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Submitted via regulations.gov & minorityhealth@hhs.gov

Re: OMH RFI: AAPI Best Practices -Request for Information (86 FR 37757) on Best Practices for Advancing Cultural Competency, Language Access and Sensitivity Toward Asian Americans and Pacific Islanders

Dear Ms. Bui,

Below please find comments submitted by the Asian Pacific Institute on Gender Based Violence (API-GBV) in response to the Request for Information (86 FR 37757), published July 16, 2021, requesting information regarding best practices for advancing cultural competency, language access, and sensitivity toward Asian American Pacific Islanders (AAPIs) in the context of the federal government's COVID-19 response, and in response to the January 26, 2021 White House Memorandum Condemning Racism, Xenophobia, and Intolerance Against Asian Americans and Pacific Islanders in the United States.

API-GBV is a national resource center on domestic violence, sexual violence, human trafficking, and other forms of gender-based violence in Asian American and Pacific Islander and immigrant communities. API-GBV works in partnership with various national networks of advocates, community-based service programs, national and state organizations, health and mental health professionals, researchers, legal system professionals, policy advocates, and activists from social justice organizations to better address the needs of Asian American and Pacific Islander (AAPI) and immigrant victims. API-GBV analyzes critical issues, promotes culturally relevant evidence-informed intervention and prevention, provides consultation, technical assistance, and training; develops resources, conducts and disseminates research and impacts systems change through administrative advocacy and policy analysis. API-GBV partners with HHS' FVPSA office as a culturally specific resource center, as well as with the Department of Justice (OVW and OVC),

in providing support to communities to improve their responses to AAPI and immigrant survivors of domestic violence, sexual assault, and human trafficking.

All federal responses must take into account the intersectional nature of racism, misogyny, xenophobia, homophobia and transphobia as well as the impacts poverty, disability, and colonization on AAPI survivors of sexual and domestic violence. This past year moreover has especially demonstrated that Asian women face targeted attacks at the intersection of race and gender. There were over 9,000 reported anti-Asian incidents from March 19, 2020 – June 30, 2021, with women making up a far higher share of the reports (63.3 percent) compared to men (30.4 percent).¹ Following the March 2021 shootings in Atlanta that took the lives of six Asian women, API women’s experiences with the intersections of racism, sexism, and xenophobia, have been made more visible.²

In the context of the federal government’s COVID-19 response, we submit these comments on the following topics to share best practices for serving and meeting the needs of our communities with these intersections in mind:

- Assisting AAPI survivors of domestic and sexual violence in COVID-19 Activities;
- Access to Healthcare;
- Confidentiality and privacy related to data collection;
- Language translation and interpretation;
- Strengthening disaggregated data collection across AAPI communities; and
- Training and resource development.

Introduction

The unprecedented COVID-19 pandemic has had a tremendous impact on the Asian American Pacific Islander community in the United States, and laid bare the harsh healthcare and economic inequities for marginalized groups and immigrant communities across the country. In a recent survey of Asian American patients at community health centers, nearly half of respondents say the pandemic negatively affected their ability to pay for basic needs like housing, utilities, and food, and over half say someone in their household experienced job or income loss due to the pandemic. Moreover, one in three respondents report that they felt more discrimination on their racial/ethnic background since the COVID-19 pandemic began, and over four in ten respondents say they worry that they or a family member could be detained or deported.³

¹ Stop AAPI Hate National Report, see <https://stopaapihate.org/wp-content/uploads/2021/08/Stop-AAPI-Hate-National-Report-Final.pdf>

² API-GBV Statement on Shootings at Atlanta-Area Spas and Crimes Against Asian Americans, see <https://www.api-gbv.org/resources/atlanta-spas-statement/>

³ Kaiser (2021), Asian Immigrant Experiences with Racism, Immigration-Related Fears, and the COVID-19 Pandemic, see <https://www.kff.org/racial-equity-and-health-policy/issue-brief/asian-immigrant-experiences-with-racism-immigration-related-fears-and-the-covid-19-pandemic/>

