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Resource Paper

Structural Racism and Its Effects on Native Hawaiians and Pacific Islanders in the United States: Issues of Health Equity, Census Undercounting, and Voter Disenfranchisement

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Abstract

In the current historical moment, Native Hawaiians and Pacific Islanders (NHPIs) in the United States experience high levels of COVID-19 infection and death, risk losing billions in federal funding due to census undercounting, and have less political power due to systemic voter disenfranchisement. We believe these challenges result in large part from structural racism—the inequitable systems that reinforce racial discrimination in society—that unjustly disadvantages NHPIs and other people of color. In this paper, we describe how structural racism is manifesting in health and social inequities for NHPIs in the United States. Lastly, we provide recommendations for achieving justice and equity for NHPI communities.

Introduction

Under the shadow of the current COVID-19 global pandemic, Native Hawaiians and Pacific Islanders (NHPIs) in the United States are disproportionately suffering from high rates of infection and death, as

well as the socioeconomic strain of shelter-in-place orders (Botts, 2020; Huang, 2020). Adding to these burdens, NHPIs run the risk of losing billions in federal funding and having inadequate political representation, due to the likelihood of being undercounted in the 2020 U.S. Census (Fuchs, 2018). With such high stakes in this 2020 presidential election year, NHPIs are at high risk of experiencing voter disenfranchisement, thus diminishing their political power (Murriel, 2016). These important issues are not unrelated. We contend that the health and social inequities facing NHPI communities in the United States fundamentally stem from long-standing, embedded *structural racism* (Gee & Ford, 2011).

Structural racism is defined as "the totality of ways in which societies foster racial discrimination, via mutually reinforcing inequitable systems (e.g., in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values, and distribution of resources, reflected in history, culture, and interconnected institutions" (Bailey et al., 2017, pp. 1454). Importantly, structural racism may be the result of direct, intentional racial bias, or it may be the result of automatic, subconscious disparate treatment (i.e., implicit bias) directed at a group of people (Reskin, 2012). Therefore, purposeful biased treatment and intentions are not necessary components of structural racism; the disparate impact of a program or policy that unjustifiably disadvantages a racial/ethnic group is enough to support a structural racism framework (Gee & Ford, 2011).

This paper provides context for how historical structural racism affects NHPIs in the United States today. We demonstrate how structural racism is manifesting in the context of the COVID-19 pandemic, the 2020 U.S. Census, and upcoming democratic elections. Further, we provide recommendations for how to mitigate the effects and undo the bonds of structural racism against NHPIs (Geronimus, 2000).

A Brief Overview of Structural Racism and Its Effects on NHPIs

The history of NHPIs in the United States is one marred by colonialism, oppression, and exploitation driven primarily by white supremacy (Kaholokula, 2016; Kaholokula et al., 2020). Before we embark into this brief overview, it is important to note that NHPIs are extremely diverse, with various histories, languages, cultures, and aspirations. An in-depth exploration of each of these histories is beyond the scope of this paper. Instead, we provide a brief overview of how these histories are linked to structural racism in the U.S. context.

NHPIs are the indigenous peoples of three major regions of the Pacific: Melanesia (e.g., Fiji and Vanuatu), Micronesia (e.g., the Federated States of Micronesia, Guam, the Marshall Islands, and Palau), and Polynesia (e.g., American Sāmoa, Hawaiʻi, Sāmoa, and Tonga) (Fischer, 2002). Europeans arrived in the Pacific Islands as early as the sixteenth century following Ferdinand Magellan's expedition for new trade routes (Camacho, 2011). By the late 1700s, colonizers began arriving in greater numbers with the intent to Christianize the natives, exploit the natural resources, and develop commerce (Kaholokula et al., 2020). The arrival of these foreigners introduced infectious diseases such as smallpox, measles, and influenza to the Pacific Islands, for which the indigenous people had no natural immunity, almost entirely decimating NHPI populations within the following century (Bushnell, 1993; Goo, 2015). In addition, colonizers abducted many NHPIs to exploit their bodies and labor on plantations (Christopher, Pybus, & Rediker, 2007; Speedy, 2015).

International violent conflicts in the late 1800s to early 1900s led to increased military occupation and eventual takeover of many Pacific Islands by the United States (Kaholokula et al., 2020). Following World War II, the United States used the Marshall Islands to conduct sixty-seven thermonuclear tests, detonating the explosive yield equivalent of 7,200 Hiroshima bombs (an average of 1.6 Hiroshima bombs per day) for twelve years between 1946 and 1958 (Palafox & Hixon, 2011). This resulted in indigenous Marshallese and other Micronesians being exposed to high levels of radiation, causing acute health problems as well as increased risk for various cancers and metabolic diseases that persist to the present (McElfish, Hallgren, & Yamada, 2015; Pollock, 2002). The radiation deemed some islands completely uninhabitable and caused extensive environmental degradation, displacing Micronesians who had lived on those islands and disrupting the way of life (diet, economy, communal practices, etc.) that had sustained the health and well-being of the indigenous people for millennia (Yamada & Akiyama, 2013; Yamada & Palafox, 2001).

