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The Asian American Network for Cancer Awareness, Research, and Training's Role in Cancer Awareness, Research, and Training

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Abstract

Purpose—The purpose of this paper is to describe the content for the Asian American Network for Cancer Awareness Research and Training (AANCART) with respect to Asian American demographic characteristics and their cancer burden, highlights of accomplishments in various AANCART regions, aspirations for AANCART, and an interim assessment of AANCART's activities to date.

Methods—The author compiled literature and other data references to describe the context for Asian American demographic characteristics and their cancer burden. As the AANCART Principal Investigator, he collected data from internal AANCART reports to depict highlights of accomplishments in various AANCART regions and offer evidence that AANCART's first two specific aims have been attained.

Principal Findings—With respect to our first specific aim, we have built an infrastructure for cancer awareness, research and training operationally at a Network-wide basis through program directors for biostatistics, community, clinical, and research and in our four original AANCART regions: New York, Seattle, San Francisco, and Los Angeles. With respect to our second specific aim, we have established partnerships as exemplified by working collaboratively with New York's Charles B. Wang Community Health Center in securing external funding with them for a tobacco control initiative and nationally with the American Cancer Society. With respect to our third specific aim, we have been fortunate to assist at least eight junior investigators in receiving NCI-funded pilot studies. The most notable change was the transfer of AANCART's national headquarters from Columbus, Ohio to Sacramento, California along with potentially an increased diversification of Asian American ethnic groups as well as an expansion to Hawaii and Houston.

Conclusion—As of the end of year 2 of AANCART, AANCART's two specific aims have been achieved. We are focusing on our third specific aim.

The National Cancer Institute (NCI) made history in April 2000 when it funded Special Populations Networks to address cancer awareness, research, and training for Asian Americans and Pacific Islanders.^{1–4} Along with sibling NCI Special Populations Networks headquarters in Honolulu (*Imi Hale*)², Philadelphia (Asian Tobacco Education, Cancer Awareness and Research or ATEC)³, and Irvine (Pacific Islander Cancer Control Network or PICCN)⁴, the Asian American Network for Cancer Awareness, Research, and Training (AANCART) launched infrastructures for cancer awareness, research, and training with their respective Asian American or Pacific Islander populations in defined geographic regions. This paper provides an overview of AANCART, the NCI's Special Populations Network targeting Asian Americans on a national basis. First, the context for AANCART will be described; second, AANCART's initial accomplishments from its establishment as a cooperative agreement at The Ohio State University to the transfer of its national headquarters to the University of California, Davis will be reviewed; finally, an interim assessment of AANCART's role in promoting cancer awareness, research, and training for Asian Americans will be proposed.

Context for AANCART: Asian American demographic characteristics and cancer burden

AANCART's establishment in 2000 is significant because it represents the first time that the National Cancer Institute has ever funded a Special Populations Network to address cancer awareness, research, and training of Asian Americans on a national basis. (Previously, the NCI had only funded predecessors to the Special Populations Networks for African Americans and Hispanics.)

Two aspects of the establishment of AANCART are particularly important: (1) Asian Americans' demographic characteristics and (2) their cancer burden. Asian Americans, defined by the Federal government to be someone from Asia or the Far East⁵ are in percentage terms, the fastest growing racial/ethnic population group in the U.S. (48%), even outpacing Hispanic/Latinos (43%).⁵ As with other population groups defined by the Federal Office of Management and Budget (OMB), racial/ethnic designations are artificial and fail to delineate the heterogeneity represented within any single OMB classification. For instance, the Federal definition of being "Asian American" encompasses a geographical scope (the continent of Asia) that potentially includes people originating from where more than one-half of the world's population lives. In geographic terms, the boundaries for Asia may be the Arctic Ocean on the north (to include the Russian Far East), the South China Sea (separating Indonesia from Australia), Japan on the east, and perhaps the Sinai Desert on the west (separating the Middle East from Africa). If this definition of the continent of Asia were to be used, at least 30 distinctive languages, over 200 dialects, and multiple cultures would be included.⁶ Properly communicating the awareness of cancer and its risk factors as well as developing effective cancer prevention and control interventions would require incorporating linguistic and cultural factors in addition to the standard considerations for educational levels and socio-economic factors.⁷⁻⁹ Fortunately, AANCART's Steering Committee members are among the Nation's most experienced and expert in working with Asian Americans and are national resources to address cancer awareness, research, and training among and within Asian American groups. See www.aancart.org. Examples of some of the Steering Committee members' prolific publications relating to cancer awareness and research affecting Asian Americans are cited. 10-19

AANCART's Steering Committee members also represent among the Nation's most actively funded cancer control researchers who have investigated the cancer burden among Asian Americans. In this instance, cancer burden is operationally defined as the impact of cancer as measured by incidence and prevalence rates of cancer risk factors and mortality. In comparison to other racial/ethnic populations, the cancer burden affecting Asian Americans may be characterized as being unique, unusual, and unnecessary.

