Health of Asians and Pacific Islanders in New York City

NYC Health

Letter From the Commissioner

Dear Fellow New Yorker,

We are excited to present "Health of Asians and Pacific Islanders in New York City," the first comprehensive report from the New York City Department of Health and Mental Hygiene (NYC Health Department) about the health of Asians and Pacific Islanders (APIs) living in our city.

NYC is home to over one million APIs, representing 14% of the city's 8.5 million people. I am proud to be one of them. As the son of Indian immigrants to the United States, I was always acutely aware of the links between health and opportunity; from being hospitalized with asthma attacks when I was a child to watching my father and other family members face the ongoing challenges of diabetes, I was inspired to become the first doctor in my family in part to help immigrants and people of color from all walks of life receive the care they deserve, often in the face of inequity leading to illness. And as NYC's first API Commissioner of Health, I have the privilege to serve these populations on a wider scale, focusing on the disease prevention and community well-being that are at the heart of public health.

But for all the belated attention now being paid to racial inequity in public health, APIs in NYC remain understudied and misrepresented, despite being among the city's fastest-growing populations. Often described as a single group, APIs in NYC, as elsewhere, are diverse, representing more than 48 unique countries and speaking various languages and dialects.

The social, political and economic histories of API countries influence the different health outcomes of API New Yorkers. This report highlights differences in demographic characteristics, health behaviors, and health status among the largest API ancestry groups in NYC and provides comparisons with the overall API population and NYC population, based on best sources of available public health data. Some key results:

- As a single group, APIs in NYC have a lower prevalence of obesity, higher rates of fruit and vegetable consumption, and a higher likelihood of getting the flu vaccination compared with the overall NYC population.
- Rates of colon cancer screening, HIV testing and preventive dental cleaning fall below the NYC average.
- Nearly one in four API men smokes cigarettes.
- The rate of self-reported postpartum depression among API pregnant people is higher than the overall NYC population.

Our results also reveal differences in outcomes among different API ancestry groups that are not apparent when considering APIs as a single group.

- The prevalence of high blood pressure ranges from 15% among those of Korean ancestry to 31% among those of Indian ancestry.
- Sugary drink consumption rates among API ancestry groups vary from 7% among East Asian adults to 28% among Native Hawaiian and Pacific Islander adults.
- Among Asian ancestry groups, a greater proportion of Indian adults report needing medical care but not getting it compared with Chinese adults.

Numerous public health challenges exist for reaching and engaging API populations, including language inaccessibility in our health systems that delay and prevent access to care, culturally inappropriate assessment and diagnostic criteria between the service system and people served, and trauma associated with immigration status. In addition, more granular-level data need to be collected on ancestry, country of origin and language group to better understand the gaps within the API community.

More recently, the 2020 global outbreak of COVID-19, the disease caused by a novel coronavirus first identified in China, has further exacerbated the racial inequities and trauma of NYC's API populations. This, coupled with a history of systemic discrimination toward APIs in the United States, has heightened xenophobic sentiment and led to an increase in racist attacks and violent crimes aimed at people of API descent. The consequences of these inequities must be accounted for as we implement health-focused strategies and services for API New Yorkers.

We hope that this report enriches understanding of the health of NYC's API communities and identifies its gaps, so that we can more productively work with policymakers, communities and community-based organizations to explore promising practices and improve strategies and services that better address health priorities for API New Yorkers.

Dave A. Chokshi, MD, MSc
Commissioner, NYC Health Department

About This Report

This report focuses on the social determinants of health (the conditions in places where people live, learn, work and play), well-being and health outcomes of APIs living in NYC. To determine the best measures to represent the health of the API population, the NYC Health Department collaborated with a group of 21 partners who bring the expertise of health and service providers, academics and community-based organizers who know what information is needed to empower the API communities they serve.

Using data from more than 20 sources, APIs were identified by race, ethnicity and ancestry fields. Definitions of API race and ancestry groups may vary for each data source. Where possible, mixed-race and mixed-ethnicity APIs were included. Because each health measure is shown among as many API ancestries as possible, the API ancestry group breakdowns will vary depending on the data source. When ancestry-level data were not available, data are shown only among APIs overall. Online supplemental tables provide additional statistical comparisons by major race and ethnicity groups, household poverty levels among APIs, nativity [United States-born (U.S.-born) and non-U.S.-born] among APIs, and years lived in the U.S. [less than (<) 10 and greater than or equal to (≥) 10 years] among APIs born outside of the U.S. These tables contain technical notes for further details.

Additional health topics that did not have adequate population-based data were identified and included to provide a fuller picture of the health of the API community. These special sections may reference data from non-population-based studies or data from outside the NYC Health Department.

Contents

Introduction

New Yorkers of API ancestry come from many different linguistic, religious, cultural and economic backgrounds.

Some, for example, can trace their lineage to the expansion of Spain's Pacific Empire or the rise of the British Empire from the 16th to 19th centuries, both of which led Asian sailors, enslaved people and indentured servants to disperse across the globe, including to the U.S. The U.S. colonial and military engagements in the Philippines, Japan, Korea and Southeast Asia in the 20th century also brought Asians to the U.S. as colonial subjects, military brides, adoptees and refugees. While relocation to the U.S. may not have been a choice for many Asians, many others were drawn to the opportunities and sought a better life for themselves and their families in the U.S.

Before World War II, Chinese and Japanese families were the largest Asian American communities in the U.S., although Indians, Koreans and Filipinos also arrived in significant numbers. Nearing the end of the 19th century, Hawaiians were granted U.S. citizenship, amid decades of U.S. exploitation in the Pacific archipelago, and Hawaii became a U.S. state in 1959.[1] The Hart-Celler Immigration and Nationality Act of 1965 allowed for increased immigration to the U.S. for API populations from a number of countries and regions, including India, Pakistan, Bangladesh, Hong Kong, Taiwan and Pacific Island nations, as well as the entry of refugees from Vietnam, Cambodia, Laos and Tibet. Today, some South Asian diasporas in NYC, such as Bangladeshi and Pakistani, represent the largest communities in the U.S.

There is no single, defining API New York community, story or perspective.

Too often, the phrase "Asian American community" refers to East Asian ethnicities exclusively, and this can be harmful to the health and well-being of other API ancestry groups who are underrepresented as a result. Despite the "model minority" myth that suggests all APIs experience unprecedented health, economic and academic success, there are stark health and socioeconomic inequities across all API ancestry groups. Ultimately, this prevents APIs from being considered a racial or ethnic minority deserving of resources at societal, governmental and individual levels. Not only does the "model minority" myth erase the vastly different experiences of API communities, but it is also weaponized against Black and Indigenous communities, undercutting the struggle for racial equity.[2] Most recently, the COVID-19 public health emergency is raising awareness about the need for data among more ancestry groups to further combat the preexisting social and health disparities that API, Black, Latino and Indigenous communities face.

Historically, selective immigration policies favoring skilled, professional workers such as the Hart-Celler Act have produced harmful, implicit biases (automatic, unconscious associations of stereotypes or attitudes toward particular groups) about the perceived health of API New Yorkers and have made the unique health needs of API communities seem less significant or complex than they really are. This misconception has affected the lives of many API New Yorkers, concealing the hardships and failing to address health needs faced by many API communities. Recognizing and dispelling the notion of APIs as a "model minority" is a crucial step to eliminating racial and ethnic health disparities (differences in health outcomes). Without accurate data to guide decision-making, we cannot hope to serve the many, varied communities represented by API New Yorkers.

Better representation through the collection, analysis and reporting of data has been at the foundation of advocating for the API community. Having granular ancestry group data about API New Yorkers is a first step toward creating visibility for API communities that are frequently underrepresented, allowing for the development of evidence-based policies and interventions to make health services and resources available at the local level.

Over 200 Years of Immigration and Inequity, and the Impact on Health for Asians and Pacific Islanders

Throughout history, exclusionary immigration policies, racial discrimination and unaddressed health disparities have played roles in shaping API communities in NYC and the U.S. Understanding this history gives us insight into how the many levels of racism built into our systems and structures continues to affect the health and well-being of the API community today as reflected in the data we present in this report.

1587 The first Asians known to arrive in North America after European colonization were a group of Filipinos known as "Luzonians" serving as part of the crew aboard a galleon ship built in Manila docking in Morro Bay, California.

1834 Afong Moy, the first recognized female Chinese immigrant to the U.S., arrived in New York Harbor and was put on display as "The Chinese Lady" as part of an exhibit.

1875 The Page Act prohibited entry of undesirable immigrants, specifically Chinese women in fear that they would become sex workers and transmit diseases to their White clientele.

1876 Smallpox hit San Francisco, and health officials blamed Chinatown for its spread because the location was considered less hygienic due to inadequate city structures.

1860 1870 1880 1890 1900 1910 1920 1930 1940 1950 1960 1970 1980 1990 2000 2010 2020

1882 The Chinese Exclusion Act barred Chinese nationals from U.S. citizenship and immigration, representing one of the first citizenship laws to discriminate against one nationality, and it was renewed every decade until 1943.

1921 In the U.S. vs. Bhagat Singh Thind case of 1923, the Supreme Court ruled that Indians were ineligible for naturalized citizenship because they are not considered White. The Luce-Celler Act later reversed the Thind decision. Thind is considered a pioneer in expanding naturalization for immigrants in the U.S.

1900 to 1904 Rats transmitted bubonic plague from ships to Chinatowns in both the mainland and Hawaii. Honolulu's Chinatown was burned down by U.S. military troops. California's Governor Henry Gage denied the existence of an epidemic for fear of economic damage, but he eventually placed San Francisco's Chinatown under quarantine.

1924 The Immigration Act of 1924 limited immigration through a national origins quota, specifically preventing immigration from Asia.

1942 Considered one of the most atrocious violations of civil rights in American history, President Franklin D. Roosevelt declared Executive Order 9066, which established Japanese internment camps, relocating over 120,000 Japanese Americans who were deemed threats to national security.

1971 Charles B. Wang Community Health Center was constructed to ensure that NYC's Asian American population faces no language, financial or discriminatory barriers to receiving health care.

1974 Asian Americans for Equality (AAFE), a grassroots movement, was created in NYC's Chinatown in response to unequal rights and access to City services.

1982 The murder of Vincent Chin was a hate crime that served as a turning point for Asian American civil rights engagement. Chin was attacked by two White men who blamed him for the success of Japan's auto industry that took away their jobs. Both men served no jail time despite pleading guilty to manslaughter.

1990 to 2000 The South Asian population in the U.S. dramatically increased. By 2000, the Bangladeshi population quadrupled in NYC and became the fastest-growing Asian ancestry group in the U.S.

2002 to 2004 The SARS outbreak occurred, which was initially identified in China. Although a relatively rare disease (27 U.S. cases), it still led to anti-Asian racism that affected Asian American businesses and communities.

2003 New York University established the Center for the Study of Asian American Health with funding from the National Institutes of Health, which remains the only U.S. center that is solely dedicated to research and evaluation on Asian American health disparities.

2018 Public Charge threatens to deport many Asian refugees and immigrants whom the government deem a "liability." Organizations such as One Nation AAPI formed to fight Public Charge and strengthen the collective API voice.

1965 The Hart-Celler Act established a new immigration policy based on uniting immigrant families and attracting skilled labor to the U.S. While this act served to benefit the U.S., it has also caused countries of origin to lose their best and brightest talent.

1989 The Asian American Federation of New York is established to raise the influence and well-being of the Asian American community through research, policy advocacy, public awareness and organizational development.

2001 The September 11 World Trade Center disaster resulted in increased discrimination and hate crimes against Arabs, Muslims, Sikh and South Asian Americans.

2020 A novel coronavirus, COVID-19, first identified in China, quickly becomes a worldwide public health emergency affecting the economy and all aspects of life. COVID-19-related stigma, discrimination, hate crimes and xenophobia against the API community are on the rise. The impact of this disease disproportionally affects communities of color, whose health continues to be worsened by historic inequities and structural racism.

A Note About COVID-19

The COVID-19 pandemic has impacted nearly every aspect of society. Since the first reported cases in December 2019, over 188 million recorded cases and over four million deaths have been reported worldwide.[3]

With well-publicized origins in China, COVID-19 has resulted in significant attention on people from API communities. Early in the pandemic, efforts were made to identify and isolate people who might have been exposed to the virus that causes COVID-19 while in China. While the virus was transmitted throughout both Asia and Europe, biased policies targeted people traveling from Asian countries and regions including China, Hong Kong and Japan, and extending into Middle Eastern countries such as Iran. Travel bans for European countries were imposed much later. Despite travel restrictions, research using genetic sequencing has since demonstrated that the original strain of COVID-19 in NYC likely originated from Europe.[4]

In NYC, the virus that causes COVID-19 does not seem to have impacted API communities as severely as other communities of color according to available data and limited media reporting. However, limitations in data collected are apparent, including potentially higher likelihood of race misclassification for API and the lack of data disaggregation by ancestry.[5] These limitations point to larger infrastructure changes necessary to improve data collection practices in administrative datasets. According to the best available data at the city level, New Yorkers who identify as API have some of the lowest numbers of reported COVID-19 cases, hospitalizations and deaths. To date, there are over 2,500 reported deaths among APIs in NYC out of over 33,000 COVID-19 reported deaths.[6] Yet the case-fatality rate among APIs remains higher than the overall population and further research highlights disparities in infection and hospitalization among South Asians, and in mortality for Chinese New Yorkers.[7, 8] Additionally, an analysis by National Nurses United showed a disproportionate impact on API health care workers, particularly nurses of Filipino ancestry, who accounted for over 30% of the COVID-19 deaths among nurses.

Since late 2019, API communities have experienced increased stigma and hate as a result of the COVID-19 pandemic.[9] The NYC Commission on Human Rights has observed a seven-fold increase in anti-Asian bias incidents in NYC from 2019 to 2020, which is consistent with national trends. The total number of anti-Asian inquiries and incidents reported to the Commission for 2020 was 205, and there have been 120 inquiries and incidents in the first four months of 2021 alone. These attacks have been verbal and physical assaults occurring in person or online and some have been extreme. Some are civil rights violations while others amount to criminal acts. In an NYC Health Opinion Poll conducted in March 2020, 21% of API participants reported being harassed or insulted in person in connection to COVID-19 (overall poll data not yet published). Additionally, Asian-owned businesses experienced economic burdens, with marked slowdowns stemming from anti-Asian stigma starting at the beginning of 2020.[10]

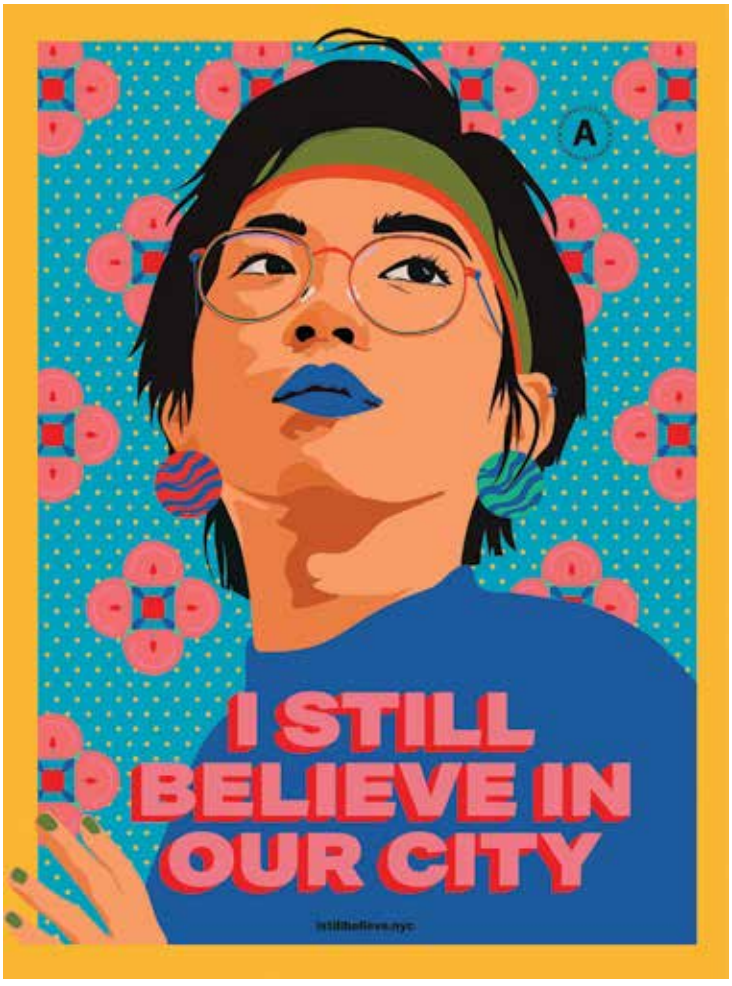
The use of coded language, particularly within our political institutions, as well as explicitly stigmatizing language such as referring to the virus that causes COVID-19 as the "Chinese virus," continues to fuel race-based fear and discrimination. In the early months of vaccination efforts, vaccination rates among API New Yorkers increased rapidly as community organizations and providers rallied around API communities in light of the onslaught of hate

crimes against APIs.[11] API vaccination rates are currently the highest in NYC. However, we must be cautious of how this might perpetuate the "model minority myth" and in turn dilute the severe impacts COVID-19 has had on communities of color and the challenges of equitable vaccine distribution. As we continue to respond and recover from the COVID-19 public health emergency and plan for possible future waves of transmission, we must recognize the physical, mental and economic toll API communities have experienced.

The NYC Health Department has implemented several initiatives to address and mitigate stigma and discrimination in API communities. Initial steps involved building internal capacity by identifying community engagement staff to reach out to API community partners. Key partnerships across City agencies are being leveraged to ensure that the needs of API communities are heard and have fair access to resources.

In April 2020, the NYC Commission on Human Rights announced the formation of a COVID-19 Response Team to handle reports of harassment and discrimination related to COVID-19. The response team is comprised of the Commission's Law Enforcement Bureau and Community Relations Bureau. The team quickly and efficiently tracks and responds to reports of COVID-19-related harassment and discrimination. Since its formation, the COVID-19 Response Team has taken action in 275 cases, including conducting early or emergency intervention, providing information on how to request a reasonable accommodation, referring individuals to another service or agency, or commencing an investigation. The NYC Commission on Human Rights has organized virtual events, such as town halls and Know Your Rights presentations, reaching thousands of community members across the city. Events and outreach have been conducted in English, Mandarin, Cantonese, Korean, Japanese and Tagalog. The Commission has also provided multilanguage Bystander Intervention Trainings to help communities learn de-escalation strategies to non-violently intervene to disrupt acts of discrimination, bias or hate speech.

The Commission's Public Artist in Residence (PAIR) Amanda Phingbodhipakkiya's "I Still Believe in Our City" posters were part of a public education campaign. Launched in 2020, the first round in the series was a testament to the resilience of New Yorkers and, specifically, honored API and Black New Yorkers in the face of racial injustice, xenophobia and COVID-19-related discrimination, harassment and bias. The second round in the series was an array of colorful posters featuring text in Chinese, Japanese, Korean, Tagalog and Vietnamese, and highlighting the unique impact of COVID-19-related bias, discrimination and harassment on API New Yorkers, business owners, essential workers and health care professionals. The works showcase the beauty and strength of New York's API communities amid a rise in violent attacks against API communities nationwide.