In compensation for its role in inflicting harm through nuclear testing, and to guarantee continued access to strategic areas, the United States signed Compacts of Free Association (COFA) treaties in the late 1980s with three nations in Micronesia—the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and Palau (Shek & Yamada, 2011). These agreements give the United States exclusive military access in exchange for funding for health and educa-

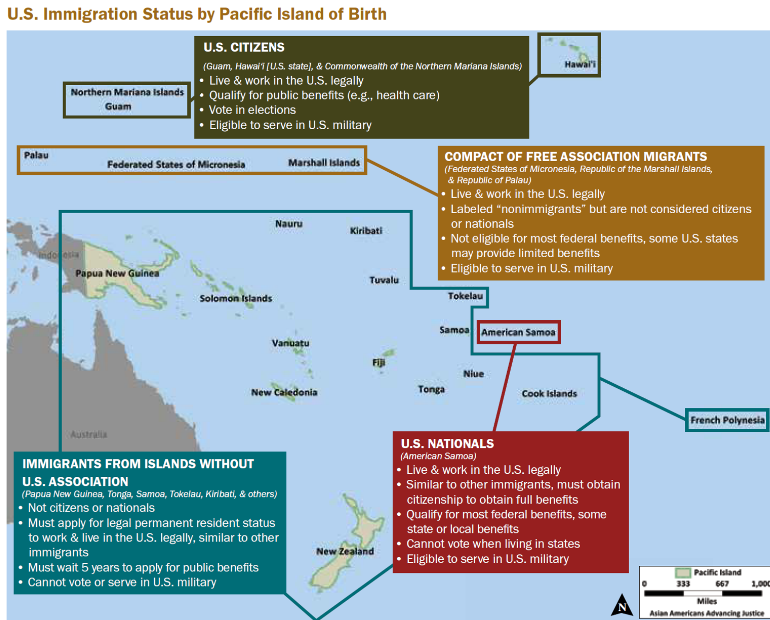
tion infrastructure on these island nations. In addition, COFA migrants may freely enter and work in the United States without a visa. Today, the fastest-growing Pacific Islander groups in the United States come from COFA countries (Hixson, Hepler, & Kim, 2012; Jimeno & Rafael, 2013). Many migrate to the United States under COFA seeking better economic opportunities. However, as many scholars and activists have argued, the U.S. government has failed to uphold its obligations under the COFA treaties (Asian & Pacific Islander American Health Forum, 2020; McElfish et al., 2019; Riklon et al., 2010). Although COFA migrants are required to pay taxes, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 removed their eligibility for federal programs including Medicaid and the Children's Health Insurance Program (McElfish et al., 2015).[1] COFA renegotiations are underway for renewal in 2023 (FSM and RMI) and 2024 (Palau).

Other examples of structural racism are reflected within the Native Hawaiian experience. The U.S. government backed an insurgence of white colonizers that overthrew the Hawaiian monarchy in 1893, leading to the forceful annexation of the Hawaiian Islands (Dougherty, 1992). For perspective, this colonization and subjugation of Hawai'i occurred less than thirty years after the abolition of slavery in 1865. In the years after annexation of the Hawaiian Islands, wealth was systematically stolen from Native Hawaiians by U.S. colonizers, laying the basis for perpetuating economic marginalization across generations (Ong, 2009). The lasting effects of racism and white supremacy are apparent: Today Native Hawaiians have lower wages, a higher likelihood of being homeless or incarcerated, and higher rates of chronic illness compared to other racial/ethnic groups in Hawai'i (Carratala & Maxwell, 2020; Office of Hawaiian Affairs, 2010).

Overall, NHPIs in the United States have vastly different rights and privileges depending upon from where they originated. Figure 1 provides an overview of the immigration status of NHPI populations in the United States (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). Native Hawaiians are U.S. citizens, and therefore have access to health care and can freely travel. Those born on the U.S. territories of Guam and the Commonwealth of the Northern Mariana Islands (CNMI) are also considered U.S. citizens, but they do not have voting rights for U.S. elections while living on the islands, as we will later discuss. Those from the U.S. territory of American Sāmoa are considered U.S. nationals, qualify for Medicare and Medicaid, but do not enjoy the rights of citizenship.[2] COFA migrants, as

mentioned previously, have special status to work in the United States without a visa, but are denied many rights and health care access in the United States (McElfish et al., 2019). In contrast, Pacific Islanders from independent countries, such as Tonga and Sāmoa (formerly known as Western Sāmoa), arrive as immigrants and have no unique rights or privileges in the United States.

Figure 1. U.S. Immigration Status by Pacific Island of Birth



U.S. Citizenship and Immigration Services, National Immigration Law Center, U.S. Department of the Interior, Office of Insular Affairs; Hawai'i Appleseed Center for Law and Economic Justice; APIAHF "Access to Health Coverage for Pacific Islanders in the United States." Note: Smaller islands not labeled on map. Information provided on the chart is generalized information based on islands of birth. The information above may not be true for all immigrants born on these islands. Native Hawaiians living in Hawai'i are indigenous people and not immigrants. As indigenous people, Native Hawaiians qualify for other federal benefits through programs such as the Hawaiian Homes Commission Act.

Source*:* Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014.

NHPIs who are U.S. citizens, nationals, and COFA migrants are all eligible to serve in the U.S. military, and many have risen to this call. NHPIs serve in the military at a higher rate than any other racial group in the United States. As shown in Table 1, NHPIs are the most overrepresented racial group among active duty members, making up a proportion of the military that is almost six times greater than their representation in the United States (U.S. Census Bureau, 2019; U.S. Department of Defense, 2018). Unfortunately, the military casualty rate

among Pacific Islanders from the U.S. territories is also higher than in the general population, with a rate higher than that of any U.S. state (Scharnberg, 2007; Zoroya, 2005).

Table 1. Racial Representation in the U.S. Military Compared to the U.S. Population in 2018

Race	% Active Duty Military	% of U.S. Population	Ratio: % Active Duty / % of U.S. Population
Native Hawaiian or Pacific Islander	1.1	0.2	5.9
American Indian or Alaska Native	1.1	0.9	1.3
Asian	4.5	5.6	0.8
Black	17.1	12.7	1.3
Multiracial	3.0	3.4	0.9
Other	4.2	5.0	0.8
White	69.0	72.2	1.0

Source: U.S. Department of Defense 2018 Demographics Report: Profile of the Military Community. U.S. population data from the American Community Survey 2018 1-Year estimates.

