"Health Equity for Asian American, Native Hawaiian, and Pacific Islander Children and Youth: What's Racism Got to Do With It?,"

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- Since entering high school, Kekoa, a 16-year-old obese Native Hawaiian male with type 2 diabetes, has become depressed and taken up cigarette smoking and drinking on a daily basis.
- In 2007, Seung-Hui Cho, a 23-year-old Korean American college student with mental illness, killed 32 people and wounded many more, before committing suicide.

These are two individual examples of health inequities that threaten the well-being of Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) children and youth. In this commentary, we highlight these health inequities and pose the question: "What's racism got to do with it?" We begin by presenting data on health inequities and briefly discuss existing investigation and theory. We then explore, through the stories of Kekoa and Seung-Hui, how the health of children and youth of AA and NHPI communities is shaped by pervasive racism in our society. While focusing on the fundamental problems that contribute to health inequities among AA and NHPI children and youth, we also discuss the supportive role that family, community and culture can play in fostering their health and well-being.

Disaggregating AA and NHPI

NHPI and AA communities have distinct histories, cultures, experiences and health challenges. The arbitrary grouping together of NHPI and AA for data collection and funding purposes creates barriers to understanding and addressing their health issues. Within both the NHPI and AA categories, there are numerous communities whose acculturation experiences, socioeconomic status and health issues are very different. Therefore, when possible, we will make distinctions between different ethnic groups that fall under these broader classifications and respect each group's cultural and classification preferences.

Recognizing Health Inequities

Before we can address AA and NHPI health inequities, they must be acknowledged. Over the past few decades, AA and NHPI advocates and researchers have increased visibility for health inequities that impact their communities. NHPI communities have worked to have their health issues become visible and recognized as distinct from those impacting AAs. AA communities have worked to dispel the myth of the model minority and, with the use of disaggregated data, have demonstrated that not all AAs are healthy, particularly recent immigrant and low-income AAs. (Native Hawaiians and other Pacific Islanders are people whose origins are from three main groups of Islands in the Pacific: Polynesia, Micronesia and Melanesia. Native Hawaiians are the largest group of Pacific Islanders in the U.S. Other major Pacific Islander groups in the U.S. include Samoans, Guamanians (Chamorro) and other Micronesian Groups (Federated State of Micronesia, Republic of the Marshall Islands and Republic of Palau). Asian Americans are persons with ancestry from Asian countries and islands in the Pacific Rim who live in the United States. The largest Asian-American populations are Chinese, Filipino, Asian Indian, Vietnamese, Korean and Japanese, each of which number over 1 million. Cambodian, Laotian, Pakistani and Hmong number over 200,000 each.) Although much of the data is focused on adults, there is recently a growing body of evidence that health inequities do indeed exist for AA and NHPI children and youth. Here are some examples:

Native Hawaiian and Pacific Islander Children and Youth

- From 2003-2005, NHPI mothers in California and Hawaii had higher rates of low birth weight and pre-term birth than Whites (4.1% LBW and 7.5% pre-term birth), with rates for Marshallese mothers among the highest: low birth weight 8.4% and pre-term birth 18.8%.
- 54% of Samoan children (5th graders) in California followed by "Other" Pacific Islander (42%), Guamanian (35%), Native Hawaiian (35%) and Tahitian (34%) children are not within the Healthy Fitness Zone according to their body mass index, compared to the state average (32%) and Whites (23%).
- Native Hawaiian youth are also more likely to be obese and smoke cigarettes. compared to youth of other ethnic groups.
- 30% of NHPI adolescents (ages 12-17) in California were diagnosed with asthma in 2003-2005, compared with the state average (20%).

Asian-American Children and Youth

- From 2003-2005, Cambodian and Laotian mothers in California and Hawaii had higher rates of both low birth weight (8.8% and 9.2%, respectively) and pre-term birth (14.0% and 13.7%, respectively), compared to Whites (4.1% LBW and 7.5% pre-term birth).
- 28% of South Asian adolescents (ages 12-17) in California were diagnosed with asthma in 2003-2005. compared with the state average (20%).
- 30% of Filipino and 29% of Laotian children (5th graders) in California are not within the Healthy Fitness Zone according to their body mass index, compared to Whites (23%).
- 36% of sexually active Chinese adolescents or their partner in California, followed by Filipino (49%), Korean (50%) and South Asian (51%) adolescents or their partner, used any type of birth control the last time they had sex, compared to the state average (72%) and Whites (79%).

