THIS IS THE WAY WE RISE

Pacific Islander Data
Modernization in Oregon **2021**

THIS IS THE WAY WE RISE
Pacific Islander Data Modernization in Oregon

Table of Contents

Acknowledgements

DEDICATION

This report is dedicated to our home, Oceania, and the ancestors who never let us forget the waters that birthed us.

LAND ACKNOWLEDGEMENT

The Lenape story about the Great Turtle is shared by the Indigenous peoples of the Northeastern Woodlands and carries throughout all of North America. Through these stories, we continue to learn about those who have stewarded these lands since time immemorial. We would like to express our appreciation and respect of the Indigenous peoples' inherent kinship beliefs when it comes to the land, especially since those beliefs were restricted for so long. The United States was built on broken treaties. The lasting effects of federal and state policies, both past and present, have systematically oppressed Alaska Natives and American Indians for hundreds of years. It is on all of us, whether we are descendants of colonizers or inhabitants of stolen land, to decolonize and act in solidarity with Indigenous peoples.

We would like to honor and acknowledge the Indigenous peoples and rightful owners of this occupied land in which we do our work: the Klamath tribe of the Southern Oregon plateau; the Burns Paiute of the high-desert east; the Coquille of Southern Oregon's coastal forests; the Confederated Tribes of Grand Ronde in the northern Coast Range; the Cow Creek Band of Umpqua in the Southern Oregon foothills; the Confederated Tribes of Umatilla in the Blue Mountains; the Confederated Tribes of Siletz in Oregon's northern rainforests; the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw on the windblown southern coast; the Confederated Tribes of Warm Springs on the sunny eastern slopes of the Oregon Cascades; and all indigenous communities who hold ancestral ties to this land.[1]

[1] Adapted from the Land Acknowledgement written by Ka Lei Hali'a O Ka Lokelani utilizing www.native-land.ca

Contributors

Pacific Islander Data Modernization is a collaboration between leaders of Oregon's diverse Pacific Islander communities, local Pacific Islander-led community-based organizations, Pacific Islander community researchers, and state and county government staff. This work was funded by the Oregon Health Authority's Public Health Division and supported by the Multnomah County Health Department.

This body of work represents the collective effort to tell the stories of the people of Oceania living in Oregon. This work would not be possible without the wisdom, partnership, and dedication of Oregon's Pacific Islander communities. The contributors are listed below in alphabetical order by name/last name:

ORGANIZATIONS

Alyshia Macaysa Consulting
Ka 'Aha Lāhui O 'Olekona Hawaiian Civic Club
	of Oregon and SW Washington (KALO HCC)
Le'o 'o e 'OFA
Living Islands
Micronesian Islander Community (MIC)
Oregon Pacific Islander Coalition (OPIC)
Tongan Women's Association
United Territories of Pacific Islanders Alliance -
	Portland Chapter (UTOPIA PDX)

COMMUNITY RESEARCH WORKERS

Sisilia Afemui
Kianna Angelo
Bella Borja
Jonathan Cruz
Natlie Dutro
Jacinta Galeai
Adri Jones (Multnomah County Intern)
Jasmine Kahananui
Elizabeth Paulson (Multnomah County Intern)
Siiri Visto (Multnomah County Intern)

PACIFIC ISLANDER LANGUAGE EXPERTS

Sisilia Afemui (Tongan)
Susifina Afemui-Pittorf (Tongan)
Diane Bonju (Marshallese)
Bella Borja (CHamoru/Chamorro)
Kevin Joseph (Pohnpeian)
Leialoha Ka'ula ('Ōlelo Hawai'i)
Katokakala Kavapalu (Tongan)
Mele Kavapalu (Tongan)
Sylvia Lolan (Marshallese)
Paulina Perman (Pohnpeian)

PROJECT CONSULTANTS

Dr. Alma Trinidad
Sandi Wells

CORE PIDM RESEARCH TEAM

Margaret Braun
Maria Dizon
Dr. Aileen Duldulao
Virginia Luka
Alyshia Macaysa

PROGRAM DESIGN AND EVALUATION SERVICES (PDES) SURVEY MODERNIZATION TEAM

Renee Boyd
Margaret Braun
Julia Dilley
Erik Everson
Kusuma Madamala
Julie Maher
Jamie Matson
Tom Peterson
Kristen Rohde
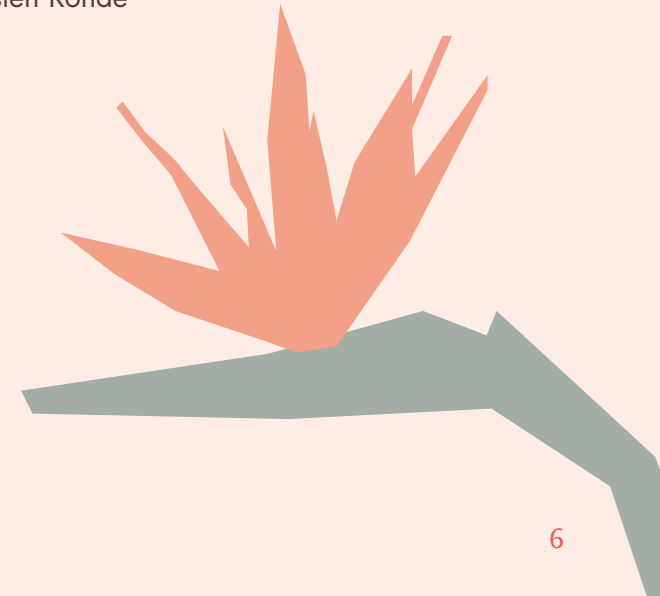
This report, and its included data, is owned by the

OREGON PACIFIC ISLANDER COALITION

Please reach out to info@oregonpacificislanders.org
if you have any questions.

Introduction

Introduction

A Brief History

Pacific Islanders are indigenous to Oceania. Oceania is made up of three regions: Melanesia, Micronesia, and Polynesia - all of which are situated in the largest water mass (the Pacific Ocean) on the planet. Like its waters, Pacific Islanders hold rich and vast experiences rooted in culture, language, and a deep kinship with our ancestral lands.

Between 2000 and 2010, the Pacific Islander population was the fastest growing racial or ethnic group in the United States (US).[1] Population estimates from the 2019 US Census' American Community Survey[2] indicate that Oregon is one of ten states in the US with the largest Pacific Islander populations (Hawaii, California, Washington, Texas, Utah, Florida, Nevada, New York, and Arizona are the others in the top ten). The estimated size of the Pacific Islander population will undoubtedly increase again with the 2020 Census results, being one of several racial and ethnic groups that were a specific focus of the US Census' expanded communications campaign[3] to encourage participation in the 2020 decennial Census.
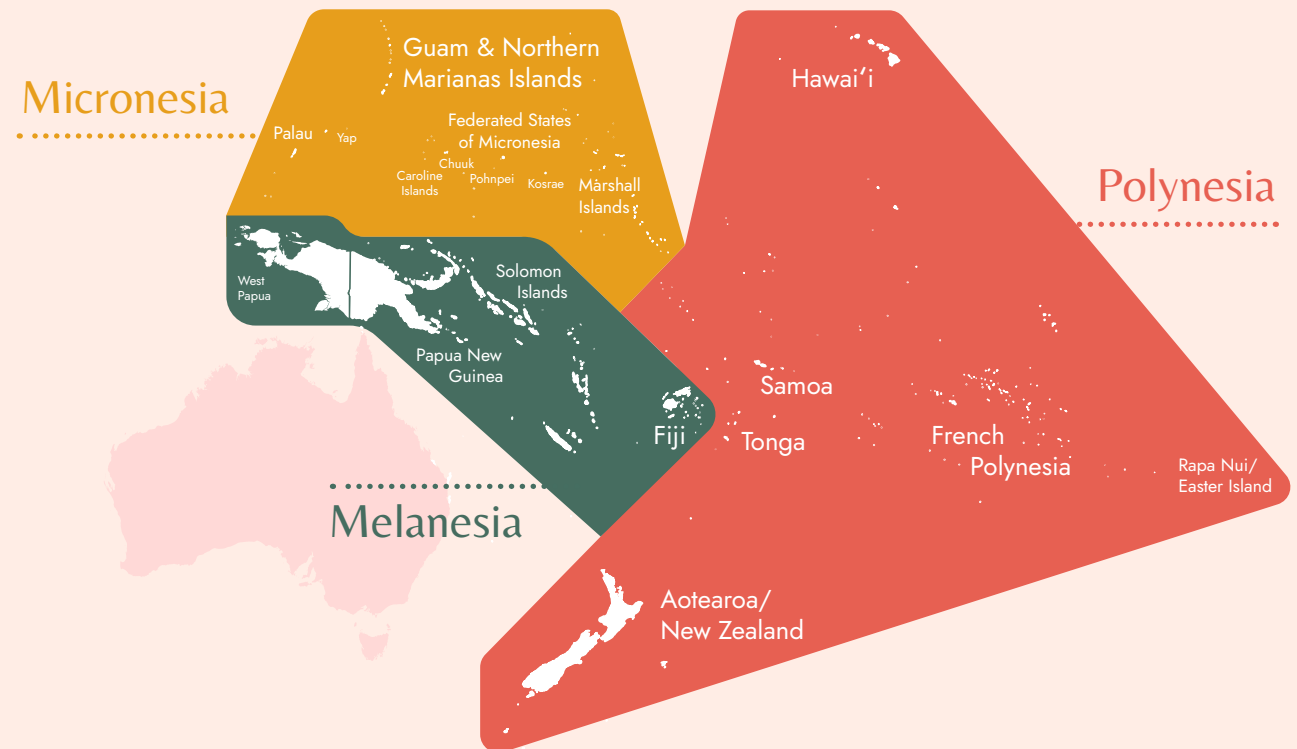
Despite the increasing size of the population in Oregon there is a significant lack of disaggregated data on Pacific Islander communities. Even basic information, such as an accurate and community-verified count of Pacific Islander individuals throughout the state, is lacking.[4] Pacific Islanders are also underrepresented in data from state and local public health surveys like the Behavioral Risk Factor Surveillance System (BRFSS). The

BRFSS is the largest, continuously conducted telephone health survey in the world and is a collaborative project between the Centers for Disease Control and Prevention (CDC) and US states and territories. In Oregon, the BRFSS is coordinated and administered by the Oregon Health Authority's Public Health Division.

[1] 2010 Census Brief, The Native Hawaiian and Other Pacific Islander Population: 2010
[2] 2019 US Census' American Community Survey
[3] US Census Bureau, 'Census Bureau Reaches Native Hawaiians and Pacific Islanders Through Music'
[4] Coalition of Communities of Color, 'The Asian & Pacific Islander Community in Multnomah County: An Unsettling Profile'

OCEANIA

Micronesia

Guam & Northern Marianas Islands

Palau   Yap

Federated States of Micronesia

Caroline Islands   Chuuk   Pohnpei   Kosrae   Marshall Islands

West Papua

Solomon Islands

Papua New Guinea

Fiji

Melanesia

Hawai'i

Polynesia

Samoa

Tonga

French Polynesia

Rapa Nui/ Easter Island

Aotearoa/ New Zealand

Introduction
Data Challenges

Photo credit: Oregon Pacific Islander Coalition

The BRFSS aims to collect state-specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. Oregon's state and local health departments rely heavily on the BRFSS for population health data. Oregon Health Authority's Public Health Division conducts over 8,000 BRFSS telephone surveys every year with a random sample of adults as well as a racial and ethnic oversample every 4-6 years to increase the number of BRFSS respondents from Oregon's Black and African American communities, American Indian and Alaska Native communities, Asian communities, and Pacific Islander communities. Oregon's state and local health departments depend on BRFSS data for a variety of purposes, including decisions about where to target and fund services, priorities for seeking grant funding, which health issues to address, what legislation to propose, and how to measure progress toward health objectives.

The BRFSS faces numerous challenges in terms of data quality, validity, reliability, and sustainability. For example, the BRFSS survey has become very long to accommodate demands for additional questions because it serves as the primary source of data on many health indicators in Oregon. With the added length, Pacific Islander respondents – who have never benefited from their participation – are met with interviewers who move quickly through questions in order to ensure completion. These interviewers often lack the relationships, cultural competency, language abilities and trauma-informed practice necessary to engage Pacific Islanders. The BRFSS survey covers sensitive topics (e.g., adverse childhood experiences or ACEs, food insecurity, and housing stability), and rushing through them - let alone discussing such private information at all - could be traumatizing for some respondents. The topic areas covered by the BRFSS have never been informed through community engagement and often fail to capture the health priorities of specific communities.

Given these limitations, it is not surprising that Pacific Islanders are severely underrepresented in the BRFSS - more so than any other racial or ethnic group in Oregon. To illustrate, the last racial and ethnic oversample conducted for the Oregon BRFSS successfully recruited only 106 Pacific Islander respondents over the course of 3 years. Clearly, the BRFSS' general approach, methods, uninformed topic areas, and lack of diverse languages are particularly consequential in Pacific Islander communities. For these reasons, Oregon's Pacific Islander communities partnered with Program Design and Evaluation Services (PDES) and the Oregon Health Authority's Public Health Division on Pacific Islander Data Modernization (PIDM). PIDM represents one component of work funded through the Oregon Legislature's investment in Public Health Modernization focused on updating Oregon's adult survey systems to address the challenges mentioned above.

Previous Works

PIDM builds off of previous efforts to expand data collection on Pacific Islanders in Oregon: Multnomah County's Pacific Islander Data Project and Community Counts. The Pacific Islander Data Project (PIDP) launched in November 2018 with five objectives in mind:

1 Understand Tradition

Develop an understanding of the culturally-based traditions and strengths that support the health and well-being of Pacific Islanders in Multnomah County.

2 Understand Health

Understand major health issues and barriers to healthcare access experienced by the Pacific Islander community.

3 Increase PI Data

Increase the availability of data on the health of the Pacific Islander community at the granular level (i.e., disaggregated from data on Asian communities).

4 Build Capacity

Build capacity in the Pacific Islander community in understanding data about the community and to design and participate in community-based participatory action research.

5 Strengthen Partnerships

Strengthen partnerships between the Multnomah County Health Department (MCHD) and Pacific Islander-serving community-based organizations.

PIDP resulted in five community compasses (brief reports) focused on: Sexual Health and Gender Identity, Parent and Child Health, Mental Health, Climate Change and Chronic Disease, and Nutrition. Each of these topic areas were selected, co-facilitated, and validated by the community. Embedded in each compass are recommendations on how to best navigate addressing the complex health status of Pacific Islanders. These recommendations named that achieving health equity for Pacific Islanders requires thoughtful disaggregation of data, and

robust engagement of Pacific Islander leadership in research.

