

# 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>

# Minimizing the Impacts of COVID-19 on Ohio's Populations



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**Top-Level Recommendations from *Ohio's COVID-19 Populations Needs Assessment* 343**

1. Center the COVID-19 response in the organizations and cultures of local communities
2. Explicitly address economic injustice and its widespread health and social impacts by directly providing resources
3. Directly address racism and immigration-related fears
4. Strengthen employment policy and other relevant public policies
5. Increase access to affordable, low-density housing
6. Improve public and shared transportation services
7. Improve the quality of COVID-related education and increase its dissemination
8. Address language and communication barriers

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The data, analyses, findings, and population-specific recommendations described above cumulatively reveal eight top-level recommendations to minimize the impacts of COVID-19 on all of Ohio's populations. These key recommendations encapsulate those ideas that will have the strongest positive impact on reducing the COVID-related burdens on the populations studied in this *Needs Assessment*, as well as the longest-lasting public health impact for marginalized communities across the state. Each of these eight recommendations holds the promise of increasing the capability of multiple populations to mitigate the impacts of COVID-19 in their communities by improving their ability to use multiple public health strategies. These recommendations also address the social determinants of health and systemic, institutionalized oppression. In the long term, then, they will also improve community conditions to reduce health disparities and improve health outcomes throughout Ohio.

*Needs Assessment* respondents clearly articulated the critical and urgent nature of all eight sets of recommended changes, without which COVID-related protections will continue to be out of reach for many of Ohio's residents. The recommendations are presented below in a logical order, starting with those that are most structural in nature and apply similarly across all studied populations. The discussion of our top-level recommendations below – along with the detailed findings and recommendations presented above – provide data-driven evidence that can both guide the implementation of necessary changes across the state and support the policy- or funding-related advocacy of stakeholders aiming to improve the COVID-19 response and advance health equity.

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# Discussion of Top-Level Recommendations

## KEY RECOMMENDATION #1: Center the COVID-19 response in the organizations and cultures of local communities

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### **Barriers stemming from lack of cultural responsiveness in COVID-19 protection strategies**

Communities across Ohio have specific values, traditions, norms, and beliefs that fundamentally shape their responses to public health advice and their ability to utilize COVID-protective strategies. These cultural elements are at the core of what ties a community together, often constituting its central strengths, sources of meaning, and feelings of belonging and joy for community members. In cases when COVID-19 protective strategies have been developed and disseminated without consideration of key cultural elements, however, they can also be a source of barriers to the use of those public health strategies.

Various forms of familism, collectivism, and communalism are central to the cultures of all the communities of color studied in this *Needs Assessment*.<sup>1</sup> These principles prioritize the essential value of the family or group over the individual, and are expressed in the everyday importance of maintaining close community contact. Within this context, creating physical distance between people who are normally close, avoiding social events, and wearing masks or other PPE can feel contradictory to essential cultural values and family norms. In various communities, for example, greeting without hugging or touching, avoiding in-person religious ceremonies, canceling large family gatherings, and allowing a loved one to live in isolation for a period of time can be interpreted and experienced as wrong, disrespectful, and profoundly isolating. These consequences are not mere inconveniences; they may have serious outcomes including familial conflict, community ostracization, and loss of mental health.

Beyond the importance of close community contact that is expressed in various forms across groups, other beliefs and norms can also make it difficult for community members to connect to or figure out how to use COVID-protective strategies. These include the beliefs that only God controls who will get sick (also termed 'fatalism', particularly relevant in Latino/Hispanic communities); a norm of relying on family rather than outsiders for help and advice (particularly relevant in Latino/Hispanic communities); strong orientation toward keeping personal and family information private (particularly relevant in Asian/Asian American and rural communities); and strong gender norms that make it difficult for men to accept advice or help from women (particularly relevant in some immigrant/refugee communities).

The potential mental health impacts of behaviors to protect oneself or others from COVID-19 are an especially relevant concern for some immigrants and refugees. Individuals who have a history of trauma may particularly fear having to maintain physical distance from people they feel close to, the potential need to live in isolation, and the possibility of dying alone. In addition, these individuals may have unmet mental health needs that are accentuated by changes in routine and physical separation from loved ones and communities. In immigrant, refugee, and some other communities there is also substantial stigma surrounding both mental health treatment and infectious diseases such as COVID-19.

1. On familism, collectivism, and communalism, see Campos et al. (2014), Delgado-Gaitan (1994), Jagers & Mock (1995), Lukwago et al. (2001), Raeff et al. (2000), and Vega (1995).

