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# Unmasking an Invisible Community: Unique Influences on and Consequences of COVID-19 among South Asians in the United States

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## Abstract

The COVID-19 epidemic in the United States has shed light on health disparities, and the social, economic, and political contexts in which they occur. With respect to race and ethnicity, much of the narrative surrounding Asian Americans has focused on xenophobia and historical parallels to discrimination targeting this population during prior outbreaks. One minority group whose unique contextual experiences and needs remain mostly absent in the discourse is the South Asian community. This essay aims to explain the distinct influences on and consequences of the epidemic on the second-largest Asian American population and to delineate specific recommendations within a framework of health equity.

## Introduction

The global pandemic of novel coronavirus (COVID-19) is an unheralded event in contemporary human history. The impacts have been particularly devastating in the United States, with official reports of more than 8 million cases and more than 219,000 deaths (as of Oc-

tober 19, 2020; CDC, 2020a). The spread of this incurable infectious disease continues to have broad consequences on the economy and healthcare, impacting every social determinant of health (Abrams and Szefer, 2020; Benfer and Wiley, 2020; Khoo and Lantos, 2020). The disease has disrupted the ability for public congregation paramount for social support functions embedded in religious, cultural, community, and extended family gatherings (Galea et al., 2020; Pitas and Ehmer, 2020).

The cornerstone of any health equity framework is predicated on values of fairness and social justice (NASEM, 2016). Public health interventions should result in equitable distribution of benefits and risks as they relate to health outcomes and their social, environmental, and institutional antecedents regardless of income/wealth, type of residence, and education status. Within such a framework, preventable disparities among racial, ethnic, and social groups should be viewed as violations of a fundamental right to health and well-being (Williams and Cooper, 2020). Despite transmission by an indiscriminate viral agent, the differential rate of testing, prevalence, and mortality reveal underlying inequities in the burden of COVID-19 experienced by racial and ethnic minorities.

### **Disparities in COVID Testing, Infection, and Mortality**

Emerging COVID-19 data reflect disparities inconsistent with a fundamental right to health. The biology of COVID-19 indicates that males, older individuals, and those with underlying conditions are vulnerable to severe complications and death (Azar et al., 2020; Hooper et al., 2020). However, unrelated to biology, disproportionate burdens of COVID-19-related outcomes are stark among racial and ethnic minorities. Native Hawai'ians (NHs) and Pacific Islanders (PIs) are bearing the most significant brunt of COVID-19 cases (Hayes-Bautista and Hsu, 2020; Kaholokula et al., 2020), whereas Blacks and Latinos are overrepresented in COVID-19 deaths (Hooper et al., 2020). Uneven distribution of testing among racial and ethnic groups is evidenced by the geographic regions in which diagnostic resources are available (Borjas, 2020; Farmer, 2020; Fliesler, 2020; Jannene, 2020; Laughland and Zannoli, 2020). These data reflect structural inequities in health and healthcare that predate the presence of the COVID-19 epidemic.

Preliminary estimates indicate burdens of COVID-19 among Asian Americans (AAs) proportional to the population (Kaur, 2020), although New Jersey reports AAs having the highest diagnosis rate (New Jersey Business and Industry Association, 2020). A recent analysis from San

Francisco found the highest proportion of deaths among those infected was among AAs, mirroring patterns in the rest of California and eight other states (Yan et. al, 2020). Data reflecting patterns of COVID-19 outcomes among AAs are not available in all states, with several including PIs within a composite racial / ethnic category (American Public Media Research Lab, 2020).

Infection and death rates among South Asians (SAs) living in the United States have been unclear primarily due to collection and presentation under an aggregate AAs category.

### **Need for Data Disaggregation**

In 1985, a government report used aggregated data on AAs and PIs to conclude this group was healthier than other populations (API-AHF, n.d.). Despite calls to the contrary, data aggregation for health, economic, and social indicators on AAs remains an issue (Ghosh, 2003; Gordon et al., 2019). Most surveys use inconsistent definitions of AAs; some include major AA populations, whereas others oversample populations based on geographic location (Islam et al., 2010).

Presenting aggregate data on social, economic, and health variables suggest that AAs perform better in key indicators than other marginalized groups (AAAJ, n.d.). In addition, to counter demands from Black communities calling for equal treatment as citizens, AAs have been touted as a “model minority” to perpetuate a notion that communities need not protest discrimination but work hard and quietly like “Chinese and Japanese Americans” to achieve success (Chou and Feagin, 2016).