Community Counts was a partnership between Oregon's Chuukese community and PDES, and was funded by the Oregon Health Authority's Office of Equity and Inclusion and the Public Health Division. Community Counts tested a respondent-driven sampling approach to administering a BRFSS-type survey and successfully recruited 120 participants, nearly all of whom completed the interview for the survey

in Chuukese. Data collected from the surveys and during follow-up listening sessions emphasized many community strengths, a few challenges, essential guidance for advancing Pacific Islanders' health and well-being, and recommendations for improving public health surveys for Pacific Islanders. Chief among these recommendations was to engage communities in the processes of leading the research effort including designing methods, developing participant recruitment strategies, creating data collection tools, and interpreting and reporting findings.

Introduction

Community-Led Research Model

*Photo credit: Pacific Islander Data Modernization*

The lessons from these previous bodies of work helped develop PIDM's community-led research model. The community-led research model is rooted in decolonization. Decolonization is the act of dismantling the settler-colonial logic that not only drives, but also justifies the erasure of Pacific Islanders. This erasure happens through complex systems of alienation, coercion, and exploitation. More importantly, decolonization centers community healing and an equitable distribution of power. This translates to cultivating trusting relationships, and recognizing Pacific Islanders' rights to self-determining what is required to create healthy communities for Pacific Islanders.

Through this approach, the Oregon Pacific Islander Coalition required the Oregon Health Authority's Public Health Division to enter a Data Sovereignty Agreement (DSA). In this case, the DSA outlines the power structure between the sponsoring research institution, the researchers,

and the community being researched. The DSA prevents researchers and institutions from extracting data from communities and claiming the research solely as their own, which is a common practice of settler-colonial logic. Instead, the community is the primary beneficiary of the work, the final decision-maker, and an owner and author of the resulting research. This means that the community:

1 Served as the research experts, engagement experts, language experts, and writers;

2 Was properly compensated for the expertise that they provided at every stage of the project; and

3 Utilized the Oregon Health Authority's Public Health Division as a technical assistance resource rather than as a governing body for the work.

The DSA also created the conditions that allowed this project to utilize a Pacific Islander framework on community health, rather than one predetermined by existing government surveys (such as the BRFSS) that fail to capture the community's unique relationship to health and health equity. This resulted in the development of the Pacific Islander Health, Equity, and Liberation (PI HEAL) Assessment - the primary data collection tool used in this project. The tool honors Pacific Islander ways of knowing and being, including our relational worldview, holistic approach to health, and collectivist cultures.
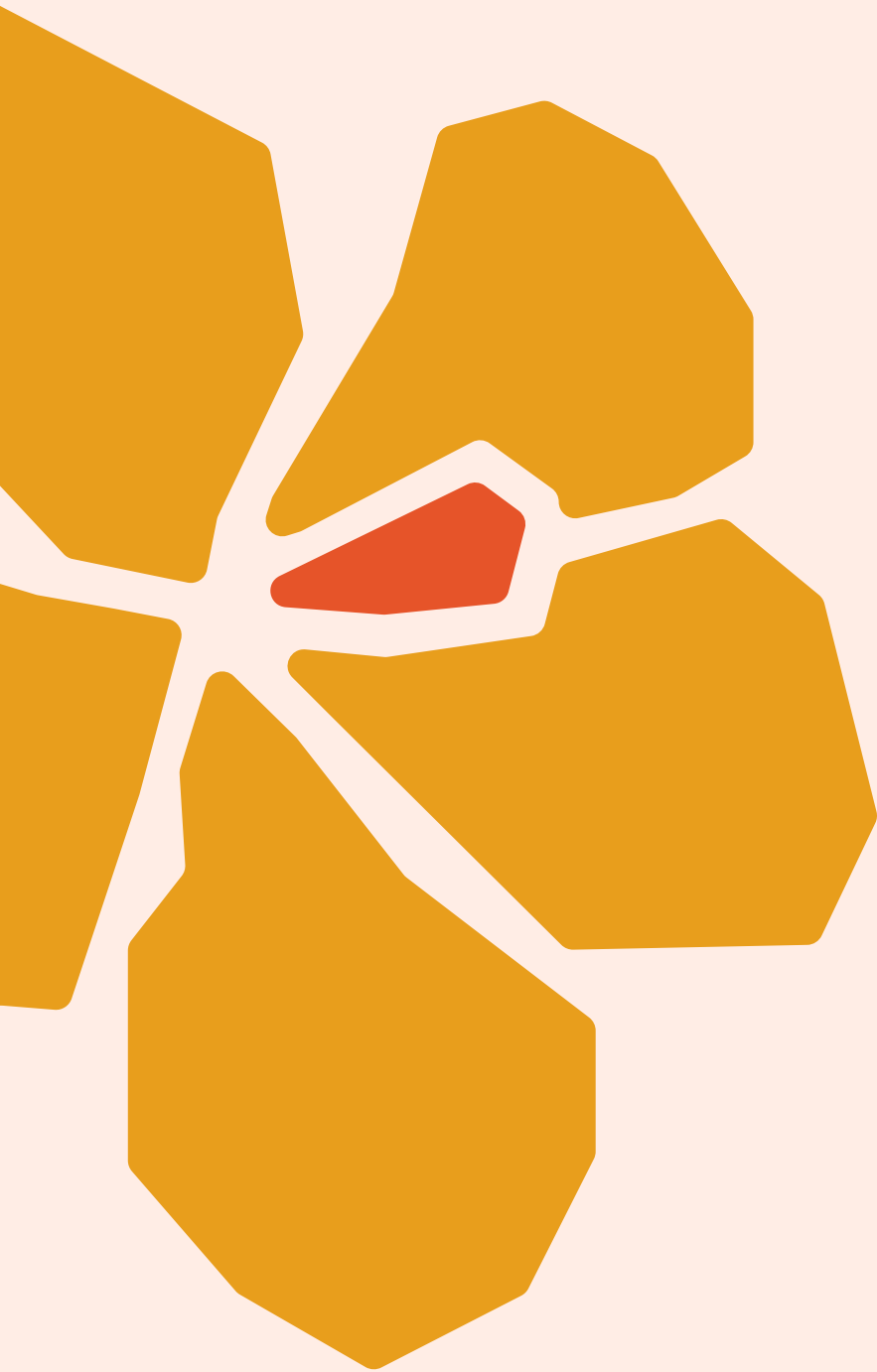
Methods

Photo credit: Oregon Pacific Islander Coalition

Community Leadership

Community leadership is the core to the success of this work. There were three main levels of engaging Pacific Islander leadership:

1 **Core Research Team**

The Core Research Team was responsible for the overall approach, timeline, budget, community engagement, data collection, and data analysis for the project. Three out of five of the Core Research Team members are public health practitioners/researchers with deep ties to Oceania.

2 **Community Based Organizations**

Community-Based Organizations (CBOs) served as high-level advisors on the project, workshop hosts, and outreach experts. All CBOs involved are led by and provide service to Pacific Islanders.

3 **Community Research Workers**

Community Research Workers (CRWs) co-developed and co-facilitated the data workshops that provided the robust qualitative data included in this work, and supported overall data analysis. All but one CRW identified as Pacific Islander.

Through these avenues, Pacific Islanders served as the subject matter experts leading the dialogue (and thus, data collection) with other Pacific Islanders on what practices, opportunities, and challenges exist for Pacific Islanders when it comes to health and healing.

Methods
PI HEAL Assessment

The Pacific Islander Health, Equity, and Liberation (PI HEAL) Assessment was developed to tell the story of Pacific Islander health and healing. It draws inspiration from Prevention Institute's THRIVE (Tool for Health & Resilience in Vulnerable Environments) framework to assess different community health factors significant to Pacific Islanders. The assessment is composed of four overarching categories and their respective community health factors:

PEOPLE
Community Connections, Care for Community, and Community Values

PLACE
Housing, Food, Access to Land, Getting Around, and Cultural Centers
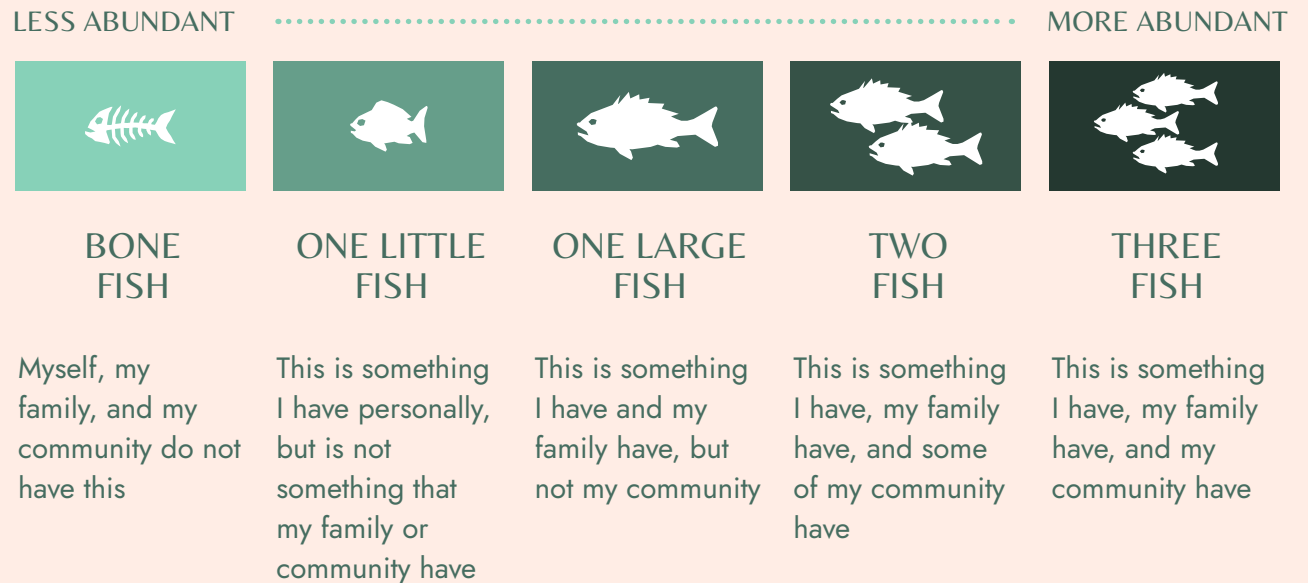
OPPORTUNITY
Living Wages, Local Wealth, Education, and Information

HEALING
Self Determination, Decolonization, Spiritual Health, and Healthcare

Knowing that the core value of Pacific Islanders is caring for the larger community*, rather than the individual alone, participants were asked to rate each of the community factors by selecting an option on our "fish" scale that best represents how accessible and abundant this factor is to Pacific Islanders in Oregon. For example:

*Participants identified "the larger community" as other Pacific Islanders in Oregon, extended relatives, people they go to church with, or their neighbors

LESS ABUNDANT ···················· MORE ABUNDANT

BONE FISH	ONE LITTLE FISH	ONE LARGE FISH	TWO FISH	THREE FISH
Myself, my family, and my community do not have this	This is something I have personally, but is not something that my family or community have	This is something I have and my family have, but not my community	This is something I have, my family have, and some of my community have	This is something I have, my family have, and my community have

An example of the PI HEAL Assessment with full descriptions of each community health factor appears in the Appendix.

Methods

Data Collection

Photo credit: Oregon Pacific Islander Coalition

All PI HEAL Assessment data was collected through an online version of the assessment. The English, ʻŌlelo Hawaiʻi, Pohnpeian, and Tongan versions of the assessment were accessible through the Pacific Islander HEAL website. Respondents who took the online survey, but did not attend a workshop, were entered into a raffle to win one of five $100 gift cards.

The Core Research Team also partnered with the Pacific Islander-led and serving CBOs to host five data workshops. Workshops were co-designed and co-facilitated by a Workshop Team. Each Workshop Team had two CRWs, at least one CBO representative, and at least one

Core Researcher. The Data Workshops served two purposes:

1   Collect meaningful qualitative data to contextualize online assessment results.

2   Build/lift up data and research capacity within the Pacific Islander community.

The workshops made time for each participant to respond to the PI HEAL Assessment on their own. Afterwards, participants were broken up into small group discussions to share their initial feedback on the assessment and to explain why they responded the way they did. Participants

were brought back together as a large group to debrief and close out the workshop. Workshop participants were compensated $75 in recognition of the time, energy, and wisdom they provided.
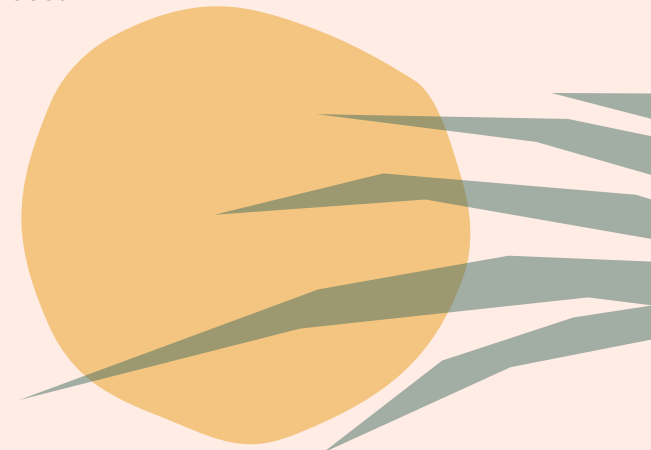
Methods
Data Analysis

Photo credit: Ka ʻAha Lāhui O ʻOlekona Hawaiian Civic Club of Oregon and SW Washington (KALO HCC)

Responses to the PI HEAL Assessment were analyzed in aggregate using IBM SPSS Statistics version 24. Response frequencies and percentages were calculated for each assessment question. Means and standard deviations were computed where possible and appropriate (e.g., average age of respondents). We intended to conduct a more detailed analysis by subgroups of interest (e.g., by Pacific Islander ethnic identity, age, gender identity, county, and disability status, etc.), however we were unable to do so given the small numbers of responses in these subgroups. As data collection efforts further develop with Pacific Islander communities in Oregon, we hope that future iterations of this work will allow for analyses by subgroups.

Discussions from the Data Workshops were recorded by notetakers and via Zoom recording. CRWs and Core Research Team members conducted thematic coding of the discussion data from individual workshops, utilizing the PI HEAL community health factors as the primary codes to which the data was organized. Additional categories such as feedback on the assessment, quality of the workshop, and recommendations to further strengthen the work were included. The CRWs and Core Researchers across all workshop teams then co-developed causal diagrams to thread together a narrative for how the community health factors are intrinsically connected to the overall health and well-being of the Pacific Islander community.

Results

Characteristics of Respondents

Characteristics of Respondents

Findings from the PI HEAL Assessment and Data Workshops are presented in the charts, tables, and text in the following pages. Responses to the assessment are presented in raw, unweighted form. Response categories may not total 100% due to rounding and because participants could select more than one response on certain questions (e.g., when reporting racial and ethnic identities).

