Simultaneously Blamed and Ignored: Barriers, Behaviors, and Impact of COVID-19 on Asian Americans

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Abstract

Background: The diverse Asian American population is impacted by the COVID-19 pandemic, but due to limited data and other factors, disparities for this population are hidden.

Objective: Our objective was to describe the Asian American community's experiences and impacts during this pandemic, focusing on the Greater San Francisco Bay Area, California, to better inform our health care services.

Methods: We conducted a cross-sectional survey in May-June 2020 with 1,297 Asian American participants, with questions on COVID-19-related testing and preventative behaviors, economic impacts of COVID-19, experience with anti-Asian violence, and mental health challenges.

Results: We found that only 3% (n=39) were tested, and 49% stated that they could not find a place to get tested. Three-quarters of participants reported feeling stressed, and about one-quarter reported feeling depressed. 6% of participants reported being treated unfairly because of their race/ethnicity. 36.3% of participants had lost their regular jobs and 25.4% had reduced hours or reduced income.

Conclusions: Our findings highlight the longstanding need for culturally and linguistically-appropriate mental health services and resources. These findings led to the establishment of the first Asian multi-lingual and multi-cultural COVID-19 testing site in the county.

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Conclusion: Our findings highlight the longstanding need for culturally and linguistically-appropriate mental health services and resources. These findings led to the establishment of the first Asian multi-lingual and multi-cultural COVID-19 testing site in the county.

Introduction

The Asian American population is diverse in language, culture, and immigration history, which affects their experiences with the coronavirus disease (COVID-19) pandemic. Due to language barriers and limited data collection, disparities for this population often remain hidden [1]. During this pandemic, these issues may become exacerbated, and this population may run the risk of suffering in silence. Data from different geographic areas suggest that Asian Americans have high death rates among those who test positive for COVID-19 [2].

Asian Health Services (AHS), a federally qualified health center, provides medical, dental, behavioral health, and health education/outreach services in 14 languages to approximately 50,000 patients in Alameda County, California. When the pandemic emerged in March 2020, AHS staff shared hundreds of patient stories that underscored the ongoing anti-Asian attacks and discrimination, the fear and isolation as many went underground and hid in their homes, and the growing mental health, including suicide attempts and domestic violence. As part of a rapid response, AHS implemented telehealth services and continued to provide high quality care amid COVD-19, while responding to rising social needs, sounding the alarm on Anti-Asian racism, and advocating for better data collection and disaggregation. AHS observed low testing rates in Asian American communities, and suspected these rates were due to barriers such as language, fear and stigma in the rising anti-Asian landscape [3], and lack of information on resources. Our objective was to describe the Asian American community's lived experience during this pandemic, focusing on the Greater San Francisco Bay Area, California, to better inform our health care services.

Methods

We conducted a cross-sectional survey between May 20 to June 23, 2020 using a multi-pronged recruitment approach, including word-of-mouth through AHS social networks, AHS patient

recruitment, and social media posts. The survey was self-administered online or administered in-language over the phone by AHS staff in English, Cantonese, Mandarin, and Vietnamese. The survey included demographics, COVID-19-related testing and preventative behaviors, economic impacts of COVID-19, experience with anti-Asian violence, and mental health challenges (see Supplemental Materials). We included responses from individuals older than 11 years old. Descriptive statistics were conducted to summarize respondent characteristics and COVID-19 related responses.

Results

We surveyed 1,279 participants over a two-month period. The majority of participants were women (59.7%), Chinese (88.2%), foreign-born (81.3%), not fluent in English (56.1%), and resided in Oakland (52.7%) (see Table 1).

Table 1 – Demographic Characteristics of Participants (n=1,279)

Characteristic	**No.**	**Percent**
Gender	1273	
Male	513	40.3%
Female	760	59.7%
Race/Ethnicity	1278	
Cambodian	20	1.6%
Chinese	1127	88.2%
Vietnamese	103	8.1%
Other Asian	20	1.5%
Two or more races	8	0.6%
Age Groups	1141	
12-18 years	13	1.1%
18 to 24 years	332	29.1%
25 to 44 years	222	19.4%
45 to 64 years	323	28.3%
65 years and older	251	22.0%
Birthplace	1254	
US born	234	18.7%
Foreign born	1020	81.3%

Average no. of people per household	1278	
Average	3.5	
SD	1.6	
English Fluency	1279	
Fluent or speak pretty well	388	30.3%
Speak somewhat well	173	13.5%
Not very well or not at all	718	56.1%
Residence	1113	
Oakland	586	52.7%
San Leandro	202	18.1%
Alameda	79	7.1%
San Francisco	41	3.7%
Other cities in Alameda County	143	12.8%
Other cities	62	5.6%

**percent based on non-missing numbers*

Only 3% (n=39) were tested and there was a 5% positivity rate (Table 2). The primary reasons for low testing were not finding a testing site, and not being concerned that they had been exposed to the virus. Three-quarters of participants reported feeling stressed, and about one-quarter reported feeling depressed. Six percent reported being treated unfairly because of their race/ethnicity, greater that the state average [4]. Over one-third of participants had lost their regular jobs and one-quarter had reduced hours or reduced income. The majority of participants reported wearing a mask before it was required by the government (78.8%), and about 73% reported avoiding leaving their house, including going to the grocery store, church and school.

