



Brief No. 3: **Visibility & Survival in the Age of COVID-19**

INTRODUCTION

In August 2020, the Coalition of Asian American Leaders (CAAL) held the third session in a series addressing the state of Asian Minnesotans, intending to tackle research, data, stories, community narratives, and bring timely discussions that are pertinent to understanding the diverse and resilient communities that make up Minnesota's Asian population.

This session took place as cases of COVID-19 were continuing to rise in Minnesota, particularly within Asian communities and specific Asian ethnicities. In advance of a forecasted fall season of increasing caseloads and deepening health disparities, speakers Ignatius Bau, Chao Yang, Dr. Ia Xiong and Hedy Tripp wove together a range of perspectives on the critical work of this moment as well as the long-standing issues in health equity illuminated by the pandemic.

KEY THEMES

- 1.** The invisibility of Asian communities and issues has deadly effects during the pandemic and shapes access to information, resources, and decision-makers.
 - 1a.** The lack of data disaggregation for ethnic groups within the Asian demographic category obscures which communities face specific risks and impacts and impedes community-specific responses.
- 2.** The pandemic is exacerbating existing disparities and systemic inequalities that intersect with community health.
 - 2a.** This includes economic disparities for Asian Minnesotans;
 - 2b.** Anti-Black racism, anti-Asian racism, and xenophobia (both systemic and personal) are exacerbated by the pandemic as well.
- 3.** The pandemic has also affected communities' mental health and triggered collective, historical, and individual trauma; recognizing culturally specific resilience and healing practices is key to a holistic response.

CONTEXT

Beyond jingoist language about COVID-19 as the “China Virus” or Kung Flu,” Asian Minnesotans face unique risks related to the virus both independent of and related to challenges in accessing care and accurately measuring the virus’ impact on Asian Minnesotan communities. These challenges are rooted in the plurality of the Asian experience, the impacts of public health policy rooted in anti-Blackness, and lack of access to resources in other aspects of life.

In every policy discussion, it must be acknowledged that while “Asian American” is a political identity created by Asian organizers in the 1960s to build shared power, it is also a demographic term rooted in a Western/white-centric worldview that classifies a wide plurality of cultures, ethnicities, and histories under one umbrella term.

While interaction with and response to whiteness may be similar for some Asian ethnic groups, the histories and challenges within these groups are very different and should not be assumed to be the same. Additionally, while anti-Asian racism and xenophobia have captured public attention since the outbreak of COVID-19, existing Islamophobia continues to threaten Muslim Asian communities.

In the face of a pandemic that has slowed the world’s pace and forced us to re-examine and rebuild systems and structures, it is more crucial than ever to disaggregate data on the Asian community so that we may build truly equitable responses. Our very lives depend on it.

SUMMARY

COVID-19 Issues & Impact

Ignatius Bau, National Health Policy Consultant, reflected broadly on the current state of COVID-19 in the United States to open the session. At the time of the session, the United States had 5.8 million cases of COVID-19 that had resulted in over 179,000 deaths. Bau noted that, beyond the immediate impact of infections and deaths on individuals and their families, we are already seeing ripple effects on the economy due to job loss and worker shortages as well as the “cascading” impacts of COVID-19 caused by people putting off non-essential medical procedures, dental appointments, and, in some cases, not seeking out or being able to access mental health services. Further, the murder of George Floyd in Minneapolis, the resulting uprising, and the ongoing reckoning around racism across many systems and institutions led to several cities declaring racism a public health crisis, framing the moment as the intersection of two pandemics: COVID-19 and racism.

While the COVID-19 pandemic has impacted people across racial and economic lines, the intersections of ongoing systemic failures and entrenched white supremacy exacerbate and amplify the effects of COVID-19 on Black, Indigenous, and people of color.

Specific to Asian Americans, the model minority myth creates a notion that Asian Americans are less impacted by the pandemic and by racism. The “invisibility” of Asian Americans/Asian Minnesotans is based on a lack of general data but especially the lack of disaggregated data. For example, aggregated data¹ from 2019 show on-time high school completion rates for Asian Americans in

1 <https://www.twincities.com/2019/04/23/minnesota-high-school-graduation-rate-ticks-up-while-st-paul-falls-back/>

Minnesota as 87%, which erases much lower percentages by specific communities and hides the challenges and lack of support available for these specific groups. Current available COVID data indicates higher death rates among Asian Americans, specifically Pacific Islanders, even as infection rates are consistent with other populations. Pacific Islanders are often “lumped together” with all other Asian ethnicities, which creates challenges in determining the exact impact areas.