Some assessment results cannot be reported when counts are low to protect the privacy and anonymity of community members. In addition, some response categories are combined to maintain privacy. For example, the response options of "Don't know" and "Do not want to answer" are sometimes presented in combination. Data is presented for all available response categories whenever possible.

Community members had the option of skipping questions they did not want to answer. For this reason, the number of responses varied by question.

Photo credit: Oregon Pacific Islander Coalition
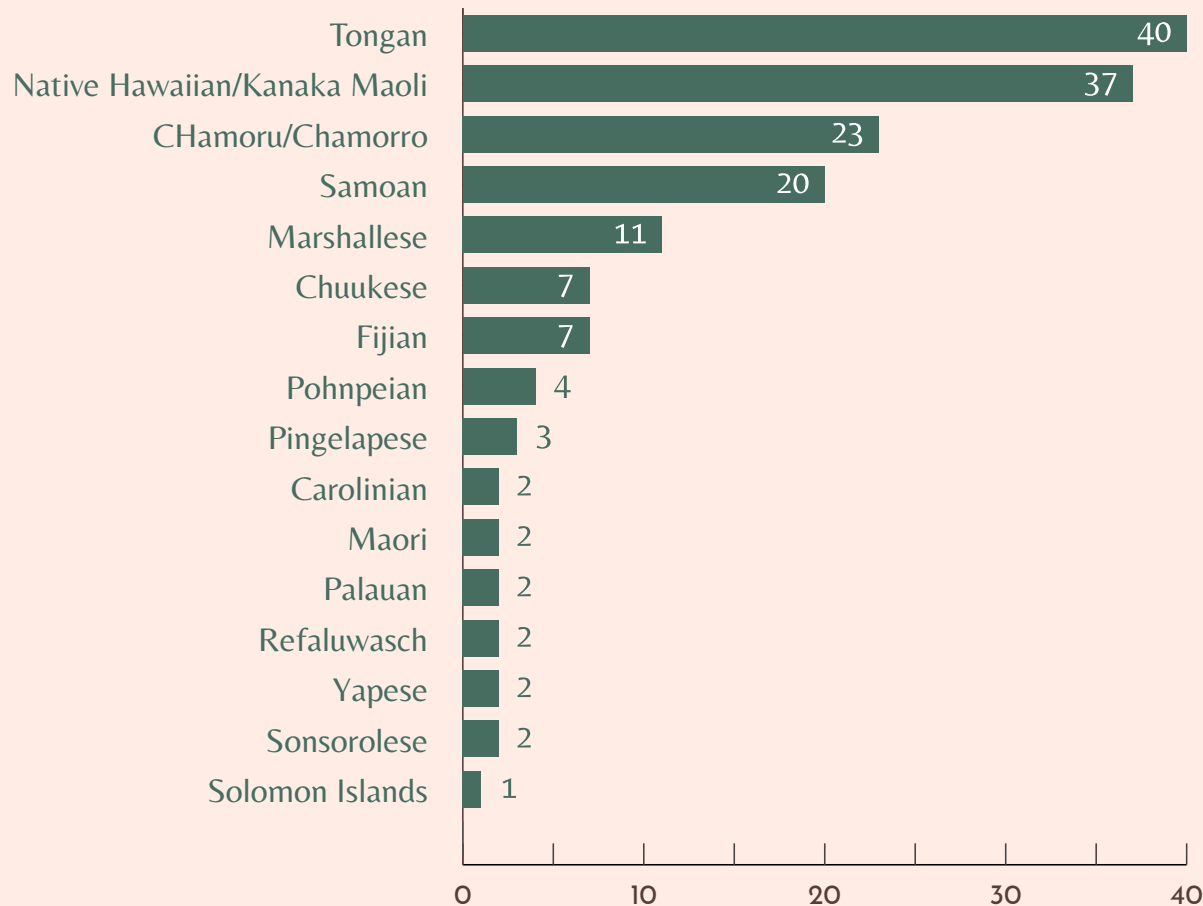
Whose voices are present?

In all, 136 Pacific Islander community members responded to the PI HEAL Assessment. Ninety-nine community members submitted complete responses and 37 answered some but not all of the questions. Six community members responded to the Tongan assessment and 130 responded to the English assessment.

This section describes the voices that are present in the responses, including how they reported race, ethnicity, language, disability, gender identity, sexual orientation, age, and where they live in Oregon/SW Washington. We also report the number of community members who attended a PI HEAL Data Workshop, described in the previous section.

Race & Ethnicity

Ethnicity	Count
Tongan	40
Native Hawaiian/Kanaka Maoli	37
CHamoru/Chamorro	23
Samoan	20
Marshallese	11
Chuukese	7
Fijian	7
Pohnpeian	4
Pingelapese	3
Carolinian	2
Maori	2
Palauan	2
Refaluwasch	2
Yapese	2
Sonsorolese	2
Solomon Islands	1

PACIFIC ISLANDER ETHNIC IDENTITY

The PI HEAL Assessment was intended for Pacific Islander community members, therefore all 136 respondents reported one or more Pacific Islander ethnicities. The chart displayed here shows the different Pacific Islander ethnicities respondents reported either alone or in combination with other Pacific Islander ethnicities or non-Pacific Islander racial and ethnic identities. Overall, community members reported 16 different Pacific Islander ethnic identities representing Polynesia, Micronesia, and Melanesia.

Race & Ethnicity

OTHER RACIAL AND ETHNIC IDENTITIES

PI HEAL Assessment respondents had the opportunity to select multiple racial and ethnic identities to reflect how they identified and how they wanted to be represented in the data. The chart displayed here shows that most PI HEAL respondents reported one primary racial or ethnic identity while 20% said they identified as Biracial or Multiracial or that they had multiple primary racial or ethnic identities. These community members reported a wide variety of racial and ethnic identities in addition to their Pacific Islander identities including: Filipino/a, Chinese, American Indian or Alaska Native, Japanese, South Asian, Asian Indian, Vietnemese, Taiwainese, African American, Mexican, Puerto Rican, North African, Eastern European, and Western European. The number and variety of racial and ethnic identities reported by community members aligns with previous research that Pacific Islanders often report multiple races and/or ethnic identities— sometimes more than any other racial or ethnic group.[1]

PI HEAL respondents were also invited to describe their racial or ethnic identity using their own words. Below are a few example responses that further demonstrate the breadth of Pacific Islander community members' racial and ethnic identities:

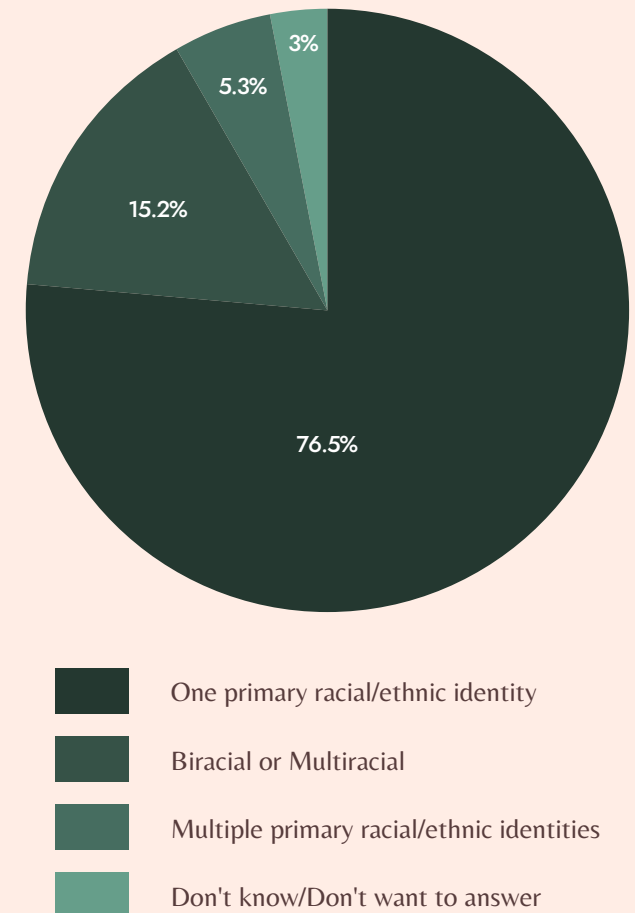"I am multiple ethnicity, but I identify as Tongan American because that is the cultural background I grew up in."

"Micronesian –> Marshall Islands –> Mokauleej Clan."

"I am multicultural, but I identify as Tongan."

"Native Hawaiian/Otoe Missouria Tribe of Oklahoma."

"The flowering of colonizer and colonized roots."

RACIAL & ETHNIC IDENTITY

- One primary racial/ethnic identity
- Biracial or Multiracial
- Multiple primary racial/ethnic identities
- Don't know/Don't want to answer

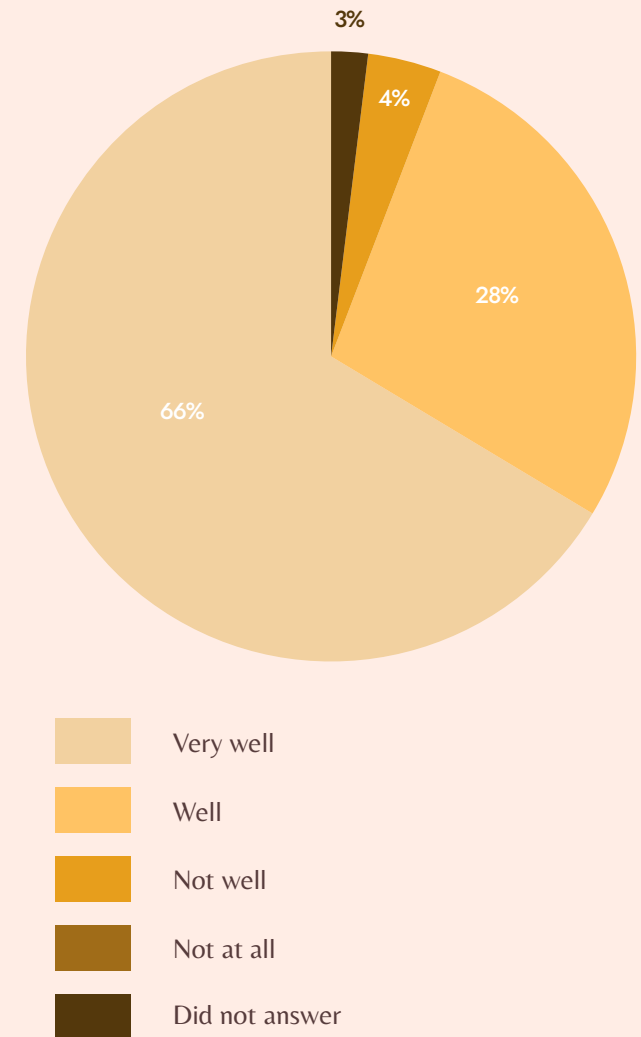Pie chart values: 76.5%, 15.2%, 5.3%, 3%

Language

The PI HEAL Assessment asked community members about their language preferences in two questions: "In what language would you like us to speak with you?" and "In what language would you like us to write to you?" The majority said they preferred English for both speaking (86%) and writing (85%). Several said they prefer to speak and write both in English and one or more Pacific Islander languages (7%), and a few said they preferred only Pacific Islander languages for speaking (7%) and writing (6%). The Pacific Islander languages community members reported speaking and writing included CHamoru, Chuukese, Marshallese, ʻŌlelo Hawaiʻi, Samoan, and Tongan.

Community members were also asked how well they speak English. The chart to the right shows that the majority said they speak English "very well" or "well," and a few said "not well."

"HOW WELL DO YOU SPEAK ENGLISH?"

Pie chart values: 3%, 4%, 28%, 66%

Legend:
- Very well
- Well
- Not well
- Not at all
- Did not answer

Respondents who said they speak English "not well" were automatically asked a follow up question about whether they would like additional help completing the assessment and/or needed the questions in a different language. No respondents requested additional help, and those who needed the assessment in a different language were automatically redirected to the PI HEAL webpage to take the assessment in one of the available Pacific Islander languages.

Results | Characteristics of Respondents
Disability

PI HEAL respondents' disability status was assessed in a series of questions about a variety of disability characteristics. Some disability questions were followed by another question asking the respondent's age when the condition began. Each question about disability characteristics is presented in the table below along with community members' responses.

The data shows that no community members reported being deaf or having serious difficulty hearing. A few community members reported being blind or having serious difficulty seeing, and those who did said their vision troubles began anywhere from 12 to 49 years old. About 6% of respondents reported difficulty walking or climbing stairs that started anywhere from 34 to 60 years old. Very few community members said they have difficulty with self-care like dressing or bathing. About 10% reported having a physical, mental, or emotional condition that limits their activities in some way. Nine percent reported having a physical, mental, or emotional condition that causes serious difficulty

Assessment Question	Yes	No	Don't know/ Don't want to answer	Did not answer
Are you deaf or do you have serious difficulty hearing?	0%	96%	4%	0%
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	3%	92%	0%	5%
Do you have serious difficulty walking or climbing stairs?	6%	89%	0%	5%
Do you have difficulty dressing or bathing?	1%	94%	0%	5%
Does a physical, mental, or emotional condition limit your activities in any way?	10%	82%	3%	4%
Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	9%	82%	4%	5%
Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?	4%	88%	3%	5%

concentrating, remembering, or making decisions, and about 4% said a physical, mental, or emotional condition causes them serious difficulty running errands alone. Community members who reported these physical, mental, or emotional conditions said they started anywhere from childhood to when they were in their 60s. A few community members said these difficulties began after experiencing a stressful event (e.g., the death of a loved one).

Overall, about 18% of community members who responded to the PI HEAL Assessment reported experiencing one or more disabilities.

