Introduction

Asian Americans (AA), Native Hawaiians, and Pacific Islanders (NH/PI) are the fastest growing racial and ethnic group including over 50 ethnicities with over 100 languages spoken. Limited English Proficiency (LEP) restricts access to quality health care. Reasons for this disparity include insufficient insurance coverage, complicated systems to enroll in coverage, noncitizenship, lower incomes, and lower levels of education.

Intersection of AA and NH/PI with Intimate Partner Violence (IPV) and Human Trafficking (HT)

Intimate Partner Violence and human trafficking are prevalent within many AA and NH/PI communities. Up to half of all Asian women in the U.S. have experienced intimate partner physical and/or sexual violence in their lifetime. World Health Organization data estimates that 60-80% of PI women and girls experience physical or sexual violence by a partner or other individual in their lifetimes. The 2021 National Human Trafficking Hotline found that of the 2,227 survivors whose race/ethnicity was known, the second largest group was Asian at 24% (after Caucasian or White, at 30%).
Intersection of IPV and HT with Emergencies

IPV and HT increase during public health emergencies and natural disasters (referred to here as ‘emergencies’).\(^7\) After Hurricane Katrina, the Deepwater Horizon oil spill, and the COVID-19 pandemic, the prevalence and severity of IPV, HT, and other gender-based violence increased.\(^8,9,10\) At the height of the COVID-19 pandemic, IPV rates increased between 8-30% across the U.S.\(^11,12\) and HT rates increased up to 40% globally.\(^13,14\)

Factors for these increases include:

- Access to resources and support are more challenging during emergencies;

- Some strategies to reduce risk, such as lock downs and social isolation during the pandemic, may worsen situations for survivors; and/or

- Abusive partners or employers may use emergencies to further isolate and control their partners, children, and/or employees.

Structural inequities such as poor language access, unemployment, under-insurance, transportation limitations, geographic distance from care, and limited access to phones/internet hinder survivors’ access to care. Social inequities such as threats of deportation, stigma, and discrimination by service providers further impact survivors’ willingness to seek support.\(^16\) Emergencies exacerbate these barriers.\(^17\)

Intersection of AA and NH/PI with Natural Disasters and Public Health Emergencies

AA’s are one of the nation’s largest immigrant groups, and a majority of (66%) speak a language other than English at home.\(^18\) Disaggregated data about AAs reveals housing, income, and education disparities between subgroups of different ethnic origins.\(^19\) Compared to all other groups, NH/PIs have lower median household income and less access to health insurance and disease prevention programs.\(^20\) These disparities mean that AA and NH/PIs are often disproportionately impacted by emergencies.\(^21\)
Disproportionate Impacts of Emergencies on AA and NH/PI population

- Increases in climate chaos have led to the widespread global displacement of communities of color. The number of climate refugees from AA and PI countries migrating to the continental U.S. increases every year.\textsuperscript{22}

- NHs, undocumented Southeast Asian populations, and migratory PI populations were among the most disproportionately impacted by the 2023 wildfires in Lahaina, Maui.\textsuperscript{23,24,25}

- Immigrants with LEP, and in particular, undocumented immigrants are more likely to live in illegal and substandard housing conditions that leave them more vulnerable to natural disasters. One example of this is the flooding in New York City caused by Hurricane Ida and the impacts on immigrants who lived in basements. The majority of deaths were AA immigrants.\textsuperscript{26}

- Climate change and nuclear testing by the American military have displaced many Marshallese from their homes in the Pacific Islands to the continental U.S. including a large resettlement area in Northwest Arkansas, which frequently experiences tornadoes.\textsuperscript{27,28}

- Due to the ongoing impacts of colonization and historical trauma, PIs experienced some of the worst outcomes related to COVID-19 morbidity and mortality relative to any other racial or ethnic group.\textsuperscript{29,30}

- Rates of anti-Asian violence and hate crimes increased by up to 77% during the height of COVID-19, leading many patients and providers to fear seeking and providing health care.\textsuperscript{31,32,33,34} Further, due to stigma and cultural taboos, these data are largely unreported.