In order to address these health inequities, there is a need to understand the broader social framework that shapes children's lives and health. Some researchers have articulated that racial constructions, exposures to racism, and other environmental and psychosocial stressors interact with biological systems to increase health risks and problems among adults.

We next discuss existing frameworks that explore the impact of racism on children's health. There have been few studies investigating the role of racism in children's health, including a few focused on racism and mental health among AA adolescents. Huge gaps exist in research on racism and children's health for both AA and NHPI communities. There is a dire need for more work on this topic in order to document community assets and needs, and develop effective intervention strategies and policies.

Theoretical Framework

To conceptualize the role of racism in child health, K. Sanders-Phillips and colleagues propose a general framework that draws from different theoretical models. From ecological theory, they discuss the role of a child's immediate environment (microsystem) and larger social environment (macrosystem). They suggest that institutional racism at the macrosystem level, such as educational and housing policies that put a particular racial/ethnic group at a disadvantage, can impact variables at the microsystem, such as family functioning and neighborhood health conditions that increase behavioral and biological health risks for children of color. From social stratification theory, they suggest that a group's historical and current place in the social hierarchy can impact experiences and exposure to risk factors. From theories of racial inequality and social integration, they posit that racial discrimination has an impact on individuals' judgments, decisions and behaviors. There are multiple resulting consequences for children and their parents, which ultimately lead to inequities in biological, behavioral and social functioning. Protective factors mentioned in the model include racial awareness, racial socialization and certain parenting styles that protect against the negative impact of discrimination.

Table 1. Model of Racial Discrimination and Child Health

Exposure to racial discrimination Microsystem (individual and immediate environment) Examples: experiences of racial discrimination, bullying Macrosystem (structural level) Examples: educational practices, negative images in media	Psychological and biological responses Psychological distress Changes in allostatic load	Child health outcomes and disparities Increased risk of: Low birth weight, premature birth Alcohol and other substance use and abuse Violent behaviors Chronic stress-related illnesses (diabetes, cardiovascular disease, hypertension and others) Susceptibility to infectious disease

In the Sanders-Phillips model (Table 1), exposure to racial discrimination at both the microsystem and macrosystem levels creates psychological responses, such as decreased self-efficacy and depression, and biological responses through changes in chronic stress and allostatic load, which in turn may produce decreased immune function and higher, or paradoxically blunted, cortisol levels. This, in turn, results in disparities or inequities in child health outcomes. A simplified version of Sanders-Phillips model is shown on the previous page.

In the section that follows, we explore two case examples of health inequities among NHPI and AA youth using Sanders-Phillips' framework as a point of reference.

Case Studies

The stories of Kekoa and Seung-Hui give us a window into how racism interacts with other social and cultural factors to impact the health of some AA and NHPI children and youth. These two examples do not represent the full spectrum of the AA or NHPI experience. However, they do bear witness to health issues and social dynamics that we cannot afford to ignore.

Kekoa's Story

Kekoa, a 16-year-old Native Hawaiian male, lives in a Hawaiian homestead community with his parents and three siblings and attends a nearby public high school in urban Honolulu.

Exposure to Racial Discrimination. Racism and colonialism are difficult to disentangle in the Pacific, as racism can be considered the ideology that has informed and justified the contagion of colonialism across the Pacific. Kekoa's story illustrates how present-day colonialism continues to structure the distribution of power, resources and money largely along racial and ethnic lines. His ancestors were dispossessed of their land and resources and became second-class citizens in Hawaii's ethnic/racial hierarchy—a social ranking that continues today. The Hawaiian homestead he and his family reside in is the result of a settlement to return Native Hawaiians back to their lands after the occupation of Hawaii by the U.S. However, many Hawaiian homesteads are among the most impoverished and obesiogenic neighborhoods in Hawai'i.

Kekoa often hears his parents' wish for Native Hawaiians to regain political autonomy from the U.S. so they can improve their quality of life. He also learns from his parents of how the U.S. illegally took over Hawai'i and made Native Hawaiians second-class citizens in their own homeland. Most neighbors in his homestead community share similar thoughts and frustrations and struggle to make ends meet. Ironically, most or all of this communication occurs not in the Hawaiian language, but in English, a further result of colonization.

Kekoa's family has an annual household income of $35,000, which is barely enough to pay the bills and provide for the four children, in a state with one of the highest costs of living. He experiences the frustration and sense of helplessness of his parents in trying to make ends meet. Because of their economic hardship and resulting stressors, his father often turns to alcohol to deal with the stress and frustration. After drinking, his father sometimes physically abuses his mother.

