



DiversityPreparedness.Org E-Newsletter

Produced by the Center for Health Equality at the Drexel University School of Public Health with support from the U.S. Department of Health & Human Services' Office of Minority Health.

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Dear Colleagues,

Welcome to the Sixth Issue of the DiversityPreparedness.Org E-Newsletter. This issue provides an update on the H1N1 outbreak and features Population Data and Community Characteristics as the Topic of the Month, providing links to a variety of publicly available data sources. Additionally, we spoke with Dr. Suhaila Khan of the Asian & Pacific Islander American Health Forum about barriers and strategies to collecting and reporting data on racial/ethnic sub-groups.

Director's Desk:

Thoughts from Dennis P. Andrulis, PhD, MPH, Director of the Center for Health Equality and Associate Dean for Research at the Drexel University School of Public Health.



Challenges and Opportunities for Meeting the Needs of Diverse Communities this Flu Season

The flu season is now entering the time of year when influenza has historically affected the greatest number of people. Those most likely to be affected by this epidemic are high priority populations, including individuals with chronic diseases, pregnant women, households or caregivers with young children as well as children and youth¹—all groups significantly if not disproportionately represented in diverse communities. For example, the Hispanic population has an excessively high teenage pregnancy rate while nearly half of all African American adults suffer from a chronic condition or disability.^{2,3}

Experiences with previous epidemics tragically affirm that culturally diverse communities suffer greater health consequences than whites, including higher death rates; and that they are less likely to be vaccinated.⁴ As identified by our National Consensus Panel on Emergency Preparedness and Cultural Diversity, some of the causes of this disparity reflect concerns endemic to preparedness, response and recovery challenges. These include the need for community involvement before a disaster strikes, knowing and engaging trusted sources for disseminating information (e.g., ethnic media), building trust between public health/emergency preparedness agencies and diverse communities, and assuring culturally competent translation of critical information. At the same time there are distinct issues and actions of greater priority in addressing influenza.

These include building and maintaining a working knowledge and profile of the most susceptible communities through such actions as:

- **Building awareness of influenza history and experiences in diverse communities.** Knowing what has happened in previous flu seasons can give planners and responders a sense of what did or did not work effectively, issues of special concern, and residual effects (e.g., perceived discrimination, access problems and perceptions).
- **Using demographic data to identify concentrations of diverse populations.** Public health departments and other agencies can use publicly available data and information on racially and ethnically diverse individuals and their locations and match it with the CDC priority categories to identify where those most vulnerable to influenza reside.
- **Understanding influenza response actions that may require targeted information or attention.** Quarantining and social isolation during epidemics may pose significant cultural conflicts or challenges in some communities where such recommendations are contrary to beliefs and lifestyle. Staying home from work may be especially burdensome to low-income families who do not receive paid sick leave. Understanding the cultural beliefs and customs as well as social and economic conditions of communities and adapting education programs for these residents in preparing for and responding to flu outbreaks may help obviate problems later.
- **Engaging diverse communities at federal, state and local levels.** Actively involving communities, through educational forums and meetings, can help allay fears as well as help planners and responders understand concerns and perceptions to improve trust, communication and compliance.

This flu season offers a significant opportunity to see if the nation is making progress toward achieving public health preparedness and response goals. When we look back in Spring 2010, how will we answer this question: How well did we use lessons from the past to assure equity for all in the emergency challenges facing the nation?

1. CDC. (2009). [H1N1 Flu \(Swine Flu\): Information for Specific Groups](#)
2. CDC. National Vital Statistics Report. (2003). [Revised Birth and Fertility Rates for the 1990s and New Rates for Hispanic Populations, 2000 and 2001: United States.](#) (51)12.
3. Mead H. et al. (2008). [Racial and ethnic disparities in U.S. health care: A chartbook.](#) New York: The Commonwealth Fund.
4. Hutchins, SS., Fiscella, K., Levine, RS., Ompad, DC., McDonald, M. (2009). [Protection of Racial/Ethnic Minority Populations During an Influenza Pandemic.](#) American Journal of Public Health. 99(S2): S261-S270.