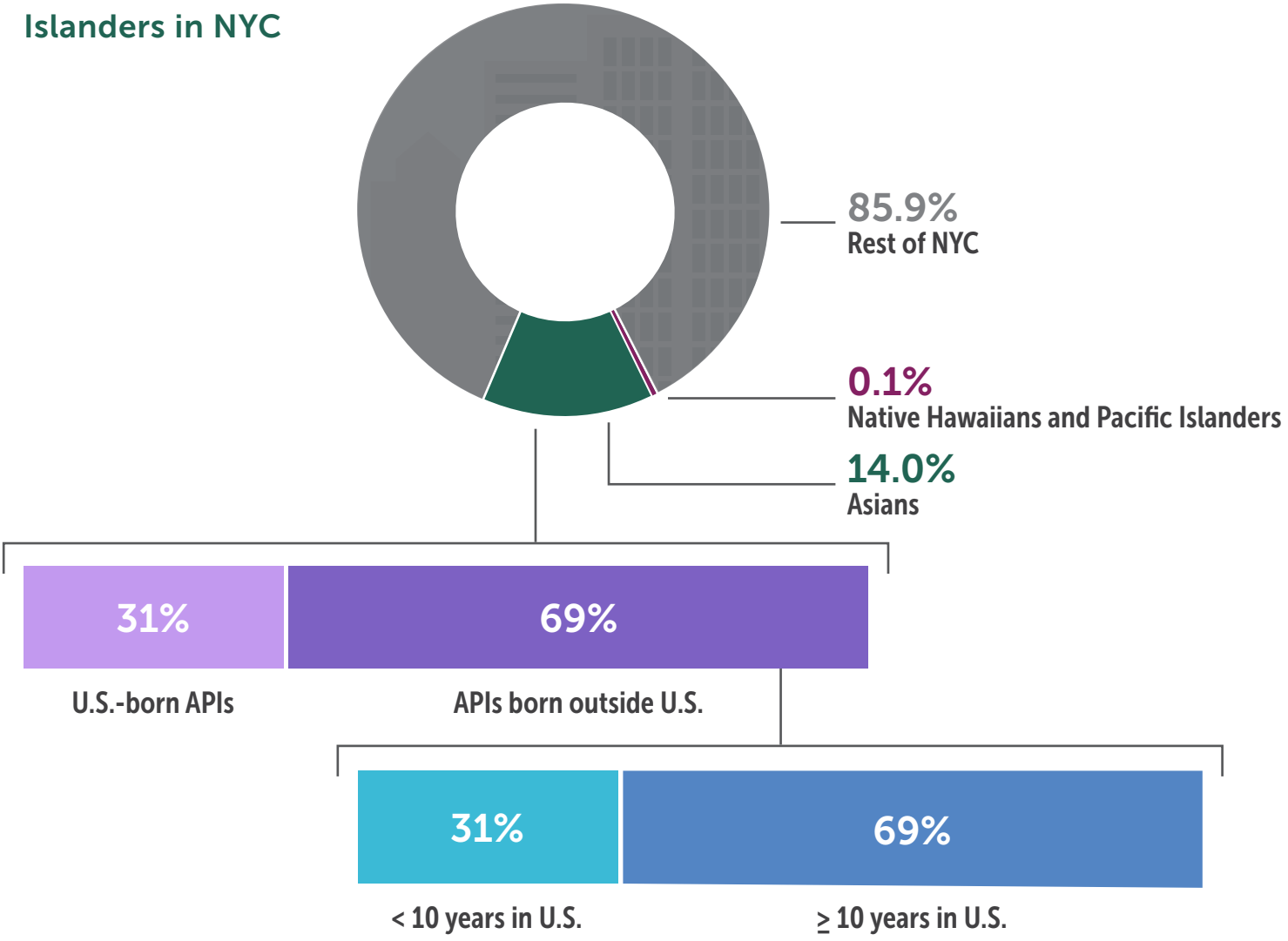


Asians and Pacific Islanders in New York City

NYC residents who identify as API represent 14% of the NYC population. From 2000 to 2017, the Asian population grew by 48% to 1,198,000. Over the same time period, the Native Hawaiian and Pacific Islander (NHPI) population grew by 25% to 4,400.

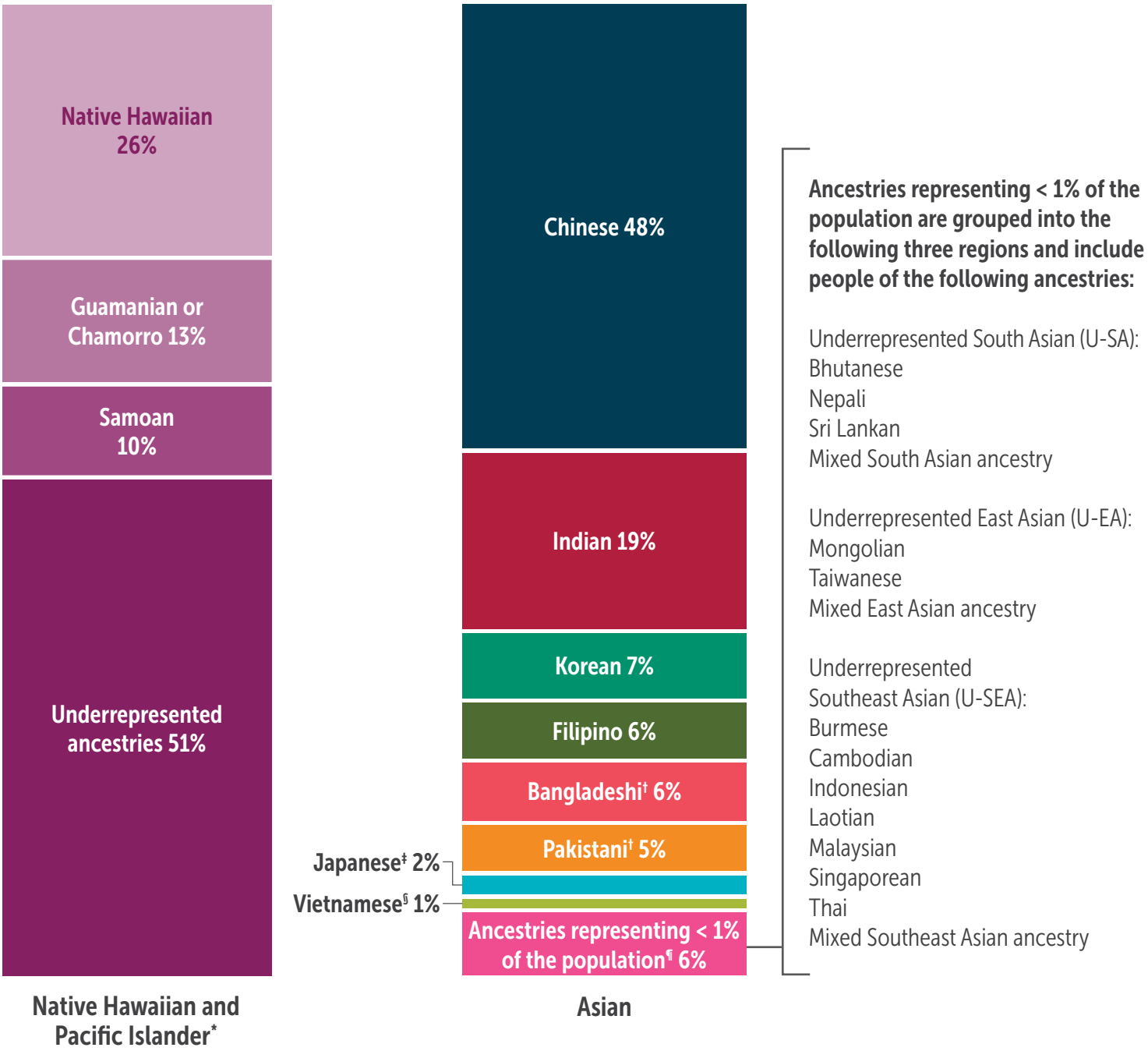
Chinese New Yorkers are the largest ancestry group, representing nearly half of all Asians in NYC, followed (in order of largest to smallest) by people of Indian, Korean, Filipino, Bangladeshi, Pakistani, Japanese and Vietnamese ancestry. In this report, there are 12 ancestries that represent less than 1% of the NYC API population that have been grouped into three Asian regions: South, East and Southeast. NHPIs represent less than 1% of API New Yorkers. Sixty-nine percent of APIs were born outside of the U.S. Among them, nearly 70% have lived in the U.S. for 10 years or more.

Asians and Pacific Islanders in NYC



Data source: (API population growth trend) NYC Health Department population estimates, modified from U.S. Census Bureau interpolated intercensal population estimates, 2000-2018. Updated Sept. 2019; (API population) American Community Survey (ACS), 2013-2017

API ancestries in NYC



* Native Hawaiian and Pacific Islanders (NHPIs) are presented as one group, separate from Asians in data from the American Community Survey (ACS) and NYC Health Department Community Health Survey (CHS) and Office of Vital Statistics (OVS). NHPIs are grouped with Asians in all other data.

† Bangladeshi and Pakistani ancestries are shown in data from ACS and OVS, grouped as Underrepresented South Asians (U-SA) in CHS.

‡ Japanese ancestry is shown in data from ACS and OVS, grouped as Underrepresented East Asians (U-EA) in CHS.

§ Vietnamese ancestry is shown in data from ACS and OVS, grouped as Underrepresented Southeast Asians (U-SEA) in CHS.

¶ Underrepresented Asians are grouped into three regions when possible. All other populations who identified as API but were unable to be grouped into any of the other ancestry groups were considered API, non-specified (U-NS).

Data source: American Community Survey (ACS), 2013-2017

A note on Native Hawaiians and Pacific Islanders

Native Hawaiians and Pacific Islanders (NHPIs) together represent many ancestries with different countries of origin, cultural backgrounds and languages. Among the estimated 4,400 NHPIs in NYC, the largest ancestry groups are Native Hawaiians, Guamanians or Chamorros, and Samoans. Because this population is small, NHPIs are presented as one group, and for some measures, their data are combined with that of Asians (abbreviated as APIs). However, it should be noted that different economic, social and political factors among different NHPI ancestries may lead to differences in income, employment, education, health behaviors and outcomes.[12]

A note on South Asian diaspora communities

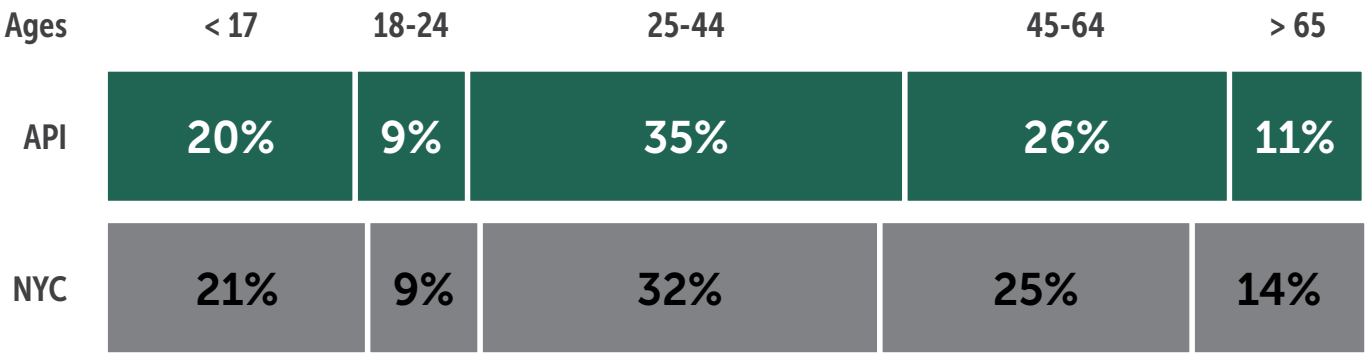
South Asians in NYC are a diverse group that can trace their origins to many countries, including Bangladesh, India, Nepal, Pakistan and Sri Lanka. In addition, many New Yorkers in the South Asian diasporic communities have roots in the Caribbean (Indo-Caribbeans), including Guyana, Jamaica, and Trinidad and Tobago. In addition to geographic diversity, there is great variation in the languages spoken and religions practiced by South Asian groups. For example, an ethnographic study of Indo-Caribbean youth in NYC found that their ethno-racial identities were complex, differed by gender and "could not be categorized simply." They were "South Asian by race, West Indian by ethnicity, American by nationality, and Hindu, Christian and Muslim by religious background."[13] As a result, this can lead to difficulties in fully understanding this community's size, makeup in NYC and health status. The citywide population of South Asians is over 300,000 with the largest concentration in the borough of Queens.[14]

Despite the rapid growth in both the U.S. and NYC of the South Asian population, many studies neglect to capture health data among South Asian groups. With increasing evidence of higher cardiovascular risk and diabetes prevalence in this population and guidance suggesting that clinicians may consider South Asian ancestry in their cardiovascular risk assessments, ensuring health research reflects their geographic, cultural and social diversity becomes essential.[15,16]

Age distribution

The age distribution of the API population in NYC is similar to NYC overall, with slightly lower percentages of children ages 0 to 17 years and adults ages 65 years and older.

Age distribution



Data source: American Community Survey (ACS), 2013-2017

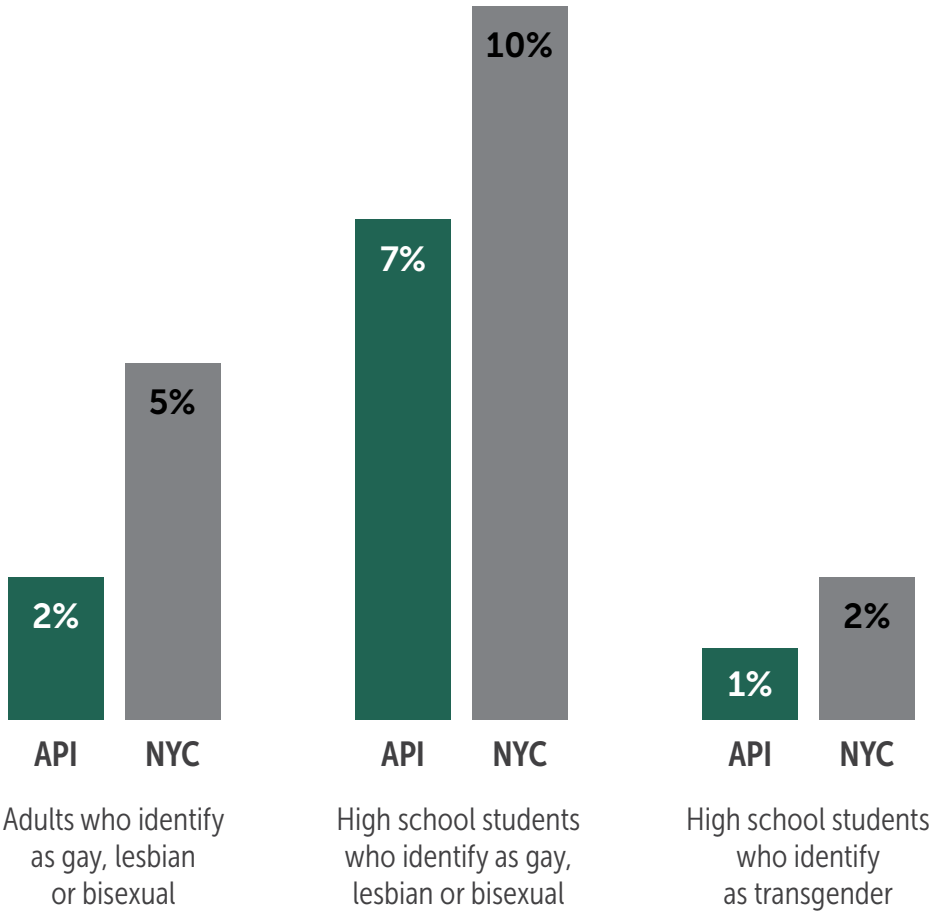
Sexual orientation and gender identity

Compared with NYC adults overall, a lower percentage of API adults identify as gay, lesbian or bisexual. Less than 1% of API adults identify as transgender, similar to NYC adults overall.

Similarly, among public high school students, a smaller proportion of APIs identify as gay, lesbian or bisexual compared with the citywide average. The percentage of API public high school students who identify as transgender does not differ from NYC public high school students overall (1% vs. 2%). According to a national survey on youth who identify as lesbian, gay, bisexual, transgender and queer (LGBTQ), 55% of LGBTQ API students were harassed or assaulted in school due to their sexual orientation, 52% due to their gender identity, and 55% due to their race or ethnicity.[17]

The multiple overlapping identities on LGBTQ APIs affect how they experience discrimination. Not only do they experience racism, homophobia and transphobia from within and outside the LGBTQ community but also from within and outside the API community. Cultural norms, anticipated stigma and family expectations can make identity disclosure, or "coming out," particularly difficult for LGBTQ APIs.[18] These overlapping or intersecting forms of oppression can lead to social isolation and can limit access to support, health information and public health messaging, which may not be appropriately targeted to one or multiple parts of their identity.