A. Addressing Increased Domestic and Sexual Violence in the AAPI Community

Any COVID-19 response must take survivors of domestic violence, sexual violence, and human trafficking into consideration. COVID-19 poses many unique challenges and dangers for survivors, as survivors from communities of color and immigrant communities, including AAPI survivors, are especially experiencing increasing barriers to safety as a consequence of the COVID-19 pandemic. Social distancing and home isolation measures have increased exposure to abuse, exacerbated the isolation facing many survivors, and reduced access to safety and stability.⁴

Between 21-55% of AAPI women report experiencing domestic or sexual violence during their lifetimes.⁵ The United Nations estimates this figure to be even higher for Pacific Islanders, estimating that 60-80% of Pacific Islander women and girls experience physical or sexual violence by a partner or other individual in their lifetimes.⁶ A study conducted by Centers for Disease Control found that in the Asian and Pacific Islander (API) community, 22.9% of women and 9.4% of men experienced some sort of contact sexual violence and 21.4% women and 9.4% men experienced non-contact unwanted sexual experiences in their lifetime.⁷

While some victim services organizations reported decreased calls earlier during the pandemic, potentially because survivors have been thwarted from reaching out for help due to lack of privacy at home, fear of leaving home to seek help due to upticks of anti-Asian racism,⁸ or fear of seeking services due to concerns of contracting COVID, when they do, their injuries have reportedly been more severe.⁹ As stay-at-home orders have loosened as the pandemic progresses, victim advocates communities are reporting that AAPI survivors are experiencing heightened surveillance and cyberstalking.¹⁰

⁴ Amanda Taub, A New Covid-19 Crisis: Domestic Abuse Rises Worldwide, New York Times, April 6, 2020; Emma Graham-Harrison, Angela Giuffrida, Helena Smith and Liz Ford, Lockdowns around the world bring rise in domestic violence, The Guardian, March 28, 2020.

⁵ Yoshihama, M. & Dabby, C. (2015) Asian Pacific Institute on Gender-Based Violence. Facts & Stats Report: Domestic Violence in Asian and Pacific Islander Homes, Oakland, CA: Available at <https://www.apigbv.org/resources/facts-stats-dv-api-homes/>

⁶ United Nations Population Fund, Pacific Sub-Regional Office (2014, April). Population and Development Profiles: Pacific Island Countries. Available at: https://pacific.unfpa.org/sites/default/files/pubpdf/web_140414_UNFPA_PopulationandDevelopmentProfiles-PacificSub-RegionExtendedv1LRv2_0.pdf

⁷ Centers for Disease Control and Prevention. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Available at <https://www.cdc.gov/violenceprevention/pdf/NISVSStateReportBook.pdf>

⁸ Tessler, H., Choi, M., & Kao, G. (June 2020) The Anxiety of Being Asian American: Hate Crimes and Negative Biases During the COVID-19 Pandemic, *American Journal of Criminal Justice*, 1-11.

⁹ Al-Arshani, S. (Aug. 2020). COVID-19 lockdowns generated a crisis within a crisis for the victims of domestic violence, new study finds. *Insider*. Retrieved from <https://www.insider.com/covid-19-lockdowns-amplified-the-severity-of-domestic-abuse-cases-2020-8>

¹⁰ Kam, K. (Oct. 2020). Why domestic violence calls are surging for Asian American women during the pandemic, NBC News. Retrieved from <https://www.nbcnews.com/news/asian-america/why-domestic-violence-calls-are-surg-ing-asian-american-women-amid-n1240663>

The National Domestic Violence Hotline has explained that when an abusive partner feels a loss of power and control, such as during a time of crisis, abuse often escalates in intensity and frequency. It is clear that pandemic-induced isolation measures, and health and economic stressors, can make survivors still more vulnerable. The United Nations Secretary-General called attention on April 5, 2020 to a “horrifying global surge in domestic violence” as fear of the virus has grown, along with its social and economic consequences.¹¹ As the federal government continues to address this ongoing pandemic and its economic and social consequences, it is imperative that the public health response must incorporate measures to address the rise in the intensity of domestic and family violence.

