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Introduction: Shining the Light on Asian American, Native Hawaiian, and Pacific Islander Health

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The United States' diverse Asian American and Native Hawaiian and Pacific Islander (AA and NHPI) populations have grown faster than those of any other racial/ ethnic group over the past three decades.* Out of the shadows and into the light, the health and health care issues faced by our AA and NHPI communities across the U.S., its territories, and freely associated states matter more and more to the vitality and future of the nation.

In 2015, we mark the 30th anniversary of the Heckler Report,⁴ the seminal Report of the Secretary's Task Force on Black and Minority Health documenting national health inequities by race and ethnicity, which led to the establishment of the Office of Minority Health by Congress in 1986.⁵ Notably, the report concluded that Asian/Pacific Islanders in aggregate were healthier than any other racial group in the U.S. In this supplement, Ponce and colleagues† retrace the story of the first national AA and NHPI data initiatives and key milestones for data equity that were established as a direct response to this report, and specifically to dispel the so-called model minority myth, to strengthen AA and NHPI voices, and to advance federal efforts to promote health issues facing AA and NHPI communities. Indeed, the Heckler Report spawned the creation of two of our communities' national institutions, the Asian & Pacific Islander American Health Forum (APIAHF) and the Association of Asian Pacific Community Health Organizations (AAPCHO).

Over the past 30 years, tremendous strides have been made in documenting and monitoring persistent and increasing health inequities disfavoring AAs and NHPs and the critical steps needed to address gaps in the evidence base to focus on unequal health by race, ethnicity, language, and other social determinants.^{6–11} Ko Chin and Caballero* present a community perspective on the leadership of Assistant Secretary for Health, Dr. Howard Koh, and his work in shepherding new national health equity initiatives, including the Patient Protection and Affordable Care Act of 2010, the reauthorization of the Office of Minority Health (OMH), the creation of the first national U.S. Department of Health and Human Services (HHS) Plan for Asian American, Native Hawaiian, and Pacific Islander Health,¹² and the new HHS data standards for race, ethnicity, sex, primary language, and disability status from Section 4302 of the Affordable Care Act (ACA).^{13,14} In addition, the National Standards for Culturally and Linguistically Appropriate Service in Health and Health Care were updated

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in 2013 to provide a comprehensive framework of health and health care organizations for the delivery of culturally respectful and linguistically responsive care and services to all.¹⁵ We honor the heroes and transformative ideas that have worked to advance AA and NHPI health equity.¹⁶

Asian American and NHPI advocates, researchers, and community leaders have also made tremendous strides in building local and regional community coalitions to document health disparities and advance health equity on behalf of our diverse communities over the past decades.^{17,18} In this supplement, Trinh-Shevrin and colleagues[†] present the critical need to shift the public health paradigm from a biomedical health framework to a population health equity framework in order to address the relevant health issues facing Asian Americans and other underserved communities of color. Other articles showcase innovative and creative stakeholder coalitions^{‡§¶} and community-academic partnerships^{**††} that are being implemented for disease prevention and health promotion in AA and NHPI communities across the continental U.S., Hawaii, and the Pacific Islands. The articles also document the critical roles of communities, environment, historical and political forces for advancing health equity. Health topic areas explored

- * Ko Chin K, Caballero J. Transforming and advancing health equity: Dr. Howard Kyongju Koh. (this issue)
- † Trinh-Shevrin C, Nadkarni S, Park R, et al. Defining an integrative approach for health promotion and disease prevention: population health equity framework. (this issue)
- ‡ Nitta M, Tanner C, Narvarte K, et al. Policy, system, and environmental strategies to promote physical activity and healthy food sources to address Guam's disparate non-communicable disease burden. (this issue)
- § Quach T, Tsoh J, Le G, et al. Identifying and understanding the role of key stakeholders in promoting worker health and safety in nail salons. (this issue)
- ¶ Kwon SC, Rideout C, Patel S, et al. Improving access to healthy foods for Asian Americans, Native Hawaiians, and Pacific Islanders: lessons learned from the STRIVE program. (this issue)
- ** Ma GX, Fang C, Tan Y, et al. Increasing cervical cancer screening among Vietnamese Americans: a community-based intervention trial. (this issue)
- †† Sabado P, Jo A, Kagawa-Singer M, et al. Community Collaborative for colorectal cancer screening in Los Angeles Koreatown. (this issue) in this supplement include childhood obesity,^{*†‡} diabetes and cardiovascular disease,^{§¶} cancer, and mental health.^{**}