Note: Race is reported as race alone, separately from Hispanic ethnicity.

NHPIs in the United States face many socioeconomic barriers. Sāmoans (16 percent), Tongans (16 percent), and Guamanians/Chamorros (11 percent) have higher poverty rates compared to Whites (7 percent), and these same groups have lower proportions of homeownership compared to Whites (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). An assessment of financial status and distress among NHPI adults in Southern California found large proportions reported talking to a credit counselor (25 percent), filing for bankruptcy (16 percent), and experiencing foreclosure (11 percent); low proportions knew about health savings accounts (18 percent) and Cloverdell Education Savings Accounts (25 percent) (Tanjasiri, Takahashi, & Sablan-Santos, 2015). NHPIs are overrepresented in blue-collar occupations, such as in food preparation workers, grounds maintenance workers, hand laborers, health care aides, military service people, security officers, store clerks, and transportation/delivery workers (Asian Americans Advancing Justice-Los Angeles & Asian American Federation, 2014). NHPIs also have high proportions of uninsured: 26 percent of Tongans, 24 percent of Marshallese, 17 percent of Fijians, 16 percent

of Guamanians/Chamorros, and 15 percent of Sāmoans compared to 11 percent of Whites (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). NHPIs in urban areas are more likely to live in neighborhoods with high levels of poverty and environmental pollution (Morey, 2014). Lastly, NHPIs are disproportionately represented among incarcerated persons. In Hawaiʻi, NHPIs have the highest incarceration rate of any other racial group, and in 2010 their representation in the state's prison population was nearly four times their representation in the state's overall population (Prison Policy Initiative, 2020). In California, there has been a sharp rise in the number of incarcerated NHPIs, increasing 144 percent among NHPIs compared to only 2 percent in the total population in California (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014).

These social inequities have led to many health inequities. NHPIs suffer disproportionately from chronic conditions such as cancer, cardiovascular diseases, obesity, and diabetes (Hawley & McGarvey, 2015; Hsu et al., 2012; Reddy et al., 2009; Subica et al., 2017). Health risk behaviors are also higher among NHPIs: 32.6 percent of Sāmoans, 25 percent of Tongans, and 21.3 percent of Native Hawaiians were current smokers compared to only 14 percent in California overall (California Health Interview Survey, 2019). Evidence among Pacific Islander young adults show excessive burden of hazardous drinking and alcohol-related harms (Subica et al., 2020). In summary, the histories of colonialism and oppression affecting NHPIs have created the long-standing social and health inequities we see today.

The Inequitable Impact of COVID-19 on NHPI Communities

NHPIs who experience health and social inequity due to structural racism have been hit hard by COVID-19 (Botts, 2020; The Guardian, 2020). Our calculations show that NHPIs have among the highest case and death rates for COVID-19 compared to all other racial/ethnic groups in the United States. Table 2 reports the COVID-19 case and death rates for NHPIs for several states and counties that have disaggregated data for NHPIs as of June 7, 2020. Of ten states reporting COVID-19 cases for NHPIs, seven have NHPIs ranked as having the highest case rate compared to all other racial/ethnic groups including non-Hispanic whites, Black Americans, Latinxs/Hispanics, Asians, American Indians/Alaska Natives, and multiracial persons. NHPIs rank in the top three racial/ethnic groups with the highest case rates in all ten of these states. In seven states that report NHPI COVID-19 deaths,

NHPIs are dying at the highest rate compared to all other racial/ethnic groups. We find similar patterns in counties within these states as well: In the counties that provide disaggregated data, NHPIs are suffering the most from the COVID-19 pandemic.

Table 2. COVID-19 Cases and Deaths by Race/Ethnicity in States and Counties with NHPI Data

COVID-19 Cases					
State	**Date of Data**	**No. of NHPI Cases**	**NHPI Case Rate/100,000**	**NHPI Case Rate/ Total Case Rate**	**Rank of NHPIs**
Alaska	6/3/20	15	188	2.8	1
Arkansas	6/6/20	423	4501	14.9	1
California	6/2/20	652	455	1.5	1
Colorado	6/7/20	118	1778	3.6	1
Hawai'i	6/5/20	148	39	0.8	3
Idaho	6/4/20	12	540	3.1	2
Illinois	6/4/20	302	10461	10.7	1
Oregon	6/3/20	76	405	3.9	1
Utah	6/3/20	416	874	2.6	2
Washington	6/3/20	404	775	2.6	1
County					
King County, WA	6/5/20	165	964	2.6	1
Los Angeles County, CA	6/4/20	304	1362	2.3	1
Multnomah County	6/2/20	41	757	5.1	1
Orange County, CA	6/3/20	30	314	1.5	1
Pierce County, WA	6/5/20	95	735	3.3	1
Salt Lake County, UT	6/2/20	NR	1489	2.8	1
San Bernardino County, CA	6/3/20	23	364	1.4	1
San Diego County, CA	6/3/20	47	367	1.6	1
San Francisco, CA	6/3/20	32	1535	5.1	1
San Mateo County, CA	6/4/20	17	201	0.7	2