Lack of Research and Disaggregated Data

Cisgender women are not the only survivors of IPV and HT;\textsuperscript{35} 57.5% of non-binary and other gender-queer AAs, 59% of transgender AA women, and 62.8% of transgender AA men have experienced partner abuse or partner violence.\textsuperscript{36,37} Data on the breadth of violence against the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) AA and NH/
Recommendations for Operationalizing Emergency Preparedness in CHCs

PI community is lacking.\textsuperscript{38,39} This is due to miscategorization, inaccurate reporting, and poor relationships between law enforcement and LGBTQI+ communities of color. Additionally, the systemic lack of disaggregated race and ethnicity data among AA and NH/PI survivors of IPV and HT erases the unique experiences of NH/PI communities as well as smaller ethnic subgroups within the AA diaspora.\textsuperscript{40}

Community Health Centers and AA and NH/PI-Serving Health Centers

There are more than 1.3 million AA and NH/PI patients served at community health centers (CHCs).\textsuperscript{41} Of the nearly 1,400 federal qualified health centers across the U.S., only 137 are designated as AA- and NH/PI-serving.\textsuperscript{21} All health centers experienced challenges with receiving and spending restricted disaster relief funds during the COVID-19 Public Health Emergency. However, culturally affirming organizations, such as those serving AA and NH/PI populations, faced additional demands. They were often enlisted to help other community-based organizations reach and provide care for refugee and immigrant communities.

AA- and NH/PI-serving CHCs are often the most well-prepared to meet the unique health needs of AA and NH/PI populations during emergencies. CHCs employ community members

Recommendations for Operationalizing Emergency Preparedness in CHCs

AA and NH/PI communities experience a disproportionate burden of IPV and HT and limited access to services. IPV and HT increase in severity and frequency during emergencies.\textsuperscript{42} The following recommendations will help ensure readiness for emergencies to support AA and NH/PI survivors:

Create internal Protocols for Individual Assessments and System-Wide Response

Create protocols for emergency response prior to a destabilizing event. CHCs can collaborate with local municipalities to mitigate the consequences of emergencies on patients vulnerable to IPV and HT. Patients may be reticent to disclose sensitive situations due to fear of retaliation or law enforcement involvement. CHCs should be prepared to offer universal education about available supports and resources for all patients regardless of disclosure.\textsuperscript{43}

1. Conduct Social Needs Assessments

Implement comprehensive Social Drivers of Health (SDOH) assessments for patients on an organizational level. Assessments should be trauma-sensitive as well as culturally and linguistically responsive. SDOH data collection should measure a patient’s experiences, risks, strengths, and assets. This data helps CHCs assess population health needs and external partnerships that support the community.
Systemic SDOH assessment helps identify gaps in services for AA and NH/PI populations in CHCs who are not categorized as AA and NH/PI-serving. This may lead to funding, support, or resources for CHCs to enhance language justice, community impact, and other social services.

2. **Universal Patient Education and Resources**
   Standardize universal education for all patients on IPV and HT and other SDOH supports (e.g. counseling, support groups, or other social service providers). CHCs should ensure that all patients understand what resources are available, without requiring disclosure of abuse, exploitation, being undocumented, or having housing instability.\(^{44}\)

3. **Train Staff on Universal Education on IPV and HT**
   All CHC staff, not just providers, should receive primers on the importance of universal education. Further, CHCs should standardize staff training on how to conduct SDOH assessments with an emphasis on empathic listening and motivational interviewing.

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**Invest in Language Access**

Language access is critical when mapping out preparedness and response strategies for AA and NH/PI communities. Messaging in languages familiar to patients builds trust and gets information and resources to people who are highly vulnerable to IPV and HT. In-language outreach, screening, patient education, and referrals to population-specific resources are critical for AA and NH/PI survivors.

