright Fred Ong. Used with permission.





Members of the Japanese American Citizens League actively lobbied Arizona congressmen to support the Walter McCarren Act, which allowed first-generation Japanese Americans to apply for and receive naturalized citizenship beginning in 1952. In 1959, Hank Oyama of Tucson and his wife were one of five couples whose civil suit ended the anti-miscegenation laws in Arizona.

Just as Asian Americans have contributed to the development of civil rights in Arizona, they also helped to build the state's economic infrastructure. In the late 1890s, Japanese immigrant Hachiro Onuki settled in Phoenix and with his

business partners founded an electrical power company (today known as APS) and introduced electric street-lamps to the city. At the turn of the century Asian immigrants worked to complete the railroads. By far the primary area of impact in the first half of the 20<sup>th</sup> century, however, was in agriculture. Japanese American farmers also created innovative techniques for growing cantaloupes and strawberries. In the 1940s, Asian Indian Rala Singh founded Singh Farms close to what is now Glendale, and was one of the most successful farmers of watermelons and onions in the country (Sachdev, 2008).

#### Implications of Contemporary AAPI Population Growth for Arizona

The rate of growth of these Asian American ethnic communities in the interior west, mountain and southern states has implications for the state and its Asian American and Pacific Islander communities. The population growth in general reflects the economic growth of the mountain and southern states. The Selig Center for Economic Growth notes that from 1990 to 2006, of the top 10 states with the greatest percentage increase of buying power, Nevada (281%) and Arizona (211%) ranked number one and number two. The center estimates that Asian Americans'

buying power will increase by 434% between 1990 and 2011, compared to the increased buying power of Hispanics (457%), American Indians (270%), African Americans (237%), the U.S. population as a whole (190%), and Euroamericans (175%). Pacific Islanders are notably absent from this analysis.

The Asian American market in the United States in 2006 was \$427 billion. Projecting Asian Americans to constitute 5% of the U.S. population by 2011, the Selig Center estimates the Asian American market will grow to \$622 billion. According to center director Jeffrey M. Humphreys, this buying power reflects the "rapid growth" of this group, the higher earning power due to higher rates of education, and the fact that 95% of Asian Americans live in urban and metropolitan areas. Arizona is sixth out of the top 10 states with the largest rate of Asian American buying power from 1990 to 2006, with an increase of 481%, and 20<sup>th</sup> among states with the largest Asian American consumer markets. Center director Humphreys suggests:

*The group's fast-paced growth in buying power demonstrates the increased importance of Asian consumers and should create great opportunities for businesses that pay attention to their needs. Because the group contains consumers of so many national ancestries, languages, and such diverse cultures, firms that target specific subgroups—Chinese or*

*Filipino, for example—may find niche markets particularly rewarding.* (Humphreys 2006, p. 5)

Arizona is projected to be among the states with the highest increase in African American, Asian American and Euroamerican buying power from 1990 to 2006; it already was among the top 10 states for American Indian and Hispanic buying power in 2006. Clearly, Arizona is in a strong position with its already and increasingly "multicultural economy." It remains to be seen whether Arizonans will be able to cultivate the state's ever-more diverse population into a multicultural community. ■

**Karen J. Leong** (Ph.D., History) is an associate professor of Asian Pacific American Studies and Women and Gender Studies at Arizona State University and is the former director of the APAS program.

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Rala Singh Farms Label, ca. 1955. Courtesy of Vince Murray, Arizona Historical Research.







## **II. Health Issues in Arizona AAPI**



## Risks, Services & Usage

### By Howard J. Eng

The U.S. Census Bureau has reported that Asian Americans are the fastest-growing population (by portion) of the four major minority groups. Together with Pacific Islanders, they comprise 4.3% of the U.S. population (13.9 million Asian Americans and 976,395 Pacific Islanders) in 2004. In Arizona, although the Asian American and Pacific Islander community is smaller than other ethnic minority groups, AAPIs grew by 57.4% between 2000 and 2006.

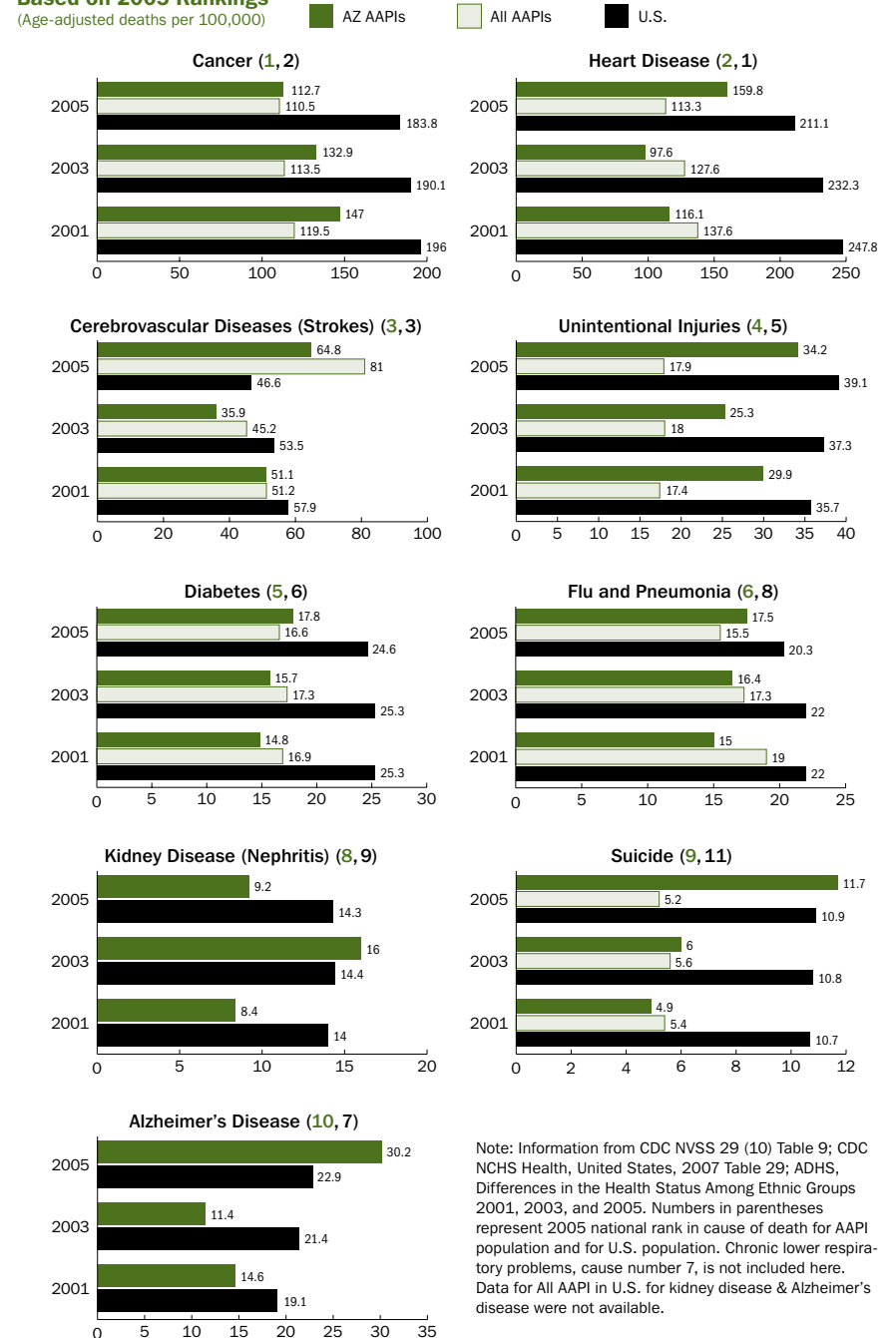
As the AAPI population continues to grow, there will be increases in need and demand for health services. In order to meet these needs in Arizona, health care providers need to understand the AAPI health-related issues.