In many rural communities, a particular constellation of political beliefs and community norms stand in the way of community members' understanding of, and investment in, most methods of protecting themselves from COVID-19. This suite of widely held beliefs and norms includes: general anti-science attitudes; conservative political ideology; beliefs that COVID-19 is fake or only affects urban residents; beliefs that protective methods are ineffective or intended to constrain personal freedom; distrust of advice from government leaders; general aversion to 'being told what to do' and 'ratting people out'; distrust of privacy guarantees from testing sites and contact tracers; and experiencing social pressure to conform to these community beliefs.

Finally, public health strategies to minimize COVID-19 risks have often not been developed with the needs of people with disabilities in mind. Individuals with disabilities have particular fears, such as not having access to interpreters or communication devices in testing or healthcare situations, not being allowed to have a companion or caregiver with them for COVID-related care, and not receiving the same quality of care as people without disabilities. Based in actual experiences of this community, these fears make it particularly difficult for people with disabilities to engage with COVID-19 testing, contact tracing, healthcare, and public health advice. Isolation and quarantine also hold particular dangers for some individuals with disabilities, so planning for these possibilities without specific accommodations can present a mental health challenge as well.

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## Solutions involving centering the COVID-19 response in communities and cultures

Addressing the wide range of barriers that emerges from friction between COVID-protective strategies as they have been articulated and the lived experiences, values, traditions, norms, and beliefs of communities requires that public health work be purposefully grounded in local organizations and cultures. Developing, disseminating, and implementing specific methods of protecting individuals and groups from COVID-19 will likely be most effective when it unfolds through multi-sectoral partnerships centered in trusted community groups who are empowered and funded to do this critical work.

Community-based organizations are critical to alleviating the COVID-related barriers faced by all the groups of Ohioans studied in this *Needs Assessment*. Across the state, specific local groups, institutions, and retail sites are already trusted and frequented by community members. These ‘centers-of-community’ include ethnic and neighborhood organizations, community centers, places of worship, schools, free clinics, ethnic grocers and restaurants, 4H clubs, university extension offices, barber shops, locally-owned gas stations, dollar stores, and more.<sup>1</sup> Because they are already points where community members experience feelings of belonging and trust, connect to one another, and access a range of resources, centers-of-community are ideally situated to be centers of the COVID-19 response.

Expanding existing centers-of-community into centers of COVID-19 response requires at least three important elements. First, their leaders, owners, and decision makers must be interested and motivated in helping their communities respond to the pandemic. Most

communities are already home to many leaders enthusiastically willing to serve in such roles. In some rural communities, however, trust in public health advice is particularly low and will first have to be built between community leaders and individual health experts who are respected – such as pharmacists. Second, networks must be built to connect centers-of-community to the forms of expertise and resources that will allow them to fulfill new functions for their communities (or expand COVID-related work they are already doing); these connections might include public health expertise, clinical expertise, social service agencies, and local or state government entities. Third, succeeding as centers of COVID-19 response will require that centers-of-community have the financial resources to do this work, through new or expanded connections with government funders or private donors.

As centers of COVID-19 response, centers-of-community can serve a range of critical functions. Leaders and members of these centers are trusted gatekeepers to community access. They know their communities from the inside, and understand the lived experiences, values, norms, beliefs, and traditions central to peoples’ lives. As such, these individuals could be profoundly helpful in developing tailored educational materials, adapting COVID-related protection strategies to work within their communities, and contributing expertise in the design of all COVID-related policies and interventions. Incorporating (and prioritizing) their input could remedy many of the current disconnects between COVID-protective advice and community cultures, thereby making

1. For examples of how such centers-of-community have been used as partners in effective health interventions, see Campbell et al. (2007), Hardison-Moody & Yao (2019), Ma et al. (2012), Balcázar et al. (2012), Berkley-Patton et al. (2016), and Han et al. (2017).

significant inroads in alleviating many of the barriers described above.

In addition to providing much-needed expertise and guidance to all components of the COVID-19 response, centers-of-community could serve a variety of other concrete functions. As distribution sites and delivery coordinators, they could help ensure that community members are able to access cleaning and disinfecting supplies, masks and other PPE, and educational information related to COVID-19. Centers with physical homes could function as local testing sites that community members would feel comfortable entering and worksites for community-based contact tracers, community health workers, and/or patient navigators. They could also create COVID-safe WiFi hot spots to increase access to telehealth and other remote resources. Community members who work and spend time in these locations could serve as role models for mask-wearing and social distancing; demonstrate frequent cleaning of high-touch surfaces; offer community- or culture-specific guidance about how to make isolation and quarantine work within the real patterns and constraints of peoples' lives; and connect individuals to affordable and trustworthy healthcare providers. Centers-of-community could also launch and connect community members to virtual social interaction opportunities to help those suffering from lost social connections due to the pandemic.