However, assuming homogeneity conceals key population disparities within the AA population (Vaghul and Edlagan, 2016). For example, income inequality among AAs is rising rapidly (Kauh, 2018; Kochhar and Cilluffo, 2018; Ponce et al., 2016; Shah and Ramakrishnan, 2017). From 1970 to 2016, the gap in income between AAs near the top and bottom nearly doubled, making it one of most unequal among all racial and ethnic groups in the United States. AAs at the top of the income ladder hold about 8.7 times the income of groups at the bottom of the ladder (Kochhar and Cilluffo, 2018).

In case of the epidemic, to date, there are no data reporting disaggregated case counts, the proportion of hospitalizations, or mortality rates due to COVID-19 by the AA community. Lack of granularity reflects a broader implementation of uniform standards in data collection, despite sustained recommendations and policy directives to unmask

significant health disparities among diverse AA communities (Holland and Palaniappan, 2012; Islam et al., 2010; Nguyen et al., 2014; Teranishi et al., 2014). This need is evidenced by a national report from Public Health England indicating that, in the United Kingdom, Bangladeshis had twice the risk of death from COVID-19 than their White counterparts, with Asian Indians, Chinese, and Pakistanis with 10–50 percent higher (Siddique, 2020). Also, SAs are presumably relegated to “other” or “unknown” racial/ethnic categories (Chung et al., 2020). In other cases, SAs are combined with other AAs masking important distinctions in salient social determinants or differential impacts (Valentine and Tan, 2020). Lack of disaggregation is of critical concern to accurate reporting on the impacts of this epidemic on AA and SA communities.

Although this segment of the AA population, SAs, exhibit tremendous diversity, population-level research and targeted organizational advocacy have largely coalesced around the SA identifier, stemming from a regional intergovernmental coalition of countries found in the native subcontinent named the South Asian Association for Regional Cooperation (Saez, 2012). Notwithstanding considerable heterogeneity, SA perspectives as a whole are invisible in both research and media released during this pandemic.

### **Absence of South Asian Perspective (Research and Media)**

According to Lee and Ramakrishnan (2020), East Asians living in the United States experience racial assignment congruity, which means that they perceive themselves as Asian, and are also perceived as Asian by other AAs and other racial population groups. By contrast, SAs reported experiencing racial assignment incongruity, which implies that even though they perceive themselves as Asian, other AAs and racial population groups are significantly less likely to perceive them as AAs. SAs experience marginalization and exclusion from other AAs due to differences in culture and religion (Nadal, 2019). Despite being the second-largest community in the AA population, SAs are disproportionately underrepresented in narrative and media coverage (David, 2016; Nadal, 2019).

Much of the media narrative surrounding AAs and COVID-19 have revolved around racial discrimination and violence, including verbal insults, spitting and coughing, and physical assaults on individuals perceived to be members of this population (Kang, 2020a; Litam, 2020). A national tracking site reports almost 2,000 incidents from forty-five states and the District of Columbia, with more than one-third occur-

ring in public venues (Asian Pacific Policy and Planning Council, 2020), although most media reports indicate a conflation of two racial/ethnic identifiers: Chinese/Chinese-American (and anyone racialized to be as such) and Asian/Asian-American. Implicit and overt racism toward any group should be considered abhorrent. However, outside of historical references to discriminatory attitudes and hate crimes against individuals of SA descent, narratives surrounding amplified xenophobia among AAs in context of COVID-19 lack any significant acknowledgment of targeted bias and disproportionate burdens of consequences related to the pandemic suffered by the second-largest AA population, despite an uptick in attacks during critical periods of U.S. history, post-9/11, and since the 2016 general election (SAALT, 2017).

Accordingly, the purpose of this essay is to elucidate important contextual impacts of COVID-19 among SAs in the United States and to delineate an inclusive agenda for equity among all AAs in response to short- and long-term effects of the pandemic. Although the focus of this work is on raising visibility regarding unique SA concerns, arguments for data disaggregation and granular analyses hold true for other AA populations, and other communities who are categorized in broad monoliths, despite considerable intragroup diversity (Ho, 2019; Rubin et al., 2018). This report highlights the unique historical context and current circumstances faced by SAs during the COVID-19 pandemic, outlines health- and immigration-related considerations for this invisible population, and provides recommendations for parity in health among all communities.

## Context of South Asians in the United States

### **Who Are South Asians in the United States?**

The SA population in the United States comprises individuals from Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and the Maldives. It also includes members of the SA diaspora, comprising generations of SAs who settled in places including the Caribbean, Africa, Middle East, and Pacific Islands. SAs are the second-largest AA population in the United States (numbering 5.4 million), having grown by 40 percent between 2010 and 2017. In addition to national origins, SAs represent diversity in religion, language, occupation, socioeconomic position, and immigration status (SAALT, 2019a)—many social and health indicators are bimodally distributed within the SA community (Yi et al., 2016a).