While current infection and death numbers from Minnesota reflect the disproportionate impact of COVID-19 on Black, non-Hispanic Minnesotans and Hispanic Minnesotans, the same shortfalls in data gathering and measurement apparent in education apply to Asian Minnesotans in health data. As “perpetual foreigners,” Asian people in the United States have historically been lumped together, despite very different relationships to the United States and the state of Minnesota. Where this has persisted as a quality of life issue, outdated and inaccurate white Euro-centric evaluation models now cost the lives of Asian Minnesotans.

In his presentation, Ignatious Bau highlighted some examples of translated informational materials and the availability of translators in Minnesota, lifting up the on-going importance of multi-language accessibility in healthcare and the progress being made during the COVID-19 pandemic. Simply sending MN Department of Health workers into Asian Minnesotan communities to administer COVID-19 tests is not a realistic response to decades of systemic neglect and cultural exclusivity at the policy level; culturally and linguistically appropriate contact tracing, including utilizing trusted community leaders, is essential to any successful contact tracing operation. This, unfortunately, runs counter to white-led efforts that evoke dynamics of paternalism and White Saviorism rather than centering, uplifting, and believing the voices of those who are most vulnerable (such as healthcare workers or essential/low-wage workers), both within the Asian community and outside it.

Intersecting and compounding the need for disaggregated data to address the spread of COVID-19, the Trump administration's anti-immigration policies and proclamations have created an “invisible wall,” creating major barriers to COVID-19 testing and treatment for immigrant communities at large. It should be noted that, at the time of this session, there were several pieces of responsive legislation introduced intended to benefit immigrants and other vulnerable populations, highlighting the importance of policy change in responding to COVID-19.

There have been important advances for Asian Americans at the federal level, for example, the Civil Rights Act, which specified the right to language access under Title VI, the Voting Rights Act, and the creation of bilingual ballots. Increasing public xenophobia and racism during COVID-19 demands continued action.



Bau noted that Minneapolis is one of 170+ cities in 23 states that have declared racism a public health emergency and allocated funding toward dismantling systemic racism. Additionally, the Minnesota House of Representatives passed a resolution declaring racism a public health crisis in Minnesota. However, at the time of the session, the Minnesota Senate had not followed suit. It should also be noted that while declarations are an important step in the process, they must be followed by meaningful action. In the case of Minneapolis, a day after declaring racism a public health crisis, the City Council ordered the removal of a homeless encampment (consisting of primarily BIPOC residents) from Powderhorn Park.

The City Council's actions in Minneapolis illustrate the conscious thought needed in rebuilding systems rather than relying on previous institutions that were not working for too many people. Bau referenced an op-ed by Dr. Thomas Lee about the problem with "going back to normal" in healthcare versus creating a new, more inclusive normal. In the webinar, Bau suggests a new normal should use the World Health Organization's definition of health, which is not tied to insurance and is applied at individual, family, and community levels.

WHO Definition of Health:

"Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Current social determinants of health are tied directly to access and equity; barriers to health and healthcare for immigrant and BIPOC communities result from racist capitalism and the myth of American individualism that rewards hoarding resources over inclusion and perceived individualism over community. While they are deeply ingrained in our culture, these systems are neither intuitive nor irreparable; however, they are entrenched and require work and trust in one's community to dismantle.

Health Equity

Health equity is attainment of the *highest level of health for all people*. Achieving health equity requires valuing everyone equally with focused and ongoing *societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities*.



Just as unjust and inequitable systems have taken generations to take hold, they cannot be dismantled overnight. In the immediate future, Bau argued, to protect the most vulnerable members of our community, we must provide patient and family-centered healthcare and health insurance for all, even as we re-imagine the need for health insurance. In addition, COVID-19 has shown the potential for expansion of healthcare access through telehealth services and brought wider attention to the digital divide and language barriers.

