

Overweight and Obesity Differences Across Ethnically Diverse Subgroups of Asian American Men

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Abstract

Asian Americans develop health complications at lower BMIs than other racial/ethnic groups. Given increasing overweight and obesity rates nationwide, growing numbers of Asian American men, and limited research on overweight and obesity in this population, understanding overweight and obesity differences across Asian subgroups of men is crucial to advancing health equity. This study examined overweight and obesity prevalence both among ethnic subgroups of Asian American men and compared to non-Hispanic White (NHW) men. Prevalence ratios were derived from 2002 to 2015 National Health Interview Survey data to determine associations between race/ethnicity and (a) overweight, and (b) obesity, across ($n = 221,376$) racial/ethnic groups of men (Chinese; Filipino; Asian Indian; Other Asian; NHW). Overweight and obesity for all Asian subgroups were defined using Asian-specific BMI cut points. Adjusted overweight prevalence was higher across all Asian subgroups compared to NHW men, except Filipinos. No significant pairwise relationships were observed for overweight prevalence among Asian subgroups. Filipinos had higher adjusted obesity prevalence compared to NHW men. Comparing among Asian American men, Asian Indians and Other Asians had higher adjusted obesity prevalence relative to Chinese. Filipinos had higher adjusted obesity prevalence compared to all other Asian subgroups (Chinese; Asian Indian; Other Asian). The current findings highlight the need for use of (a) WHO-recommended Asian-specific BMI cut points and (b) data disaggregated by Asian American subgroup, to provide more accurate depictions of overweight and obesity rates and associated health risks. Accounting for subgroup differences is necessary to ensure Asian American men receive equitable, appropriate care.

Keywords

Asian American men, overweight, obesity, men's health

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Overweight and obesity, assessed via body mass index (BMI), a measure of body fat based on height and weight, is associated with increased risk of serious chronic health conditions such as type 2 diabetes, stroke, heart disease, and certain cancers (Centers for Disease Control and Prevention, 2017a; National Heart, Lung, and Blood Institute, 2017). In the United States, overweight and obesity is a growing public health concern, with over 70% of American adults classified as overweight or obese (Fryar, Carroll, & Ogden, 2016) and all 50 states currently reporting an adult overweight prevalence of 30% or higher as well as obesity prevalence of 20% or higher (Centers for Disease Control and Prevention, 2017b). Comparisons of adult obesity prevalence across

racial and ethnic groups indicate lowest prevalence among Asian Americans (Bates, Acevedo-Garcia,

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Alegría, & Krieger, 2008; Lauderdale & Rathouz, 2002; Ogden, Carroll, Fryar, & Flegal, 2015). This has contributed to limited research being conducted on overweight and obesity in Asian Americans as compared to groups with higher obesity prevalence, such as Hispanics and non-Hispanic Blacks. Beyond the health risks associated with obesity, being overweight has been linked to race-based perception of American identity, with overweight Asian Americans being perceived as more “American” than their normal weight Asian American peers (Fiske & Neuberger, 1990; Handron, Kirby, Wang, Matskewich, & Cheryan, 2017). Notably, this observation was limited only to Asian Americans, and was not observed among non-Hispanic Whites, Hispanics, and non-Hispanic Blacks (Handron et al., 2017).

Compared to non-Hispanic Whites, Asian Americans tend to have higher percentages of body fat at lower BMIs (Alpert & Thomason, 2016; Deurenberg, Deurenberg-Yap, & Guricci, 2002). Since 2002, World Health Organization (WHO)-recommended Asian-specific BMI cut points have been used to account for these differences and provide a more appropriate estimate of obesity-related chronic conditions (Moyer, 2012; Palaniappan, Wong, Shin, Fortmann, & Lauderdale, 2011; WHO Expert Consultation, 2004; Yi, Kwon, Wyatt, Islam, & Trinh-Shevrin, 2015). BMI cut points for overweight and obesity in Asians were lowered to 23–27.4 kg/m² and ≥ 27.5 kg/m², respectively, compared to standard BMI cut points for overweight (25–29.9 kg/m²) and obese (≥ 30 kg/m²) (Jih et al., 2014; WHO Expert Consultation, 2004). These recommendations have not been formally integrated into clinical guidelines and are not always used.

