



National  
Urban League

# COVID-19

## COMMUNITIES OF COLOR NEEDS ASSESSMENT

Asian American Psychological Association  
**Asian Americans**

A PARTNERSHIP WITH  
**The Alliance for National Psychological Associations for Racial and Ethnic Equity**



## ABOUT THE NATIONAL URBAN LEAGUE

The National Urban League is a historic civil rights and urban advocacy organization. Driven to secure economic self-reliance, parity, power, and civil rights for our nation's marginalized populations, the National Urban League works towards economic empowerment and the elevation of the standard of living in historically underserved urban communities.

Founded in 1910 and headquartered in New York City, the National Urban League has improved the lives of more than two million people annually through direct service programs run by 90 local affiliates in 36 states and the District of Columbia. The National Urban League also conducts public policy research and advocacy work from its Washington, D.C. bureau.

The National Urban League is a BBB-accredited organization and has earned a 4-star rating from Charity Navigator, placing it in the top 10% of all U.S. charities for adhering to good governance, fiscal responsibility, and other best practices.

## THE ASIAN AMERICAN PSYCHOLOGICAL ASSOCIATION

The Asian American Psychological Association strives to advance the mental health and well-being of Asian American communities through research, professional practice, education, and policy.

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# Introduction

The Asian American Psychological Association used a national sample (N = 3,736) of Asian American adults (18 years and older) who were living in the United States since March 13, 2020. Despite the recent national attention to anti-Asian hate incidents, limited attention has been given to how Asian Americans are generally faring during the COVID-19 pandemic. The AA & NH/PI COVID-19 Needs Assessment Study provides a broader framing of the different facets of Asian American experiences during the pandemic. We include analyses of the economic and housing impact of COVID-19, food security, health and health care access, mental health, and education. The survey data was further supplemented by qualitative data obtained from informal interviews with Asian American community members. Additionally, we report results from a follow-up survey with 421 respondents who reported anti-Asian hate incidents to the Stop AA & NH/PI Hate Reporting Center. The report concludes with a series of recommendations for policy and data needs.

It is important to note that the survey sample of N = 3,736 respondents intentionally captured the diversity within Asian Americans because we:

- Oversampled several Asian American ethnic groups (Chinese, Vietnamese, Filipinx, Korean, and South Asian including Indian, Pakistani, and Bangladeshi),
- Translated our survey instrument into nine languages (traditional and simplified Chinese, Vietnamese, Tagalog, Korean, Hindi, Urdu, Bangla, and Khmer).
- Concentrated participant recruitment efforts in metropolitan areas heavily populated by our targeting Asian ethnic groups.
- Reached out to national and regional community organizations and networks serving Asian Americans before expanding outreach through word of mouth.
- Recruited English-speaking Asian Americans (specifically, Chinese, Korean, Vietnamese, Filipino, and Indian Americans) through Qualtrics panel recruitment.

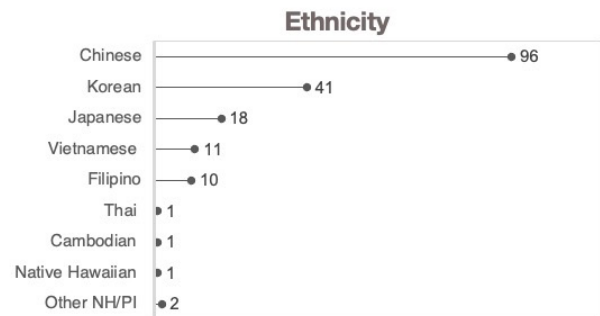
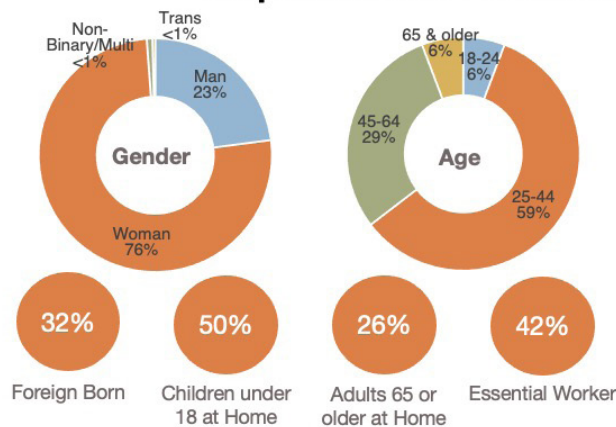
More about our sampling strategy and methods can be found in Appendix 1.



# Sample Demographics Stop AA & NH/PI Hate Sample (N = 421)

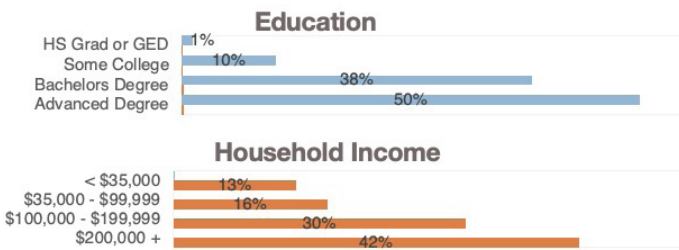
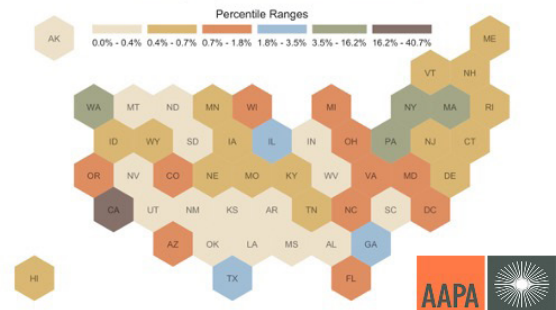
A majority (76%) of the Stop AA & NH/PI Hate sample identified as female, while close to one-fourth (23%) identified as male. Over half (59%) of the respondents were 25-44 years of age, with 29% 45-64 years of age. The primary ethnic groups sampled were Chinese (23%) and Korean (10%). Close to one-third (32%) were foreign born. Half (50%) had children under 18 at home, while one in four (26%) had adults 65 years or older at home. Over one third (42%) were essential workers. In terms of education level, half (50%) of the respondents had an advanced degree, with 38% having a bachelor's degree (32%). Over one in three (42%) had a household income of \$200,000 or higher, while 30% had an income of \$100,000-\$199,000. The geographic areas with the highest response rates were California, followed by Washington, Pennsylvania, New York, and Massachusetts.

## Stop AA & NH/PI Hate Sample Demographics (N = 421)



Ethnicity data are missing for many respondents.

### Geographic Distribution



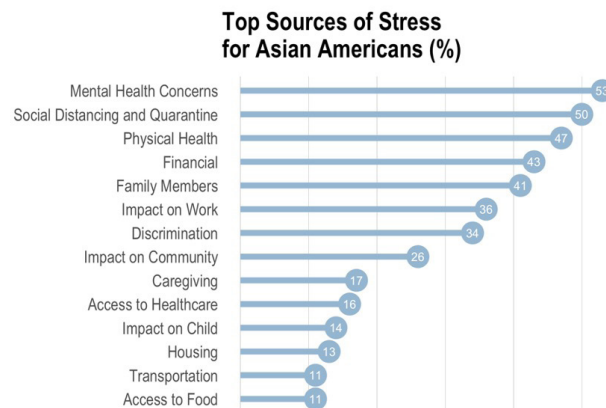
# Key Findings on the Needs and Impacts of Covid-19 on Asian American Communities

## Top Sources of Stress During COVID-19 Pandemic

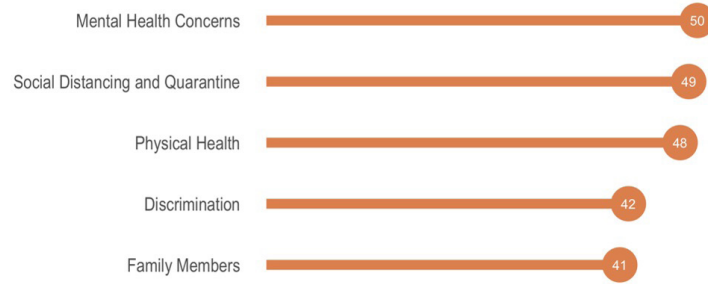
Asian Americans are facing widespread and deep impacts from the COVID-19 pandemic and other related personal, family, community, and societal issues, such as declines in health, educational challenges, job losses, and anti-Asian discrimination. These compounding issues are causing significant stress, with long-term repercussions for health and wellbeing. Sources of stress and their impacts are not experienced uniformly across Asian American groups. Sources of stress vary in magnitude and significance, and consequences of these stressors depend on factors such as pre-pandemic or current individual and community resources.