Bau concluded his presentation with his recommendations for achieving health equity:

- Acknowledge racism in health care
- Collect and report demographic data
- Provide culturally and linguistically appropriate care
- Diversify the health workforce
- Address the social determinants of health

Local Overview

The COVID-19 pandemic has boosted long-standing local efforts at community and policy levels to address inequities and disaggregate data. Chao Yang, Public Health Educator from St. Paul Ramsey County Public Health (SPRCPH), provided an overview of the efforts of Ramsey County to provide COVID-19 testing and treatment to all residents and the challenges and triumphs within these efforts.

Minnesota's Asian population's ethnic composition is vastly different from other major Metro areas, so even broad federal policy affecting different states would benefit from disaggregating data. This is true for all ethnicities and racial groups but, as continually stated in this paper, Asian Americans are a uniquely amorphous racial group within the context of the United States. Since public health exists to protect the health of communities/the whole population (as opposed to treating individuals), the unique traits of the whole population must be considered in order to be effective.

St. Paul Ramsey County Public Health (SPRCPH) Response

The current SPRCPH COVID-19 Response includes special attention to prevent the spread of the virus within Hmong and Karen communities. There are higher rates of COVID-19 among Asian Minnesotans which is anecdotally linked (but as yet not confirmed) to be the result of a more communal living style, including multi-generational families living together. Many of the successes in this response are thanks to SPRCPH

Ramsey County Quick Facts

- Over half of Minnesota's population resides in the seven counties considered the Twin Cities metro area.
- Ramsey County's size makes it Minnesota's only county with the US Census designation of "fully urbanized" with approximately 550,210 residents within its 170 square miles.
- 15% of Ramsey County's residents were born in a foreign country, with a large number of youth being first generation.
- Ramsey County has a high population of refugees, asylees, and immigrants, with especially large numbers of refugees arriving within the last ten years from Burma, Laos, Somalia, Ethiopia, and Bhutan.
- Roughly 36.5% of Ramsey County residents are classified as people of color.
- Asian Americans are the largest racial group in Ramsey County. It is also home to the largest population of Karen people (17,000+) in the United States.
- Hmong people constitute the largest Asian population in St. Paul/Ramsey County.

staff who have built meaningful relationships within Southeast Asian communities to facilitate health education and resources. The Ramsey County Dashboard has the most up to date information on COVID-19 cases, hospitalizations, deaths, and the official response. Some accomplishments of the Hmong and Karen team include:

- A weekly Hmong and Karen newsletter
- Health education outreach to Asian small businesses
- Health education outreach to Asian adult daycare
- Serving as a focal COVID-19 resource for community members
- Outreach to Hmong media (radio and TV)
- Gathering community input to inform Public Health strategies and approaches
- Working with local and state departments to coordinate the response(s)
- Advocating for the community as new needs arise (Ex. making sure Hmong funeral traditions are considered when drafting health guidelines)
- Providing free testing at sites determined by the community

“We want to ensure our staff and volunteers reflect the community we are serving.”
- Chao Yang

Other County-level Responses

Yang also noted the role of the Racial Equity and Community Engagement Response Team (RECERT), which was formed in April 2020 with the purpose of informing Ramsey County’s response and creating links between County operations and residents. RECERT’s current project at the time of this session was distributing free masks.

In addition to RECERT, the Statewide Health Improvement Team (SHIP Team) works on increasing access to healthy foods and decreasing use and exposure to tobacco, and partnerships between the Other Media Group and the Hmong Breastfeeding Coalition provide coaching around breastfeeding during the pandemic.

While there are important and meaningful steps happening at the county level and, at a slower pace, at the state and federal levels, no amount of policy will be a fully inclusive solution for any community. The community-specific response from local government response provides a hopeful model to learn from but BIPOC communities and Asian Minnesotans must remember that existing systems were not created or made successful with our well-being in mind; it is contingent upon the very people who will be most impacted by COVID-19 and racism to organize our own response, prevention plans, and care plans. As Yang pointed out, this can include actions such as staying home, wearing a mask, washing hands, social distancing, getting tested for COVID-19, and increasing visibility and access of Asian Minnesotans by volunteering with the Ramsey County Medical Reserve Corps.



Community Resilience: Hmong Mental Health During COVID-19

To elaborate on perspectives from within the community, Dr. Ia Xiong, Licensed Psychologist and Community Leader, discussed her research on the unique historical trauma within the Hmong community and the ways in which it manifests in relation to mental health and community stability. In many ways, Dr. Xiong's research shows the clearest example of the intersecting impacts of colonialism, racist immigration policy, the model minority myth/aggregated data, and lack of access to public health resources on Asian Americans.