Prevalence statistics on overweight and obesity among Asian American men generally are not derived from the WHO-recommended Asian-specific BMI cutoffs, and likewise are not disaggregated to reflect Asian subgroup differences, even though evidence indicates higher overweight and obesity prevalence among certain subgroups of Asian Americans (Yi, Kwon, Sacks, & Trinh-Shevrin, 2016). When using standard BMI cut points, Asian American men are more likely to be overweight or obese (BMI ≥ 25 kg/m²) compared to Asian American women (Aoki, Yoon, Chong, & Carroll, 2014; Maxwell, Crespi, Alano, Sudan, & Bastani, 2012). Asian American men have a higher risk for diabetes than Asian American women, and Asian Americans develop type 2 diabetes at lower BMIs than all other racial and ethnic groups (Hsu, Araneta, Kanaya, Chiang, & Fujimoto, 2015; Nguyen, Nguyen, Fischer, Ha, & Tran, 2015; Palaniappan et al., 2011). Given increased risk for weight-related health complications among Asian Americans (Alpert & Thomason, 2016; Karter et al., 2013; Palaniappan et al., 2011), it is especially important to understand how

overweight and obesity differ for Asian American men across different Asian American ethnic subgroups.

Of the existing studies examining subgroup differences in overweight and obesity among Asian American men, few have utilized the WHO-recommended Asian cut points to draw their conclusions. Multiple studies have noted higher median BMI and proportions of overweight and obesity among Filipino men, regardless of the cut points used (Huang, Appel, Nicdao, Lee, & Ai, 2013; Klatsky & Armstrong, 1991; Lauderdale & Rathouz, 2002; Maxwell et al., 2012; Oza-Frank, Ali, Vaccarino, & Narayan, 2009; Palaniappan et al., 2011). Maxwell et al. (2012) observed a considerable increase in the proportion of Asian American men categorized as overweight or obese when using Asian-specific cut points compared to the standard, to the extent that these percentages were comparable to non-Hispanic Whites. However, the data for this study were not limited to men, and only surveyed Asian Americans in California.

Among studies that utilized national data, findings are mixed. Though there is a consensus regarding high obesity proportions among Filipino men, some researchers have also noted higher BMI and overweight and obesity prevalence among Asian Indians (Barnes, Adams, & Powell-Griner, 2008; Oza-Frank et al., 2009) while others noted higher BMI among Japanese men (Huang et al., 2013; Lauderdale & Rathouz, 2002). Only one study has examined overweight and obesity subgroup differences among Asian American men alone on a national level (Huang et al., 2013). Filipino American men had the highest obesity rates, followed by “Others,” defined here to include East Indians, Japanese, Korean, and other Asian ethnic groups.

Asians are projected to become the largest immigrant group in the United States within the next 50 years, and Asian Americans are currently the fastest growing racial and ethnic minority group in the nation (Lopez, Ruiz, & Patten, 2017). Given the growing numbers of Asian American men and the increasing obesity rates in the United States, improving our understanding of overweight and obesity trends across Asian subgroups of men is crucial to developing accurate and culturally appropriate health interventions. This study’s objective was to examine differences in overweight and obesity prevalence among Chinese, Filipino, Asian Indian, and Other Asian men compared to non-Hispanic White men as well as among the Asian subgroups, using WHO-recommended BMI cut points for Asians.

Methods

Study Sample

Data for this study came from the National Health Interview Survey (NHIS), an annual, cross-sectional

household interview survey that monitors the health of noninstitutionalized civilians in the United States. Initiated in 1957, NHIS is conducted by the National Center for Health Statistics within the Centers for Disease Control and Prevention. NHIS utilizes a complex, multistage cluster sample design that incorporates state-level stratification and oversamples the following populations: adults 65 or older who are Black, Hispanic, or Asian (Parsons et al., 2014; Pleis & Lucas, 2009; Pleis, Schiller, & Benson, 2003).