Gender Identity

PI HEAL Assessment respondents were asked to report their gender identity. Like the questions about racial and ethnic identity, community members had the opportunity to select as many categories as they wanted in order to fully describe their gender identity. They could also write in a response if none of the options represented their identities as well as any additional information they wanted to include in the description of their gender. The chart to the right displays the number of community members who selected each category.
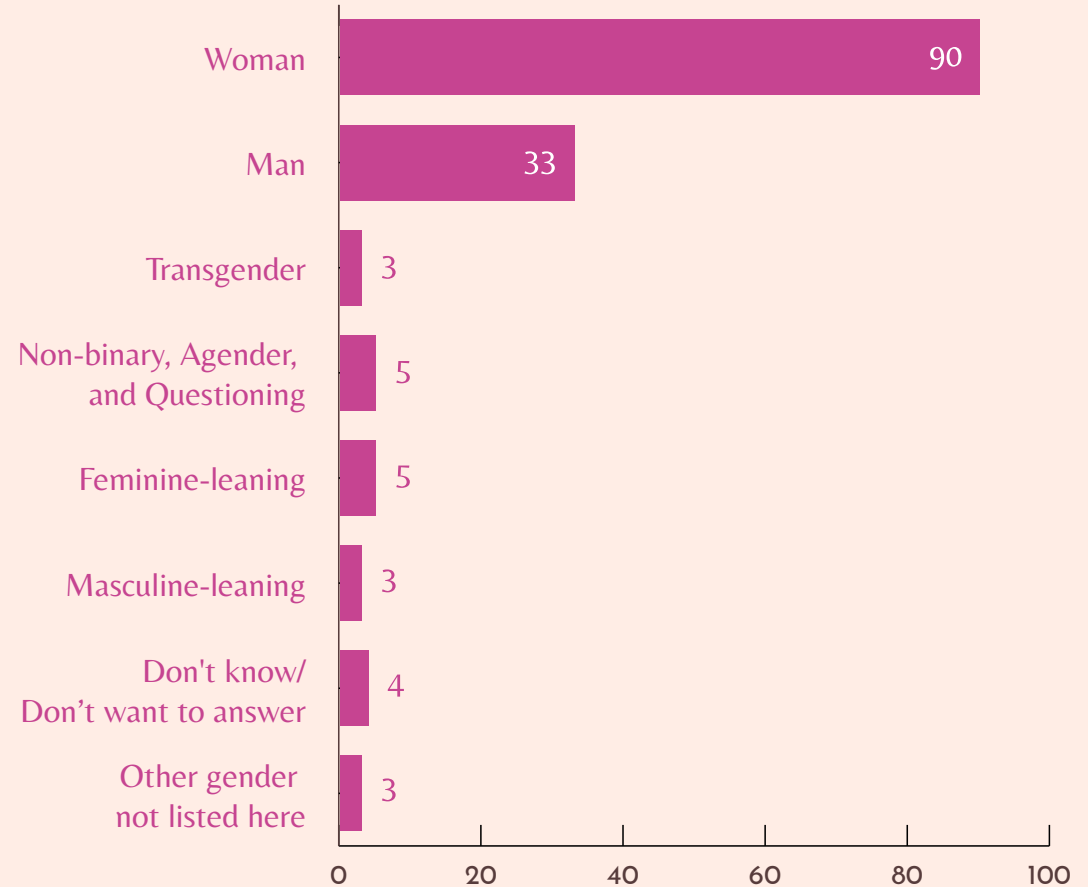
Community members also had the opportunity to briefly describe their gender identity in their own words. A few example responses were:
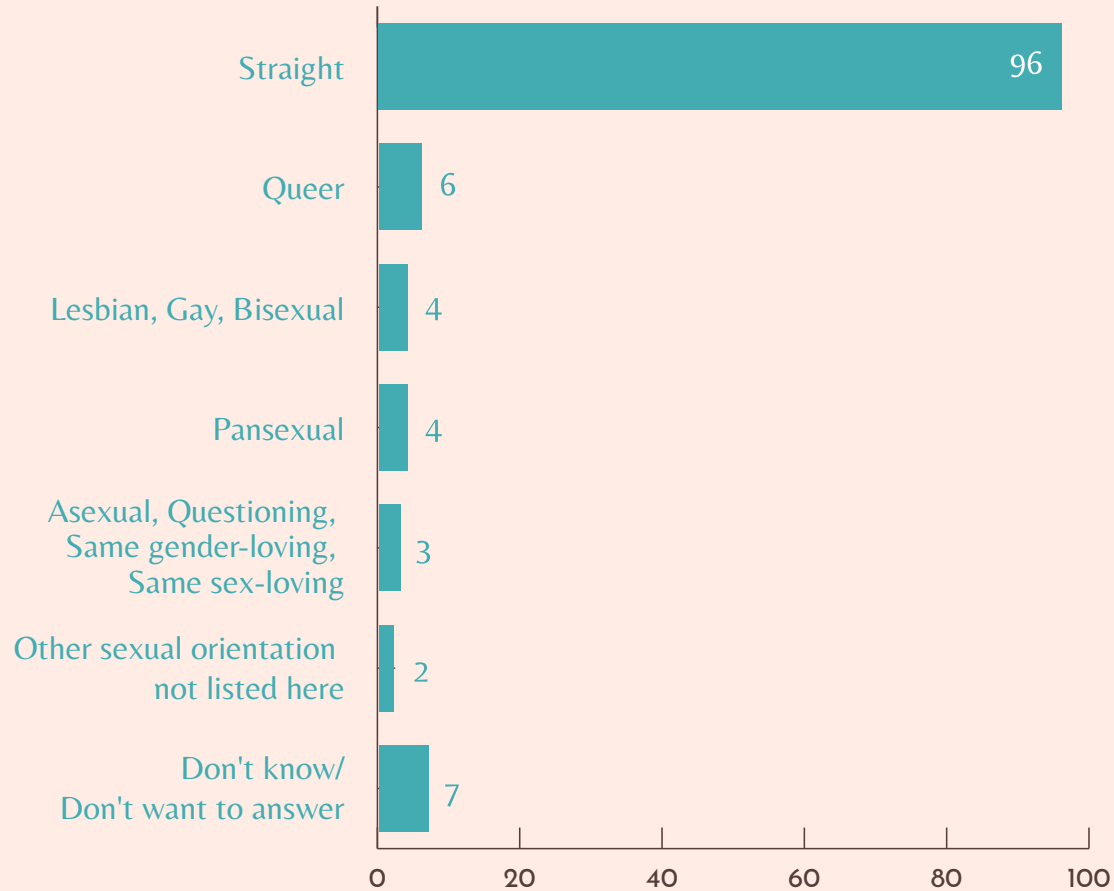
"Gender non-conforming."

"Just a man."

"I'm a female."

"In the process of transitioning."

Horizontal bar chart showing number of community members who selected each gender identity category:
- Woman: 90
- Man: 33
- Transgender: 3
- Non-binary, Agender, and Questioning: 5
- Feminine-leaning: 5
- Masculine-leaning: 3
- Don't know/ Don't want to answer: 4
- Other gender not listed here: 3

Sexual Orientation

Straight — 96
Queer — 6
Lesbian, Gay, Bisexual — 4
Pansexual — 4
Asexual, Questioning, Same gender-loving, Same sex-loving — 3
Other sexual orientation not listed here — 2
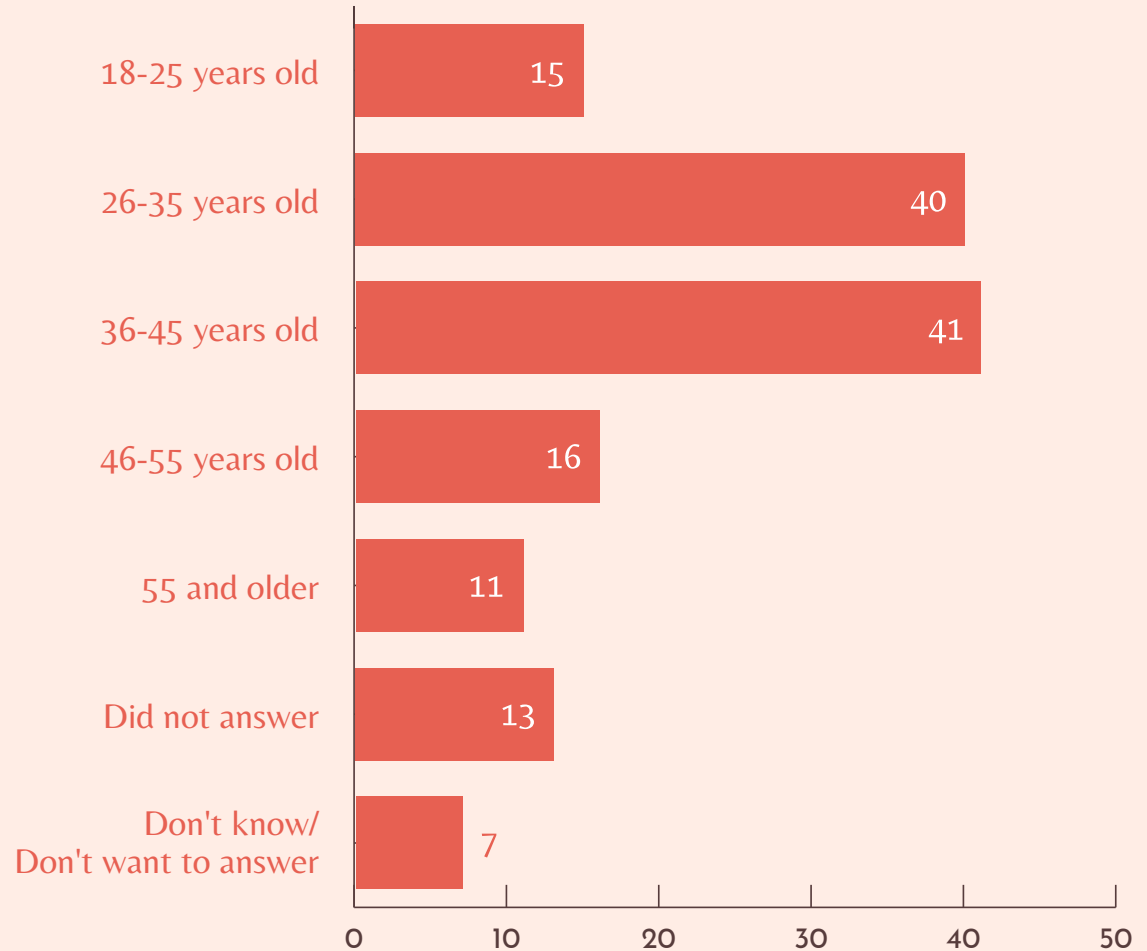**Don't know/ Don't want to answer** — 7

PI HEAL Assessment questions about sexual orientation also provided community members with the option of selecting more than one response. Community members could also describe their sexual orientation in a short response, though few did. The chart to the left displays the number of community members who selected each category.
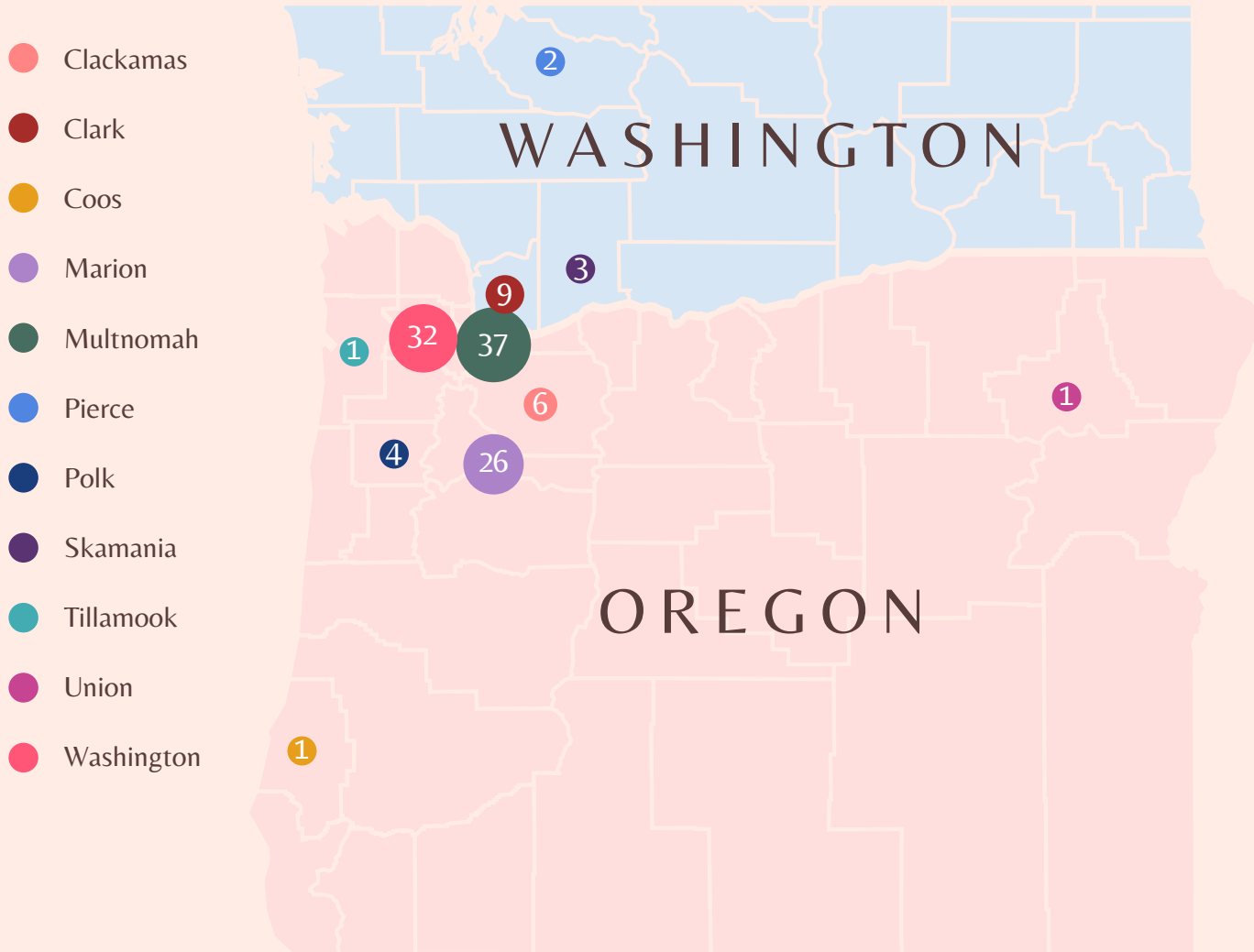
Results | Characteristics of Respondents
Age

Community members who participated in the PI HEAL Assessment varied widely in age. The chart to the right shows the majority of respondents were between the ages of 26 and 45 years old. Respondents ranged in age from 18 to 74 years old, with an average age of about 39 (standard deviation = 12).

Age Group	Count
18-25 years old	15
26-35 years old	40
36-45 years old	41
46-55 years old	16
55 and older	11
Did not answer	13
Don't know/Don't want to answer	7

County

Legend:
- Clackamas
- Clark
- Coos
- Marion
- Multnomah
- Pierce
- Polk
- Skamania
- Tillamook
- Union
- Washington

The majority of PI HEAL respondents said they lived in counties in and around the Portland metro area. This map shows there were more than 30 respondents from Washington county, nearly 40 from Multnomah county, and a few respondents from Clark and Skamania counties in SW Washington. Another large response came from community members living in Marion and Polk counties which cover the Salem metro area. A handful of responses came from more rural counties on the coast (Coos and Tillamook) and in eastern Oregon (Union).