COVID-19 Deaths					
State	**Date of Data**	**No. of NHPI Deaths**	**NHPI Death Rate/100,000**	**NHPI Death Rate/ Total Death Rate**	**Rank of NHPIs**
Alaska	6/3/20	1	13	9.4	1
Arkansas	6/6/20	NR	NR		
California	6/2/20	31	22	2.0	1
Colorado	6/7/20	6	90	3.4	1
Hawai'i	6/5/20	NR	NR		
Idaho	6/4/20	NR	NR		
Illinois	6/4/20	5	173	3.8	1
Oregon	6/3/20	2	11	2.8	1
Utah	6/3/20	NR	NR		
Washington	6/3/20	9	17	1.1	1
County					
King County, WA	6/5/20	4	23	0.9	2
Los Angeles County, CA	6/4/20	18	81	3.1	1
Multnomah County	6/2/20	2	37	4.8	1
Orange County, CA	6/3/20	3	31	6.3	1
Pierce County, WA	6/5/20	95	735	81.9	1
Salt Lake County, UT	6/2/20	NR	NR		
San Bernardino County, CA	6/3/20	0	NR		
San Diego County, CA	6/3/20	2	16	1.8	1
San Francisco, CA	6/3/20	NR	NR		
San Mateo County, CA	6/4/20	12	142	13.0	1

Source: Case and death data are from state and county health department websites, posted on dates June 2-7, 2020. Population denominators are from the 2018 American Community Survey 1-year estimates.

Notes: NHPI = Native Hawaiian or Pacific Islander. NR = not reported. Rank compares NHPI rate to white, Black, Latinx/Hispanic, Asian, American Indian/Alaska Native, and multiracial rates (highest rate = 1).

These numbers suggest that, across the nation, NHPIs who have long been victims of structural racism and its adverse health effects are now being overburdened by the pandemic. Among NHPIs there are disparities as well. Although disaggregated data for the diverse NHPI populations are sparce, data from Hawaiʻi suggest that Pacific Islanders (who are comprised of Micronesians, Sāmoans, and others) are suffering higher COVID-19 case rates than Native Hawaiians (State of Hawaiʻi, 2020). For many months, NHPIs living in Arkansas had the highest rates of COVID-19 cases and deaths among NHPIs in any other state (NHPI COVID-19 Data Policy Lab, 2020). NHPIs in Arkansas are mainly Marshallese, many of whom work in the meat processing industry in Springdale (Golden & Thompson, 2020).

High rates of NHPI deaths due to COVID-19 could be traced back to high rates of poverty and low rates of health care access (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). COVID-19 infections are made more dangerous by the likelihood of NHPIs having preexisting health conditions such as asthma, diabetes, and cancer, as well as relatively high proportions of smoking and vaping (U.S. Department of Health and Human Services Office of Minority Health, 2018). Many NHPIs live in large, multigenerational households, making social distancing within the community extremely challenging (Botts, 2020; Huang, 2020). Compounding these issues, NHPIs are much more likely to be essential workers. Outbreaks of COVID-19 in the meatpacking industry have affected many COFA migrants. Furthermore, NHPI workers are being hit hard by unemployment during an economic recession ravaged by COVID-19, placing families in financial peril and emotional distress.

Importantly, the COVID-19 pandemic has completely disrupted many NHPI communities' highly familial, spiritual, and communal way of life (Huang, 2020). The suspension of large gatherings for worship, fellowship, celebration, and mourning are stripping NHPIs of the social support and traditional cultural practices that are important community assets during times of social and economic hardship.

Yet, the picture of how NHPIs in the United States are being affected by this global pandemic is incomplete. Several states and counties with large populations of NHPIs in the United States do not disaggregate NHPIs from other races or do not disaggregate by race at all. Table 3 shows that as of June 14, 2020, only nineteen states were reporting any case data and only thirteen states were reporting any death data for NHPIs (The COVID Tracking Project, 2020). The number of states with

data for NHPIs is the lowest compared to all other racial/ethnic groups, except for the multiracial category (many NHPIs are also multiracial).

Table 3. Race/Ethnicity Reporting of Cases and Deaths in 50 States + Washington, D.C., June 14, 2020

COVID-19 Numbers	NHPI	AIAN	Multiracial	Asian	Black	Latinx	White	Other
DEATHS								
# of states that collect data on racial/ethnic group	13	21	11	41	46	22	47	42
CASES								
# of states that collect data on racial/ethnic group	19	29	13	43	48	21	48	46

Source: *The Atlantic* magazine's COVID Racial Data Tracker (data accessed June 23, 2020).
Note: NHPI = Native Hawaiian or Pacific Islander, AIAN = American Indian/Alaska Native.

NHPIs have often faced these issues of data equity (Ponce et al., 2015). When pressed to provide data for NHPIs, state and local health departments have cited anonymity issues with reporting such small numbers, fearing that providing data on a handful of cases or deaths among NHPIs will reveal the identities of those people. Alternatively, epidemiologists and statisticians justify not providing these numbers due to issues of statistical significance and unstable rates due to small sample sizes. Therefore, NHPI data are not reported or are aggregated with Asians or "other" race categories. This leads to invisibility of NHPI health data and lack of understanding of how communities are being affected (Chin & Ferati, 2020).

In one case, Clark County, Nevada was reporting disaggregated race data that showed NHPIs with the highest COVID-19 case and death rates. However, for reasons unknown, Clark County began aggregating NHPIs with Asian Americans on May 14, 2020, essentially hiding this disparity. As another example, Alameda County, California suppresses data for racial/ethnic groups that have death counts less than ten. As a result of this arbitrary cutoff, NHPI deaths are not reported.

The invisibility of data for NHPIs due to not reporting or due to aggregation is a form of structural racism. When data are suppressed,

health departments and researchers could essentially deny NHPI communities the knowledge they need to mobilize actions that would decrease disease risk and death (Papa Ola Lokahi, 2007). Without the disaggregated data, NHPI community members are unable to detect disparities and advocate for needed resources. Disaggregated data are necessary for targeting health interventions, including contact tracing efforts for local NHPI communities (Chang, Penaia, & Thomas, 2020).

