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

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

Isolation & Self-Quarantining (Topics F&G): Integrated Findings Across Population Groups

Integrated analyses of Topics F&G have been combined because the identified barriers and recommendations relevant to isolation and self-quarantining are very similar for all 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 Isolation and Self-Quarantining

These categories represent the barriers that most commonly challenge the ability of key Ohio populations to utilize isolation and self-quarantining as public health strategies to help minimize the impact of COVID-19.

Housing challenges

In all of the populations studied, housing conditions make both isolation and self-quarantining very difficult (BA, AS, RU, IR, HL, DI). Many individuals live in small, densely occupied units that house many people, large families, multiple generations, and/or multiple families (BA, AS, RU, IR, HL, DI). Others live in congregate housing arrangements including apartment buildings, halfway houses, group homes, shelters, and migrant camps (BA, AS, HL, DI). These arrangements often require many people to share space, including bathrooms and bedrooms (BA, RU, IR, HL). In addition, caregivers cannot isolate from the person they care for (AS, DI). Alternate living situations are usually not available or affordable (RU, IR, HL, DI). Isolating or self-quarantining also requires someone else to supply groceries or supplies (RU, DI).

Need to work

Many members of all the populations studied must go to work – often in essential, healthcare, and/or low-wage jobs – to provide for their families and maintain a basic income (BA, AS, RU, IR, HL, DI). Attendance is often mandatory at their jobs, with no sick time, working from home, or time off allowed (BA, AS, RU, IR, HL, DI). Individuals fear losing jobs and/or benefits if they stay away from work while isolating or self-quarantining (BA, RU, IR, HL, DI).

Gaps in education, information, and understanding

Members of most of the populations studied lack up-to-date health information relevant to COVID-19, including information about when isolation or self-quarantine is necessary, and how to do it (AS, RU, IR, HL, DI). Low general levels of education and health literacy can exacerbate this problem (RU, IR, HL, DI). Information is commonly available only in English, which is inaccessible to those with limited English literacy or proficiency (IR, HL). Refugees who have survived other communicable diseases may also feel COVID-19 is unlikely to be a significant threat (IR).

Cultural norms, political beliefs, and attitudes

The values and norms of most of the populations studied make isolation and self-quarantining difficult (AS, RU, IR, HL, DI). Ties to family and community are essential parts of normal life and critical to mental health; self-quarantine and isolation are challenging because they separate individuals from their families and communities (AS, RU, IR, HL, DI). Distrust of government authorities limits information sharing and education about isolation and self-quarantining (RU, IR). Many members of rural communities also have political beliefs that can impede isolation and self-quarantining, including not believing that COVID-19 is real, anti-science attitudes, objecting to restraints on personal freedom, and social pressures to conform to these beliefs (RU). COVID-19 is stigmatized in some communities and the resulting fears may prevent engagement with public health advice (IR, HL).

Caregiving responsibilities and needs

Individuals with caregiving responsibilities for children or other family members often do not have anyone else to fill those roles, making isolating or self-quarantining very challenging (BA). Individuals with disabilities may not be able to isolate or self-quarantine without a caregiver (DI).

Commonly Proposed Solutions to Facilitate Use of Isolation and Self-Quarantining

These categories represent our respondents' commonly proposed solutions to the barriers that impede use of isolation and self-quarantining by Ohio populations.

Provide housing options and financial resources

Direct supports could help individuals in all the populations studied isolate or self-quarantine when necessary (BA, AS, RU, IR, HL, DI). This could include providing separate temporary housing for those who need to isolate or self-quarantine; creating temporary free housing options for sick or self-quarantining individuals; offering hotel vouchers or financial assistance to help individuals procure their own separate temporary housing; and creating options for isolation/quarantine within congregate living situations (BA, AS, RU, IR, HL, DI). Community health workers could develop isolation/quarantine plans for those living in different housing situations (BA).

Increase and improve COVID-related education

Increasing education and improving public understanding of COVID-19 in general, as well as isolation and self-quarantining specifically, would help increase use of these protective strategies (BA, AS, RU, HL, DI). Relevant topics for increased educational efforts include the severity and real threat of COVID-19, current public health guidelines, the difference between social distancing and isolation/quarantine, when and why isolation or quarantine are important, and practicalities of how to isolate/quarantine (BA, AS, RU, IR, HL, DI). Other relevant topics include how to stay connected with others during isolation/quarantine (BA), stigma around COVID-19 (IR), and public assistance for individuals who are isolated/quarantined (RU). Educational materials must be accessible in multiple languages and to individuals with low literacy levels (BA, AS, RU, IR, HL); they must include lots of visual aids and culturally relevant messaging with diverse graphics (BA, AS, RU, IR). They must also be sensitive to community norms and religious teachings (IR, HL).

Partner with community members and leaders

Directly involving community members, leaders, and organizations in providing education and support will help increase the use of isolation and self-quarantining (AS, IR, HL). Community health workers (AS, IR, HL) and individuals who speak the languages of communities are essential in this effort (AS, IR, HL). In some communities, it may be necessary for public health authorities to first earn the trust of community leaders (HL).

Provide support for those in isolation or self-quarantine

Direct support for individuals who are isolating or quarantining would make these strategies more widely usable (BA, IR, DI, RU). These support strategies could helpfully include allowing a family member or caregiver to isolate or quarantine with affected individuals (IR, DI), delivering groceries and meals (RU, DI), providing community health workers or other lay workers to make home visits (BA), and providing increased access to social and mental health services (IR).

Other recommendations – relevant to specific populations

- Increase social pressure to use isolation and self-quarantining when appropriate (RU)