Reflecting considerable income inequality (Kochhar and Cilluffo,

2018), many SAs have low paid and temporary jobs, including in the informal sector, with little or no savings. Despite the presence of a visible segment of the population with high incomes, many SAs assume employment in social, cleaning, and rideshare services nationwide. Some earn to support extended families in both the United States and countries of origin (Rahman et al., 2014). Nearly 10 percent of SAs live in poverty, with Bangladeshi and Nepali communities reporting lowest median household incomes among all AA groups (SAALT, 2019a)

SAs constitute a substantial portion of clinical and healthcare positions in the United States. One in twenty doctors nationwide are of Indian origin (Rao, 2020; Raymer, 2004). International Medical Graduates (IMGs) are immigrant physicians who graduated from foreign medical schools, and are currently training and practicing in the United States. Among all applicants for medical residency graduate programs in 2015, 59 percent were IMGs and, of the latter, 13.3 percent and 5.9 percent were from medical schools in India and Pakistan, respectively (ECFMG, 2015).

In 2017, more than 11 percent SAs were undocumented, with 630,000 solely from India (SAALT, 2019a). Undocumented SAs hold positions essential to the functioning of society, working in deli and grocery stores, as taxi drivers, and as allied health staff (Chowdhury, 2020; Naveed, 2020; New York City Comptroller, 2020). More than 9.5 percent of green card recipients in 2017 are from countries of SA origin (SAALT, 2019a). Many SAs hold nonimmigrant visas with authorization to live and work in the United States (H1-B, TPS, OPT) (Ruiz and Budiman, 2018). H-1B visas are issued to high-skilled workers to work in the United States on a temporary basis, and H-4 visas are issued to spouses and children under twenty-one years old of H-1B visa holders. Since May 2015, a new rule was implemented that allowed spouses with H-4 visas to obtain work authorization through an H-4 Employment Authorization Document (EAD). However, in 2019, U.S. Citizenship and Immigration Services (USCIS) issued a proposal to remove H-4 dependent spouses from the class of individuals eligible for employment authorization. Since the adoption of the H-4 work authorization policy in 2015, 93 percent of all H-4 EADs have been granted to SAs, and 93 percent of these EAD holders are women (Bhatt et al., 2019). Uncertainty around the continuation of H-4 work authorization has led to instability in the workforce leading to multiple challenges such as economic insecurity, termination of employment among currently employed EAD holders, and prolonged job insecurity.

In terms of healthcare, although more than half of the population report access to healthcare, nearly 20 percent of SAs lack health insurance (Ramakrishnan and Ahmad, 2014), with approximately two in five under the age of sixty-five reporting no regular source of care (SAALT, 2009). Similarly, although most SA adults have employer-based health insurance in the state with the largest number of SAs (California), 13.7 percent are uninsured with an additional 4.9 percent on Medi-Cal and 13.5 percent reporting no regular access to care (UCLA, n.d.). Linguistic and cultural barriers serve as additional limitations (Lee et al., 2010), adding to discomfort and unfamiliarity with the healthcare system.

### **Disenfranchisement of South Asians Living in the United States: Past and Present**

Throughout history, SAs have been considered as foreign, threatening, or “the other” (Bhatia and Ram, 2018). Rejection of SAs were codified in exclusionary immigration policies, violence, and racism as early as 1907 when they were referred to as “nuisances” who were “taking away jobs” or as diseased, spreading infection into the country (Desai, 2014).

With the incidents of 9/11, the shroud of Islamophobia has intensified for many SAs irrespective of religion; the first person murdered after attacks on the World Trade Center was a Sikh man misidentified as being Muslim (SALDEF, 2011). Attacks on those perceived as Muslims have seen an uptick during years with significant events, such as federal or local elections (SAALT, 2017). Despite likely underreporting, hate crimes against Sikh communities surged by 243 percent in 2016 (SAALT, 2018). Further, SAs hailing from both Muslim and non-Muslim countries of origin continue to face structural discrimination. In 2001, President Bush enacted policies curtailing the freedoms of many communities, including SA communities (ACLU, 2004).