Recommendations:

API-GBV recommends that as the federal government continues to deploy resources to address the pandemic, that attention to domestic and sexual violence be an integral part of this response, including in AAPI communities. For example, as OMH works to strengthen its health partnerships to address health disparities, that domestic violence, sexual assault, and family violence in AAPI communities should be topics of focus in those projects. Healthcare responses should build on efforts such as projects formerly supported through the Office of Women’s Health and Futures Without Violence’s Intimate Partner and Health Resource Center to strengthen the partnerships between healthcare providers and domestic violence programs.¹² In particular, community health and community mental health centers focused on AAPI communities can play a critical role in routinely screening and referring patients experiencing domestic violence to culturally relevant community-based domestic violence and sexual assault services who have a strong understanding of the cultural barriers impacting access and services, such as those in API-GBV’s network.¹³

In addition, federal agency and program funding for COVID-19 services of all kinds, notwithstanding the specific program purpose, i.e., healthcare, mental health, contract tracing, outreach, housing, economic supports, etc., should include institutional support and training for ***trauma-informed lens towards domestic and sexual violence***. Survivors of gender-based violence who are accessing basic services, are frequently in contact with a web of service providers who could be the first to spot signs of domestic and sexual violence and direct survivors to these community-based victim advocacy resources.

Relatedly, as the federal government is examining questions regarding the distribution of resources to allocate personal protective equipment (PPE), provide economic or housing assistance to those experiencing disproportionate effects from COVID-19, place testing sites or vaccination

¹¹ National Taskforce to End Domestic Violence, Fast Facts: Survivors of Domestic and Sexual Violence are at Heightened Risk Now, and Will Remain So Long After this Crisis, see <https://static1.squarespace.com/static/57d7477b9de4bb8b14256cf4/t/5e9dc0e935d08275a98b9925/1587396842687/NTF+Fact+Sheet.DV-SA+survivors+and+the+COVID19+crisis.pdf>

¹² See, Futures Without Violence, National Resource Center on Domestic Violence, <https://ipvhealth.org>

¹³ See, <https://www.api-gbv.org/resources/directory-api-services/>

sites, and outreach efforts, there must be intentional integration of AAPI culturally specific domestic violence and sexual assault services organizations in local planning endeavors. These culturally specific organizations are often the only connection that AAPI survivors of domestic and sexual violence have outside of their households, and they play a critical role providing not only safety planning and victim related services, but also in-language information to limited-English speaking survivors and their families about relevant COVID-19 public health announcements, eviction moratoria, updates about stimulus payments and child tax credits, as well as information about other services and resources.

B. Barriers to Access to COVID Testing, Treatment, and Vaccines

AAPI immigrant survivors and their family members, like other immigrants, are avoiding COVID-19 testing, treatment and vaccination based on concerns about the cost of care, and fears related to their immigration status. In a survey of immigrant households in Massachusetts, nearly 42 percent of respondents said that no one in the household had been tested or treated for COVID-19; instead, if someone fell ill, they would take care of them at home on their own. On a follow up question, one out of six people responded that they did not get tested because they are uninsured and were worried about the cost.¹⁴ In addition, Kaiser Family Foundation research, based on the 2019 National Health Interview Survey, found that 32 percent of uninsured people postponed seeking care due to cost, regardless of where they were born.

These onerous barriers to accessing healthcare disproportionately harm AAPI and other immigrant women, as women are the majority of immigrants, and are particularly likely to be low-income, young, and uninsured. One-third of noncitizen immigrant women ages 15-44 are uninsured. For women in that group who are also low income, that proportion grows to almost half.¹⁵

One significant reason for the lack of healthcare coverage is due to the complex patchwork of immigrant eligibility rules for coverage which differs by program and by state. Since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”),¹⁶ only non-citizens who are “qualified” are eligible for Medicaid (and Children’s Health), and that is only after a five year wait for many. States have had the option to cover some additional lawfully residing immigrants without the five-year waiting period—particularly children and pregnant women under the Immigrant Children’s Health Improvement Act (ICHIA) option—but not all states have opted to use federal funds to cover these groups. In addition, some

¹⁴ <https://www.miracoalition.org/resources/covid19/community-survey-the-impact-of-covid-19-on-immigrants-in-mass/>

¹⁵ Guttmacher Institute, Immigrant women need health coverage, not legal barriers, December 4, 2018, <https://www.guttmacher.org/infographic/2018/immigrant-women-need-health-coverage-not-legal-barriers-0>. Low-income women are those in families with incomes under the federal poverty level (\$20,420 for a family of three in 2017). Data include some information on undocumented immigrants, although that information is generally acknowledged to be a considerable undercount of that population group.