### Key Findings

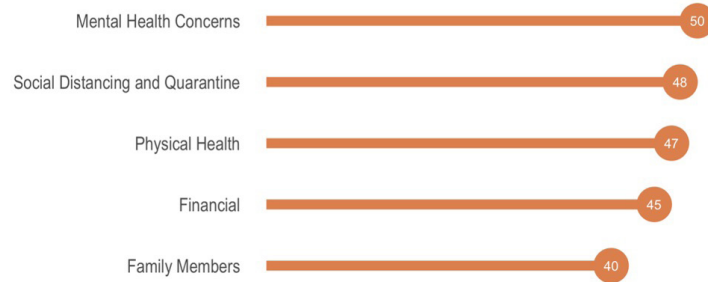
- *Mental health* was the top stressor among Asian Americans overall, endorsed by over one in two Asian Americans (52.7%); it was also the top first or second most endorsed stressor for each of the eight largest ethnic groups in the study.
- Other top stressors included: social distancing/quarantine (49.8%), physical health concerns (47%), finances (42.9%), impact on family (41.1%), impact on work (36.3%), discrimination (34.3%), and impact on community (25.7%). Although the sample of Cambodian Americans was relatively small (n=45), it is noteworthy that two-thirds reported finances as a top stressor.
- Younger adults (18-24 and 25-44) endorsed more sources of stress than older adults (45-64 and 65 and older).
- Women and non-binary (note small sample size of 28) endorsed more sources of stress than men.
- Asian Americans earning less than \$25,000 endorsed more sources of stress than those earning more than \$100,000.



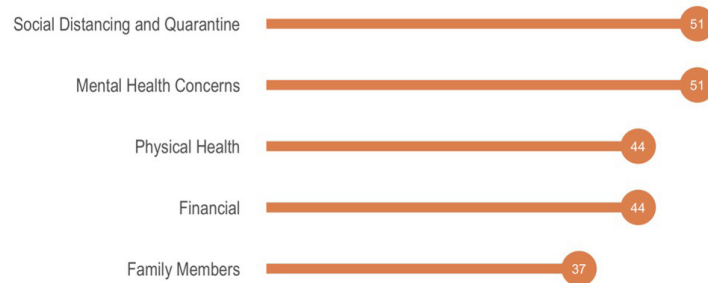
### Top Sources of Stress for Chinese Participants (%)



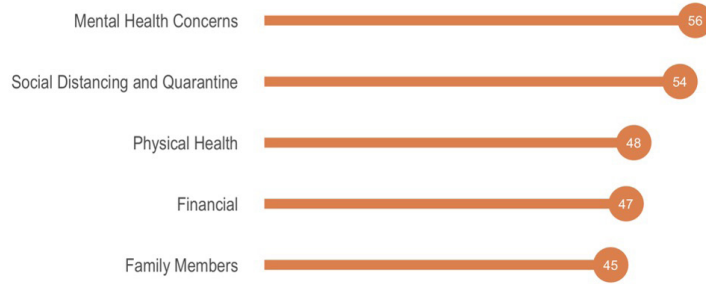
### Top Sources of Stress for Filipino Participants (%)



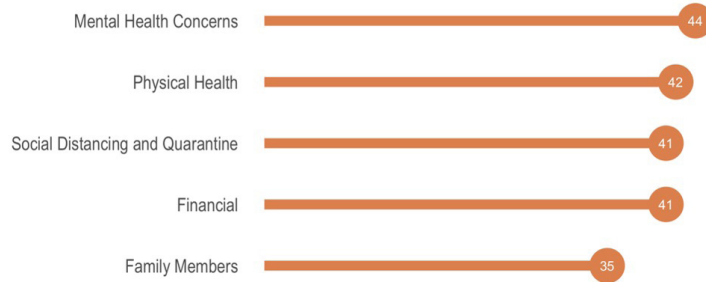
### Top Sources of Stress for Korean Participants (%)



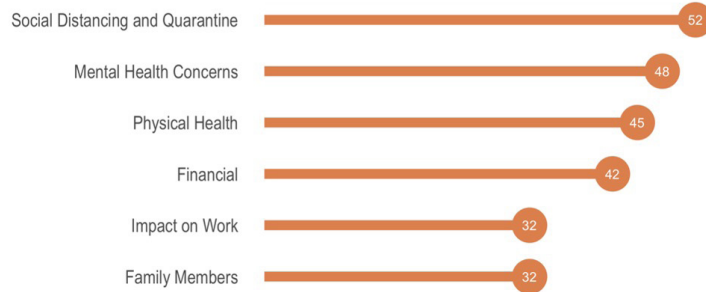
### Top Sources of Stress for Vietnamese Participants (%)



### Top Sources of Stress for Indian Participants (%)

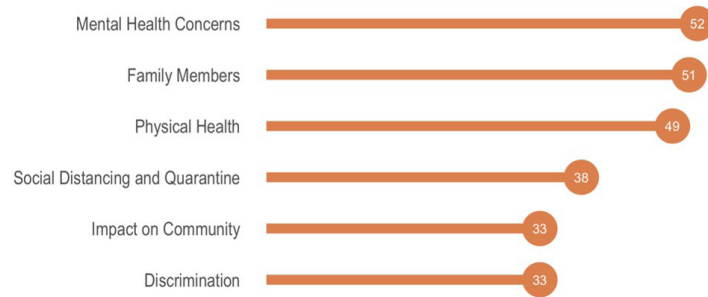


### Top Sources of Stress for Pakistani Participants (%)

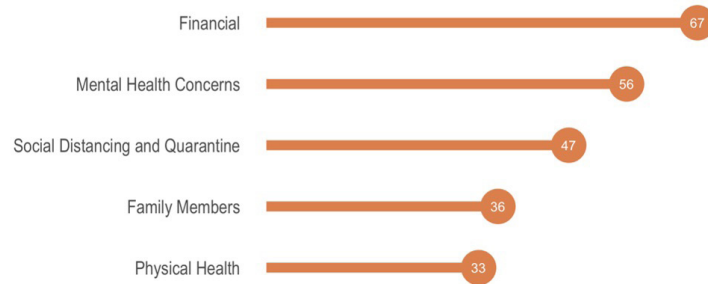




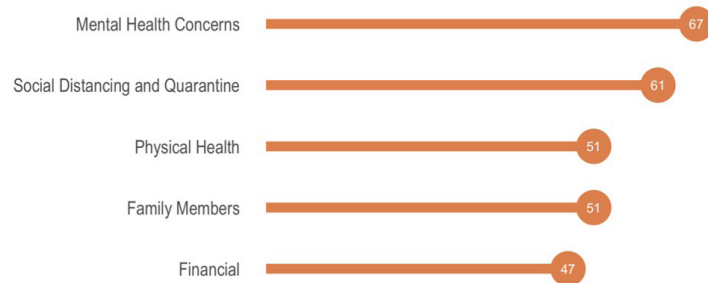
### Top Sources of Stress for Japanese Participants (%)



### Top Sources of Stress for Cambodian Participants (%)



### Top Sources of Stress for Multiethnic Participants (%)



## Food Insufficiency

Food access has emerged as a major issue during the pandemic as the economic recession has led to sharp increases in unemployment and poverty. Asian Americans have the highest income inequality compared to other racial groups<sup>4</sup> and recent research has found significant disparities in food access across income levels and within Asian subgroups during the COVID-19 pandemic.<sup>5,6</sup> More importantly, however, because of the high visibility of the highest income Asian Americans, the middle to lowest income Asian Americans often get left out of federal, state and local food relief efforts.