The cancer burden is unique in that Asian American and Pacific Islander females are the only demographic group who currently experiences cancer as the leading cause of death.²⁰ All other racial/ethnic/gender groups experience cardiovascular disease as the leading cause of death. Furthermore, Asian American and Pacific Islander females were the only group to show overall increase in cancer mortality for all sites (except lung) for 1990-95. Cancer is also the leading cause of death for Asian American and Pacific Islander males, for their entire young-middle adult years (ages 25-64), compared with being the leading cause of death for the middle-older years (ages 45-64) as it is for White males.²¹

The cancer burden affecting Asian Americans is also unusual in that both infectious and chronic types of cancer are prominent. Among the infectious or communicable types of cancer, Vietnamese American women experience the highest incidence for cervical cancer (etiologically related to HPV); Korean Americans experience the highest incidence for stomach

cancer (etiologically related to *H. pylori*), Chinese men experience the highest incidence of liver cancer (etiologically related to HBV) and nasopharyngeal cancer.²² Among the chronic or long-latency types of cancer, breast cancer incidence rates for Asian American women have been increasing with being American-born (versus foreign-born), an increasing number of generations in the USA, and a more Westernized diet.^{23–25} More recently, breast cancer rates among Japanese American women appear to be increasing at rates greater than those of non-Hispanic white women.²⁶ Similarly, colon cancer incidence rates for Asian Americans appear to be between the two extremes of being the lowest for Chinese in China with Caucasians in the U.S.²⁷ and prostate cancer incidence rates appear to be increasing with greater duration of U.S. residence and increased fat in the diet.²⁸

Finally, the cancer burden affecting Asian Americans can be characterized as being unnecessary. For example, all cancers for which tobacco is the etiological agent are considered unnecessary³⁰ since whether one uses tobacco is considered to be typically a matter of choice. Yet, smoking rates among Asian American and Pacific Islander men are among the highest.²⁹ Death due to cervical cancer is considered unnecessary because of the advent of the Pap test and its usefulness in early detection and hence potential for earlier treatment. Yet, Asian American women have the lowest cervical cancer screening rates of all racial/ethnic groups. Liver cancer morbidity and mortality may be potentially unnecessary because of the hepatitis B vaccination.³⁰ Thus, the rationale for the launching of AANCART included recognition of the demographic heterogeneity of Asian Americans and at the same time, elements of the unique, unusual, and unnecessary aspects of their cancer burden.

Accomplishments

The NCI established AANCART as a cooperative agreement originally with The Ohio State University with three specific aims that correspond to the NCI's three phases for Special Populations Networks:

1. Building an infrastructure for cancer awareness, research, and training (Phase I);
2. Establishing partnerships for increasing accrual in clinical trials, training, and the conduct of pilot studies (Phase II); and
3. Formulating grant-funded research (Phase III).

By 2001, Specific Aim #1 (building of an infrastructure) was achieved and cancer awareness activities continue. AANCART's overall infrastructure consists of a 15 member Steering Committee chaired by the Principal Investigator (Moon S. Chen, Jr., Ph.D., M.P.H.) Other members include Asian American public health leaders, directors of cross-cutting Network-wide programs, and Regional Principal Investigators. Directors of cross-cutting Network-wide programs are: Biostatistical (Melvin Moeschberger, Ph.D.), Clinical (Reginald Ho, M.D.), Community (Susan Shinagawa), and Research (Frederick Li, M.D., M.A.). The Biostatistics Program focuses on providing biostatistical expertise for AANCART-wide use; the Clinical Program has developed a Clinician's kit to guide clinicians treating Asian Americans on recommended clinical procedures for cancer screening; the Community Program has initiated a variety of outreach programs including a mini-grants program for relatively unreached Asian American populations; the Research Program has guided the preparation of fundable and funded pilot study grants. Finally, the national infrastructure has partnered with the San Francisco, Boston, and Seattle regions to offer ethnic-specific Asian American cancer control academies. These academies are typically two days long and offer programs that an in-depth focus on a particular Asian American ethnic group and a cancer of particular importance to that ethnic group. In 2001, the first AANCART Academy was held in Oakland, focused on Vietnamese Americans and Chinese Americans and their associated cancers of importance:

lung and liver cancers. AANCART's 2002 Academies focused on Korean Americans and diet-related cancers (Boston) and on Cambodian Americans and cervical cancer (Seattle).