Topic of the Month: Population Data & Community Characteristics

Disasters do not occur in a vacuum. A wide range of social, economic, and cultural forces shape how individuals prepare for, respond to, and recover from disasters. In order for emergency preparedness, response, and recovery plans to be effective they must take into account the unique characteristics of the target population—and this entails robust data. In addition to demographic characteristics such as race, ethnicity, and language, information on housing, transportation, health status, and a variety of other variables are critical to developing community-appropriate strategies. Below is a list of publicly available data sources to help inform emergency plans which are inclusive of distinct community needs.

General :

- **Decennials Census:** Provides data on a wide range of indicators including language spoken at home, level of English proficiency, country of origin, years living in U.S., housing, and transportation. Information is available at the national, state, territory, region, city, county, and residential block levels.

- **American Community Survey:** Collects information on demographics, housing, language, and transportation, and is reported for single and three-year averages. Data are available for geographic regions with populations over 65,000.



- **CDC SNAPS 1.5:** Pools various data sources to develop national, state, and county profiles consisting of indicators relevant to emergency preparedness. SNAPS allows users to create community profiles with information on demographics, faith-based organizations, immigrant country of origin, language, migrant health clinics, religious affiliation, socioeconomic indicators, and transportation.

Socioeconomic:

- **National Center for Education Statistics-Common Core of Data:** Allows users to view data on school enrollment at various levels, including individual schools, and can be viewed by race/ethnicity, sex, and grade level.
- **Geographic Profile of Employment and Unemployment:** Provides tables on employment at national, state, core-based statistical area, metropolitan statistical area, and school district levels, as well as by race/ethnicity, sex, and occupation.
- **Civil Rights and Emergency Preparedness:** Provides information on civil rights laws and transportation as it relates to emergency preparedness. The website provides GIS maps of 20 metropolitan regions, highlighting areas with high concentrations of minority and LEP populations as well as public transit services.
- **American Housing Survey:** Collects information on a range neighborhood and housing characteristics. Data are provided at the national level, as well as for metropolitan areas and geographic regions with populations over 100,000.

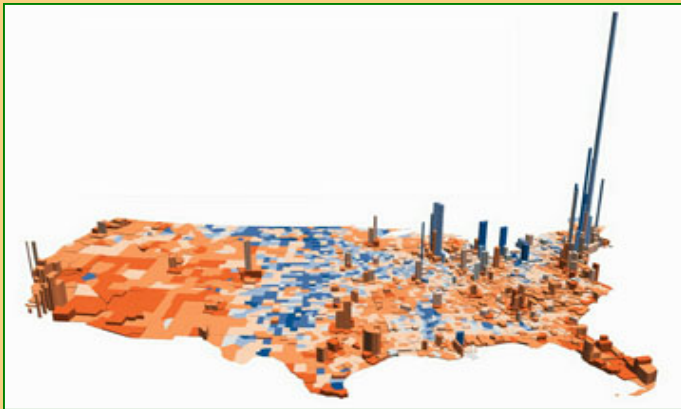
Health:

- **Behavioral Risk Factor Surveillance System:** Provides information on health behaviors, insurance coverage, immunization status, disease prevalence, and other indicators of population health among adults. Data are available by race/ethnicity, sex, age, education and income. Data are available at national and state levels with estimates possible for smaller areas in some states.
- **Quick Health Data Online:** Draws from a number of different data sources to provide information on 11 health-related categories, each of which has numerous sub-categories. Variables include: disease prevalence, health care access/coverage, health status, and race/ethnicity. Data are available at national, state, and county levels.
- **National Immunization Survey:** Provides information on the immunization status of children, by race/ethnicity, poverty status, and health care provider type. Data are available at national, state, metropolitan statistical area, and Immunization Action Plan levels.

Specific Racial/Ethnic Populations:

- **Asian and Pacific Islander Population, Growth, & Socioeconomic Status:** Provides information on the growth and socioeconomic characteristics of 21 Asian American and Pacific Islander ethnic sub-groups, as well as for other major racial/ethnic groups. Data are available at national, state, and county levels. Free registration is required.
- **Pew Hispanic Center:** Collects data on Hispanics and Latinos through several variables including demographics, ethnicity, immigrant status, labor, political affiliation, remittances, and socioeconomic status. Data are presented in the form of datasets, maps, statistical profiles, and fact sheets at national, state, and county levels.

