

COVID-19 VACCINE HESITANCY AND SOCIAL DETERMINANTS OF HEALTH AMONG EIGHT ASIAN AMERICAN ETHNIC SUBGROUPS IN CUYAHOGA COUNTY

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Funded by Cuyahoga County Board of Health

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SEPTEMBER 2023

**ASIAN AMERICAN PACIFIC ISLANDER (AAPI)
COMMUNITY ASSESSMENTS**

ON

**COVID-19 VACCINE HESITANCY AND SOCIAL
DETERMINANTS OF HEALTH**

(Project funded by Cuyahoga County Board of Health)

FINAL REPORT

**Ye Fan Glavin, May Chen, Uma Irfan, Ellaine Irani,
Feiran Yang, Peijian Wang, Karen Chu, and Susan Wong**

SEPTEMBER 2023

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BACKGROUND

Asian American and Pacific Islander (AAPI) communities encounter multiple healthcare challenges, which have been exacerbated during and after the COVID-19 pandemic. A recent environmental scan done in Cuyahoga County and the City of Cleveland indicated that AAPI communities often experience language and cultural barriers, poor healthcare access, financial difficulties, and social isolation due to xenophobia. During the environmental scan, the leaders from our community at large also expressed difficulty in serving the AAPI populations especially due to the lack of data, the non-specific clinical guidelines, limited translation services, and the absence of a centralized support resource. All these challenges call for the formation of an “AAPI Health Coalition” to address grass root AAPI community issues systematically and collectively. A “working definition” for the Health Coalition was assembled: *“to bring people together to raise awareness about issues, create solutions, build capacities, and empower the community through advocacy, education, research and technical assistance around a common goal to better serve the AAPI population”*. The community needs assessment report and initiation of AAPI Health Coalition development have been presented to City of Cleveland’s AAPI Advisory Group and Community Relations Board and received their support and endorsement.

With the support of COVID response resources allocated from the Cuyahoga County Board of Health (CCBH), we collaborated with 8 community organizations representing 8 AAPI communities (Chinese, Asian Indian, Filipino, Korean, Vietnamese, Afghan, Nepal-Bhutanese, Myanmar-Burmese) to complete 8 focus group discussions and 200 COVID vaccine hesitancy and social determinant of health surveys. The purpose of the focus group interviews and surveys was to understand the critical social and health issues facing the AAPI community, including: language barriers, lack of healthcare practice guidelines, lack of understanding and access to healthcare benefits, economic instability and distrust in the health system resulting in delayed diagnosis and treatments, immigration difficulties, transportation limitations and poor social and community support and network.

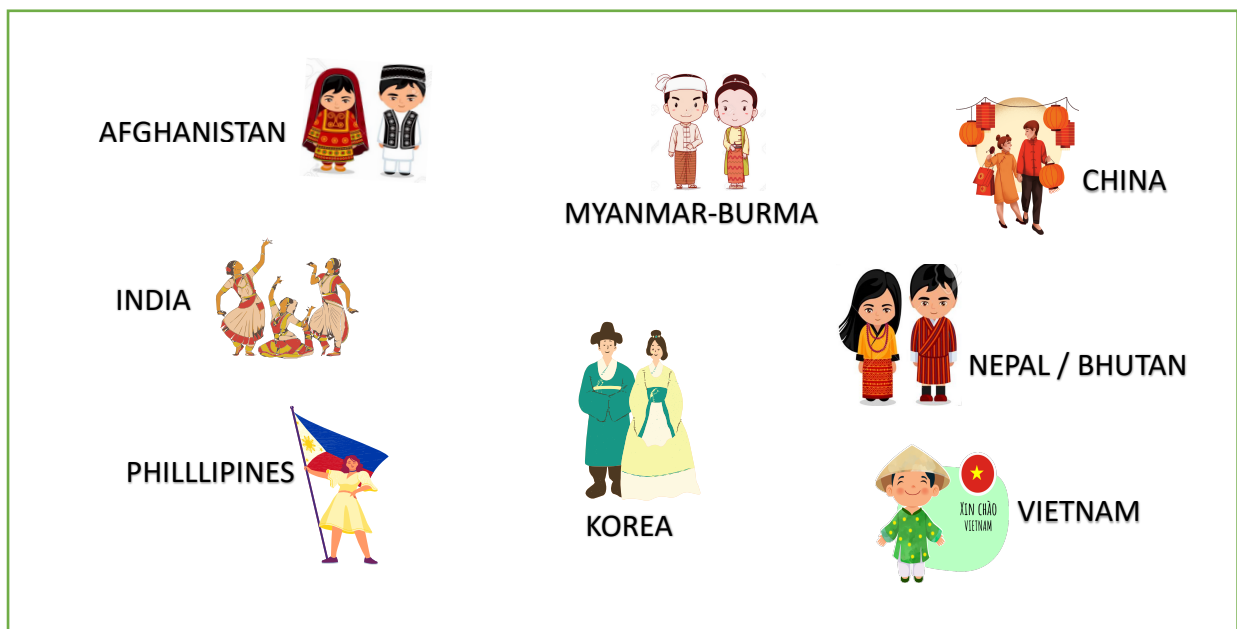
COMMUNITY ASSESSMENT SURVEY METHODS

The community assessment methods included a cross-sectional survey and a focus group discussion among AAPI community members residing in Cuyahoga County; that was conducted during April – June 2023.

The survey included a 59-item standardized structured questionnaire that was designed to elicit information on socio-demographics, COVID-19 vaccine hesitancy and social determinants of health (i.e., health care access and quality, economic stability, neighborhood and built

environment, and social and community context). Twenty-five participants from each of the 8 AAPI subgroups completed the survey. A few Asian subgroups translated the English questionnaires into their native language to enable their community members to better understand and give appropriate responses to the questions. Community leaders were engaged to distribute and collect completed questionnaires from survey participants of their respective communities, while maximizing variability in participants' experiences and making sure that the participants reflect grassroots populations' experiences and needs. Survey participants were given \$25 gift card for completing the survey questionnaire. Reverse translations into English for open-ended responses were done to assimilate all the collected information from the Asian subgroups. Data from the 200 questionnaires were entered and analyzed in Excel.

Figure 1: The 8 participating Asian Ethnic Sub-groups.



SURVEY RESULTS

From the qualitative and quantitative data analyses, we concluded that the health issues and downstream health impacts are different for each of the 8 Asian ethnic subgroups, despite the existence of common challenges that all Asian groups need to face, the available resources and coping mechanisms are also varied among ethnic groups that calls for a population-specific and outcome-based approach to optimize the relevance for positive health impacts for the respective Asian ethnic subgroups.

SOCIO-DEMOGRAPHICS

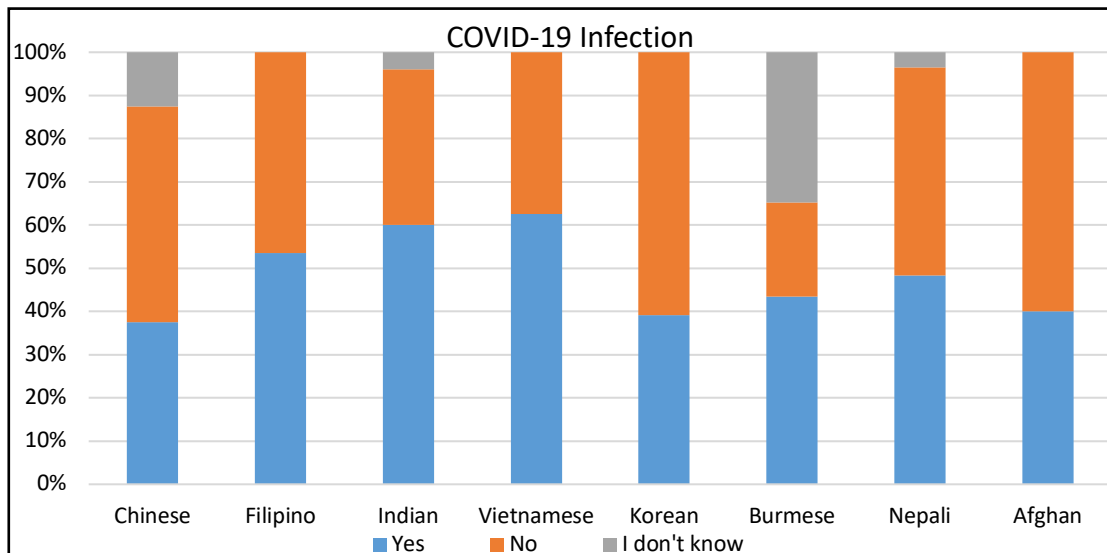
- Education
 - All Filipino Americans have a degree higher than high school.

- Indian Americans had the highest percentage of a bachelor’s degree and above.
- Burmese Americans had the lowest level of education, followed by Nepali-Bhutanese American and Afghan American.
- Socio-Economic Status
 - Filipino American participants have the highest percentage who live comfortable with more than enough to make ends meet, followed by Indian American and Korean American.
 - Burmese American participants have the highest percentage who cannot make ends meet, followed by Nepali-Bhutanese American.
 - None of the Nepali-Bhutanese or Vietnamese participants claim to have more than enough to make ends meet.
- Further details on this data will be presented in the “Technical Notes” below.

COVID-19 INFECTION and VACCINE HESITANCY:

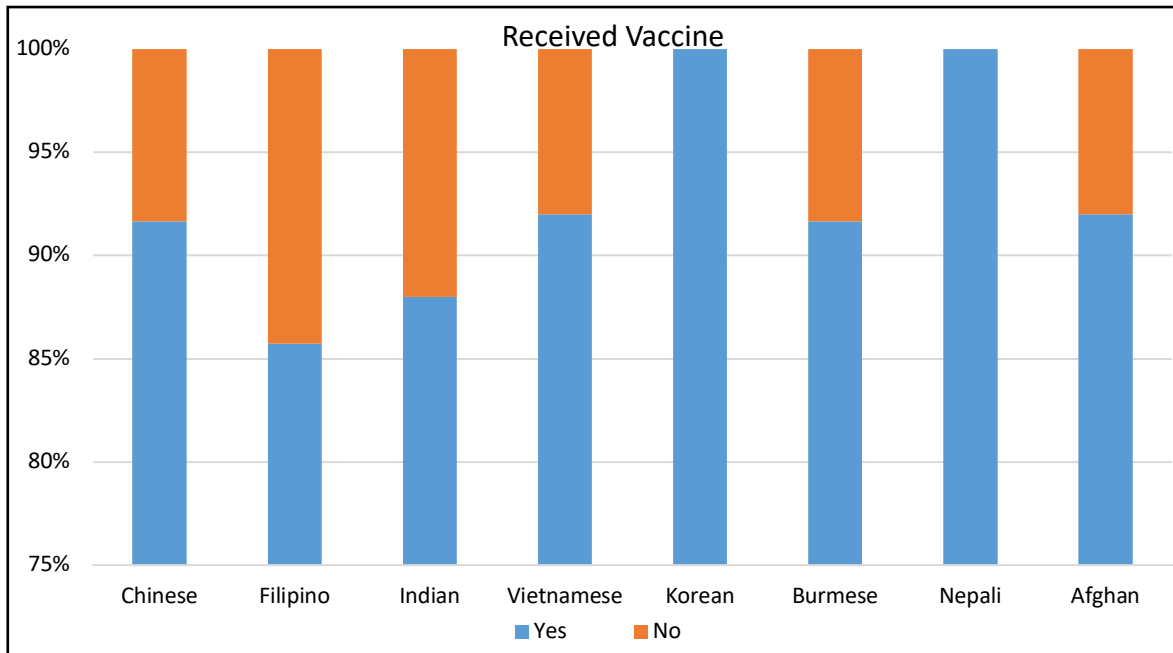
- Almost half (48.2%) of the participants had history of COVID-19 infection. About 40% in each group tested positive, but the Vietnamese American and Indian American had the highest rate (> 60%) of COVID-19 infections.