Immediately after 9/11, in the name of national security, federal agents arrested and detained individuals, mostly male, from predominantly SA and Arab neighborhoods across the United States with no access to family contact or open hearings and held for months in dire conditions. Individuals were placed on Terrorism Watch and No Fly lists solely based on their ethnic origin or a potential name match with suspects or “Muslim”-sounding names. Restricting travel through the use of lists was an antecedent to the travel ban from majority-Muslim countries that was instituted mere days after the inauguration of the president in January 2017. These travel bans are reminiscent of exclusion



laws against Chinese immigrants and laws that established Japanese internment camps in the early twentieth century (Ngai, 2017; United States Courts, n.d.). In 2020, for a long time, a travel ban was the sole major policy adopted to control the spread of COVID-19 (Palmer, 2020); President Trump introduced travel restrictions from China without taking further steps to curb disease spread inside the United States for weeks (Blake, 2020; The White House, 2020a). Moreover, despite reports of the first cases of the virus on the East Coast being brought in from Europe, travel restrictions from Europe were implemented much later in mid-March (The White House, 2020b; Zimmer, 2020).

Under the Patriot Act—which targeted many SAs post-9/11—the government had the authority to monitor all phone and e-mail communications, track Internet activity, and record bank reports of American citizens (ACLU, 2020). In June 2002, the National Security Entry Exit Registration System (NSEERS) system was established as a surveillance mechanism of Muslim men aged fifteen and over, originating from twenty-five countries (including Bangladesh and Pakistan), to report to the government to be fingerprinted, photographed, and questioned. This program was disbanded in December 2016 without any terrorism-related convictions in its fourteen years of implementation. Some jurisdictions went even further, as evidenced by the New York Police Department adopting policies of suspicion-less monitoring of communities believed to be Muslim using photo and video surveillance, mapping, individual tracking, police informants, and police rakers (Bridge Initiative Team, 2020). Law enforcement sent informants to collect information on attendees at religious institutions, events, or programs or incite individuals to utter potential incendiary language or plan suspected terrorist activity. This program failed to produce any credible suspect in all the years of its running and was deemed illegal after it was unveiled through an Associated Press report and subsequent legal action (NPR, 2012). However, the program succeeded in reinforcing fear of authorities among affected communities and individuals.

Historical and ongoing treatment as “the other,” combined with rises in Islamophobia, have engendered fear and distrust, often amplified during crises. Under the backdrop of persistent structural inequities and discrimination, it is paramount to address unique healthcare and immigration considerations for SA communities in the United States during and following the COVID-19 pandemic.

## Healthcare Considerations during the COVID-19 Pandemic

## **Access to Healthcare**

The pandemic exacerbated disparities in access to care with detrimental effects on the SA community. Many immigrant communities experienced sudden job losses and closures of small businesses (Liao, 2020; Mozumder, 2020), likely resulting in rises in numbers of uninsured SAs without any source of care. Many dependent on public hospitals and emergency rooms for affordable care found themselves with more limited healthcare options, particularly exacerbated in at-risk cities, including Queens County, New York (the epicenter of the initial U.S. epidemic) (Correal and Jacobs, 2020), where SAs comprise more than 35 percent of the population (U.S. Census Bureau, 2016, Table B02015). Emerging “public charge” legislation has heightened immigrants’ wariness in seeking services needed (Page et al., 2020). The Public Charge rule, implemented in 2019, limits noncitizens from using government programs (Kaiser Family Foundation, 2019). Even though it has been paused for COVID-19 testing and treatment, immigrants remain hesitant to utilize healthcare due to misinformation and fear of deportation (McFarling, 2020), disproportionately affecting low-income SA families (Jha, 2019) who reside in areas hit hard by COVID-19 (AAPI Data, 2018; The New York Times, 2020).

Healthcare delivery rapidly transformed in the wake of the outbreak, adapting to an increased need for virtual services (Wosik et al., 2020). Amid increasing COVID-19 rates, people were advised to turn to telehealth and mobile health. With SA communities being forced to social distance in their homes—often without family members capable of providing translation services and technological help—sudden reliance on telehealth services may become a burden (Williams, 2020). For instance, despite a federal mandate to make translation services available, many healthcare centers fail to provide comprehensive linguistic services for non-English speakers (Eldred, 2018; Kang, 2020b). Among existing services, languages offered are limited and exclude those frequently spoken by SAs (Scarborough et al., 2018). SA community organizations report increased need for language support and are overwhelmed trying to aid the community with limited resources (Chung et al., 2020). Limited healthcare access compounds adverse effects of the pandemic due to higher prevalence of comorbidities and mental health concerns in this community.