- **The Joint Center Data Bank:** Draws from a number of data sources to provide tables and charts by race/ethnicity—including information on internet access, minority businesses, family structure, housing, and elected officials. Data are available at national, state, regional, county, municipal, and school district levels.
- **The Urban Institute- Immigrant Data:** Provides a series of reports and statistical tables on immigrants in the United States. Variables of interest include level of English proficiency, race/ethnicity, and socioeconomic indicators. Data are available at national, state, and county levels.



137th American Public Health Association Annual Meeting

Philadelphia, PA

November 7-11, 2009

The APHA Annual Meeting is the oldest and largest gathering of public health professionals in the world, attracting more than 13,000 national and international attendees. For registration information and a full program of events and sessions [CLICK HERE](#).

Below are links to some of the sessions which address issues surrounding preparedness and diversity.

- [Emergency Preparedness, Communication Systems, and Response: A Chinese Limited English Proficiency Community Perspective](#)
- [Making Up For History: Advancing Programs and Policies to Integrate Culturally Diverse Communities into Public Health Emergency Preparedness through Public-Private Sector Initiatives](#)
- [Low-Income Non-English Speaking Hispanics Perceptions of Trust in Public Health for Disaster Preparedness and Response](#)
- [Emergency Preparedness Among the Foreign Born: Reaching Asians and Pacific Islander in a Crisis](#)
- [Exploring the Role of Community-Based Organizations in Helping Limited English Proficient Populations Prepare and Respond to Emergencies](#)
- [Risk Communication: Emergency Response to Pandemic Flu Preparedness Messaging](#)

Below are links to recent and upcoming events and initiatives as well as recently published reports and articles.

Events & Training:

2010 Public Health Preparedness Summit

Atlanta, GA

February 16-19, 2009

The 2010 Public Health Preparedness Summit, "Partners in Preparedness: Engaging a Community for a Successful Public Health Response," will provide a range of informative sessions on public health preparedness to enhance the capabilities of public health professionals. For more information on the Summit [CLICK HERE](#).

2010 Emergency Management Summit

Washington, DC

March 3-5, 2010

The Emergency Management Summit provides emergency managers, first responders, emergency physicians, and other professionals with the opportunity to increase their knowledge on how to best prepare for, respond to, and recover from disasters. For more information on the Summit [CLICK HERE](#).

Initiatives & Publications:

Pandemic Influenza Preparedness and Response Among Immigrants and Refugees

This recent *AJPH* article discusses health-related, social, and economic factors that contribute to the increased risk of immigrants and refugees in an influenza pandemic and strategies for reaching this population. To obtain the full article [CLICK HERE](#).

Protection of Racial/Ethnic Minority Populations During an Influenza Pandemic

This recent *AJPH* article describes underlying factors which put racial/ethnic minorities at increased risk for disproportionately adverse health outcomes during an influenza pandemic and promising strategies for implementing interventions. To obtain the full article [CLICK HERE](#).

NPR: Officials Find Swine Flu Hits Minorities Harder

This National Public Radio audio feature describes some of the social factors contributing to an elevated incidence rate of H1N1 among low-income minorities in the Boston area. While there is nothing about the virus itself that makes minorities more susceptible than whites, social factors, such as the ability to take time-off from work, are believed to have contributed to this disparity. To listen to the full story [CLICK HERE](#).

Preparing For Next Disaster Takes Community Effort

This radio feature describes the findings of a report which examined efforts to integrate racial and ethnically diverse communities into emergency preparedness plans in California and contains interviews with Dr. Dennis Andrulis of Drexel University School of Public Health and Ron Lane of the San Diego County Office of Emergency Services. To hear the full story [CLICK HERE](#).

A Guide to Enhance Grassroots Risk Communication Among Low-Income Populations

The guide serves as a resource for public health and emergency management practitioners who plan and implement emergency and disaster preparedness activities that entail collaborating with grassroots organizations serving low-income populations. The Guide provides practical step-by-step instructions on how to work with grassroots organizations in order to deliver critical information to low-income populations before, during, and after a disaster. To view the full guide [CLICK HERE](#).

