

# Ohio's COVID-19 Populations Needs Assessment

Minimizing the Disparate Impact of the Pandemic and Building Foundations for Health Equity



This document contains excerpts from the full report, which can be found here: <https://go.osu.edu/inequitable-burdens-covid-19>

# Findings Relevant to the CDC's Public Health Strategies to Combat COVID-19

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# Hygiene (Topic A): Integrated Findings Across Population Groups

In the findings below, key Ohio population groups that repeatedly mentioned each item are indicated by the following abbreviations:

**BA:** Black and African American

**AS:** Asian and Asian American

**RU:** Rural

**HL:** Latino and Hispanic

**IR:** Immigrant & Refugee

**DI:** Living with Disabilities

## Key Barriers to Using Hygiene

These categories represent the barriers that most commonly challenge the ability of key Ohio populations to utilize hygiene as a public health strategy to help minimize the impact of COVID-19.

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### **Lack of access, availability, and cost**

Hygiene products are generally difficult to obtain within all the populations studied; this includes cleaning and disinfecting supplies as well as masks (BA, AS, DI, HL, IR, RU). Some communities also lack access to laundry facilities and warm running water (BA, IR, RU). Hygiene products are often too expensive for low-income individuals to buy; their general un-affordability is also exacerbated by price gouging and by the fact that many individuals lack credit cards and therefore cannot purchase items online (BA, AS, DI, HL, IR, RU). Local stores often do not have these items in stock (BA, AS, HL, IR), and individuals don't always know where to look for them (BA).

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## **Mistrust of government and healthcare systems**

For several populations studied, mistrust of government, healthcare providers, and/or healthcare systems impede community members' ability to learn about or implement public health strategies to minimize the effects of COVID-19 (HL, IR, RU). The origins of this mistrust come from several directions, including histories of healthcare providers and researchers abusing Black and minority populations (BA, IR), fear that health and healthcare interactions might involve community members with law enforcement or immigration officials (IR, HL), and general distrust of government leaders and rules (RU). Additional elements exacerbate mistrust, including: lack of racial and ethnic diversity among healthcare providers (IR), confidentiality and privacy concerns (RU), not trusting healthcare providers to act in their patients' best interests (RU), and fear of being shamed by public officials or healthcare providers (e.g.: for only having one bathroom) (HL).

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## **Barriers related to work and school**

The need to work, and conditions at work, constitute significant barriers that affect the ability of individuals in all populations studied to practice protective hygiene (BA, AS, DI, HL, IR, RU). Many of these individuals work in low-wage jobs and must go to work to support themselves and their families (BA, AS, DI, HL, IR, RU). Many are essential workers in jobs that require considerable face-to-face contact with the public or other workers, and do not offer the option to work remotely or from home (BA, AS, DI, HL, IR, RU); in Asian communities these are often healthcare jobs (AS). Work attendance is often mandatory with little or no time off or sick time arrangements (BA, AS, DI, HL); staying home would risk job loss or loss of benefits (BA, HL, RU). Avoiding close contact is often impossible at work, and many workplaces do not enforce protective hygiene guidelines (BA, AS, DI, HL, IR); some jobs (e.g.: cashiers) make frequent handwashing or other hygiene practices impossible (DI, HL, IR, RU). Schools raise related issues including limitations on how often students can wash hands, children coming to school sick because their parents have to work, and students changing classrooms often throughout the high school day (BA).

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## **Language and communication barriers**

Language and communication barriers limit the ability of several Ohio communities to obtain hygiene-related information and resources (AS, HL, IR, DI). Information about protective hygiene practices and how to use them is usually presented only in English, which severely limits their benefit to non-English speakers and those with low English proficiency (AS, HL, IR). Professional translators and interpreters for individuals with disabilities are often unavailable when hygiene-related information is being shared; family members and children are limited in their availability and skill at translating information (AS, HL, HR, DI). In addition to large gaps in understanding of protective hygiene, confusion, misinterpretation, and fear may also result (AS).

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## **Housing challenges**

Within all the populations studied, housing conditions limit community members' ability to use protective hygiene practices (BA, AS, DI, HL, IR, RU). Housing units are often small and densely crowded (BA, AS, DI, HL, IR, RU), serving as homes to many people, several families, and/or multiple generations of a family (BA, AS, HL, IR). Sharing bathrooms, kitchens, bedrooms, and beds are particular challenges to hygiene and disinfection (BA, HL, IR, RU). These conditions are particularly true of low-income, immigrant, and refugee households (AS, IR). Many neighborhoods are also densely populated, making it difficult to avoid close contact with sick people and keep frequently touched surfaces disinfected (BA). Congregate housing arrangements impede protective disinfecting and avoiding close contact with sick people; these include apartments, public housing, shelters, halfway houses, and prisons (BA, DI, RU). Individuals in all communities studied lack access to alternate temporary housing or shelter for sick people or confirmed COVID-19 cases (BA, AS, DI, HL, IR, RU). Homelessness and housing instability also create lack of control over hygiene conditions (BA, DI, RU); migrant agricultural workers often live in camps and share bathrooms (HL). Necessary caregivers cannot avoid close contact with the individuals for whom they care (AS, DI).

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## **Lack of personal transportation**

Lack of personal transportation means that many members of the community rely on public transportation to get to work and move around the community, which impedes the use of protective hygiene practices and social distancing (BA, RU). The transportation that is available for shopping and moving around the community is sometimes too expensive to use (RU).