¹⁶ Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub.L. 104-193 (1996).

states have utilized enhanced federal Medicaid funding included in the March 2020 Families First Coronavirus Response Act (FFCRA) to expand coverage to larger numbers of non-citizens.¹⁷

In addition, even AAPI immigrant victims who may be eligible for federal or state-funded healthcare coverage may be foregoing such coverage due to concerns that receiving such benefits will subject them to the negative immigration impacts of the public charge rule.¹⁸ In some particularly troubling examples, victim advocates have reported that survivors who have physical injuries or who have been sexually assaulted have been reluctant or have declined to go to the hospital to be treated for their injuries or to have a sexual assault forensic examination conducted due to fear of negative immigration consequences.¹⁹

Recommendations

API-GBV recommends that the Administration strongly encourage states that receive enhanced funding to cover COVID-19 vaccination for all Medicaid enrollees, including improving access for pregnant immigrant women enrolled in the Children’s Health Improvement Program (CHIP). API-GBV further recommends that the Administration discourage states that receive enhanced funding from reducing, but rather encourage maintaining existing levels of cost sharing for Medicaid program participants. HHS should interpret Medicaid Maintenance of Efforts (MOE) costs to include expenditures on non-citizens, as excluding them from coverage is particularly problematic given the disproportionate impact of COVID-19 on immigrant communities.²⁰ In addition, HHS should clearly provide guidance interpreting COVID-19 testing and treatment as emergency conditions that should be covered under emergency Medicaid.²¹

In addition, the Administration, through DHS, and with support from HHS, should work to update the regulation on Inadmissibility on Public Charge Grounds²² to reassure AAPI and immigrant survivors of domestic violence, sexual assault, and other crimes, that they can access COVID related healthcare, food assistance, housing benefits, and other public supports to help overcome abuse without negatively impacting their ability to regularize their immigration status. While many immigrant survivors may be exempt from the public charge inadmissibility ground if they are seeking VAWA immigration relief, T & U visas, or asylum, many other victims of domestic violence, sexual assault, and human trafficking, along with their family members, seek status in

¹⁷ Families First Coronavirus Response Act, Public Law No. 116-127 (Mar. 18, 2020)

¹⁸ S. Artiga, U. Petry, *Living in An Immigrant Family in America: How Fear and Toxic Stress Are Affecting Daily Life, Wellbeing, and Health*, The Henry J. Kaiser Family Foundation (2017), Available at <https://www.kff.org/report-section/living-in-an-immigrant-family-in-america-issue-brief/>

¹⁹ Jordan, M. (March 2020). ‘We’re Petrified: Immigrants Afraid to Seek Medical Care for Coronavirus, *New York Times*, Retrieved from <https://www.nytimes.com/2020/03/18/us/coronavirus-immigrants.html>

²⁰ C.D.C., *COVID-19 Case Investigation and Contact Tracing among Refugee, Immigrant, and Migrant (RIM) Populations; Important Considerations for Health Departments* (Dec.4, 2020) Available at: <https://www.cdc.gov/coronavirus/2019-ncov/php/rim-considerations.html>

²¹ KFF, *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19* (2020), Available at: <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>

²² [84 Fed. Reg. 41292](#) (Aug. 14, 2019); [84 Fed. Reg. 52357](#) (Oct. 2, 2019)

other, non-victim based, immigration categories. Relatedly, USCIS should *provide a clear list of benefits* that count as factors in a public charge determination, as well as a guidance clarifying examples of benefits that do not count as factors, such as COVID related benefits. This is particularly important for survivors who are accessing victim services and benefits, including federal supports and assistance provided through programs funded under the Violence Against Women Act, Family Violence Service Prevention Act, or Victims of Crime Act, among others, as well as state, local, and privately funded programs intended to address the needs of victims.