Recent Events and Updates:

H1N1 Update:

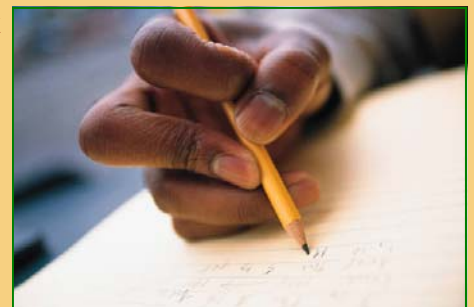
Below are links to selected resources on H1N1 and the needs of culturally/linguistically diverse communities. For a comprehensive list of resources and translated materials on H1N1 and pan flu [CLICK HERE](#).



- **H1N1 Flu: A Guide for Community and Faith-based Organizations:** This guide provides information about the roles of community and faith-based organizations in regard to mitigating the effects of H1N1. Information includes: faith-based and community involvement, vaccine distribution, communication, vulnerable and hard-to-reach populations, mental health, childcare, and work environments.
- **ECHO Minnesota H1N1 Resources:** Emergency, Community, and Health Outreach (ECHO) Minnesota has developed multimedia resources on H1N1 in 11 languages. Topics include preventive behaviors and vaccination information (**Amharic, Arabic, English, Hmong, Karen, Khmer/Cambodian, Laotian, Oromo, Russian, Somali, Spanish and Vietnamese**).
- **Say No to Pandemic Influenza:** This flyer shows how influenza is spread and how to prevent spreading the virus to others (**Afrikaans, Albanian, Arabic, Chinese, English, French, Georgian, Laotian, Macedonian, Portuguese, Romanian, Spanish, Vietnamese, and Zulu**).

User Feedback Survey:

One of the primary objectives of DiversityPreparedness.Org is to provide professionals, such as yourselves, with



resources to advance emergency preparedness in culturally diverse communities. In order to help us better meet your information needs we request your feedback through a brief 9-question survey. We thank you in advance for your participation and support. To take the survey [CLICK HERE](#).

Voices from the Field: Dr. Suhaila Khan¹, Asian & Pacific Islander American Health Forum

Efforts to collect information on the residents of the United States (U.S.) predate the Declaration of Independence and were signed into law with the Constitution in 1788. Since 1790, when the first official U.S. Census was conducted, methods of data collection and reporting have grown increasingly robust. In spite of this, a recent **Institute of Medicine report**, indicated that national surveys often fail to adequately depict the racial, ethnic, and linguistic diversity of the nation.

We spoke with Dr. Suhaila Khan¹ of the Asian & Pacific Islander American Health Forum (APIAHF) to learn more about the importance of collecting data on multiple race/ethnicity, barriers to accomplishing this, and APIAHF's efforts to promote programs and policies which support this endeavor to collect and report more reliable data.

According to Dr. Khan, the rationale behind collecting population data is rather straightforward: for programs and policies to be effective and efficient they need to be grounded in evidence on the characteristics of the populations they are intended to serve. As racial/ethnic minorities are often underserved and have distinct needs—such as limited English proficiency and distinct cultural beliefs and customs—reliable information on these populations is particularly important to program planning. The Office of Management and Budget's (OMB) Policy Directive No. 15 establishes minimum standards for collecting data by race/ethnicity, consisting of five racial categories (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White) and two ethnic categories (Hispanic/Latino and not Hispanic/Latino).² Dr. Khan and others in the field believe that these minimum categories are incapable of fully capturing the ethnic diversity of the nation to enable effective programs and services.

Dr. Khan explained that there are over 50 different Asian American, Native Hawaiian, and Pacific Islander ethnic groups in the U.S., who together speak more than 100 languages. When data are reported on these populations in aggregate it masks important differences between these distinct communities. For example, 17% of Asians are uninsured. But when data are disaggregated, it becomes clear that certain Asian sub-groups differ substantially from Asians as a group—such as Koreans who have an uninsurance rate of 31%.³

Such disparities are evident among a number of ethnic sub-groups across a wide range of socioeconomic indicators which contribute to a community's ability to prepare for, respond to, and recover from emergencies. For example, the aggregate poverty rate for Asians as a group is 8.2%, but nearly three times that for the Hmong (26.4%).⁴ Information on the distinct needs of these ethnic sub-groups is critical to developing preparedness and response plans that are inclusive of the needs of the entire population.