Figure 2: Distribution of COVID-19 infections as reported by survey participants.



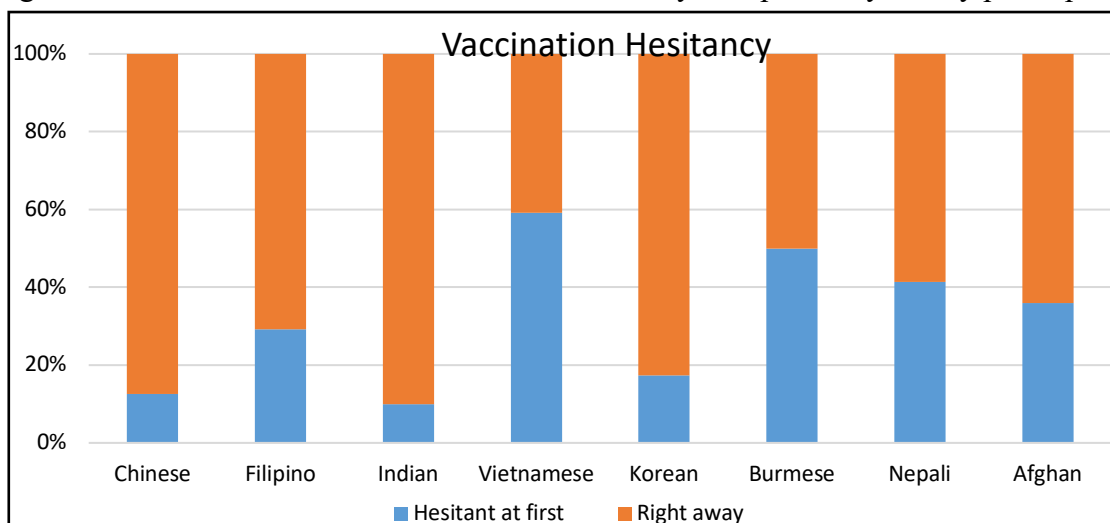
- Over 90% (92.6%) of the participants had received at least one dose of a COVID-19 vaccination. Filipino American and Indian American were the only two groups whose vaccination rate was below 90%, and all Korean American and Nepali-Bhutanese American received at least one dose of a COVID-19 vaccination.

Figure 3: Distribution of COVID-19 vaccine uptake as reported by survey participants.



- Almost one third (32.3%) of the participants reported being hesitant before getting the COVID-19 vaccine. There was hesitation in every group, including Korean American and Nepali-Bhutanese American, who all got vaccination eventually however, the Indian Americans had the lowest rate for vaccine hesitation. People who had not earned a college degree were slightly less likely to get vaccinated than those who had a college degree or higher level of education (93.4%). People who could not make ends meet had a higher vaccination rate (96.2%) than those who had enough to do so (90.7%) and those who were financially comfortable (92.3%). Nearly 70% of the participants clearly expressed confidence in the vaccines, although some of them expressed concerns about the vaccine, even if they had received the vaccine.

Figure 4: Distribution of COVID-19 vaccine hesitancy as reported by survey participants.



- The following images show the responses from different groups about COVID-19 vaccine safety perception and concern about getting COVID-19.

Figure 5: Distribution of survey participants' attitude towards safety of COVID-19 vaccine

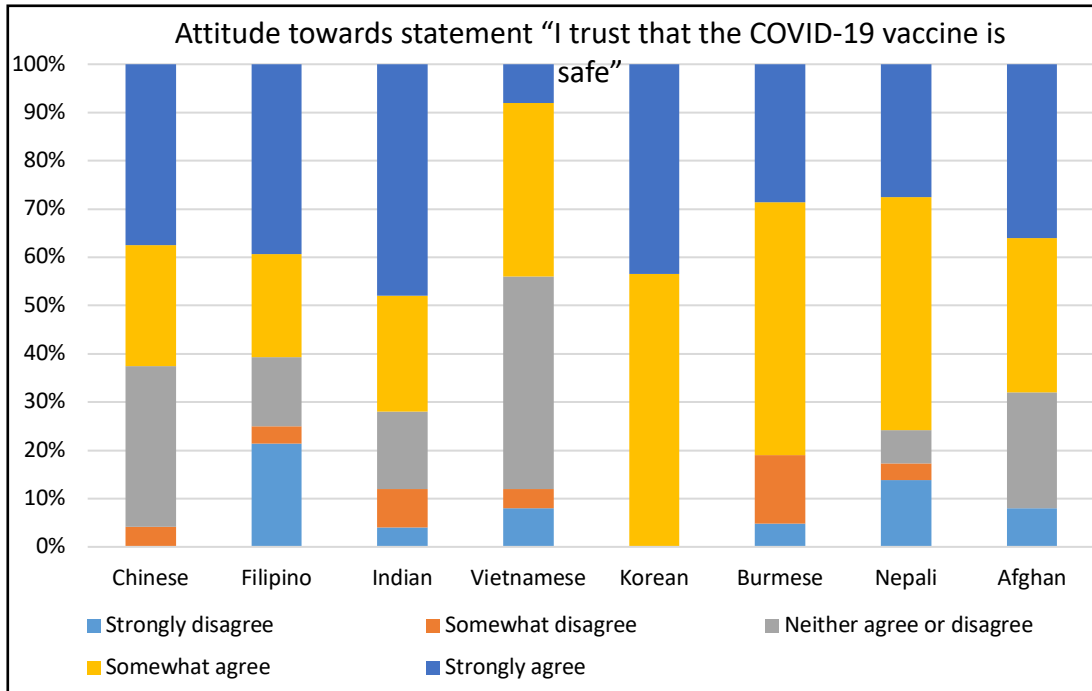
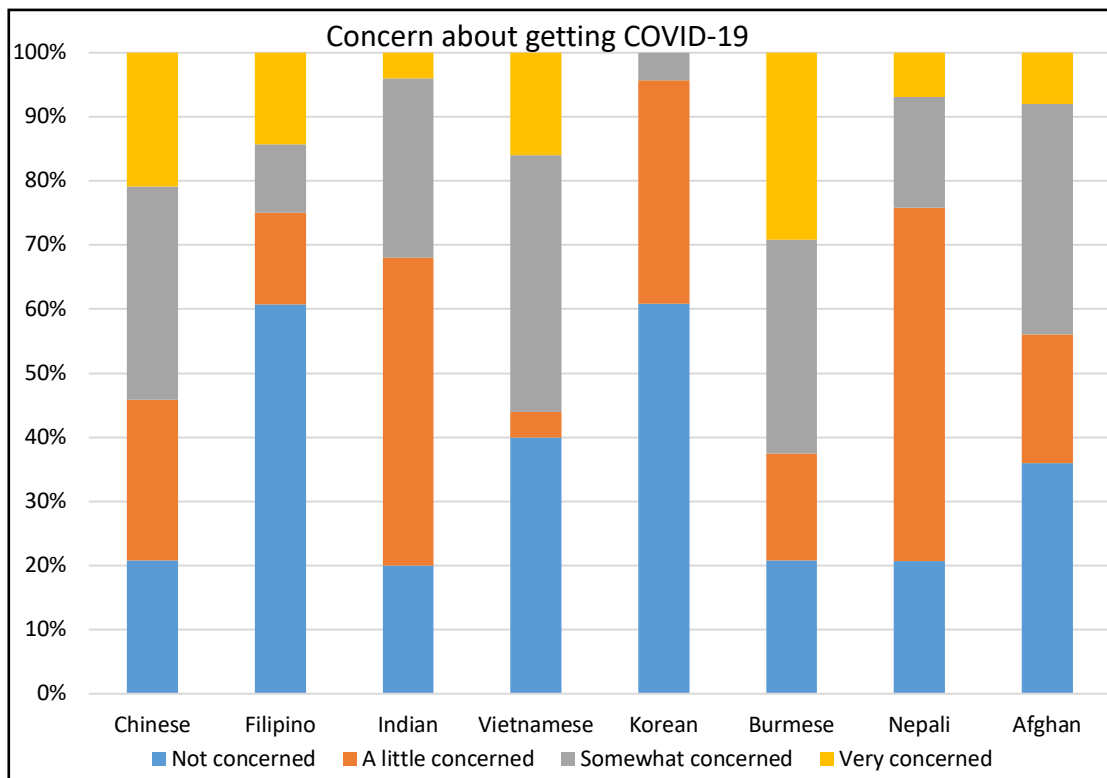


Figure 6: Distribution of survey participants' concerns about getting COVID-19 vaccine



- The biggest concern for participants who were not confident to get vaccinated was the side effects of the vaccine, and other reasons include trust in natural immunity (Filipino), religious reasons (Filipino) and the fear of injections (Nepali-Bhutanese).

Table 1: Reasons for not taking COVID-19 vaccine as reported by participants.

Ethnic Group	Highest Frequency Reason	Unique Reason
Afghan	Side Effect	
Burmese	Side Effect	
Chinese	Side Effect	
Filipino	Side Effect	Natural Immunity, Religious Reason
Indian	Side Effect	
Korean	Not Feeling Safe	
Nepali	Not Feeling Safe	
Vietnamese	Side Effect Not Feeling Safe	Afraid of Needle/Injection Political Reason

- The most common factors that motivated participants to get vaccinated were travel/work/health requirements. Other factors that might promote the rate of vaccination include more research and data (Filipino), death of family members and/or friends (Korean) and rewards, easier access, and encouragement from trusted people (Nepali-Bhutanese).

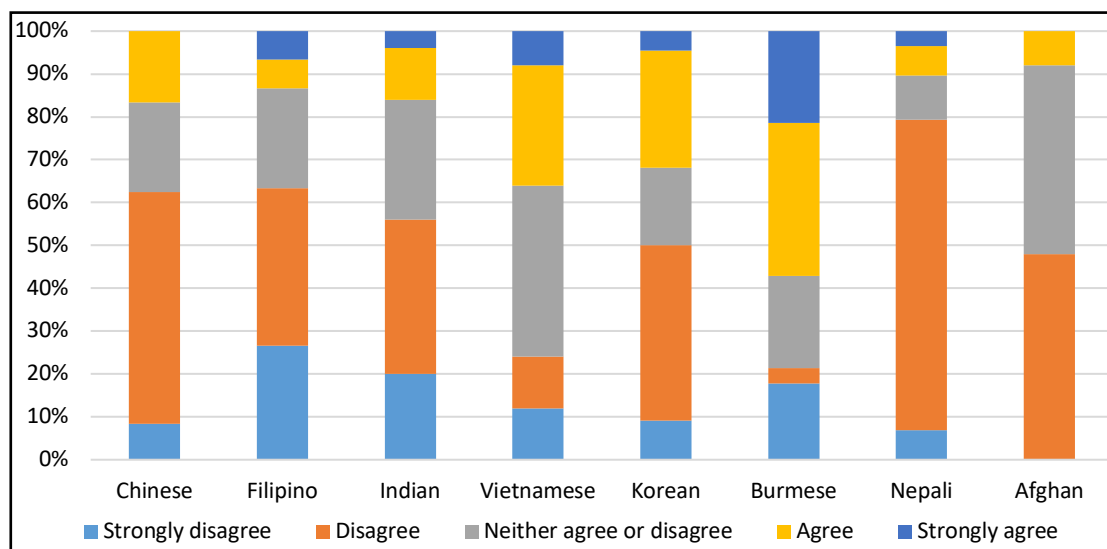
Table 2: Factors influencing the uptake of COVID-19 vaccine as reported by participants.

