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Closing Remarks
University of Medicine and Dentistry of New Jersey
The 1st South Asian American Health Conference
“Developing an Agenda for Action to Address Health Disparities”
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Thank you all for making this conference such a success. Your evaluations are crucial to learn for the future.

Please join me in thanking the faculty for their excellent presentations and the staff and UMDNJ leaders for their leadership and organization and the hotel for their great facilities and service.

We have had an engaging day!

- What did we learn,
- What do we take home and
- What agenda did we develop for the future?

The South Asian community is 2 million strong and has more than doubled nationally in 10 years.

We saw how we may be a model minority in some ways and yet face serious and urgent health disparities in access, utilization of services, health status and nutrition, and

High disease burden in:

- Diabetes
- Heart disease
- Cancer
- Oral health
- Mental illness
- Domestic violence and
- Infections.

We learnt that diabetes and heart disease affect us many times more frequently and at younger age and kill us younger too, that our oral health can be much better as we have a lot of periodontal disease

Oral cancer occurs at 5 to 6 times the overall US rate and accounts for 30% of all cancers in South Asians all to do with use of tobacco and *paan* and *guthka*.

and that head and neck and perhaps some other cancers are more prevalent amongst us.

We learnt how domestic violence ravages our community – 40% reported IPV in a study in Boston and yet we shrink from seeking help; and

a quarter of all cases of TB in the US is in Asians, who are only 3.5% of the population, and over half of new cases in 2004 were in foreign born.

AIDS, we learnt, is growing at 10% in APIs (Asian {Pacific Islanders}).

Not only do we suffer like any other community with mental health problems, but have cultural barriers to overcome.

We discussed our lack of understanding of the nuances in nutrition and the need to help the community learn.

We saw the many factors that contribute to disparities many intrinsic to the community:

- Identity/ Communication
- Lower thresholds of risk factors
- Disproportionate Disease Burden
- Disease characteristics- affecting young
- Health Beliefs/ Behavior
- Help Seeking Behavior in Health and Disease

and several from external factors:

- Access problems
- “Dispensation” Bias- among professionals and in the system
- Lack of “cultural empathy”
- Use of standard and therefore not sensitive enough thresholds for Screening / Treatment

We also saw a common thread- prevention and early intervention can be very effective- in diabetes and heart disease, in cancer and oral health and much more.

And another- the need for using more rigorous thresholds for screening and intervention for weight and BMI, waist measurements, and other traditional markers as well as the need to identify other risk factors or predictors,

And to encourage seeking early intervention and adherence to recommended treatment while nurturing “cultural empathy” in health care professionals and the system.

“You must be the change you wish to see in the world” said, Mahatma Gandhi.
We can and must change ourselves as well as the environment.
If we do not help ourselves, who will?

And that is easier said than done!

The single most important take home and “to do” is the need to inform and motivate the community, and help it learn

- healthy habits and
- wellness behavior and
- disease prevention.

Each of us has a responsibility

Through our personal effort and through community leaders as well as by creating new programs and guiding existing ones to work on culturally competent outreach for education and behavior modification.

Simple things, so simple that we tend to forget to act on:

- avoiding harmful habits such as
- smoking and chewing tobacco and *paan* and
- keeping physically active and exercising regularly
- and maintaining a nutritious diet with moderation
- so as to keep moderate body weight and
- have regular check up and
- follow professional advice.

Sounds so simple, and it is, but we need to help people learn these and apply them and teach their children young.

We cannot each work in our own world to do it. We need to work across disciplines!

Here are the collective agenda goals we seem to be looking to:

First for **increasing access**, we need to be a part of the national and local efforts to make access universal and work with legislators and funding sources and agencies both private and governmental to increase outreach and access.

Second, to **help people navigate the system** we need to educate people to avail of access that people are entitled to and help government and other organizations for effective outreach in this.

For data, we need to advocate for the creation of a South Asian category at data collection in ongoing efforts so that the existing data banks such as NHANES will yield valuable information about this community in the future

Foster primary research in South Asians-

- into disease patterns and
- on achieving behavior change

This makes good economic sense for the results will not only help this community be more productive and more importantly not be a drain on the economy from disability, but also the results would likely be transferable to all of America and beyond.

Researchers would look at this group as a fertile substrate for research- the high prevalence of certain conditions offers excellent opportunity for fruitful research that could be applied to other populations.

We learnt that 2% of 1% of Government grants goes for AAPI specific health projects and almost none into research.

Of millions of articles cited in Medline, less than 400 related to health of AAPIs in the US and of that the South Asian related are negligible.

We learnt about how we can and must lobby- that is the American way!
We cannot accept “No” for an answer!

We need to create culturally competent community outreach systems to help learning to include:

- Health literacy
- Health and wellness knowledge
- Preventive health and
- Disease specific knowledge
- And culturally competent help for behavior modification in:
- Avoiding harmful habits
- such as smoking, tobacco and pan chewing

We need to learn and help others learn to seek:

- regular health screening
- early intervention and
- timely treatment and
- Compliance with treatment programs.

We need to inform health professionals and other leaders

- of the high prevalence of these conditions and
- the need to use more stringent thresholds
- for screening and
- treatment and the need for
- cultural competency and

- cultural empathy.

We need to reach out to health care organizations and companies to

- raise awareness and
- involve them affirmatively in
- the outreach to the community and
- to the profession

It is like the proverbial “teaching a man to fish”

I would like to see the day when we get tired of too much of this “fish” of an informed, engaged and healthy community-

A true model minority

What I would hope is that at the 2nd Annual Conference,

We hear not about our community’s health and wellness problems but rather the efforts made by you and those at the to yet be born UMDNJ Center for Health Disparities and others towards these goals and the triumphs and tribulations so that this collective journey will get the needed course correction.

Thank You!