### AAPI Health Profiles

Health can be defined by the individual's self-perception of health or defined by the individual's health problems (i.e., physical, mental, social and spiritual health). Table 2-1 compares the U.S. population and the AAPI population for the top 10 causes of death in 2005. There are distinct differences between the two groups. The primary cause of death for the U.S. population overall is heart disease, whereas for the AAPI population it is cancer (malignant neoplasm).

Of the top 10 national causes of death for the AAPI population, there were declines in three causes of death from 2001 to 2005: heart diseases, cerebrovascular diseases, and influenza and pneumonia. Figure 2-2 shows the age-adjusted death

**Figure 2-2**  
**Top Causes of Death, U.S., All AAPI for U.S. & Arizona AAPI**  
**Based on 2005 Rankings**  
 (Age-adjusted deaths per 100,000)



**Table 2-1**  
**U.S. Total Population and U.S. AAPI Population Top 10 Causes of Death in 2005**

Rank	U.S. Population	Asian Americans and Pacific Islanders
1	Heart diseases	Malignant neoplasms
2	Malignant neoplasms	Heart diseases
3	Cerebrovascular diseases	Cerebrovascular diseases
4	Chronic lower respiratory diseases	Unintentional injuries
5	Unintentional injuries	Diabetes mellitus
6	Diabetes mellitus	Influenza and pneumonia
7	Alzheimer's disease	Chronic lower respiratory diseases
8	Influenza and pneumonia	Nephritis, nephritic syndrome, and nephrosis
9	Nephritis, nephritic syndrome, and nephrosis (Kidney diseases)	Suicide
10	Septicemia	Alzheimer's disease

Source: CDC NCHS Health, United States, 2007, Table 31.(National Vital Statistics Reports)

Note: Information from CDC NVSS 29 (10) Table 9; CDC NCHS Health, United States, 2007 Table 29; ADHS, Differences in the Health Status Among Ethnic Groups 2001, 2003, and 2005. Numbers in parentheses represent 2005 national rank in cause of death for AAPI population and for U.S. population. Chronic lower respiratory problems, cause number 7, is not included here. Data for All AAPI in U.S. for kidney disease & Alzheimer's disease were not available.

rate changes in the top causes of death for the U.S. population overall, and for all AAPI and AAPI in Arizona during the five years. Unlike the national trends, Arizona had net rate increases in 8 of the 10 leading causes of death for the AAPI population during 2001 to 2005.

A total of 260 Arizona AAPI adults (18 years of age or older) completed the APAZI Community Survey. The APAZI AAPI adults were healthier than the general population in Arizona. Of the respondents, 158 (69.9%) had reported their health status was either very good or excellent, and 17 (7.5%) had reported their health status was either fair or poor. This was higher than the Arizona 2006 Behavioral Risk Factor Surveillance System (BRFSS) of 52.7% and lower than the BRFSS of 16.3%, respectively.

In addition, 62.3% of the respondents indicated having no health problems. Twenty-seven percent reported having one health problem.

**AAPI Health Risk Patterns**

Starfeld suggested that health status can be influenced by four major factors: (1) a person’s individual behaviors, (2) genetic makeup, (3) medical practice, and (4) the environment. The Centers for Disease Control (CDC) estimated that premature death in the U.S. population can be directly related to individual lifestyle and behaviors (50%), individual’s inherited genetic profile (20%), social and environmental factors (20%), and inadequate access to medical care (10%).

Health risk factors included predisposing factors (e.g., high

blood pressure, overweight and high cholesterol levels) and individual lifestyle, behavior and health practices (e.g., lack of exercise and tobacco use). For example, uncontrolled high blood pressure over a long period of time can lead to stroke and heart problems, and individuals who are overweight are at greater risk for heart disease, high blood pressure, diabetes, arthritis-related disabilities and some cancers.

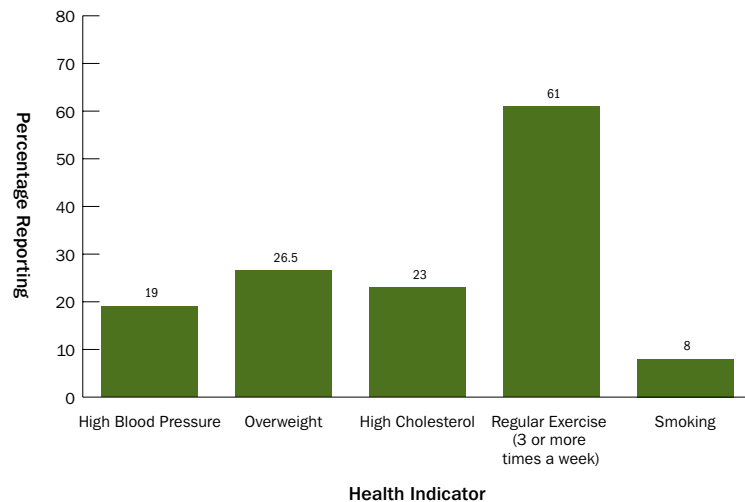
The APAZI survey showed most Arizona AAPI have low health risk factors (see Figure 2-3), with less than a quarter of the respondents reporting high blood pressure or high cholesterol levels. Just 8% of the respondents were smokers, much lower than the 2006 BRFSS report for Arizona overall, where 18.2% were smokers. Less than one-third of the

APAZI respondents reported being overweight; in comparison, in 2000, more than 57% of the U.S. adult population was overweight. The high rate of physical activity in our respondents may be one reason for the APAZI respondents’ low rates of being overweight; more than 60% said they exercise regularly at least three times a week.

**AAPI Health Service Usage Barriers**

There are many barriers to access to health services that can influence their use. These include: financial barriers, cultural and language, lack of a medical home (regular source of health care), and availability of health services. Having health care coverage is the primary means for reducing the financial barriers and increasing

**Figure 2-3**  
Arizona APAZI Respondents’ Health Indicators  
(N=260)



**Table 2-4**  
Health Insurance Coverage of the U.S. Non-elderly Population, 2005

Race/Ethnicity	Private	Public	Uninsured
Total Non-elderly Population	66.2%	15.9%	17.9%
White only	75.0%	11.8%	13.2%
Black or African American only	50.7%	28.4%	20.9%
American Indian and Alaska Native only	42.6%	23.2%	34.2%
Asian American and Pacific Islanders only	70.3%	10.3%	19.4%
Hispanic or Latino	45.3%	22.7%	32.0%

Source: The Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America 2005 Data Update Report, 2006.





the access and availability to health services. Most health insurance is provided by employers. Medicare is the largest publicly funded health coverage program in the United States. Federally and state funded Medicaid (AHCCCS) and the State Children Health Insurance Program (Kidscare) provide health care coverage for low-income individuals and children, respectively.

Although Asian Americans have higher median family incomes than the general population, they also have higher poverty rates, with the Chinese, Thai, Korean, Vietnamese, Pakistani, Lao, Cambodian and Hmong American populations having much higher poverty rates than both the Asian American and general population rates. These groups were the most likely not to have health insurance.

Table 2-4 compares the 2005 national health coverage profiles for AAPI with the total non-elderly, White, Black/African American, American Indian/Alaska Native, and Hispanic/Latino populations. AAPI had a higher private health insurance rate than the general population, but 19.4% of its population was uninsured. AAPI had the lowest publicly funded health coverage (10.3%) of the five racial/ethnic groups.