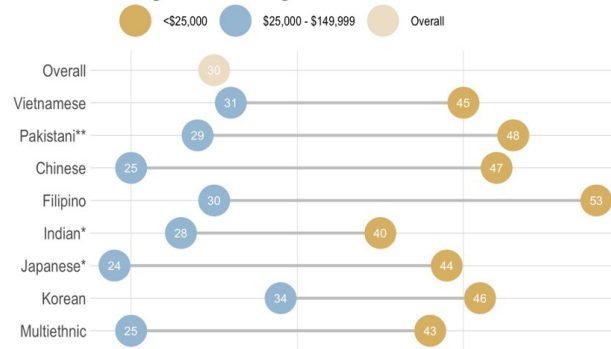
While less data have been historically available on Asian Americans in national surveys on food insecurity, local data—particularly in urban areas such as New York City—have highlighted the high burden.<sup>7</sup> Food insufficiency (i.e., whether there was enough to eat), measured on the current survey, overlaps with, but is distinct from, food insecurity (i.e., incorporates multiple dimensions of nutrition, diet quality and purchasing/procurement ability).<sup>8</sup>

According to the Household Pulse Survey, food insufficiency was reported by 3.7% of households in 2019, but rose to 9.6% during the COVID-19 pandemic.<sup>9</sup>

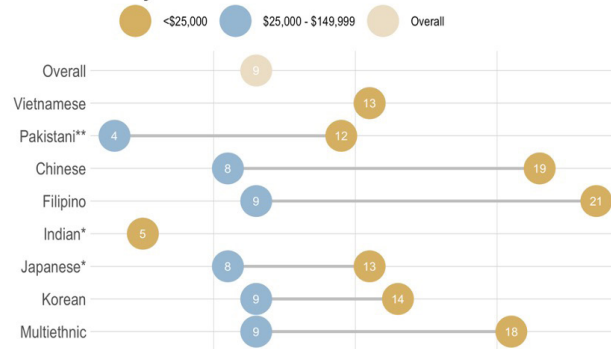
### Key Findings

- **7% of Asian American respondents were food insufficient both before and during the COVID-19 pandemic.**
  - This differed greatly by income level; Asian subgroups earning \$25,000 or less annually reported nearly 14 times more food insufficiency than those earning \$150,000+ (11.4% vs. 0.8%).
  - Most concerning, one in two (50%) did not have enough food because they were afraid to go outside, while over one-third (38%) could not afford more food.
- **High levels of need were observed among Asian subgroups earning <\$25,000 per year across all key measures of food access.**
  - Lower income Asian Americans were less likely to engage in practices conducive to health and safety, such as cooking at home more or using online grocery or delivery services.
- **Accessing food assistance programs was rare even amongst the lowest income group.**
  - 9% used a food bank or food pantry; only 3% overall (4%, lowest income group) used a community-based food delivery program (e.g., Meals on Wheels), and just 5% relied on food from their children's school (5%, lowest income group).
- **Filipino, Korean, Japanese and multiethnic subgroups had the highest levels of need across different measures of food access.**
- **Asian-language survey takers faced more food access challenges than English-language survey takers.**
  - 23.5% of Asian-language respondents reported food insufficiency (vs. 3% English-language respondents).
  - 52% of Asian-language respondents needed help accessing food (vs. 26% English-language respondents).
- **Younger U.S. born Asian Americans (18-24 years old) were particularly vulnerable to food access issues** (i.e., food bank use and/or meal rationing/skipping was highest with this group)

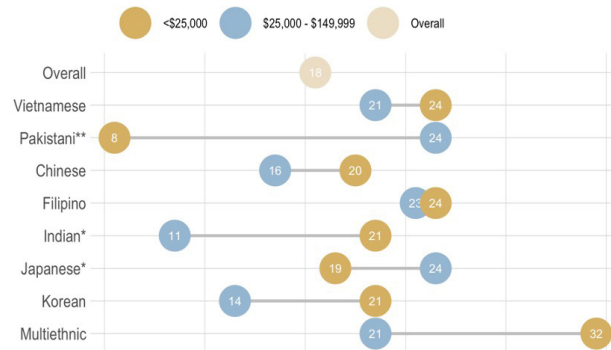
### Percent Who Reported Needing More Help Getting Food During the COVID-19 Pandemic



### Percent Who Reported Using a Food Pantry Since the Start of the Pandemic

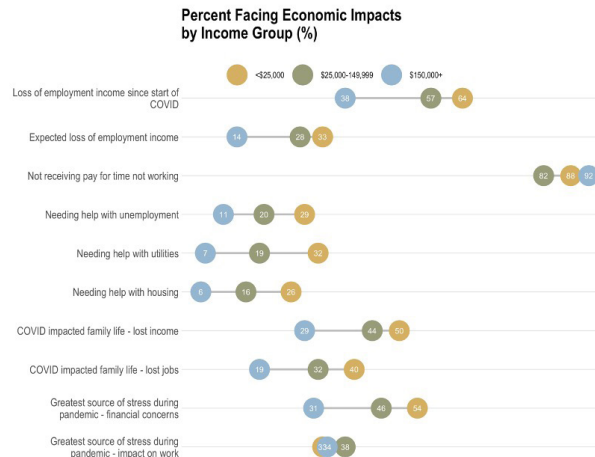
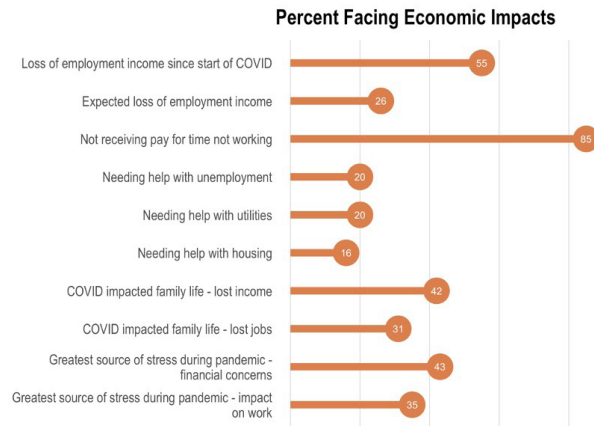


### Percent Who Reported Meal Rationing or Skipping Meals Since the Start of the COVID-19 Pandemic



## Economic Impact

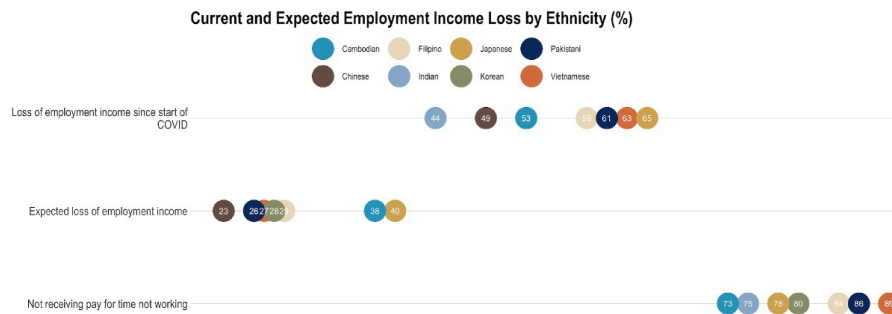
Asian American small business owners – especially in the food industry – are hard hit across the country.<sup>10, 11</sup> Chinese ethnic neighborhoods are experiencing disproportionate business closures,<sup>12</sup> and the unemployment rate for Asian Americans jumped from 2.8% in August 2019 to 15.0% in May 2020 and stabilized at 6.6% as of January 2021.<sup>13, 14</sup> The current plight of the economic condition of the Asian American community may in part be attributed to a number of factors, including 1) employment in some of most affected sectors (e.g., food service, hospitality); 2) residing in states where the pandemic has hit hardest; or 3) increased discrimination towards Asian-owned businesses - though these factors are only speculation at this time.



### Economic Impacts by Income Level

- Over half (55%) of Asian Americans reported that either they or someone in their household experienced a loss of employment income since the start of the COVID-19 pandemic; over a quarter (26%) expected a household member to lose employment income in the coming months.
  - The highest employment income loss was among Japanese and Vietnamese adults; while expected employment income loss was highest among Japanese and Filipino adults.
- A majority (85%) of Asian Americans did not receive pay for the time they were not working; this was most common for Chinese and Vietnamese adults. Indian adults had the highest rates of paid leave.





- One in five Asian Americans needed more help with unemployment services (20%) and utilities (19%); 15% needed help with housing.
- Of those who reported a significant impact on family life, 42% lost income and 31% lost jobs.
- Vietnamese, Korean and Filipino adults were most affected by economic concerns, income loss or needing support.

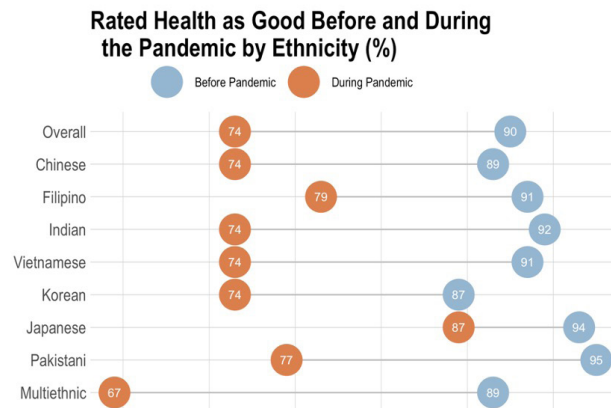
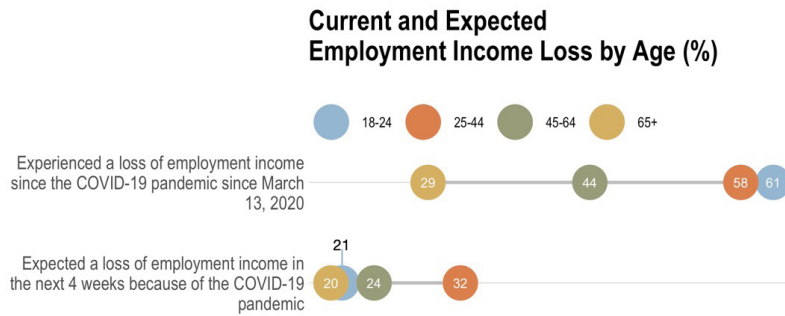
## Health and Healthcare Access

Self-rated health predicts mortality across populations, including Asian Americans.<sup>15</sup> Pre-existing health conditions (both physical and mental health), and healthcare access are some of the direct determinants of self-rated health. Disparities in healthcare access among Asian Americans related to structural and cultural barriers and delay in seeking healthcare have existed long before the pandemic.<sup>16, 17</sup> Because of shelter-in-place, fears of COVID-19 exposure, the pandemic has likely widened the gaps further. This study examined the impacts from the pandemic as perceived by Asian Americans on their self-rated health and healthcare access experiences.