Attendance & Perspectives

PI HEAL WORKSHOP ATTENDANCE

One of the last questions on the PI HEAL Assessment asked respondents whether they attended one of five PI HEAL workshops that were hosted by local Pacific Islander-led community-based organizations. Of those who responded to the question, 57% said they attended a PI HEAL workshop. The remaining 43% did not attend a workshop.

WHAT PACIFIC ISLANDER PERSPECTIVES ARE MISSING?

We are delighted by the number and representation of Pacific Islander community members who responded to the PI HEAL Assessment. We also acknowledge that despite the great response, not all Pacific Islander perspectives are represented in the data. Oceania is vast, with over 30 Pacific Island nations and 20,000 islands. While Pacific Islanders from each ethnographic region -- Melanesia, Micronesia, and Polynesia -- are represented in this data set, better and more equitable representation of all Pacific Islanders is required.

Because of the COVID-19 global pandemic and public health restrictions on in-person gatherings, we were only able to offer the PI HEAL workshops and assessment online. This may have excluded community members who do not have access to a computer or smartphone and those who are not connected to the Internet. CBO partners were provided additional funds to support community members with computing hardware and technical assistance, but community members who are not connected to a CBO likely missed that opportunity. In subsequent years, it will be essential to offer the assessment in multiple modes including online, on paper, and over the phone with a Pacific Islander interviewer.

The fact that we relied on an entirely online survey may have prevented the participation of certain community members who otherwise would have taken part if it had been offered in other formats. This includes but is not limited to Pacific Islander elders, who made up a relatively small percentage of our PI HEAL respondents. The wisdom, experiences, and knowledge of Pacific Islander elders are critical to understanding the community's health and well-being, and we recognize that their perspectives are not fully represented in the data.

Another perspective that is missing is that of Pacific Islanders who do not speak, read, or write in the languages in which the assessment was offered (English, ʻŌlelo Hawaiʻi, Pohnpeian, and Tongan). The assessment was also translated into Marshallese and CHamoru/Chamorro, however we were unable to post the assessment and collect data in these languages within our project time frame. We hope to re-engage our language experts in Chuukese, Kapinga Marangi, Palauan, and Samoan to translate the PI HEAL Assessment into these languages for future work with the community.

While our CBO partners and recruitment strategies successfully recruited a number of Pacific Islanders living outside the Portland metro area, the voices of community members from Oregon's rural areas are mostly lacking. The majority of PI HEAL respondents reported living in the Portland metro area, and many others reported living around the I-5 corridor (i.e., Marion county and the Salem metro area). There are growing Pacific Islander communities in counties in Oregon's Eastern, Southern, and Coastal areas that should have a larger presence in future iterations of this work.

Results

Assessment & Workshop Results

Ratings of Community Health Factors

PEOPLE   **PLACE**   **OPPORTUNITY**   **HEALING**
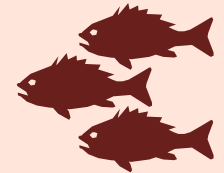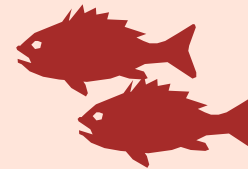
The PI HEAL Assessment asked Pacific Islander community members to rate 16 community health factors based on how accessible and abundant they believe the factor is to Pacific Islanders in Oregon. The sections below present how community members rated each health factor using the PI HEAL Assessment "fish" scale, which allowed respondents to consider accessibility and abundance for themselves, their families, and their community.

Each section of the results is organized by the four PI HEAL Assessment categories: People, Place, Opportunity, and Healing. Under each category is a written summary of the quantitative data and a visual representation of the quantitative data. Each data visual is followed by a qualitative analysis highlighting the written comments in the online assessment and responses when community members were asked "Why did you respond to the assessment the way you did?" during the data workshops. Not all community health factors are individually highlighted due to a lack of response, lack of time to discuss, or discussion of them being rolled into other community health factors.
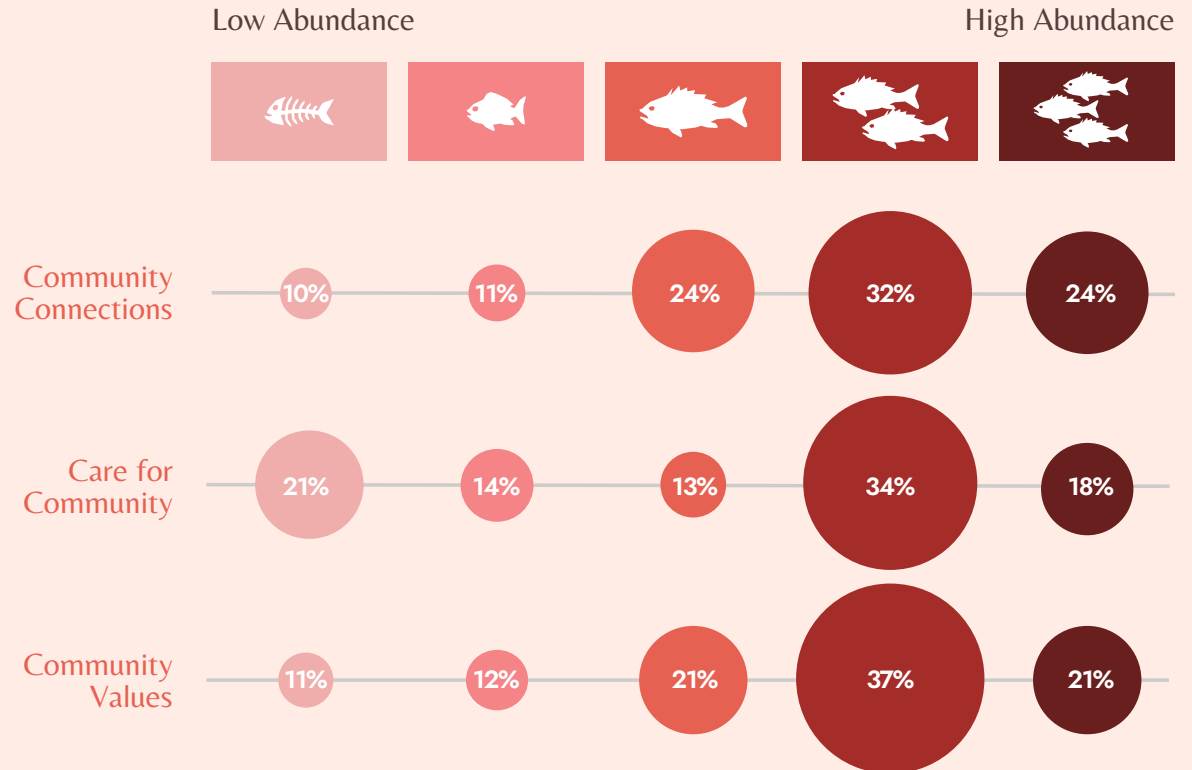
Community Members in this scenario refer to the workshop participants or online assessment respondents. Community Leaders in this scenario refer specifically to those who identified themselves as members of a community organization or church during the workshops.

People

HOW DID THE COMMUNITY RATE THE ABUNDANCE OF EACH FACTOR?

The People category within the PI HEAL Assessment asked community members to rate the accessibility and abundance of Community Connections, Care for Community, and Community Values. The chart here shows that overall, a little over half of community members reported that Community Connections, Care for Community, and Community Values are abundant and accessible for themselves, their families, and at least some of their broader community.

Low Abundance   High Abundance

	Community Connections	Care for Community	Community Values
Low Abundance	10%	21%	11%
	11%	14%	12%
	24%	13%	21%
	32%	34%	37%
High Abundance	24%	18%	21%

People CONTINUED

WHY DID THE COMMUNITY RESPOND TO THE ASSESSMENT THE WAY THEY DID?

Community connections can grow the abundance of access to resources or completely dissolve it.

Community members frequently commented on the lack of a direct relationship with the state and how reliant they are on church leaders, elders and family members for resources such as access to affordable housing, medical interpretation, or support with health insurance applications. This can be challenging because social hierarchies within the community can limit the few resources that are available. At the same time, the community serves as an irreplaceable resource on healing, cultural preservation, and formation of one's identity. These connections are critical on a practical and spiritual level and a core protective factor for Pacific Islanders.

Care for the community often shows up heavily through church involvement, but community members want to see greater Pacific Islander care in other areas, such as political advocacy groups or school-based communities.

For example, Marshallese leaders noted that it is hard to have political power when you cannot vote as a COFA Citizen, so greater political advocacy is needed; especially on intergenerational issues such as nuclear testing and Medicaid restoration which greatly impact their health. Community members also shared that supporting each other during difficult times, providing financial support, and coming together for celebrations is core to Pacific Islander cultures but isolation in Oregon presents several barriers that are mentioned throughout this report. Because churches are the primary resource hub in the community, those not linked to a church are not receiving the support and care that they need.

Making space to talk about intersectionality and how the community values LGBTQIA+ people is important, but still a taboo topic.

Some community members were not sure what the acronym stood for, others avoided the discussion, and a few raised that lumping inclusion of LGBTQIA+ people with respect for elders in the same definition felt inappropriate. However, there are also community members who said that the community's values around LGBTQIA+ people, prevalence of anti-Blackness, and the friction between religious customs and cultural customs needs to be challenged. Across these perspectives community members shared that multigenerational conversations need to happen if we want to see shifts in these values. Elders in particular play a huge role in defining social hierarchies and setting the values of the community.

"We are our own medicine."

- DATA WORKSHOP PARTICIPANT

Place

HOW DID THE COMMUNITY RATE THE ABUNDANCE OF EACH FACTOR?

The Place category asked community members to rate the accessibility and abundance of Housing, Food, Access to Land, Getting Around, and Cultural Centers. Compared to the community health factors in the People category, community members' ratings of health factors in the Place category were a little more varied. About 40% of community members reported that Housing is something that is accessible and abundant for themselves, their families, and at least some of their community. More than half reported the same level of abundance and accessibility for Food. A little less than half reported that Access to Land was something that they have personally, their families have, and at least some community members have.

Low Abundance   High Abundance

Housing	22%	14%	25%	31%	8%
Food	18%	11%	18%	38%	15%
Access to land	29%	8%	15%	30%	18%
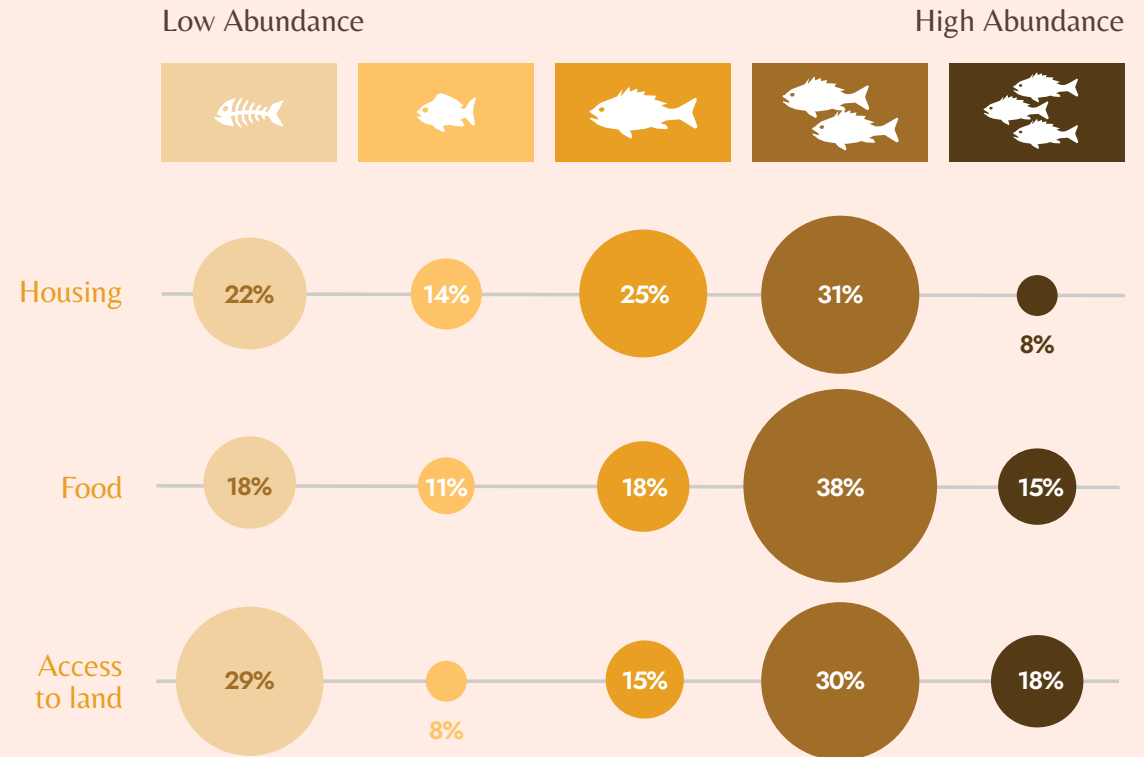
Place CONTINUED

HOW DID THE COMMUNITY RATE THE ABUNDANCE OF EACH FACTOR?

The community health factor of Getting Around received the highest ratings, with nearly 75% of community members reporting that ease of transportation is something that they have personally, their families have, and at least some of their community has. Cultural Centers, however, is something that more than half of community members said is not accessible or abundant for themselves, their families, or their community.