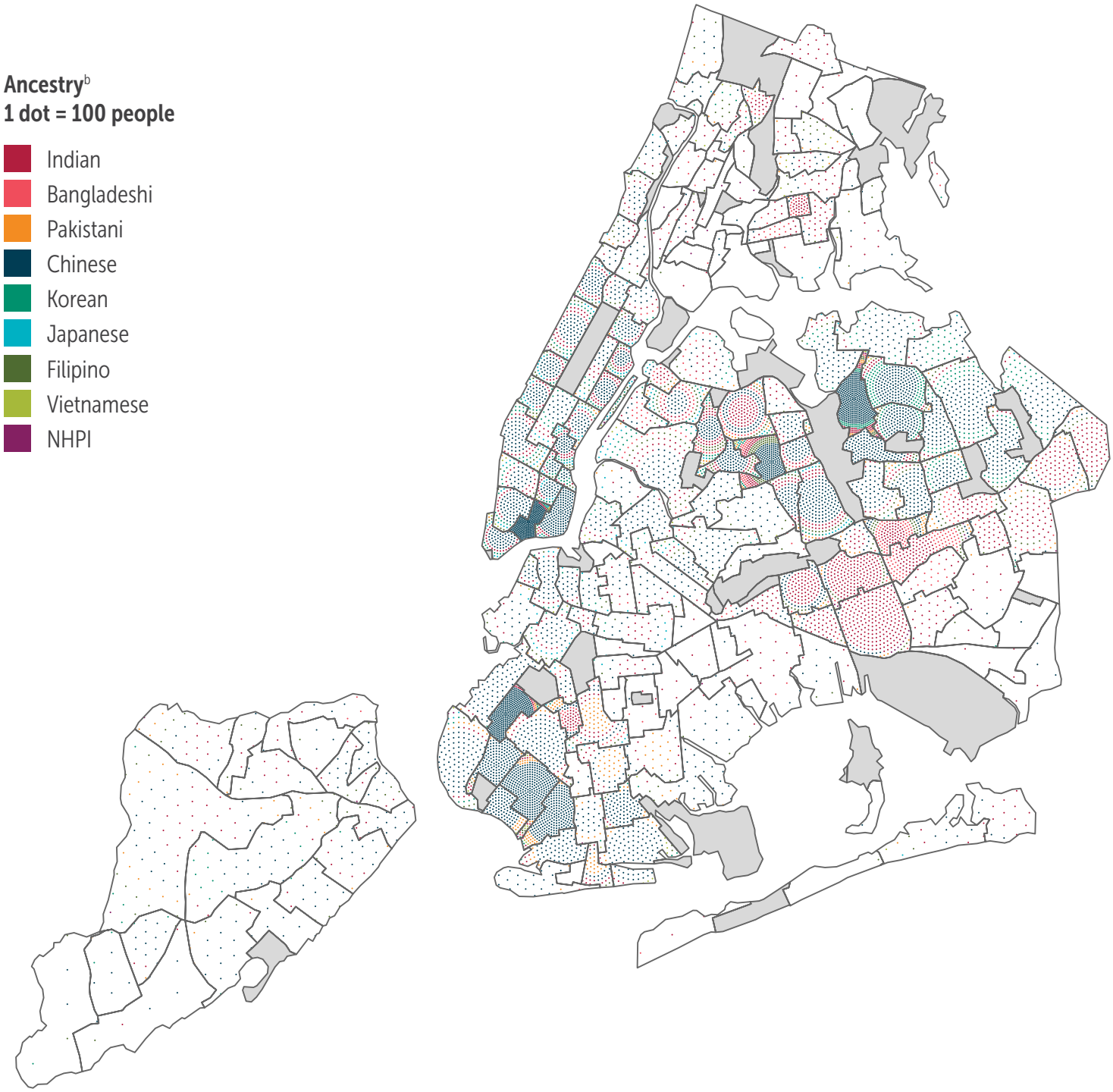
Sexual orientation and gender identity



Data source: (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017

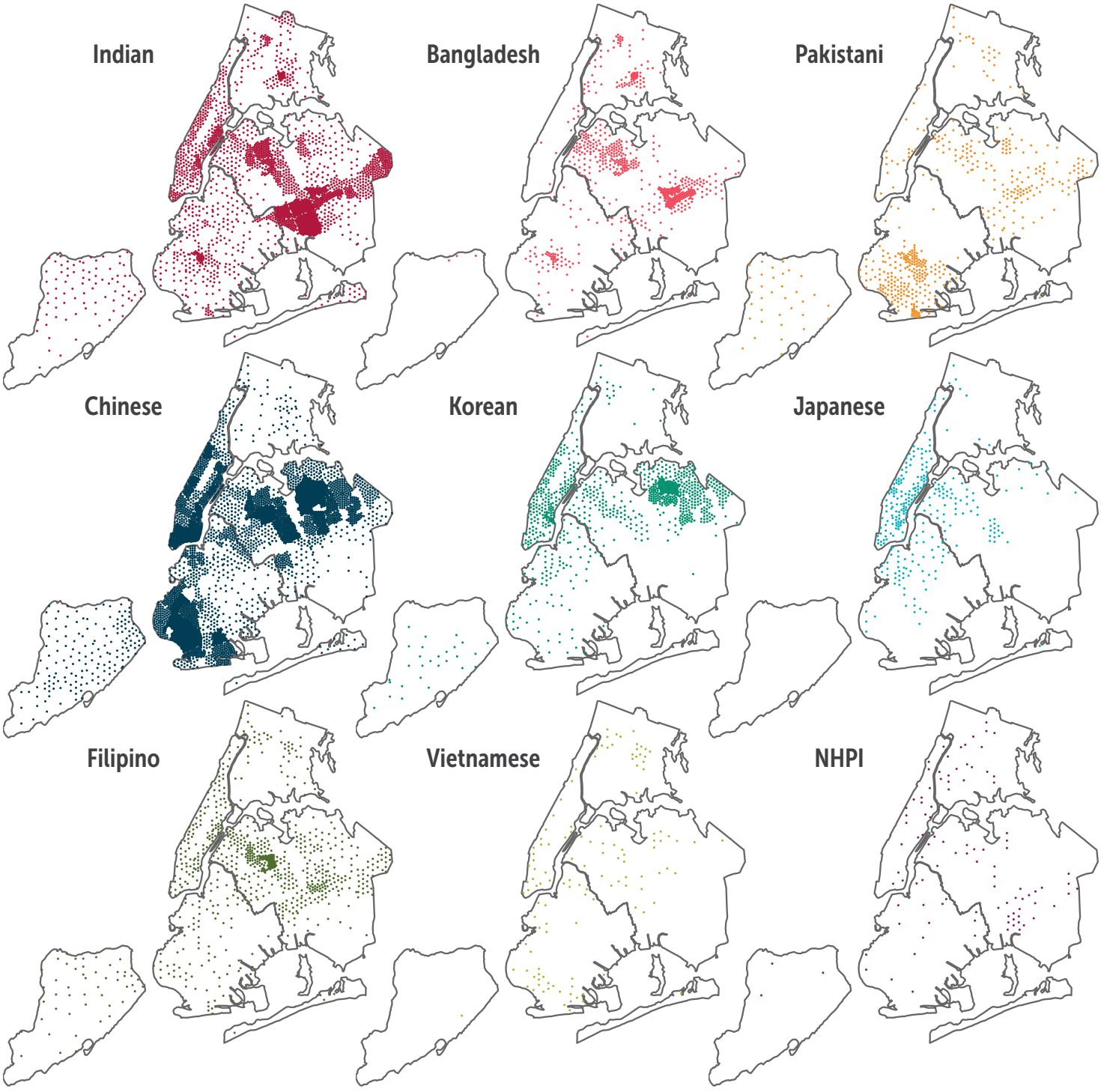
API populations by neighborhood

This map presents the number of residents who identify as API by neighborhood tabulation area (NTA).[a] The neighborhoods with the highest percentage of API residents are Flushing, East Flushing, Queensboro Hill and Murray Hill in Queens, Chinatown in Manhattan, and Sunset Park East in Brooklyn.



Data source: American Community Survey (ACS), 2013-2017. [a] Neighborhood tabulation areas (NTAs) are aggregations of census tracts that represent a minimum population of 15,000 residents and were created to project populations at a small area level for PlaNYC. For more information, visit nyc.gov/planning and search for "neighborhood tabulation areas." [b] One dot represents 100 people. Dots are arranged in a bull's-eye formation in the center of each NTA and represent a measure of density within each NTA, not an exact location. The largest ancestry for that neighborhood is located at the center.

API ancestries by neighborhood[a,b]



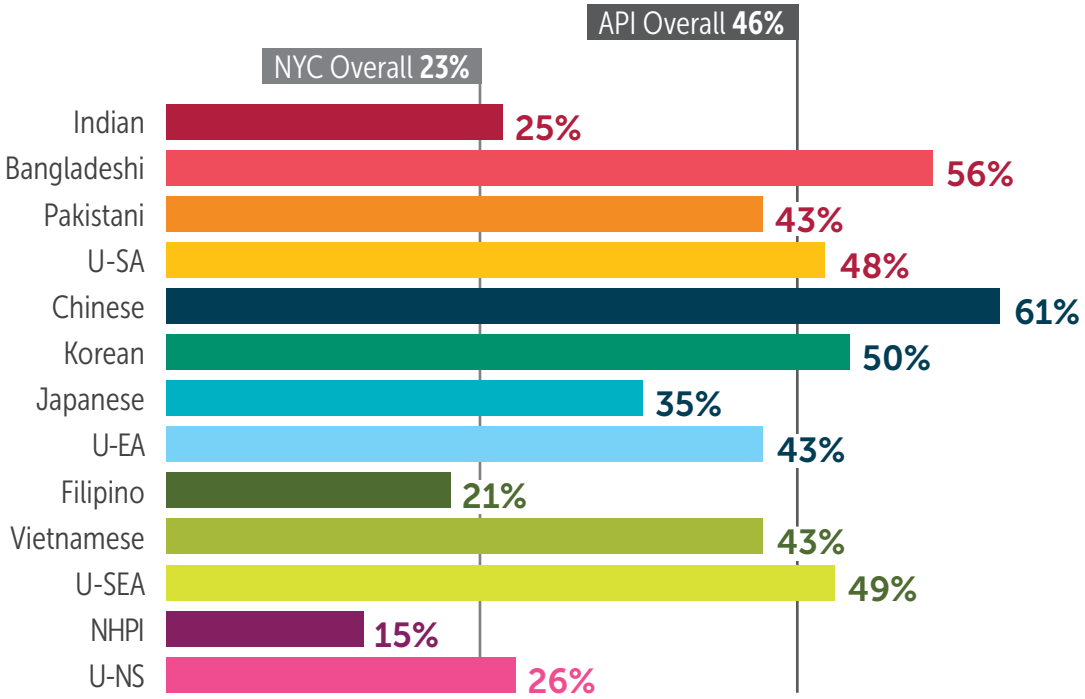
Data source: American Community Survey (ACS), 2013-2017. [a] Neighborhood tabulation areas (NTAs) are aggregations of census tracts that represent a minimum population of 15,000 residents and were created to project populations at a small area level for PlaNYC. For more information, visit nyc.gov/planning and search for "neighborhood tabulation areas." [b] One dot represents 100 people. Dots are arranged in a bull's-eye formation in the center of each NTA and represent a measure of density within each NTA, not an exact location.

English proficiency and limited English-speaking households

A higher proportion of API New Yorkers report speaking English "less than very well" compared with New Yorkers overall.

Among APIs born outside of the U.S., the proportion is 59%, compared with 46% among APIs overall. Among all API ancestry groups regardless of birthplace, the percentage who speak English "less than very well" varies from 21% among Filipinos to 61% among Chinese. Fifteen percent of NHPIs speak English "less than very well."

Limited English-speaking households[c]



[c] Household where no one age 5 or older reports speaking English "very well".
U-SA: Underrepresented South Asians include participants who identified as Bhutanese, Nepali, Sri Lankan and/or mixed South Asian ancestry.
U-EA: Underrepresented East Asians include participants who identified as Taiwanese, Mongolian and/or mixed East Asian ancestry.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or mixed Southeast Asian ancestry.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

Data source: American Community Survey (ACS), 2013-2017

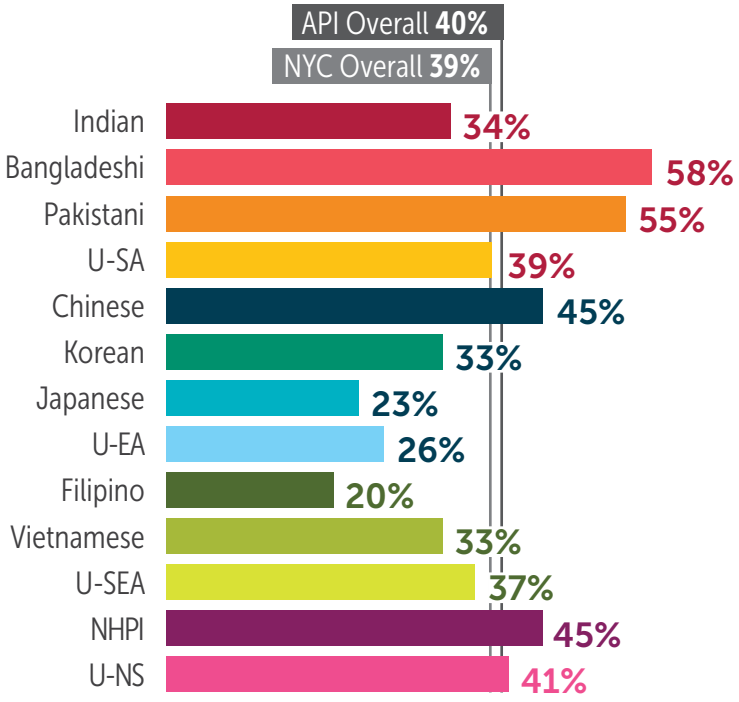
Social and Economic Conditions

Structural barriers such as racism, language limitations, lack of access to living-wage jobs and inability to build wealth create income inequality and affect the economic security of some API New Yorkers. Poverty, unemployment and lack of education limit access to resources that promote health and prevent illness. These conditions are stressors that can also negatively impact behavioral health outcomes.

Economic stress

The proportion of APIs who live below 200% of the federal poverty level does not differ from NYC overall. (For more information about the federal poverty level, visit aspe.hhs.gov/2021-poverty-guidelines.) However, Bangladeshi, Pakistani and Chinese ancestry groups all have higher rates of poverty compared with the citywide average. APIs have the highest income inequality of all racial and ethnic groups, and it is the visibility of APIs with high income that cause APIs with low income to become invisible.[19] Despite these higher proportions, API New Yorkers who qualify for low-income services are less likely to access the benefits available to them, potentially due to lack of awareness, immigration status, or linguistic or cultural accessibility. Additionally, structural bias informed by the "model minority" assumption that APIs have higher incomes may prevent API community organizations from receiving adequate funding.[20]

Income below 200% of the federal poverty level



U-SA: Underrepresented South Asians include participants who identified as Bhutanese, Nepali, Sri Lankan and/or mixed South Asian ancestry.
U-EA: Underrepresented East Asians include participants who identified as Taiwanese, Mongolian and/or mixed East Asian ancestry.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or mixed Southeast Asian ancestry.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

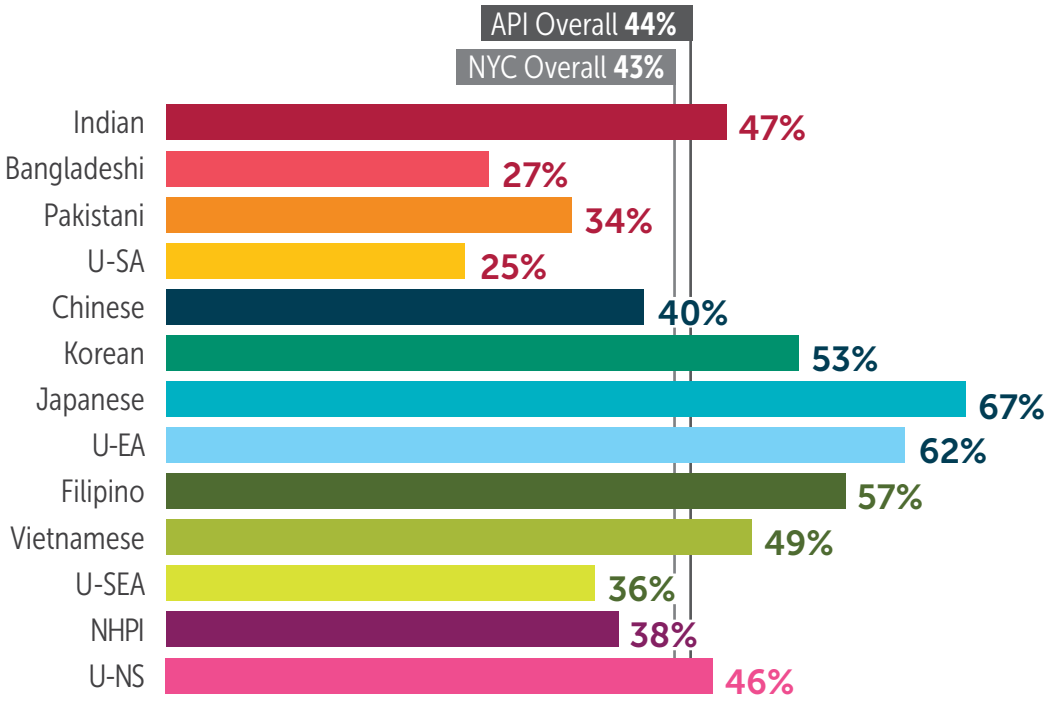
Data source: American Community Survey (ACS), 2013-2017

Employment

Compared with NYC overall, a higher percentage of APIs are employed, and this is consistent across ancestries.

APIs are less likely to be in construction and maintenance occupations, and more likely to be in production, transportation and moving occupations than NYC residents overall. Among API ancestry groups, Bangladeshis are half as likely as Filipinos or Japanese to be in management or professional occupations.

APIs ages 16 and older working in management and professional occupations



U-SA: Underrepresented South Asians include participants who identified as Bhutanese, Nepali, Sri Lankan and/or mixed South Asian ancestry.
U-EA: Underrepresented East Asians include participants who identified as Taiwanese, Mongolian and/or mixed East Asian ancestry.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or mixed Southeast Asian ancestry.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

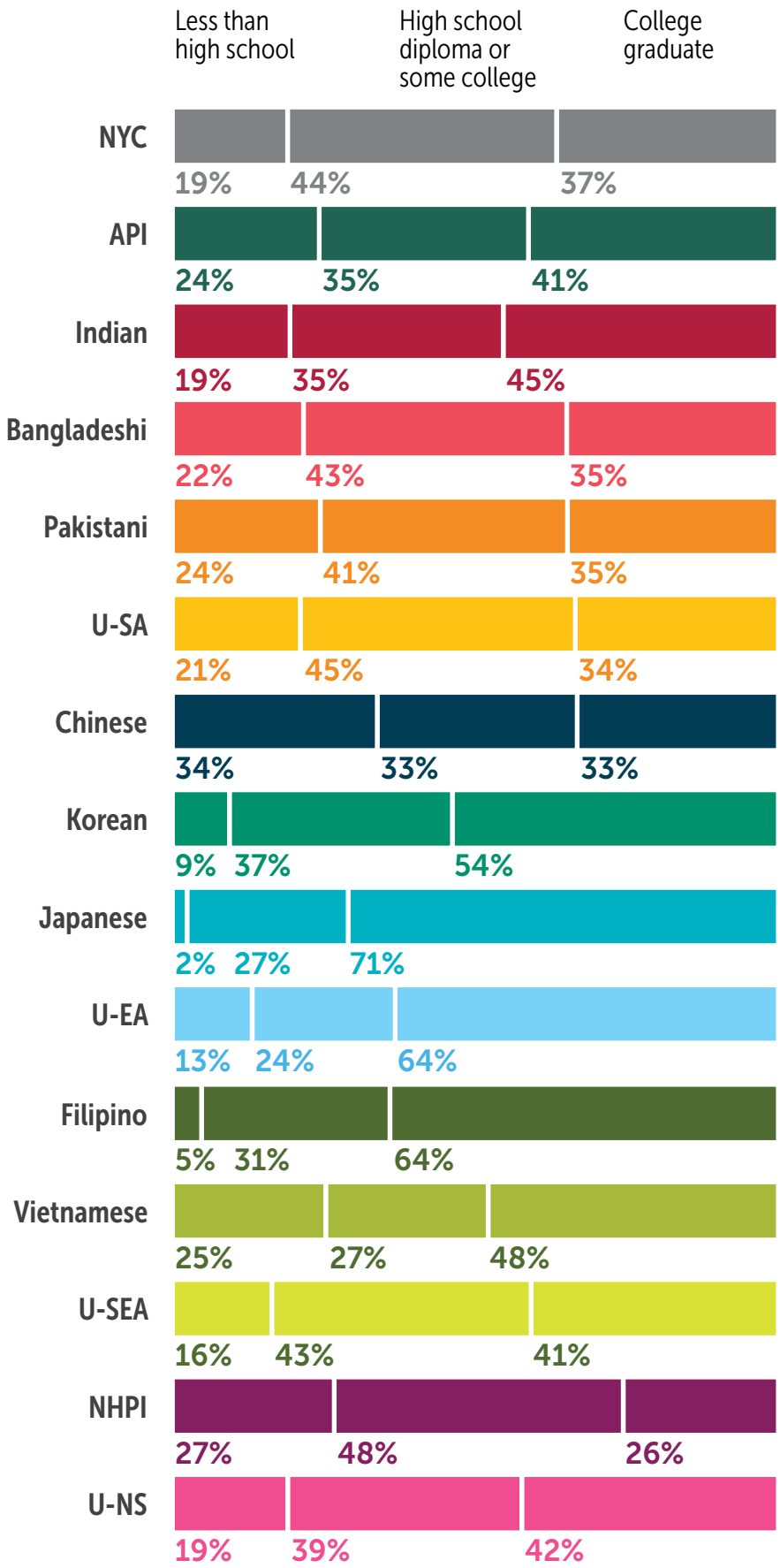
Data source: American Community Survey (ACS), 2013-2017

Education

Among API adults ages 25 and older, 24% do not have a high school education.

This is a greater proportion compared with NYC overall. Notably, a higher proportion of API adults have a college degree or higher compared with NYC overall. Among ancestry groups, the percentage of adults with one college degree or more varies from 26% among NHPI adults to 71% among Japanese adults.

Education attainment among adults ages 25 and older



U-SA: Underrepresented South Asians include participants who identified as Bhutanese, Nepali, Sri Lankan and/or mixed South Asian ancestry.
U-EA: Underrepresented East Asians include participants who identified as Taiwanese, Mongolian and/or mixed East Asian ancestry.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or mixed Southeast Asian ancestry.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

Data source: American Community Survey (ACS), 2013-2017

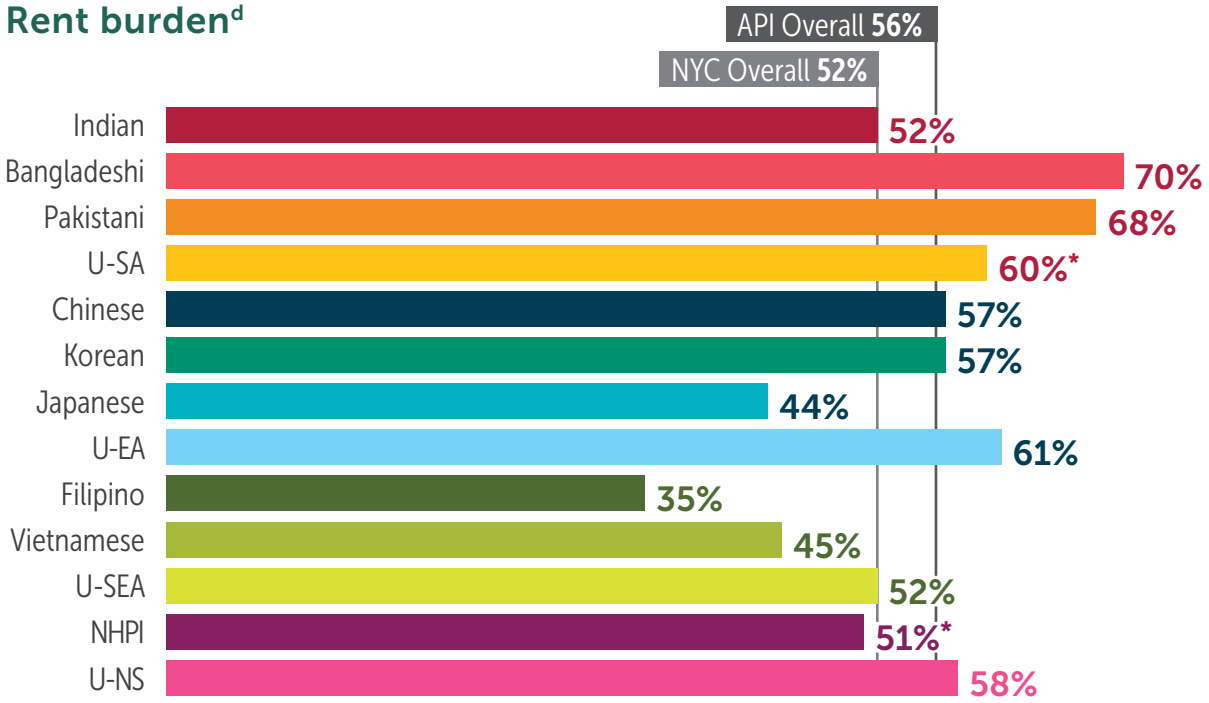
Housing and Community

Rent burden and housing security

Every New Yorker has the right to live in safe, affordable housing, but many households pay more than 30% of their income for housing and have difficulty affording food, clothing, transportation and medical care.