Prior to the COVID-19 pandemic, barriers to mental healthcare for Hmong people included lack of access (Ex. transportation) to care professionals, limited representation of Hmong people in the mental healthcare field, a distrust in services, and a lack of culturally appropriate care/multicultural competence (Ex. holistic perspectives that focus on the connection of mind, body, and soul). These factors stem from the history of Hmong people in the United States, which has contributed to a cycle of historical trauma and exclusion.

Historical and Intersectional Trauma

As a distinct group, Hmong people have faced massive group trauma through genocide, slavery, forced relocation, and destruction of cultural practices stemming from their treatment throughout Asia, their service to the United States during the Vietnam War, and their subsequent post-war treatment by the United States and its allies. Dr. Xiong argues that this has created an overrepresentation of Historical Trauma Response (HTR) (Ex. depression, anxiety, PTSD, violence within community, and substance abuse) within the community, resulting in an intergenerational transmission of historical trauma. The descendants of people who experienced genocide or forced relocation show trauma responses despite not experiencing genocide or forced relocation

directly. Placed within the context of American anti-Blackness and the model minority myth, the Hmong community faces an especially cruel set of barriers to inclusion and access to all forms of healthcare, especially mental health care.

Key differences between Western and Hmong perspectives of mental health create an invisible but no less present barrier to mental health care. Specifically, the Western use of the medical model (which historically normalizes white men), an individualistic approach, and a focus on diagnosis and treatment run counter to Hmong culture, which is more collectivist. While a lack of disaggregation means there is currently little research and data specific to Hmong mental health, the available data shows disproportionately high mental health concerns and significant health disparities. Available data is often based on mental health professionals reacting to Hmong community members in crisis instead of preventative treatment.

Compounding Effects of COVID-19 on Existing Trauma

COVID-19 triggers existing historical trauma for the Hmong community in a myriad of ways. These triggers include but are not limited to:

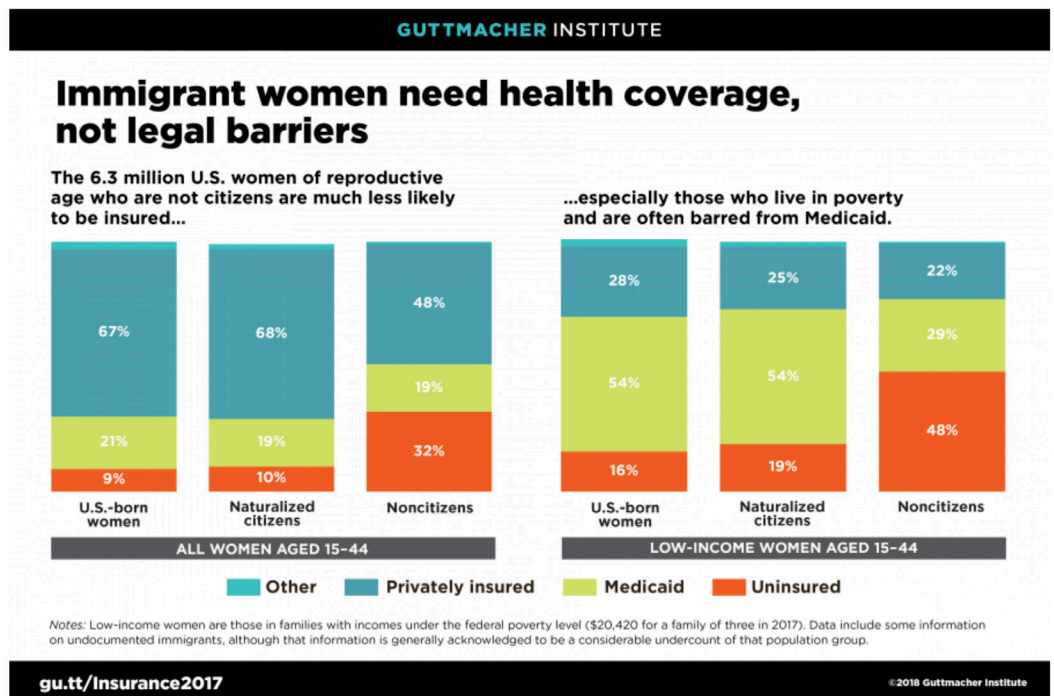
- Increased instances and reports of racism and xenophobia toward Asian people (for more on this, see CAAL SOAM Session 1);
- Distrust in governmental COVID-19 recommendations, stemming from the unique relationship of Hmong people to the US Government (for more on this, see Vang Tao section of CAAL SOAM Session 2);
- Fight or flight responses including hoarding of food and household goods, such as rice or toilet paper.