Eighty-four percent of the APAZI survey respondents indicated that they had health care coverage. This is higher than the Kaiser Commission on Medicaid and the Uninsured reported for AAPI (80.6%) in 2005. However, this is slightly lower than

for the total U.S. population in 2006 (84.2%) reported by the U.S. Census Bureau, but higher than for Arizona as a whole (79.1%, reported by the U.S. Census Bureau, and 80.4%, reported by BRFSS). The Kaiser Commission also reported that those with lower family incomes were more likely to be uninsured (Asians at less than 200% of the Federal Poverty Level had 40% uninsured rates, compared to those at greater than 200%, who had 12% uninsured rates in 2003).

Even if one has health care coverage, culture and language can be major barriers in the use of health services. One's perceived health status, health beliefs, health practices and lifestyles are also influenced by culture. In 2000, the U.S. Census Bureau reported that Asian Americans nationally had five times the percentage of foreign-born, non-citizen and non-English or English spoken not very well at home than the general population. Eighty-one percent of the APAZI survey respondents indicated that they were U.S. citizens (the majority were foreign-born, naturalized citizens). Forty-one percent of the respondents spoke English only at home. The remaining respondents indicated that another language other than English was spoken at home, and both English and another language were spoken at home. Several comments from the APAZI community focus groups indicated that there is a need for more AAPI medical interpreters and culturally competent health professionals in Arizona as well as health education materials translated

into different Asian languages.

Lack of a medical home can also be a barrier to access to health services. Even though 83.5% of the APAZI survey respondents reported they had health care coverage, only 42.8% indicated that they had a regular source of health care. This is significantly lower percentage than for Arizonans in 2006 (71.7%), reported by the BRFSS, and for Asian Americans nationally in 2004–05 (81.2%), reported by the CDC National Center for Health Statistics.

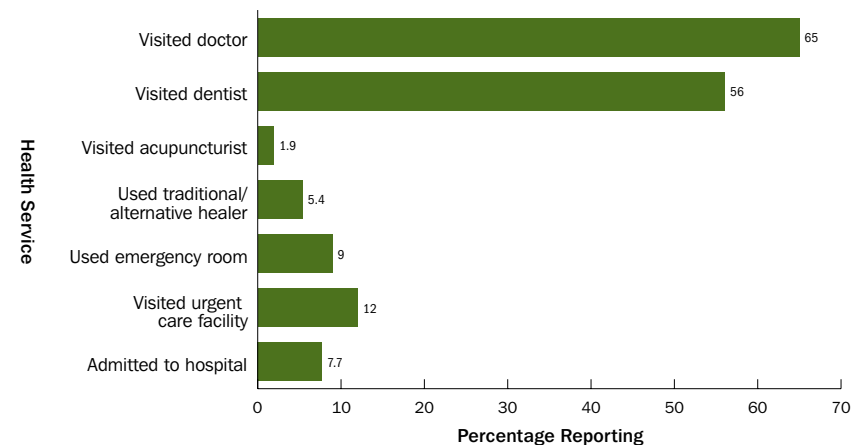
### AAPI Health Services Usage Patterns

Nationally, AAPI adults have lower user rates of medical care (doctor visits, urgent care visits, emergency room visits and hospital admissions) than does the general population.

The APAZI survey also showed most Arizonan AAPI adults are low users of medical services. It is more likely for U.S. citizens, women and those with health care coverage to use medical services.

Figure 2-5 includes information on APAZI participants' use of health services. Although a majority of the APAZI survey respondents indicated that they had visited a doctor during the past two years, it was lower than the rate reported by the CDC for Asian Americans nationally (79%) and the overall population (84%) during the past year. A majority of APAZI respondents reported that they had visited a dentist during the past two years. In addition, a small number of APAZI survey respondents had also visited an acupuncturist and/or a traditional/alternative healer during the past

**Figure 2-5**  
Arizona APAZI Respondents' Use of Health Services During the Past 2 Years  
(N=260)





two years. Most of these were U.S. citizens and had health care coverage.

The percentage of APAZI respondents who had visited urgent care or an emergency room in the last two years was also lower than national statistics. Although less than 8% of APAZI respondents reported they were admitted to the hospital during the past two years, this was twice the rate reported by CDC for Asian Americans (3.8%) admitted to the hospital during the past year who were 1 year of age or older in 2004. However, this was close to the national annual rate of 7.4%.

Influenza and pneumonia was the sixth cause of death for AAPI in 2005. Vaccination is an important preventative step taken before the flu season. It can reduce the chances of getting the flu and/or reduce the

severity of the flu. The CDC reported that only 39.5% of the adult population received influenza vaccination during the past 12 months in 2005, and for Asian Americans, it was much lower—30.6%. Thirty-four percent of the APAZI survey respondents had reported that they had a flu shot during the past two years (see Figure 2-6).

In 2005, cancer was the top cause of death for the AAPI population. Timely screenings can detect early stages of cancer and lead to early treatment and prevent unnecessary deaths. The CDC reported nationally that Asian American women had the lowest mammogram and Pap test rates of the four major minority populations in 2005, although the APAZI survey respondents had higher rates for both screenings (see Figure 2-6). It has been recommended that

women aged 40 or over should routinely have mammograms every one to two years. A mammogram is an X-ray of each breast to look for breast cancer. Sixty-four percent of APAZI survey female respondents aged 40 or over indicated they had a mammogram during the past two years. This was higher than the average for Asian American women reported by the CDC in 2005 (54.6%). A Pap test is used to detect cervical cancer. It is recommended that women should begin getting a Pap test no later than 18 years of age. Seventy-two percent of the women respondents reported that they had a Pap test during the past three years. In 2005, the CDC reported a lower Pap test rate for Asian American women during the past three years (64.4%).

For men, two of the most common tests used by doctors to screen for prostate cancer are the digital rectal exam and the prostate specific antigen test. Less than half of APAZI AAPI men respondents aged 40 or over indicated that they have had a prostate exam during the past two years.

The several comments from the APAZI community focus groups indicated that there are access issues and cultural barriers preventing AAPIs from getting timely cancer screenings, especially for women:

- “AAPI women don’t access mammograms and Pap smears at the rates that non-Asian women do... and we think the reasons are in part cultural. Maybe there are issues of modesty or concerns what

the husband thinks, about another man examining his wife. Could be financial barriers, maybe the person doesn’t have health insurance or can’t afford to see a doctor or get the test, get the screening test.”

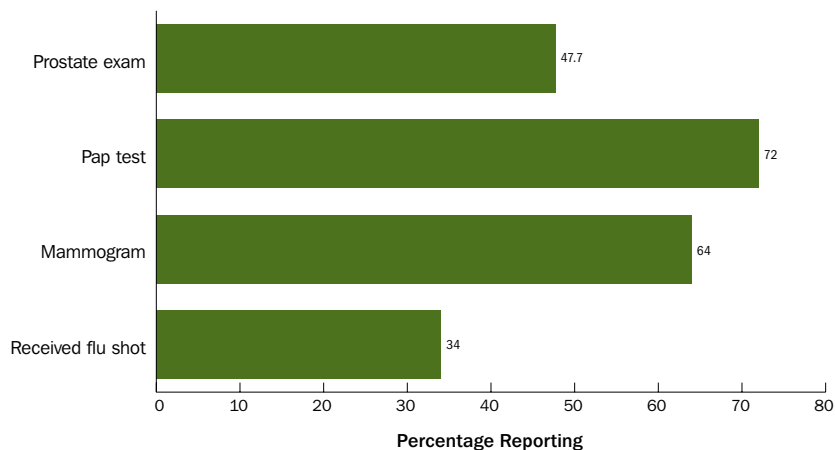
- “The idea of Yin and Yang and their body being in balance or out of balance, works, in some respects, against the notion of preventive screening because what it philosophically is saying, that when your body is out of balance, you know that because you get sick. And so for tests like mammograms and Pap smears that are trying to detect, in many cases, possibly asymptomatic disease, it’s not culturally consistent because the culture’s saying you’ll know when you’re sick because something will happen to alert you, and that works against the notion of preventive screening.”