Ethnic Group	Highest Frequency Factor	Unique Factor
Afghan	Travel/Work/Health Requirement	
Burmese	Travel/Work/Health Requirement	
Chinese	Travel/Work/Health Requirement	
Filipino	Travel/Work/Health Requirement	Researches/Data
Indian	Travel/Work/Health Requirement	
Korean	Travel/Work/Health Requirement	Death of Family/Friend
Nepali	Travel/Work/Health Requirement	Cash/Prize Easier Access to Vaccine Encouraged by Trusted People
Vietnamese	Travel/Work/Health Requirement	

SOCIAL DETERMINANTS OF HEALTH: Health Care Access and Quality

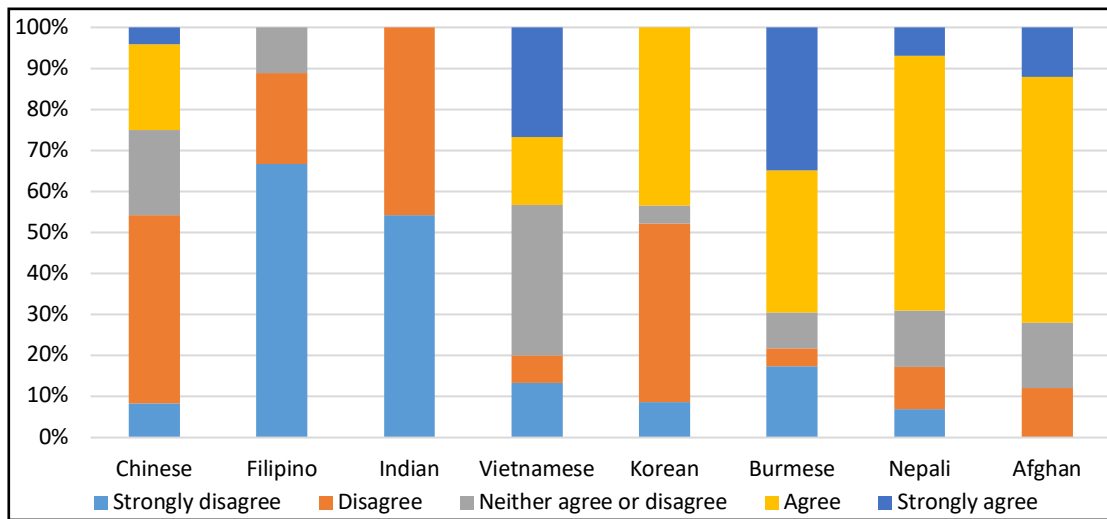
- Over one fifth (23.6%) of the participants struggled to use health care system. People who had not earned a college degree struggled more to use health care system (26.6%) than those who had a college degree or higher level of education (18.5%).
- The following image displays the responses from different groups when asked if they struggled to use health care system. All groups faced different levels of struggle, and Burmese American suffered the most whereas Nepali-Bhutanese American were the least affected.

Figure 7: Distribution of survey participants' response to "I struggle to use the healthcare system".



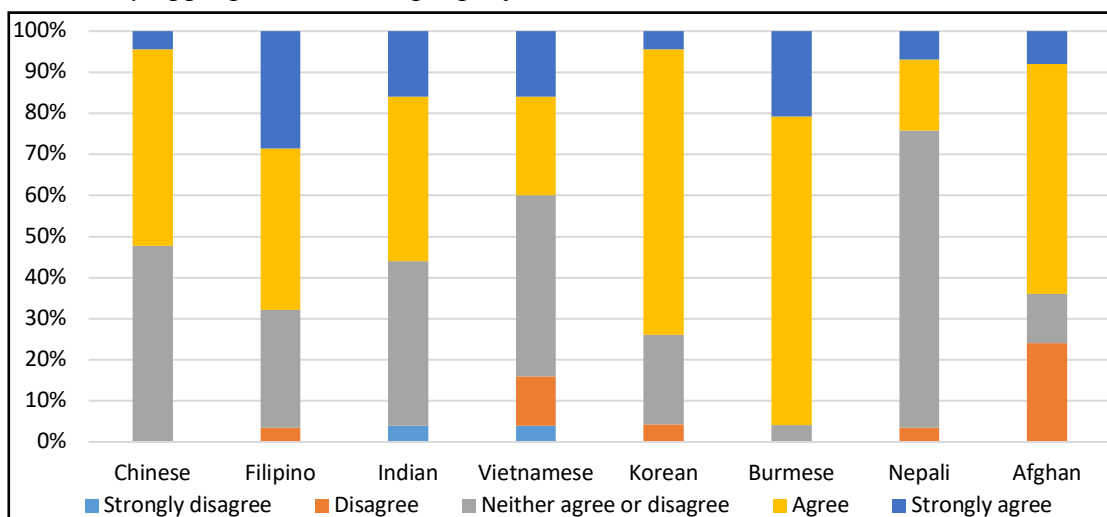
- Over two fifth (40.5%) of the participants struggled to communicate with health care provider in English. People who had not earned a college degree had a rate of struggled to communicate with health care provider in English (57.3%) almost 6 times higher than those who had a college degree or higher level of education (8.6%).
- The following image displays the responses from different groups when asked if they struggled to communicate with health care provider in English. Indian American and Filipino American struggled the least, while Nepali-Bhutanese American struggle the most, followed by Afghan American and Burmese American.

Figure 8: Distribution of survey participants’ response to “I struggle to communicate with my providers in English”.



- Less than 60% (58.4%) of the participants agreed that their healthcare providers provide culturally appropriate care to people from diverse cultures.
- The following image displays the responses from different groups when asked if their healthcare providers provide culturally appropriate care to people from diverse cultures. Nepali-Bhutanese American reported the lowest rate of satisfaction, followed by Vietnamese American. And Afghan American had the highest rate of unsatisfactory, followed by Vietnamese American.

Figure 9: Distribution of survey participants’ response to “My healthcare providers provide culturally appropriate care to people from diverse cultures”.

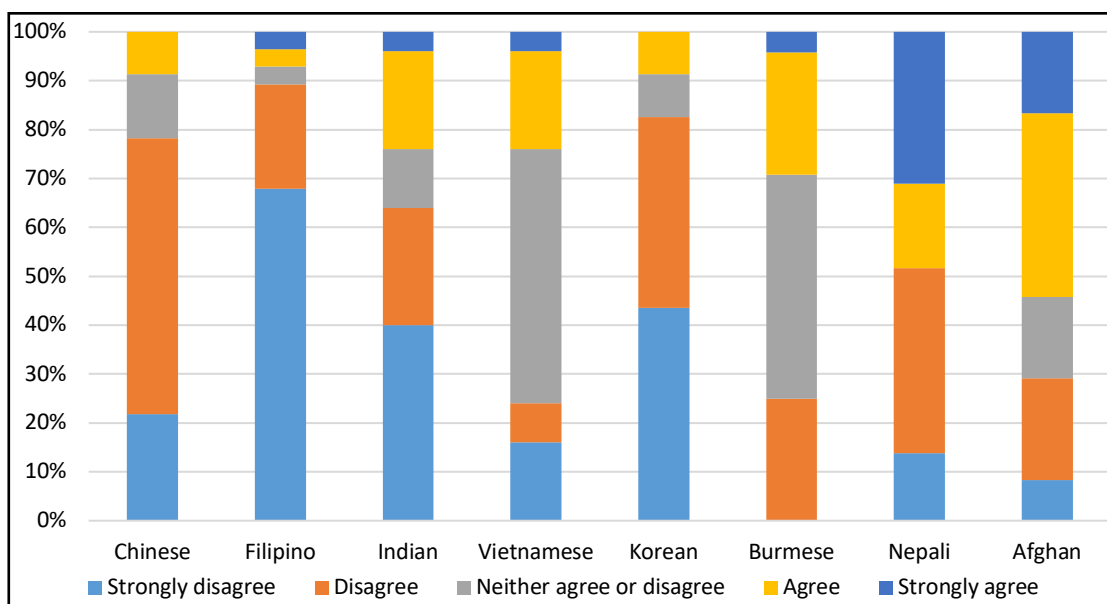


- Over one fourth (25.1%) of the participants reported that lack of transportation has kept them from medical appointments, meetings, work, or from getting things they need for daily living in the past 12 months. People who can not make their ends meet had a higher

rate to experience transportation barriers (40.4%) than those who have enough to do so (25.2%) and those who are comfortable financially (9%).

- The following image displays the responses from different groups when asked if lack of transportation has kept them from medical appointments, meetings, work, or from getting things they need for daily living in the past 12 months. All groups faced different levels of transportation barrier, whereas Afghan American and Nepali-Bhutanese American struggled the most.

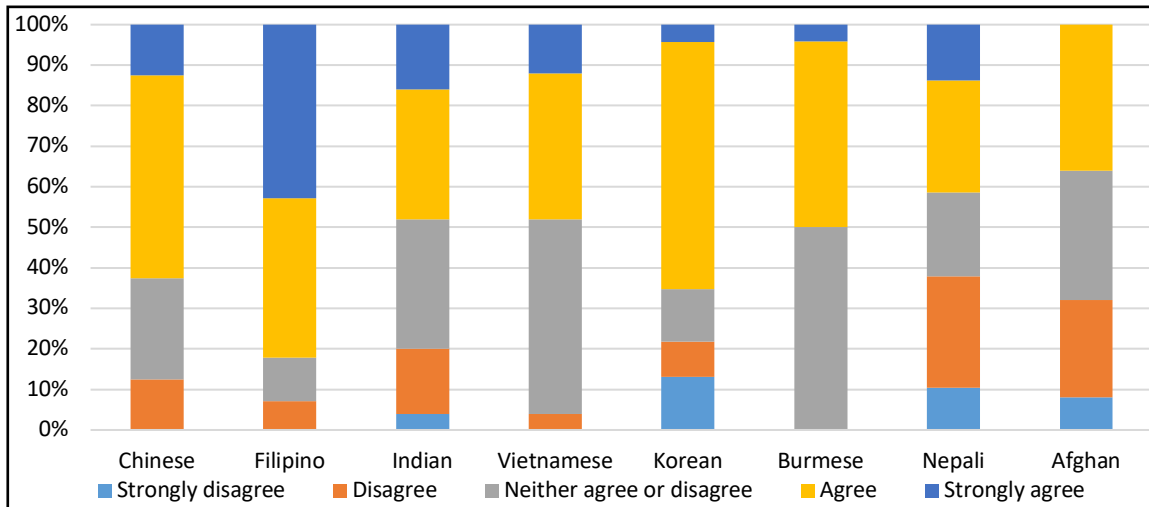
Figure 10: Distribution of survey participants’ response to “In the past 12 months, lack of transportation has kept me from medical appointments, meetings, work, or from getting things I need for daily living”.