A greater proportion of API New Yorkers spend more than 30% of their monthly household income on rent compared with NYC overall. Among APIs, Bangladeshi (70%) and Pakistani (68%) households are the most rent burdened. Rent burden is also higher among non-citizens — both green card holders and immigrants who are undocumented.[21] In addition to rent burden, many API adults 65 years and older with low incomes live in shared housing, and face overcrowding, safety concerns and limited access to medications. Additionally, in 2019 there were over 78,000 New Yorkers experiencing sheltered and unsheltered homelessness, including individuals served by a range of government and not-for-profit shelter providers. Of these individuals, 1,965 (2.5%) were API.

Rent burden[d]



[d] Households that spend more than 30% of their income on rent.

U-SA: Underrepresented South Asians include participants who identified as Bhutanese, Nepali, Sri Lankan and/or mixed South Asian ancestry.

U-EA: Underrepresented East Asians include participants who identified as Taiwanese, Mongolian and/or mixed East Asian ancestry.

U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or mixed Southeast Asian ancestry.

NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.

U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

* Interpret estimate with caution due to small sample size.

Data source: (Rent burden) American Community Survey (ACS), 2013-2017; (Homelessness) NYC Department of Homeless Services, 2019

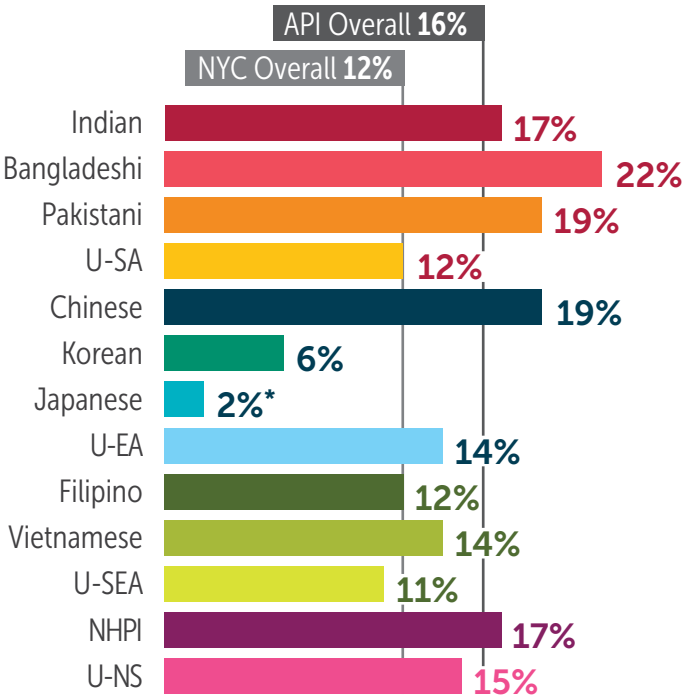
Multigenerational households, family and social support

Living with family can be an important source of social support, and strong social connections can have a positive impact on the health of individuals and communities.

Multigenerational households consist of three or more generations such as a grandparent, an adult child and a grandchild living in one household. In NYC, a higher percentage of Bangladeshi, Pakistani, Chinese and Indian households include three or more generations compared with NYC residents overall.

Many older API adults living alone are at high risk of feeling socially or linguistically isolated.[22] Among API adults, 48% reported getting together with family and friends a few times or less in the past 30 days, which is similar to the city overall (47%).

Multigenerational households[e]



[e] Multigenerational households consist of three or more generations such as a grandparent, an adult child and a grandchild living in one household.

U-SA: Underrepresented South Asians include participants who identified as Bhutanese, Nepali, Sri Lankan and/or mixed South Asian ancestry.

U-EA: Underrepresented East Asians include participants who identified as Taiwanese, Mongolian and/or mixed East Asian ancestry.

U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or mixed Southeast Asian ancestry.

NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.

U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

* Interpret estimate with caution due to small sample size.

Data source: (Multigenerational households) American Community Survey (ACS), 2013-2017; (Getting together with family and friends) NYC Health Department Social Determinants of Health Survey, 2017

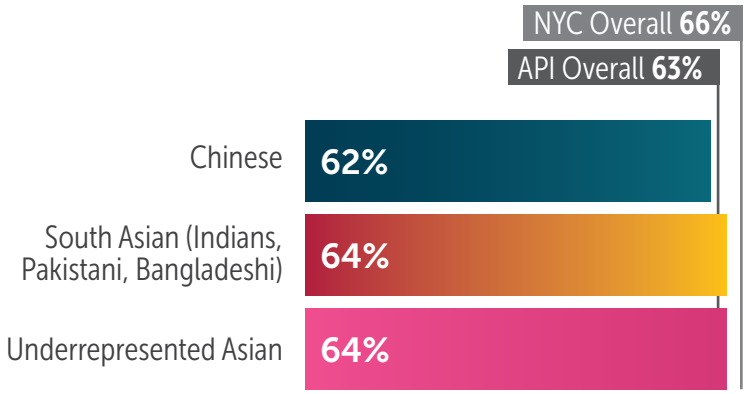
Maintenance problems and air conditioning

Poorly maintained housing can worsen asthma and other respiratory illnesses.

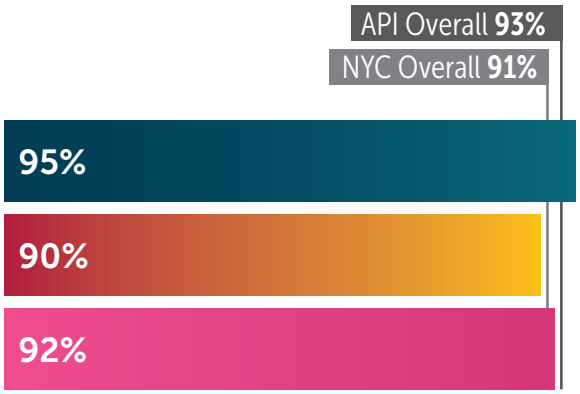
The percentage of renter-occupied homes that are inadequately maintained by landlords — including water leaks, cracks and holes, inadequate heating, no air conditioning, presence of pests, toilet breakdowns, or peeling paint — is similar among API households when compared with the citywide average.

Notably, a smaller proportion of South Asian households report having working air conditioners compared with Chinese households. Most heat stroke deaths in NYC occur in homes without air conditioning.

Households with maintenance problems[f, g]



Households with working air conditioners[g]



[f] Maintenance problems include water leaks, cracks and holes, inadequate heating, no air conditioning, presence of cockroaches, mice or rats, toilet breakdowns, or peeling paint.

[g] API and ancestries are based on race and ethnicity of household respondent. Only Chinese had a large enough sample size to fully disaggregate. Some South Asian ancestries were grouped together, and all other ancestries were grouped into "Underrepresented Asian."

Incarceration

Involvement with the criminal legal system is associated with poor physical and mental health outcomes that may impact individuals, their families and their communities.

Due to racism and discrimination, Black and Latino New Yorkers are disproportionately exposed to the criminal legal system compared with White and API New Yorkers. The average daily population of people in prison or jail is less than 2% Asian, compared with 53% Black, 34% Latino and 8% White. Similarly, 8% of API public high school students report having a parent who has spent time in prison as required by their sentence, the lowest proportion among all major race and ethnicity groups. However, a 2017 report from the Urban Institute reported that API incarceration is on the rise,[23] and that the lack of data grouped by ancestry is masking any nuances among API groups. Due to the public charge rule, increases in the number of APIs in prison or jail are also tied to the rise of immigration detention and deportation. Deportation rates have been particularly high in Muslim and South Asian communities, which have experienced a targeted increase in profiling and surveillance since the September 11 World Trade Center disaster.

Data source: (Maintenance problems and air conditioning) NYC Housing and Vacancy Survey, 2017; (Incarceration) NYC Department of Correction, 2018-2019; (Teens with parental criminal legal involvement) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017

Lead and mercury exposure

Lead and mercury are highly toxic metals and are especially dangerous to children and pregnant people.

South Asian children and adults in NYC are more likely to have elevated blood lead levels [5 micrograms per deciliter (mcg/dL) or greater] than the citywide tested population. Lead-based paint is commonly identified as a potential source of exposure among children in NYC, but it is not the only source. In South Asian communities, lead exposures have been associated with the use of traditional powders and remedies such as rasa shastra Ayurvedic medications, spices and amulets. Some skin-lightening creams, soaps and certain Ayurvedic medications have also been found to contain extremely high levels of mercury.

One population study estimated that about 30% of East and Southeast Asian New Yorkers have blood mercury levels of 5 micrograms per liter (mcg/L), which is the NYS reportable level, or higher, compared with 12% citywide.[24] Higher blood mercury levels are typically associated with more frequent fish consumption. Fish is part of a healthy diet, but pregnant or breastfeeding people and young children who eat fish regularly should choose fish that are lower in mercury.

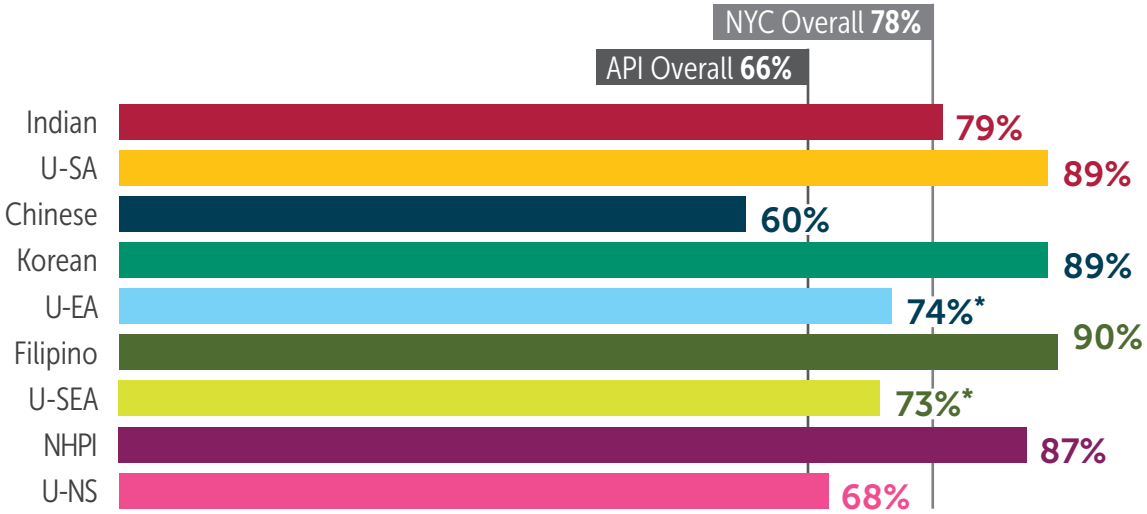
Healthy Living

Self-reported health

About two-thirds of API adults (66%) report their general health as "excellent," "very good" or "good" compared with 78% of all adult New Yorkers.

Although self-reported health is often used to measure physical and mental well-being, this measure may be based on personal feelings or opinions that have cultural differences in interpretation.[25] Among API ancestry groups, the percentage reporting their health as "good" to "excellent" ranges from 90% among Filipino to 60% among Chinese adults, who notably also have the highest and lowest English-proficiency rates, respectively. Among API adults, those who are born outside of the U.S. are less likely to report "good" to "excellent" health compared with those who are U.S.-born (65% vs. 88%), as are those in households with low incomes compared with those in households with middle or high incomes (59% vs. 76% and 83%, respectively).

Adults who report general health as "excellent," "very good" or "good"



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

Data source: NYC Health Department Community Health Survey (CHS), 2014-2018

Fruits and vegetables

Ready access to fresh fruit and vegetables is important to maintain a healthy diet.

Compared with NYC overall, a lower proportion of API adults can buy fresh fruits and vegetables within a five-minute walk from their home.

Despite this, API adult New Yorkers are more likely to report consuming one or more fruit and vegetable servings per day compared with NYC adults overall.

Almost three-quarters of API public high school students (74%) report consuming one or more servings of fruit and vegetable on average per day, compared with 58% of all NYC public high school students.

Adults who eat one or more servings of fruits and vegetables per day

High school students who eat an average of one or more servings of fruits and vegetables per day

Data source: (Fruit and vegetable consumption) (Adults) NYC Health Department Community Health Survey (CHS), 2017-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (Fruit and vegetable access) NYC Health Department Community Health Survey (CHS), 2014

Sugary drinks

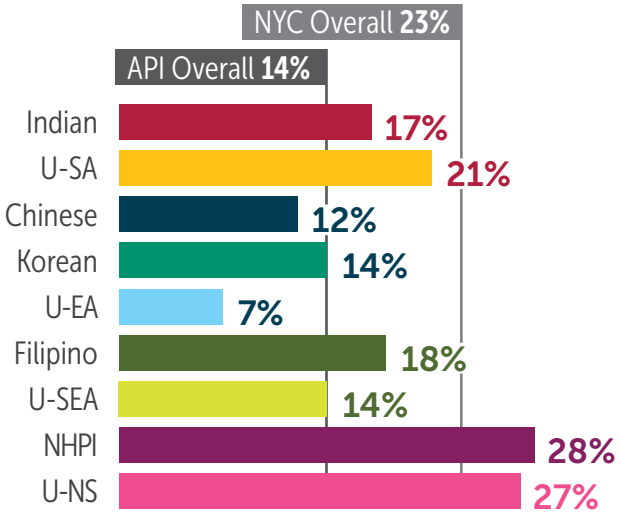
Consuming sugary drinks is associated with weight gain and obesity, which can increase the risk of chronic diseases such as diabetes and high blood pressure.

API adults are less likely to consume one or more sugary drinks per day than NYC adults overall. However, rates among API ancestry groups vary from 7% among Underrepresented East Asian adults to 27% among Underrepresented Asians, non-specified.[h] Additionally, over one-quarter of NHPI adults consume one or more sugary drinks per day. This may reflect the effects of colonization that have shaped both the culture and diet of NHPI communities.[26]

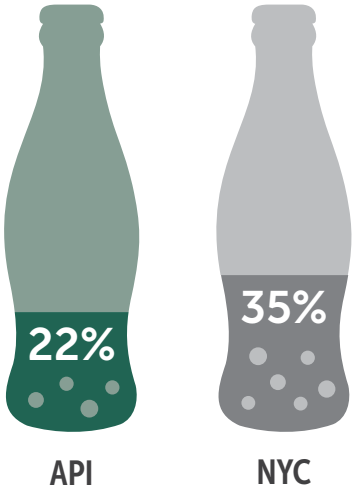
Among these effects, the erasure of traditional food growing and food preparation skills, and introduction of imported foods, such as sugary drinks, led to rapidly growing obesity rates in NHPI communities.

Among public high school students, 22% of API teens consume one or more sugary drinks per day, lower than the rate citywide.

Adult sugary drink consumption



Teen sugary drink consumption



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

Data source: (Sugary drink consumption) (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017. [h] Underrepresented East Asians are Taiwanese, Mongolian and/or mixed East Asian ancestry; Underrepresented API, non-specified, are those who identified as API but were unable to be grouped into any of the other ancestry groups.

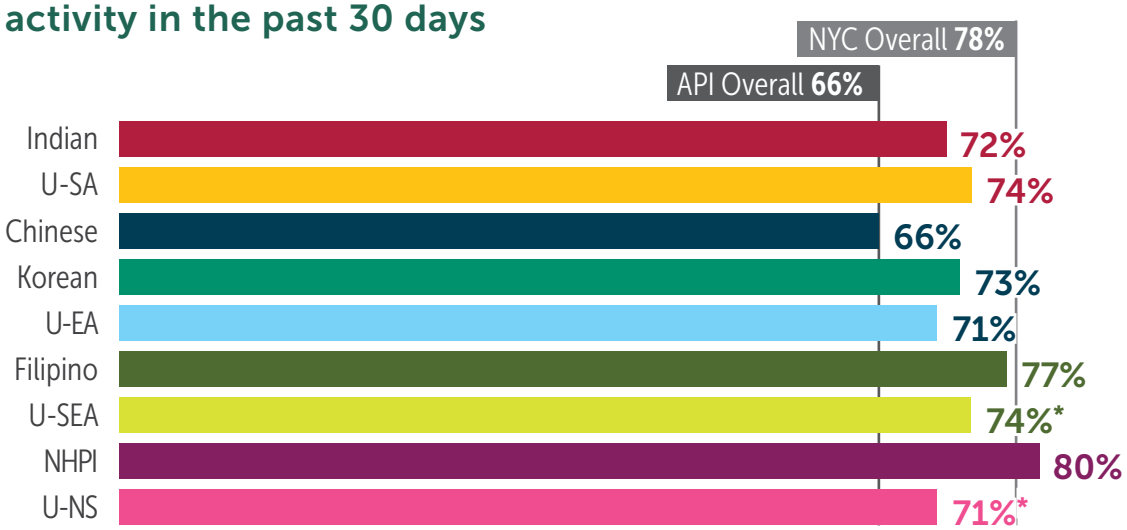
Physical activity

Regular physical activity plays an important role in maintaining and improving one's overall health.

API adults are less likely to have participated in physical activity in the past 30 days when compared with NYC overall. Among API adult New Yorkers, U.S.-born adults have a higher rate of physical activity than adults born outside of the U.S. Among Asian ancestry groups, rates of physical activity vary from 66% among Chinese to 77% among Filipinos; this rate was 80% among NHPIs.

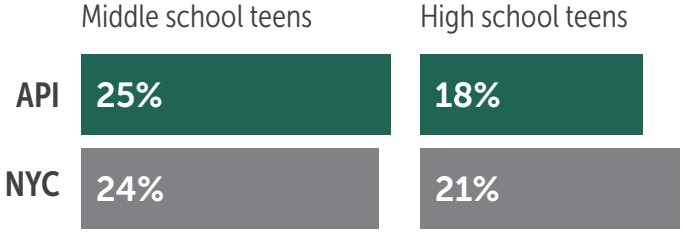
Among public high school students, API teens are less likely to be physically active at least 60 minutes per day compared with White teens (18% vs. 26%). Among API public middle school students, only one-quarter (25%) are physically active at least 60 minutes per day, though this prevalence is similar to NYC public middle school students overall.

Adults who participate in physical activity in the past 30 days



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

Students who are physically active at least 60 minutes per day in the past seven days



Data source: (Physical activity) (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (Middle school students) NYC Health Department Middle School Youth Risk Behavior Survey, 2018

Current smoking, including vaping and smokeless tobacco use

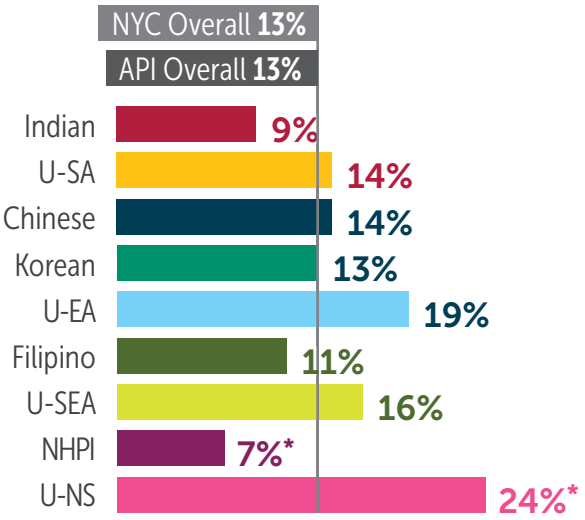
Smoking is a risk factor for heart disease, stroke and over 10 types of cancer, including lung cancer.