Kekoa's social environment at home and in his homestead community, where a majority is Native Hawaiian, is in sharp contrast to his school environment. Although a large number of students are Native Hawaiian and other Pacific Islanders (35%), the faculty of the school is predominantly of Asian descent (50%), with only a small minority (8%) being Native Hawaiian and other Pacific Islander. At school, Kekoa does not feel comfortable or accepted by his teachers and peers, who are of other ethnic groups. He prefers hanging out with other Native Hawaiian students whom he can better relate to. As a result of these and other factors, the public school system in Hawai'i has been accused of inadvertently maintaining the poor social and economic condition of Native Hawaiians and other Pacific Islanders.

Psychological and Biological Response. Since entering high school, Kekoa has become depressed. He does not feel valued as a Native Hawaiian and believes society does not have much to offer him in the way of a bright future. When asked what is going on with him, he just responds by saying, "I Hawaiian so no moa [more] much for me. No make sense. I not going college so no need get good grades. Mo bettah I get one job and help my 'ohana [family]." Although Kekoa has always been overweight, he has gained a significant amount of excess weight since starting high school and is now obese, which has markedly decreased his physical functioning.

Resulting Health Inequities. Kekoa has taken up cigarette smoking and drinking on a daily basis, his grades have dropped, and he is frequently absent from school. He was recently diagnosed with type 2 diabetes. However, his retinal exam showed early signs of eye disease, suggesting that he has had diabetes for some time. Coupled with his smoking and drinking, he is at risk for other diabetes-related complications, such as cardiovascular and kidney disease.

For NHPI children in the U.S., racism has both direct and indirect effects, experienced both in immediate health outcomes and through shaping the social determinants of health. Many believe the compulsory acculturation process due to U.S. occupation of Hawaii has had direct adverse effects on the health of Native Hawaiians through increased chronic stress, allostatic load, historical/cultural trauma, and impoverished, damaged environments. These effects may be directly implicated in the higher suicide attempt rates for Native Hawaiian youth, compared to youth of other ethnic groups in Hawai'i (12.9% vs. 9.6%).

Eliminating Health Inequities. The resilience and fortitude of Native Hawaiians have allowed them to withstand many adversities and remain steadfast in their cultural beliefs, practices and aspirations. These cultural practices and beliefs are being revived to uplift Native Hawaiian youth and their families. For example, Hawaiian language immersion schools and cultural-based public charter schools in Hawai'i (open to students of all races and ethnicities) are building a stronger Hawaiian identity and providing the educational milieu necessary to improve the social and self-image of Native Hawaiian youth. Many substance abuse interventions involve reconnecting Native Hawaiian youth to land- and sea-based activities, such as Kalo farming, aquaculture and canoeing, as the venue for building the personal, cultural and social assets and supports needed to overcome their addiction. Cultural-based programs such as these offer the promise of addressing the social determinants of Native Hawaiian health inequities. On a larger scale, there are a multitude of Native Hawaiian efforts to increase self-governance.

Ultimately, addressing the effects of racism and U.S. occupation on Native Hawaiian children requires deconstructing the genealogy of the "sick" islander child, whether from attention deficit disorder, anxiety, depression, obesity or diabetes. The deconstruction of the "sick" child can provide a historical context to shift the discourse away from one of "blame the victim" to one of restoring the agency of resistance, persistence and reclamation among NHPI children and families.

Seung-Hui's Story

On April 16, 2007, Seung-Hui Cho, a 23-year-old Korean college senior, killed 32 people and wounded many others in what has been known as the "Virginia Tech massacre" before committing suicide. The national coverage labeled Seung-Hui as primarily responsible for his rampage and for not seeking help sooner. Blame

was placed on this mentally ill Korean immigrant student instead of examining and addressing the root causes and solutions to youth violence among our growing diverse populations.

Exposure to Racial Discrimination. A closer examination of the Seung-Hui Cho's personal history and mental health trajectory suggests that the chain of events leading to the shooting rampage and suicide started in childhood. Racism, closely connected with xenophobia, played a large part in his immigrant experiences, which included social alienation, generational and cultural gaps, bullying and inadequate services. Seung-Hui came to the U.S. from Korea when he was 8 years old. His father worked as a presser at a dry cleaner to help pay for his children's education. Seung-Hui was labeled as a shy boy with an accent who did not speak much. His classmates in junior high and high school made fun of him and occasionally called out to him "go back to China." He was also bullied by affluent Korean youth through Korean church groups. At home, he was shy and not talkative, and often misunderstood by his immigrant parents due to their traditional Korean expectations of his American academic and social life.