Low Abundance   High Abundance

Getting around
9% | 13% | 6% | 39% | 34%

Cultural centers
56% | 7% | 11% | 18% | 8%
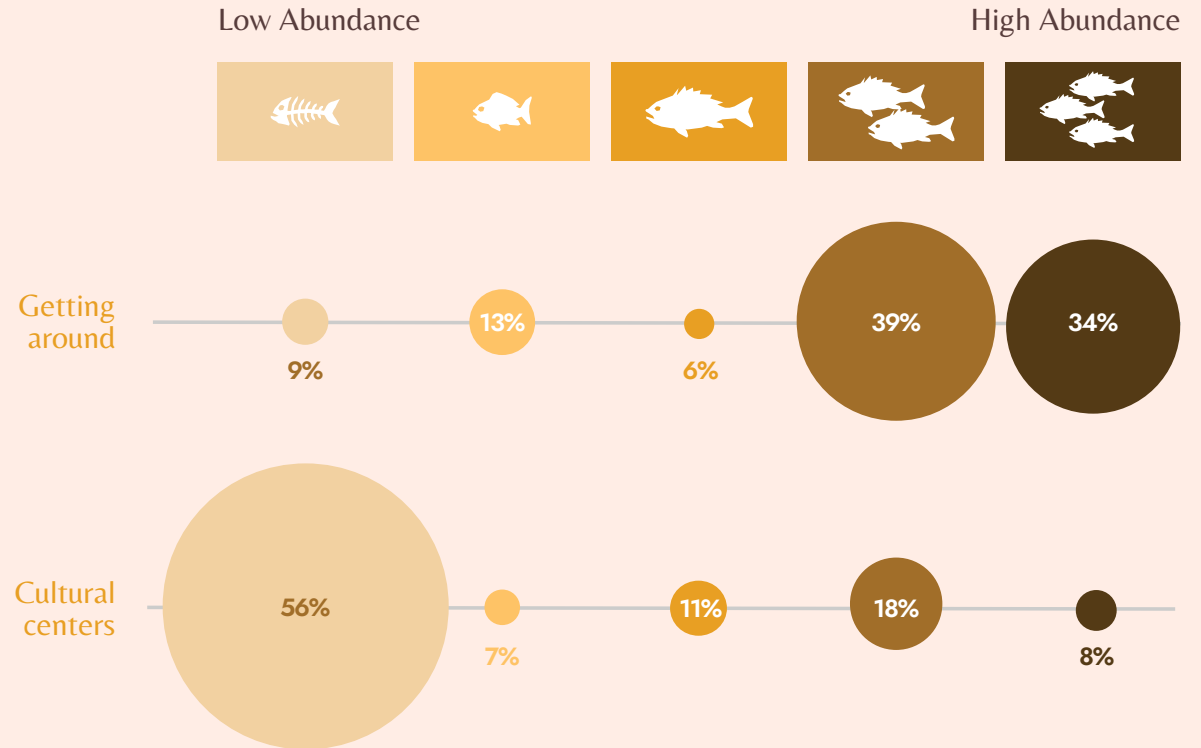
Place CONTINUED

WHY DID THE COMMUNITY RESPOND TO THE ASSESSMENT THE WAY THEY DID?

Affordable and quality housing in safe neighborhoods that can host multigenerational and multifamily households is critical and yet extremely difficult to come by.

The lack of connection to existing affordable housing resources means the community is reliant upon church or family to access housing. This can be difficult for LGBTQIA+ community members or those not connected to the church. Those who can access the housing resources still have trouble affording what is available due to poor credit histories, challenges providing proof of self-employment income, or lack of a livable income all together. Even when housing is secured, it is hard to maintain. This can be due to high utility bills in the winter, competing financial priorities given the household's limited income, or the risk of getting evicted given the number of people in the home.

Affordable rentals are important, <u>and</u> the community wants to see greater investments and resources put into home ownership.

Transitioning to an economic and social environment where home and land ownership is not a cultural norm or financially feasible is hard. An important part of cultural preservation is having land to house your family and grow traditional foods over generations. Yet, many community members feel discouraged because of the lack of affordability or difficulty restoring their credit. Even in situations where money

"Without space, we lose our culture and ability to exercise our customs."

- DATA WORKSHOP PARTICIPANT

may not be the challenge, community members recall racist mistreatment by realtors, banks, or potential neighbors when purchasing a home.

There is a deep desire to see cultural foods more widely accessible through community gardens, food pantries, and mainstream grocery stores.

Cultural foods are hard to come by and typically available through social media, either for purchase or through community food drives. Cultural foods, such as poi, octopus, or pandan, typically have to be shipped in from the islands at heavy cost to community members. This is due to the cost of the product, shipping costs, and minimum purchase requirements to ship overseas. There is also difficulty around not having enough food in the home in general. Youth in particular are placed in compromising situations because of this. Parents can hold a lot of shame around asking for support to feed their families. The youth's loyalty and respect for their parents

Place CONTINUED

prevent them from asking for help, but their role as a caretaker to younger siblings demands that they find food to feed their family. Even when youth make an effort to access food services, they are often denied because they do not have parental permission or are under the age of 18.

Having a physical community space is required to sustain culture and the Pacific Islander community has big visions for what that could look like.

The dream for many of the community members and leaders who attended the workshops is to have a Pacific Islander specific cultural center to share ideas, build connections, and host community gatherings in Oregon/SW Washington. The community wants a space where all Pacific Islanders know they can go there to access resources, to receive support, or to just connect with other community members. Community members suggested that the center could be a hub for programs related to cultural education, youth mentorship, culturally specific health services, job readiness training,

community gardens, and more. It was also important to community members to recognize that this potential cultural center would be built on Native American land. Community members felt that proper recognition of this required building stronger relationships between Native Americans and Pacific Islanders.
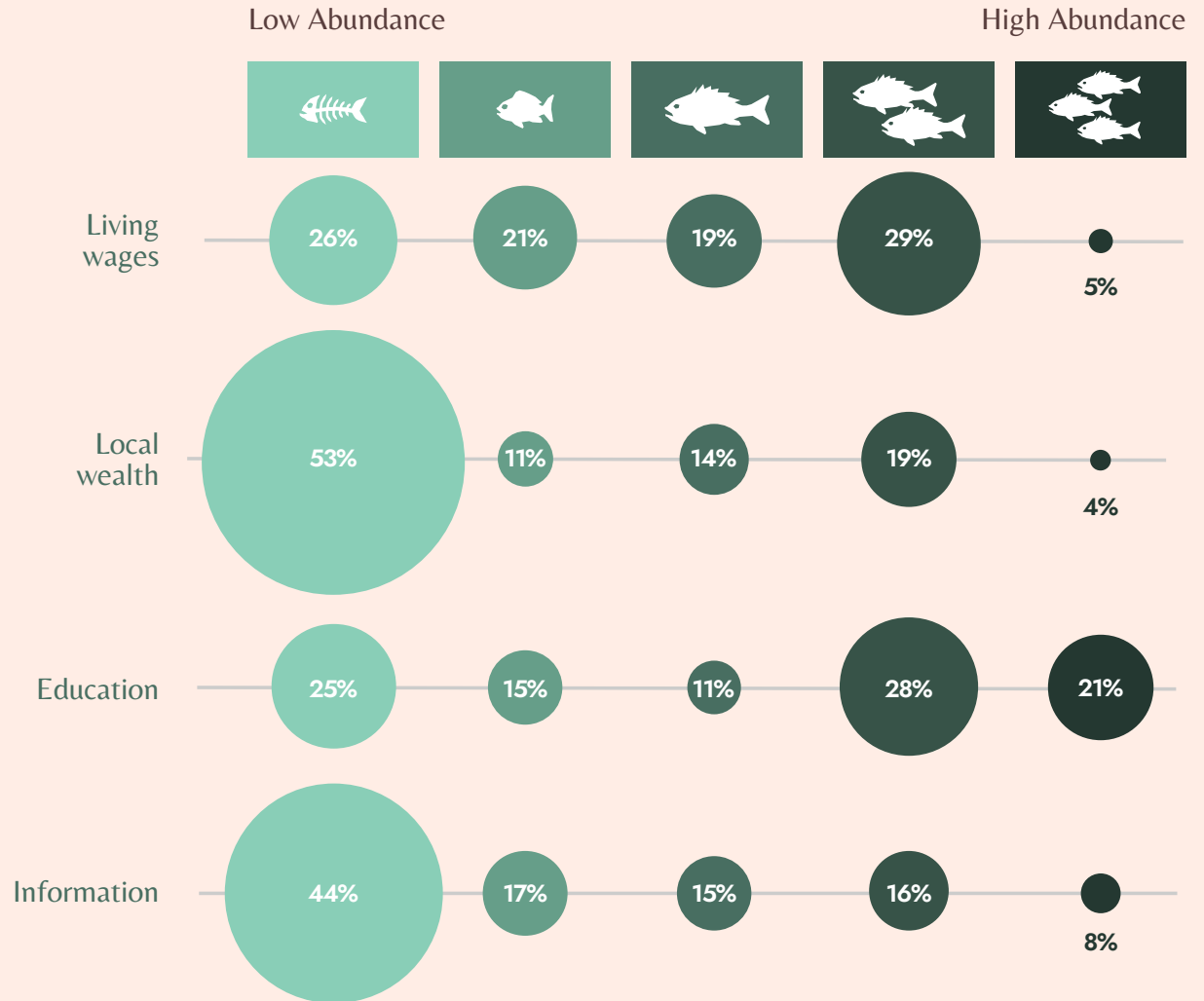
Opportunity

HOW DID THE COMMUNITY RATE THE ABUNDANCE OF EACH FACTOR?

Living Wages, Local Wealth, Education, and Information are the health factors in the Opportunity category. The chart to the right shows that the factors in the Opportunity category are not as abundant or accessible as the factors associated with People and Place. Only one third of community members reported that Living Wages were abundant and accessible to themselves personally, their families, and at least some of the broader community. Ratings for Local Wealth were somewhat worse, with just over 20% of community members reporting it is accessible and abundant for themselves, their families, and at least some of their community.

In stark contrast, more than half of respondents reported that Local Wealth was not something that they have, their families have, or their communities have. Community members rated Education as something that was slightly more accessible and abundant, with just under 50% reporting it as something they have, their families have, and at least some of the community has.

	Low Abundance				High Abundance
Living wages	26%	21%	19%	29%	5%
Local wealth	53%	11%	14%	19%	4%
Education	25%	15%	11%	28%	21%
Information	44%	17%	15%	16%	8%

Opportunity CONTINUED

Finally, only about a quarter of community members reported that Information is something they have, their families have, and at least some of the community has. Similar to Local Wealth, 44% of respondents said that Information is something that is lacking for them personally, their families, and their community.

"Western knowledge focuses primarily on individual achievement. We believe that our younger generation needs to learn about community values from our elders."

- DATA WORKSHOP PARTICIPANT

WHY DID THE COMMUNITY RESPOND TO THE ASSESSMENT THE WAY THEY DID?

There are a number of challenges when it comes to jobs, wages, and wealth. The resources available do not align with the community's desire to own their own businesses or have career opportunities. Many Pacific Islander families are living paycheck to paycheck and finding livable wages or stabilizing career opportunities are pervasive challenges. With the amount of barriers and challenges to stabilizing finances, community members noted that local wealth and future planning felt so out of reach that it was almost insulting to even include in the PI HEAL assessment. In addition to financial stressors, community members stressed how not being accustomed to the US or utilizing English as their primary language impacts access to steady employment. For example, in Tonga, high school is referred to as college, but this can be difficult to explain or understand when you do not speak English. Some community members are self-employed through construction or landscaping and often provide job opportunities to family members. However, these businesses need more support in recordkeeping so that employees can provide employment and income history when needed, and so that the business is recognized and validated by employment and business institutions. Yet there is also a fear of disclosing or filing formal paperwork because of community members' immigration statuses.

Opportunity CONTINUED

Pacific Islanders across generations are deeply invested in the future of the youth and want to ensure that their development is rooted in cultural values and educational opportunities.

This can be challenging given how individualistic Western education is, the income challenges of their families, and the cultural protocol of their elders. Youth often have to make a choice between providing for their families or investing in their individual education, with many prioritizing the former over the latter. The community wants to see more educational opportunities in youth mentorship, adult education, and English as a Second Language (ESL) for youth. At the same time, community members do not want this education to conflict with or erase cultural teachings and community values. Proper cultural education for youth is just as important to invest in for the future of the entire community.

Institutions are deeply lacking in providing culturally relevant and accessible information to Pacific Islanders.