For the purposes of this study, NHIS data from 2002 to 2015 were combined to ensure adequate sample size among ethnic subgroups of Asian American men. There was a total of 820,479 adult respondents ages 18 to 60 across all years examined. Respondents above the age of 60 were not included because the effects of increasing age on health, particularly among older adults, can impact BMI (Lauderdale & Rathouz, 2002). The following exclusions were made to focus on overweight and obesity prevalence among Asian men: women ($n = 427,613$), non-Hispanic Black men ($n = 45,257$), Hispanic men ($n = 85,098$), and men who reported an unknown ethnicity ($n = 33,815$). Exclusions were also made for any respondents who selected Asian as their race but did not select an Asian subgroup as their ethnicity ($n = 72$). The sample size for analysis thus consisted of 221,376 non-Hispanic White ($n = 199,767$, 90.2%) and Asian ($n = 21,609$, 9.8%) men. Asian ethnic subgroups in this study included Chinese ($n = 4,473$, 2.0%), Filipino ($n = 4,293$, 1.9%), Asian Indian ($n = 4,819$, 2.2%) and Other Asian ($n = 8,024$, 3.6%).

Measures

Outcome variable. Overweight and obesity were based on BMI, which was calculated as self-reported weight (kg) divided by self-reported height (m^2). Overweight and obesity among non-Hispanic Whites were defined according to standard cut points for BMI, with overweight defined as BMI of 25–29.9 kg/m^2 and obesity defined as BMI greater than or equal to 30 kg/m^2 (WHO, 1995). Because existing research indicates that standard BMI cut points do not appropriately estimate obesity among Asians (Jih et al., 2014; WHO Expert Consultation, 2004), WHO-recommended Asian-specific BMI cut points were used to define overweight and obesity for all Asian subgroups. Overweight was defined as BMI greater than or equal to 23 kg/m^2 and less than 27.5 kg/m^2 , and obesity was defined as BMI greater than or equal to 27.5 kg/m^2 .

Independent variable. Self-reported Asian race/ethnicity was defined as men who both selected their race as Asian only, and also identified their ethnicity as Chinese,

Filipino, Asian Indian, or Other Asian. The Other Asian category includes all respondents identifying as Korean, Japanese, Vietnamese, and Other Asian. Self-reported non-Hispanic Whites were defined as men who identified their race as White and ethnicity as Not Hispanic/Spanish origin. Non-Hispanic Whites were included in this study given their widespread use as a primary comparison group when examining Asian American health, and to provide comparable data for overweight and obesity prevalence when utilizing standard versus Asian-specific BMI cut points.

The covariates used in this study were based on prior work (Hill et al., 2015). Covariates included: age, marital status, education, income, insurance status, physical activity, and nativity. Age was measured in continuous years. Marital status was classified in three categories: currently married, never married, or formerly married (widowed, separated, or divorced). Education status was classified as: less than high school graduate/GED recipient, high school graduate/GED recipient, or beyond high school graduate/GED. Annual household income was categorized into: \$0–\$34,999, \$35,000–\$74,999, \$75,000+, and missing, with the missing category reflecting respondents who did not provide income information. Participation in physical activity was categorized as “yes” or “no.” Respondents who reported vigorous–moderate physical activity were considered to be physically active. Nativity was defined as whether or not the respondent was born in the United States. Individuals born in a U.S. territory were classified as foreign born. Inclusion of nativity was necessary to account for lifestyle differences between individuals born in the United States versus other countries.