Ensuring a successful community-based COVID-19 response also requires hiring and training community members to fulfill the many roles outlined above. This approach to staffing the COVID-19 response will help ensure that all elements are delivered in ways that make sense within the context of local cultures, facilitate trust between testers/contact tracers and community members, and help deliver services in the native languages of communities. Community health workers – who can serve as bridges between community members, community organizations, health information, and health and social resources – should also be hired from within the communities they will serve.<sup>1 2</sup>

These recommendations – to involve community leaders in all aspects of the COVID-19 response, expand centers-of-community into centers of COVID-19 response, and build an infrastructure of community health workers – are critical to a successful state response to the pandemic. They also have the potential to reduce health disparities in marginalized communities over the longer term. By investing new resources and expertise in community-based organizations, building capacity in those organizations, and integrating community expertise into public health work, they can create the infrastructure to support improved social determinants of health, healthcare access over time, and more community resilience in the face of future crises.

1. Health navigators and health educators are other categories of community-based personnel who could be trained and employed to fill similar roles.

2. For evidence on the effectiveness of community health workers in addressing public health barriers in marginalized communities, see Adams (2020) and Russel et al. (2010). For other comments on the potential for community health workers to be a critical resource in the COVID-19 response, see Bhaumik et al. (2020) and Wells et al. (2020).

## KEY RECOMMENDATION #2: Explicitly address economic injustice and its widespread health and social impacts by directly providing resources

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### Barriers stemming from lack of resources

Economic inequality – the unequal distribution of income and opportunity between different groups in society – is a longstanding structural feature of U.S. society that has been steadily intensifying over the past 50 years. <sup>1</sup> Rising income inequality is the result of faster income growth among high-income social groups than middle- and low-income groups. Furthermore, people of color have systematically earned considerably less income than Whites, a trend reported since the US Census began collecting these data in the late 1960s. <sup>2</sup> Household net worth has become increasingly bifurcated as well, with the wealth gap between the richest and poorer families more than doubling since 1989. <sup>3</sup> Economic inequality is a fundamental cause of health disparities. <sup>4</sup> These facets of economic injustice are reflected in the data collected on every subject from our *Needs Assessment* respondents, and powerfully impact the ability of all marginalized groups to use public health strategies to protect themselves from COVID-19. <sup>5</sup> Numerous gaps in access to resources necessary to minimize the impacts of COVID-19 result from the fact that many (but by no means all) members of Ohio's marginalized communities live in low-income households with little reserve wealth.

Members of all the communities studied in this *Needs Assessment* reported consistent difficulty gaining access to cleaning agents, disinfecting supplies, gloves, masks, and other

PPE. These products are often unavailable locally and unaffordable even when available. These problems are exacerbated by price gouging by vendors, hoarding of supplies by those who can afford to do so, lack of access to credit cards (to purchase items online), and the fact that food stamps cannot be used to purchase many necessary supplies. Masks and PPE are needed both at work and at home, and even healthcare workers, caregivers, and essential workers have difficulty procuring them. Some individuals make masks for themselves and their communities, but mask-making supplies can also be difficult to both find and purchase.

Although most members of these communities are highly motivated to use COVID-19 testing when appropriate, testing is generally difficult to access and specifically unavailable in community neighborhoods. The dearth of testing sites and testing capacity in many regions of the state is exacerbated by other constraints: some communities have experienced long waits to get tested or receive results; some areas have testing mostly within large hospital systems that will test only their own enrolled patients or those who can get to the hospital in person; there are few testing sites within low-income communities of color and only some allow testing without a prior visit to a healthcare provider.

1 This commonly used definition of economic inequality is taken from IZA World of Labor (2020).

2 Pew Research Center, 2016.

3 Schaeffer, 2020.

4 Link & Phelan, 2006.

5 On the concept of economic injustice and its relationship to economic inequality and public health, see Hayes (2020), Winslow (2017), and Whiteis (2010).