- “I think that a lot of time, we view Asian people as being shy, being quiet, and I think that there is some truth to it, because we do not like to discuss our personal feelings, our personal problems. ... So [with] mental health, and depression, or even if you have a mass in the breast, you don’t want to share it, you don’t want to show it to people.”

### Summary and Recommendations

There are differences in the top causes of death between the general population and the AAPI population.

**Figure 2-6**  
Arizona APAZI Respondents Receiving Flu Shot and Cancer Screenings During the Past 2 Years (N = 260)





“ There should be increases in the number of AAPI medical interpreters and culturally competent health professionals in Arizona. There should also be an increase in the availability of health education materials translated into different Asian languages.”

Although nationally there has been improvement in reducing the rates of top causes of death for AAPI, Arizona has not done as well. Studies are needed to determine why there are significant improvements in reducing the AAPI death rates at the national level, but not in Arizona. Specific health programs are also needed to reduce the overall Arizona AAPI top causes of death rates.

Most of the AAPI who received the APAZI community survey and participated in the community focus groups were at the higher family income levels and low health risks. However, it is not known if the general AAPI population in Arizona has the same health, health risks and health coverage as the APAZI respondents; that is especially the case for those with lower family incomes. Many of the survey respondents encountered the same cultural and language barriers, lack of a medical home, and low health services usage rates as the national AAPI population. Health studies that include a broader representation of the Arizona AAPI population are needed to obtain a more complete picture of health profile, health risks and health coverage.

Nationally, the AAPI population has higher uninsured rates than the general population, but Arizona AAPI were doing better in this area. Arizona AAPI who are the mostly likely to be uninsured are those with low-paying jobs in which health insurance is not offered, part-time workers with no benefits, family-owned small businesses, and recent immigrants. Nationally, AAPI has the lowest percentage of publicly funded health care coverage of the four major minority groups. It is not known whether this is the situation in Arizona.

The common barriers to access to health services include: financial barriers, lack of a medical home, and culture and language. Even though the majority of the APAZI survey respondents reported they had health care coverage, less than half indicated that they had a regular source of health care. Nationally, AAPI have low usage rates of health services (e.g., doctor visits, urgent care visits, emergency room visits, hospital admissions, mammograms, Pap smears and flu vaccinations). Similar patterns appear in Arizona. In addition, because cancer is the AAPI top cause of death, timely screenings

are critical in detecting early stages of the disease.

There is a need to increase the percentage of AAPIs with a medical home. The APAZI community focus groups recommended that there should be increases in the number of AAPI medical interpreters and culturally competent health professionals in the Arizona. There should also be an increase in the availability of health education materials translated into different Asian languages. Overcoming the cultural and access barriers is also crucial in raising screening rates.

There are a number of health areas that can be improved in Arizona AAPI communities. To make these improvements will require community changes at different levels. AAPI community members need to develop a greater self-awareness of community health and health services needs. AAPI community leaders need to increase their community awareness of health issues, to enhance their advocacy skills to bring about community health solutions, and to improve community response to health and health services needs. In addition, the AAPI community needs to work with health agencies, institutions and

organizations to increase their awareness of the health issues (e.g., advocate for community health assessment) and to improve their response to AAPI health and health services needs. These changes are vital to the improvement of health status in AAPI communities. ■

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## Improving Outcomes

### By Doug Hirano

Often characterized as the nation's "model minority," Asian American and Pacific Islanders are frequently assumed to be healthy and wealthy. However, in terms of health, there are in fact several problem areas for AAPIs.

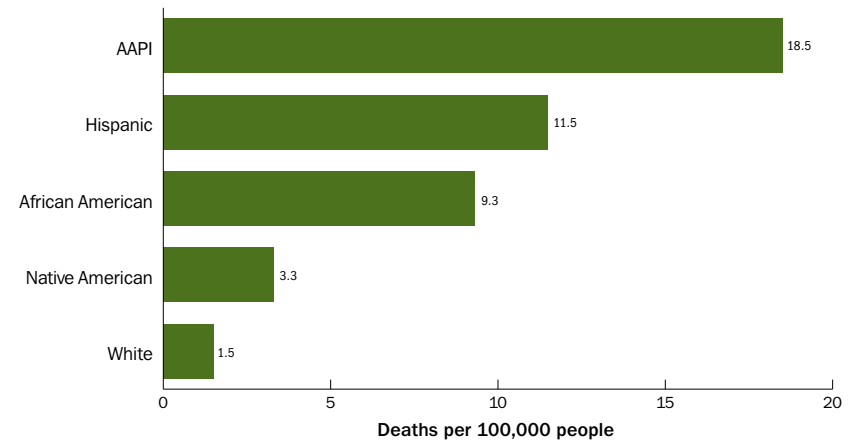
It is estimated that 10% of all AAPIs in the United States are chronically infected with the hepatitis B virus—a major cause of liver cancer. This compares to an infection rate of just 0.4% (1 in 250) among all U.S. residents. One in four individuals with chronic hepatitis B infection will suffer serious, if not fatal, liver disease without adequate monitoring and treatment. In Maricopa County, local hepatitis B screening clinics have found an infection rate of approximately 8% among AAPIs. Statewide, more than half of all pregnant women found to have chronic hepatitis B infection are AAPIs.

Rates of tuberculosis are also disproportionately high among AAPIs in Arizona. In 2006, the rate of tuberculosis cases among AAPIs was 18.5 per 100,000 Arizona residents—more than 12 times the rate (1.5 per 100,000) for non-Hispanic Whites (see Figure 2-7). Data from the Arizona Department of Health Services indicates that within the AAPI group, individuals from Vietnam, India and the Philippines had the highest tuberculosis rates.

AAPIs in Arizona carry a disproportionate burden of poor health due to infectious diseases, such as hepatitis B and tuberculosis. Culturally proficient outreach and education can assist in identifying and treating infected individuals. Chronic conditions such as diabetes and selected cancers are on the increase among AAPIs and require improved access to preventative services, such as mammography and Pap smears, as well as effective health promotion services in the areas of nutrition, physical exercise and tobacco cessation. Community-wide leadership and participation can improve the effectiveness of these efforts.

In this regard, the Asian Pacific Community in Action (APCA), a Phoenix-based nonprofit organization, has been working since 2002 to improve the health of AAPIs in Maricopa County. The overarching goal of APCA is to establish a sustainable community-wide approach toward maintaining optimal health and wellness within the AAPI community. This larger goal includes multiple subgoals: (1) monitoring AAPI health status, health-seeking behaviors and community capacity; (2) coordinating the provision of culturally and linguistically proficient health education and preventive clinical services; (3) establishing enduring and broad-based health partnerships; (4)

**Figure 2-7**  
Arizona Deaths Due to Tuberculosis  
(Source: Arizona Department of Health, 2006)



improving community capacity for health improvement; and (5) continuously advocating for policies and programs that improve AAPI health. APCA currently boasts a staff of six employees and an annual budget of \$450,000.

In the past six years, APCA has made considerable progress in addressing the aforementioned goals. Achievements include holding the first seminars, workshops, conferences and health fairs targeting the local AAPI community; establishing programs in the areas of breast cancer prevention, hepatitis B screening and education, tobacco prevention and cessation, and diabetes screening and education; and conducting surveys and focus groups to better understand local AAPI health needs and behaviors. Much of the progress made by APCA is a testament to its support from volunteers, private donors, and corporate and government partners.