Regional Principal Investigators direct the work in AANCART's regions in New York (Ruby Senie, Ph.D.), Seattle (Vicky Taylor, M.D., M.P.H.), San Francisco (Stephen McPhee, M.D.), and Los Angeles (Roshan Bastani, Ph.D.). Within each region, AANCART's Regional Principal Investigators have stimulated activities and capacity-building targeting Asian Americans in cancer awareness, research, and training. (The next issue of this Journal will include papers describing cancer awareness and education efforts in greater depth.)

For example, in New York, AANCART consists of two councils: (1) the New York AANCART Researchers' Council and (2) the New York Asian Council. These partnerships of mostly Korean and South Asian community groups have led to several educational campaigns regarding hepatitis B vaccination and screening and tobacco control among Asian American teens. One of the more creative activities of the New York AANCART team was the conduct of a survey among taxi drivers, many of who are South Asians.

In Seattle, AANCART has convened three separate community coalition groups: Pan-Asian, Cambodian, and Vietnamese. In so doing, they address both the needs of individual ethnic groups and those of the broader Asian American community in Seattle.

In San Francisco, AANCART meetings are regularly held to train young Asian Americans to analyze epidemiological and cultural factors in understanding cancer control challenges for specific Asian American ethnic groups. These meetings allow younger Asian Americans to identify approaches to address cancer awareness and control in distinct Asian American ethnic groups and benefit from the guidance provided by more senior investigators. AANCART collaborators at the San Francisco Medical Society Foundation meet quarterly for a Chinese Council advisory meeting. This Council has been involved in community outreach, e.g., Breast Cancer Awareness events within the Chinatown community, Hepatitis B awareness and screening among at-risk adolescents and adults, and dissemination of the AANCART Clinicians' Kit.

In Los Angeles, the AANCART offers team meets weekly to coordinate community-based cancer awareness activities and is the basis for encouraging university-community collaborations. They have five working groups: the Health Provider Working Group, the Colorectal Cancer Working Group, the South Asian Working Group, the Symposium Planning Committee and the Newsletter Committee. As part of the process to better understand the various communities, UCLA AANCART staff has continued to visit community-based organizations (CBOs) and has increased their CBO roster from eight to eleven.

By the end of 2001, Specific Aim #2 (establishing partnerships), was also being attained throughout AANCART's regions. Each AANCART region has established partnerships with multiple organizations, creating synergy. Two of the more non-traditional partnerships are exemplified through the relationships with the (1) Charles B. Wang Community Health Center; and (2) American Cancer Society National Home Office.

The partnership between The Ohio State University (National AANCART) and New York's Charles B. Wang Community Health Center (formerly known as "Chinatown Health Clinic") illustrated a reversal in roles. Initially the research partner, in this case, National AANCART was the lead institution. The Ohio State University secured a \$100,000 grant from the American Legacy Foundation for "Preparing the Ground War Against Tobacco Among Chinese Americans in New York" and sub-contracted 60% of the grant funds for this one-year grant to the Charles B. Wang Community Health Center. Prior to the end of the grant period, The Ohio State University provided sufficient technical assistance to the Charles B. Wang Community

Health Center such that they secured a three-year \$527,000 grant from the American Legacy Foundation to initiate the New York Chinese American Tobacco Initiative. As the lead institution, the Charles B. Wang Community Health Center then issued a \$25,000 subcontract per year to The Ohio State University for research expertise where the community based organization is clearly the lead institution. This is an example of role reversal for an academic institution, from being the “lead” to now being “led”.

Another example of a partnership is an emerging relationship between National AANCART and the American Cancer Society’s Asian American and Pacific Islander Initiative. AANCART and American Cancer Society representatives met in 2002 to share resources in cancer education materials for Asian Americans. One of the goals of this partnership is to collaborate in jointly identifying cancer education materials and make them available through electronic means. Both National AANCART and the American Cancer Society have equally contributed financially towards this goal.

Specific Aim #3 relates to formulating grant-funded research. AANCART’s Steering Committee members mentor junior investigators and foster technical guidance in improving pilot study applications. As a consequence, the number of AANCART-sponsored junior investigators who have secured \$50,000 one-year pilot study grants exceeds the overall Special Populations Networks norm. See Table 1.