## **Comorbidities**

SAs in the United States are at increased risk of complications and

mortality from COVID-19 due to existing comorbidities such as cardiovascular disease (CVD), hypertension, and diabetes (Pareek et al., 2020). While AAs in aggregate report lower rates of these conditions, SAs consistently have higher CVD incidence, hospitalizations, and mortality than non-Hispanic Whites and other racial/ethnic groups (Volgman et al., 2018). Prevalence of hypertension is estimated to be 27 percent for SAs in New York City (compared to 23 percent of non-Hispanic Whites) (Yi et al., 2016b), while national prevalence of diagnosed or undiagnosed diabetes is 23 percent (compared to 12 percent of non-Hispanic Whites) (Cheng et al., 2019); Asian Indians have higher odds of diabetes compared to other AA communities (Lee et al., 2011).

### **Mental Health**

Prior outbreaks have been linked to poorer mental health outcomes (Blendon et al., 2004; Shultz et al., 2015). In the current pandemic, almost one-third of Americans report anxiety symptoms (as of June 2, 2020; CDC, 2020b). Although SAs report relatively lower rates of mental disorders, 21 percent experience a lifetime mood or anxiety disorder, of which 13 percent is subthreshold anxiety (Masood et al., 2009). Evidence suggests that AAs, including SAs, experience more subthreshold symptoms, particularly somatic ones that could contribute to underdiagnosis and undertreatment (Kim et al., 2015). With high levels of mental health stigma and low levels of mental health service utilization (Karasz et al., 2019), SAs may be particularly vulnerable to increases in mental distress without any concomitant increase in support during and in the aftermath of the immediate pandemic. The substantial number of SAs on the frontline with a higher possibility of infection and death (Jewett et al., 2020; Rao, 2020); economic shocks for low-income and undocumented SA workers (Liao, 2020; Mozumder, 2020); and current social, immigration, and travel-related restrictions (including the inability to engage in bereavement) for a collectivist culture where family is both the most integral form of support and the greatest cause of mental health problems (Karasz et al., 2019) may amplify COVID-related issues of trauma (Galea et al., 2020; Gunnell et al., 2020; Thombs et al., 2020).

Large numbers of SAs on the frontlines in healthcare and other essential services suggest a disproportionate mental health burden for these communities. Frontline workers are at risk of potentially traumatic experiences and associated mental health consequences (Benedek et al., 2007; Sim, 2020). For COVID-19, this is likely compounded by stresses of inadequate personal protective equipment, overburdened

healthcare systems, high mortality rates within one's own social networks, and self-quarantine to prevent exposure to others.

Similarly, SAs experiencing the economic shocks of reductions to or losses in employment are at greater risk of worse mental health (Sim, 2020). Because many SAs immigrate for better economic opportunities, loss of work could challenge their self-identity for why they came to the United States, as has been found among AA communities (Yang et al., 2014). Migration-related stressors may primarily impact mental health for SAs when they intersect with broader social determinants of unemployment and poverty (Karasz et al., 2019), primarily when it results in the occupation of a lower social position, which has been associated with mental distress for SA men (Masood et al., 2009).

Given the collectivist nature of SA culture, social restrictions are particularly likely to impact mental health (Galea et al., 2020; Perera and Chang, 2018) especially as family plays a central role to SA culture with positive and negative impacts on psychological functioning (Masood et al., 2009). For those at home with family, complicated family dynamics, including intergenerational conflict and violence, are a major cause for mental health problems among SAs, particularly for women, youth, and older adults (Karasz et al., 2019). In response to coping with new-found disconnect in social support, an anticipated rise in alcohol use (Galea et al., 2020) may also contribute to long-term consequences, as alcohol use in SA men is linked with family violence and disruption, financial problems, drinking and driving, and legal problems. SAs are less likely to receive treatment for alcohol disorders (Khera and Nakamura, 2018; Puri et al., 2018). In contrast, family support can be protective, and those separated from family could experience increased isolation and distress (Karasz et al., 2019). SAs often turn to religion to deal with mental health distress (*ibid.*), and social restrictions have limited visits to places of worship, negating social and religious benefits of such gatherings.

For SA older adults who are already at greater risk for psychological distress, these restrictions in movement will amplify known risk factors including social isolation, loneliness, abuse and neglect, acculturative stress, and intergenerational conflict (*ibid.*; Sayegh et al., 2013). For children, the closure of schools and decreased access to resources and a sense of routine will likely affect mental health (Lee, 2020), which could be worsened by the pressures of academic achievement in some SA communities. For SA adolescents, social restrictions could exacerbate risk factors for suicide, including interpersonal problems with family members, domestic violence, gender role expectations, and cultural

conflicts without the protective benefits of relationships with peers or other adults outside the home (Sharma and Shaligam, 2018).