Most recently, APCA was one of eight AAPI organizations nationally chosen to participate in the "Health Through Action" program funded by the W. K. Kellogg Foundation. This groundbreaking program is the largest AAPI health initiative ever launched. Through this four-year initiative, APCA will be building a community-wide coalition to develop and implement a long-term cancer prevention program in the AAPI community. This coalition-building work offers an opportunity for the many subgroups that constitute AAPIs in Maricopa County to create a broad-based community health movement and a realistic opportunity to improve its health status indicators related to cancer. This project also can serve as a model for the AAPI community to address other health and human services issues. ■

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## Mental Health Strengths & Risk Factors

By Brandon Yoo

Asian Americans and Pacific Islanders are an extremely diverse group. Tracing their roots to more than 40 Asian countries of origin or ethnic groups, AAPIs significantly vary by socioeconomic status, language, values, nativity, generational status, acculturation, religion, purpose of immigration, and many more factors (Okazaki & Hall, 2002). They also continue to be one of the fastest-growing populations in Arizona and in the larger United States (U.S. Census Bureau, 2002, 2007). Despite this diversity and continual population growth, very little is known about the mental health status and needs of AAPIs, particularly in Arizona.

Research examining mental health issues among AAPIs and their ethnic communities is limited. According to a recent first-ever national study of mental health focused on AAPIs, mental health issues are of great concern in this community, with significant variability in the rates of mental disorders based on demographic, cultural and immigration factors (Takeuchi, et al., 2007). Although there are a number of collective strengths in this community (e.g., family cohesion, educational achievements, motivation for upward mobility, strong work ethic), there are equally as many risk factors for mental illnesses (e.g., acculturative stress, achievement pressure,

language difficulties, individual and cultural racism) (U.S. Department of Health and Human Services, 2001). Continual empirical studies are warranted to systematically identify rates and distribution of mental health problems, as well as their protective and risk factors.

Culture can significantly influence the experience and expression of mental disorders among AAPI individuals. For instance, White Americans often describe symptoms of depression based on affect (e.g., "I feel sad"), whereas less-aculturated AAPIs describe symptoms of depression based on physical complaints (e.g., "My stomach hurts"). Our current classification system of mental disorders (i.e., the Diagnostic & Statistical Manual of Mental Disorders) does not take this into consideration. Consequently, understanding how AAPI individuals experience mental disorders may be limited. Research and clinical service need to take into account these cultural differences to understand the full complexity in the experience of mental disorders among Asian Americans and their ethnic subgroups.

AAPIs have the lowest rates of utilizing mental health services among all other racial groups. This underuse is comparable regardless of gender, age and geographic location. However, Asian Americans who seek



care for mental illness often present with more severe illnesses (U.S. Department of Health and Human Services, 2001). The low use of mental services may be accounted for by a number of factors, including stigma and shame over using services, lack of financial resources and language barriers. In addition, culturally sensitive treatment services may not be available. This is particularly unfortunate given that culture-sensitive interventions among racial minorities are often greatly beneficial in treatment effectiveness (Kurasaki, Sue, Chun, & Gee, 2000; Lau & Zane, 2000). Development of culturally and linguistically appropriate services for AAPIs are sorely needed. ■

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## The Mental & Behavioral Health of AAPI Youth

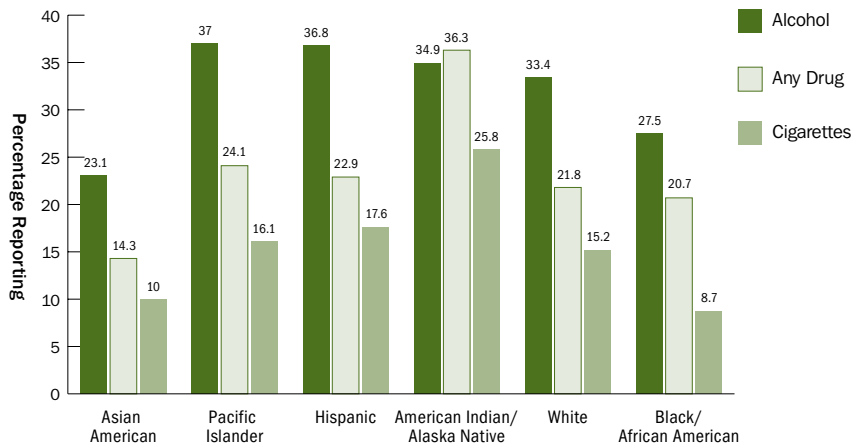
By Angela Chia-Chen Chen

Empirical evidence suggests that Asian American adolescents have higher levels of depressive symptoms than do their White counterparts (Greenberger & Chen, 1996). They are, however, less likely to receive services for emotional problems due to the model-minority myth (Chang & Sue, 2003). Depression has been found to be associated with many negative outcomes, such as academic problems, risky sexual behavior, substance abuse, physical health problems, impaired social relationships and risk of completed suicide among youth (Horowitz & Garber, 2006). In Arizona, Asian American and Pacific Islander youth also have varying rates of substance abuse (see Figure 2-8), with Pacific Islander youth

reporting the highest rate of alcohol consumption.

Arizona has the second-highest suicide mortality rate in the United States among adolescents 15–19 years old (Arizona Department of Health Services, 2003). Furthermore, children with non-English-speaking parents experience barriers to accessing medical care and have greater risk for unmet medical needs (Yu, Nyman, Huang, & Schwalberg, 2004). In 2005, among people 5 years old and older in Arizona, 27% spoke a language other than English at home, and 43% reported that they did not speak English “very well” (U.S. Census, 2006). Early and culturally appropriate intervention services are essential to reduce racial and ethnic

**Figure 2-8**  
Substance Use Among Arizona 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> Graders, 2006  
(Source: Arizona Youth Survey, State Report, 2006 )



disparities in mental health and behavioral issues among AAPI youth.

The impact of the family and the potential interactions among different social environments on youths' well-being has been recognized but often neglected in empirical studies. Parents represent powerful socializing agents for their children (Collins, Maccoby, Steinberg, Hetherington & Bornstein, 2000). The use of unsupportive parenting practices has been linked to more depressive symptoms in children of immigrants (Dumka, Roosa & Jackson, 1997). Asian American/immigrant parents who are widely separated from their children in terms of acculturation may be more inclined to use unsupportive parenting practices because of the lack of shared understanding between parents and children, which in turn may increase depressive symptoms in their adolescent child. Thus, it is urgent to research contextual factors, such as family environment, that are critical to influencing the mental health of AAPI youth.

To understand the factors that can result in depressive symptoms among youth, we examined the relation between parent–child differences in cultural orientation (acculturation), parenting, and depressive symptoms among 451 Chinese American families residing in Northern California (Weaver, Kim & Chen, 2007). Categories for acculturation were *bicultural*, *more American*, or *more Chinese*. The findings suggested that the most advantageous group (those who had the least depressive symptoms) comprised families in which parents and adolescents reported bicultural orientation; the parent–child dyads with the least supportive parenting and highest depressive symptoms were in families in which the adolescent was *more American* but the parents were *more Chinese* (Weaver & Kim, 2008).

Although the association between acculturation, parenting and adolescent mental health in Chinese American and other AAPI families has been largely unexamined, findings of this empirical study highlight the importance of assessing intergenerational cultural dissonance, conflict and parenting practices when working with AAPI families.