C. Confidentiality and Privacy Related to Data Collection

In addition to concerns about healthcare coverage and immigration impacts of seeking care, are fears about the lack of privacy protections for health information, which may lead survivors in particular to decline to fully participate in the health care system. Survivors often use some form of privacy-protective behavior to minimize unwanted disclosure of their health information, including withholding information from their providers, paying out-of-pocket or avoid submitting claim, doctor-hop in an attempt to keep their records separate, and, in the most serious cases, avoiding care altogether. Real safety concerns for survivors make the disclosure of health information a significant risk. Especially during the pandemic, when there has been a significant shift to telehealth, the need for privacy is particularly acute for survivors.²³

While all health care consumers have some concern about the disclosure of their health information, domestic violence, sexual assault, or stalking survivors have some specific privacy concerns. Survivors may become vulnerable to further abuse and unwelcome exposure through the inappropriate disclosure of their health information. For example, perpetrators who discover that a victim has sought care for injuries and disclosed the abuse may retaliate with further violence. Employers, housing providers, insurers, law enforcement agencies, and even members of a victim's community who discover abuse in health records may discriminate against a victim or alert the perpetrator.

Furthermore, AAPI immigrant survivors have the additional concern that their health information might be disclosed to immigration enforcement, likely decreasing their willingness to access COVID-19 related or other healthcare.

Recommendations

In order to protect survivors of domestic violence, sexual assault, stalking, human trafficking, as well as others may have justified concerns about what information is collected, all policies, protocols, and practice about the use and disclosure of health information, especially that about survivors, should respect patient autonomy and confidentiality, and should further their safety and health. Particularly important are thoughtful policies and protocols about how information is

²³ M.I. Ragavan et.al, Supporting Intimate Partner Violence Survivors and Their Children During the COVID-19 Pandemic, *Pediatrics*. 2020;146(3): e20201276

stored and with whom and for what purpose it might be shared, with priority for confidentiality and privacy. In addition, the Administration should promote best practices regarding training for contract-tracers in identifying domestic or family violence, in order to conduct contract tracing in a manner that reduces risks to survivors, and to provide relevant referrals for survivor support.

API-GBV further recommends resources and training for culturally specific victim services providers, in particular, that provide shelter and housing for victims, to develop policies and protocols, as well as in-language materials for program participants to respond to COVID contact-tracers,²⁴ addressing confidentiality obligations as well as the need to reduce the spread of COVID-19.

With respect to health, human services and housing programs, the Administration should promulgate guidance and training recommending that unnecessary personal information should not be collected and shared. For example, while the CDC's Data Use Agreement states that Social Security, driver's license and passport numbers will not be requested, federal, state and local health agencies must be required to safeguard all personally identifiable information necessary for public health purposes, such as address or date of birth. We are concerned that collection of identifiable information would be a deterrent for immigrants and other communities impacted by disparities. No identifiable information should be collected, stored or transmitted by any level of government beyond what is needed to ensure completion of second doses of a vaccine, monitor vaccine safety, and to analyze and report high level demographic disparities data. Clear, in-language, consumer-facing information must be given to individuals receiving the vaccine about how their data will be used. Any existing or future agreements that share unnecessary data should be terminated or modified to ensure such identifying information is not transmitted.

It must also be made explicitly clear that no data will be used for immigration enforcement purposes. Federal, state and local health agency guidance and data sharing agreements must explicitly state that any data collected from vaccine recipients will not be shared with law or immigration enforcement agencies under any circumstances, nor with public or private entities that provide data to those agencies. These standards should be publicly available, to address vaccine hesitancy among immigrants for fear of enforcement purposes.