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### **Cultural values and norms**

For many of the populations studied, community norms and values inhibit the use of protective hygiene strategies that involve avoiding close contact and maintaining disinfected surfaces (AB, AS, HL, IR). Many cultures and communities emphasize collective and communal connections, creating the desire to maintain social functions, in-person contact, and physical touching (BA, AS, DI, HL, IR). Close contact is important in times of celebration, when offering support, and when engaging in religious life (BA, AS, HL, IR). Limiting normal social and physical contact can trigger feelings of isolation, rejection, and/or stigma (AS, DI, HL, IR), particularly for individuals and communities who have experienced considerable past trauma (AS, DI, IR). In rural communities, many do not believe COVID-19 is a real problem, is a problem in their areas, or will affect them personally; many also resist listening to government advice and feel pressure not to.

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### **Caregiving responsibilities**

Family members often serve as caregivers for loved ones. Caregiving roles – including for disabled individuals, children, and the elderly – impede avoiding close contact and using protective hygiene practices (BA, AS, DI). These relationships also mean that caregivers are responsible for protecting both themselves and those for whom they care (DI).

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### **Lack of health information**

Some members of the populations studied lack up-to-date information about specific hygiene practices that offer protection from COVID-19 (BA, DI, HL, IR, RU). Low health literacy and low general levels of education exacerbate this challenge (RU).

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### **Barriers specifically relevant for people with disabilities**

Disabilities can create direct barriers to using protective hygiene practices (DI). Some individuals require touch to communicate, are unable to cover their coughs or sneezes, and/or habitually put hands to mouth or touch their eyes. Individuals with disabilities may also rely on others for help with handwashing, cleaning, personal care, activities of daily living, and more. Much of caregiving requires close proximity and physical touch. Reliance on caregivers means that caregivers must understand and follow protective guidelines.

## Commonly Proposed Solutions to Facilitate Use of Hygiene

These categories represent our respondents' commonly proposed solutions to the barriers that impede use of COVID-related hygiene practices by Ohio populations.

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### **Provide resources directly**

Directly providing the resources and supplies to which communities lack access would improve the use of protective hygiene (BA, AS, DI, HL, IR, RU). Specifically, this could involve making masks, gloves, and cleaning products available free or at reduced cost (BA, AS, DI, HL, IR, RU). Direct financial supports – including unemployment, emergency pay, stimulus payments, increased funding for disability service providers – would facilitate community members' ability to purchase their own supplies (BA, DI, HL, IR, RU). In addition to making supplies more available at sites where they are normally found – such as grocery stores and neighborhood pantries — community organizations and public agencies could distribute supplies directly to homes or community sites (BA, AS, DI, HL, RU). Touchless hand sanitizer could be made widely available in public places (BA).

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### **Partner with trusted community organizations and organizations**

In order to most effectively address barriers to use of protective hygiene practices, services, information, and resources should be provided by trusted community members and sites (BA, AS, HL, DI, IR, RU). These might include community organizations and their leaders, religious leaders and organizations, community youth, and community health workers (BA, AS, HL, DI, IR, RU).

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### **Improve employment policies**

Improving workplace policies could make individuals safer; these could involve ensuring that workplaces are following hygiene guidelines and allowing employees to do so, and offering employees more penalty-free options for sick time or working from home (BA, IR). Caregivers for individuals with disabilities should be considered essential employees (DI).

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### **Improve and create housing options**

Improving housing options would allow for more systematic use of protective housing among some population groups (BA, HL, DI, IR). These steps could include identifying interim housing options where sick people could distance themselves from others they live with (BA, DI, HL, IR). Options for this might include hotels or motels, unfilled public housing units, convention centers, schools, and emergency evacuation locations. Direct financial assistance could also allow individuals to create these solutions for themselves (HL).

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### **Increase and improve COVID-related education**

High-quality, accessible education about hygiene practices would help several groups use these protective strategies (BA, AS, IR, RU). Community members would benefit from accessible educational information about proper handwashing, the importance of cleaning, and where/when/how to disinfect surfaces (BA, AS, HL, IR). The delivery of this information should be culturally relevant (BA, IR), available in multiple languages appropriate to each community (AS, HL, IR), comprehensible by individuals with limited literacy and/or health literacy (BA), and utilize terms and images that resonate with each community (BA, AS, IR). Many different modes can be used to deliver relevant information, including flyers, pamphlets, mailers, social media, community signage, YouTube videos, ethnic communication venues, discussion with individuals attending testing or healthcare sites, and special webinars or video events (BA, AS, HL, RU). Caregivers should receive education about how to use hygiene practices in their caregiving roles (DI).

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### **Improve transportation options**

Improvements to public transportation systems could help address hygiene barriers, both by making transportation itself safer, and by improving access to shopping and community resources. Improvements could include increasing the frequency of public transportation (BA), issuing free bus passes (BA), cleaning public transportation vehicles more often (BA), and adding plexiglass barriers in buses (BA).

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### **Directly address disability-specific challenges**

Directly involving people with disabilities in policy, planning, and educational efforts can help ensure that protective measures are designed or can be adapted for individuals with various disabilities (DI). Individuals caring for people with disabilities need specific training related to protective hygiene practices and educational resources (DI).