Lung cancer is the leading cause of cancer death, and smoking is the reported cause in more than 80% of lung cancer deaths. About 13% of API adult New Yorkers currently smoke cigarettes, similar to NYC overall. However, API men are about six times more likely to smoke than API women. Among public high school students, API and Black students are less likely to smoke cigarettes compared with Latino and White students (both 3% vs. 5% and 7%, respectively).

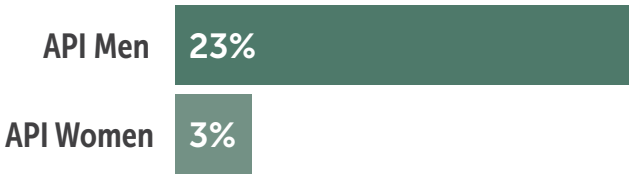
One in nine API public high school students currently vapes [uses an electronic cigarette (e-cigarette) or similar device and products]. The prevalence of vaping among API and Black public high school students is lower than the prevalence among Latino and White public high school students.

Additionally, smokeless tobacco products such as gutkha and paan play a significant social role in some API cultures, and can lead to nicotine addiction and cause serious health problems.

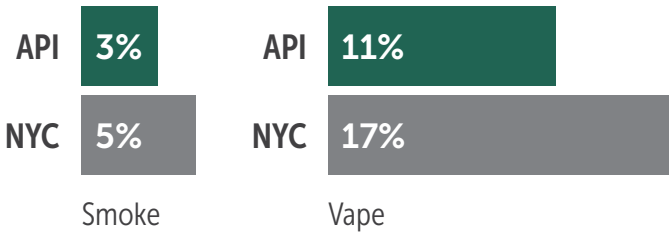
Adults who currently smoke



API adults who currently smoke



High school students who currently smoke or use electronic vapor products in the past 30 days



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

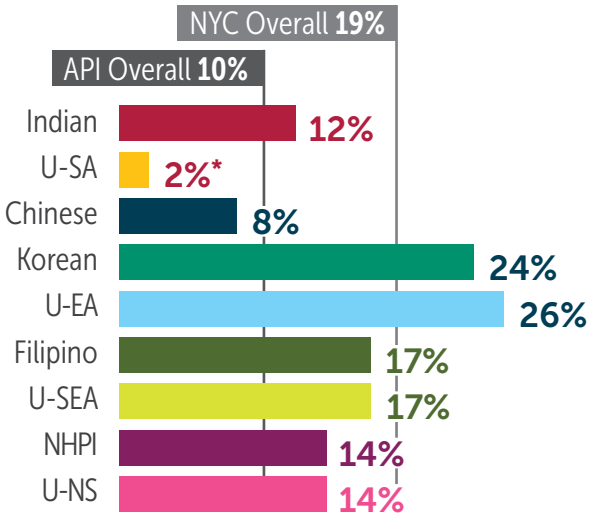
Data source: (Smoking) (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Smoking and vaping) (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017

Alcohol use

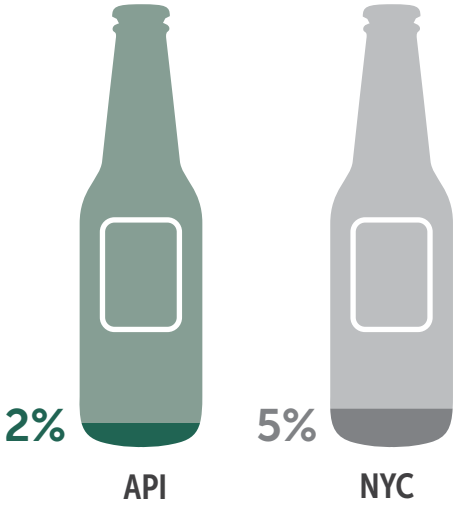
Excessive alcohol consumption, including binge drinking (defined as five or more drinks on one occasion for men, and four or more drinks on one occasion for women) and heavy drinking (defined as consuming an average of more than two drinks per day for men and more than one drink per day for women), is associated with health risk behaviors and problems such as accidents, injuries, high blood pressure and depression. About one in 10 API adult New Yorkers drinks excessively (binge drinks or heavily drinks), which is lower than the NYC average. Among API adult New Yorkers, both Korean and Underrepresented East Asian adults are three times as likely as Chinese adults to consume alcohol excessively. Compared with Chinese adults, Indian, Filipino, Underrepresented Southeast Asians and NHPI adults are also more likely to drink excessively.

Among public high school students, the percentage of API students who binge drink alcohol is less than half the citywide average.

Adults who excessively drink[i]



Teens who binge drink[j]



[i] Excessive alcohol consumption is defined as either binge drinking (defined as five or more drinks on any one occasion for men, and four or more drinks on any one occasion for women) or heavy drinking (defined as consuming an average of more than two drinks per day for men and more than one drink per day for women).

[j] Binge drinking is defined as five or more drinks in a row (within a few hours) on one or more of the past 30 days.

U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.

U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.

U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.

NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.

U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

* Interpret estimate with caution due to small sample size.

Data source: (Alcohol use) (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017

Condom use

Consistent condom use is highly effective in reducing the risk of sexually transmitted infections, including HIV infection. API adults are more likely to use a condom than Black, Latino and White adults (37% vs. 33%, 30% and 26%, respectively).

Among sexually active NYC public high school students, condom use among API teens is similar to the city overall (65%[k] vs. 57%).

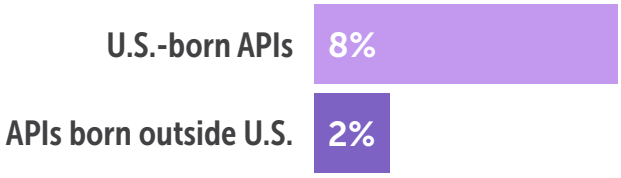
Intimate partner violence

About 9% of adult New Yorkers report experiencing physical violence (ever having been hit, slapped, shoved, choked, kicked, shaken or physically hurt) by an intimate partner; about 3% of API adults report experiencing physical violence by an intimate partner, which is the lowest among all racial and ethnic groups.

However, intimate partner violence may be underreported among APIs due to the stigma attached to being a victim, internalized traditional gender norms or fear of culturally significant consequences.[27] Additionally, the prevalence of experiencing physical violence by an intimate partner among U.S.-born API adults is about three times that of API adults born outside of the U.S. (8% vs. 2%). API adults willing to report intimate partner violence may face barriers due to language accessibility in our health systems or lack of knowledge of resources.

Among public high school students who dated someone in the past 12 months, a similar percentage of API students report physical dating violence (7% vs. 10%) or sexual dating violence (18% vs. 15%) compared with NYC overall.

Adults who experience intimate partner violence



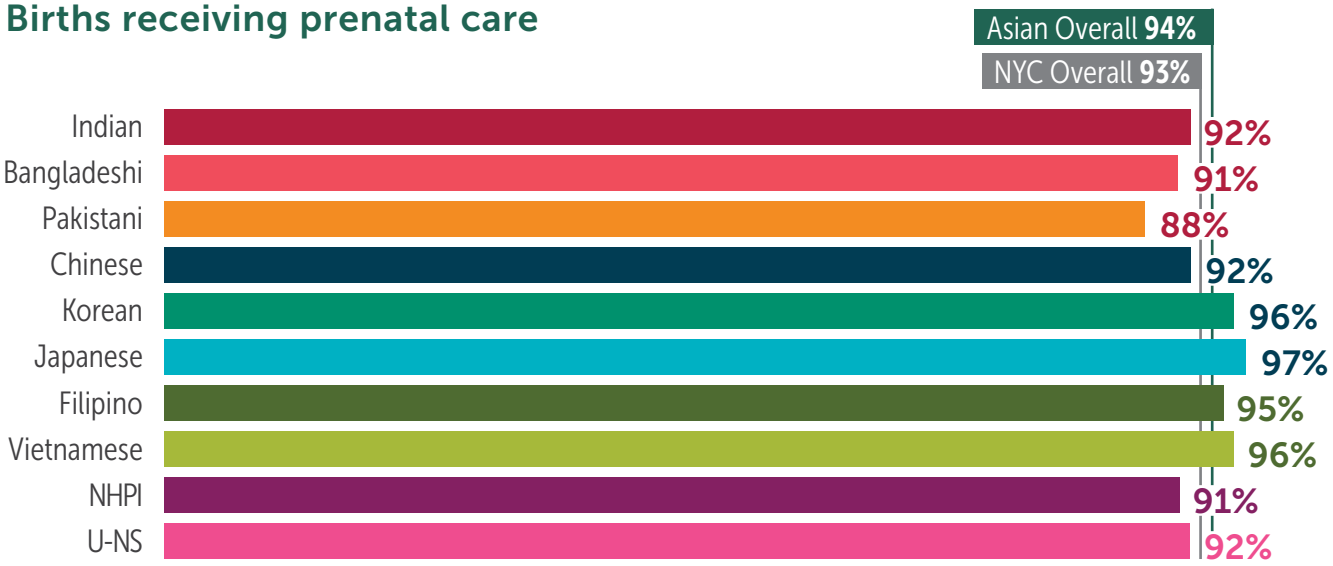
Data source: (Condom use) (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (Intimate partner violence) (Adults) NYC Health Department Community Health Survey (CHS), 2016, 2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017. [k] Interpret estimate with caution due to small sample size.

Family and Child Health

Prenatal care

Prenatal care is critical to the health of people who are pregnant and their babies, before pregnancy, during pregnancy, labor and childbirth, and after giving birth. API people who give birth in NYC are more likely to receive prenatal care compared with NYC overall. Among birth parents with API ancestry, the percentage who receive prenatal care varies from 88% among Pakistani to 97% among Japanese birth parents.

Births receiving prenatal care



NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

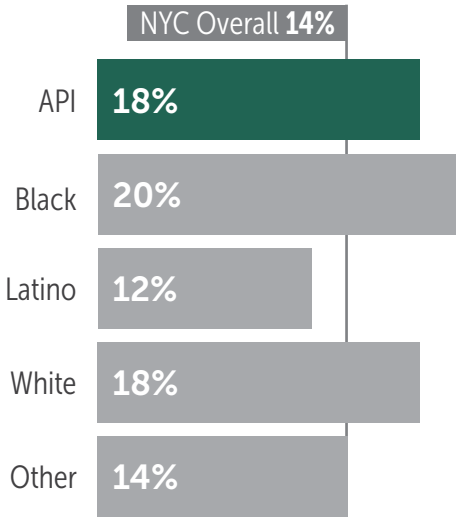
Data source: NYC Health Department Office of Vital Statistics, 2008-2017

Postpartum depression

Postpartum depression is defined as a depressive episode that occurs within 12 months after giving birth.

Although postpartum depression is treatable with therapy or medication, it can cause substantial distress and impairment among parents who have recently given birth and is also associated with short- and long-term impacts on child development. In NYC, 18% of API people who gave birth experienced postpartum depressive symptoms compared with 14% citywide.

Postpartum depression by race/ethnicity groups



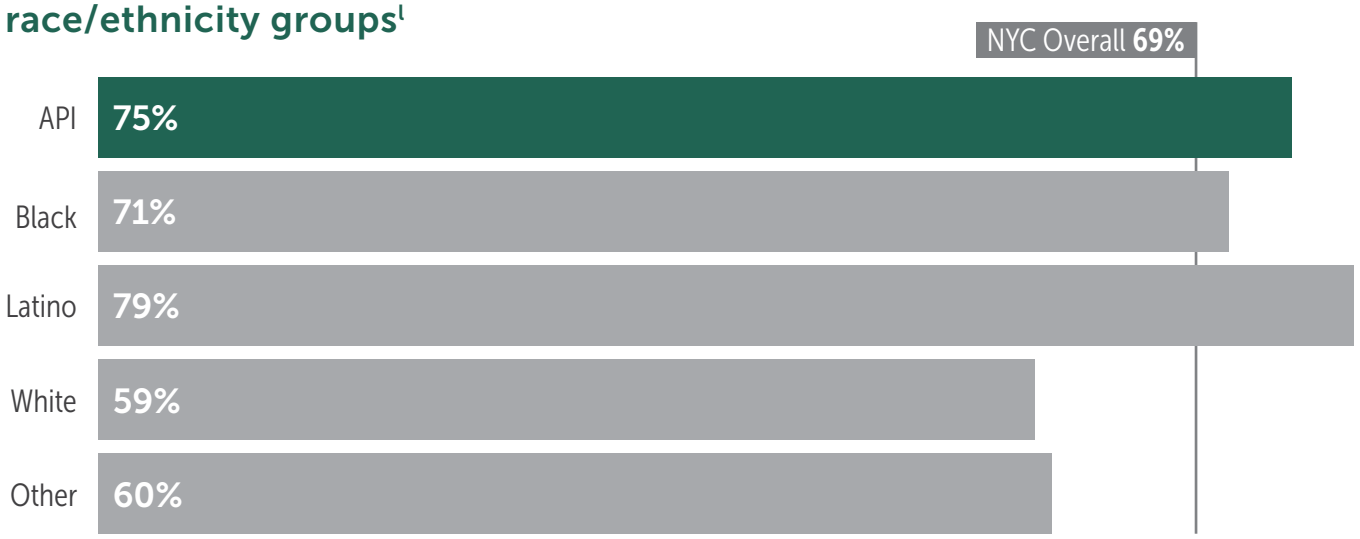
Preterm births

Babies born before 37 weeks of gestation may be at risk for medical complications, including infant death. The proportion of preterm births among API people is slightly lower than NYC overall (8% vs. 9%). However, among Filipino, Pakistani and Indian people, rates are higher than the citywide average (all 10%).

Childhood vaccination

Many life-threatening childhood illnesses, such as measles, polio and pertussis (whooping cough), can be prevented by vaccines. To protect all New Yorkers, parents should work with a health care provider to make sure all children get their vaccinations on schedule. Among API children, 75% are fully vaccinated, higher than the citywide rate. Vaccination rates by race and ethnicity vary from 59% among White children to 79% among Latino children.

Fully vaccinated children by race/ethnicity groups[l]



[l] Defined as children who get a full series of seven vaccinations before they turn 3 years old.

Data source: (Postpartum depression) NYC Health Department Pregnancy Risk Assessment Monitoring System, 2016-2018; (Preterm births) NYC Health Department Office of Vital Statistics, 2008-2017; (Fully vaccinated children) NYC Health Department Citywide Immunization Registry, as of February 2020

Awareness of early intervention programs

Early identification of children experiencing developmental difficulties followed by appropriate intervention has been found to improve long-term academic, social and health outcomes, with benefits to children, families and society. A lower proportion of API parents with children younger than 6 years old are aware of early intervention programs compared with the city overall.

Awareness of early intervention programs[m]

[m] As reported by parents of children younger than 6 years.

A note about the effects of family separation on API families

Family separation has lasting effects that can result in intergenerational trauma, stress, and poor physical and mental health outcomes.

Among API families, family separation is intertwined with the challenges of navigating a system that tends to look at APIs as one uniform community, rather than as a diverse group of communities, each with its own unique set of strengths and challenges.[28,29,30]

Family separation can occur through reverse migration, which is the practice of sending U.S.-born children to their parents' country of origin to be raised by extended family members with the intention of bringing the children back to the U.S. once they reach school age. Family separation also occurs through the formation of transnational families. Transnational families are primarily defined as those with one or both parents who migrate to another country, often for work to support their immediate and extended families. Transnational workers, like other immigrants, face the challenges of adapting to a new culture and differences in language and communication, and accessing educational, health and social systems. Transnational workers and their families must also cope with the challenges of family separation. A 2011 study found poorer psychological well-being among children in Southeast Asia who were left behind by their migrant parents compared with children in non-migrant households.[31]

Family separation also occurs through immigration enforcement, which has a deep impact on API communities in NYC. Data show that U.S. Immigration and Customs Enforcement (ICE) is disproportionately targeting APIs living in NYC for detention and deportation. From 2016 to 2018, Chinese immigrants made up 21% of immigration cases, the largest of any nationality, followed by Indian immigrants at 10%.[32] These API ancestry groups are overrepresented in immigration court cases compared with the proportion of non-citizens living in NYC by nationality.

Data source: NYC Health Department NYC KIDS Survey, 2017

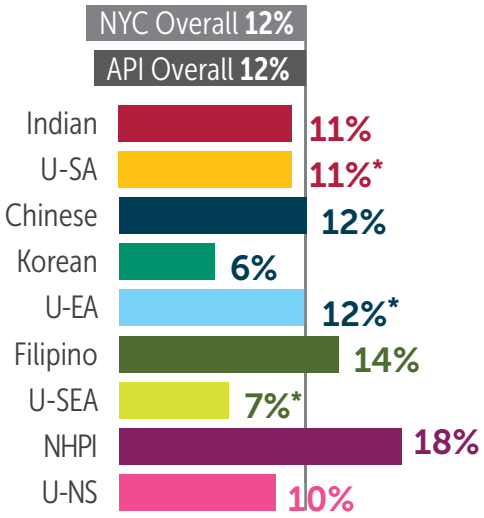
Health Care and Access

Health insurance

Having health insurance supports access to preventive and primary care services and reduces out-of-pocket medical costs.

API adults are twice as likely to be uninsured as White adults in NYC. Among Asian ancestry groups, the percentages of adults without insurance varies from 6% among Koreans to 14% among Filipinos; this rate is 18% among NHPI adults. Compared with U.S.-born API adults, twice as many API adults born outside of the U.S. are uninsured (6% vs. 13%). API adults born outside of the U.S. may face challenges due to cultural differences and language inaccessibility in our health systems. Legislative barriers, such as the threat of being labeled a public charge, or a fear of unknown and high out-of-pocket costs may prevent many from seeking medical attention at all.[33]

Adults without health insurance



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

Data source: NYC Health Department Community Health Survey (CHS), 2014-2018

Access to medical care

Medical care includes doctor visits, tests, procedures, prescription medication and hospitalizations.

A similar percentage of API adults report unmet medical care needs compared with all NYC adults (9% vs. 10%). Among Asian ancestry groups, a greater proportion of Indian and Underrepresented South Asians report needing medical care but not getting it compared with Chinese adults (13% and 22%, respectively, vs. 7%).

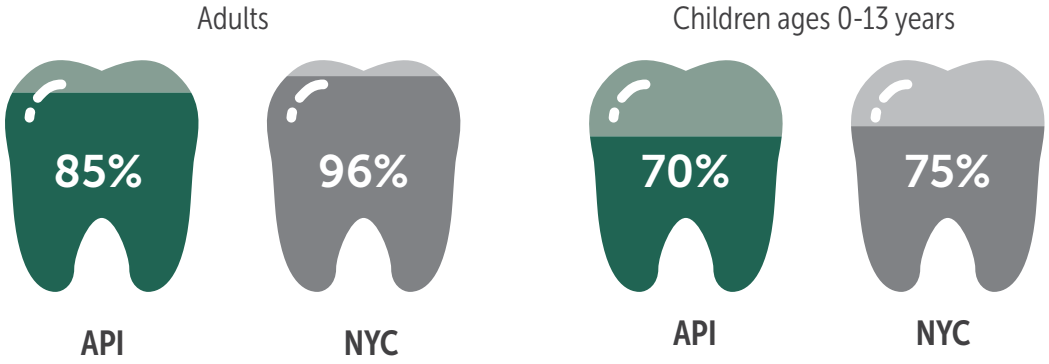
Access to a primary care provider

Primary care providers are important for both disease prevention and treatment. Compared with NYC adults, API adults are similarly likely to have a primary care provider (84% vs. 85%). Among API ancestry groups, Chinese adults are less likely than Indian adults to have a primary care provider (84% vs. 89%).

Dental health

Oral health is an essential part of overall health, and regular visits to the dentist are important to maintain healthy teeth and gums. A higher percentage of API adults have never had a preventive dental cleaning compared with NYC adults overall. Additionally, a smaller proportion of API children get preventive dental care in the past 12 months compared with White and Latino children.