The community-based studies and interventions in this issue underscore the critical need to adapt evidence-based strategies to the community where they are adopted to fit the sociocultural context of AAs and NHPs. They also highlight the value of sub- population research. Community-based studies or interventions focused on AA and NHPI ethnic subgroups—such as the colorectal cancer screening intervention in Korean Americans living in Los Angeles presented by Sabado and colleagues or the cervical cancer screening

intervention in Vietnamese Americans by Ma and colleagues—are necessary to identify relevant and meaningful strategies to achieve health equity. A one-size-fits-all approach may not be appropriate for AAs and NHPs according to Kwon and colleagues, who also argue that improving health and achieving health equity for AAs and NHPs requires community initiative and engagement.

The three articles by Fialkowski, Lu, Paulino and colleagues explore the issue of childhood obesity in AAs and NHPs, underscoring the widespread concern about the emerging issue of childhood obesity across our nation. Wyatt and colleagues take a close look at the literature on youth depression and suicide in AA and NHP communities. As a nation, we care deeply about its children's health and how that affects the country's future. Yet, very little is understood about the health issues facing AA and NHP children and youth.¹⁹

Authors across the articles by Huang, Islam,^{††} Lu, Sentell, Trinh-Shevrin, and Wyatt note similar limitations in their work (including the lack of disaggregated ethnic subgroup-specific data). Hagiwara, Trinh-Shevrin, Wyatt, and colleagues allude to the often indirect, invisible roles of structural racism and the persistent model minority myth on AAs and NHPs. Huang and colleagues document the increased risk of diabetes by generational status in the U.S., and the need to understand our research better and expand its reach to elucidate the roles of acculturation, acculturative stress, and generational status on health and health outcomes.*Paulino YC, Leon Guerrero RT, Uncangco AA, et al. Overweight and obesity prevalence among public school children in Guam. (this issue) †Fialkowski MK, Hattori-Uchima M, Leslie JH, et al. Children's Healthy Living program (CHL) indigenous workforce training to prevent childhood obesity in the underserved U.S. affiliated Pacific region. (this issue) ‡Lu W, Diep CS, McKyer ELJ. Risk factors for childhood obesity among Asian Americans: a systematic review of literature and recommendations for health care research. (this issue) §Huang ZJ, Zheng CY. Type 2 diabetes among 6 Asian ethnic groups in California: the nexus of ethnicity, gender, and generational status. (this issue) ¶Sentell TL, Ahn HJ, Miyamura J, Juarez DT. Cost burden of potentially preventable hospitalizations for cardiovascular disease and diabetes for Asian Americans, Pacific Islanders, and Whites in Hawai'i. (this issue) **Wyatt LC, Ung T, Park R, Kwon SC, Trinh-Shevrin C. Risk factors of suicide and depression among Asian American, Native Hawaiian, and Pacific Islander youth: a systematic literature review. (this issue) ††Islam NS, Zanowiak JM, Riley L, Nadkarni SK, Kwon SC, Trinh-Shevrin C. Characteristics of Asian American, Native Hawaiian, and Pacific Islander community health worker programs: a systematic review. (this issue)

This supplement also contributes to the evidence base for Native Hawaiian and Pacific Islander health. Hagiwara and colleagues shine light on the neglect of health care coverage for Micronesians and other Compact of Free Association (COFA) migrants due to U.S. policies. Sentell and colleagues highlight the disproportionate cost burden of diabetes and cardiovascular disease for Native Hawaiians in Hawaii. Paulino and colleagues highlight the persistent childhood obesity for children in the public schools of Guam. The articles by Nitta, Kwon, and colleagues highlight efforts to promote physical activity and healthy foods for Pacific Islanders through worksite wellness and community gardens in Guam. One of the key goals of the HHS Plan for Asian American, Native Hawaiian and Pacific Islander