Future studies that target Chinese American and other Asian American/immigrant youth in Arizona will help policy-makers and health care providers understand the underlying mechanism of these influential factors affecting the mental health of AAPI youth and assist in designing culturally appropriate preventative interventions and services. In addition, the following recommendations should be implemented:

- Mental health and behavioral service providers should examine carefully the differences in parent–child cultural orientation (acculturation) and parenting practices for optimal mental and behavioral health among AAPI youth.
- More rigorous studies should be done to determine whether acculturation has positive or negative implications for parenting practices and, in turn, whether it influences child mental and behavioral health among AAPI families. ■

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## Growing Older in Arizona

By Linda K. Don & Lynne T. Tomasa

Arizona’s AAPI general population is increasing rapidly as the state’s entire population is aging. In 2003, the over-65 age group comprised 13% of Arizona’s population, and it is projected to increase to 17% by 2015 and 21.3% by 2025. Researchers estimate that Arizona will have the 13th-highest proportion of elderly in 2025 among the 50 states, including the District of Columbia. Putting all this in context, the number of older AAPIs in Arizona may be growing, but it is still a very small population. The small size makes it difficult to accurately characterize this group.

Describing Arizona’s AAPI community is challenging because of its diversity and getting access to the various communities is not easy. There are numerous definitions of who is an “elder,” and there is no general agreement on the age at which a person becomes old. In American culture, the chronological age of 65 is commonly used and is tied into what was viewed as the age of retirement or access to governmental benefits like Medicare. Census data are often calculated using the below-65 and over-65 categories. In contrast, Social Security benefits can begin at age 62 and other discount based benefits may begin as young as 50. Due to increasing longevity, we also see sub-grouping of our older population into the young-old (65–74); middle-old (75–84); and old-old (85 and up).

In considering the AAPI elderly, it is important to note the group’s heterogeneity. The term “AAPI” encompasses Arizonans of Chinese, Japanese, Korean, Indian, Hmong, Samoan and Filipino descent—just to name a few. There are also considerable differences within the ethnic/cultural groups according to the proximity of the immigration experience. Elders who are immigrants have different worldviews, needs and values than do those who are American-born and whose families may have been in the United States for generations. Most Arizona-born AAPIs and those who have lived in the state for many years also have acknowledged differences in lifestyle and group perspectives compared to AAPI communities in other states.

Considering all these factors, it is no wonder that the main observation to make about our state’s AAPI elders is that data are greatly lacking for this population. Consequently, many comments about Arizona’s AAPI elders must be drawn from national data and extrapolated to the local group.

### Health

Specific state-by-state data are scarce, but nationally, AAPIs seem to suffer fewer health disparities compared to other ethnic minority groups—with a caveat, though. While AAPIs appear to have excellent health status, there are higher than average rates of specific diseases for many

of the groups when the population is disaggregated. For example, despite many epidemiological rates that are better even than for Whites, AAPI groups individually still have higher incidences for specific cancers, as can be seen in the following snapshot:

- Filipinos have the second-poorest five-year survival rates for colon and rectal cancers of all U.S. ethnic groups (second to American Indians).
- Koreans have the highest incidence and mortality rates of stomach cancer among all Asian subgroups. This is a fivefold increased rate of stomach cancer over White American men. Koreans have the lowest rate of colorectal cancer screening.
- Lung cancer rates among Southeast Asians are 18% higher than among White Americans.

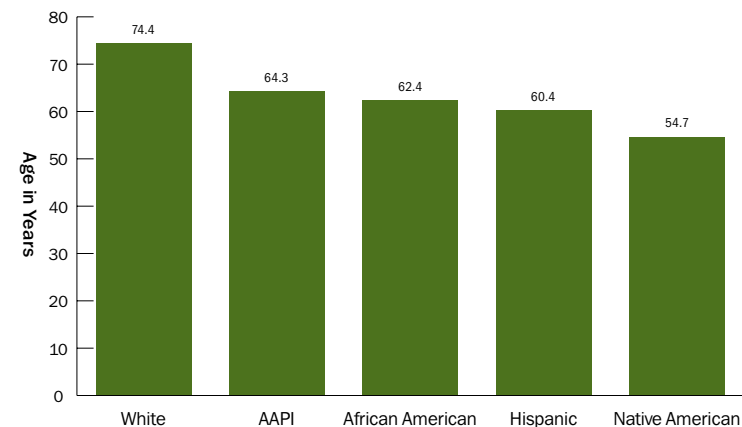
- Cervical cancer incidence rates in Vietnamese women are five times higher than the rate among White American women.
- Vietnamese men have the highest rates of liver cancer for all racial/ethnic groups.
- The incidence of liver cancer in Chinese, Filipino, Japanese, Korean and Vietnamese populations are 1.7 to 11.3 times higher than rates among White Americans.

(Asian American Network for Cancer Awareness, Research and Training, 2007).

A main indicator of a group’s health status that is indicative of a group’s level of health disparities is average age of death. Figure 2-9 suggests a disparity in overall health between Asian-descent Arizonans and their non-minority counterparts. As reflected below, there is a 10 year dif-

**Figure 2-9**  
Arizona Average Age at Death

(Source: Health Disparities in Arizona’s Racial and Ethnic Minority Populations, Arizona Public Health Association—November, 2005)







ference between the average age of death for Caucasians and AAPI in Arizona.

#### **Access to Services/Quality of Life**

A major concern for Arizona's AAPI elders is transportation as a way to access health care, shopping and other services. The ability to travel around one's community is also a key to reducing feelings of isolation, depression, and dependency that frequently accompany debilitating conditions associated with aging. *Aging Americans: Stranded Without Options* notes, "As people grow older, they often become less willing or able to drive, making it necessary to depend on alternative methods of transportation" (Surface Transportation Policy Partnership, 2004). A report by the Arizona Department of Transportation (2008) on rural transit reported that nearly one-third of the state's elderly population (defined as ages 60 and older) resides in rural Arizona, where mass transit is severely lacking. Lack of transportation can impact access to preventive health services. For example, the Office of Minority Health (2007) reports, "In 2005, Asian/Pacific Islander adults aged 65 years and older were 40% less likely to have ever received the pneumonia shot, compared to non-Hispanic white adults of the same age group." More data are needed about Arizona's AAPI elders and their need for public transportation.

In both rural and urban areas, AAPI communities are seeing a change in the ability of adult children to care

for and support their aging relatives. Whether it involves providing transportation, companionship, or financial assistance, some AAPI elders may experience a lower quality of life and increase their risk for health problems. Changing cultural traditions, coupled with the fact that fewer adult children can afford to stay at home to care for aging relatives, may be increasing the demand for culturally sensitive assisted-living apartments and nursing homes. Needs assessments also should be conducted into what kinds of alternative living arrangements may be required for AAPI elders.

The mental health of AAPI elders is something that needs to be addressed. Often viewed as a model community, many face the same mental health problems as other groups. The American Psychiatric Association (2007) highlights the rates of addiction, gambling and family violence that affect this community, and in some instances the prevalence rates are estimated to be higher. For example, suicide rates among Asian American women over 65 were estimated to be 10 times higher than among White elderly women. Immigration also can make this group at risk for post-traumatic stress disorder.

Finally, Arizona's Attorney General cautions that the state's seniors are frequent targets of financial exploitation crime, such as household repair, sweepstakes and magazine subscription scams. Again, ethnic-specific data are sorely needed to better assess the level of risk for our AAPI elders. ■

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## Health

### References & Further Readings

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### **III. Economic & Financial Issues in Arizona AAPI**



## Profiting From a Diverse Community

By Wei Li

Asian Americans and Pacific Islanders have been instrumental in building the state of Arizona since the 19<sup>th</sup> century, when they were miners, farmers, small business owners and domestic laborers. As Arizona’s economy grows and prospers and AAPI communities become increasingly larger and more diverse, those communities play more important roles in contemporary Arizona and beyond as business owners, a work force and a consumer base. They have become an inseparable component of Arizona’s economic and financial structure.