Table 2. Questions on COVID-19 testing, impacts and behaviors

Questions	**No.**	**%**
Have you ever had, or thought you might have had COVID-19?	1276	
Yes	47	3.7%
No	1229	96.3%
Were you ever tested for COVID-19?	1273	
Yes	39	3.1%
No	1234	96.9%
What was the reason why you did not get tested?	841	

I was not able to find a place that would test me.	392	46.6%
I was told by a health professional that I did not need to get tested.	37	4.4%
I was afraid that a positive test would require me to get health care, and I was worried about the cost.	20	2.4%
I was afraid that using health care could affect my immigration status.	6	0.7%
I was afraid of being discriminated against if others knew I was positive.	5	0.6%
I thought if I could just isolate myself in my home, I would get better and not infect other people.	35	4.2%
I was not concerned that I had been exposed to the virus.	355	42.2%
Did you ever receive a positive test result for COVID-19?	39	
Yes	2	5.1%
No	37	94.9%
Has anyone in your household that you live with ever been tested positive for COVID-19?	1262	
Yes	10	0.8%
No	1252	99.2%
Impact of COVID	678	
I've lost my regular job.	246	36.3%
I've had a reduction in hours, or a reduction in income.	172	25.4%
I've switched to working from home.	121	17.8%
I've continued to report to work because I was an essential worker.	88	13.0%
I've had difficulty in obtaining childcare, or had an increase in childcare expenses.	53	7.8%
I've had financial difficulties with paying rent or mortgage.	92	13.6%
I've had financial difficulties with basic necessities, such as paying bills, tuition, affording groceries, etc.	97	14.3%
Other challenges	7	1.0%
Experienced discrimination or violence due to your race/ethnicity	1275	
Yes	72	5.6%
No	1203	94.4%
Have you reported your experience?		
Yes	1	1.4%
No	71	98.6%
Have you felt any of the following?	636	
Felt depressed	160	25.2%
Felt hopeless	45	7.1%
Felt stressed	477	75.0%
Felt restless or fidgety	112	17.6%
Other	12	1.9%
Have you talked to your doctor or a mental health professional about how you felt?	1265	
Yes	69	5.5%

No	1196	94.5%
How long have you been wearing a mask?	1297	
Wore mask before shelter-in-place	503	38.8%
Wore mask when shelter-in-place started	519	40.0%
Wore mask after the government required us to do so.	243	18.7%
I do not wear a mask in public.	5	0.4%
What have you done to reduce your chances of getting infected?	1267	
Avoid leaving my house to go to any public places (such as grocery stores, church, and school).	918	72.5%
Avoid going to any of my health care appointments.	105	8.3%
Avoid taking public transportation.	238	18.8%
Other	27	2.1%

**percent based on non-missing numbers*

Discussion

The survey results underscore different interconnected needs and issues in the Asian American community. The high percentage of respondents reporting they do not leave their house may be due, at least in part, to the fear of experiencing anti-Asian hate harassment and discrimination. This avoidance behavior may be associated with the low testing rate in this group (3%). In comparison, testing rates in Alameda County, where a majority of participants reside, is 195.8 per 1,000 (19.6%), across all races, with Asian Americans being the lowest (6.4%) [5]. Furthermore, the avoidance of leaving the house in addition to the anti-Asian hate may also explain the high prevalence of self-reported mental health issues.

Our findings highlight the longstanding need for culturally and linguistically-appropriate mental health services and resources. The results confirm what AHS staff have been hearing from patients during the pandemic – fear, anti-Asian discrimination, isolation, limited information and resources, and rising mental health issues.

Given the results, AHS has established a COVID community testing site that provides culturally

appropriate services in-language. In addition, AHS launched a multi-lingual helpline to assist with information and navigation on the COVID-19 testing process, and providing social services needed (e.g., food and unemployment assistance), consultation for isolation and quarantine, and other case management and mental health referrals. AHS will expand the work to include case investigation and contact tracing in a culturally and linguistically competent approach.

The survey findings highlight the ongoing need to utilize community-based approaches, including culturally and linguistically competent survey instruments, to document emerging issues in vulnerable populations to inform care and implement strategies to address disparities.

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Supplementary Files

Multimedia Appendixes

Survey Instrument.
URL: https://asset.jmir.pub/assets/9b0162a5ab86f22fac776fae12223f87.docx