NHPIs alone or in combination make up 0.4 percent of the U.S. population or 1.4 million people in the United States (U.S. Census Bureau, 2019). Therefore, at the national, state, and county levels, NHPIs will *always* have relatively "small numbers," even in population data. Therefore, data should not be suppressed due to an arbitrary number, such as less than five cases/deaths, and we recommend that data should be provided for NHPIs and other relatively small populations transparently. These disaggregated numbers are urgently needed to drive public health action, especially when the stakes are so high as is the case with the COVID-19 pandemic.

While the virus that causes COVID-19 does not discriminate by race, the pandemic is affecting some communities more than others. The grim burden of COVID-19 on NHPI communities can be linked to existing underlying health and social conditions that were in place before the pandemic hit. This is similar to what is being reported among Black Americans who also disproportionately experience COVID-19 cases and deaths compared to non-Hispanic whites (Anderson, 2020). The COVID-19 pandemic has magnified the disadvantages stemming from structural racism against NHPI communities and other communities of color. Only by disaggregating data can we uncover these NHPI health disparities and call out the structural inequities causing them.

Undercount of NHPIs in the U.S. Census

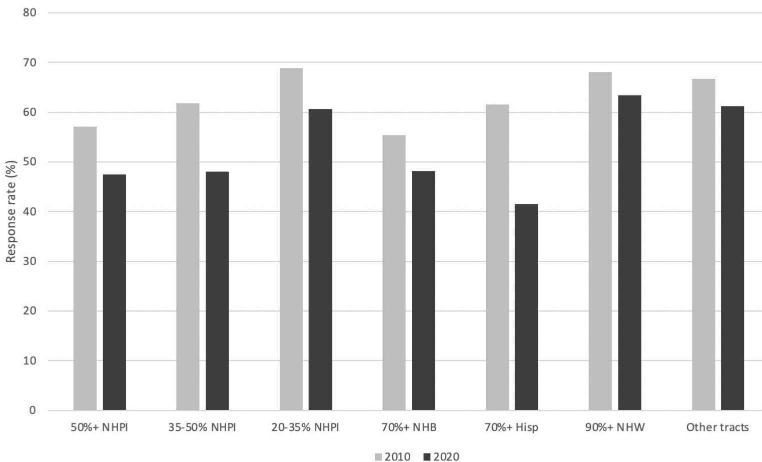
Accurately counting NHPIs in the U.S. Census is of paramount importance because it determines how billions of federal dollars will be allocated to fund hospitals, schools, transportation, and public assistance programs in the places where they live. Census numbers additionally provide the denominators used to calculate rates of disease, poverty, health care access, and so forth. Furthermore, the results of the 2020 census will determine how political boundaries are drawn for the federal, state, and local elections for the next decade. Notably, the COVID-19 pandemic has caused delays in census outreach, leading to serious problems surrounding redistricting for elections (Rudensky, Li, &

Lo, 2020). If states fail to make the adjustments needed to complete redistricting on time, then courts will intervene to draw district maps for the upcoming elections. This means that politically appointed judges will wield the power of redistricting, which may further disenfranchise NHPIs and many others from having appropriate political representation (ibid.).

NHPIs are the second fastest-growing racial group in the United States behind Asians (Hixson et al., 2012). Population projections predict that the NHPI population alone or in combination with other races will grow from 1.5 million in 2015 to 2.3 million in 2040 (Ong, Ong, & Ong, 2016). At least half of the population will be of mixed race. If NHPIs are undercounted in the 2020 census, the distribution of resources and political power to NHPI communities may be deficient, proliferating health and social inequity.

Data show that undercounting of NHPIs and other communities of color in the census is systemic and ongoing. While rates of undercounting of NHPIs decreased from the 2000 to 2010 censuses (O'Hare, 2019), NHPIs were still vastly undercounted in 2010. The omissions rate—which captures the share of a group missed in the census—shows

Figure 2. Response Rates to the U.S. Census in Tracts by Racial/Ethnic Composition, comparing 2010 to 2020



Source data: U.S. Census Bureau Planning Database; U.S. Census Bureau Response Rates; 2014-18 American Community Survey Estimates.
Note: NHPI = Native Hawaiian or Pacific Islander. NHB = non-Hispanic Black. Hisp = Hispanic/Latinx. NHW = non-Hispanic white.

that in 2010, NHPIs alone or in combination were omitted at a rate almost double (7.9 percent) compared to non-Hispanic whites (3.8 percent) (ibid.). In fact, NHPIs overall were undercounted in the 2010 census, while non-Hispanic whites had a net overcount. Currently in 2020, census response rates are lower than in 2010, and the gap is more pronounced in census tracts with high concentrations of people of color (see Figure 2) (U.S. Census Bureau, 2020b). Census tracts with high proportion of NHPIs, non-Hispanic Black Americans, and Hispanics are showing larger gaps than other census tracts in current response rates compared to in 2010.

The barriers to ensuring complete counts of NHPIs are the result of a combination of issues linked to structural racism. The 2020 Census Barriers, Attitudes, and Motivators Study Survey found that of the 150 NHPIs respondents in the survey, they were just as likely to complete the census as non-NHPI respondents. However, about one in four NHPIs were familiar with the U.S. Census, compared to only one in six non-NHPIs (U.S. Census Bureau, 2020a). Moreover, NHPI were between one and a half to two times as likely to distrust either the federal, state, or local government compared to non-NHPIs. Finally, one-quarter of NHPIs were concerned that census information could be used against them, compared to one-fifth of non-NHPIs. Some COFA migrants reported fears that their answers to the 2020 census may threaten their treaty renegotiations in the coming years (Fuchs, 2018).

These barriers are compounded by socioeconomic inequity. One-third of NHPIs live in census tracts that are considered difficult to count (Leadership Conference Education Fund, 2018). NHPIs move more often and are more likely to rent their homes, which census experts say contribute to undercounting. Long working hours and complex housing and family arrangements also make census counting more challenging (Fuchs, 2018).