### The AAPI Labor Force in Arizona

With abundant natural resources, Arizona’s economy traditionally relied on the “5Cs”: copper, citrus, climate, cotton and cattle. However, high-tech employers have increased dramatically in recent decades along the Phoenix–Tucson corridor, dubbed the “Silicon Desert,” and Arizona views itself as a key player in the knowledge-based economy. The employment patterns of AAPI individuals over time closely mirror this statewide economic structural change.

Asian Americans possess overall higher levels of human capital and occupational prestige, but a closer look shows that Native Hawaiian and other Pacific Islanders (NHOPI) fare less well. For example, more than 45% of all Asian Americans 25 years and older hold at least a bachelor’s degree (the figure for the state is 25.5%), whereas the figure for

NHOPI is less than 20%. Such varied educational attainment levels partially contribute to the divergent occupational structures in the state.

In 2006, three quarters of the Asian American adult civilian work force (16 years or older) engaged in the following five industries: education, health and social services; manufacturing; retail trade; professional, science and technical services; and arts, entertainment, recreation, accommodation and food services (see Table 3-1). However, women were more likely to work in education, health and social services (25%) and less likely in manufacturing (17%) than were men (16% and 26%, respectively, in the same categories). Three primary occupations held by Asian Americans are management, professional and related occupations; sales and office; and services (see Figure 3-2). But gender difference again is important, as men hold more management, professional and related occupations (52% vs. women, 40%) and less in sales and office (16% vs. 31%).

Among NHOPIs in 2000, the top five industries were retail trade; education, health and social services; arts, entertainment, recreation, accommodation and food services; professional, science and technical services; followed by manufacturing (see Table 3-1). The three primary occupations by rank are sales and office; management, professional and related occupations; and services

(Figure 3-2). Women, again, were more likely to work in education, health and social services (24 %) or sales and office occupations (49%) compared to men (4% and 20%, respectively).

Subgroup differences were striking, as well. For example, among Asian Indian Americans, 78% of men and 58% of women hold management, professional and related occupations. In contrast, less than 23% of Polynesian Americans hold these positions. Such variations in occupations have great impacts on earning, purchasing power and capability for asset building.

### AAPI Businesses

Some AAPI adults participate in the economy as self-employed individuals or serve as unpaid family labor. AAPI-owned businesses are generally small, with limited numbers of (or no) paid

employees and relatively low revenue. They are most likely concentrated in service and retail sectors. Large-scale “Asian-theme” malls, such as the Chinese Cultural Center in Phoenix and Mekong Plaza in Mesa, anchored by Asian supermarkets (e.g., Ranch Market and Manila Oriental Market, respectively) and other large Asian supermarkets such as Lee Lee’s Oriental Market, have emerged and become more prominent over time. AAPI businesses are also no longer just locally owned but reflect the transnational and cross-regional nature of financial flows. For example, the two shopping plazas named here are financed and/or were developed by a mainland China firm and a California-based Vietnamese American developer, respectively.

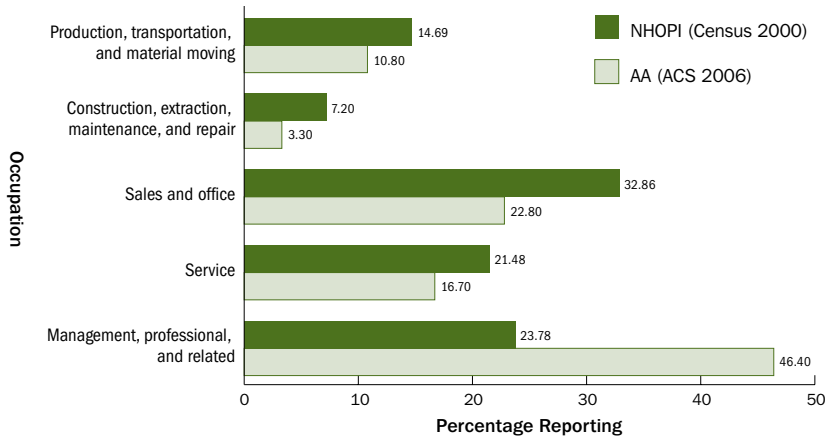
The U.S. Economic Census reported rapid growth of Asian American- and Pacific Islander-owned busi-

**Table 3-1**  
**Distribution of Arizona AAPI in Industry**  
(Source: ACS 2006 for AA; U.S. Census 2000 for NHOPI)

Industry	% AA	% NHOPI
Educational, health, and social services	22.00	13.09 (2)
Manufacturing	18.20	10.87 (5)
Retail trade	12.60	15.24 (1)
Professional, scientific, management, administrative, and waste management services	11.90	11.39 (4)
Arts, entertainment, recreation, accommodation and food services	10.20	12.02 (3)
Other services (except public administration)	6.40	2.97
Finance, insurance, real estate and rental and leasing	5.20	5.16
Public administration	4.10	6.79
Transportation and warehousing, and utilities	3.60	7.23
Construction	2.40	5.34
Wholesale trade	2.00	4.67
Information	1.30	4.93
Agriculture, forestry, fishing and hunting, and mining	0.20	0.30

NOTE: Ordered by rankings for Asian Americans, ranking of top 5 industries for NHOPI are in parentheses.

**Figure 3-2**  
**Distribution of Employed Arizona AAPI Civilian Population**  
**Among Occupations (16 Years and over)**



nesses in Arizona in recent years. For example, the total number of Asian American-owned businesses increased 48% in a five-year span, with more than 10,000 businesses reported in 2002. Total sales and receipts of these businesses reached \$2.4 billion, a 27% increase, with an average revenue total of more than \$230,000 per business. NHOPI-owned firms also increased 48% in 2002, to nearly 350 businesses, with average revenue at just under \$110,000 per business. Asian Americans as a whole have a self-employment rate comparable to the state average (above 6%), with a lower average among NHOPIs (below 3%).

**AAPI Income & Finance**

As a result of their overall higher human capital and job prestige, Asian Americans earn a higher average income compared to state averages. One conventional image of immigrants is that they earn money in the United States and remit these funds to their home countries. To the contrary, as a result of rapid economic growth in some Asian countries, many Asian immigrants now bring financial resources

with them; others pump money to Arizona by either directly transferring money from their home country to support their families, or by parents paying bills in their home country for their children’s spending in Arizona as international students. Therefore, the contemporary income and financial picture of AAPIs are complex, multifaceted and transnational.

The APAZI survey results indicate that 68% of respondents have at least two people working per household. Figure 3-3 includes information on median household and per capita income. According to census data, the Asian American median household income was almost \$46,000 in 1999, with NHOPI’s median household income almost \$40,000. Per capita mean income was about \$22,000 for Asian Americans and just over \$15,000 for NHOPIs, compared to the state per capita mean of \$24,110 and \$20,275 in the same years. Differences among various AAPI ethnic groups reflect the wide disparity between salaries. For example, the per capita mean income of Asian Indian Americans was more than \$30,000, in comparison to Tongan Americans, whose mean per capita income was

just over \$8,500. However, the Tongan Americans have a higher median household income than the state median, a reflection of more people in the labor force per household.

Figure 3-4 provides information on the percentage of individuals living below the poverty level for each ethnic group. Although that percentage for Asian Americans in Arizona is less than the state average (12% vs. 13.9%), for NHOPI communities it is higher than the state average (16%). Like income, there is a wide disparity in this analysis, with Indonesian Americans and Tongan Americans having the highest rate, at 18.5%.