SOCIAL DETERMINANTS OF HEALTH: Economic Stability

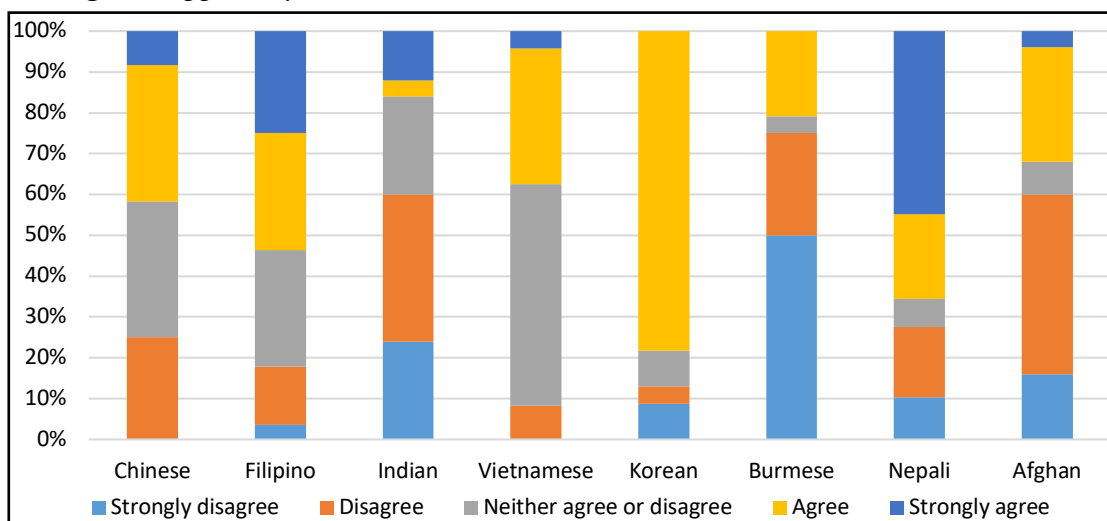
- Over half (54.2%) of the participants were confident in their ability to manage financial situation, handle a major unexpected expense, and support their hobbies / interests. People who had not earned a college degree were less confident about their ability of financial management (42.7%) than those who had a college degree or higher level of education (69.1%).
- The following image displays the responses from different groups when asked if they were confident about their ability of financial management. Nepali- Bhutanese American had the least confidence, followed by Afghan American.

Figure 11: Distribution of survey participants’ response to “I am confident in my ability to manage my financial situation, handle a major unexpected expense, and support my hobbies/interests”.



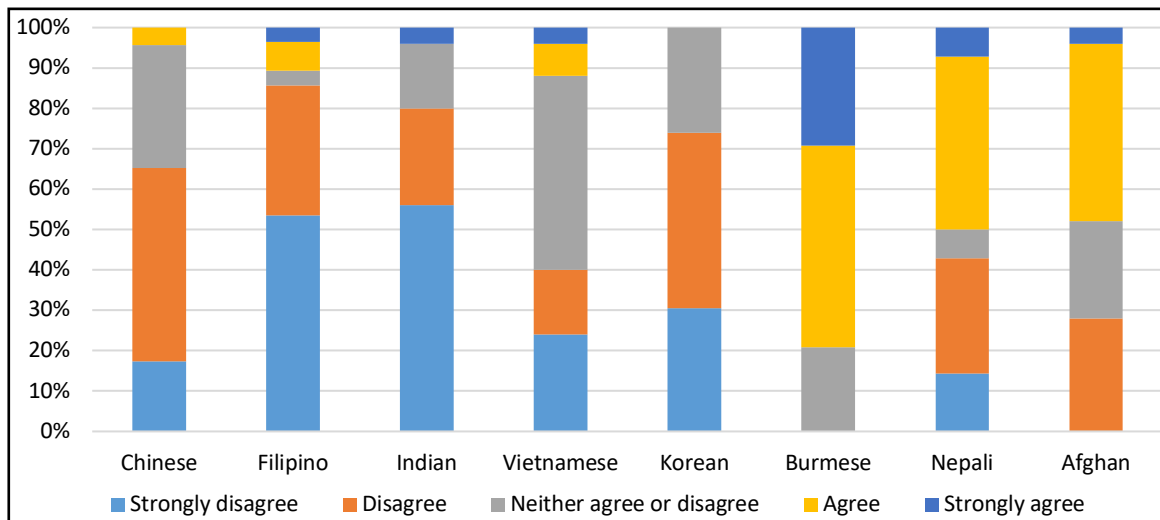
- Less than half (43.6%) of the participants agreed that their current financial status is enough to support their retirement. People who had not earned a college degree were less confident that their current financial status is enough to support my retirement (39.5%) than those who had a college degree or higher level of education (49.4%).
- The following image displays the responses from different groups when asked if their current financial status is enough to support their retirement. All groups worried about not having enough for retirement at different level. Burmese American worried the most, followed by Afghan American. And Korean American had the least concern, followed by Nepali-Bhutanese American and Filipino American.

Figure 12: Distribution of survey participants’ response to “My current financial status is enough to support my retirement”.



- Over one fourth (26.4%) of the participants worried that food would run out before they could buy more within the past 12 months. People who had not earned a college degree had a higher rate worrying about their food supply (40.3%) than those who had a college degree or higher level of education (7.4%).
- The following image displays the responses from different groups when asked if they worried about food supply. Burmese American had the highest rate of worrying about food, followed by Nepali-Bhutanese American and Afghan American.

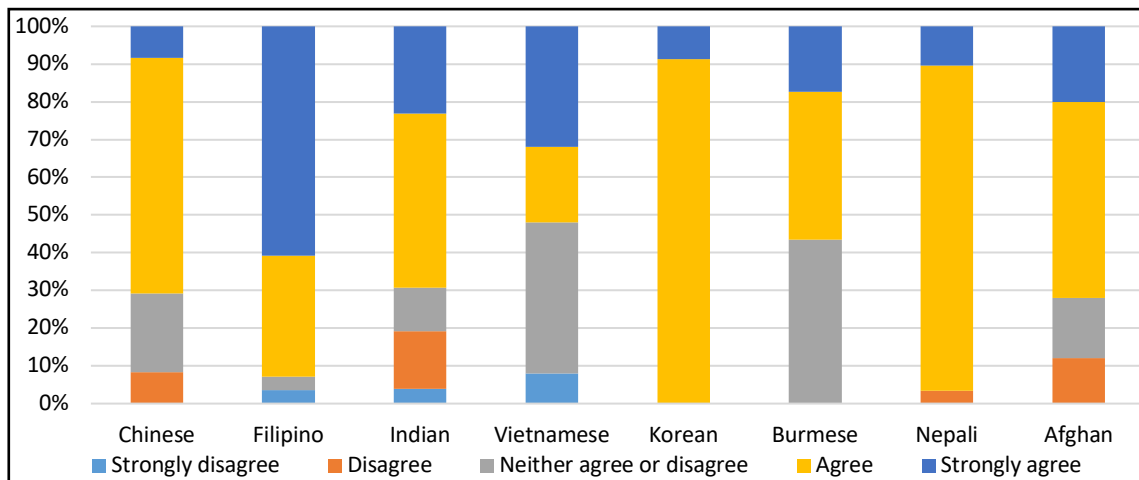
Figure 13: Distribution of survey participants’ response to “*Within the past 12 months, I worried that food would run out before I could more*”.



SOCIAL DETERMINANT OF HEALTH: Neighborhood Safety

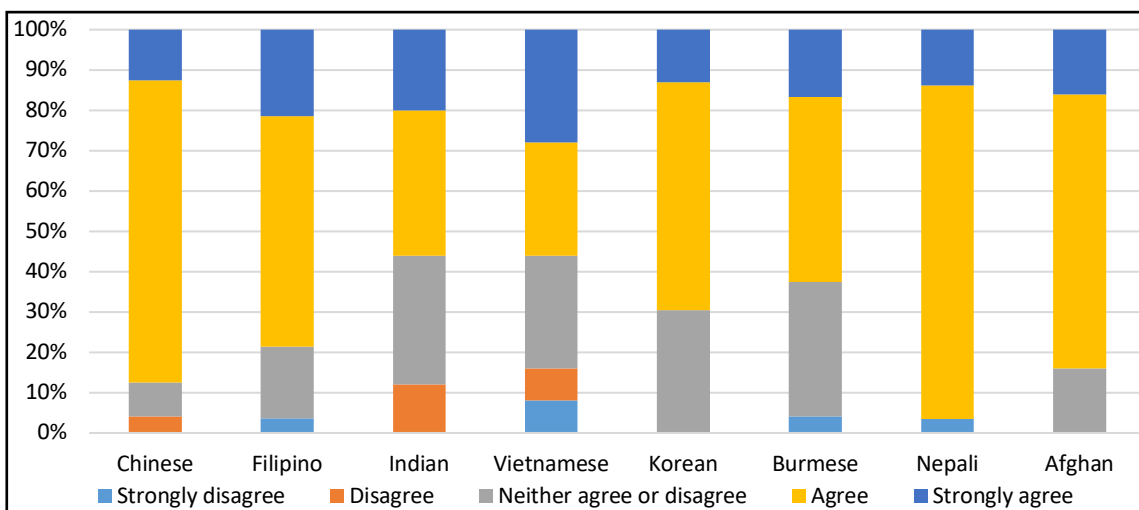
- Three-quarters (76.8%) of the participants reported feeling safe in their neighborhood, whereas 7% of them stated explicitly that they did not feel safe in their neighborhood. People who had not earned a college degree had a slightly lower rate of feeling safe in their neighborhood (75%) than those who had a college degree or higher level of education (79%). People who cannot make their ends meet had a lower rate to feeling safe in their neighborhood (70.4%) than those who have enough to do so (73.8%) and those who live in a comfortable life (88.6%).
- The following image displays the responses from different groups when asked if they feel safe in their neighborhood. Korean American were satisfied with neighborhood safety, when Indian American had the highest rate of worrying about neighborhood safety, followed by Afghan American and Chinese American.

Figure 14: Distribution of survey participants’ response to “ I feel safe in the neighborhood I live in”.



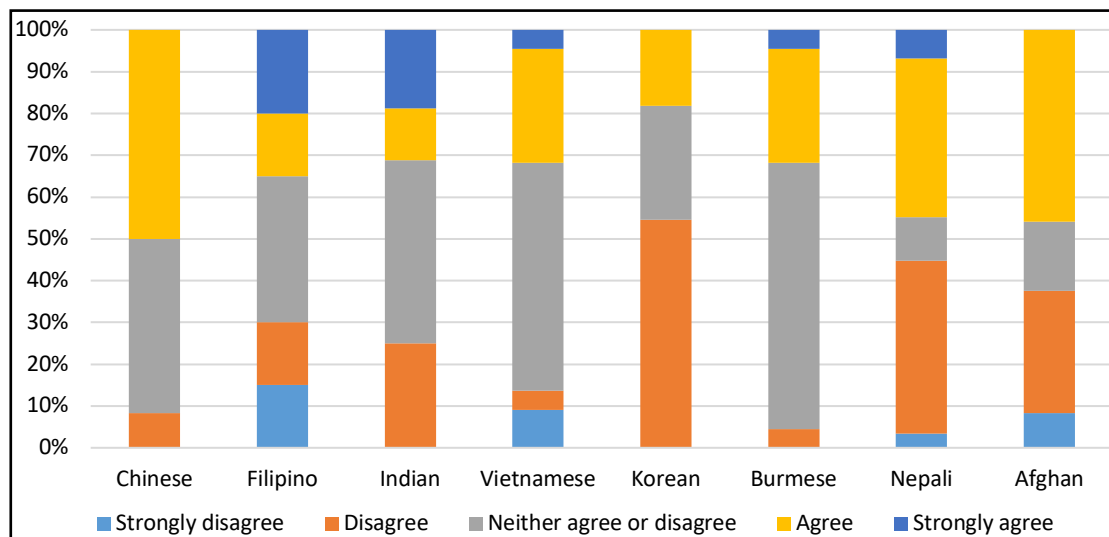
- 74.4% of the participants trusted that law enforcement will keep them safe, whereas 5.4% of them stated explicitly that they did not trust law enforcement. People who had not earned a college degree had a higher rate of trusting that law enforcement will keep them safe (73.4%) than those who had a college degree or higher level of education (66.7%). People who cannot make their ends meet had a higher rate of trusting that law enforcement will keep them safe (74.5%) than those who have enough to do so (71%) and those who live in a comfortable life (72.7%).
- The following image displays the responses from different groups when asked if they trusted that law enforcement will keep them safe. Vietnamese American and Indian American had less trust in law enforcement.