Healthcare is also difficult to access – for COVID-specific care, but also for preventive care and management of chronic health conditions. Many low-income individuals lack health insurance because they earn too much to qualify for Medicaid but too little to purchase it on the market, and healthcare is very difficult to afford without insurance. Undocumented individuals are ineligible for public or private insurance, and many other immigrants are reluctant to apply even though they are eligible. <sup>1</sup> Shortages of primary health care and mental health care particularly affect marginalized communities and individuals who rely on Medicaid. Many healthcare and mental health providers, including primary health homes and community health centers serving low-income communities, have closed or limited their services due to the pandemic, exacerbating concerns about access. <sup>2</sup>

Low-income individuals and households often lack access to Internet service, affordable data plans, and up-to-date devices that can access the Internet and run teleconferencing and multimedia applications. Rural communities – which sometimes have no Internet service providers at all – are particularly affected by these technological gaps. This ‘digital divide’ impedes the use of a range of protective strategies, including remote work options, telehealth substitutes for in-person healthcare, online education, online information that helps people stay informed, online worship services, other activities that keep people connected, and more. <sup>3</sup>

Compounding these many COVID-specific resource gaps are underlying constraints caused by lack of financial resources. Many members of marginalized communities have no savings to rely on, no emergency funds, and no source for subsistence funds if their workplaces close or they lose income due to the need to isolate or self-quarantine. Unemployment often takes longer to come through than individuals living paycheck-to-paycheck can afford without serious hardship. Even without the additional financial strains caused by the pandemic, many individuals lack access to clean water, full-service grocery stores, or sufficient funds to regularly pay for rent, utilities, and other necessities. Non-citizens (both undocumented and documented residents) lack access to public funds, benefits, and COVID-19 emergency funds. For all individuals coping with economic insecurity, meeting basic needs can at any time be a more critical use of the funds they do have than protecting themselves from COVID-19.

1 See the discussion of Key Recommendation #3 for more on this point.

2 Health Resources and Services Administration (HRSA), 2020; Larry Green Center, 2020.

3 For an overview of research on the digital divide, see van Dijk (2006) and van Dijk (2017).

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## **Solutions that involve providing and increasing availability of resources**

A broad range of solutions could alleviate the many barriers caused by economic inequality; these chiefly involve increasing access to necessary resources and directly providing these resources to communities and individuals. A first important step is to facilitate ready access to masks and PPE, disinfecting/cleaning supplies, and other essential supplies. There are many ways to accomplish this, but any successful approach will require improving availability, affordability, and community-based distribution of all these supplies. Making supplies routinely available could be accomplished by improving stock at local retail sites, establishing semi-permanent COVID-supply storefronts, opening supply distribution centers at local community hubs, ensuring that healthcare and essential work sites provide the full range of necessary supplies for all workers, and/or distributing supply kits to households. Affordability is a critical issue – particularly for low-income households – that could be addressed by providing free supplies for distribution to households or at community sites, using government or private subsidies to reduce prices, and/or by setting limits on allowable prices and purchase quantities.<sup>1</sup> Community-based distribution is also necessary to facilitate both physical accessibility and the trust of local community members.

Improving the utilization of COVID-19 testing requires creating free testing sites near the locations where people live, shop, or work, and ensuring that they are easily accessible. Convenient testing sites should be located in well-used community locations or in mobile vans that visit workplaces and neighborhoods, particularly in neighborhoods with transportation obstacles. Local and mobile sites also facilitate access for individuals who

are caregivers for children, elderly people, or other family members. Testing access can be increased by ensuring it is free to all patients, does not require a doctor's order, does not require presentation of immigration-related documentation (including driver's licenses), and is supported by translation and interpretation services to facilitate use by individuals with disabilities or low English proficiency.

Healthcare access must also be improved to ensure that those who test positive can be effectively linked to ongoing care, and that those who experience severe symptoms can receive treatment as needed. New free and low-cost health clinics should be placed in neighborhoods where many individuals currently lack access; these can be developed through or in partnership with existing federally qualified health centers, community health centers, public health authorities, pharmacies approved to provide clinical services, and private healthcare systems. Expanded telehealth services – along with HIPAA adjustments and free/low-cost options – would increase access while patient flow is limited by the pandemic. Community health workers and patient navigators can help those who are eligible enroll in health insurance, access public support programs, and schedule appointments. Translation and interpretation services must be accessible at all healthcare sites, and healthcare must be provided without any potential repercussions for immigration processes. Increasing availability of mental health and substance use disorder services would help individuals cope with many of the secondary effects of the pandemic. Mandating strong charity care programs across all hospitals and health centers would help provide care for more uninsured individuals.

1. For a review of the evidence on how – and when – direct provision of resources improves health outcomes, see Persaud et al. (2019).