People who received preventive dental care



Flu vaccination

Influenza (flu) is a serious, contagious respiratory illness caused by influenza viruses that can lead to hospitalization and death. Everyone ages 6 months and older should get the flu vaccine every year with rare exception.[n] API adults are more likely to have gotten a flu vaccine in the past 12 months compared with adults in NYC overall (48% vs. 44%).

Data source: (Access to medical care, primary care provider, flu vaccination) NYC Health Department Community Health Survey (CHS), 2014-2018; (Dental health) (Adults) NYC Health Department Community Health Survey (CHS), 2014; (Kids) NYC Health Department NYC KIDS Survey, 2017. [n] Some vaccines are not recommended in some situations or for some people.

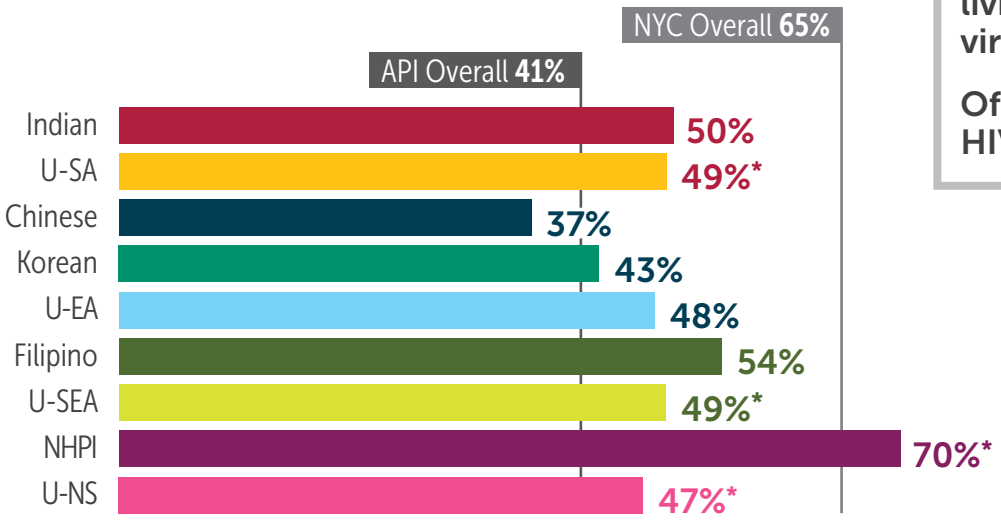
HIV prevention, testing and treatment

Some people with HIV do not know their HIV-positive status. Getting tested is the first step in getting HIV care and treatment and engaging in HIV prevention, but the stigmatization of HIV and openness to discussing sexual health may prevent APIs from getting tested.[34]

Only 41% of API adults report having ever been tested for HIV compared with 65% of all NYC adults, the lowest proportion among all major race and ethnicity groups. Among API adults, those born outside of the U.S. are less likely to have ever been tested than those born in the U.S. (39% vs. 59%). Among API ancestry groups, HIV testing proportions range from 37% among Chinese adults to 54% among Filipino adults; this rate is 70%° among NHPI adults. Of new HIV diagnoses among New Yorkers, 5% are among people who are API, although new diagnoses in this group could be underrepresented due to the relatively lower rate of testing among API New Yorkers.[35] Additionally, API adults are less likely to be aware of pre-exposure prophylaxis (PrEP) compared with White, Black and Latino adults (15% vs. 34%, 31% and 19%, respectively).

There are currently over 3,000 API New Yorkers living with HIV. Among APIs newly diagnosed with HIV, 84% were linked to HIV care within one month of their diagnosis. Finally, 92% of APIs living with HIV and receiving HIV medical care are virally suppressed.

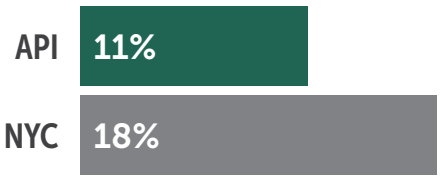
Adults ever tested for HIV



Of the 3,000 APIs currently living with HIV/AIDS, 92% are virally suppressed.

Of APIs newly diagnosed with HIV, 84% receive timely care.

High school students ever tested for HIV



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

Data source: (Testing and awareness of PReP) (Adults) NYC Health Department Community Health Survey, 2014-2018; (Testing) (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (New diagnoses, PLWHA and timely care) NYC Health Department HIV/AIDS Surveillance Registry, 1970-2018. ° Interpret estimate with caution due to small sample size.

Cancer screening

Early detection of breast and cervical cancer is important for effective treatment and care. Among female[p] APIs ages 40 years and older, 90% have ever had a mammogram, which is a similar percentage as female New Yorkers overall.

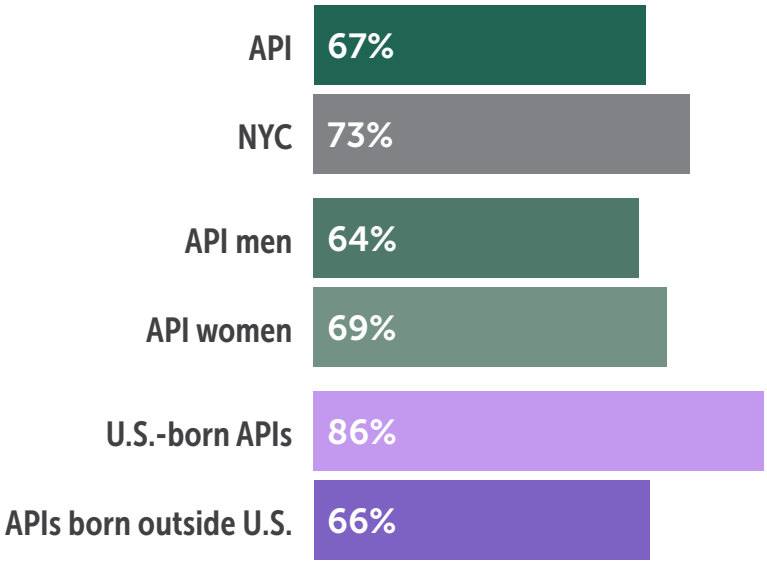
However, the percentage of female APIs who ever had a Pap smear (a test that can identify cervical cancer) is lower than the NYC average (67% vs. 85%). Female APIs who were born outside of the U.S. are less likely to have ever had a Pap smear compared with U.S.-born female APIs (65% vs. 86%).

Colon cancer, also called colorectal cancer, is the second-leading cause of cancer death in NYC. Screening is recommended because it can help prevent or detect colon cancer early, however there are known disparities in screening rates among API adults.[36] API adults ages 50 years and older are less likely to report ever receiving a colonoscopy compared with NYC adults ages 50 and older overall (67% vs. 73%). Among API adults, rates of colonoscopy screening are higher among women compared with men (69% vs. 64%) and among U.S.-born API adults compared with API adults born outside of the U.S. (86% vs. 66%).

Females[p] who have had a mammogram

Females[p] who have had a Pap smear

Adults ages 50 and older who have had a colonoscopy



[p] Those who reported their sex assigned at birth as female.

Data source: (Breast cancer screening) NYC Health Department Community Health Survey (CHS), 2014; (Cervical cancer screening) NYC Health Department Community Health Survey (CHS), 2017; (Colon cancer screening) NYC Health Department Community Health Survey (CHS), 2014-2018. [p] Those who reported their sex assigned at birth as female.

Mental Health

Mental health is a key part of overall well-being. Language, culture, and history – factors that influence mental health – vary among each API ancestry group.

The contrast between one's identity and cultural norms, a desire to fit in as an American, and experiences of discrimination and racism (historical, lived and ongoing) can affect mental health in API communities.[37,38] These experiences impact Asian ancestry groups in different ways,[38] and in the U.S., research suggests that some Asian ancestry groups experience more mental health problems than others.[39]

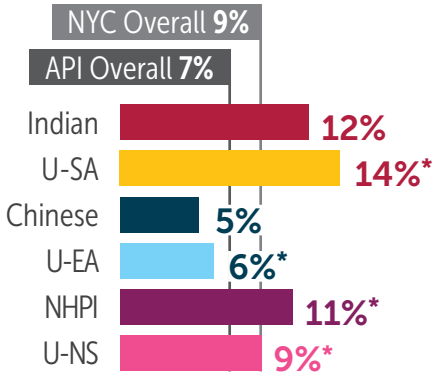
Use of mental health services varies by Asian ancestry group.[40] Access to culturally competent services and providers can influence one's connection to health care.[40]

API New Yorkers may not have access to quality care in their primary language, and mental health-related questions a doctor may ask may not translate into all Asian dialects.[41] Due to these cultural or linguistic differences, health care providers may lack knowledge of the ways that APIs may speak about mental health issues, making it harder to correctly interpret their mental health needs.[42] As the population of API New Yorkers continues to grow, designing mental health programs that provide culturally and linguistically responsive mental health care requires an understanding of how language, culture and history influence well-being.

Depression

The percentage of API New Yorkers who report experiencing depression is lower than the citywide average; however, the prevalence of depression varies by API ancestry groups. Indian adults have a higher prevalence of depression compared with Chinese New Yorkers.

Adults who experience depression[q]



[q] Data among Korean, Filipino and Underrepresented Southeast Asians (U-SEA) ancestry groups are suppressed due to imprecise and unreliable estimates.

U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.

U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.

NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.

U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

* Interpret estimate with caution due to small sample size.

Data source: NYC Health Department Community Health Survey (CHS), 2016-2018

Mental health care access and treatment

The percentage of adults who report needing mental health treatment but not getting it in the past year is lower among API adults than among NYC adults overall (2% vs. 4%).

However, this may underestimate the prevalence of unmet need, as many factors, including English-language proficiency and cultural norms as well as having a provider of the same heritage, are known to impact subjective assessments of mental health care needs.[43,44]

Mental health treatment can involve counseling, therapy or taking prescription medicines. API New Yorkers with depression are less likely to receive mental health treatment than White New Yorkers with depression (31% vs. 53%).

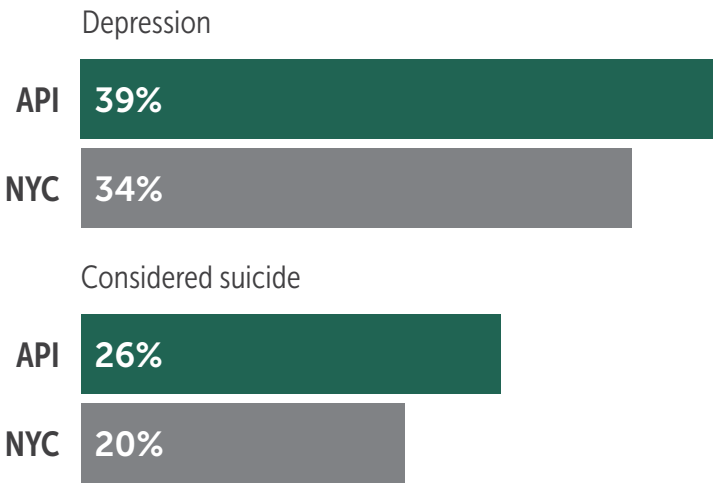
Teen mental health

Feeling sad or hopeless or considering suicide can be signs of depression or other mental health problems. Risk factors that make API youth particularly susceptible to depression and suicidality include bicultural tension, the struggle of preserving one's ethnic identity, ethnic marginalization and stereotypes such as the "model minority" myth.[45] Among NYC public high school students, similar proportions of API and White students have felt sad or hopeless for two or more weeks in the past year, to the extent that they stopped doing their usual activities (28% vs. 29%) or have considered suicide (14% vs. 15%). However, a lower proportion of API high school students seek help from a school counselor compared with their White peers (11% vs. 17%).

Among NYC public middle school students, similar proportions of API and White students report depressive symptoms (39% vs. 32%) or having considered suicide (26% vs. 20%). API middle school students are more likely to report having considered suicide than their Black or Latino peers (26% vs. 18% and 21%, respectively).

Mental health among public high school students

Mental health among public middle school students

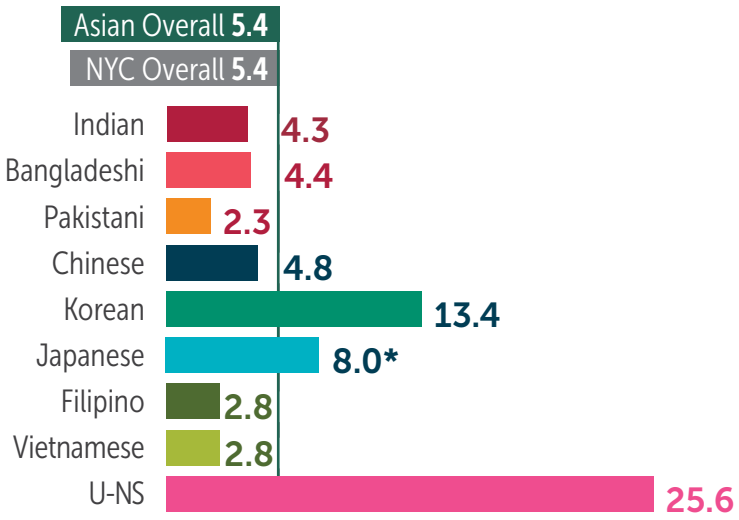


Data source: (Mental health care access and treatment) NYC Health Department Community Health Survey (CHS), 2016-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (Middle school students) NYC Health Department Middle School Youth Risk Behavior Survey, 2018

Suicide deaths

In 2008-2017, the average rate of suicide among APIs was 5.4 per 100,000, similar to the citywide rate. However, among Koreans and Japanese, this rate is higher than the citywide rate (13.4 and 8.0* per 100,000, respectively). Suicide is a leading cause of death in both South Korea and Japan[46] and is of particular concern among API teen girls.

Suicide rates[r]



[r] Age-adjusted rates per 100,000 population. Rates among NHPIs cannot be shown due to small number of events.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small number of events.

Unintentional drug overdose

In 2019, opioids were involved in 83% of all unintentional drug overdose deaths in NYC. APIs lower rate of unintentional overdose deaths compared with NYC overall (3.0 vs. 21.2 per 100,000).

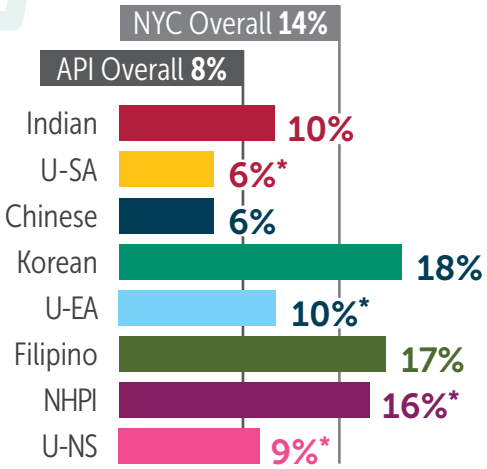
Data source: (Suicide rates) NYC Health Department Office of Vital Statistics, 2008-2017; (Overdose deaths) NYC Health Department Office of Vital Statistics/Office of the Chief Medical Examiner, 2019. * Interpret estimate with caution due to small number of events.

Health Outcomes

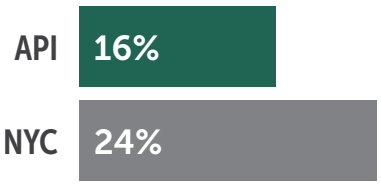
Asthma

The percentage of API children who have asthma is similar to NYC children overall. API public high school students have a lower asthma prevalence compared with NYC public high school students overall. API adults have a lower asthma prevalence compared with NYC adults overall.

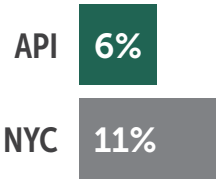
Adults who ever had asthma[s]



Teens who ever had asthma



Children (ages 0-13 years) who ever had asthma



[s] Data among Underrepresented Southeast Asians ancestry group are suppressed due to imprecise and unreliable estimates.
U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

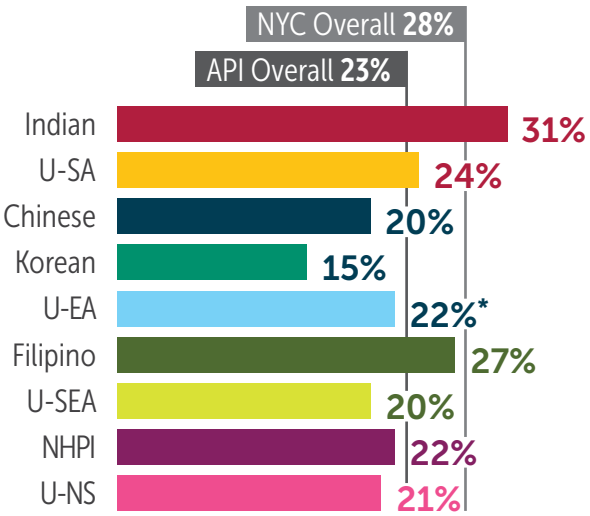
Data source: (Adults) NYC Health Department Community Health Survey (CHS), 2017-2018; (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (Children) NYC Health Department NYC KIDS Survey, 2017

High blood pressure

High blood pressure is the leading risk factor for stroke and heart diseases.

API adults have a lower prevalence of high blood pressure compared with NYC overall, but this varies among API ancestry groups. Almost one-third of Indian adults (31%) have high blood pressure, a higher rate than adults who identify as Chinese, Korean, Underrepresented Southeast Asian or Underrepresented Asian, non-specified.

Adults with high blood pressure



U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-EA: Underrepresented East Asians include participants who identified as Japanese and/or Mongolian.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

Obesity

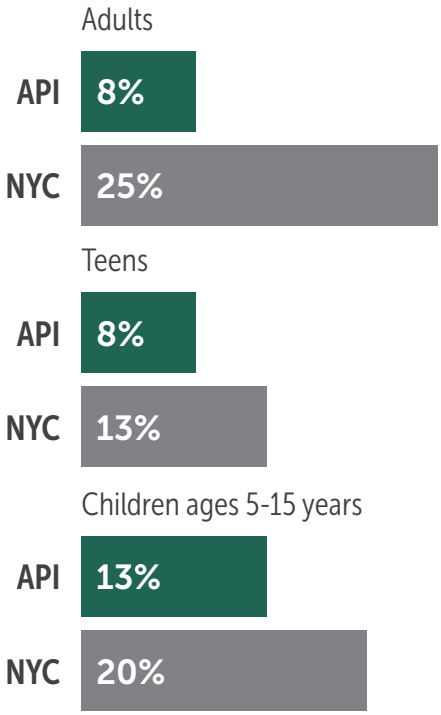
Obesity (having a body mass index, or BMI, of 30 or higher) can lead to serious health issues, including diabetes and heart disease.

Only 8% of API adults have obesity compared with 25% of all NYC adults. The obesity rate among API children is also lower than the citywide average (13% vs. 20%).

While API adults, in aggregate, have the lowest obesity rate among major race and ethnicity groups, API adults may be at higher risk of weight-related diseases, such as diabetes, at a lower BMI threshold.[47] Alternate thresholds published in the literature are variable,[48,49] but if the lowest proposed BMI cut-off for obesity is used (25 or higher instead of 30 or higher), 36% of API adults have obesity. API adults who are born outside of the U.S. are less likely to have obesity than those born in the U.S. (35% vs. 41%).

If the BMI cutoff was lowered to 25 or higher, 36% of APIs would have obesity.

People who have obesity[t]



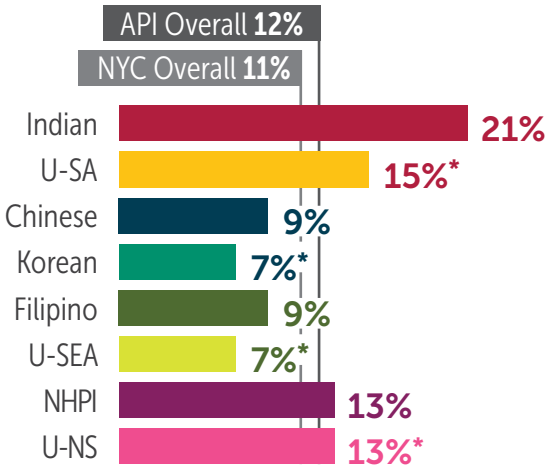
[t] Obesity is defined as having a BMI ≥ 30 for adults, and 95th percentile BMI for teens and children.