Aspirations

To date, AANCART’s accomplishments have contributed to the attainment of its first two specific aims and hence qualified for the NCI’s designation for being in Phase II of their three-phase progression for Special Populations Networks. Quantitative accomplishments for the first two years of AANCART are listed on the AANCART website, www.aancart.org.

The most notable change beginning on July 1, 2002, was the transfer of the National AANCART headquarters from Columbus, Ohio(The Ohio State University) to Sacramento, California (The University of California, Davis). This transfer occurred because of the Principal Investigator’s move to the University of California, Davis and its Cancer Center in Sacramento. The major potential impacts of this move is two-fold: (1) Locating in a sizable, yet relatively unreached and heterogeneous Asian American community in the Sacramento Metro Area as well as having AANCART’s headquarters located at approximately the geographic center of AANCART’s regions with Hawaii as its farthest western region and New York as its farthest eastern region; (2) Joining with Dileep G. Bal, M.D., M.P.H., Chief, Cancer Control Branch for the California Department of Health Services, and his colleagues to offer cancer awareness, research, and training opportunities to Asian Americans in the Sacramento Metro Area and California’s Central Valley.

Along with the expansion of AANCART to Hawaii and to Houston, the proportion of the Asian American population in the U.S. has increased. More importantly, though, the heterogeneity of the Asian American population accessible to AANCART has been increased. See Table 2.

Interim Assessment of AANCART

Any interim assessment of AANCART would require an examination of what we proposed we would do in comparison to what we have accomplished. In this paper, we limited ourselves only to our first two specific aims, (1) building an infrastructure; and (2) establishing partnerships for our first two years (April 2000-March 2002). We believe we have accomplished those two specific aims. In this and the coming years, we need to continue building upon our infrastructure and cancer awareness activities and foster the growth of our partnerships. Furthermore, we believe that the three Cancer Control Academies that we have

sponsored, have been valuable contributions to packaging the knowledge gained, research findings, and lessons learned in terms of conducting cancer control studies within the context of specific Asian American cultures and with specific Asian American ethnic groups.

We are also focusing on our third specific aim, formulating grant-funded research. We sense a good beginning through the pilot studies funded through AANCART/NCI and especially the pilot study principal investigators whom we are training.

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Table 1

Funded Pilot Studies for first three rounds

Round	Pilot PI	Institution	Funded	Pilot Study Title
1	Ninez Ponce, Ph.D.	UCLA	9/24/01	Does Competition Equally Benefit Minority Groups
2	Grace Yoo, Ph.D. Jill Watanabe, M.D., M.P.H.	San Francisco State University University of Washington	10/01/02 10/01/02	Risk Factors, Cervical Cancer, & Young Asian Women End-of-Life Decision-Making in Southeast Asian Families
3	Angela Jo, M.D. Angela Sun, M.P.H. Shing-Ping Tu, M.D., M.P.H. Clifford Ko, M.D., M.S.H.S. Quyven Ngo-Metzger, M.D., M.P.H.	UCLA San Francisco Medical Society Foundation University of Washington UCLA Beth Israel Deaconess Medical Center	10/01/02 10/01/02 10/01/02 Approved for funding Approved for funding	Understanding Colorectal Cancer Screening among Korean Americans Quality of Life and Chinese Cancer Patients Computer-based Cancer Education among Chinese Americans Understanding Disparities in Colorectal Cancer Outcomes Hospice Use and Patterns of Care among Older Asian Americans

Table 2

Percentage Increases in Asian American populations served by AANCART Expansion to Hawaii, Houston, & Sacramento*

	Percentage of AA Ethnic Group AANCART Serve (exclude Houston, Hawaii & Sacramento-Yolo)	Percentage of AA Ethnic Group AANCART Serve (include Houston, Hawaii, & Sacramento-Yolo)
Asian Indian	19.48%	23.67%
Cambodian	27.07%	29.27%
Chinese	42.61%	48.51%
Filipino	25.71%	37.73%
Hmong	0.98%	10.59%
Japanese	25.13%	52.95%
Korean	31.26%	35.05%
Laotian	7.07%	14.76%
Thai	27.98%	31.39%
Vietnamese	14.40%	22.41%
Other Asian	25.51%	34.10%
Total Asian	27.36%	35.98%

* 2000 Census for Asian American Ethnic Groups in Cities AANCART Serve