Figure 15: Distribution of survey participants’ response to “ I trust that law enforcement will keep me safe”.



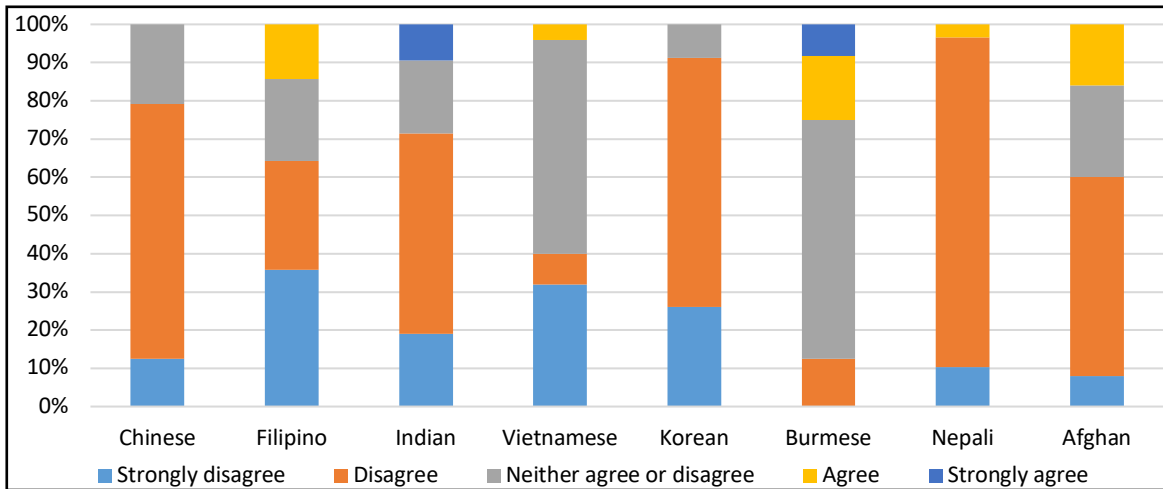
- More than one third (37.2%) of the participants feared for their safety on public transportation, whereas 27.6% of them stated explicitly that they did not feel so. People who had not earned a college degree had a rate of fearing for their safety on public transportation (33%) twice as high as those who had a college degree or higher level of education (18.5%). People who cannot make their ends meet (29.4%) and those who have enough to do so (30.8%) had a higher rate to fear for their safety on public transportation than those who live in a comfortable life (11.4%).
- The following image displays the responses from different groups when asked if they feared for their safety on public transportation. All groups feared for their safety on public transportation at different level. Chinese, Nepali-Bhutanese and Afghan American has a higher rate for over 40%.

Figure 16: Distribution of survey participants’ response to “I fear for my safety on public transportation”.



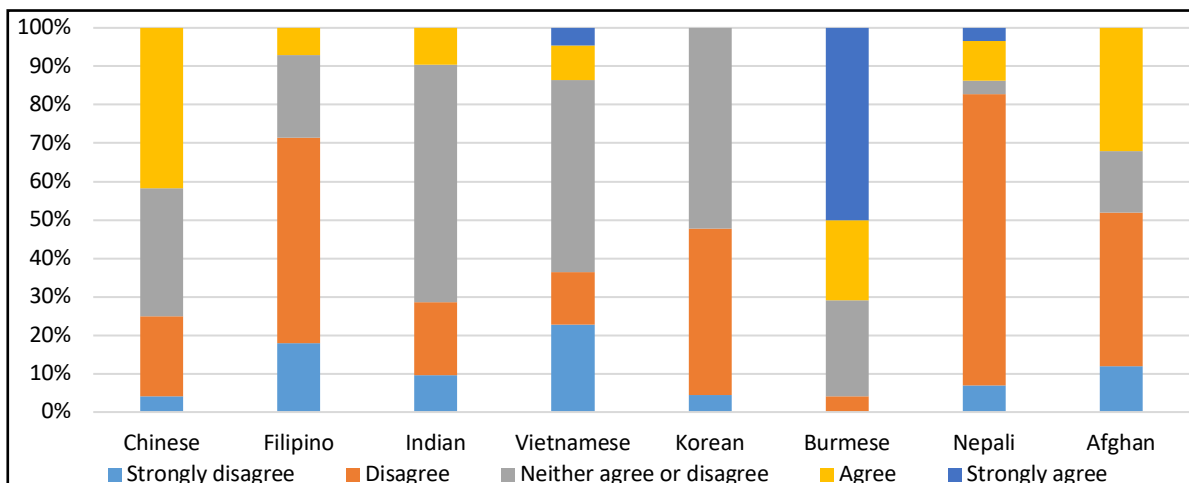
- Nearly one out of ten (9%) of the participants agreed that hate crimes have occurred in their neighborhood, whereas 64.8% of them of them stated explicitly that they did not feel the same way. People who had not earned a college degree had a slightly higher rate of claiming that hate crimes have occurred in their neighborhood (9.7%) than those who had a college degree or higher level of education (7.4%). People who cannot make their ends meet (7.7%) and those who have enough to do so (11.2%) had a higher rate to agree that hate crimes have occurred in their neighborhood than those who live in a comfortable life (4.5%).
- The following image displays the responses from different groups when asked if they agreed that hate crimes have occurred in their neighborhood. Burmese American had the highest rate of agreement, followed by Afghan and Filipino.

Figure 17: Distribution of survey participants’ response to “Hate crimes have occurred in my neighborhood”.



- Over one fifth (23.5%) of the participants felt discriminated against due to their racial or ethnic identity, whereas only less than half (45.4%) of them of them stated explicitly that they did not feel discriminated against due to their racial or ethnic identity. People who had not earned a college degree had a rate of feeling discriminated against due to their racial or ethnic identity (32.3%) almost 5 times higher than those who had a college degree or higher level of education (6.5%). People who could not make their ends meet had a higher rate to felt discriminated against due to their racial or ethnic identity (30.8%) than those who have enough to do so (22.4%) and those who live in a comfortable life (13.6%).
- The following image displays the responses from different groups when asked if they felt discriminated against due to their racial or ethnic identity. Burmese, Chinese and Afghan American reported more discrimination than other groups.

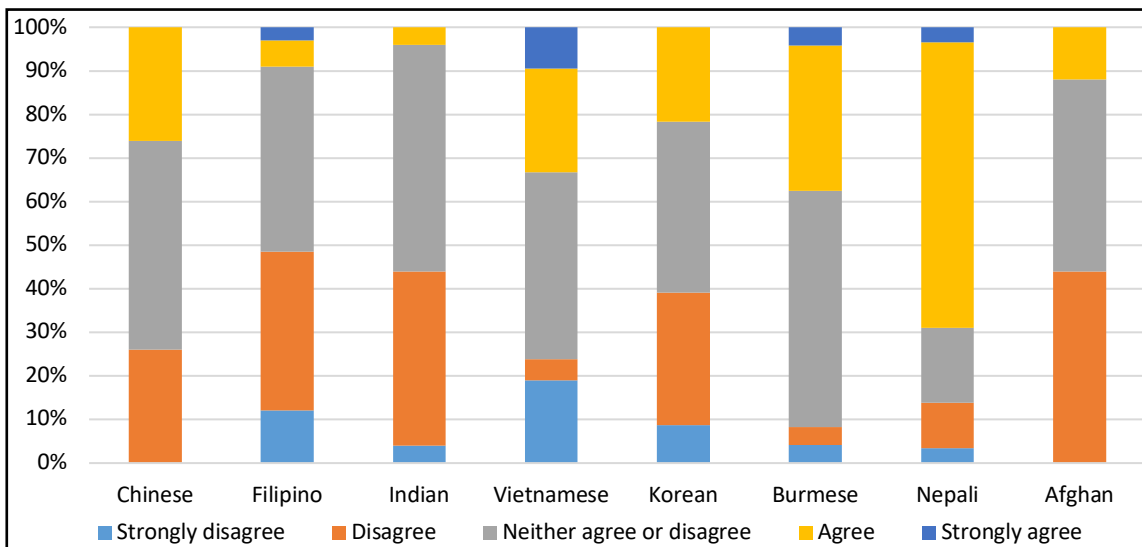
Figure 18: Distribution of survey participants’ response to “I feel discriminated against due to my racial or ethnic identity”.



SOCIAL DETERMINANTS OF HEALTH: Social Network

- Over one fourth (26.6%) of the participants reported struggling to get their opinion acknowledged when discussing AAPI discrimination. People who had not earned a college degree had a rate of struggling to get their opinion acknowledged when discussing AAPI discrimination (37.1%) more than 3 times higher than those who had a college degree or higher level of education (9.9%). People who can not make their ends meet had a higher rate of struggling to get their opinion acknowledged when discussing AAPI discrimination (50%) than those who have enough to do so (21.5%) and those who live in a comfortable life (13.6%).
- The following images displays the responses from different groups when asked if they struggled to get their opinion acknowledged when discussing AAPI discrimination. All groups struggled at different level, whereas Nepali- Bhutanese American stands out with nearly 70% of them felt struggle. Over 30% of Burmese and Vietnamese American and over 25% of Chinese American reported to feel struggle.

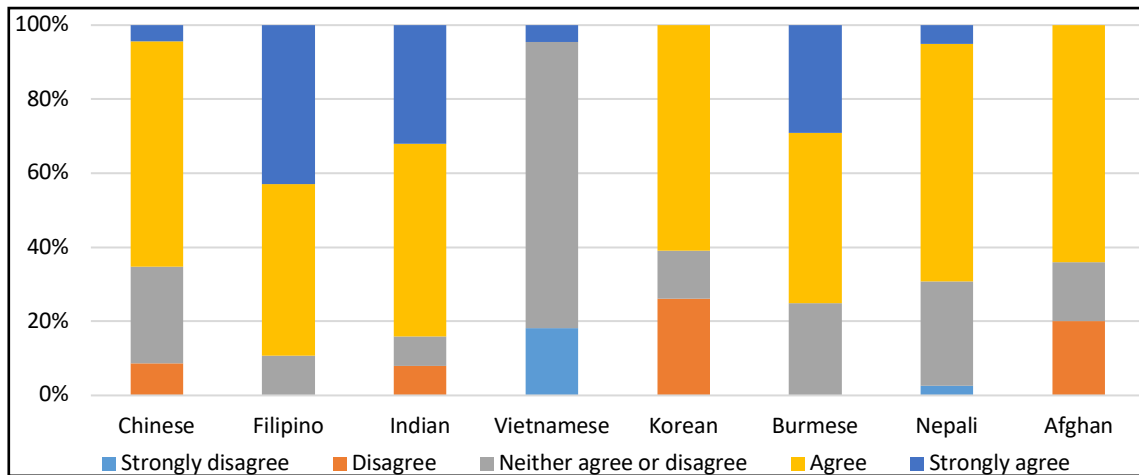
Figure 19: Distribution of survey participants’ response to “I struggle to get my opinion acknowledged when discussing AAPI discrimination”.



- Nearly 10% (9.6%) of the participants reported not receiving support and maintained friendships outside of their ethnic/racial community. People who had not earned a college degree had a slightly lower rate of receiving support and maintained friendships outside of their ethnic/racial community (63.7%) than those who had a college degree or higher level of education (74.1%). People who cannot make their ends meet (65.4%) and those who have just enough to do so (64.5%) had a lower rate of receiving support and maintained friendships outside of their ethnic/racial community than those who live in a comfortable life (75%).

- The following image displays the responses from different groups when asked if they received support and maintained friendships outside of their ethnic/racial community. All groups but Burmese and Filipino reported not receiving support.