The current political environment is also affecting undercounting. The debate and ensuing confusion caused by the current presidential administration's failed push to add a citizenship question on the census has led to heightened fear and confusion among NHPI communities. NHPIs vary so widely in their citizenship statuses in the United States, as discussed previously, and an often-overlooked group are undocumented Pacific Islanders. Undocumented Pacific Islanders may have immigrated to the United States on travel visas that later expired (Guzman-Lopez, 2011; Migration Policy Institute, 2020). The same fears and structural barriers affecting other undocumented groups also affect

undocumented Pacific Islanders (Morey, 2018). Unfortunately, there is a lack of data on undocumented Pacific Islanders separately from the aggregate Asian and Pacific Islander label. Several Pacific Islander families have mixed-documentation status, with children and adults who may be U.S.-born citizens, legal immigrants, or undocumented immigrants. Even though Pacific Islander immigrants have not been the main focus of the current antiimmigrant animus, Pacific Islanders are paying close attention to how other immigrant persons of color, including those in the Latinx community, have been treated by government authorities. Pacific Islander immigrants fear similar treatment, adding an additional barrier for community advocates working to increase participation in the census (Fuchs, 2018).

These issues raise the importance of supporting NHPI community organizers who are tirelessly working to spread the word about the 2020 census within their communities. There have been positive developments. The majority of NHPIs in the United States rely on social media, and by harnessing the power of venues such as Facebook, Twitter, and Instagram, advocates have been able to target messages about census participation to NHPI communities. In recent years, NHPI podcasters have gained platforms within the community as a means for sharing news and culture. NHPI podcasters have been effective in reaching the community with culturally tailored census messaging. Supporting NHPI community-based messaging and advocacy work is vital for ensuring accurate census counts.

While the barriers to accurate census counting are great within NHPI communities, the 2020 census also poses a unique opportunity to create positive structural change. Being counted builds hope. It allows for better community organizing and strategizing around the growing NHPI populations. Accurate census counts allow NHPI community organizers to be part of redistricting efforts, creating more political power within democratic institutions. Therefore, NHPI leaders are fighting for their communities to be counted to build a better future for themselves and for other Americans.

Voter Disenfranchisement among NHPIs

Voting rights for NHPIs vary widely, depending on policies governing their relationship with the U.S. government (Empowering Pacific Islander Communities & Asian Americans Advancing Justice, 2014). As noted earlier, Native Hawaiians are U.S. citizens and accordingly have full voting rights. People born on the U.S. territories of Guam, Virgin

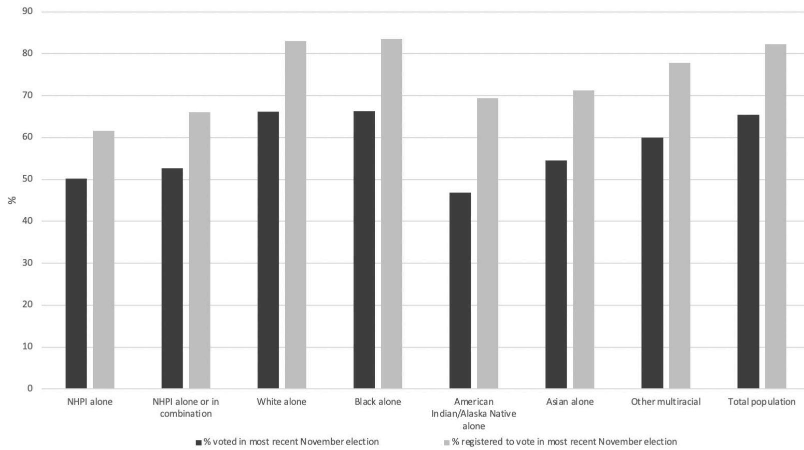
Islands, and CNMI are also U.S. citizens; however, they cannot vote in U.S. presidential elections while living on the islands. They must establish residency in one of the fifty states to vote for the president. U.S. nationals originating from American Sāmoa may vote for their congressional delegate (a nonvoting member of Congress) and hold presidential primaries, but they are not currently allowed to vote in U.S. presidential elections unless they go through the naturalization process. All other Pacific Islander immigrants—including COFA migrants, Tongans, and Sāmoans—cannot vote in U.S. elections unless they become naturalized.

Taken together, these various restrictions create confusion among NHPI communities about whether they are eligible to vote. For many, the structural barriers are enough to discourage them from engaging in politics. Nevertheless, the fates of NHPIs depend on U.S. congressional and executive decisions. NHPI patriotism and dedication have been demonstrated through current and past U.S. military service. And yet, while many NHPIs have been forced, have been coerced, or have willingly given up their lands, seas, and lives for American causes, they lack political voice, presence, and power in broader U.S. politics.

Barriers to voting in the United States among eligible NHPIs results in low voter turnout rates, leaving only the most highly motivated to vote in elections. Data from the Current Population Survey's 2018 Voter Supplement show that NHPIs reported the second-lowest voter turnout rate behind American Indians / Alaska Natives, and the lowest voter registration rate of the other racial groups (see Figure 3) (Flood et al., 2020). Some of the largest and most rapidly growing populations of NHPIs in the United States live in states with strict voter identification and registration laws, including Arkansas, Arizona, Florida, Rhode Island, South Dakota, Texas, and Utah (Fuchs, 2018; U.S. Department of Health and Human Services Office of Minority Health, 2018). Higher incarceration rates among NHPIs than in the general population also mean that currently incarcerated and many formerly incarcerated persons are restricted from participating in elections (National Conference of State Legislatures, 2020). Unfortunately, data are lacking regarding voting among disaggregated NHPI subgroups in the United States. Therefore, it is unclear if low voter turnout is due to ineligibility, voter suppression, or other factors.