For lesbian, gay, bisexual, transgender, and queer (LGBTQ) SAs, who experience prejudice and discrimination and have high rates of self-reported mental health problems (Satrang and South Asian Network, 2007), social restrictions raise concerns about the safety of home environments where they may not be able to be fully themselves. LGBTQ youth, who already have poorer mental health than peers, are at increasing risk due to decreases in positive peer influences, greater negative interactions with unaccepting family members, and economic and housing concerns (Russell and Fish, 2016; The Trevor Project, 2020). Transgender and gender nonconforming individuals are at greater risk for worsening mental health due to increased body dysphoria and social stigma exacerbated by reduced access to gender-affirming medical care deemed nonessential during the pandemic (van der Miesen et al., 2020).

### **Women's Health**

There are unique considerations related to health of women in SA communities; however, limited data highlights broader need for research. The precarious position of many in terms of formal and informal work, immigration status, and power within a patriarchal culture likely put SA women at greater risk for health, economic, and social consequences due to the pandemic.

An overlooked concern during the pandemic has been intimate partner violence (IPV), disproportionately affecting women. Social isolation measures during this time have resulted in an exponential increase in gender-based violence (United Nations, 2020). High levels of domestic abuse among SAs predate the pandemic; nearly 40 percent of SA women in the United States experience IPV, according to a community-based study. Many SA organizations providing domestic violence support report decreases in use of services while indicating increased domestic abuse incidents during the pandemic (Valentine and Tan, 2020). Social isolation measures, economic and immigration-related pressures, underreporting of incidents due to cultural stigma, and inaccessibility of domestic violence shelters have put SA women in a vulnerable position (*ibid.*).

For the abuser, COVID-19 has provided a mechanism for power and control to restrict access to phones, finance, and privacy for survivors because they are “locked down” at home. Due to loss of income,

abusers may eliminate crucial resources for survivors. For example, spouses may disconnect cellphones to save money, eliminating access to hotline services (Southall, 2020). Economic abuse by perpetrators has resulted in withholding of unemployment benefits and stimulus checks to prevent survivors from leaving the perpetrator or stopping court-ordered payments citing COVID-19 as reasons for inability to pay (Kamdar, 2020; Mukherji, 2020; Valentine and Tan, 2020). Amid financial insecurity, women are often unable to earn, granting the abuser more control. Moreover, SA women dependent on their spouse's citizenship status cannot leave the marriage fearing deportation (Kamdar, 2020). Undocumented survivors are most vulnerable because they cannot find legal employment, are ineligible for benefits such as unemployment aid, and have limited access to healthcare.

SA organizations working with survivors believe there is a large-scale underreporting of incidents. A substantial decrease in the number of calls to domestic hotlines and the decline in criminal complaints indicates the lack of reporting (Fougere, 2020; Mukherji, 2020; Southall, 2020; Valentine and Tan, 2020). For example, New York-based Sakhi reported a 76 percent decline in calls to their helpline since COVID-19 measures were enforced (Fougere, 2020)

Domestic violence shelters are either full or have closed to new clients to prevent an outbreak. In fear of contracting COVID-19, many women have left shelters, returning home to their abusers. Reciprocally, many women are unable to leave abusive households because shelters have closed (*ibid.*). Accessing help may be especially challenging for SA immigrants due to lack of support systems and unfamiliarity with accessing justice and legal systems.

Given this situation, organizations are innovating new solutions for survivors. Counseling sessions, legal services, and guidance on available resources have shifted remotely. Some are fundraising for extended hotel stays (Mukherji, 2020). Organizations have observed increases in online chat services, which are of potential value but introduce language barriers (Fougere, 2020; Southall, 2020). If contact is established with clients, organizations are assuring women to connect to police, hospitals, or courts and will facilitate access to essential services (Mukherji, 2020). Public and institutional awareness of increased risk of IPV is critical to provide survivors with support (Gelder et al., 2020). This pandemic has intensified survivors' needs, both for those confined to their homes and those who are in shelters.

## Immigration and Other Policies

SAs face unique challenges related to immigration policies. As of late 2020, there are dynamic and constantly shifting proclamations on immigration policies being announced by the federal government (The Legal Aid Society, 2020; The White House, 2020c). These are particularly concerning for individuals with nonimmigrant or undocumented visa status, thus, affecting SAs in the short and long term.

### **Nonimmigrant Visa Status**

Between 2008 to 2016, international students on F-1 visas grew by 104 percent, and about 1.5 million foreign graduating students obtained living and work authorization through the Optional Practical Training program (OPT). More than 70 percent of all OPT approvals were students from Asia, with more than 30 percent of them from India (Ruiz and Budiman, 2018). Currently, one in four physicians practicing in the United States are IMGs (Ahmed et al., 2018; Nwadiuko et al., 2018; Ranasinghe, 2015). Most SA IMGs are from India (13.3 percent) and Pakistan (5.9 percent), who report mainly practicing in primary care specialties and underserved rural areas.