Statistical Analysis

Percentages, means and standard errors were calculated to describe the sample. t -tests and Pearson χ^2 tests were performed to compare mean and proportional differences, respectively, between demographic and health-related characteristics and race/ethnicity of men. The prevalence of overweight and obesity was greater than 10%; therefore, a modified Poisson regression with robust standard errors was used to derive the prevalence ratios and corresponding 95% confidence intervals (CIs) (McNutt, Wu, Xue, & Hafner, 2003; Zou, 2004). Two models were specified. Model 1 examined the association between overweight and race/ethnicity. Model 2 examined the relationship between obesity and race/ethnicity. All the models controlled for nativity, age, marital status, income, insurance status, and physical activity. A Bonferroni correction was made to examine pairwise comparisons of race/ethnicity as it relates to overweight or obesity. The appropriate weights and design factors were invoked in

Table 1. Distribution of Demographic and Health-Related Characteristics of Asian American and Non-Hispanic White Men Ages 18 to 60 (*n* = 221,376) From the 2002 to 2015 National Health Interview Surveys.

Characteristic	Total Asian (<i>n</i> = 21,609)	Asian Indian (<i>n</i> = 4,819)	Chinese (<i>n</i> = 4,473)	Filipino (<i>n</i> = 4,293)	Other Asian (<i>n</i> = 8,024)	Non-Hispanic White (<i>n</i> = 199,767)	<i>p</i> -value
Age, years (mean ± SE) (range 18–60)	37.8 ± 0.2	36.8 ± 0.4	38.1 ± 0.4	39.2 ± 0.5	37.5 ± 0.4	39.6 ± 0.1	<.001
Marital status, %							
Never	30.9	25.8	32.6	30.0	33.9	25.9	<.001
Currently	65.2	71.6	63.7	64.4	62.2	63.9	<.001
Formerly	3.9	2.6	3.7	5.6	4.0	10.2	<.001
Education, %							
Less than high school	7.2	5.0	7.2	4.4	10.0	9.3	<.001
High school graduate/ GED	15.2	8.2	12.7	19.0	19.0	28.8	<.001
More than high school	77.7	86.8	80.1	76.7	71.0	62.0	<.001
Income, %							
\$0–\$34,999	22.5	19.5	27.5	14.7	25.9	21.6	<.001
\$35,000–\$74,999	26.1	24.6	21.2	27.3	28.9	30.3	<.001
\$75,000+	35.9	41.5	34.6	42.4	29.5	35.6	<.001
Missing	15.6	14.4	16.8	15.6	15.7	12.6	<.001
Insured, %	80.7	83.8	83.9	86.2	74.1	83.0	<.001
Physical activity, %	69.4	70.0	69.6	72.5	67.2	72.9	<.001
Foreign born, %	78.7	93.0	76.8	66.5	76.7	4.7	<.001
BMI (standard cut points and WHO- recommended Asian- specific cut points)	49.1	52.1	48.6	48.3	47.8	41.2	<.001
Overweight, %							
Obese, %	21.8	19.8	15.0	34.7	19.8	28.1	<.001

Note. Other Asian category includes Korean, Japanese, Vietnamese, and Other Asian subgroups. Physical activity is defined as % physically inactive with no report of vigorous–moderate physical activity. BMI calculations: Standard cut points: overweight (BMI = 25–29.9), obese (BMI ≥ 30). WHO–recommended Asian-specific cut points: overweight (BMI = 23–27.4), obese (BMI ≥ 27.5). SE = standard error.

all of the analyses to account for the multistage probability sampling design of NHIS (Parsons et al., 2014). *p* values less than .05 were considered significant. All of the analyses were performed using STATA v. 14 (StataCorp LP, College Station, TX).