D. Language translation and interpretation

One of the greatest challenges AAPI survivors of domestic and sexual violence are facing during the COVID-19 pandemic is language access. Over 25 million individuals in the United States are Limited English Proficient (LEP),²⁵ with approximately 20 percent who speak Asian languages.²⁶

²⁴ See, e.g., <https://www.techsafety.org/contact-tracing-scenarios>

²⁵ Asian & Pacific Islander American Health Forum Analysis of 2017 American Community Survey Data.

²⁶ Monica Whatley and Jeanne Batalova, Limited English Proficient Population of the United States, Migration Policy Institute (2013), <https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-0>

Nearly 48% of Asians and Pacific Islanders in the U.S. report speaking English less than “very well.”²⁷

Language assistance is necessary for LEP persons, including survivors of domestic violence and sexual assault, to access federally funded programs and services as well as state and local programs. Often, the impacts of failure to provide meaningful language access can have cascading, inequitable impacts. AAPI immigrant survivors of violence often do not have opportunities to learn English, as abusers commonly prevent them from doing so, force them into isolation, and/or prevent them from working.²⁸

AAPI survivors and others who have limited English proficiency (LEP) face difficulty obtaining current, accurate information about the coronavirus pandemic and corresponding stay-at-home orders, business restrictions, and accessing testing, vaccines, care, and the services they need, putting their health and safety at risk. Most of the information and resources about COVID-19 are available online, such as on the websites of public health agencies like the Centers for Disease Control and Prevention, or through media like briefings streamed on television or news articles, and are primarily provided in English. Although some are translated into other languages, they are rarely provided in enough Asian and Pacific Islander languages to meaningfully reach the AAPI community.²⁹ The information and resources posted online are also likely to be difficult to find, especially when the websites housing them are in English. Several AAPI-serving organizations and programs have taken it upon themselves to provide translated information and materials to the community – often sharing through social media. However, this still poses a challenge for many AAPI survivors of domestic violence to learn about COVID-19, as abusers may prevent them from using social media.

In addition, AAPI survivors who are uncomfortable speaking English may fail to receive proper care if they contract COVID-19 and go to a clinic or hospital for treatment. If the health care provider lacks a robust language access plan and protocol, LEP survivors will face challenges in providing emergency health care providers with critical information, such as their medical history, the intensity or duration of the symptoms, other health concerns or complications that may be co-occurring, any questions they may have, or other information that health care providers need to make medical decisions. Health care providers and survivors have to rely on interpreters to help them understand one another.

²⁷U.S. Census Bureau (Oct. 2015). 2009-2013 American Community Survey. <https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html>;

²⁸ Kim, C., & Sung, H.E. (2016). The Effects of Acculturation on Intimate Partner Violence Among Chinese Immigrants in New York City, *Journal of Family Violence*, 31: 325-336.

²⁹ Bergstrom, D. (March 2020). Fresno-area translators race to get coronavirus info to Hmong, Punjabi, Spanish speakers. *The Fresno Bee*. Retrieved from <https://www.fresnobee.com/fresnoland/article241450391.html>; Bernal, R., & Moreno, J. E. March 2020). Language barriers hamper coronavirus response. *The Hill*. Retrieved from <https://thehill.com/latino/488834-language-barriers-hamper-coronavirus-response>

With COVID-19, however, having to rely on interpretation and translation comes with its own complications. Many hospitals are currently employing remote interpretation services, and it can be difficult to reach an interpreter on such short notice, especially if the language the survivor speaks is not a common one.³⁰ In addition, even with the help of interpreters, communication between health care workers and survivors can still be confusing. Several health care providers note that the inability for health care providers, interpreters, and LEP patients to be able to clearly speak with and hear one another may have contributed to potentially unnecessary deaths of LEP patients with COVID-19.³¹

During this crisis, the gaps that we have seen in the past regarding lack of language access have made themselves more evident. There have been reports of people arriving at hospitals and language access not being afforded, leading to negative outcomes. Departments of Health and other government agencies have failed to provide in some cases information in other languages, leaving individuals to depend on private non-profit or community activists to generate their own materials in other languages. In the courts, interpreters have mentioned losing jobs due to the lack of opportunities as courts have closed and emergency services have moved to Zoom, Adobe Connect, Skype and other platforms. Interpreters some times are not called to interpret for victims in virtual settings. Those who have, are reporting issues with technology and victims do not know how to connect and use the technology properly.³²