Information and resources are typically passed on verbally through existing community connections. Many community members need and want help but are not sure where to go or who to receive guidance from. This includes medical translations, general contracting information, affordable housing access, support with taxes, etc. Community leaders expressed their own lack of understanding on what the government is actually able to provide, and emphasized that the community will not read information that is not in their own language.
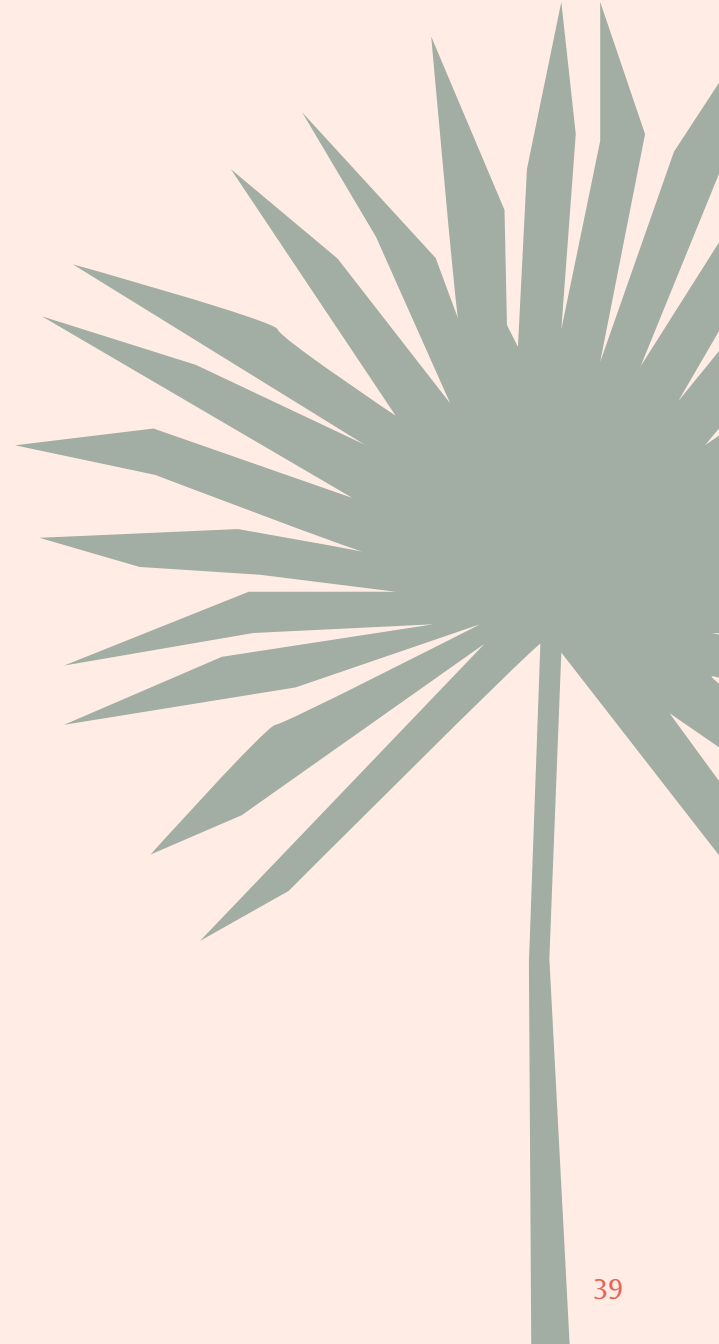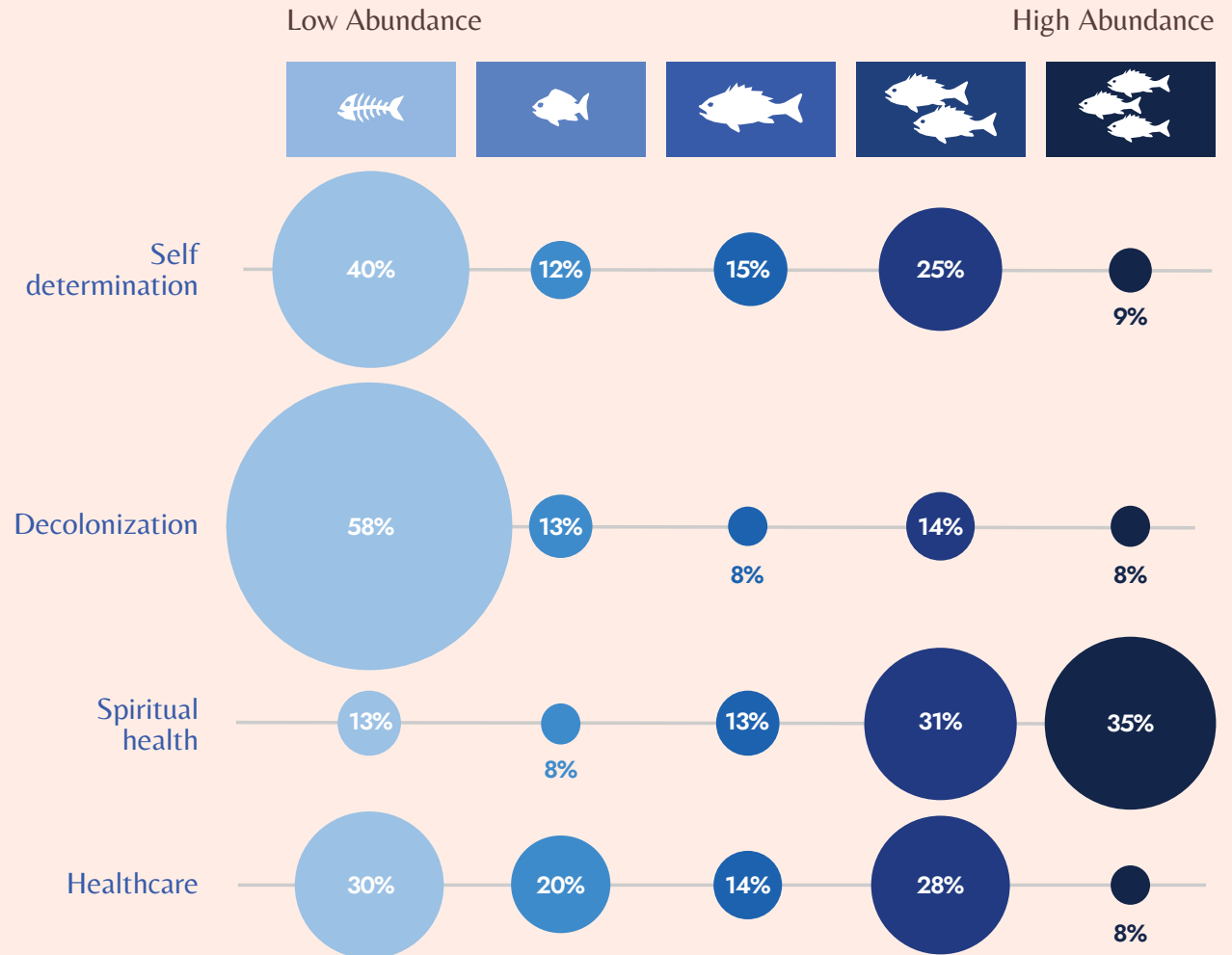
Healing

HOW DID THE COMMUNITY RATE THE ABUNDANCE OF EACH FACTOR?

The last category within the PI HEAL Assessment is Healing, which included Self Determination, Decolonization, Spiritual Health, and Healthcare. A little over a third of community members reported that Self Determination is abundant and accessible for themselves, their families, and at least some community members. Forty percent, however, said Self Determination is something that is missing for themselves, their families, and their community. Nearly 60% of respondents rated Decolonization as something that is neither accessible nor abundant for themselves, their families, and their community. Spiritual Health was the most abundant and accessible factor within the Healing category, with about two thirds of community members reporting it as something they have, their families have, and at least some of the community has. Ratings of the Healthcare factor were

Low Abundance   High Abundance

	Self determination	Decolonization	Spiritual health	Healthcare
(fish bones)	40%	58%	13%	30%
(single fish)	12%	13%	8%	20%
(fish)	15%	8%	13%	14%
(two fish)	25%	14%	31%	28%
(three fish)	9%	8%	35%	8%

Healing CONTINUED

mixed, with just over a third of community members saying it is something they have, their families have, and at least some of the community has. Another 30% said that Healthcare is lacking entirely for themselves, their family, and their community.

WHY DID THE COMMUNITY RESPOND TO THE ASSESSMENT THE WAY THEY DID?

There needs to be more space to discuss, define, and envision what decolonization and self determination means for Pacific Islanders. Community members gave important feedback on how confusing and loaded the definitions for these two terms were on the PI HEAL Assessment. For example, it was unclear if the decolonization section applied to their experiences in Oregon, or to the lands community members are indigenous to. Some community members noted that while they understood what colonization is, that it was hard to imagine what decolonization could look like. That being said, community members still made the connection between how what happens back home impacts their experiences

in Oregon, such as the desecration of Mauna Kea or the 70+ years of exile from Bikini Atoll. Community members also noted the importance of organizing for indigenous sovereignty, while recognizing that we must support the leadership of those indigenous to Oregon's occupied lands.

The conversations on the "People" category framed community connections as a core piece of spiritual health, and the factors in "Place" as a core barrier to spiritual health. Culturally specific churches are the bastions of community where culture is practiced, language is reinforced, and community and food are shared. But churches are not a safe space for all Pacific Islanders. Thus, it's important to have multiple spaces of healing so that spiritual health is accessible

> ## "We are a collectivist culture. We are affected by everything and everyone around us."
>
> ### - DATA WORKSHOP PARTICIPANT

to everyone. Physical space, and its proximity to clean water, are important to practice cultural customs like ceremonies or celebrations.

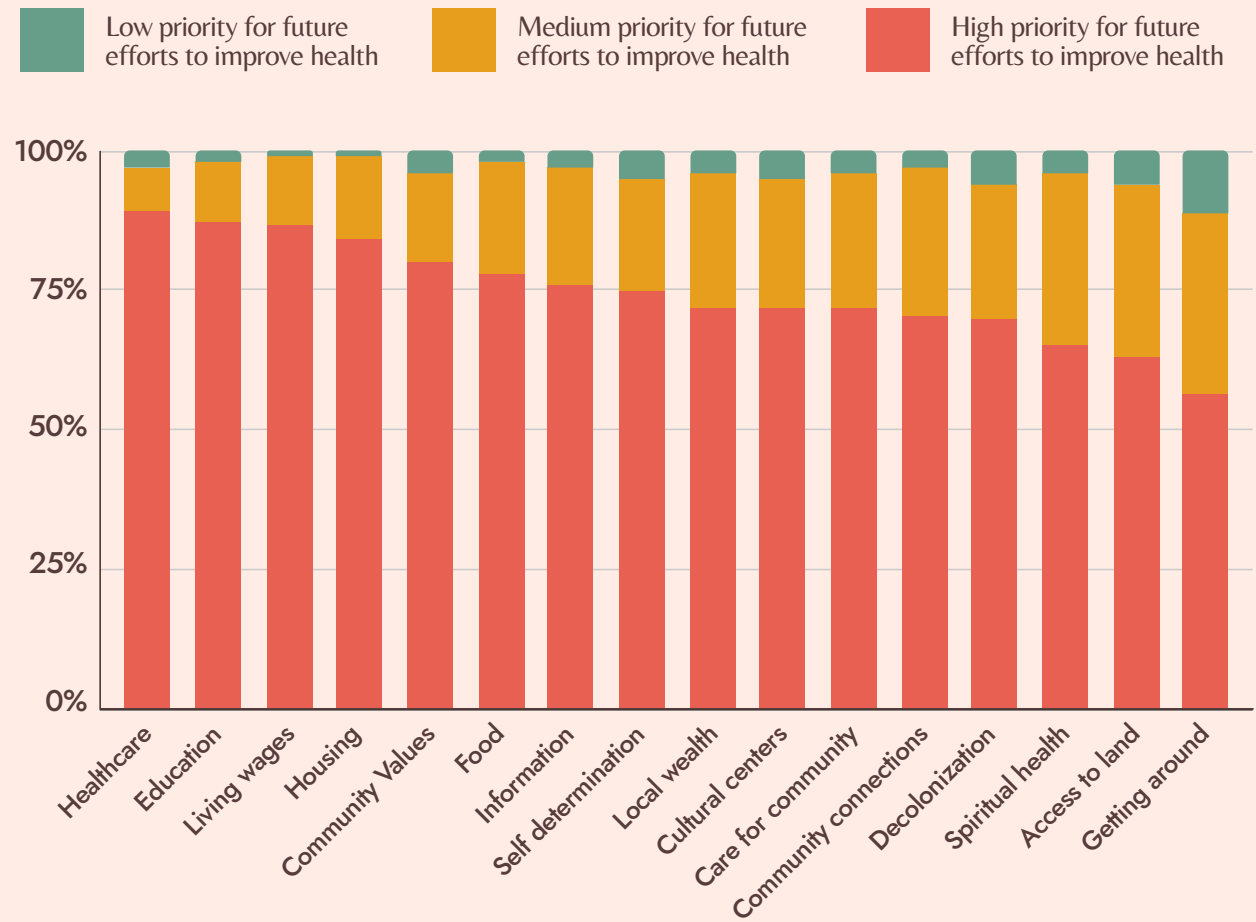***Access, comfort, and safety within the healthcare system remains a large concern for Pacific Islanders.*** Community members want to be healthy but feel preventative care opportunities and health insurance access are severely lacking. These barriers have transformed into fatalism in which community members fear going to the doctor out of belief that it will be a bad outcome that they are not able to financially, practically, or emotionally manage with their family responsibilities. There is also a need for medical interpreters who are subject matter experts, can speak the needed languages, will respect the privacy of community members, and are of the same gender. Community members fear that interpreters will spread information given the tight-knight community relationships that exist. Children are often serving as medical interpreters, but can be afraid to ask follow up questions or may not be able to accurately interpret the information between the doctor and the adult.
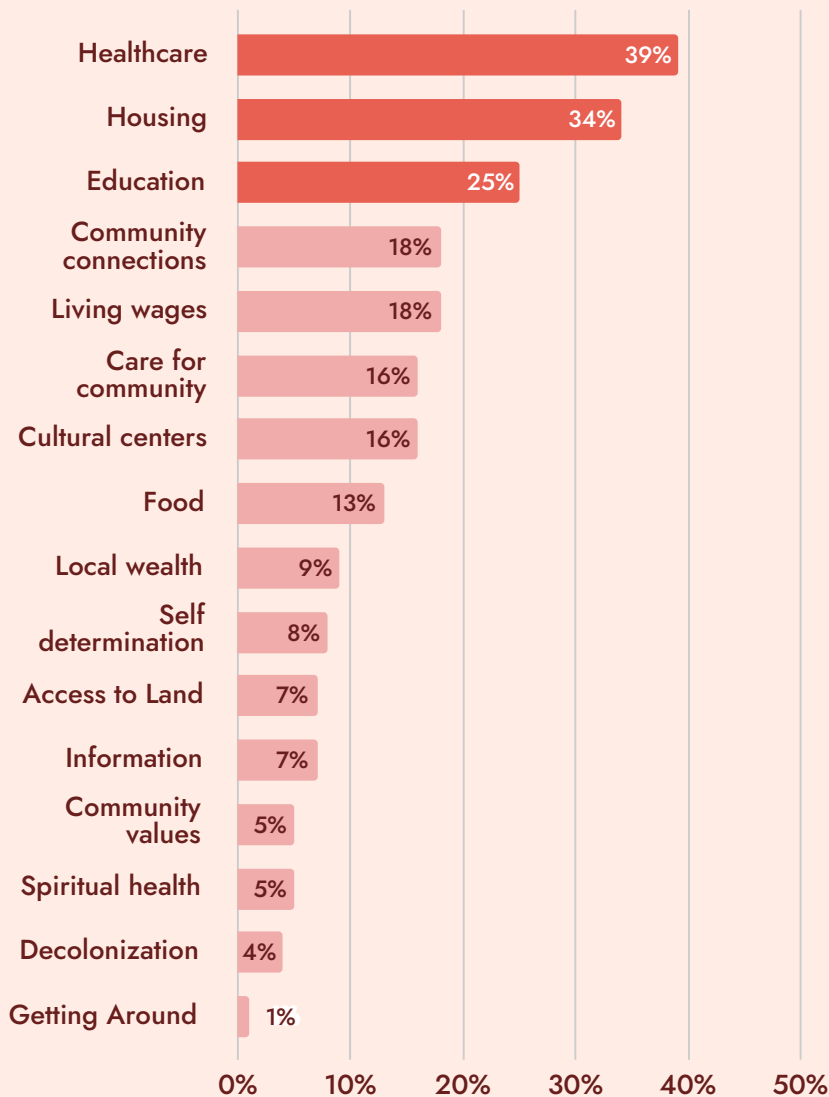
Priority Level of Community Health Factors

After assessing each community health factor, the PI HEAL Assessment asked respondents to rate their importance in terms of any future efforts to improve health in that area. Respondents were asked to rate each factor as either high, medium, or low priority for consideration in future efforts.

The chart to the right shows that ratings for every health factor overwhelmingly categorized each factor as a high priority for future health improvement efforts. These ratings are no doubt the result of historical disinvestment in Pacific Islander communities and suggest the need for universal efforts to improve all aspects of Pacific Islanders' health and well-being. Defining these efforts requires further collaboration between the Pacific Islander community and the agencies that drive these structural inequities.

Legend:
- Low priority for future efforts to improve health
- Medium priority for future efforts to improve health
- High priority for future efforts to improve health

Categories: Healthcare, Education, Living wages, Housing, Community Values, Food, Information, Self determination, Local wealth, Cultural centers, Care for community, Community connections, Decolonization, Spiritual health, Access to land, Getting around

Top Three Community Health Factors

Factor	Percentage
Healthcare	39%
Housing	34%
Education	25%
Community connections	18%
Living wages	18%
Care for community	16%
Cultural centers	16%
Food	13%
Local wealth	9%
Self determination	8%
Access to Land	7%
Information	7%
Community values	5%
Spiritual health	5%
Decolonization	4%
Getting Around	1%

As a final step, PI HEAL Assessment respondents were asked to select the top three community health factors they felt Pacific Islanders should focus on improving first. The chart to the left shows the percentage of community members who chose each health factor for one of their top three priorities, listed from factors that received the most votes to those that received the fewest votes. Healthcare, Housing, and Education received the most votes for top three priority, followed by Community Connections, Living Wages, Care for Community, and Cultural Centers.