Results

The distribution of select demographic and health-related characteristics of Asian American and non-Hispanic White men ages 18–60 is displayed in Table 1. All of the Asian American subgroups of men were younger than non-Hispanic Whites, with Asian Indians being the youngest group (36.8 ± 0.4 years). Only Asian Indians had a higher proportion of men who reported being currently married (71.6% vs. 63.9%; *n* = 3,450/4,819 vs. 127,651/199,767, *p* < .001) relative to non-Hispanic Whites. Relative to non-Hispanic Whites, all Asian American subgroups of men had a lower prevalence of earning no higher than a high school diploma or GED, with Asian Indians having the lowest prevalence (8.2%

vs. 28.8%; *n* = 395/4,819 vs. 57,533/199,767; *p* < .001). Filipino men exhibited the highest prevalence of income (42.4%; *n* = 1,820) of all the groups; whereas Other Asians had the lowest prevalence (29.5%; *n* = 2,367) compared to non-Hispanic Whites. Other Asians had the lowest prevalence of reporting having insurance (74.1% vs. 83.0%; *n* = 5,946/8,024 vs. 165,807/199,767; *p* < .001) compared to non-Hispanic Whites. Among the subgroups of Asian men, Other Asians had the highest prevalence of conducting physical activity (67.2% vs. 72.9%; *n* = 5,932/8,024 vs. 145,630/199,767; *p* < .001) compared to non-Hispanic Whites. Asian Indians had the highest prevalence of reporting being foreign born (93.0% vs. 4.7%; *n* = 4,482/4,819 vs. 9,389/199,767; *p* < .001) compared to non-Hispanic Whites. With regard to overweight and obesity, when compared to non-Hispanic Whites, Asian Indians also had the highest prevalence of being overweight, followed by Other Asians. Filipinos reported the highest prevalence of obesity (34.7% vs. 28.1%; *n* = 1,490/4,293 vs. 56,134/199,767; *p* < .001) compared to non-Hispanic Whites.

Table 2. Associations Between Race/Ethnicity and Overweight/Obesity Among Asian American and Non-Hispanic White Men Ages 18–60 in the 2002–2015 National Health Interview Surveys.

Ethnicity	Overweight	Obesity
	PR [95% CI]	PR [95% CI]
Chinese vs. Non-Hispanic White	1.14 [1.02, 1.28]	0.70 [0.54, 0.90]
Filipino vs. Non-Hispanic White	1.12 [0.99, 1.26]	1.60 [1.36, 1.87]
Asian Indian vs. Non-Hispanic White	1.21 [1.09, 1.34]	1.02 [0.81, 1.27]
Other Asian vs. Non-Hispanic White	1.14 [1.04, 1.26]	0.96 [0.78, 1.18]
Chinese vs. Asian Indian	0.95 [0.84, 1.08]	0.68 [0.51, 0.91]
Filipino vs. Asian Indian	0.93 [0.81, 1.06]	1.57 [1.24, 1.99]
Other Asian vs. Asian Indian	0.95 [0.84, 1.07]	0.94 [0.72, 1.22]
Filipino vs. Chinese	0.98 [0.84, 1.13]	2.29 [1.74, 3.02]
Other Asian vs. Chinese	1.00 [0.88, 1.14]	1.38 [1.02, 1.85]
Other Asian vs. Filipino	1.02 [0.89, 1.18]	0.60 [0.47, 0.76]

Note. Model adjusts for nativity as well as age, marital status, education, income, insurance status, and physical activity. Other Asian category includes Korean, Japanese, Vietnamese, and Other Asian subgroups. PR = prevalence ratio; 95% CI = 95% confidence interval.

The associations between overweight and obesity and Asian American and non-Hispanic White men are reported in Table 2. When examining associations relating to being overweight: Chinese (prevalence ratio (PR) = 1.14, 95% CI [1.02, 1.28]), Asian Indian (PR = 1.21, 95% CI [1.09, 1.34]), and Other Asian men (PR = 1.14, 95% CI [1.04, 1.26]) had a higher adjusted prevalence of being overweight relative to non-Hispanic White men. No pairwise relationships were observed among the Asian American subgroups.