Additionally, increased isolation needed to slow the spread of the virus can trigger both depression and traumatic disruption of cultural practices (family gatherings, funerals, ceremonies). While social distance and physical isolation is necessary and recommended by the Center of Disease Control, like all American policies, it was planned and implemented under the assumption of white Euro-American normalcy, which places a lower value on community cooperation and togetherness.

Many of these access barriers were being endured by individual communities before, but the pandemic's sheer scale provides improvement opportunities. Improvements could include increased speed of change, increased awareness of different cultural needs within mental health, and creativity and innovation during a time of systemic flux. Emphasis must be placed on the importance of inclusive policy and representation to avoid repeating historical traumas, and attention to holistic care and psychological flexibility must be intrinsic to any action plan's success. The Hmong community's resilience and strength should be celebrated for what it is rather than repeatedly tested.

Community Resilience: The HEAL Act

In closing, Hedy Tripp, Elder Leader with National Asian Pacific American Women's Forum (NAPAWF) St. Cloud Chapter, shared information about her community work to address specific needs of the Asian American community, often erased by aggregated data and the model minority myth. The National Asian Pacific American Women's Forum (NAPAWF) is a pan-Asian, non-partisan organization that works to build collective power so that all AAPI women and girls have full agency over their lives, families, and communities. Recognizing the intersectionality of this mission, NAPAWF's is working to pass the HEAL Act (Health, Equity, and Access under the Law for Immigrant Women and Families Act) to expand access to healthcare services for immigrants.



Current U.S. policies on immigration create a significant barrier to healthcare for people still waiting on/working toward their citizenship. Tripp shared the example of women who recently immigrated being diagnosed with breast cancer but then needed to wait for treatment even as the disease progresses. She noted uninsured non-citizen immigrant women tend to be in their child-bearing years and are more likely to be low-income and barred from affordable healthcare and other resources.

The COVID-19 pandemic has shown, among many other things, that healthcare must be available to everyone, regardless of their immigration status, in order to minimize the spread of the virus. This should be the case during non-pandemic times since it will improve and sustain everyone's overall health; however, the voices of the most vulnerable people are routinely excluded from or ignored by policy making bodies. Therefore, it is contingent upon communities to advocate for themselves at the individual, local, state, and federal levels (See CAAL SOAM Session 4).

***“Access to health care
should not depend on
immigration status.”
- Hedy Tripp***

Based in St. Cloud, Tripp also brought a perspective from Greater Minnesota. Asian Minnesotans in Greater Minnesota face unique challenges such as greater isolation (St. Cloud's population is ~3% AAPI), which creates fewer inroads to community integration and connection and is compounded by the social distancing requirements in the face of the pandemic. Further, Asian Minnesotans who are still waiting to complete their citizenship process (See CAAL SOAM Session 2) face additional barriers to accessing healthcare. As movement builders and leaders, it is important to bring and sustain these voices to the table when building community and re-imagining public health.

FUTURE CONSIDERATIONS

As the pandemic continues to exacerbate systemic inequalities related to access, care and resources, Asian Minnesotans need both immediate responses and long-term attention to the systems that created this crisis as we rebuild and reimagine. This conversation raised the following questions to be explored further:

- 1.** The pandemic has shown with immovable certainty that existing systems were not created with the health, care and well-being of BIPOC communities in mind.
 - 1a.** To what degree can these systems be reformed and restructured?
 - 1b.** To what degree must our communities envision and build alternatives to truly serve and center BIPOC community needs?
- 2.** As illustrated, a lack of disaggregated data within health systems can be a matter of life and death, particularly in the case of COVID-19. Yet, talk of “disaggregating data” can lead to a focus on the data being collected rather than what its collection makes possible. How can we continue to advance the call for disaggregated data and increased community visibility with the urgency it deserves, in a way that names what the impacts on the community really are?
- 3.** What is the work needed to address mental health and historical trauma within communities holistically?
 - 3a.** How can our health systems and discussions of healthcare include culturally specific approaches to mental health and healing?
 - 3b.** How can we work to ensure efforts around cultural practices for healing and resilience are understood as a critical health intervention?
- 4.** Even within this conversation, multiple policy avenues were raised as a response to health access and coverage, from health insurance for all to universal healthcare.
 - 4a.** What tensions, contradictions, or analyses underlie these differences, and how do we, as Asian Minnesotans, navigate what is politically possible while remaining focused on which solutions truly meet our communities' diverse needs?
 - 4b.** Without a specific organization focused solely on Asian Minnesotans and health, what are the opportunities, avenues, and structures needed to ensure Asian Minnesotans have a voice in specific policy solutions to address community health inequities?

Summary by Jon F. Jee

REFLECTION

by ThaoMee Xiong (in verbal interview with CAAL staff)

This interview has been edited for length and clarity. The content includes discussion of the death of loved ones due to COVID-19.

Can you tell me how COVID-19 has affected you and your family?

It's impacted me personally, as my household is a multi-generational household, which is very common for a lot of Hmong American families. There's a beauty in it, like we're together and we get to help each other manage whatever's happening, but the hard thing is that we've been cooped up together for nine months. I have an elementary school child and a middle school child, and they do 100% distance learning. That's kind of added an additional responsibility for both my husband and I, even around simple things like when everyone eats lunch, and to be able to help them if there are technical problems. And then also, I think my morale has gone down. It's been really hard to not be in close proximity to friends, family and colleagues. And so I think mentally, emotionally, it's taken a toll on our entire family.

We have had lots of family members pass away due to COVID-19. And honestly, even trying to talk about it is really emotional. Because one, not only did they pass away from COVID, but two, it's like we didn't even get the opportunity to properly mourn them. Hmong funerals are usually—in our family it usually starts Saturday morning and goes all the way till Monday morning, so it's three days and two nights, and it's typically 24 hours. Now we've cut the funerals back [during COVID]. Some people do it one day, eight hour day, some people do the two days with one night. But even when we are at the funeral home, everyone is in their face masks, gloves. A lot of the components that would allow the community to come together to celebrate the life of the person that's passed away, they've had to be removed, because it requires people to congregate or it makes it easier for people to congregate. And the whole mindset about social distancing is that we have to put things in place so people don't congregate, and that means we have to minimize food, minimize drinks, minimize the number of people that can be in a place.

So that has been traumatic. I think it hit me hardest when one of our first cousins passed away. He didn't tell anybody he was sick, so when he passed away it was a total shock. And by that time he had already infected so many people, and they were also severely very sick. So it's just been really hard.

How would you say our systems' inability to really support people to protect themselves from the virus affected your family situation?

I feel like my immediate family has been very lucky. We've maintained our jobs, and we have a space in place where we can quarantine together. The cousin who passed away in October, he got sick because his company did not require people to wear masks. He got sick from a co-worker, as he's one of those essential workers who is still going to work. So I think that, because large swaths of young Americans are a critical part of the central workforce, they're more vulnerable to getting COVID. So I think if there's a way to eliminate the fact that we don't have to be in such vulnerable work environments and if there were stronger regulations in place for workers and protections for workers, I think that will be very helpful.

And then because of the way we live in very big congregated spaces, they're more likely to spread COVID and have multiple people in the family be infected by COVID. I think what Hmong American families did to survive and be able to, you know, thrive in Minnesota, like the way we live, also made us much more vulnerable. I was just told the other day that one of our cousins from my mom's side of the family, now has passed away because of COVID, and it was the exact same scenario. The daughter is a factory worker, and she went and got sick at the factory. She then came home and gave it to her mom, her mom gave it to her dad, and now her dad has passed away from it. So we just see this pattern playing out over and over again.

And then if these communities, meaning communities of color, if they already have high rates of underlying health conditions—like diabetes, hypertension, cancers that are really prevalent in Asian communities, and different things like that—it adds to the trauma of the situation and to the high rates at which people are getting COVID.

Is there more that you want to share specifically about your cousin and what happened with him, or about the impact on your family?

My cousin was older, in his fifties. He's the main breadwinner for the family and his wife works with him too, but he makes, you know, double what she makes. And so they both work for the same factory, but had different roles. And then he has adult children living with him, and he also provided a lot of financial support for his grown children, who have a lot of kids.