Psychological Response. Lack of adequate, culturally competent mental health services also played a role in the chain of events. In 8th grade, he was diagnosed with selective-mutism, a symptom of schizophrenia. He often refused or avoided taking medication when it was prescribed. Throughout his youth, his family sought help for him through Korean churches, but avoided mental health services. In college, he was labeled "question-mark kid" by classmates. Seung-Hui's mental condition progressively worsened over the years, without adequate care or support, and led to increasing social alienation and humiliation at school and at home. He underwent basic psychiatric assessments in college, but continued to fall through the cracks of the school and mental health systems. His mental health condition was not fully diagnosed before he committed suicide.

Resulting Health Inequities. Although the level of violence and tragedy in Seung-Hui's case is unprecedented, it would be a mistake to view his mental illness as an isolated case. The lack of awareness and understanding by family members, schools and health care providers about the experiences of Seung-Hui and other Korean and Asian immigrant youth with mild and severe mental health challenges pose major barriers to ensuring the provision of needed support and care.

The leading causes of death among Asian-American youth are unintentional injuries, suicide and homicide, but little is known about their root causes in Asian communities, such as the potential roles of racism and youth violence, and the impact of violent death at an early age on the neighborhood, behavioral and mental health of Asian families, and communities across America.

Eliminating Health Inequities. Seung-Hui's story points to the importance of ensuring that Asian immigrant youth with mild and severe mental health conditions are fully supported at home, school, in the communities and by service providers. In Korean communities, for example, school teachers and service providers need to ensure they are culturally sensitive and engage family members, friends and churches who play central roles to care for Korean youth in everyday life. Reducing racism and youth violence across Asian American communities also requires more data and research, prevention programs, community engagement and advocacy.

Currently, few or no data exist about racism, youth violence and mental health among Asian-American children and youth. More data are needed to identify the causes of these issues, their interconnections, and to develop strategies for prevention. Data collection should be culturally appropriate and ensure disaggregation of Asian ethnic subgroups.

Prevention strategies must be aimed at addressing root causes, such as racial discrimination and the culture of violence in American schools and communities, while also building on community and cultural strengths, educating Asian immigrant youth and their parents to access and navigate American social and mental health services in their neighborhoods and schools, and fostering youth resilience.

Asian-American youth programs that build a sense of belonging and self-esteem can facilitate the prevention of violence, reduce risk factors and strengthen protective factors in the community. Such youth programs can mobilize families and communities, conduct research projects, implement prevention programs and lead advocacy efforts. In addition, cultural competency training is critical for all service providers and should include respect and understanding about Asian mental health beliefs and practices, particularly about "face"; the importance of culturally appropriate mental health services to ensure accurate diagnosis and treatment; the importance of ensuring family member involvement in all aspects of mental healthcare; and the provision of social support and health education for family caregivers.

Finally, partnerships of broad community collaborations across Asian youth, family members, schools, mental health providers, advocates and law enforcement in undoing racism and strengthening youth violence prevention initiatives, and working together in caring and advocating for Asian youth with behavioral and mental health conditions across our nation are more critical than ever in preventing youth violence and building healthy families and safe communities for Asian youth.

Conclusion

AA and NHPI children and youth are impacted by a wide spectrum of interconnected social and health inequities, including those that seriously threaten their quality of life and life itself. Understanding and addressing these inequities requires that we look beyond the surface and confront difficult social issues that are embedded in history and current realities. We need to disaggregate our data and ethnic community experiences to seek a richer understanding of the cultural contexts and gaps facing different ethnic communities.

There is an urgent need for further exploration of social, physical and mental health inequities. The theoretical model proposed by Sanders-Phillips and her colleagues shows promise as a framework for understanding

and addressing the role of racism. Further work to build an evidence base will be needed to confirm the relevance of this framework among AA and NHPI communities. While empirical studies may help us understand the direct role of racism as a determinant of health, it is crucial that we also examine the indirect, invisible role racism plays in shaping other social determinants. In this regard, it is essential to place our efforts in historical context and explore the role that racism has played in colonial devastation and displacement of indigenous people as well as xenophobia and anti-immigrant discrimination, and their effects in shaping contemporary institutions and policies. This exploration can be effective only if we deconstruct narratives of victim-blaming and "sick" children, and work to restore agency in resisting oppression and building community health.

In this context, it is essential to acknowledge the role that family, culture and community can play in fostering health equity in developing strategies at the microsystem and macrosystem levels. There are rich opportunities to learn from existing cultural and community-based programs to discover and build upon promising practices.

Resources

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