When examining associations relating to obesity: Chinese men (PR = 0.70, 95% CI [0.54, 0.90]) had a lower adjusted prevalence of being obese; whereas Filipino men (PR = 1.60, 95% CI [1.36, 1.87]) had a higher adjusted prevalence of being obese compared to non-Hispanic White men. Comparing among Asian American men, Chinese men (PR = 0.68, 95% CI [0.51, 0.91]) had a lower adjusted prevalence of obesity compared to Asian Indians. Filipino men (PR = 1.57, 95% CI [1.24, 1.99]) had a higher adjusted prevalence of being obese than Asian Indians. Filipino (PR = 2.29, 95% CI [1.74, 3.02]) and Other Asian men (PR = 1.38, 95% CI [1.02, 1.85]) had a higher adjusted prevalence of obesity relative to Chinese men. Other Asian men (PR = 0.60, 95% CI [0.47, 0.76]) had a lower adjusted prevalence of being obese than Filipino men.

Discussion

This study utilized WHO-recommended BMI cut points to examine variations in prevalence of overweight and obesity at a national level within and among Asian American subgroups of men as well as in comparison to non-Hispanic White men. Overweight prevalence was higher across all Asian American subgroups compared to

non-Hispanic Whites, with the exception of Filipinos. There were no significant pairwise relationships among the Asian subgroups. However, this trend did not extend to obesity prevalence. Filipino men were the only subgroup to have a higher likelihood of obesity than non-Hispanic Whites. Variations among subgroups were also identified, with Chinese men less likely to be obese compared to all other Asian American subgroups, and Filipino men more likely to be obese than all other subgroups.

The current study aligns with substantial evidence that Filipinos are more likely to be obese in comparison to non-Hispanic Whites as well as other Asian American subgroups (Barnes et al., 2008; Huang et al., 2013; Oza-Frank et al., 2009; Staimez, Weber, Narayan, & Oza-Frank, 2013). This contrasts existing findings that Filipino men have a greater likelihood of both overweight and obesity (Huang et al., 2013), as the current findings only indicated significance for obesity. Among Asian American subgroups, Lauderdale and Rathouz (2002) utilized 1992–1995 NHIS data to determine that a higher percentage of Japanese men were overweight compared to Vietnamese men. As NHIS has since aggregated Japanese and Vietnamese into a single “Other Asians” group for data release, the authors were not able to replicate this particular finding.

Because Asian Americans develop weight-related health complications at lower BMIs than people of other ethnicities/races (Alpert & Thomason, 2016; Karter et al., 2013; Palaniappan et al., 2011), it is important for clinical practitioners to increase their understanding of subgroup differences in Asian American health in order to better serve the needs of this population. The current findings corroborate existing literature that overweight and obesity prevalence varies by Asian American subgroup. When aggregated, Asian Americans as a whole have

lower rates of overweight and obesity than other racial/ethnic groups (Ogden et al., 2015), though this prevalence is not calculated using WHO-recommended cut points for Asians. Literature reports that upon using Asian-specific cut points, the percentage of Asian American men categorized as overweight or obese becomes comparable to non-Hispanic Whites (Maxwell et al., 2012). Yet, when examining prevalence by disaggregated Asian American subgroups using WHO-recommended Asian cut points, the current findings indicated that overweight prevalence was actually higher among Chinese, Asian Indian, and Other Asian men compared to non-Hispanic Whites, while Filipino men were more likely to be obese than non-Hispanic Whites. The findings support existing evidence on the need for use of (a) WHO-recommended Asian-specific BMI cut points and (b) data disaggregated by Asian American subgroup, to provide a more accurate depiction of overweight and obesity rates and their associated health risks in this population (Islam et al., 2010; Yi et al., 2016).

The authors' finding that overweight prevalence is higher among many of the Asian American subgroups compared to non-Hispanic Whites also has social and psychological implications for health given a recent study by Handron et al. (2017) indicating that being overweight protects Asian Americans from prejudice against foreigners. Handron's study further determined that Asian American men who were overweight were perceived as less likely to be undocumented than those who were of normal weight. These perceptions were shared across Asian Americans and non-Asians, though the authors did not examine the basis for these observations within versus external to the Asian American community. While being overweight is generally linked to stigmatization (Puhl & Brownell, 2001), Handron et al.'s findings suggest that being overweight could be viewed positively, as it provides a buffer from prejudice. Stronger emphasis should be placed on the need for culturally appropriate health interventions and patient-provider communications targeting increased awareness among men across all Asian American subgroups around the chronic health risks associated with being overweight and not just obese.