First of all, no one knew he was sick. He was told by his coworker that his co-worker's daughter was sick. And then he started coughing and having some mild symptoms, and then he went on a car trip with his brothers. On that trip, he kept coughing and was really sick, and everyone was like, "What's wrong with you? Why are you so sick?" He said, "I don't know, maybe I caught COVID from work."

They were already on the trip at that point, but when they came home, he was much sicker and everyone in that car got sick: his three brothers, and two of their wives. And so that meant five people got sick from him, and then they came home and they all quarantined. And then he told his employer that he was sick, and once his employer found out, the wife had to come home too and quarantine. He was quarantined for almost two weeks, but he didn't get better. But because he has fears of the Western medical system, he just kept resisting going to the hospital.

The night before he passed away, his wife kept saying, "Look, I should take you to the ER." But he insisted that he would be fine. So she went to sleep, because she was quarantining upstairs and he was quarantining downstairs, and by the time she went to go check in on him the next morning, he must have died a couple hours earlier.

That's when they started calling everyone to let people know that he had passed away at home. And then his wife and his two kids got it too, and then they had to be separated from the rest of the families. It was just such a huge shock and it still feels really unreal, because I never get to see them, so I won't feel the difference without him being around to start hanging out again. I think that's the other thing that's so hard, because it just feels surreal. It's hard to feel the impact yet, because we're not together. But I know that their family has made a lot of changes to be able to kind of move forward, and it's been really traumatic.

And the employer still hasn't been held accountable, right? Like the employer's done what the employer needs to do, but I think one of the challenges is that there needs to be accountability for employers, when they have workers coming in. I work for the City of St. Paul and we've got parameters in place to protect employees who get COVID. They get the presumption of workers compensation once they get COVID. It's just presumed that if they get COVID, it's through work, so they get compensated that way.

For this particular employer, and these stories about the meatpacking companies down in southern Minnesota, where large numbers of employees are infected by COVID—it's like, who ends up being able to protect the employee who got COVID from work? And if they have ongoing persistent health conditions, does that mean they can get fired? Does that mean they can get protected by unemployment? And unemployment just gives you enough to survive, to survive in like the simplest way possible.

Some communities are actually benefiting from COVID. There's job stability or companies that are booming but at the expense of workers. Think about Amazon, and all the deliveries, but look at all the frontline packagers. What is in place to help protect them and other workers in certain locations in Minnesota where Amazon has their hubs? Immigrant communities are the ones who are packaging and moving these packages. We're able to enjoy the luxuries that we can afford at the expense of people who need to be out and about working. And I still go to these fast food places, and then I think about all the people who are always working in these fast food joints. They're trying to make our life easier, while continuing to be vulnerable to getting COVID because they're in contact with so many people. The line is always so long, when I go to any of these places. So what are we doing really to protect our frontline workers?

This income disparity and the jobs disparity in the state of Minnesota, it's super problematic and that needs to be looked at. Many of our folks in the Hmong American community may not have citizenship, we may not have legal status, so what does [this pandemic] mean for people who don't have any benefits whatsoever, such as health care benefits? How do their families continue to survive in this economy when all the people who could be working to bring in money can no longer work?

Thank you so much, ThaoMee. Is there anything else you want to make sure to share? Anything we missed that you want to include?

I think more stories need to be told about the people who've passed away, to hear from their family members about [the impact]. Like if the head of household passes away, the impact it has. If a child has passed away, the impact it has. If it's a community leader, the impact it's had on the community. We hear that there's a disproportionate impact of communities of color who get infected with COVID and who die from home. And in Minnesota, the highest numbers of people who get infected are in the Latinx community, but they're not also the highest number that die from COVID. So there are different populations being impacted in different ways and different areas of Minnesota communities are impacted in different ways. And it matters, the more we can speak to and have a more human face to the people who passed away, versus just seeing these numbers every day.

I feel like we—we meaning people of color—carry the brunt of the deaths and the tragedies and the traumas being experienced by COVID-19, but all the conversation [doesn't recognize that]. There are still policymakers who refuse to accept the fact that there is structural racism and racial inequity in the state of Minnesota, that create the conditions for more people of color to be infected and to die from COVID. So that is a story that's not being told enough.



THE STATE OF
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