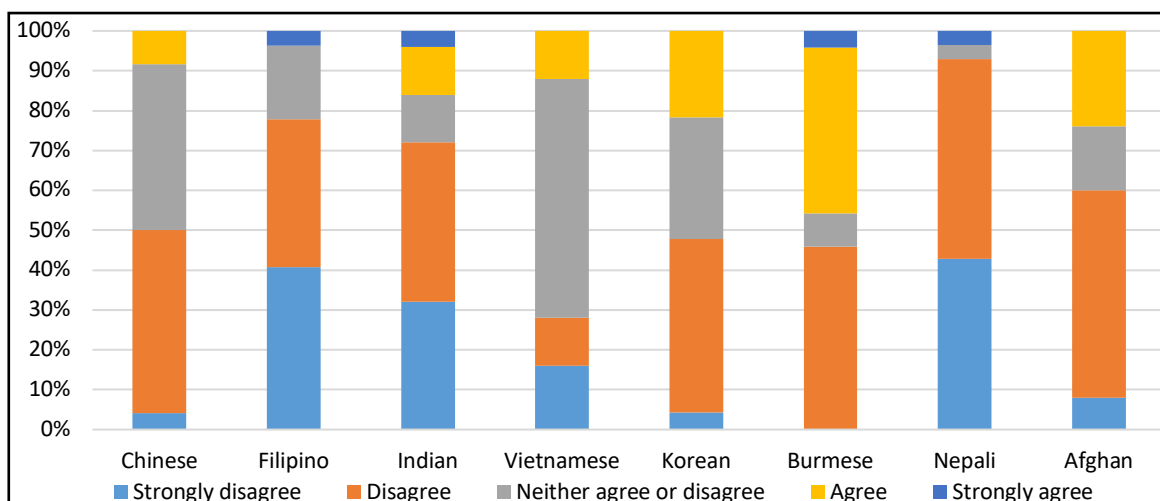
Figure 20: Distribution of survey participants’ response to “I have received support and maintained friendships outside my ethnic-racial community”.



- Over one seventh (16.4%) of the participants reported not having a supportive social network. People who had not earned a college degree had a rate reporting of not having a supportive social network (20.2%) twice as high as those who had a college degree or higher level of education (8.6%). People who cannot make their ends meet (19.2%) and those who have enough to do so (18.7%) had a rate of not having a supportive social network more than twice higher than those who live in a comfortable life (9.1%).

- The following image displays responses from different groups when asked if they agree with not having a supportive social network. All groups lack supportive social network at different level, whereas Burmese, Afghan and Korean American stood out.

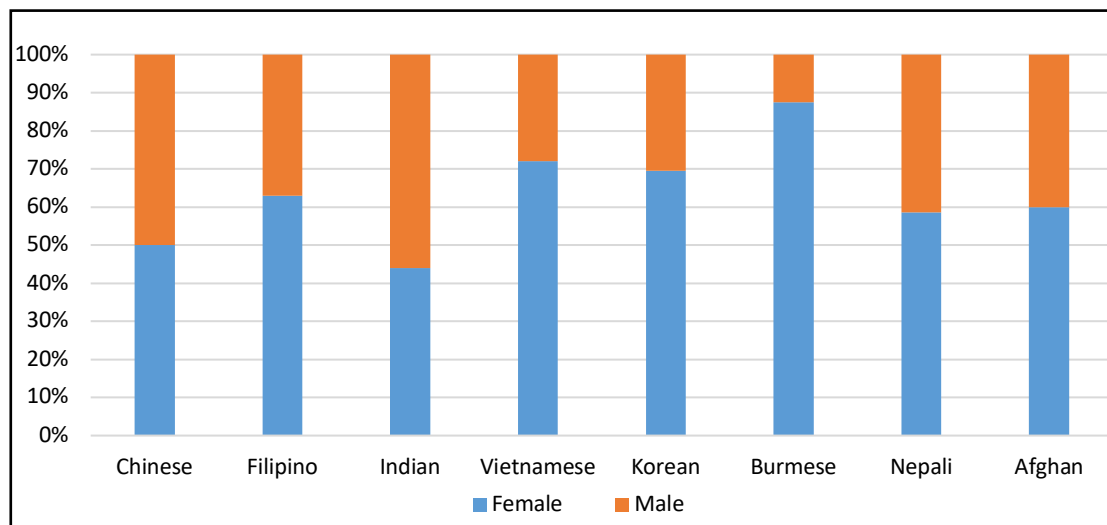
Figure 21: Distribution of survey participants’ response to “I do not have a supportive social network”.



TECHNICAL NOTES:

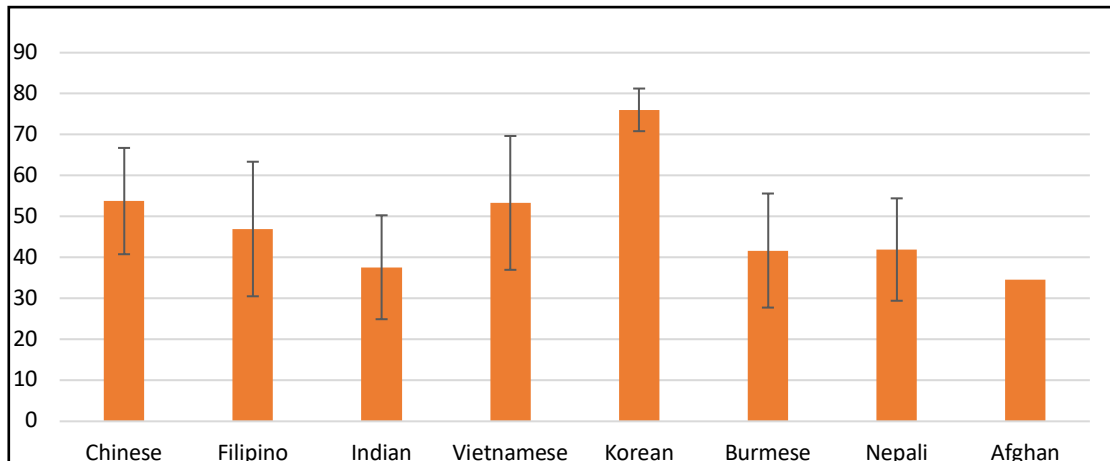
- The survey was conducted among people from communities in Cuyahoga County who self-identified as Asian American, and volunteered to participate in. 200 people originally from Afghanistan, China, India, Korea, Myanmar-Burma, Nepal-Bhutan, Philippines, and Vietnam participated in the survey, 25 people from each ethical group.
- The survey was conducted in English (for Filipino Americans and Indian Americans), Korean, KaRen, Mandarin, Nepali, Pashto, and Vietnamese, given the different levels of English of the participants. The translations and interpretation of open-ended questions in the survey was conducted with the help of Asian Services of Action, Inc. (ASIA) and community leaders.
- The paper copies of the survey were delivered to the participants and were collected by the corresponding community leaders after finished. A total of 200 valid questionnaires were collected.
- Characteristics of survey participants:
 - Gender: ■ Female: 62.9% ■ Male: 37.1%

Figure 22: Sex distribution of survey participants.



- Age:
 - 18-25: 7%
 - 26-45: 37.7%
 - 46-64: 31.7%
 - 65+: 23.6%

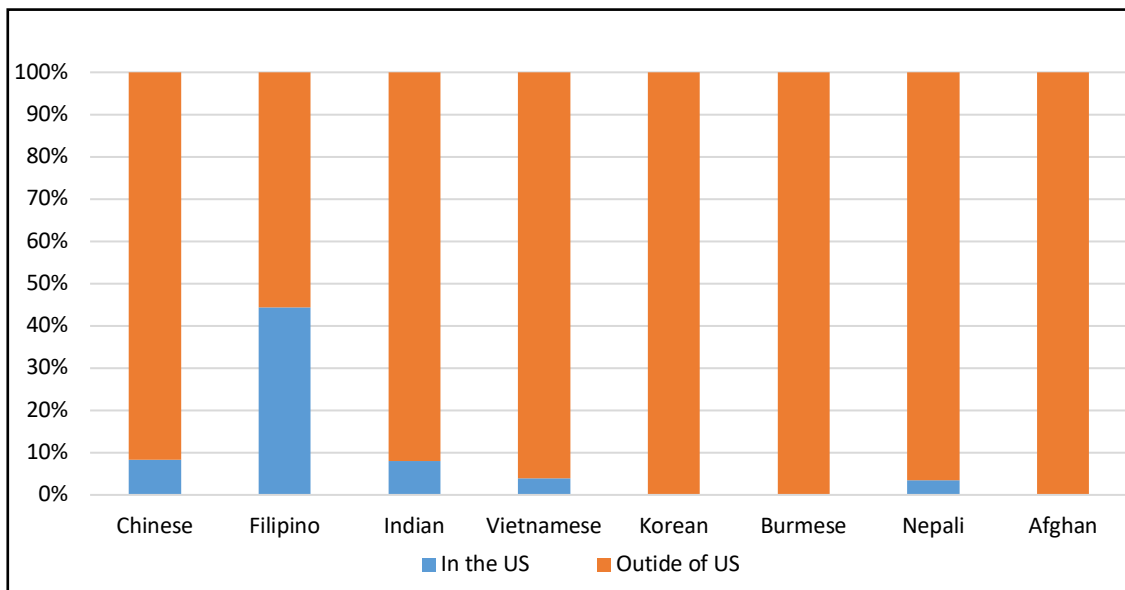
Figure 23: Mean age distribution of survey participants.



○ Place of birth:

- In the United States: 9%
- Outside the United States: 91%

Figure 24: Distribution of survey participants' place of birth.

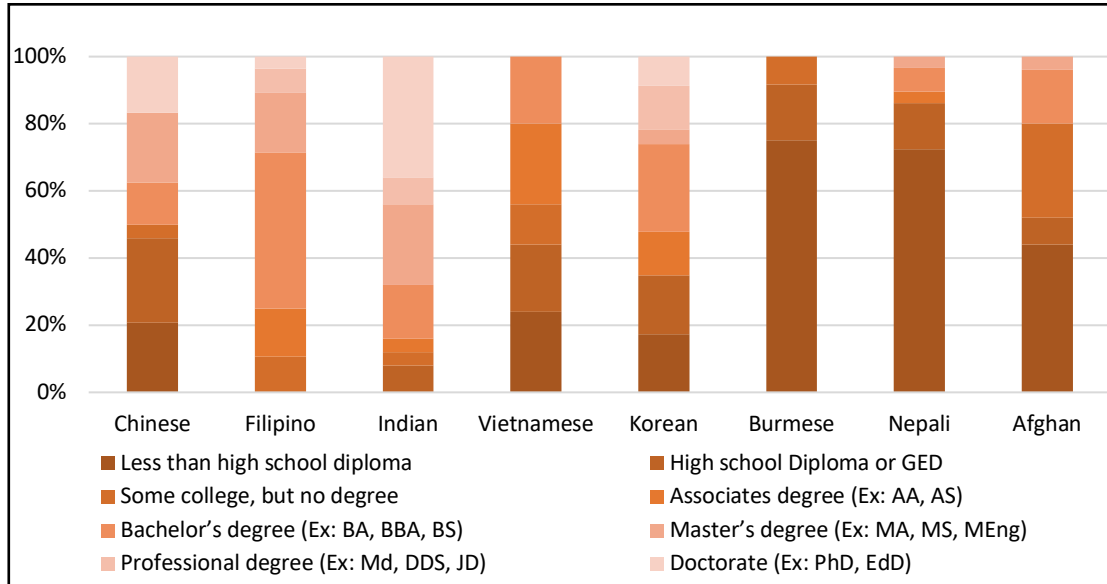


○ Education:

- Individuals who had less than high school diploma: 32%
- Individuals who had earned a high school diploma or GED: 13.3%
- Individuals who had attended college but nor earned a degree: 8.4%
- Individuals who had earned a associate degree: 7.4%
- Individuals who had earned a bachelor's degree: 18.2%
- Individuals who had earned a master's degree: 9.4%

- Individuals who had earned a professional’s degree: 3.4%
- Individuals who had earned a doctorate degree: 7.9%

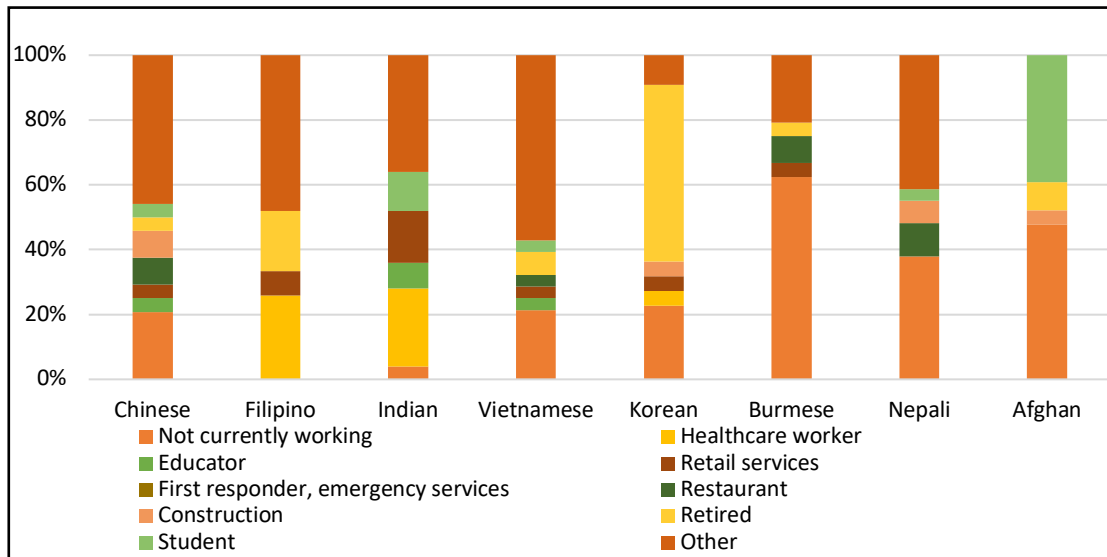
Figure 25: Distribution of survey participants’ educational attainment.



○ Employment:

- Not currently working: 26.7%
- Healthcare worker: 6.9%
- Educator: 2%
- Retail services: 5%
- First responder or emergency services: 0%
- Restaurant: 4%
- Construction: 3%
- Student: 7.4%
- Retired: 11.4%
- Others: 33.6%

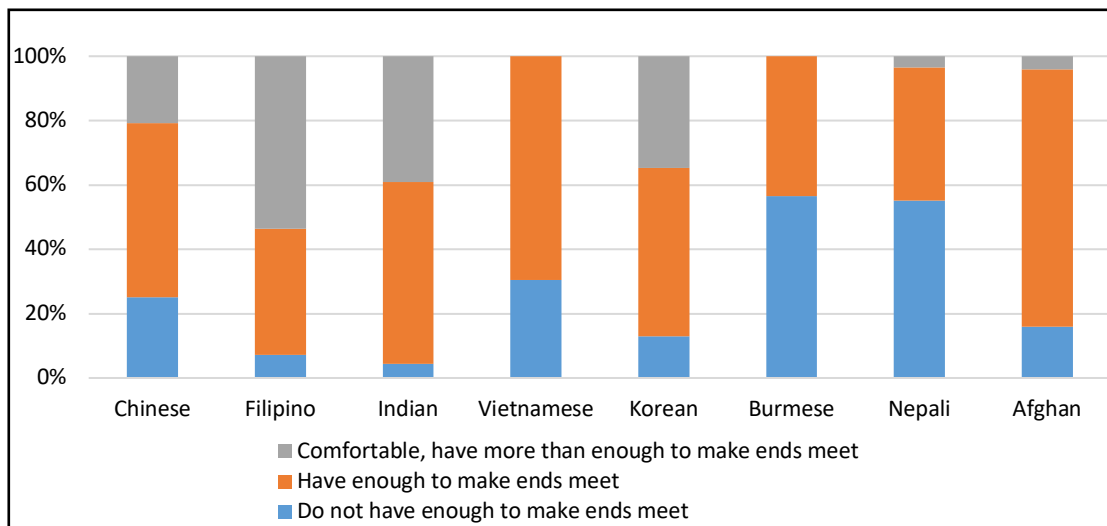
Figure 26: Distribution of survey participants' employment status.



○ Economic status:

- Do not have enough to make ends meet: 26.3%
- Have enough to make ends meet: 54%
- Have more than enough to make ends meet: 19.7%

Figure 27: Distribution of survey participants' economic status.



FOCUS GROUP DISCUSSION

The Focus Group discussions were centered around three topics: (1) COVID-19 pandemic and vaccine experiences, (2) healthcare needs and access, (3) lessons learned and recommendations. Leaders of the 8 identified AAPI communities, arranged their own groups to engage in a discussion with 10 participants. Community leaders were presented with an interview guide consisting of open-ended questions to guide the discussion. In cases where the interviews were conducted in their native language, we instructed our community leaders to translate the questions while using culturally and linguistically appropriate statements while making sure that they remain as close as possible to the original questions. During the discussion, participants were invited to share stories of real-life experiences about healthcare and social challenges during and after the COVID-19 pandemic. Participants were also asked to provide recommendations to address social and health needs within their communities. The Focus group participants were given \$25 gift card for their participation. Community leaders from the 8 Asian sub-groups collated the information gathered during their focus group discussions and submitted a summary report to project personnel.

FOCUS GROUP DISCUSSION METHODS

In order to gather information and recommendations for the development of an AAPI Health Coalition, the Focus group discussions primarily focused on the difficulties Asian Americans encountered in differentiating themselves from other races during the epidemic, as well as community building and self-help actions that were taken based on community assets. The questions and statements that guided the discussions were:

- 1) COVID-19 pandemic and vaccine experiences:
 - As an Asian American*, how has the COVID-19 pandemic affected you and your community?
 - Have you or anyone you know been directly impacted by COVID-19?
 - How did you feel about getting the COVID-19 vaccine when it became available to the public?
 - Has your perspective about the vaccine changed over time? If so, what made it change?
 - What barriers have you encountered in accessing and receiving the COVID-19 vaccine?
 - How have you addressed these barriers?
 - What challenges have you experienced when accessing and receiving healthcare services during the COVID-19 pandemic?
- 2) Healthcare needs and accessibility:

- Do you have any personal experiences, or have you heard of any experiences that have affected your trust in the health care system as an Asian American? If so, can you share with us some stories?
 - What community-led initiatives, mutual aid, or activism have helped to address health and social needs, and access services within your cultural community?
- 3) Lessons and recommendations:
- What lessons can be drawn from your experiences as an Asian American in improving healthcare access and equity in the context of pandemics and global health crises?
 - What recommendations do you have for healthcare providers, policymakers, and researchers to address the health and social needs and challenges faced by Asian Americans*?

FOCUS GROUP DISCUSSION RESULTS

In regard to COVID-19, AAPI communities face a number of shared challenges and issues in addition to having their own issues related to their distinctive cultural traits. The significant findings are examined in detail below using the 8 groups' varied experiences and their common issues and challenges being explored as a starting point.

COMMON ISSUES IDENTIFIED AMONG 8 ASIAN ETHNIC SUBGROUPS:

- Language Barrier: Difficulty communicating when visiting a doctor, needing an interpreter.
- Lack of AAPI Healthcare Practice Guidelines: Healthcare providers are not familiar with common diseases and needed diagnostics for Asian subgroups.
- Lack of PPE Resources: Lack of PPE information like purchase channels, subsidies.
- Delayed Diagnosis and Treatment: The shortage or even collapse of medical resources during COVID pandemic caused delays and untimely treatment.
- COVID-Testing Difficulties: Different locations/reagents/kits detect different results which caused stress and anxiety.
- Hard to Understand Health Benefits: The Healthcare system is not very friendly to inform Asians about health insurance, Medicare, Medicaid, medical expenses, etc.
- U.S. Entry and Exit Difficulties: Vaccines/Quarantine/Regional Requirements for Flights are some of the impediments encountered by Asian communities.

REPORTED ISSUES OF INDIVIDUAL ETHNIC GROUPS:

1) AFGHANISTAN: Mostly refugees

- Languages: Dari and Pashtu.
- Roughly 150 households residing in Cuyahoga and Summit counties. Divided based on specific tribes so, smaller and more fragmented.
- Gender roles: men are the only source of income, women have housewife duties, take care of children, and do not have any opportunity to work outside the home.
 - *Males are the only source of income for families. Females tend to stay home and engage in “housewife” duties, they designated primary caretaker of children so, may do not get the opportunity to work outside of the home.*
- Low-income: Educational degrees gained in Afghanistan are not valid in the U.S. The options that remain for them are to: Re-enter school or find blue-collared jobs: as truck drivers, factory workers, mechanics and free-lance delivery drivers (Uber, Door Dash, Ext)
 - *Most educational degrees gained in Afghanistan are not valid in the United States. There are many community members that have the Afghan equivalent of a bachelor’s degree but, these credentials are not viewed as valid so, many people are forced to either re-enter school or find blue-collared jobs. The community cannot enter American educational institutions because they lack the money and time required for school. For these reasons, most men in this community are truck drivers, factory workers, mechanics, and free-lance delivery drivers (Uber, Door Dash, etc.).*
- Social Isolation: Struggle due to the disconnect with mainstream resources. Few and inaccurate translations are the only available resource.
 - *There are major cultural and language barriers within this community, so they struggle to connect with mainstream sources of information, such as government institutions and news outlets. This became a big problem during the pandemic. Due to this lack of connection, members heavily relied on their community leaders for a sense of direction during the pandemic.*
- Resettling in the U.S.: For recent refugees, the 3-month period is not nearly enough time to properly resettle, learn English, and assimilate into the U.S. society.
- Health Care Needs: Linguistically appropriate resources, fluent, correct, and easy to understand information is lacking. Healthcare education for families is much needed.
 - *More information disclosure - "don't let us feel as if we are left in the dark."*
- Issues during COVID -19: They were unable to purchase necessary household items. The lack of social interaction took a toll on the community's mental health and these struggles are still ongoing.

2) BHUTANESE/NEPALI: BCGC Members

- Languages: Nepali
- 2008 was the year the Nepali speaking Bhutanese started resettling in the city of Cleveland. Initially settled in the Noble Road area, and on the west side of Cleveland areas nearby Lorain Avenue and Triskett Road. There are around 12,000 to 15,000 Bhutanese living in different parts in Cleveland.
- They have very limited healthcare knowledge.
- Most of them do not have knowledge about the services provided by medical professionals.
- Many of them were missing services due to lack information and transportation.
- They are unaware about the prevalence of racial discrimination and do not know where to report in case of a discrimination incident.
- They require specific sectors/community department to seek help when in need.
- Most of them have below average annual income according to their family sizes.

3) MYANMAR AND KAREN:

- Languages: Burmese and KaRen
- There are two Burmese communities in Cleveland. The KaRen, and the Chin. Around 40 families live in Lakewood and the northwest Cleveland area.
- Neighborhoods do not have gatherings as a community, so there are no existing community resources.
- KaRen has fewer medical terms in their language. Even translation is difficult. Translators may also cause confusion because they do not know the terminology and how to explain it in their language.
- Difficult to clarify negative information: People spread false rumors to block members from getting the vaccine.
 - “Some people said if we get the vaccine, we will also encounter other sicknesses.”*
- Some people trust the healthcare system because they see some nurses and doctors have to put their lives in danger to save their patients.
- Education: the lack of technology support resulted in children's campus education being hindered.