Failing to collect data on ethnic sub-groups is one part of the problem, but as Dr. Khan explained, data is often collected but not reported. The U.S. Census Bureau only reports on ethnic subgroups with populations over 65,000. This poses a major barrier to obtaining data on smaller ethnic sub-groups, especially at the state or county level. For example, in 2006 there were only 69,687 Bangladeshi living in the U.S. and 86,246 Indonesians. A reporting threshold of 65,000 makes it virtually impossible to acquire information on these populations beyond the national level.⁵ While these reporting standards are intended to protect privacy, Dr. Khan and her colleagues at APIAHF have been vocal in advocating for innovative methods which expand reporting thresholds while maintaining privacy.

Another issue surrounding ethnic sub-groups with small population sizes is that of statistical validity. Most population surveys, such as the U.S. Census's American Community Survey (ACS), make population estimates based on a random sample of the population. Samples of some racial/ethnic sub-groups are often so small in size that they are unable to produce population estimates that have statistical validity. For example, the 2008 ACS estimates that there are 738 Vietnamese in Montana, with a margin of error of +/- 738.⁶

Oversampling, the practice of intentionally surveying an elevated number of people from certain groups, is one technique to address this issue. APIAHF has advocated for oversampling practices in national surveys and a provision in the various 2009 health care reform bills (i.e. senate, house) would require oversampling for certain racial/ethnic sub-groups. This technique produces more accurate estimates of a population's demographic profile which can then be used to inform evidence-based programs and policies. APIAHF has also advocated for conducting standardized state level surveys across the nation.

In light of these challenges, APIAHF has launched a number of initiatives to improve data collection standards and centralize and distribute available data on Asian Americans, Native Hawaiians, Pacific Islanders, and their ethnic sub-groups. In addition to their advocacy work in the policy realm, APIAHF has developed a number of practical reports and online tools. One such resource is the **Population, Growth and Socioeconomic Status tool**. This interactive resource uses 1990 and 2000 Decennial Census data to create portraits of Asian American, Native Hawaiian, and Pacific Islander sub-groups at national, state, and county levels. The tool provides information on a wide range of variables including language, education, income, immigration status, and household characteristics.

Another valuable resource is a data chart entitled **Asian American, Native Hawaiian and Pacific Islander Population Demographics 2006**. This data chart uses 2006 ACS data (the most currently available and corrected) to depict the characteristics of Asian American, Native Hawaiian, and Pacific Islander sub-groups in the U.S. The report provides narratives, graphs, and figures on a wide range of categories such as English proficiency, income, and health insurance. The report also provides a detailed table of data on the ethnic sub-groups in each state in the U.S.

While barriers exist to obtaining reliable data on racial/ethnic sub-groups, there are a number of valuable resources to help maximize the utility of existing data. As Dr. Khan emphasized, collecting and reporting data on racial/ethnic sub-groups is only the first step.

After the characteristics of these communities are identified, their needs and assets must be incorporated into emergency preparedness, response, and recovery plans. Such evidence-based actions are critical to reducing racial/ethnic disparities in disaster outcomes and protecting the health and safety of an increasingly diverse population.

1. Suhaila Khan, MD, PhD, MPH is a Program Director at the Asian & Pacific Islander American Health Forum.
2. Office of Management and Budget. (1997). Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity.
3. Khan, S., Fung, Y., Giang, E., Wong, S., & Tantoco, N. (2009). Asian American, Native Hawaiian and Pacific Islander Population Demographics 2006.
4. Ibid.
5. Ibid.
6. U.S. Census Bureau. (2008). American Community Survey.

We encourage you to share the National Resource Center with your peers and colleagues and welcome you to link to the website. Please also feel free to e-mail your comments and any feedback to our team. We look forward to working with you to making this site a resourceful and useful tool in advancing the preparedness of our nation's diverse communities.

Sincerely,

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