Recently, the USCIS has announced it will honor employment contracts of IMGs if they are temporarily unable to work full-time due to illness, are provided reduced hours at healthcare facilities, or suffer other impacts related to the pandemic (USCIS, 2020). This waiver, however, does not extend to cover all legal challenges experienced by healthcare workers. The federal government has suspended routine visa services and premium processing for H-1B renewals due to the outbreak, which leave IMGs unable to renew nonimmigrant visa status to continue working. IMG physicians have voiced immense concerns regarding their H-1B visa status tied to their employment (Constable, 2020; Malhotra, 2020), as inability to return to work due to extended disability, incapacitation, or death may result in deportation of dependents.

The American Medical Association (AMA) has been actively advocating for IMG physicians, and is helping ensure that visa-related issues do not stop them from taking care of their patients (AMA, 2020). The AMA is urging the federal government to permit H-1B physicians to quickly receive work authorization to be allowed to work at multiple healthcare facilities. Despite this advocacy, constant changes and updates regarding immigration policies place continuous burdens on already overwhelmed frontline healthcare workers.

## Undocumented Immigrants

Prior to the COVID-19 pandemic, undocumented people in the United States already faced multiple health-related challenges from inequitable immigration policies (Hacker et al., 2015; Martinez et al., 2015). Organizations advocating for SAs in the United States, including the undocumented, have identified barriers to health such as a lack of language access (Committee Against Anti-Asian Violence, 2015), inadequate or overcrowded housing (Chhaya CDC, 2008), and economic insecurity due to precarious employment and lack of access to financing (Chhaya CDC, 2020; DRUM, 2012). These inequities have been exacerbated through pandemic-related legislation that has reproduced existing bias, such as excluding undocumented individuals and mixed-status families filing taxes jointly from cash aid in the CARES Act (Hsu, 2020), inadequate provisions for language access in the HEROES Act (APIAHF, 2020), and inaccessible testing and treatment for undocumented people (National Immigration Law Center, 2020), including more than 630,000 individuals of SA descent (Hanifa, 2019).

Like many immigrants, SA DACA recipients (Deferred Action for Childhood Arrival) do frontline work without any guarantee from the federal government that their immigration status will be safe (Chowdhury, 2020; MPI, 2020a; Naveed, 2020). While data for all SA DACA applicants and recipients by nationality is incomplete, at least 20,000 Indian Americans were eligible in 2018, of whom 2,550 (13 percent) were recipients (SAALT, 2019b). By comparison, as of March 2020, 643,560 (49 percent) of the total estimated 1,326,000 DACA-eligible population were recipients (MPI, 2020b).

One group of undocumented SAs remains outside the reach of most community support—immigration detainees. To date, 34,000 SAs have been apprehended at the border, with 17,000 arrested by Customs and Border Protection between October 2014 and April 2018; as of 2019, more than 3,000 were being held in immigration detention centers (SAALT, 2019b). Immigration and Customs Enforcement has drawn harsh criticism for inadequate care and outright negligence of detainee health (Human Rights Watch, 2018; SAALT, 2019c). Under the pandemic, legal advocates have found that conditions have worsened (New York Lawyers for the Public Interest, 2020), with the only viable solution to mitigating transmission in overcrowded facilities being the release of detainees (Meyer et al., 2020).

## Implications and Recommendations



Given the specific healthcare and immigration concerns identified among SAs, we propose a number of recommendations. A key need outlined is the importance of disaggregated information. Without disaggregated data, organizations are unable to tailor informed COVID-19 responses to the priorities of their communities (Maybank, 2020). Proposed standards recommended by the Office of Management and Budget for uniform data collection need to be adopted and implemented for enhanced data quality representing race and ethnicity categories (Dorsey et al., 2014). Understanding differential access to testing and treatment among SAs, as well as disparities in hospitalizations, morbidity, and mortality related to COVID-19, will provide critical information about areas where resources and support are most needed. Contextual impacts of COVID-19 faced by older adults, women, and LGBTQ individuals are absent from scientific literature warranting particular investigation of pandemic-related risks and outcomes among diverse SA populations.