4) VIETNAMESE:

- Over 3000 Vietnamese American live in east side Cuyahoga County, Medina County, Summit County. There are a lot of first- and second-generation immigrants.

- Doubts about vaccine safety:
 - *“Because so many people die, but people are afraid that vaccination can cause death, but if not vaccinated, infected with the COVID-19 also will die.”*
 - *“The vaccine was what everyone was expecting at the time to save their lives and many others, but it also takes time to get feedback and see how reliable the results are.”*
 - *“Some are still hesitant to wait for time to monitor the effectiveness of the vaccine before injecting, others do not want to take covid vaccine.”*
- They trust providers on certain issues but they are guided by their own instincts. Also, they trust in the Lord for the outcomes that occur.
- The Personal Protective Equipment (PPE) shortage induced a lot of anxiety and worry.

5) ASIAN INDIAN: Highly Educated

- Languages: Multiple (22 recognized languages – Indian Constitution).
- According to the 2020 US Census, the Asian Indian population living in Cuyahoga County constitute 34% of all Asians (N=34,861) that approximates to about 11,853 persons, that originally came from the Indian sub-continent. A large proportion of this ethnic group live around University Circle; Shaker Heights and Cleveland Heights; Mayfield Heights; Richmond Heights; Solon; Twinsburg; Lakewood; and Westlake.
- There is great belief and confidence among the Indian diaspora on traditional practices.
 - *To quote a respondents’ health belief practice: “We were taking some home remedies like making tea with Cloves, Cinnamon, black seed oil, lemon juice and manuka honey to protect us from flu symptoms. Also, we were practicing inhalation with cloves in boiling water. When I talked about these methods with my doctor in the US, he said it is a dummy; but I told him that these are common everyday practices in India that helps our immune system and protects us from infections; but he would not believe it.”*
- U.S. Providers lack knowledge about diagnosis of common genetic diseases among South Asians.
 - *“When I go to a General Practitioner, they do not check me for diseases that are more prevalent among South Asian communities. Like they don’t check for thyroid and when I was pregnant, they did not check me for gestational diabetes. So, most doctors don’t have international experience or do not know about South Asian culture and prevalent illnesses among them.”*
- Need more streamlined health insurance and more affordable health care costs.
 - *“I think the insurance companies in the US are very complicated. In the beginning they say some treatment is covered, but later on you are left to pay*

50% of the bill, as it is not fully covered. Some of the doctors are not working with some insurance agencies and you would be forced to get the medical service in case of an emergency and pay out of pocket. These things have to be simplified and healthcare access and cost has to be more streamlined and made easy for common people.”

- *“People below the poverty line and the elderly get healthcare through Medicaid and Medicare. What about people who are just above the poverty line? They lack access to healthcare services. This gap in access to healthcare services need to be addressed. I got a ridiculous \$1,800 bill for a ‘covered’ sleep apnea test; the greedy mercenary healthcare system. The US government should put its money in overhauling the entire healthcare system.”*

6) CHINESE: Business Owner, Medical Staff

- Languages: Mandarin and Cantonese
- 26.1% of all Asians about 9100 population in Cuyahoga. Asia Town, which has a population of 2,800, with 40% of the residents identifying as Chinese American and first-generation immigrants, 1/4 residents have limited English proficiency.
- Businesses were shut down, with High handling fees for online orders during COVID.
 - *“I experienced a personal loss just before the pandemic hit - my mother passed away. I had planned to take her ashes back to our hometown in China, but travel restrictions prevented me from doing so. Simultaneously, my restaurant was forced to close, and although I tried to retain my employees for as long as possible, the situation became untenable. We had never felt the need for a website or social media presence before since we had loyal customers throughout the years. However, during the pandemic, delivery companies such as Door Dash and Uber Eats sent representatives who could speak Chinese and offered to help market our business online. Unfortunately, we were unaware that each take-out order would come with a 20-35% charge, significantly impacting our revenue.”*
- Changed communication patterns: Seniors and community members have adjusted by utilizing virtual communication platforms, like Zoom and WeChat.
- Xenophobia and discrimination
 - *“In the fall of 2020, we decided to take the kids out to a park for some fresh air. Unfortunately, we experienced a distressing incident when a white male yelled at us, demanding that we go back to China. Such acts of racism and xenophobia deeply saddened and angered us, as we were simply trying to enjoy a day out with our family. It is disheartening that during the Covid-19 crisis, the*

government and social media platforms played a significant role in fueling Asian hate. The manipulation of Covid-19 data and the transformation of a global health crisis into a political scandal have been among my greatest grievances with the government.”

7) KOREAN: Seniors

- About 3000-4000 Korean American in Northeast Ohio, Cuyahoga County, Medina County, Summit County. The most dominant populations were senior citizens.
- Suffering mental and physical health issues such as: depression, weight gain, loneliness, loss of family members and loss of jobs.
- Struggling to receive health care treatments, such as booking doctor appointments, and receiving limited medical treatments. Lacking trust in the health care system due to a lack of nurses but also the lack of medical staff to care for those that didn't have Covid-19. There were a lot of elderly people that weren't given the medical attention that was needed.
 - *“There was an elderly parent that had a severe condition, he was mistreated, abandoned and there was a language barrier between him and the medical staff, and he passed away. If he was given the proper treatment and allowed one family member to be by his side, he may have survived the pandemic.”*
- The demands of the seniors: need community support.
 - *“Many are experiencing a decline and we worry that professionals inexperienced with Korean culture will not be able to properly care for our seniors.”*
- Need more Professional Korean doctors and popularization of Korean medicine.
 - *“Some of the lessons that we've drawn involve voting and educating people on how to access the resources and help available.”*
 - *“Members that are in the healthcare system, they can be a representative and have a voice for what is needed for the people. Policy makers, healthcare providers and researchers should reach out to different communities if they would like to receive feedback and make a change to improve the concerns of Covid-19 or any global healthcare crisis. This is to help spread the word to/for communities.”*

8) PHILIPPINE: Nursing Staff

- About 3140, Surrounding suburbs, 9% of all Philippine that approximates to nurses and doctors, work in healthcare system.
- Job safety: Not willing to get vaccines based on cultural factors but had to, to keep jobs.

- *“I used exemption and accepted by the facility.”*
- Need house calls from Filipino providers.
- They trust providers on certain issues but also are guided by their own beliefs.
- Visitor Restrictions:
 - *“When child seen with health care provider, parents were not permitted to join them in the appointment which is not the norm.”*

A summary of the challenges and opportunities that were discussed and reported by the participants of the focus group are listed in Table 3.

Table 3: Challenges and opportunities reported by participants of the Focus Group

Challenges	Opportunities
<ul style="list-style-type: none"> □ Healthcare access and costs need to be more streamlined, simplified and made easy for the people, particularly, removing the paradox of health insurance companies. □ Need more streamlined insurance and more affordable health care costs. □ Should enlist and involve ethnic minorities in healthcare research and get it to the forefront. □ Healthcare system needs to recognize the diversity in its patient population and must include healthcare professionals with diverse ethnic backgrounds to mitigate the barriers (language, age, gender, culture, diet, genetic predisposition to disease, etc.) faced by ethnic minorities in the healthcare system. 	<ul style="list-style-type: none"> □ Healthcare Providers: The number of patients a doctor sees in a day can be reduced, reviewed and re-defined. Doctors need to spend more time listening to patients. Age and gender appropriate care needs to be rendered to all patients. □ Policy makers: During the pandemic, there was a lot of misinformation and lack of proper screening at entry points into the country – In these situations there needs to be quick and clear communication with proper screening protocols initiated in a timely manner. □ The insurance agencies need to be revamped. Doctors need to display more extensive biographies of their experience and expertise; including a short video that reveals the doctors’ practicing philosophy and portrays their personality and what really matters to them – this would go a long way to enable patients to get to know their doctor and make informed decisions while choosing their healthcare providers. □ Researchers: Include the healthcare stories of ethnic minorities in healthcare research and bring it to the forefront.

CONCLUSION

The COVID-19 pandemic has brought to light a number of challenges among Cleveland's AAPI community, including discrimination, xenophobia, and mental health issues. However, community-led projects and help from groups like Asian Services in Action Inc. have given individuals in need, a much-needed support and assistance. In the future, it will be important to ensure that everyone has access to healthcare services, especially for individuals who have trouble using computers and have language barriers, and to continue advocating for community activism and solidarity. There was a resounding consensus among all AAPI survey participants when the US healthcare system was reviewed: that it needed to be overhauled to address a number of issues including access to medical professionals who are aware of AAPI communities' cultures and ethnicities, transparency in health insurance policies, and the competence of doctors to care for AAPI communities.

The AAPI communities require knowledge and information so they can approach any health sector to ask for assistance when they are in need, no matter what they may believe to be major or minor challenges. Since some translators would understand what the doctor is saying differently, they should become more patient and familiar with medical terminology. During this period, translation errors occur and cause misunderstanding for both parties. Relationships and representation between various ethnic communities have been established in order to alleviate cross cultural barriers and provide the necessary assistance.

The members also expressed their gratitude for the AAPI effort and for the opportunity to contribute to this public health research initiative, which provides them hope for future improvements in healthcare. Making community groups more active and connected with the community to find out the difficulties and issues would be a priority going forward. In that it would be necessary to address the following: organizing various training and educational awareness programs about the various types of racial discriminations; feasible and eligible services from various health sectors, etc.; assistance in gaining the capacity and independence to access the essential services that they require; and giving assurances that they can get assistance whenever they need it; would be vital for future health coalition initiatives.

RECOMMENDATIONS

- **To Integrate Translation and Interpretation Services in Community Programs:** Incorporate translation and interpretation services into community-based education initiatives and healthcare settings to ensure that language barriers do not hinder access to vital information and services. This will enable effective communication and engagement with diverse communities.
- **To Cultivate Cross-Cultural Awareness in Health Professional Education:** Integrate cross-cultural awareness training into health professional education programs. By enhancing the cultural competency of healthcare providers, they will be better equipped to understand and address the unique needs of patients from different backgrounds, leading to improved patient outcomes and satisfaction.
- **To Include Cultural Humility in Professional Development:** Implement ongoing cultural humility training for healthcare professionals, community health workers, and other stakeholders involved in health education and service delivery. This will ensure a continuous commitment to understanding and respecting diverse cultures.
- **To Promote Advocacy to Address Racial Discrimination:** Launch awareness campaigns and workshops to advocate for racial equality and combat discrimination. Collaborate with community leaders, organizations, and policymakers to develop inclusive policies and practices that promote social justice and equity.
- **To Expand Outreach of Community Health Workers:** Increase the outreach efforts of community health workers to underserved communities, especially those with limited access to healthcare services. By reaching out to these communities and providing health-related support and resources, the overall health outcomes can be improved.
- **To Leverage Community-Based Education for Health Promotion:** Utilize community-based education programs as a platform to raise awareness about health issues and promote healthy behaviors within diverse communities. Tailor the education content to reflect the specific needs and cultural nuances of the target audience.
- **To Encourage Collaboration between Resource Center and Advocacy Groups:** Facilitate collaboration between the resource center (a culturally congruent/responsive community-based facility) and advocacy groups addressing healthcare issues and challenges regarding racial discrimination. In that, by sharing data, research findings, and expertise, they can work together to promote evidence-based policies and interventions that address health disparities and discrimination issues.