Data source: (High blood pressure and Obesity) (Adults) NYC Health Department Community Health Survey (CHS), 2014-2018; (Obesity) (Teens) NYC Health Department Youth Risk Behavior Survey (YRBS), 2017; (Obesity) (Children) NYC Department of Education, 2016-2017

Diabetes

API adults have a similar diabetes prevalence compared with NYC adults overall. However, the prevalence among Indian adults is 21%. This is higher than some of the other API ancestry groups, a finding supported by other studies.[15]

Adults with diabetes[u]



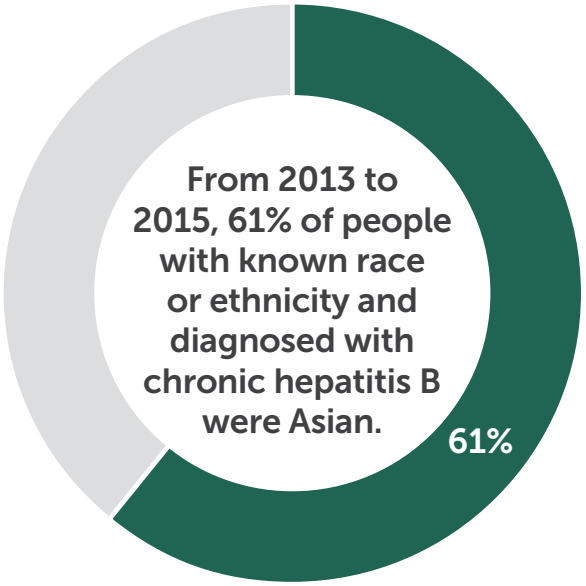
[u] Data among Underrepresented East Asians (U-EA) ancestry group are suppressed due to imprecise and unreliable estimates.
U-SA: Underrepresented South Asians include participants who identified as Bangladeshi, Bengali, Bhutanese, Nepali, Pakistani and/or Sri Lankan.
U-SEA: Underrepresented Southeast Asians include participants who identified as Burmese, Cambodian, Indonesian, Laotian, Malaysian, Singaporean, Thai and/or Vietnamese.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.
* Interpret estimate with caution due to small sample size.

Hepatitis B

Hepatitis B is a serious liver infection caused by the hepatitis B virus, which can damage the liver.

Most people living with chronic hepatitis B worldwide were infected during childbirth in an area of the world where hepatitis B is common (mainly Asia and parts of Africa). If a person who is pregnant has hepatitis B, the virus can be transmitted to the child during pregnancy and after giving birth.

Among people with chronic hepatitis B with known race or ethnicity and diagnosed from 2013 to 2015, 61% were Asian. From 2015 to 2019, of 6,523 people who gave birth and were diagnosed with chronic hepatitis B during pregnancy, 4,432 (68%) were Asian; nearly all (97%) were born outside of the U.S. Among Asian people who gave birth diagnosed with hepatitis B during pregnancy, 81% were Chinese, mainly originating from Fujian and Guangdong provinces (68% and 19%, respectively).



Data source: (Diabetes) NYC Health Department Community Health Survey (CHS), 2014-2018; (Chronic hepatitis B) NYC Health Department Communicable Disease Surveillance Registry, 2013-2015; (Perinatal hepatitis B) NYC Health Department Immunization Surveillance Registry, 2015-2019

Hepatitis A and typhoid/paratyphoid

Travelers visiting friends and relatives ("VFR travelers") in some Asian countries where infectious diseases are more common experience a greater risk of infection than other groups of international travelers.[50]

In NYC, where almost 70% of the API population is born outside of the U.S., diseases acquired during travel such as hepatitis A, typhoid and paratyphoid are a concern. Barriers for VFR travelers to protect themselves include:

- Lack of awareness of risk, including not receiving recommendations to avoid consuming untreated water and fresh fruits and vegetables when traveling to countries where diarrheal illness is common
- Lack of access to providers with travel health expertise
- Possible mistrust of the medical system
- Lack of insurance coverage for vaccines for travel

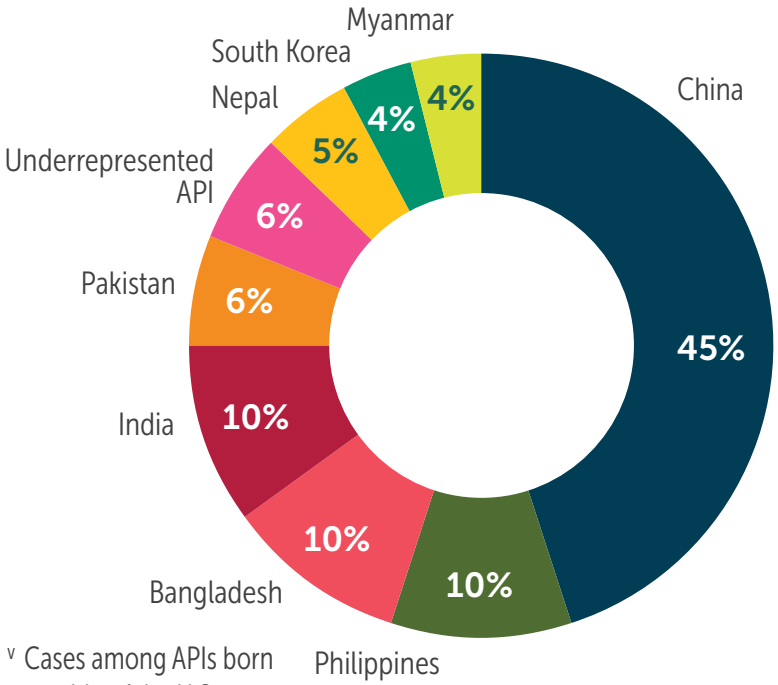
Hepatitis A is an acute, highly contagious liver infection caused by the hepatitis A virus that is transmitted fecal-orally, often through the consumption of contaminated food or water, and common in Latin America, the Caribbean, Africa, Eastern Europe and parts of Asia. In NYC, among people diagnosed with hepatitis A between 2014 to 2018 with known race or ethnicity, 16% were Asian. During this time period, 45% of all people with cases of hepatitis A infection reported travel to an area where hepatitis A is common; among Asian patients, 58% reported travel to an area where hepatitis A is common. Among Asian patients who traveled, 85% were recent immigrants, part-time residents, or were visiting friends or relatives in countries where hepatitis A is common. Similarly, more than 90% of typhoid and paratyphoid infections in the U.S. are in travelers to South Asia. Typhoid and paratyphoid are bacterial infections caused by consumption of contaminated food or water. Antibiotic treatment is available, but there has been an increase in drug resistance in South Asia, making it difficult to identify proper treatment for people who become sick.

Tuberculosis (TB)

In 2018, 84% of all confirmed NYC TB diagnoses occurred among patients born outside of the U.S.; the rate of TB among New Yorkers born outside of the U.S. is more than eight times the rate among U.S.-born.

Being born outside of the U.S. is a risk factor for TB because TB is common in many countries, including several in Asia. APIs with TB represent 49% of all NYC TB cases and of these, 98% were born outside of the U.S. By country of birth, the highest number of cases (120) are from people born in China, representing 45% of all TB cases among API New Yorkers. The highest rates of TB are among people born in Myanmar and Nepal.

TB cases by API country of birth[v]



[v] Cases among APIs born outside of the U.S.

Data source: (Hepatitis A) NYC Health Department Communicable Disease Surveillance Registry, 2014-2018; (Tuberculosis) NYC Health Department Tuberculosis Surveillance Registry, 2018

Cancer incidence

Cancer is the leading cause of death among API New Yorkers. API women have a higher rate of thyroid cancer compared with NYC women overall. API men have higher rates of liver and stomach cancer compared with NYC men overall.

Top five types of cancer

Women (rate per 100,000)	API	NYC
1. Breast	85.5	119.7
2. Thyroid (#5 NYC)	35.1	30.4
3. Lung and bronchus (#2 NYC)	30.5	40.5
4. Colon and rectum (#3 NYC)	24.8	33.3
5. Corpus uterus and NOS (not otherwise specified) (#4 NYC)	19.0	30.8

Men (rate per 100,000)	API	NYC
1. Lung and bronchus (#2 NYC)	55.2	56.6
2. Prostate (#1 NYC)	53.2	126.1
3. Colon and rectum (#3 NYC)	36.5	46.3
4. Liver/intrahepatic bile duct	23.0	18.0
5. Stomach	22.8	14.9

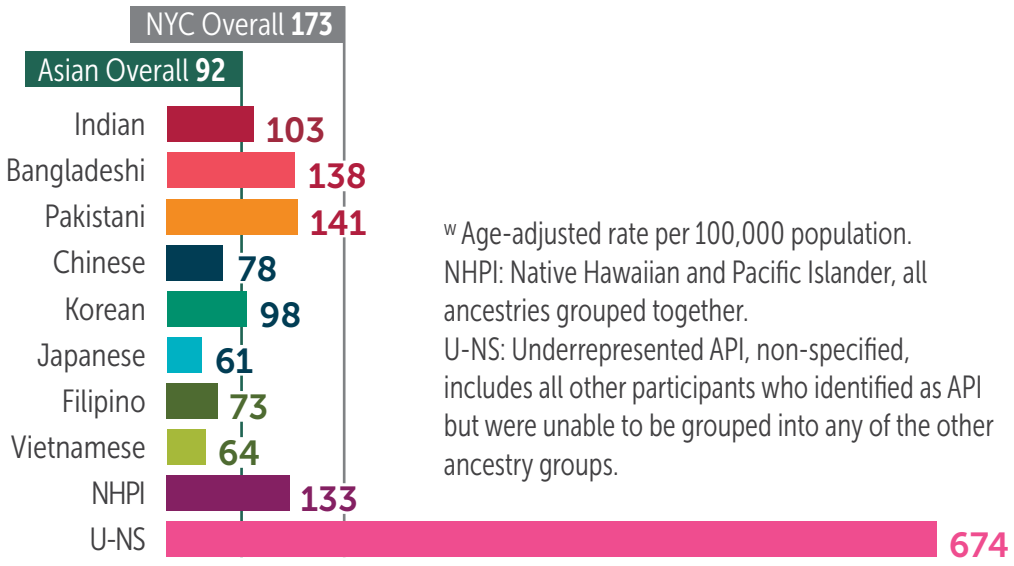
Infant death

Among all APIs, infant death rates per 1,000 live births are lower when compared with NYC overall (2.9 vs. 4.4). Chinese, Korean and Filipino infant death rates are all lower than the citywide rate (1.9, 2.2 and 3.0, respectively, vs. 4.4).

Premature death

The rate of premature death (death before the age of 65 years) is lower among Asians and NHPIs compared with NYC overall (92 and 133, respectively, vs. 173 per 100,000). Among API ancestry groups, the lowest premature death rates are 61 and 64 per 100,000 among Japanese and Vietnamese adults.

Deaths among people younger than 65 years[w]



[w] Age-adjusted rate per 100,000 population.
NHPI: Native Hawaiian and Pacific Islander, all ancestries grouped together.
U-NS: Underrepresented API, non-specified, includes all other participants who identified as API but were unable to be grouped into any of the other ancestry groups.

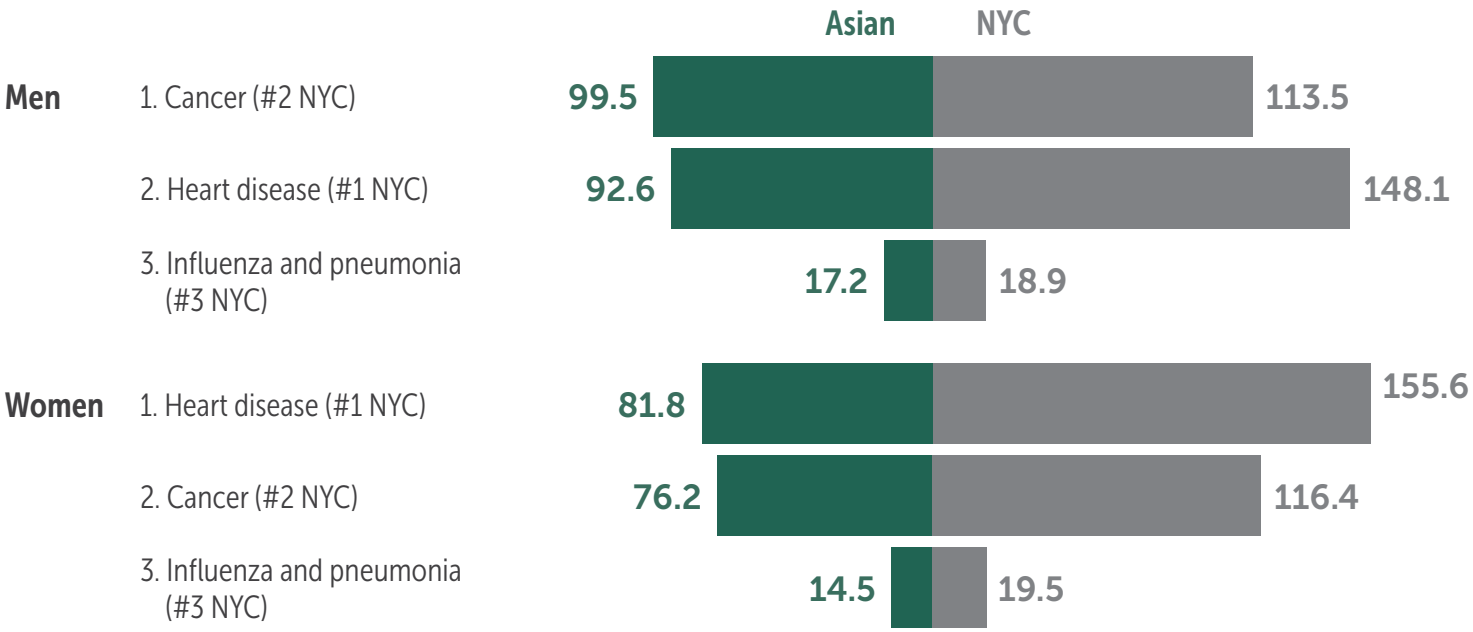
Data source: (Cancer) New York State Cancer Registry, 2012-2016; (Infant death and Premature death) NYC Health Department Office of Vital Statistics, 2008-2017

Top causes of death

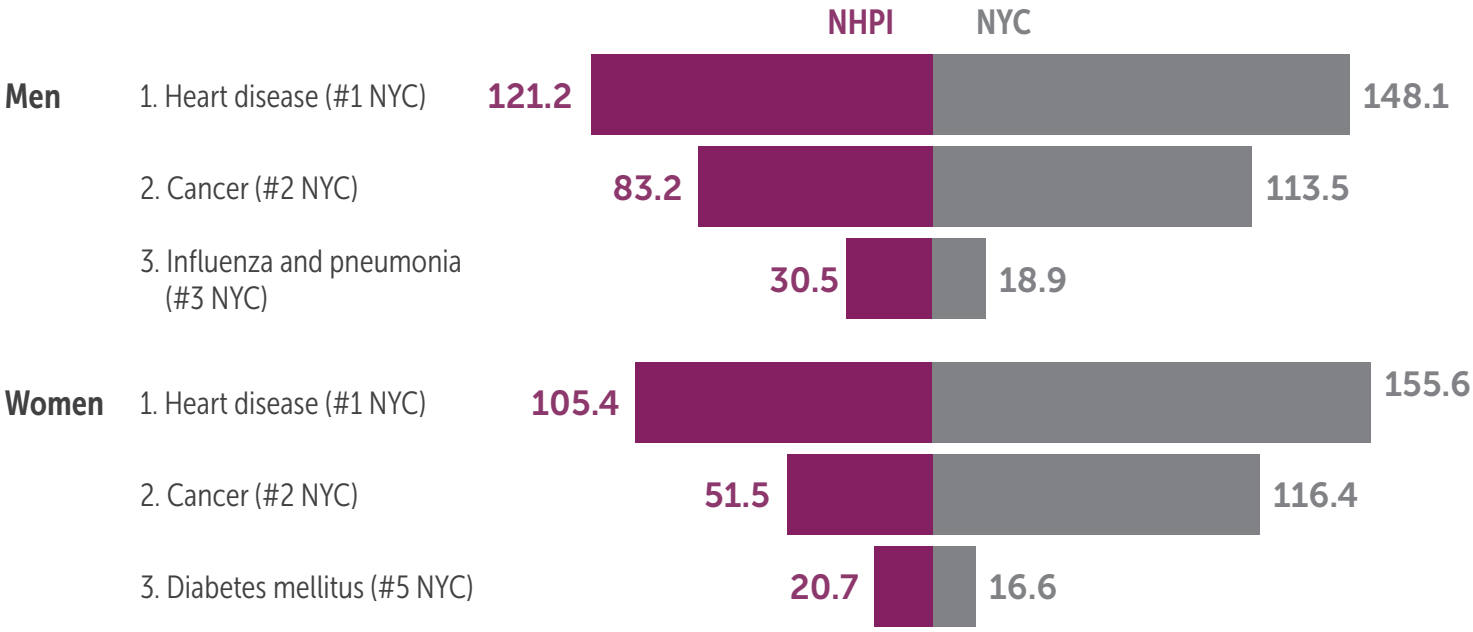
The top three causes of death among Asians are cancer, heart disease, and influenza/pneumonia. The top three causes of death among NHPIs are heart disease, cancer, and, tied for third, influenza/pneumonia and diabetes. Cancer and heart disease remain the leading causes of death among all API ancestry groups, and rates of heart disease deaths among Pakistanis are higher than NYC overall. For older adults, cultural variations must be taken into consideration to improve quality of life and palliative care (medical care for people living with serious illness) practices.A multifaceted approach to developing culturally appropriate end of life care is a necessity.[51]

Top three causes of death[x]

Asian



NHPI



[x] Age-adjusted rate per 100,000 population.

Data source: NYC Health Department Office of Vital Statistics, 2008-2017

Resources and Resilience

This report reflects an initial step in understanding and addressing the current health realities faced by the very diverse API communities in NYC. Working to redress our history of discrimination and acknowledging the multicultural tensions endured by not only APIs but so many other marginalized communities is critical to resolving the inequities in health and well-being.

Although API communities struggle with many aspects of health, these communities also connect in the face of these challenges to promote health and well-being. These connections might come from faith-based networks, social media or community-based organizations, among others. As we have seen from large-scale social and public health events, such as the Black Lives Matter movement and the COVID-19 public health emergency, it is essential to the health of our city to build resilience, share resources and support one another.

Community Partner Resources

- Apicha Community Health Center
- Asian American Federation
- Asian Americans for Equality
- Bangladeshi American Community Development and Youth Services
- Charles B. Wang Community Health Center
  - Community Resources
- Chinese-American Family Alliance for Mental Health
- New York City Commission on Human Rights
- City University of New York Borough of Manhattan Community College: Building Asian American Studies Across the Community
  - Racial Injustice Resource
- Coalition for Asian American Children and Families
- Community Healthcare Network (Asian Health Services)
- Council of Peoples Organizations
- Gay Asian and Pacific Islander Men of New York
- General Human Outreach in the Community, Inc.
- Japanese American Social Services, Inc.
- Korean Community Services
- Mayor's Office of Immigrant Affairs
  - A Demographic Snapshot: NYC's API Immigrant Population
- New York University (NYU) Center for the Study of Asian American Health
- New York University College of Nursing
- South Asian Council for Social Services
- Seventh Avenue Family Health Center at NYU Langone
- United Territories of the Pacific Islanders' Alliance NYC

Additional Resources

- 18 Million Rising
- AAPI Data
- Asian and Pacific Islander American Health Forum (APIAHF) Health Response Hate Crime Resources
- Asian Americans Advancing Justice
  - Resources for the Asian American Community on Anti-Blackness
- Asian Pacific Institute on Gender-Based Violence
- Asian American Bar Association of New York
  - A Rising Tide of Hate and Violence against Asian Americans in New York During COVID-19: Impact, Causes, Solutions
- Asian Pacific Policy and Planning Council
  - Stop AAPI Hate Reporting Center
- Association of Asian Pacific Community Health Organizations
  - COVID-19 Resources
- Chinese-American Planning Council-NYC
  - Chinese Community Resource Guide-NYC
- National Asian American Pacific Islander Mental Health Association
- National Center of Domestic and Sexual Violence-Asian American
- OCA-Asian Pacific American Advocates
- Red Canary Song

Analyses

Indicators were selected for this report based on feedback from the NYC Health Department and external content experts. The final list of indicators reflects those considered high priority and most relevant for API communities in NYC.