Recommendations

As a threshold matter, the Administration should encourage recipients of federal funding for COVID related programming, such as victim services, public safety and law enforcement, economic supports, and health programs to ***engage in language access assessment and planning to ascertain LEP service needs*** by prioritizing federal resources for such entities.³³ In addition, the Administration should ensure federal materials, forms, websites, and documents are ***translated into threshold languages, and are easy to read and user-friendly***, including providing forms and documents that are made ***available in alternative formats such as large font, Braille or electronic formats***, and providing ***sign language interpretation*** for oral communication.

To determine accuracy and relevance, federal agencies should contract with or hire racially/ ethnically diverse community-based organizations to ***“field test” translated materials*** for cultural and linguistic appropriateness.

In addition, federal agencies should support the creation of ***dedicated units and hotlines to assist LEP individuals, individuals with disabilities, and seniors*** seeking benefits with application

³⁰ Kaplan, J. (March 2020). Hospitals Have Left Many COVID-19 Patients Who Don't Speak English Alone, Confused and Without Proper Care. *ProPublica*. Available at <https://www.propublica.org/article/hospitals-have-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care>

³¹ *Id.*

³² Casa De Esperanza (April 2020), COVID-19 Survivor Impact Briefs: Immigrant and Limited English Proficient Communities, see https://reachingvictims.org/wp-content/uploads/2020/05/Immigrant-and-Limited-English-Proficient-Survivors-Impact-Brief-April-2020_5.19.20.pdf

³³ See, https://www.lep.gov/sites/lep/files/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf

questions, renewals and other needs. These hotlines should enable applicants to connect to assistance in their native language. Relatedly, federal agencies should provide *dedicated funding for community-based organization (CBO) navigators and assisters* who are representative of the diverse communities they serve, play a critical role in facilitating enrollment through online application and automated renewal systems.

To provide support for these efforts, the Administration should supplement Executive Order 13166,³⁴ and in doing so should:

1. Reestablish the interagency Limited English Proficiency (LEP) Working Group.
2. Direct federal agencies to assess their federally conducted and federally assisted programs and activities to develop plans to increase resources for language access and strengthen enforcement of and compliance with Title VI (this could include issuing program specific guidance, conducting compliance reviews, inserting language in federal grant announcements, and including specific language in terms and conditions of grants, etc.).
3. Direct the Office of Personnel Management (OPM) to develop position descriptions and mechanisms to increase the numbers of qualified bilingual staff in federal agencies that have significant contact with the public, and direct the Office of Management and Budget (OMB) and the General Services Administration to study and make recommendations for the creation of a national language line and centralized translation center for the federal government.
4. Develop guidance for translation of information on federal agency websites, and guidance on development of public information and forms by federal agencies for LEP communities.

In addition, the Administration should

1. Update and reinvigorate LEP.gov as a central hub for language access tools, model policies, and other resources for federal agencies and their state and local partners that help build momentum around language access.
2. Ensure that newly issued federal resources from across various agencies are cross published to the LEP.gov site and regularly promoted.
3. Establish a regular email newsletter to inform interested parties of the publication of new resources or other developments of interest.
4. Reestablish and rebuild HHS's Office of Civil Rights with resources for enforcement of LEP policy, especially in the context of COVID related resources.
5. Establish guidelines for research initiatives that promote the collection and reporting of data about the primary and preferred languages that individuals speak, read, and write when communicating with federal departments and agencies about services and program.