1. **Hire Culturally and Linguistically Concordant Staff**
   Multilingual and multicultural CHC staff can more easily build rapport, establish trust, and form therapeutic alliances with patients.\(^{45}\)

2. **Create Culturally Responsive Materials and Programs**
   Materials should be translated and feature culturally relevant messages and images.\(^{46}\) Interpreters, translation services, and multilingual and multicultural staff from the community can all support creation and implementation of cultural and linguistically responsive resources and services.\(^{47,48}\)

3. **Offer Linguistically Accessible Materials and Outreach**
   Many communities with LEP have an oral tradition. Health education materials, public service announcements, and other messaging should be offered in a variety of formats, including visual and audio.\(^{49}\)
**Forge Partnerships with Culturally-Specific Community Organizations**

CHCs must build partnerships with culturally-specific IPV and HT programs. AA- and NH/PI-specific organizations understand the cultural nuances, linguistic barriers, and social stigmas that can impact survivors’ care-seeking patterns and access to resources. They can provide survivors with trauma-sensitive, comprehensive, and holistic care to address not only IPV and HT but other SDOH.⁵⁰

1. **Establish Memoranda of Understanding (MOUs)**
   Partner with local IPV and HT programs and legal aid organizations for mutual aid.⁵¹ Create formal partnership agreements to operationalize referral processes, privacy management, and confidentiality. Develop relationships with community-based organizations before emergencies occur.

2. **Engage in Shared Outreach Efforts**
   Shared outreach efforts can help CHCs reach community members more easily. Engage community leaders in efforts to map out phone trees and other hyper-local systems for reaching those experiencing the greatest barriers, such as elders and people with disabilities.⁵²,⁵³ Prior to emergencies:
   - Invite community leaders to participate in preparedness planning;
   - Engage ethnic media outlets such as television and radio stations;
   - Partner with trusted community messengers such as faith-based leaders to leverage their social and print media efforts.

**Conclusion**

Health centers need to be prepared to support AA and NH/PI communities experiencing IPV and HT. Survivors’ vulnerabilities are worsened during emergencies, and CHCs must create workflows ensuring timely assistance, safety planning, and support. Ensure preparations are trauma-sensitive and survivor-centered. Embed interventions into clinical workflows and case management services. Create formal pathways to connect patients with community-based services and resources for IPV and HT, employment assistance, housing, food, civil legal aid, and other basic needs. CHC staff, programs, and resources should be culturally and linguistically responsive to the unique needs of AA and NH/PI survivors. Forge community partnerships to better identify and support AA and NH/PI survivors. Expand prevention and education efforts to raise awareness about IPV and HT within the community. Facilitate early intervention, ensuring survivors receive necessary care and resources before emergencies occur.
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Appendix: Additional Resources

- Collecting Standardized Data on Social Determinants of Health to Address Structural Racism Drive Health Equity and Respond to Public Health Emergencies, NACHC and AAPCHO

- Protocol for Responding to, and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE), NACHC and AAPCHO

- Protocol for HRSA-supported Community Health Centers to Engage Patients through Universal Education Approaches on Exploitation (E), Human Trafficking (HT), Domestic Violence (DV) and Intimate Partner Violence (IPV), Health Partners on IPV + Exploitation

- Protocol Template for Health Centers, Health Partners on IPV + Exploitation

- Prevent, Assess, and Respond: A Domestic Violence and Human Trafficking Toolkit for Health Centers & Domestic Violence Programs, Futures Without Violence & Health Partners on IPV + Exploitation

- A Guide to Person Centered Communication, NACHC and AAPCHO

- Cultural Validation Toolkit, International Rescue Committee

- Tips for Translating Materials, National Resource Center for Refugees, Immigrants, and Migrants

- Culturally and Linguistically Appropriate Services (CLAS) Standards, Department of Health and Human Services

- Community Partnership Memorandum of Understanding (MOU) Template, Health Partners on IPV + Exploitation

- Actionable Toolkit for Building Partnerships with IVP Programs, Health Partners on IPV + Exploitation

- Library of resources for language access, National Resource Center for Refugees, Immigrants, and Migrants

- Asian Pacific Institute on Gender-Based Violence (API-GBV)

- Culturally-Specific Partners, National Domestic Violence Resource Center

- Get Help Now, National Domestic Violence Hotline
• Healthcare, IPV, and Health Centers, National Domestic Violence Hotline

• Find a Health Center, Health Resource & Services Administration

• State and U.S. Territory Domestic Violence Coalitions, National Network to End Domestic Violence
Appendix: Citations

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