### Key Findings

- **46.5% of Asian Americans had at least one physical health or mental health condition as confirmed by a health care provider**
  - Anxiety was the most frequently reported health condition (21.0%), followed by depression (16.4%), hypertension (14.9%) and diabetes (5.7%).
    - 18.7% had 1 or more physical conditions (with no mental health conditions)
    - 18.5% had 1 or more mental health conditions (with no physical health conditions)
    - 9.5% had co-occurring physical and mental health conditions
  - One in three (34.4%) between the ages of 25 to 44 had a mental health condition; and over one in four (27.6%) between the ages of 18 to 24 had a mental health condition
  - Two in three (64%) ages 65 and older had a physical condition; 54.4% had a physical chronic health condition, while 10% had both.

- **Over one in three (43.5%) reported a decline in self-rated health since the pandemic.** Asian Americans who rated their health before the pandemic as “good/ very good/ excellent” (90%) decreased to 74.3% during the pandemic.



- **Chinese (47.1%) and Vietnamese (52.2%) were more likely to report a decline in overall health since the pandemic;** a lower percentage of Japanese (35.9%) rated their overall health as lower since the pandemic (after statistical adjustment with age, income, gender, survey language used and health issues or diagnoses).
- **Since the pandemic, about half (49.8%) of adults ages 18 to 24 years reported a health decline;** over one in three (43.8%) adults ages 25 to 44 year old reported a decline; and one in four (24.5%) adults ages 65 and older reported a decline.
- **Those with co-occurring physical and mental health conditions as confirmed by a health professional were most vulnerable to a health decline (50.2%).**
- Adults in the middle household income group (\$25,000-\$49,999) were more likely to report a health decline (48.7%) when compared to those at the highest income group (\$100K and higher)

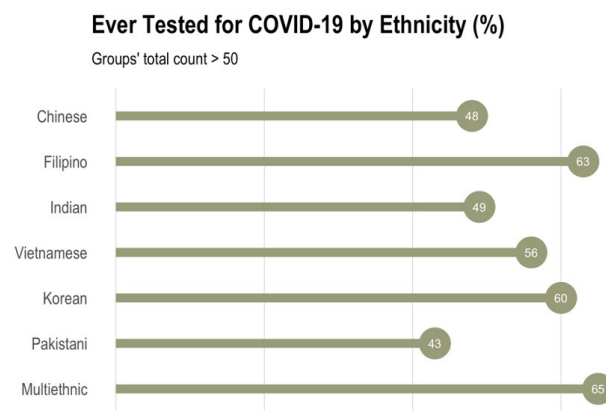
- Despite the low levels of uninsured (5.1%), **41% of respondents with medical needs delayed getting medical care because of the pandemic; 31.2% with medical needs only sought medical care for COVID-19.**
  - Nearly one third (31.3%) did not go to their healthcare appointments because of concerns about entering their healthcare provider's office. Difficulty in accessing a healthcare provider dramatically increased from 27.8% to 69.6%. Similarly, difficulty in getting routine or essential medications for self or family increased from 21.1% to 46.6%.

## COVID related health and health behaviors

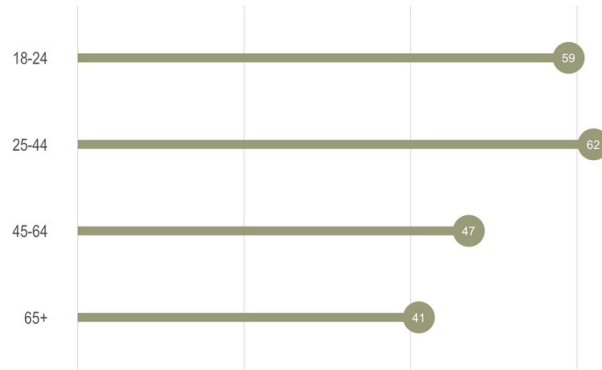
COVID-19 testing and vaccination among other safety measures such as wearing facial masks and social distancing are keys to control the pandemic. Racial disparities in COVID-19 testing and outcomes have been documented. When compared to non-Hispanic Whites, Asian Americans have lower COVID-19 testing rates but higher hospitalization and mortality rates related to COVID-19.<sup>18, 19</sup> Prior to FDA authorization of vaccine for COVID-19, although more than 80% of English-speaking Asian Americans indicated intent to get vaccinated,<sup>20</sup> a multi-lingual survey found that 76% of Asian Americans expressed at least one concern of the COVID-19 vaccine for its side effects and safety.<sup>21</sup> This study examined Asian Americans' COVID-19 testing status, safety practices against COVID-19, and receptiveness to COVID-19 vaccine 2 to 4 months since the COVID-19 vaccine has become available.

### Key Findings

- **3.2% of the respondents were hospitalized overnight due to known or suspected COVID-19 infections.**
- **The COVID-19 testing rate remained suboptimal.** Over half (56.6%) of Asian Americans were tested. In some Asian American groups—Pakistani (42.9%) Chinese (47.8%), and Asian Indian (48.5%)—less than half of the population had ever been tested.



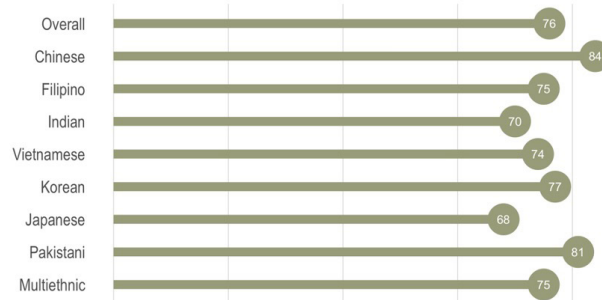
Ever Tested for COVID-19 by Age (%)



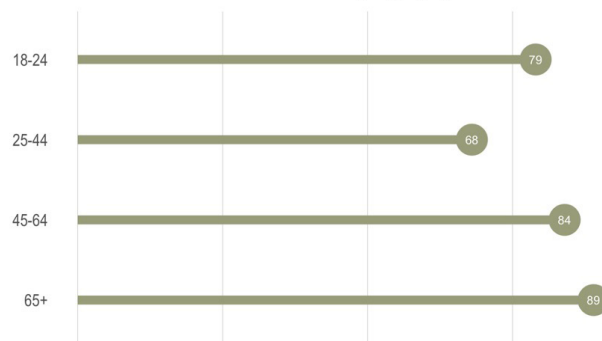
- A possible reason for low testing rates for COVID-19 is the **low perceived risk of infection**. Overall, 72.3% Asian Americans believed that they have never been infected with COVID-19.
  - Among those who have never been tested, three in four (76.3%) Asian Americans believed that they did not have or never had COVID (ranged from 81.3% among Chinese to 66.7% among Japanese adults).
  - Most (88.6%) older adults ages 65 and older believed they had never been infected with COVID-19 despite never having been tested.

Those Never Tested for COVID-19 and Perceived Low Infection Risk by Ethnicity (%)

Groups' total count > 50

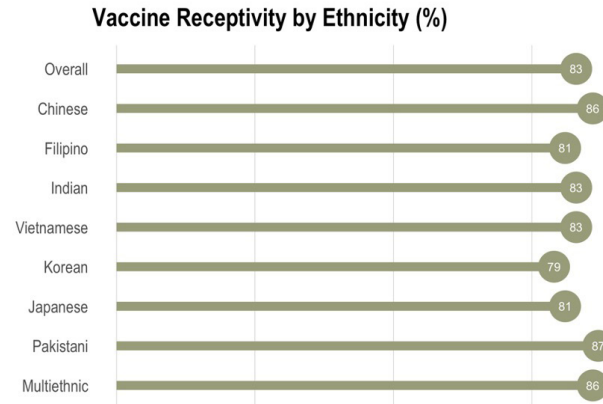


Those Never Tested for COVID-19 and Perceived Low Infection Risk by Age (%)





A majority (83.3%) were receptive to getting vaccinated for COVID-19 once it is available to the public (ranged from 86.9% among Pakistani, 85.7% Chinese, to 78.6% Korean).