Community Connections and Care for Community were selected as top priorities, despite both factors being rated as highly accessible and abundant by more than half of community members who responded to the PI HEAL Assessment. This confirms the importance of centering the community in Pacific Islanders' health and overall wellbeing.

Reflections

Reflections

This section serves as a series of high-level reflections based on the core research team's experience with project implementation and the feedback they received during the data workshops.

Capacity building

The community, and State and local public health departments, must continue to invest robust resources for equitable implementation and engagement in this research. Addressing historical inequities requires that every facet of this project - from project management, to compensation disbursement, to supporting the development of community members involved - have the people and funding to power it. In this scenario, our researchers and cultural advisors did not have the capacity to adequately or equitably implement all facets of this project. For example: the project manager also served as a researcher, cultural advisor, supervisor for community researcher workers, and supported individual community members with technology access. While each role was important to the implementation of the project, they cannot all realistically be addressed by one person.

Language expertise

The vast linguistic needs Pacific Islanders require greater staffing and a larger portion of the budget. Conducting this research in non-English languages requires that we resource the work in the way English-versions are resourced. We must move away from believing that a simple translation of the research from English to a Pacific Islander language and vice versa will be adequate. Non-English versions of this research require the leadership of subject matter experts in that language from the very beginning, as well as robust community validation sessions to finalize materials. The absence of this puts the integrity of the research and data at risk.

Photo credit: Micronesian Islander Community (MIC)

Photo credit: Ka ʻAha Lāhui O ʻOlekona Hawaiian Civic Club of Oregon and SW Washington (KALO HCC)

Making the assessment digestible

While the PI HEAL Assessment was well received and appreciated by the community, it is necessary to continue to simplify the language to increase accessibility and strengthen the data. Community members requested that assessment definitions be broken up and written into plain language. Community members also suggested developing rating scale visuals specific to each Pacific Islander culture (not all liked the fish!) and including additional rating scale options. For example: some health factors were accessible to the broader Pacific Islander community, but not the individual answering and there were no rating scale options to express that.

Deepening engagement

Pacific Islanders are ready to engage in research and do a deeper dive on this work. It's important to have a youth and elder specific components to the work given their lack of participation in this iteration, and the community's values on multigenerational wisdom. It's also important to emphasize that the Pacific Islander community is not a monolith and that there needs to be deeper engagement of each Pacific Islander community, deeper investigation of how these community health factors are impacting individuals and households, and more intersectional analyses that consider geography, race, ethnicity, gender, sexuality, language, age, ability, and more.
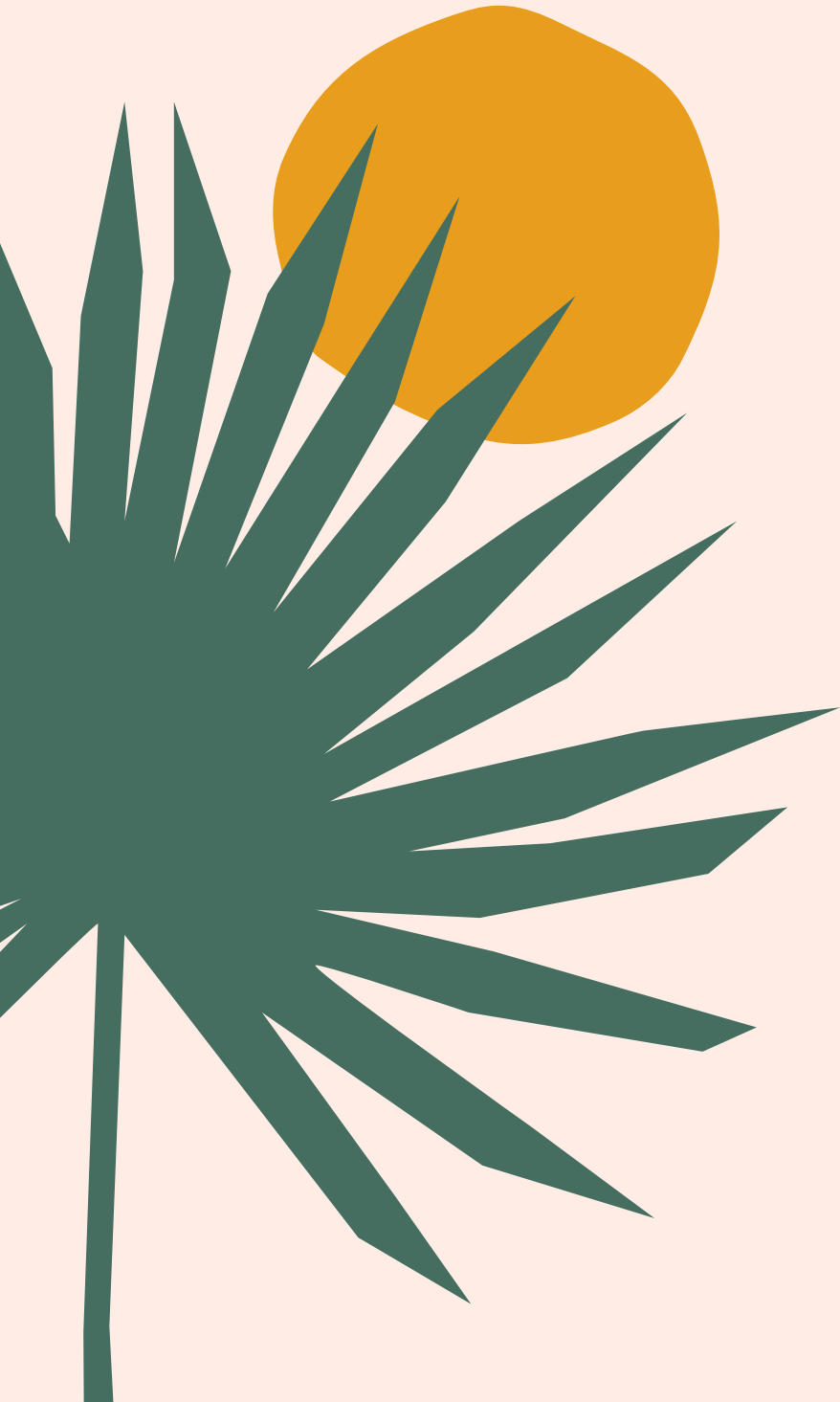
Conclusion

Conclusion

Pacific Islander Data Modernization represents what is possible when research centers and honors community wisdom, and the relationship building required to engage Pacific Islanders. While community representation is the bare minimum in decolonizing research, it also represents the impact of Pacific Islander leadership. Dominant culture methods, such as the Oregon Health Authority Public Health Division's data collection on BRFSS, rendered only 106 responses over three years. Through the leadership of the Pacific Islander community, PIDM engaged: 136 Pacific Islander survey respondents, two Pacific Islander researchers, five Pacific Islander-led organizations that represent countless Pacific Islander community members, and ten Pacific Islander community research workers in a span of six weeks. More importantly, it built a platform for Pacific Islanders to share what our vision of health and healing looks like for our community.

The work cannot stop here. Improving the quality of life for Pacific Islanders in Oregon requires a continuation of robust investments in Pacific Islander Data Modernization. The Core Research Team recommends the following next steps:

1 Map the PI HEAL Assessment community health factors to the State Health Improvement Plan to leverage existing resources and begin immediately addressing the health needs raised in this work.

2 Have the Oregon Health Authority's Public Health Division and Pacific Islander leaders enter into a project evaluation period to assess the effectiveness of the community-led research model, including Data Sovereignty Agreement, and design the next phase of this critical body of work.

3 And lastly, continue to celebrate, uplift and invest in the vast brilliance of the people of Oceania.

Appendix

PI Heal Assessment

Pacific Islander Health, Equity, and Liberation (HEAL) Assessment

Overview

Pacific Islander Data Modernization (PIDM) is a collaborative project between Pacific Islander leaders and the Oregon Public Health Division. PIDM is piloting the Healthy, Equity, and Liberation (HEAL) Assessment in an effort to identify what practices, opportunities, and challenges exist for Pacific Islanders when it comes to health and healing.

Instructions

We know that a core value of Pacific Islanders is caring for the larger community, rather than one individual alone. Rate each of the community health factors by selecting the fish that best represents how accessible and abundant this factor is to Pacific Islanders in Oregon. For example:

➢ Bonefish: Myself, my family, and my community do not have this
➢ One little fish: This is something I have personally, but is not something that my family or community have
➢ One large fish: This is something I have and my family have, but not my community
➢ Two fish: This is something I have, my family have, and some of my community have
➢ Three fish: This is something I have, my family have, and my community have

You can skip any question at any time. If you choose to skip a question, you will have a chance to tell us why you did not respond. Your comments will help us improve this assessment.
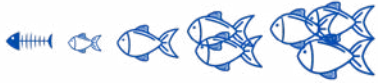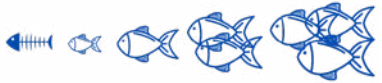
PI Heal Assessment CONTINUED

How abundant is this community health factor for Pacific Islanders in your area?	
Pacific Islander Community Health Factors	**Rating**
People	
1. **Community Connections**: Trusting relationships among community members built upon shared values, similar histories, and mutual support.	
2. **Care for Community**: Meaningful engagement with social organizations, local politics, churches, etc. to provide resources and advocate for your community.	
3. **Community Values**: There is respect for the land and its Indigenous people, a love for family, and shared responsibility to take care of the community. Elders are also respected, youth have the opportunity to grow as leaders, and LGBTQIA+ people are included.	
Comments about "People" category:	

PI Heal Assessment CONTINUED

Place	
4. **Housing**: Safe, affordable, and quality housing that can accommodate families of all forms and sizes (e.g., chosen family, multi-family and/or multi-generational).	
5. **Food**: Sustainable, nourishing, and affordable food is available. Including traditional Pacific Islander ingredients like taro or fresh fish.	
6. **Access to land**: There is access to clean water and land for fishing, growing food, recreation, celebration, or practicing ceremony.	
7. **Getting around**[1]: Sidewalks, public transit, and physical spaces that enable people to access key resources and fully participate in their communities.	
8. **Cultural Centers**: A physical space specifically for Pacific Islanders to gather the larger community to practice culture, have celebrations, provide culturally relevant resources, engage youth, etc.	
Comments about "Place" category:	

PI Heal Assessment CONTINUED

Opportunity	
9. **Living Wages**: Paychecks are enough to pay bills, buy food, save money, and do fun activities with loved ones.	
10. **Local Wealth**: People in the community own their homes; own businesses; and have opportunities to invest in the local economy.	
11. **Education**: There are opportunities for learning in a variety of settings (e.g., homes, schools, communities) that supports the development and growth of students, teachers, and the broader community.	
12. **Information**: Reliable information written and spoken in all Pacific Islander languages so people can access resources and opportunities. The information is accessible to non-English speakers, people who are hearing or visually impaired, and people of all education levels.	

PI Heal Assessment CONTINUED

Healing	
13. **Self Determination:** Pacific Islander expertise is prioritized in all decisions affecting Pacific Islanders. This expertise is valued no matter what your language, income, immigration status, level of education, ability, etc. so that all individuals hold power over what happens in their lives.	
14. **Decolonization**: An end to loss of land, forced migration, militarization of the Pacific, harmful tourism, cultural appropriation and other forms of oppression so that Indigenous peoples and their land can thrive.	
15. **Spiritual Health[2]**: Access to religion, spiritual practices, ceremony, or any resources that provide purposeful guidance in understanding the balance between the different aspects of life.	
16. **Healthcare**: Medical, dental, and vision insurance that covers holistic care for physical and mental health. It is delivered by people who are familiar with and respectful of Pacific Islander culture. The services are easy to get to, easy and quick to schedule, accepting of different insurance plans, and are affordable.	
Comments about "healing" category:	
Anything that you would like to add?	

Glossary of Acronyms & Key Terms

ACEs: Adverse Childhood Experiences. Adverse childhood experiences or ACEs refer to traumatic experiences during childhood that previous research suggests lead to prolonged toxic stress and subsequent poor health outcomes in later life.

BRFSS: The Behavioral Risk Factor Surveillance System. The BRFSS is the largest, continuously conducted telephone health survey in the world and is a collaborative project between the Centers for Disease Control and Prevention (CDC) and US states and territories. The BRFSS survey aims to collect state-specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population.

CDC: The Centers for Disease Control and Prevention.

COFA: Compact of Federal Association. The Compact of Free Association is an agreement between the US and several Pacific Island nations. The COFA agreement was established in response to a lawsuit for damages associated with nuclear weapons testing conducted in island waters by the US after World War II. The lawsuit resulted in a treaty, now known as the COFA agreement, between the US and the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. The agreement affords COFA citizens the right to travel, work, and live in the US without a visa in exchange for the US maintaining a military presence on these islands. COFA citizens are obligated to pay US federal, state, and local taxes, but are not eligible to vote or access certain benefits. Access to federal Medicaid was recently restored for COFA citizens after a 1996 welfare reform bill excluded them from the program for more than two decades.

CBOs: Community-based organizations.

CRWs: Community Research Workers.

DSA: Data Sovereignty Agreement.

ESL: English as a Second Language. Also sometimes referred to as English Language Learners (ELL).

LGBTQIA+: Lesbian, Gay, Bisexual, Trans, Queer/Questioning, Intersex, Asexuality. The "+" symbol recognizes all of the other sexual identities, genders, and sexes that are not included in these letters.

OHA: Oregon Health Authority.

OPHD: Oregon Public Health Division.

Glossary of Acronyms & Key Terms

PDES: Program Design and Evaluation Services, an applied research and evaluation unit that is shared between Multnomah County Health Department and the Oregon Health Authority's Public Health Division.

PI: Pacific Islander.

PIDM: Pacific Islander Data Modernization.

PIDP: Pacific Islander Data Project.

PI HEAL: Pacific Islander Health, Equity, and Liberation assessment.

MCHD: Multnomah County Health Department in Multnomah County, Oregon.

REALD: Race, ethnicity, language, and disability.

SOGI: Sexual orientation and gender identity.

THRIVE: Tool for Health and Resilience in Vulnerable Environments, a community health assessment from the Prevention Institute and part of the inspiration for the PI HEAL assessment.

US: United States.

THIS IS
THE WAY WE
RISE