There is at least one inspiring example of how a small NHPI community in East Palo Alto (in northern California) has been civically engaged through community organizing and coalition building. Although

Figure 3. Voter Turnout and Voter Registration for the Most Recent November Election by Race, 2018



Source data: Integrated Public Use Microdata Series, Current Population Survey, Voter Supplement 2018. N = 73,942 for voter turnout. N = 73,375 for voter registration.
Note: NHPI = Native Hawaiian or Pacific Islander

East Palo Alto consists of only 2.5 square miles and about 30,000 people, it is extremely diverse. In 2018, 62.1 percent identified as Hispanic, 11.3 percent as Black, 10.5 percent as NHPI, and 8.1 percent as non-Hispanic White (U.S. Census Bureau, 2019). Unfortunately, in 1992 East Palo Alto was known as the "murder capital of the nation," with the highest per capita murder rate of any other city in the United States (Daeenabi & Sosa-Ramos, 2019). However, in the early 2000s, a number of residents and nonprofit organizations came together to form a neighborhood improvement initiative that eventually became the community-based organization called One East Palo Alto.

The vision of One East Palo Alto is to celebrate the diversity of the community and to empower residents to engage in developing solutions to support economic, physical, and social well-being (One East Palo Alto, 2020). Their work to build coalitions across racial/ethnic groups has led to increased political power for all residents. When issues pertain to the NHPI community in East Palo Alto, the Black and Hispanic communities come alongside them to support policies and initiatives, and vice versa. It is through this community-organizing effort that structural changes have been made in the city. Between 2010 and 2017, poverty rates in East Palo Alto decreased from 21 percent to

13.7 percent (Daeenabi & Sosa-Ramos, 2019). By 2017, the violent crime rate had decreased by 60 percent and the murder rate had fallen by 97 percent compared to the 1992 rates. The current executive director of One East Palo Alto is a Pacific Islander woman, who succeeded the former executive director, a Black American woman, in 2018 (One East Palo Alto, 2020).

We provide this example as an illustration of the power of community organizing and coalition building across racial/ethnic lines to improve lives in areas where NHPIs live. While NHPIs still make up a small percentage of the voting population, the numbers of NHPIs living in communities are rising dramatically. Much of this population increase can be attributed to the U.S.-born children of NHPIs. The average age among NHPIs is twenty-eight years old, compared to fifty-eight years old among non-Hispanic Whites (Schaeffer, 2019). NHPI youth will have fewer barriers to voting than their parents' generation. Already, NHPI populations are becoming large enough to play the role of the swing vote in tightly contested local and state elections. In Hawai'i, one of the few majority-minority states, NHPIs make up nearly a third of the state's overall population, which brings the potential to significantly influence voting outcomes if NHPIs were to vote in greater numbers. Furthermore, NHPI communities are tightly interwoven. Once reached with culturally tailored messaging, word travels fast within close-knit communities, making the potential for activation high (Aitaoto et al., 2012; McElfish et al., 2017; Tanjasiri et al., 2015).

By building coalitions with other racial/ethnic groups who are similarly affected by issues of structural racism, NHPIs can gain a greater political voice to address issues that affect all Americans. The collective call to end racial injustices is one that NHPIs can contribute to and benefit from. NHPIs face similar structural barriers as Black Americans, including higher rates of policing, incarceration, residential segregation, and poverty caused by policies and implicit biases. With American Indians and Alaska Natives, NHPIs share the historical traumas of colonization, forced acculturation, and environmental injustices. As in the Latinx and Asian communities, many NHPIs share issues related to immigration, integration, and data disaggregation. These commonalities provide rich opportunities for diverse racial/ethnic groups to come together around shared structural barriers to fight for an end to race-, nationality-, language-, and skin color-based injustices.

Recommendations for Addressing the Effects of Structural Racism on NHPIs

We offer five overall recommendations for mitigating structural racism and its effects on NHPI communities (Table 4). First, public health and demographic data, including data pertaining to COVID-19 and future disease outbreaks, should be disaggregated at minimum for all five Office of Management and Budget racial categories: American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian or other Pacific Islander, and White (Office of Management and Budget, 1997). NHPIs must be disaggregated from other racial categories (Chang et al., 2020). Furthermore, NHPIs should be counted regardless of ethnic admixture (i.e., "alone or in combination with any other race") because more than half of NHPIs are of mixed racial/ethnic descendancy. We also recommend further disaggregation by specific NHPI subethnic category whenever possible. These recommendations align with prior calls for more data disaggregation by NHPI experts and community members over several years of advocacy (ibid.; Empowering Pacific Islander Communities, 2014; Kana'iaupuni, 2011; Panapasa, Crabbe, & Kaholokula, 2011; Papa Ola Lokahi, 2007). Disaggregated data increases opportunities for NHPIs to plan appropriate interventions and inform policy makers about the targeting of resources. In most cases for NHPI

Table 4. Recommendations for Addressing Effects of Structural Racism on NHPIs

1	Provide health and demographic data for NHPIs disaggregated from other racial/ethnic categories according to Office of Management and Budget guidelines. When counting NHPI, include those of mixed racial/ethnic heritage because more than half of NHPIs are of mixed race/ethnicity. When possible, disaggregate by specific NHPI race category (e.g., Chamorro/Guamanian, Micronesian, Native Hawaiian, Sāmoan, Tongan).
2	Incorporate multilevel and multisectoral approaches to interventions to address macro-level issues affecting NHPIs through local, county, state, and national policy changes.
3	Increase resources (i.e., funding and personnel) to NHPI community-based organizations.
4	Bolster community capacity through investments in NHPI youth leadership development to address issues of equity for community members of all ages.
5	Strengthen existing and build new transformational coalitions across racial/ethnic groups to address issues of structural racism affecting NHPIs and other communities of color.

communities, the benefits of having any data, even imperfect data, outweighs the consequences of being omitted altogether.