There is a popular perspective that AAPIs rely primarily on family, friends or informal financial mechanisms for loans and other financial needs; this is not borne out by the APAZI survey. More than 86% of APAZI survey respondents have received a loan from a bank. In 2006, the Asian Bank of Arizona established its headquarters in the Chinese Cultural Center in Phoenix, in response to the growing AAPI communities with different income and wealth levels and various financial needs in the state. The bank hires about equal numbers of Asian and non-Asian employees and is able to support the growing population of new immigrants who lack a U.S. credit history, have different cultural or business traditions or may have English-language difficulties. Within the Asian Bank’s short history, its financial record demonstrates rapid growth, with total deposits of \$17.8 million and total assets of \$25 million in 2007. The bank is able to absorb deposits from, and to leverage assets among, Asian Americans and Pacific Islanders and beyond, and it has become a player in the Arizona financial scene as a small but growing niche community bank.

**Challenges & Policy Implications**

Despite the apparent economic and

financial success among AAPIs in the state, they still face many challenges. The communities are extremely diverse with different needs and demands, requiring various research and policy responses.

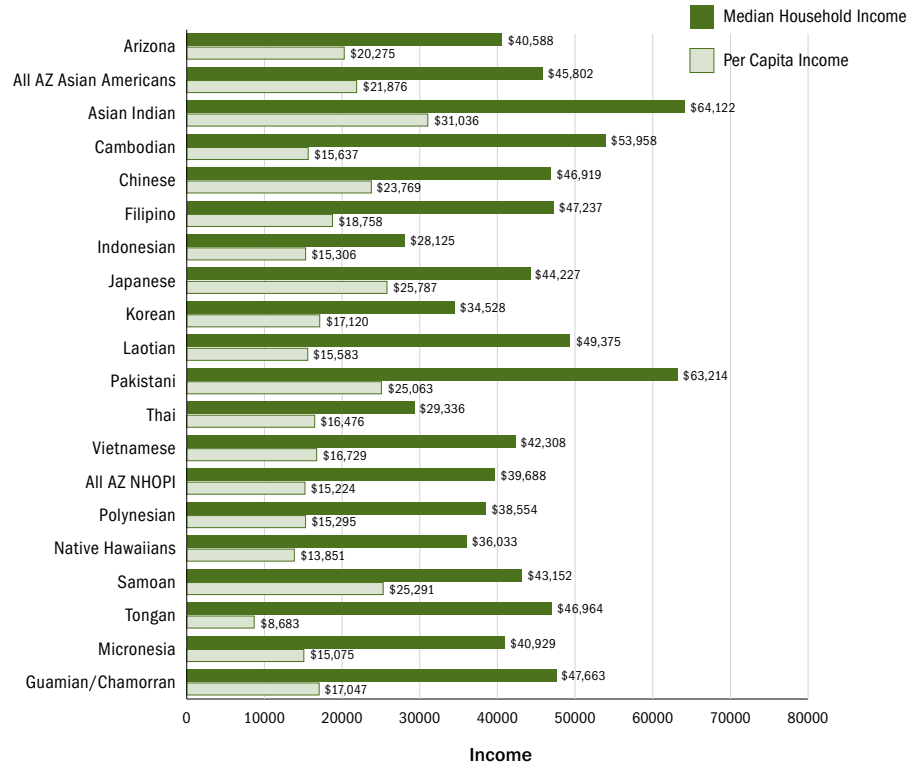
- The lower socioeconomic status and educational attainment among Native Hawaiians and other Pacific Islanders must be recognized. The grouping of NHOPI with the broader Asian American community does not help NHOPI communities receive the proper support or resources.
- For first-generation adult immigrants, there is often a language barrier, including speaking with an accent, that can be a major obstacle in obtaining mainstream jobs as well as getting promotions. This is true not only for immigrants with limited English proficiency, but also for educated Asian Americans with professional skills. The resolution of such challenges will rely, in part, on changing expectations in a global economy to value international experiences, expertise and linguistic diversity.
- There is a glass ceiling in the mainstream corporate world that hinders career advancement for both Asian immigrants and native-born Asian Americans and Pacific Islanders. For example, 14% of APAZI survey respondents agree with the statement “I have been passed up for a promotion based on my race or ethnicity.” Managerial training should offer a level playing field and equal opportunities for aspiring Asian Americans and Pacific Islanders in public and private sectors.
- Many well-educated professional Asian immigrants have credentials that are not recognized in the United States. This contributes to a





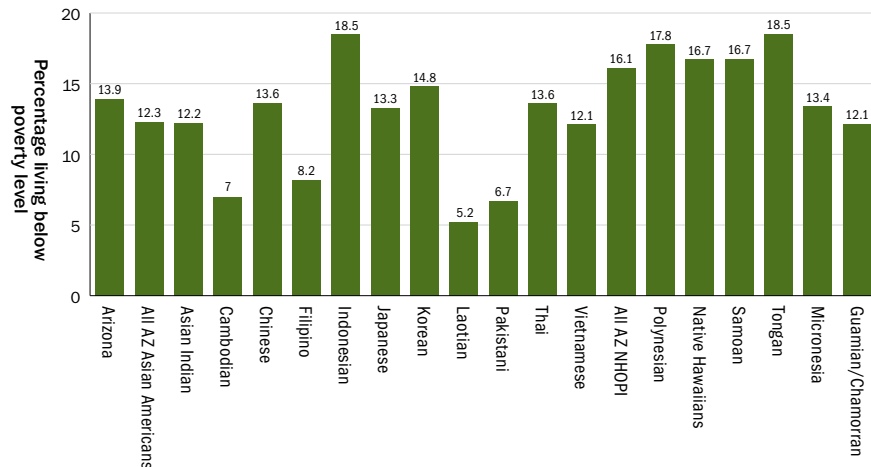
**Figure 3-3**  
**Arizona AAPI Median Household and Per Capita Income**

(Source: U.S. Census, 1999)



**Figure 3-4**  
**Arizona Poverty Rates**

(Source: U.S. Census, 1999)



“brain waste” when individuals have difficulty finding jobs that match their expertise and potential; they then turn to lower-skill positions or self-employment as a last resort. Other highly skilled international migrants (e.g., H-4 visa holders, often women, who are spouses of H-1B non-immigrant visa holders) are prohibited from working by federal immigration law. Offering on-the-job training and internship opportunities might help skilled AAPI immigrants gain required U.S. credentials, especially in the economic sectors that increasingly need more professionally trained workers, such as health care and education. Comprehensive immigration law change is needed to change visa restrictions.

The APAZI survey found that more than 73% of respondents obtain knowledge of the U.S. bureaucratic system via some form of help from either family or community, and only 2.5% learn directly from government sources. Those immigrants who open small businesses often lack an understanding of U.S. laws and practices, as well as the accounting and tax system. Such challenges are also faced by native-born AAPI who had not previously owned or run a business of their own. Education and native-language assistance are crucial, such as holding business workshops in different languages or translation of important government documents to various Asian or Pacific Island languages.

New immigrants often lack a U.S. credit history and knowledge of the banking system, regardless of their assets and wealth. Many

small businesses rely on cash transactions, which may hinder their development and finances in the long run. Slightly more than 25% of APAZI survey respondents receive help from the public sector in securing their loans. Therefore, financial education is crucial, and streamlining financial documentation would help.

Arizona AAPI businesses should be supported in expanding their customer base. For example, some serve AAPI communities but also have a Latino customer base. The current debate on immigration reform is not only important for the future of our state and nation, but also vital to business success among AAPI communities in Arizona.

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