- Groups who expressed the highest level of vaccine-hesitancy were: 1) Korean (21.4%) and Filipino (18.7%) adults between the ages of 45 and 64 (19.1%); 2) adults in the lowest income group <\$25,000 (20.3%), and 3) Asian-language respondents (24.8%). *(This analysis was conducted using multiple logistic regression with vaccine-hesitancy as an outcome and ethnicity, age, gender, income, health conditions, and survey language as covariates.)*
- **Most Asian Americans were engaging in COVID-19 safety precautions such as using a face mask and social distancing.** Nearly all (94.3%) used face masks in public places much or all of the time and 90.6% social distanced much or all of the time. Less than half (43.1%) had isolated themselves due to known or suspected exposure to COVID-19, while only 3.7% said they did not want to isolate when they had known or suspected exposure.
- **Nearly 60% of Asian Americans obtained information about the pandemic at least weekly,** with 15.2% daily.
  - Nearly all (96.5%) felt at least somewhat informed (53.0%) or very well informed (43.5%).
  - The most frequent sources of information were: online (62.6%), social media (61.4%), the government (59.4%), TV or radio (57.7%) and family and friends (54.0%).
  - Only 30.4% said they obtained information from their healthcare provider, 24.7% from the newspaper, and 6.6% from community and faith leaders.
  - Of note, 86.6% said pandemic-related information made them anxious some of the time or often.

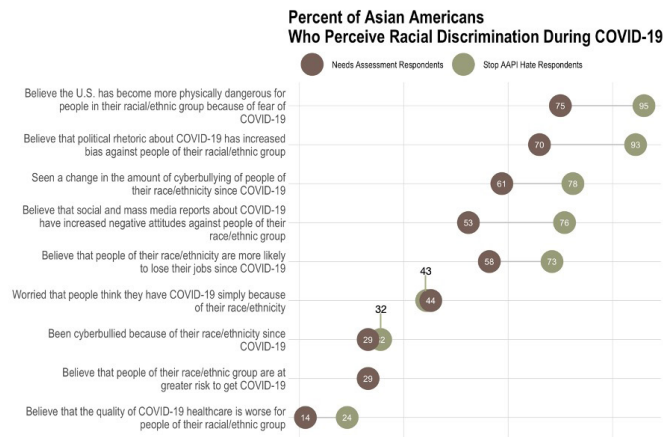
## Perceived Anti-Asian Discrimination

Although discrimination against Asian Americans is not new, there has been a sharp increase in racial discrimination since January 2020.<sup>22</sup> Between March 2020-February 2021, the Stop AA & NH/PI Hate Reporting Center recorded nearly 3,800 anti-Asian hate incidents. According to the Center for the Study of Hate and Extremism at Cal State University San Bernardino, anti-Asian hate crimes increased 149% in 2020 in 16 US cities.<sup>23</sup>

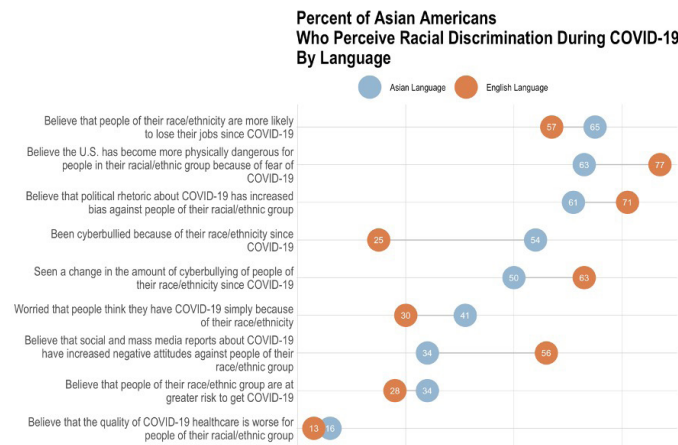
**In this study, three in ten (31%) Asian American adults faced discrimination during the COVID-19 pandemic.**

### Key Findings

- Three-quarters (75%) of Asian Americans believed the United States had become more dangerous for their racial/ethnic group
- 70% believed that political rhetoric was to blame for increased bias.
- As expected, those who experienced anti-Asian hate incidents and reported to the Stop AA & NH/PI Hate Reporting Center were more likely to perceive anti-Asian discrimination compared to respondents from the national needs assessment survey.



- More than half (54%) of Asian-language survey respondents were cyberbullied because of their race/ethnicity compared to 25% of English-language survey respondents. Differences were also observed in the types of Anti-Asian discrimination experienced by Asian-language respondents and English-language respondents:
  - Asian-language respondents perceived anti-Asian discrimination in terms of: employment, worry that people think they have COVID-19 because of their race/ethnicity, and risk of getting COVID-19.
  - English-language respondents perceived anti-Asian discrimination in terms of: seeing an increase in cyberbullying, increased physical danger, belief that political rhetoric has increased anti-Asian bias, and belief that social and mass media reports have increased anti-Asian bias.



## Mental Health

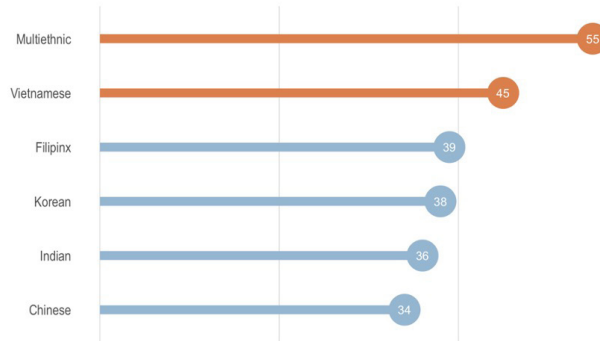
Increases in mental health concerns related to the COVID-19 pandemic have been documented, particularly among younger adults, essential workers, Black and Latinx Americans, and unpaid caregivers.<sup>24</sup> National Health Interview Study 2019 data are considered a useful benchmark of pre-pandemic mental health for Asian Americans.<sup>25</sup> These data show that 10.2% and 8.5% of Asian Americans were experiencing depression and anxiety symptoms respectively, the lowest of any racial/ethnic group.

**In this study, 41% Asian Americans reported depression or anxiety symptoms, with 29.5% reporting depression symptoms and 32.6% reporting anxiety symptoms.**

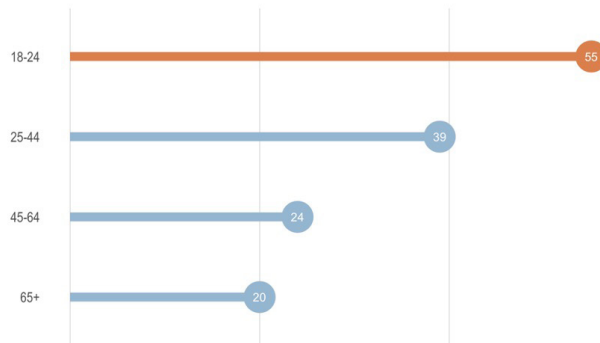
### Key Findings

- Mental health was a significant source of stress during COVID-19 for more than half of Asian Americans. It was also the first or second most endorsed stressor across all Asian American ethnic groups. (refer to “Top Sources of Stress for Asian Americans” (AA Slide 4))
- Almost one-third (29.1%) of Asian Americans would like help accessing mental health services.
- Based on multiple logistic regression analyses with ethnicity, age, gender, income, education, health conditions, and survey language included as covariates,
  - Women (44.6%), non-binary (71.4%, note small sample, n=28), and transgender (100%, note small sample, n=4) Asian Americans were more likely to report mental health symptoms than men (33%)
  - Cambodian Americans (55%) were more likely to report symptoms than other Asian ethnic groups (not shown in the figure due to small sample size)
  - Younger Asian Americans (18-44) were more likely to report mental health symptoms than older adults
  - Those with a household income less than \$25,000 were more likely to report symptoms than those with income greater than \$200,000
  - Those with some college, including AA or technical degree, were more likely to report symptoms than those with graduate degrees.
- U.S.-born Asian Americans (47.4%) were more likely to report symptoms compared to immigrants (32.5%).