E. Data disaggregation across AANHPI communities

Disaggregation by more specific race and ethnicity categories is essential to understanding inequities and disparities impacting AAPI communities. Over a year into the COVID-19 pandemic, during which the racial and ethnic disparate impacts have been frequently

³⁴ <https://www.justice.gov/crt/executive-order-13166>

acknowledged, agencies such as the Centers for Disease Control and Prevention continue to report data combining the separate Asian and Native Hawaiian and Other Pacific Islander categories, and often fail to report any data about Asians, Native Hawaiian and Other Pacific Islanders, and American Indians and Alaska Natives, lumping them into an “Other” category.³⁵ The label “Asian American” fails to distinguish the differences among Chinese, Laotian, Cambodian, Indian, Nepalese, Vietnamese, Filipino, Bangladeshi, Afghani, and smaller-size communities such as Native Hawaiians, Alaskan Natives, American Indian, and Pacific Islanders.³⁶

Fortunately, states and localities have been collecting such data at a more granular level. From these efforts, we know that Filipino and Filipino American nurses are dying from COVID-19 at disproportionately high rates in California, accounting for more than 30 percent of the 205 U.S. nurses who have died, though the group makes up just 4 percent of the total nurse workforce.³⁷ We also know that Asian Americans in San Francisco have been dying from COVID-19 at a higher rate than other ethnicities.³⁸

Recommendations

As a starting point, related to prior recommendations, the collection of demographic data should be done in ways that provide meaningful language access. Without language access in basic data collection efforts, including access for individuals with visual, hearing, and other communications barriers, there will be inaccurate data about inequities and barriers to access and utilization of COVID-19 related programs and services. For example, though statistics show that Asian Americans in the U.S. are faring relatively well through the COVID-19 pandemic, the data fails to include the most vulnerable Asian-Americans, such as those who have limited English proficiency, who don’t participate in such surveys.³⁹

In addition, federal agencies and departments should support more granular disaggregation when appropriate, and to continue to work with state and local governments to support additional disaggregation where there are more diverse racial and ethnic subpopulations.

³⁵ See, e.g., Smith AR, DeVies J, Caruso E, et al. Emergency Department Visits for COVID-19 by Race and Ethnicity- 13 States, October–December 2020. *MMWR Morb Mortal Wkly Rep* 2021;70:566-56 (data combined for “Asians and Pacific Islanders”), <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7015e3-H.pdf>

³⁶ E.g., McFish PA, Purvis R, Willis DE, Riklon S. COVID-19 disparities among Marshallese Pacific Islanders. *Prev Chronis Dis.* 2021;18(E02): 200407, https://www.cdc.gov/pcd/issues/2021/20_0407.htm; Eama A. Especially hard hit by coronavirus, City’s Bangladeshi community see failure of government to protect vulnerable New Yorkers, *Gotham Gazette*, July 20, 2020, <https://www.gothamgazette.com/city/9609-bangladeshi-community-hard-hit-coronavirus-government-failure-vulnerable-newyorkers> (over 230 Bangladeshis in New York City have died from COVID-19).

³⁷ F. Kelliher, California’s Filipino American nurses are Dying from COVID-19 at Alarming Rates (2020), Available at: <https://www.mercurynews.com/2020/10/04/californias-filipino-american-nurses-are-dying-from-covid-19-atalarming-rates/>

³⁸ M. della Cava, Asian Americans in San Francisco are dying at alarming rates from COVID-19: Racism is to blame, *USA Today*, October 18, 2020, <https://www.usatoday.com/in-depth/news/nation/2020/10/18/coronavirus-asian-americans-racism-death-rates-san-francisco/5799617002/>

³⁹ See <https://www.scientificamerican.com/article/its-a-myth-that-asian-americans-are-doing-well-in-the-pandemic/>

Conclusion

Thank you for the opportunity to provide information to OMH on addressing the needs of AAPI survivors of domestic violence, sexual assault, human trafficking, and other forms of gender-based violence. We hope there will be serious consideration to addressing COVID-19 challenges in an intersectional manner, and takes into consideration not only race and ethnicity, but also gender and gender-identity, sexual orientation, socioeconomic status, disability, immigration status, and the needs of indigenous communities. Please do not hesitate to contact Grace Huang, Director of Policy at API-GBV at ghuang@api-gbv.org with any questions or concerns. Thank you.

Respectfully submitted,

ASIAN PACIFIC INSTITUTE ON GENDER-BASED VIOLENCE

A handwritten signature in black ink, appearing to read 'Grace Huang', with a stylized flourish at the end.

GRACE HUANG