A pivotal element of an equitable and sustained response to COVID-19 parallels broader strategies addressing key structural and social determinants of health among SAs in the United States and other vulnerable communities. Legislation stimulating economic recovery must include relief for small businesses, temporary workers, and other segments of the labor force highly sensitive to turbulent and uneven access to employment, particularly those lacking regulatory health and safety protections. Restrictive immigration policies that disproportionately burden or jeopardize frontline workers or providers of other essential social and community services, such as those provided by SAs, through the course of this pandemic should be paused and reformed. Any enforcement of existing federal immigration policies, including deportation or incarceration, should remain separate and independent of municipal and state law enforcement and public safety functions.

As the public health and healthcare systems orient themselves to local physical distancing and social congregation conditions, services and outreach must adjust accordingly. Telehealth and other remote technologies must address differential access among groups with complementary strategies for those who do not or cannot successfully avail of online or distance modalities; such services must provide capacity for in-language communication for SAs and other limited English proficient communities. Given unique mental health burdens exhibited among SAs, healthcare providers and systems must have mechanisms for heightened screening and immediate referral to social support, bol-

stered by policy mechanisms that prioritize safety from physical and mental harm. This is of particular importance given the amplified consequence of IPV in the context of quarantine and other restrictions on in-person access to shelters and counseling that cannot be undertaken effectively or safely in a domestic setting.

As the United States continues to focus its efforts on mitigation and recovery, an area of emphasis to prevent future epidemic clusters throughout the nation is on contact tracing, where those recently exposed to COVID-19 are promptly identified, screened, isolated, and treated; this will reduce the magnitude of community spread. To facilitate such an effort, the United States is considering creating apps for mobile phones to assess proximity data and monitor interactions with individuals infected with COVID-19 (Volkin, 2020) adopted by other countries globally (Nature, 2020). Electronic contact tracing to evaluate disease spread poses a number of ethical and safety concerns (Kahn and Johns Hopkins, 2020). Lack of privacy protections on information collected, and legal standards placed on data partners, can harken back to databases maintained by federal and state agencies to surveil Muslims, Sikhs, Arabs, and SAs post-9/11 (Surveillance Technology Oversight Project, 2020). Governmental policies established post-9/11 provide precedence for surveillance programs across the United States in the wake of COVID-19. Thus, any contact tracing or other epidemiological monitoring strategy must be coupled with robust and transparent policy protections on the use of data solely for public health purposes with legal consequences for access not related to mitigating COVID-19.

Moving forward it is imperative that solutions to barriers to access are implemented in a rapid manner for equitable access to services in immediate response to COVID-19, while subsequently allowing for more comprehensive care for SAs from longer-term consequences. Partnering with and funding community organizations who are already doing the groundwork to provide healthcare services in SA communities is a priority. SA solidarity groups and community-based organizations have tried to meet the needs of vulnerable SAs, including undocumented people, through mutual aid, philanthropic, and crowdfunded efforts (SAALT, 2020); in the face of a lack of data disaggregation by race, these organizations have even taken on keeping count of mortality data themselves (Chung et al., 2020). By elevating the work of community organizations, existing services tailored to the cultural needs of the SA community can be more readily disseminated across the nation.

Broader policy interventions must consider the social determi-

nants of health that amplify the persistence of preventable disparities among SAs and other at-risk populations. Immigration reform underscoring a fundamental recognition of human dignity, equitable distribution of public funds and resources for local business and community assets, immediate access to comprehensive healthcare, and redress of civil rights violations is crucial for an effective and sustained response to COVID-19 for *all* affected communities.

## Conclusion

Given the state of political affairs highlighting systemic inequities in the United States in the first half of 2020, the imperative for social justice has never been greater. Inherent to this approach is a recognition that the pursuit of health and well-being is a fundamental human right and an obligation of democratic societies. A cornerstone of health equity is a process that is inclusive in representing diverse experiences, perspectives, and priorities. Moreover, such an approach must be *proactive* in ensuring optimal social and institutional capital, rather than *reactive* to addressing situational consequences, some of which may be irreversible in terms of disease, disability, and death among individuals and populations. The multiple crises of 2020 illustrate that historical injustices and unrepresentative structures of governance and leadership result in severe violations of social justice and fundamental human rights. To that end, it is paramount that the burden of and response to the ongoing epidemic be equitably distributed, with an emphasis on understanding core social and structural determinants of health that lead to preventable disparities. An inclusive response to causes and consequences of COVID-19 among AAs must acknowledge the unique contextual realities and needs of SA communities—especially among disproportionately vulnerable communities, such as immigrants, older adults, women, children and adolescents, LGBTQ individuals, frontline workers, and small business owners—and to ensure that an agenda of resilience and recovery proactively addresses its distinct political, institutional, and social determinants and manifestations. Such an effort must occur in solidarity with other disadvantaged communities to ultimately actualize a truly inclusive agenda for health and social equity among all individuals and populations.

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