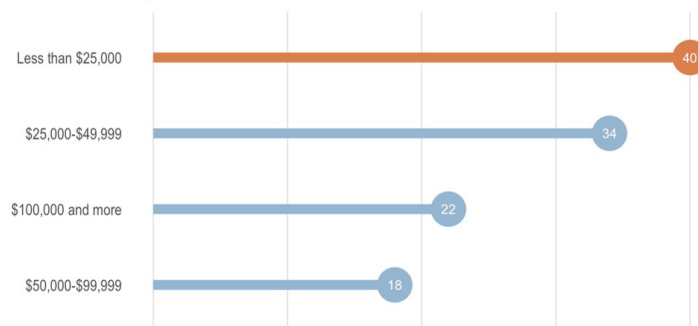
### Percent with Depression or Anxiety by Ethnicity (%)



### Percent with Depression or Anxiety by Age (%)



### Percent with Depression or Anxiety by Income (%)





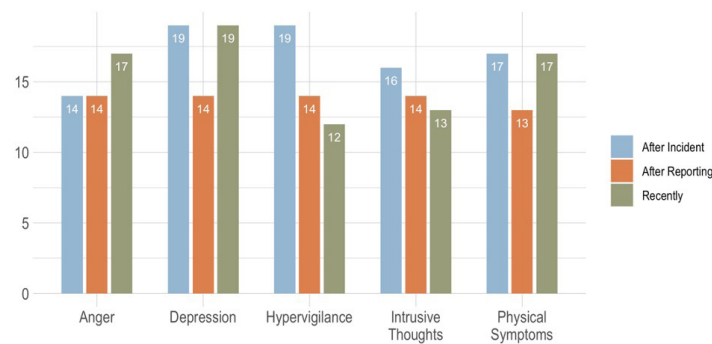
## Impact of Discrimination on Mental Health and Well-Being

Racism has profound implications for the health and mental health of Asian Americans. Racism is a chronic and acute stressor that harms health through “tax[ing] or exceed[ing] existing individual and collective resources or threaten[ing] well-being.”<sup>26</sup> In this section, we focus on the mental health of Stop AA & NH/PI Hate (SAH) respondents who have reported hate incidents in the context of the pandemic.

### Key Findings

- Discrimination was a significant source of stress for those who experienced it.
  - Discrimination was the top source of stress among SAH respondents, endorsed by more than seven in ten respondents (whereas for our national needs assessment participants, discrimination was endorsed as a top stressor less often than mental health concerns, social distancing/quarantine, physical health concerns, finances, impact on family, and impact on work).
- Racial trauma is the psychological and emotional harm caused by racism and includes symptoms of depression, anxiety, anger, avoidance, hypervigilance, intrusive thoughts, and physical symptoms. It is not a mental illness, and those who experience racial trauma should not be stigmatized as if their psychological or behavioral responses are pathological. SAH respondents were asked about race-based traumatic stress symptoms they experienced after a hate incident, after reporting to SAH, and recently.
  - Four out of ten experienced at least one race-based traumatic stress symptom after the event
  - Three out of ten experienced at least one race-based traumatic stress symptom recently, indicating that racism harms in the immediate- and short-term.

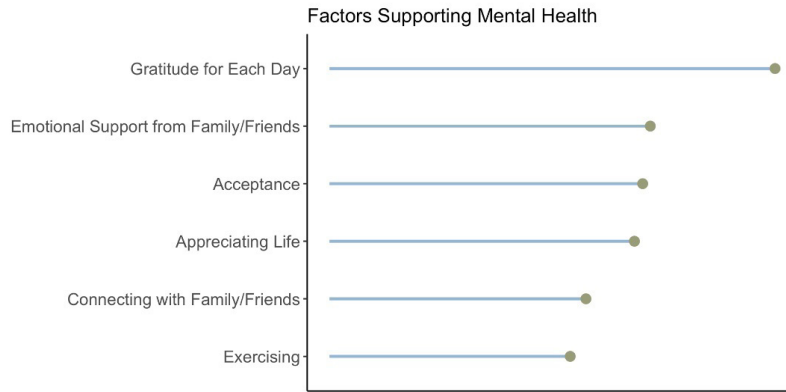
**Race-Based Traumatic Stress Symptom Change Over Time among Stop AA & NH/PI Hate Respondents (% Endorsed)**



### *Protective Factors that Reduce Depression and Anxiety Symptoms*

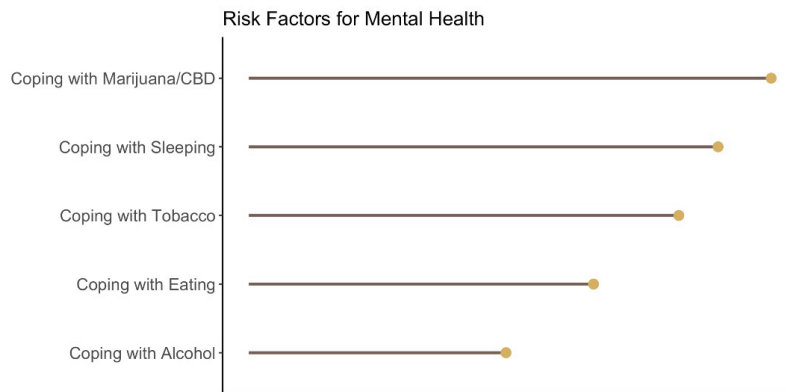
While there are various contributing factors to increased rates of anxiety and depression in Asian Americans (see above section on Mental Health), specific emotion regulation strategies, social behaviors, and health-related activities may offer a protective buffer against anxiety and depression. In the present study, key protective strategies included experiencing the following emotions and mindsets since the onset of COVID-19: increased gratitude for daily life, greater acceptance of things that cannot be changed, and a deeper appreciation for life. Additional protective factors included receiving emotional support from friends/family and finding new ways of connecting with one’s social network. Finally, exercising to cope with pandemic-related stress is related to lower depression and anxiety symptoms.

While these protective factors appear to contribute to alleviating some psychological distress, these individual-level protective factors do not directly address stress and associated psychological symptoms that are related to broader historical and structural inequities, discrimination, and racism. While it is important to provide positive coping interventions and encourage healthy behaviors that provide a buffer against depression and anxiety symptoms, it also remains critical to simultaneously work toward building more equitable societal infrastructures that will contribute to lessening fundamental causes of mental health symptoms.



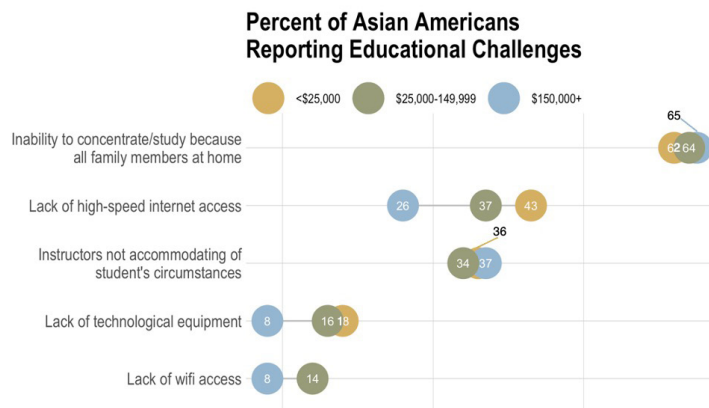
## Maladaptive Coping Strategies for Stress related to the COVID-19 Pandemic

A range of different coping strategies for mitigating pandemic-related stress were evaluated. Substance-related (marijuana, tobacco, alcohol) and health (sleeping/eating) behaviors were related to increased levels of anxiety and depression symptoms in Asian Americans.



## Educational Impacts

Asian Americans reported significant educational challenges for themselves and/or their children due to the pandemic. The most endorsed challenge faced by Asian Americans across income groups, was the inability to concentrate in the remote learning home environment (64%). However, low- and middle-income Asian Americans also reported more challenges related to high-speed internet access, lack of technological equipment, and language barriers in understanding material.



## Housing

Among Asian Americans with household income less than \$25,000, one quarter (25%) expressed a need for help with housing, 20% reported that housing is a top source of stress during the pandemic, and 23% reported little to no confidence that they could pay their next rent or mortgage payment on time.

## Role of Community-Based Organizations

Asian American-serving community-based organizations (CBOs) play critical roles in supporting Asian Americans—particularly those with limited English proficiency and/or those living in poverty—during the pandemic. Many CBOs report quickly shifting service delivery from primarily face-to-face to remote, and sometimes shifting focus to address pressing needs of community members (such as food assistance and unemployment benefit application assistance).