For most data, 95% confidence intervals (range of values in which we are 95% sure the true value lies) were calculated for API overall and NYC. If the confidence intervals did not overlap, a significant difference was inferred. This is a conservative measure of statistical difference. For comparisons by major race and ethnicity, API ancestry, nativity, sex, and household income groups, t-tests (statistical test used to compare groups) were conducted to determine if each estimate was statistically different from the reference group. Unless otherwise indicated, reference groups include API, Chinese, U.S.-born, men and household income < 200% below federal poverty level, respectively. The report text highlights significant findings but does not include all significant results.

Most estimates were evaluated for statistical stability. Estimates with a relative standard error (RSE) > 30% or with a small sample size or small numbers of events (≤ 10) are noted as follows: "Interpret estimate with caution due to small sample size." All estimates in this report are age-adjusted. Estimates were also weighted to represent the NYC population and compensate for unequal probability of selection and non-response bias.

For a complete dataset including numbers, rates, t-tests and confidence intervals, as well as more technical notes on race and ancestry definitions, analyses and data sources with complete citations, visit **nyc.gov/health** and search for **Health of Asians and Pacific Islanders in New York City**.

Acknowledgments

Thank you to everyone who contributed to this report:

Core team:

Liza King, Wen Qin Deng, Kinjia Hinterland, Hannah Gould, Musarrat Rahman, Barbara Wong, Martha Alexander, Jenny Tiberio, Qiu Xia (Helen) Guan, Christina Lee, Olivia Trieu, Lindsay Berat, Su Yadana, Chelsea Mai

The NYC Health Department Asian American and Pacific Islander Employee Resource Group

NYC Health Department advisory team:

Marivel Davila, Pauline Ferrante, Sejal Kothari, Wenhui Li, Wendy McKelvey, Katharine McVeigh, Maria (Angela) Soto, Dira Treadvance, Tsu-Yu Tsao, Tenzin Tseyang, Aishwarya (Anita) Viswanath, Olivia Weng, Ricky Wong, John Yates

Community partners:

Sudha Acharya (South Asian Council for Social Services), Linh An (Chinese-American Family Alliance for Mental Health), Kajori Chaudhuri (New York City Commission on Human Rights), Rajju Malla Dhakal (Bangladeshi American Community Development and Youth Services), Melanie Dulfo (APICHA Community Health Center), Emerson Ea (New York University (NYU) College of Nursing), Naumi Feldman (Charles B. Wang Community Health Center), Crystal Feng (Asian Americans for Equality), Sabrina Fong (Mayor's Office of Immigrant Affairs), Mary Joy Garcia-Dia (Kalusugan Coalition), Anita Gundanna (Coalition for Asian American Children and Families), Chiya Ikemi (Japanese American Social Services Inc.), Nadia Islam (New York University Center for the Study of Asian American Health (NYU CSAAH)), Soonsik "Sara" Kim (Korean Community Services), Simona Kwon (NYU CSAAH), Etienne Leomiti (United Territories of Pacific Islanders Alliance (UTOPIA) NYC), Patrick Lin (Gay Asian and Pacific Islander Men of New York), Sahnah Lim (NYU CSAAH), Soniya Munshi (City University of New York - Building Asian American Studies across the Community), Hasan Raza (Council of Peoples Organization), Jennifer Sun (Asian Americans for Equality), Christina Tsai (Seventh Avenue Family Health Center at NYU Langone Health), Freeman Tsui (General Human Outreach In the Community Inc.), Susan Yee (Community Healthcare Network - Asian Health Services)), Stella Yi (NYU CSAAH), JoAnn Yoo (Asian American Federation), Moumita Zaman (New York City Commission on Human Rights)

Contributors by section:

Asians and Pacific Islanders in New York City: Gretchen Culp, Susan Kum, Kari Patel, Neela Persad, Musarrat Rahman, Susan Resnick

A Note About COVID-19: Kajori Chaudhuri, Scott Harper, Charles Ko, Jaimie Shaff, Andy Tang, Moumita Zaman

Social and Economic Conditions: Jenny Tiberio

Housing and Community: Jayme Day (Department of Homeless Services), Paromita Hore, Wendy McKelvey, Ariel Spira-Cohen, Jenny Tiberio

Healthy Living: Wen Qin Deng, Chelsea Mai

Family and Child Health: Gemily Abadines, Tracy Agerton, Lauren Birnie, Kuen (Iris) Cheng, Sophia Day, Subhani Gurung, Kevin Konty, Marissa Langdon-Embry, Wenhui Li, Katharine McVeigh, Vassiliki Papadouka, Jaimie Shaff

Health Care and Access: Sarah Braunstein, Prapitha Suresh, Olivia Weng

Mental Health: Jennifer Hoenig, Charles Ko, Lauren Martini, Christina Norman, Jaimie Shaff, Ellenie Tuazon, Alice Welch

Health Outcomes: Shama Ahuja, Angelica Bocour, Shadi Chamany, Subhani Gurung, Julie Lazeroff, Wenhui Li, Jyotsna Ramachandran, Vasudha Reddy, Lisa Trieu, Katherine Van Oss

Additional contributors:

Nellie Afshar, Adriana Andaluz, Katherine Bartley, Caeyenne Brown, Aldo Crossa, Chinazo Cunningham, Demetre Daskalakis, Rachel Davis, Yangcheng Dongchung, Sarah Dumas, Torian Easterling, Olivia Giordano, Charon Gwynn, Subhani Gurung, Tony He, Hannah Helmy, Mary Huynh, John Jasek, Maura Kennelly, Sana Khan, Hilary Kunins, Amber Levanon Seligson, Josephine Lew, Sungwoo Lim, Nneka Lundy de la Cruz, Jennifer MacDonald, Gil Maduro, Asiya Mahmood, Tamar Marder, Michelle Morse, Aman Nakagawa, Han Nguyen, Emiko Otsubo, Denise Paone, Amanda Phi, Corinne Schiff, Catherine Stayton, Daniel Stephens, Ying Sun, Darrin Taylor, Warren Tong, Sarah Walters, Gretchen Van Wye, Abigail Velikov, Jeannette Williams, Carol Yoon, Jane Zucker

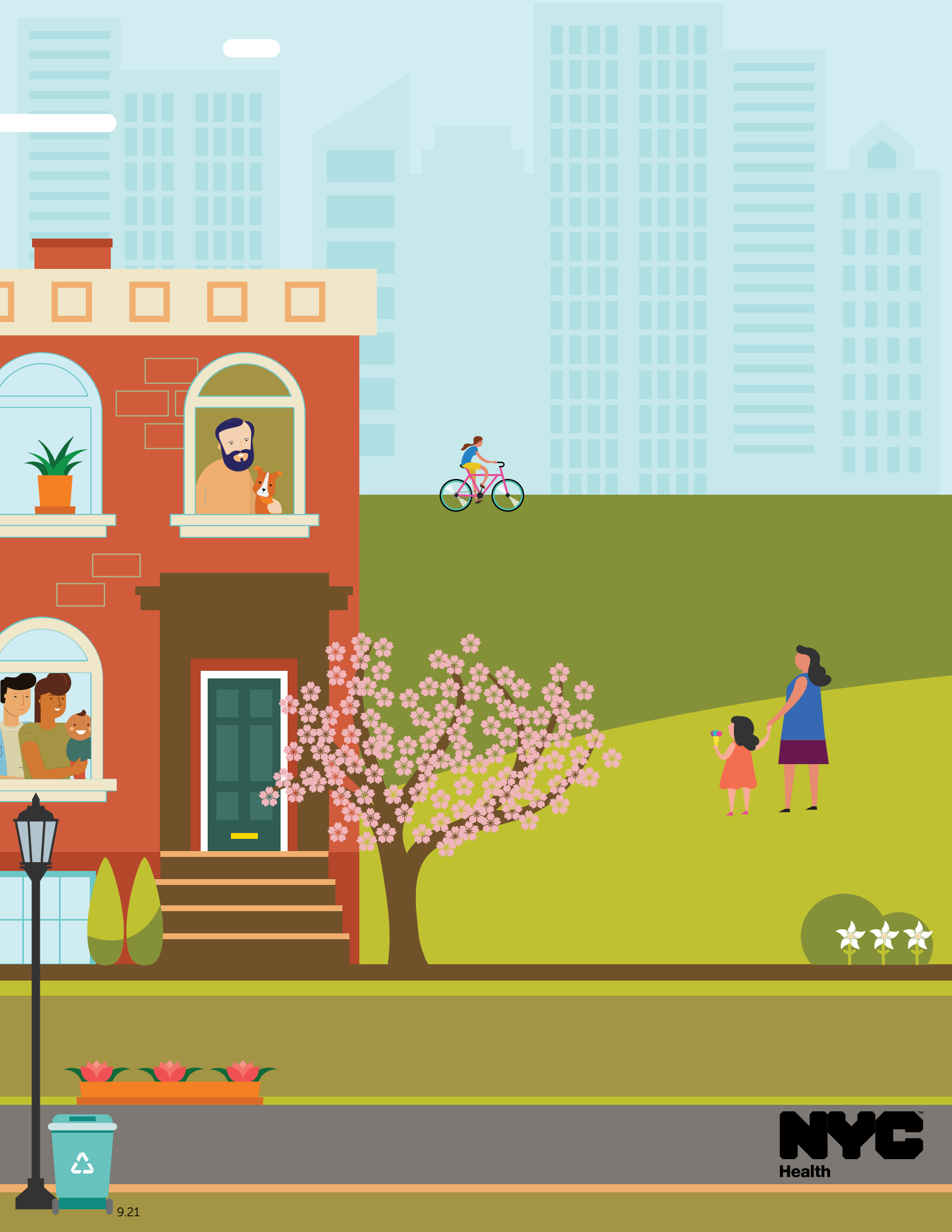
References

1. Niheu Ka, Turbin L, Yamada S. The impact of the military presence in Hawai'i on the health of Na Kănaka Maoli. Pacific health dialog. 2007; 14:205-12.
2. Poon O, Squire D, Kodama C, Byrd A, Chan J, Manzano L, et al. A Critical Review of the Model Minority Myth in Selected Literature on Asian Americans and Pacific Islanders in Higher Education. Review of Educational Research. 2016; 86:469-502.
3. Johns Hopkins Coronavirus Resource Center. COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU). Johns Hopkins University and Medicine; 2020 [updated July 14, 2021; cited 2021]; Available from: https://coronavirus.jhu.edu/map.html.
4. Mount Sinai. Mount Sinai Study Finds First Cases of COVID-19 in New York City are Primarily from European and US Sources. Available from: https://www.mountsinai.org/about/newsroom/2020/mount-sinai-study-finds-first-cases-of-covid-19-in-new-york-city-are-primarily-from-european-and-us-sources-pr.
5. Chin MK, Doan LN, Chong SK, Wong JA, Kwon SC, Yi SS. Asian American Subgroups And The COVID-19 Experience: What We Know And Still Don't Know. Health Affairs Blog. May 24, 2021.
6. New York City Department of Health and Mental Hygiene. Available from: https://www1.nyc.gov/site/doh/covid/covid-19-data.page. Date accessed: July 9, 2021.
7. Yan BW, Ng F, Chu J, Tsoh J, Nguyen T. Asian Americans Facing High COVID-19 Case Fatality. Health Affairs Blog, July 13, 2020.
8. Marcello RK, Dolle J, Tariq A, Kaur S, Wong L, Curcio J, et al. Disaggregating Asian Race Reveals COVID-19 Disparities among Asian Americans at New York City's Public Hospital System. medRxiv. 2020:2020.11.23.20233155.
9. AP3CON. Stop AAPI Hate Reporting Center. Asian Paciific Policy and Planning Council; 2020 [cited 2020]; Available from: http://www.asianpacificpolicyandplanningcouncil.org/stop-aapi-hate/.
10. Kim, A., Khan, R., & Shih, H. Small Business, Big Losses. Asian American Federation, 2021. Accessed at: https://www.aafederation.org/wpcontent/uploads/2021/05/Small_Biz_Survey.pdf.
11. Rosa A. (2021). How Asians became the most vaccinated group in New York City. The New York Times. Available from: https://www.nytimes.com/2021/05/05/nyregion/vaccinations-asian-americans.html.
12. McLennan AK, Ulijaszek SJ. Obesity emergence in the Pacific islands: why understanding colonial history and social change is important. Public Health Nutr. 2015; 18:1499-505.
13. Kasinitz P, Mollenkopf JH, Waters MC. Becoming New Yorkers: Ethnographies of the New Second Generation. Kasinitz P, Mollenkopf JH, Waters MC, editors: Russell Sage Foundation; 2004.
14. Fink Z. NYC's South Asians Continue to Be Underrepresented in State Legislature, Despite Population Growth. 2019: Available from: https://www.ny1.com/nyc/all-boroughs/politics/2019/12/17/south-asians-continue-to-be-underrepresented-in-albany.
15. Islam NS, Wyatt LC, Kapadia SB, Rey MJ, Trinh-Shevrin C, Kwon SC. Diabetes and associated risk factors among Asian American subgroups in New York City. Diabetes Care. 2013; 36:e5-e.
16. Arnett DK, Blumenthal RS, Albert MA, Buroker AB, Goldberger ZD, Hahn EJ et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019 Sep 10;140(11):e596-e646.
17. Kosciw JG, Greytak EA, Zongrone AD, Clark CM, Truong NL. The National School Climate Survey: The experience of lesbian, gay, bisexual, transgender and queer youth in our nation's schools. New York: GLSEN2018.
18. Tan JY, Xu LJ, Lopez FY, Jia JL, Pho MT, Kim KE, et al. Shared Decision Making Among Clinicians and Asian American and Pacific Islander Sexual and Gender Minorities: An Intersectional Approach to Address a Critical Care Gap. LGBT Health. 2016; 3:327-34.
19. Kochhar R, Cilluffo A. Income Inequality in the U.S. Is Rising Most Rapidly Among Asians. 2018: Available from: https://www.pewsocialtrends.org/2018/07/12/income-inequality-in-the-u-s-is-rising-most-rapidly-among-asians/.
20. Tran V. Asian Americans are falling through the cracks in data representation and social services. Urban.org: UrbanWire; 2018.
21. New York City Mayor's Office of Immigrant Affairs. State of Our Immigrant City. New York 2019.
22. Berg-Weger M, Morley JE. Editorial: Loneliness and Social Isolation in Older Adults during the COVID-19 Pandemic: Implications for Gerontological Social Work. J Nutr Health Aging. 2020; 24:456-8.
23. Hu C, Esthappan S. Asian Americans and Pacific Islanders, a missing minority in criminal justice data. Urban.org. 2017.
24. McKelvey W, Alex B, Chernov C, Hore P, Palmer CD, Steuerwald AJ, et al. Tracking Declines in Mercury Exposure in the New York City Adult Population, 2004–2014. Journal of Urban Health. 2018; 95:813-25.

Institute of Medicine (US) Committee on Assessing Interactions Among Social B, and Genetic Factors in Health. Genes, Behavior, and the Social Environment. Washington DC: National Academies Press. 2006.

25. Ulijaszek S. Modernisation, migration and nutritional health of Pacific Island populations. Environ Sci. 2005;12(3):167-76. PMID: 16077468.
26. Hu C. What we know about intimate partner violence in Asian American and Pacific Islander communities. UrbanWire: Crime and Justice. Urban.org: Urban Institute; 2018.
27. Bith-Melander P, Chowdhury N, Jindal C, Efird JT. Trauma Affecting Asian-Pacific Islanders in the San Francisco Bay Area. Int J Environ Res Public Health. 2017; 14:1053.
28. Huang K-Y, Calzada E, Cheng S, Brotman LM. Physical and mental health disparities among young children of Asian immigrants. J Pediatr. 2012; 160:331-6.e1.
29. Shih K. Transnational Families. 2015.
30. Graham E, Jordan LP. Migrant Parents and the Psychological Well-Being of Left-Behind Children in Southeast Asia. J Marriage Fam. 2011; 73:763-87.
31. Bureau of Policy and Research. The Demographics of Detention: Immigration Enforcement in NYC Under Trump. In: Stringer OotNYCCSM, editor. New York2019.
32. Le-Doux C, Stephens KS. Refugee and Immigrant Social Service Delivery. Journal of Multicultural Social Work. 1992; 2:31-46.
33. Downer G. Be Safe: A Cultural Competency Model for Asians and Pacific Islanders. Available from: https://targethiv.org/sites/default/files/file-upload/resources/BESAFE_API_2009.pdf.
34. Rahnama R, Agbayani N, Lavilla S. What are Asian and Pacific Islanders' HIV prevention needs? In: Organizations AoAPCH, editor. University of California San Francisco: John Chin, PHD: NY Academy of Medicine; 2007.
35. Rastogi N, Xia Y, Inadomi JM, Kwon SC, Trinh-Shevrin C, Liang PS. Disparities in colorectal cancer screening in New York City: An analysis of the 2014 NYC Community Health Survey. Cancer Med. 2019; 8:2572-9.
36. Chau V, Bowie JV, Juon HS. The association of perceived discrimination and depressive symptoms among Chinese, Korean, and Vietnamese Americans. Cultur Divers Ethnic Minor Psychol. 2018; 24:389-99.
37. Mohatt NV, Thompson AB, Thai ND, Tebes JK. Historical trauma as public narrative: a conceptual review of how history impacts present-day health. Soc Sci Med. 2014; 106:128-36.
38. Lui PP. Intergenerational cultural conflict, mental health, and educational outcomes among Asian and Latino/a Americans: Qualitative and meta-analytic review. Psychol Bull. 2015; 141:404-46.
39. Cho H, Kim I, Velez-Ortiz D. Factors Associated with Mental Health Service Use Among Latino and Asian Americans. Community Mental Health Journal. 2014; 50:960-7.
40. Lee SY, Martins SS, Lee HB. Mental disorders and mental health service use across Asian American subethnic groups in the United States. Community Ment Health J. 2015; 51:153-60.
41. Purnell TS, Marshall JK, Olorundare I, Stewart RW, Sisson S, Gibbs B, et al. Provider Perceptions of the Organization's Cultural Competence Climate and Their Skills and Behaviors Targeting Patient-Centered Care for Socially At-Risk Populations. J Health Care Poor Underserved. 2018; 29:481-96.
42. Bauer AM, Chen C-N, Alegría M. English language proficiency and mental health service use among Latino and Asian Americans with mental disorders. Med Care. 2010; 48:1097-104.
43. Mojtabai R, Olfson M, Mechanic D. Perceived Need and Help-Seeking in Adults With Mood, Anxiety, or Substance Use Disorders. Archives of General Psychiatry. 2002; 59:77-84.
44. 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. Journal of health care for the poor and underserved. 2015; 26:191-237.
45. Kim SY, Kim MH, Kawachi I, Cho Y. Comparative epidemiology of suicide in South Korea and Japan: effects of age, gender and suicide methods. Crisis. 2011; 32:5-14.
46. Hsu WC, Araneta MRG, Kanaya AM, Chiang JL, Fujimoto W. BMI Cut Points to Identify At-Risk Asian Americans for Type 2 Diabetes Screening. Diabetes Care. 2015; 38:150.
47. Yi SS, Kwon SC, Wyatt L, Islam N, Trinh-Shevrin C. Weighing in on the hidden Asian American obesity epidemic. Prev Med. 2015; 73:6-9.
48. Misra A. Ethnic-Specific Criteria for Classification of Body Mass Index: A Perspective for Asian Indians and American Diabetes Association Position Statement. Diabetes Technol Ther. 2015;17(9):667-671.
49. Adamson R, Reddy V, Jones L, Antwi M, Bregman B, Weiss D, et al. Epidemiology and burden of hepatitis A, malaria, and typhoid in New York City associated with travel: implications for public health policy. Am J Public Health. 2010; 100:1249-52.
50. Wei L, Walters J, Guo Q, Fetherston C, O'Connor M. Meaningful and culturally appropriate palliative care for Chinese immigrants with a terminal condition: a qualitative systematic review protocol. JBI Database System Rev Implement Rep. 2019; 17:2499-505.

Suggested citation: King L, Deng WQ, Hinterland K, Rahman M, Wong BC, Mai C, Gould LH. Health of Asians and Pacific Islanders in New York City. 2021; 1-52.



NYC Health

9.21