There are several limitations of this study. Because data were cross-sectional, assumptions about causality cannot be made. BMI-related data were self-reported and thus at risk of misreporting, though previous studies have demonstrated relatively high agreement between measured and self-reported height and weight (Willett, 1998). Accuracy of the findings could be further improved given recent literature suggesting that usage of the WHO-recommended Asian BMI cut points, while better than standard cut points, may not be enough, as cut points differ even among specific Asian American subgroups (Maxwell et al., 2012). This study was further limited by

lack of data disaggregation in publicly available NHIS data for Asian American subgroups in the Other Asian group. Since 1996, NHIS has aggregated data collected for Koreans, Japanese, and Vietnamese into the aforementioned Other Asian group for public data release. This impacts the observations and assessments that can be made about the health of men in these groups. Additional research is also needed to examine the effect of nativity on the current findings, given multiple studies indicating that BMI proportions among Asian Americans vary depending on whether an individual is foreign-born versus born in the United States (Bates et al., 2008; Lauderdale & Rathouz, 2002; Rosas, Sanchez-Vaznaugh, & Sánchez, 2015; Sanchez-Vaznaugh, Kawachi, Subramanian, Sánchez, & Acevedo-Garcia, 2008).

Despite these limitations, this study is one of only a few that have examined differences in overweight and obesity prevalence among Asian American men both among subgroups as well as in comparison to non-Hispanic Whites, at a national level, utilizing WHO-recommended Asian BMI cut points. Oza-Frank et al. (2009) used 1997–2005 NHIS data to observe that utilization of the WHO Asian cut points compared to the standard led to higher prevalence of overweight, obesity, and diabetes in all Asian subgroups plus non-Hispanic Whites. To the authors' knowledge, there is only one prior national level study to have examined subgroup differences solely among Asian American men, utilizing data from the 2002 to 2003 National Latino and Asian American Study to compare overweight and obesity prevalence (Huang et al., 2013). The current study's utilization of BMI cut points appropriate to the racial/ethnic group being studied (e.g., standard cut points for non-Hispanic Whites and WHO-recommended Asian cut points for all Asian Americans) further provides more accurate estimates of overweight and obesity in these populations. This builds on existing literature indicating the importance of using WHO-recommended Asian BMI cut points versus the standard to ensure greater accuracy in identifying risk for weight-related chronic diseases among Asian American men (Jih et al., 2014; Karter et al., 2013; Palaniappan et al., 2011). Moreover, this study contributes additional evidence toward the need for disaggregation of data on this population, to allow for better differentiation between Asian American subgroups of men and their respective risks for chronic disease while also accounting for the continually growing and changing Asian American population in the United States.

Conclusion

Asian Americans are currently the fastest growing racial/ethnic group in the United States. Caring for them requires an understanding of their unique health needs. With

obesity on the rise across the nation, plus an increased risk at lower BMI cut points among Asian American men for chronic conditions such as cardiovascular disease and diabetes, it is important to acknowledge and understand how such risks differ across subgroups in this population. This study's findings on the heterogeneity in overweight and obesity prevalence across subgroups of Asian American men, as well as in comparison to non-Hispanic White men, highlight the need for health interventions and strategies tailored to each subgroup. Additionally, utilizing WHO-recommended BMI cut points for Asians when developing treatment plans and policies could ensure greater accuracy when assessing health risks among Asian American men.

Declaration of Conflicting Interests

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Statement on Ethics Approval and Informed Consent

All data for this study were obtained via public use data files and is thus exempt from institutional review board approval and informed consent requirements.

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