# Methodological Limitations of the Current Study

The current study address many of the methodological issues that tend to plague research on Asian Americans—our large sample allowed for the disaggregation of data by ethnic group, age, income, language, and other key dimensions; the needs assessment survey instrument was available in nine Asian languages, increasing accessibility and representation; and we partnered with community and advocacy organizations and networks, further increasing geographic representation and better ensuring that our work is useful to our community stakeholders. Yet, despite our best efforts to recruit diverse Asian subgroups, some of the categories remain quite small. This is problematic, particularly for those subgroups that are very rarely captured in national or local data efforts (e.g., Indonesian, Cambodian) but have known disparities in healthcare access and socioeconomic factors (e.g., Bangladeshi).

Moreover, clustering these subgroups together into a larger aggregate category (e.g., South Asian - being inclusive of Asian Indians, Bangladeshis, Nepalese, Pakistani, Sri Lankan, etc.) we opted to keep the data disaggregated. On the one hand this allows for us to observe differences between these subgroups (e.g., Asian Indians quite distinct from other South Asian groups), but on the other hand leaves out those in the smallest groups from the broader conversation. More methodological issues are discussed in Appendix 1.



# Conclusions and Key Recommendations

This report highlights the widespread and profound impacts of the COVID-19 pandemic on diverse Asian American communities. Below, some of the most important findings are provided along with recommendations for policymakers and others advocating for the needs of Asian American communities.

- 1. One-third to one-half of Asian Americans need assistance accessing food (especially low income and foreign-born); such needs are exacerbated by the pandemic. Our communities need help with food access - especially food that is culturally appropriate. CBOs and numerous other partnering organizations have spent the last year setting up and refining new and innovative systems of food access for the Asian American community.**

## Recommendations

- *Leverage and financially support successful practices that developed during the COVID-19 pandemic (e.g., pop-up food distribution, new partnerships) vs. creating new systems.*
- *Galvanize relationships between community, local farmers, and small business owners to provide culturally appropriate and appealing produce options and support Asian American owned businesses.*
- *Expand benefits like Health Bucks; acceptance of SNAP at online retailers beyond corporate giants (e.g., Amazon, Walmart) – enhance in-language enrollment support and ensure programming is appropriately messaged (vis a vis public charge).*
- *Provide funding for the development of education and guidance materials/social marketing pertaining to: how to access services, what services are available, nutrition and cooking with ingredients readily available through food distribution programs*

## **2. Mental health is a major concern across all Asian American subgroups, and the need for mental health resources is high.**

### **Recommendations**

*Provide more funding and resources to support the following:*

- *Existing mental health services for Asian Americans. Many mental health agencies and federally qualified health centers already provide linguistically and culturally competent mental health services for Asian Americans, but need additional funding to meet increased demand.*
- *Training clinics to hire linguistically competent clinical supervisors so students with language and cultural abilities can obtain Asian-centered training*
- *Programming for community-based healing, specifically for elders that are integrated with cultural healing methods.*
- *Culturally appropriate mental health outreach programming to target Asian American elders and other Asian Americans who tend to underutilize mental health services.*
- *Trainings for multiculturally competent counseling training.*

## **3. Asian Americans are experiencing racism and xenophobia with substantial effects on their mental health.**

### **Recommendations**

*Provide more funding and resources to support the following:*

- *Public messaging campaigns against anti-Asian racism, bystander intervention trainings, and initiatives that support restorative justice, cross-racial allyship, and community-based safety measures.*
- *Development of additional channels to track, assess, and provide referrals for victims of hate incidents, including in-language hate reporting hotlines.*
- *In-language and culturally appropriate legal and mental health resources for victims of hate incidents.*
- *Modifications to required education and history curricula in U.S. school systems to teach about Asian American history.*

## **4. False information and misinformation obscure the reality that many Asian Americans experience poverty.**

*For low-income Asian Americans:*

- *Community-based organizations fill critical gaps in federal, state, and local government services.*
- *Services include in-language support and referral processes; linguistic translations; providing a trusted place to get tested, vaccinated; food distribution; rental assistance for families; short-term financial assistance for community members who aren't eligible for unemployment benefits.*

### **Recommendations**

- *Ensure funding and resources within aid relief packages are earmarked specifically for distribution to CBOs providing these direct-to-community services.*
- *Include 'Asian American' serving organizations when defining and describing organization eligibility.*

## **5. More than two in five Asian Americans reported a noticeable decline in health since the pandemic. Health decline was compounded with two- to three-fold increase in difficulty obtaining essential medications and accessing needed medical care. Some groups were more vulnerable to health decline since the pandemic, including Chinese and Vietnamese Americans, younger age groups, those with both physical and mental health conditions, and those in low-middle income groups.**

### **Recommendations**

- *Support efforts to partner with community organizations, health organizations, and employers to make wellness programs accessible and promote participation in these programs to promote both physical and mental well-being.*
- *Dedicated resources that promote access to needed medical care including preventive care are urgently needed.*
- *Increase community-based education and outreach efforts to address concerns about exposure to COVID-19 infection at medical facilities*
- *Increase resources to support utilization of telehealth to address the health care access disparities in Asian Americans that have been exacerbated during the pandemic.*

**6. Three in four Asian Americans believed that they did not have or had been infected with COVID-19 despite never being tested for COVID-19. The low perceived need for testing is a concern.**

### Recommendations

- *Resources are needed to develop and implement effective community-based, culturally and linguistically appropriate education to increase Asian Americans' awareness of testing and its recommended guidelines.*
- *Devote resources for accessible testing including at-home testing to increase uptake of COVID-19 testing.*

**7. Despite quite high vaccine receptiveness among Asian Americans (83% indicated “somewhat” to “very” likely to get vaccinated), there is no guarantee whether these levels of receptivity will translate to actual uptake and adherence to completing the required doses of vaccination.**

### Recommendations

- *Community-based and culturally targeted efforts to facilitate vaccination across diverse Asian American populations will be crucial.*
- *Some groups had more vaccine-hesitancy and increased community-based efforts targeting these groups are recommended (for examples: Korean, Filipino, lower income groups, ages between 45 and 64).*

**8. This project demonstrates the importance of partnering with communities to collect data that reflect the diversity of AA populations.**

Our communities' perspectives are not well represented due to continued aggregation of data, failing to include us in data collection/tracking efforts, or misrepresenting us in “Other” or “AA & NH/PI” groups.

### Recommendations

- Support efforts that provide disaggregated data on Asian Americans by national origin and language.
- Support efforts to partner with community organizations for research.

# General Key Findings and Recommendations

(Applicable to AA and NH/PI and other Racial/Ethnic Groups)

**Misinformation, lack of information, and stereotypes about racial groups have long-existed before COVID-19 but are exacerbated by social media that lead to a rapid dissemination of falsehoods frequently having dire consequences for racial groups and their quality of life.**

## Background

COVID-19 did not create the inequalities that American society is currently confronting. The disparities that have become evident during the pandemic existed for decades, even centuries, and are simply much more in the public view. While efforts to assist people during COVID-19 are necessary, it is also critical to provide disaggregated information and data about state of different racial/cultural groups after the pandemic ebbs, distinguish the essential and empirically validated facts from stereotypes and misinformation about each group, assess whether each racial group has the requisite access to social, economic, and health resources, and to evaluate the data needs of each group. Comprehensive reports on each racial group will be valuable and critical for policy makers to have a more holistic understanding of the needs of each racial group and essential for community agencies and programs to better serve their constituencies. Researchers will also benefit by investigating issues that are meaningful for racial groups.

Given the small number of comprehensive, credible scientific publications and reports that move beyond limited studies about single topics, we lack the capacity to address some critical questions about established and emerging communities: (a) How integrated are different racial groups in society in terms of voting, participation in civic activities, religious institutions, and other community organizations? (b) Do communities receive an equitable investment from government agencies, including the Federal and local government; private foundations; and businesses? (c) Are racial groups able to access timely and appropriate care from the health (physical and mental) and social service sectors for their unique problems? (d) Are current social problems being addressed in communities and are there hidden problems that are not receiving appropriate attention? (e) Do racial groups experience barriers that prevent them from maximizing their social, political, and economic accomplishments? Accordingly, there is urgency to produce comprehensive scientific reports that can effectively inform and engage public discussion and dialogue to eliminate the systemic factors that deter racial groups from full participation in society.