Health¹² is to focus on addressing NHPI health conditions and health care services. This work ahead of us must start with recognizing the effects of structural racism, federal policies, and U.S. occupation on NHPI health, if it is to address racial justice and restore the agency and civil rights of NHPI indigenous communities across Hawaii, the Pacific Islands, and the continental U.S.^{19–22}

The health equity goals of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, National Stakeholder Strategy for Achieving Health Equity and Healthy People 2020 offer an opportunity for strengthening public-private partnerships between government and communities to document further the structural health inequities disfavoring AA and NHPI populations.^{23,24} The new HHS data standards that examine granular ethnicity and primary languages,¹³ as they are implemented across national surveys (e.g., National Health and Nutrition Examination Survey, National Health Interview Survey, Behavioral Risk Factors Surveillance System, Youth Risk Behavioral Surveillance System) and administrative health data systems (e.g., Medicare, Medicaid, Medical Expenditure Panel Survey, Physician Quality Reporting Initiative, and Uniform Data System) and reported through Healthy People 2020 and other public health dissemination venues, will allow us to track and monitor many key health issues facing AA and NHPI populations for the first time at a national level.

The National Stakeholder Strategy for Achieving Health Equity defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”²⁴[page 9] The definition of disparities by HHS and the Healthy People program has changed over time; initially the term disparities was understood as denoting disparities by race and ethnicity and focused on health behaviors and conditions. The conception of disparities in Healthy People 2020 is much broader today and includes health disparities by race and ethnicity, gender, sexual orientation, disability status, and geography as well as an examination of other determinants of health, in addition to the health behaviors and conditions.

Current evidence indicates that national AA and NHPI health data collection and reporting still lags far behind all the other racial groups to adequately define the health concerns of these populations.^{8,25} In 2003, Ghosh⁸ defined a baseline for AA and NHPI health and summarized that only 0.2% of all federal health-related grants in the National Library of Medicine’s CRISP database from 1986–2000 and 0.01% of studies on MEDLINE from 1966–2000 referenced AAs or PIs.

Nationally, it would be valuable to define a new baseline, marking how much progress we have made in building the evidence base about AA and NHPI health by health conditions and behaviors as well as by social determinants of health. It is also important to track and monitor disparities initiatives in the Healthy People program from when they were first initiated in 1990 to present to determine the progress made towards health equity for AA and NHPI populations. Furthermore, it would be invaluable to assess the impact of the ongoing implementation of the Affordable Care Act (ACA) and associated new national data

standards for health equity as they relate to health and health care for AA and NHPI populations.

At the same time, local and state initiatives to strengthen the community infrastructure for health equity are critical to the efforts of the national health equity initiatives from the ACA and Healthy People 2020. The network of local and state AA and NHPI health coalitions such as Advancing Health Justice²⁶ that reach AA and NHPI communities across 22 states are vital to the efforts to reach out to and mobilize AA and NHPI communities for health promotion, access and quality care, and building healthy communities. These local and state community coalitions can facilitate and ensure success of local and state government health equity initiatives in AA and NHPI communities. New directions in local and state efforts for advancing health equity in emerging and new gateway communities for AAs and NHPIs are also vital to ensure no one is left behind.

Looking to the future, as we strive to become the healthiest nation in one generation,²⁷ we should also reflect on our nation's indigenous and immigrant roots from the Asia- Pacific region,^{20,28–30} as we continue work in the U.S. to design and cultivate pathways to ensure health equity for all.¹⁸ There is much work to be done. With the total U.S. population of AAs and NHPIs projected to more than double from 2015 (22 million) to 2060 (51 million),³¹ we must redouble our efforts to build and sustain healthy infrastructures for longstanding and gateway AA and NHPI communities in the years and decades ahead. The road ahead for the U.S. to become the healthiest nation may be daunting as researchers, community workers, and clinicians continue to uncover and serve rapidly growing numbers of people who may be hard to count and hard to reach, now and in the generations ahead of us. However, continuing determination and courage to surmount every challenge, such as has been demonstrated over the past 30 years and as is reflected in the pages of the present volume, will allow us to move mountains.

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