Second, future public health interventions should address the structural issues affecting NHPI communities by incorporating multilevel and multisectoral approaches. The majority of the work around addressing health disparities among NHPIs in the United States to date have been individual-level or meso-level (i.e., interactions among groups of individuals) interventions that focus on affecting health through changing individual and group attitudes, behaviors, and self-efficacies (Kaholokula et al., 2018; Kwan et al., 2017; LaBreche et al., 2016). Although we commend this needed work, more is needed to address macro-level issues through the development of healthy neighborhood, county, state, and national policies. This work is most likely to be successful if carried out through community organizing and building (Kaholokula, 2013; McElfish et al., 2018; Minkler, 2005; Tanjasir et al., 2015). Such organizing can rectify systemic injustices to create more equitable opportunities toward achieving the American dream for more NHPIs.

Third, community-based organizations serving NHPI communities must be better resourced. Too few nonprofit organizations are overburdened with spearheading community-building work in NHPI communities. The same organizations that are focused on health and social interventions are also tasked with COVID-19 pandemic response, census outreach, antiracism work, language translation, data disaggregation, voter engagement, redistricting efforts, and more. The result is that a relatively small group of community leaders are too often in crisis mode, pressed to address the most immediate needs and less able to focus on the broader structural issues affecting their communities. To effectively address the many systemic challenges facing NHPI communities, we urge foundations and government organizations, including the Centers for Disease Control and Prevention and the National Institutes of Health, to consider funding work to address NHPI health disparities to mitigate structural issues with underfunding. Funding specifically directed at community-based participatory research in NHPI communities will likely be most beneficial for addressing structural racism.

Fourth, we recommend greater investments to increase community capacity, specifically through NHPI youth leadership development. Community organization efforts in other racial/ethnic groups have found youth in this generation to be extremely receptive to organizing around issues of structural inequity, and we believe that NHPI youth have great potential (Distefano et al., 2013; Empowering Pacific Islander

Communities, 2018; Ortega et al., 2015; Wallerstein et al., 2017). It is important to build the skills of future generations of NHPI leaders, not only for their own advancement but also to give back to their communities. This can be done through investing in youth leadership programs, increasing volunteer and internship opportunities, and strengthening the pipeline for NHPIs in higher education (Tran et al., 2010). This is exemplified in the national Pacific Islander COVID-19 Response Team that has formed over the past several months in response to data showing the high burden of COVID-19 in NHPI communities in the United States (Pacific Islander Center of Primary Care Excellence, 2020). This response team has identified and gathered NHPI leaders from across the nation to engage in a comprehensive response to COVID-19. The taskforce has received media attention for their work analyzing data, delivering COVID-19 messaging, and building capacity for contact tracing (Graue, 2020; Guillermo, 2020; Johnson, 2020). It has also provided important training grounds for community-engaged work by younger NHPI leaders. This has all been driven by community volunteers, without external funds, demonstrating the remarkable capacity and motivation of NHPI community leaders. With greater funding and opportunities, these leaders will be better equipped to enact systemic improvements for their communities.

Lastly, the work of dismantling structural racism's effects on NHPIs cannot be accomplished if siloed within NHPI communities alone. It is vital for the future of NHPI communities to build coalitions across racial/ethnic groups to address issues common to communities of color. Recently, NHPI-serving organizations have coalesced across several states to respond to the COVID-19 pandemic (Pacific Islander Center of Primary Care Excellence, 2020). We have seen coalitions in the past with NHPIs and Asian Americans coming together to advocate for better data disaggregation (Chang, 2016). We have also seen examples of racially/ethnically diverse coalitions in cities such as East Palo Alto (One East Palo Alto, 2020). One of the most nefarious strategies of white supremacist movements has been to fragment communities of color so that they fight amongst each other. Pitting racial/ethnic groups against one another prevents them from finding commonalities that would allow them to gain political power. We reject the narrative that communities of color must compete over a smaller share of resources, and encourage NHPIs, Asians, American Indians, Alaska Natives, Black Americans, Latinxs, and others to unite in solidarity against structural inequity and for social justice.

Conclusion

This paper examined how structural racism affects NHPIs living in the United States and provided recommendations for future work in this area. The year 2020 will be historic due to the COVID-19 pandemic, the 2020 census, the presidential election, and the racial uprisings following the publicized killings of Black people of color, including Ahmaud Arbery, Breonna Taylor, and George Floyd. These unacceptable killings and our subsequent dialogues are hopefully elevating the interrelated issues of health disparities, socioeconomic inequity, voter suppression, police brutality, reinforced colonization, white supremacy, and racist policies. These inequities created enduring vulnerabilities affecting generations of NHPIs and other communities of color throughout our country's history. Our hope is that by highlighting how structural racism affects the lives of NHPIs, we focus our work to fundamentally improve the lives of a group long overlooked and overburdened. In addition, we support NHPI communities who are organizing for complete counts, leadership development, and civic engagement to achieve social justice and health equity.

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Notes

1 Some states, such as California, have addressed the restrictions by providing COFA migrants with access to state-funded health care. However, other states (e.g., Iowa), where there are large populations of COFA migrants, do not have state provisions for medical care access.

2 A recent (December 12, 2019) memorandum decision from the Utah District Court of the United States found that individuals born in American Sāmoa enjoy birthright citizenship under Section 1 of the Fourteenth Amendment (Fitisemanu v. United States, 2019). This ruling was appealed and is pending review by the 10th Circuit Court of Appeals.

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