## Recommendation

*Fund and direct the National Academy of Sciences (NAS), Division of Behavioral and Social Sciences and Education (DBSSE), Committee on Populations (CPOP), to conduct five consensus panels: (1) Asian Americans, (2) Black Americans, (3) Latinx, (4) Native Americans, and (5) Native Hawaiian and Pacific Islanders. The NAS is this nation's most credible, independent, and non-partisan scientific body in the US. The CPOP has expertise and expertise in conducting these types of consensus panels. Panels are composed of top researchers from different disciplines and most come from the different racial and ethnic communities. Reports on Black Americans, Latinx and Native Americans have been conducted in the past, but they are dated. No previous reports have been conducted for Asian Americans and Native Hawaiians and Pacific Islanders.*

# Community Partners

Arkansas Coalition of Marshallese  
Chuuk Community Health Center  
Chuuk Women's Council  
Empowering Pacific Islander Community  
Faith in Action Research and Resource Alliance  
First Chuukese Washington Women's Association  
Hawaii COVID-19 NHPI 3R Team  
Kosrae Community Health Center  
Kwajalein Diak Coalition  
Majuro Wellness Center  
Marianas Health  
Marshallese Women's Association  
National Tongan American Society  
Native Hawaiian and Pacific Islander Alliance  
Northern California COVID-19 Response Team  
Oregon Pacific Islander Coalition  
Oregon Pacific Islander COVID-19 Response Team  
Pacific Islander Community Association of Washington  
Pacific Islander Health Board  
Pacific Islander Primary Care Association  
Pacific Islander Regional Taskforce  
Palau Community Health Center  
Pasefika Empowerment and Advancement  
Papa Ola Lokahi  
PolyByDesign  
Southern California COVID-19 NHPI Response Team  
Tinumasalasala A Samoa Student Organization

Utah Pacific Islander Civic Engagement Coalition  
Utah Pacific Islander Health Coalition  
UTOPIA Portland  
UTOPIA Seattle  
We are Oceania  
Hana Center  
Asian & Pacific Islander American Health Forum  
Kalusugun Kalusugan Coalition  
Community & Advocacy Network PartnersAsian Pacific Partners  
for Empowerment, Advocacy, and Leadership  
Center for Pan Asian Community Services  
Coalition for Asian American Children+Families  
Asian Pacific Community in Action  
National Indo-American Museum  
Hanul Family Alliance  
Hiep Luc VN Teamwork  
Pui Tak Center  
Center for Pan Asian Community Services  
Coalition for a Better Chinese American Community  
Asian Business Association of San Diego  
Search to Involve Pilipino Americans  
Filipino American National Historic Society  
National Council of Asian Americans  
Association of Asian Pacific Community Health Organizations  
Chinese-American Planning Council



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# Appendix A

## METHODOLOGY

### Overview

The study population consisted of Asian American (AA) and Native Hawaiian and Pacific Islander (NH/PI) adults, 18 years and older, residing in the United States. Eligible respondents included people who reside in the U.S. in permanent or temporary quarters (e.g., dormitories, apartments, hotels), but who still consider their permanent residence within the U.S. A primary objective of this study was to assess emerging needs because of COVID-19 and to have diverse representation of different AA and NH/PI ethnic groups. To meet this end, the sample was initially stratified by five AA ethnic groups (Chinese, Filipino, South Asian, Vietnamese, and Korean) and five NH/PI ethnic groups (Native Hawaiian, Samoan, CHamoru, and Marshallese), but was later expanded to include all AA and NH/PI groups. AA groups included the five largest in most census estimates. The South Asian ethnic group included people with roots in India, Pakistan, Bangladesh, Sri Lanka, Nepal, among others. The NH/PI ethnic groups included the largest in the three major categories: Polynesian (Native Hawaiian, Samoan, Tongan); Micronesian (CHamoru, Marshallese); and Melanesian (Fijian). A systematic screening process verified eligibility (i.e., US residency; AA and/or NH/PI subgroup membership) for the study and ask eligible respondents to participate in the study. The study relied on self-report to measure the ethnicity of the respondent.

Children under the age of 18 years old at the time of the survey were excluded from this survey. The exclusion of children was a function of cost and time considerations since it would take considerably more effort to secure parental consent to recruit children into the sample. To obtain some information about how children are faring in the pandemic environment, the survey includes a few questions asking parents about this issue.

### Survey Design

The design used a dual frame to recruit eligible respondents for the survey. The intent of the survey was to secure a broad swath of AA and NH/PI who live in different states and who represented different ethnic groups. The first frame recruited respondents from a Qualtrics panel that provided an overall national dataset about how different AA and PI ethnic groups are doing on certain dimensions during the pandemic. Since the Qualtrics panel would likely have been biased toward highly educated, middle to high income and English proficient respondents, we supplemented this sample with a frame derived from recruiting residents from community organizations and social media platforms. Convenience samples, like the one used here, are relatively efficient and less costly means to recruit samples especially from relatively rare population. The non-probability characteristic of the convenience sample is its most serious disadvantage. It is, by nature, difficult to generalize to a specific population since we do not have sufficient information about the types of people among AA and PI populations who are do not use social media or participate in the selected organizations which are critical elements of our recruitment strategy. Accordingly, it will not be possible to make precise prevalence estimates of the outcome variables. Despite this disadvantage, the convenience sample can be enhanced to increase its value. The dual sampling strategy provided the opportunity to recruit people with different profiles which will increase the coverage and inclusion of a heterogenous final sample. In subsequent data analyses, we plan to consider recent statistical innovations that can complement convenience sample which may make it amenable to use powerful inferential statistical tools in our analyses (Hedt & Pagano, 2014). For this current report, we used the pool unweighted samples from the dual frames.

A systematic screening process verified eligibility (i.e., US residency; AA or NH/PI subgroup membership) for the study. The study relied on self-reports to measure the ethnicity of the respondent. Respondents were provided a \$10 honorarium for their participation in the survey. Eligible respondents completed a web-based survey. If eligible participants did not have access to a computer or preferred a different mode of responding to the survey, they were given a self-administered questionnaire or completed the survey through a phone or virtual interview. When this occurred, the questionnaire responses were coded and researchers entered the responses into the survey database.

## Cultural Considerations

One of the goals of this survey was to make it accessible to a broad range of respondents. Since language is a key facet in the AA and PI communities, the survey was translated from English into the following languages: Chinese (traditional and simplified); Bangla, Hindi, Urdu; Vietnamese; Korean; Tagalog; Khmer; Samoan; Tongan; CHamoru; and Marshallese. We also worked extensively with different national and community AA and PI organizations to gather input on the survey design and content, to ensure that the data can be useful and useable for policy and programmatic purposes, and to facilitate the recruitment of eligible respondents into the survey.

## Measures

Three principles guided the selection of the measures. First, the core measures agreed upon by the Alliance members were given priority for inclusion in the AA and PI survey. Second, some survey measures are taken from the Census Bureau's Household Pulse Study (HPS) project about the public's response to the COVID-19 pandemic. The inclusion of the HPS measures provided a means to compare the findings from this survey with a national probability sample. Finally, the AA and PI research team agreed on the remaining measures for the survey that were derived from other local and national COVID surveys. Measures were generally taken from established scales. At the outset, the AA and PI group agreed that the survey was to take no longer than 20 minutes to complete to minimize respondent burden.

## Data Cleaning and Verification

Extensive time was spent verifying the survey responses and cleaning the resulting survey data. Since bots are a major problem with online survey, we checked for inconsistent responses between variables such as age and birthdays, the inordinate use of the same internet protocol addresses. Since we provided a \$10 stipend for participation in the survey, we also checked for inconsistency in the address and the geographic location recorded in the survey.

## Limitations

This needs assessment study has several limitations. First, findings are based on cross-sectional surveys and it is not possible to make causal attributions. Second, we do not have data prior to the start of the pandemic. While we do ask respondents about their perception of changes before and during COVID-19, the absence of survey data on our samples do not allow us to make precise comparison between these two time periods. Third, despite our intent to provide data on specific NH/PI ethnic groups, it was not possible to do so in all cases. For example, the South Asian sample includes a number of ethnic groups and for some ethnic groups, like the Bangladeshi, the resulting sample is too small to make a statistically accurate conclusion.

Despite these limitations, the surveys produced rich datasets on AA and NH/PI residents and how they are faring during the current pandemic. This report can only touch on some of these important findings and we plan to produce more data briefs for community audiences and policy makers as well as papers for scholarly and academic outlets. It also should be noted that even when some sample sizes are too small to make definitive statistical conclusions about some ethnic groups, having representation from these groups does allow us to identify patterns that may be useful to examine in future studies.

## Human Subjects

The Asian American Pacific Community Health Organizations (AAPCHO) reviewed and approved the human subjects protocol for the surveys. The AA & NH/PI COVID-19 Needs Assessment investigators completed their individual human subjects training and are certified by their local institutions.

### Selected References

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*Few events have shaped American history and our national perspective on racial inequity as profoundly as the grief, community distress and economic devastation brought about by the COVID-19 pandemic.*

*The pandemic unmasked the stark racial inequities in our economic, health care, education and other systems and institutions — a reality of inequities to which we can not and must not return.*

— Marc H. Morial



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