A range of COVID-related protections, as well as other health-related supports would be facilitated by provision of technological resources to allow rural and low-income communities to cross the 'digital divide'. In particular, this would require universal, affordable, high-speed Internet access, and ensuring that every household has an up-to-date device (e.g.: a cell phone or computer) that can access the Internet and supports videoconferencing and other multi-media features. Training for those new to online information and services should also be provided by community-based organizations.

Direct financial supports would also substantially improve communities' ability to use COVID-related protections. Improving and speeding access to cash assistance, rental assistance, emergency pay, unemployment, and stimulus payments could help many purchase essential supplies; retain financial stability through a job loss; hire additional or substitute caregivers to cope with illness, isolation, quarantine, and employment changes; and defray costs of isolation, quarantine, and healthcare. Grace periods for unpaid rent and utility bills would help keep people housed even if their financial situation suffers due to the pandemic.

Long term social changes would more thoroughly address – and even help avoid – the many health-related consequences of income inequality and economic injustice. Universal health insurance and ongoing access to comprehensive healthcare (including primary care and mental health care) would improve health outcomes and reduce healthcare costs to the entire system. Expanding the scope of practice and credentialing for pharmacists, nurse practitioners, and physician assistants would help fill the national shortage in primary care, create new options for testing sites, and connect individuals to appropriate healthcare. Raising the minimum wage to a living wage would move many households out of poverty and enable them to purchase essential supplies during and beyond the pandemic.

## KEY RECOMMENDATION #3: Directly address racism and immigration-related fears

This key recommendation focuses on the profound impacts of racism, xenophobia, and immigration-related fears on the ability of many Ohioans to utilize public health strategies to minimize the impacts of COVID-19 on themselves and their communities. These forms of discrimination and social inequality are an important focus because they emerged so strongly from the data provided by many groups of respondents to the *Needs Assessment* survey. Other forms of discrimination and inequality also pose important barriers to use of COVID-related protections, however. The needs of people with disabilities, for instance, have historically been excluded from public health policy making, and individuals with disabilities have been subject to lower-quality and lower-priority care within the COVID-19 pandemic. <sup>1</sup> Full consideration of all COVID-related barriers and solutions must also incorporate able-ism, other 'isms', and the intersectional nature of social inequalities that compound the challenges faced by many members of Ohio's communities.<sup>2</sup>

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### Racism-Related Barriers

All communities of color addressed in this *Needs Assessment* – including Black and African Americans, Latinos and Hispanics, Asians and Asian Americans, and immigrants and refugees – reported that historical, systemic, and everyday racism have profound impacts on their ability to follow public health advice about all the strategies they might otherwise use to protect themselves from COVID-19. <sup>3</sup> This finding is consistent with recent public acknowledgments across Ohio and the nation that racism is a public health

crisis. <sup>4</sup> It is also consistent with a long history of research demonstrating that discrimination in many forms (e.g. racism, xenophobia, ableism) has negative impacts on health and well-being.<sup>5</sup> For all communities who experience racism, it raises barriers to COVID-related protective strategies that are intense and difficult to overcome.

Black and African Americans have been subject to racism and discrimination within and beyond health-related contexts since the time

1 For literature on the exclusion of the needs of people with disabilities from policy-level decision making and poorer treatment of people with disabilities affected by COVID-19, see Abedi et al. (2020), Burke (2020), Cokley (2020), and Pineda & Corburn (2020).

2 For a basic introduction to the concept of intersectionality and its impacts on discrimination and political action, see Cooper (2016) and Crenshaw (1989).

3 This discussion focuses on the impact of racism and discrimination on the ability of communities of color to utilize COVID-protective strategies. It is also the case that COVID-19 infection and hospitalization rates are following long-standing health disparities patterns that disadvantage communities of color within the U.S. (Abedi et al., 2020; Cholera et al., 2020; Dubey et al., 2020; Gee et al., 2020; Huang & Liu, 2020; Pineda & Corburn, 2020; Vestal, 2020a).

4 American Public Health Association, 2020; Brown, 2020; Came & Griffith, 2019; City of Columbus, 2020; Devakumar et al., 2020; Vestal, 2020a.

5 American Public Health Association, 2020; Bailey et al. 2017; Brown, 2020; Came & Griffith, 2019; Campbell, 2009; City of Columbus, 2020; Devakumar et al., 2020; Kreiger, 2014; Sharby et al., 2015; Shi et al., 2015; Suleman et al., 2018; Vestal, 2020a; Yip et al., 2008.

of slavery. In modern history, these groups have systematically experienced negative social determinants of health,<sup>1</sup> unethical medical testing,<sup>2</sup> and systematically worse treatment by healthcare professionals and systems.<sup>3</sup> *Needs Assessment* respondents clearly echoed themes also found in prior research, about how these abuses have resulted in mistrust of healthcare providers and government advice.<sup>4</sup> The well-documented realities of Black and African Americans being perceived of as criminals and subjected to police brutality also contribute to fear of wearing masks, particularly among men.<sup>5</sup> Anti-Black racism and discrimination thus pose substantial barriers to the ability of Black and African Americans to trust health authorities and utilize COVID-protective strategies, but they also impact other communities of color.

Among Latino/Hispanic and immigrant/refugee communities, mistrust of government and medical authorities can lead to cautious attitudes toward following public health advice, waiting until one is very ill to get tested or seek healthcare, and a belief that one's own community will only get access to testing or care after the dominant White U.S. population has been cared for. Lack of racial or

ethnic diversity among healthcare providers, being given erroneous testing information, and being turned away from testing sites at healthcare facilities have all lent credence to these concerns. Latino/Hispanic and immigrant/refugee groups also reported concerns and fears that stem from knowledge of how Black and African Americans are treated, and that impede their own use of COVID-protective strategies.

Asians/Asian Americans have also experienced chronic racism and discrimination, and anti-Asian harassment has increased since the start of the COVID-19 pandemic.<sup>6</sup> Verbal and physical assaults – often directed specifically at individuals wearing masks – have resulted in considerable reluctance to wear masks in public. Among some Asians/Asian Americans well aware of the benefits of mask-wearing, these fears also result in reluctance to leave the house. More broadly, experiences of racial targeting and hate crimes have created a general sense of fear that takes an emotional toll and deters engagement with COVID-19 information and protections, including not just mask-wearing but also COVID-19 testing, contact tracing, and healthcare.

1 Upstream negative social determinants of health include lack of clean air and water, lack of access to healthy food and space for exercise, exposure to violence, stress that originates in experiences of discrimination and produces early 'weathering', and more.

2 For a discussion of the origins and effects of medical mistrust, see Jaiswal & Halkitis (2019).

3 On systemic racism in U.S. healthcare, see Feagin & Bennefield (2014) and Bailey et al. (2017).

4 Haung & Raymond, 2020; Feagin & Bennefield, 2014; Jaiswal & Halkitis, 2019; Sharby et al., 2015; Shi et al., 2015.

5 For an overview of police violence and its impacts, see Lowery (2016) and Taylor (2016). For discussion of the origins, processes, and effects of mass incarceration, see Alexander (2012) and Hinton (2016).

6 Intensification of xenophobic attitudes has been documented in prior epidemics, pandemics, and emergencies (Onoma, 2020; Petersen et al., 2017), and also specifically in the age of COVID-19 (Noel, 2020). This current intensification may also have lasting repercussions (Dubey et al., 2020; Huang & Liu, 2020).

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## Immigration- and Xenophobia-Related Barriers

For the Latino/Hispanic, Asian/Asian American, and immigrant/refugee communities studied in this *Needs Assessment*, immigration-related fears also present powerful barriers to the use of COVID-protective strategies. Seeking a COVID-19 test, talking to a contact tracer, or visiting a healthcare provider can all raise fears that information shared for health-related reasons will be given to authorities, resulting in ICE involvement, immigration raids, imprisonment, deportation, or failure of future citizenship applications.<sup>1</sup> These concerns are not only relevant to undocumented individuals, but also to many others who know of cases where documented immigrants or U.S. citizen members of their communities have been detained or even deported.<sup>2</sup> The consequences of immigration-related fears are far-reaching. They not only impede all COVID-protective strategies that involve direct contact with healthcare providers, but also result in hesitance to engage with local health departments; refusing to share information or providing fake information to contact tracers; and eligible individuals avoiding applying for Medicaid or other health insurance programs.

1. These findings are consistent with prior findings about immigration-related fears related to accessing healthcare. See, for example Derose et al. (2007), Hacker et al. (2015), Hacker et al. (2011), and Lopez et al. (2016).

2. For prior research on how fears commonly experienced by undocumented immigrants also negatively impact other immigrants who have legal status, see Almeida et al. (2016), Gee & Ford (2011), Lopez et al. (2016), and Philbin et al. (2018).

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## Solutions that Address Racism

Addressing COVID-related barriers that stem from racism will require direct action from local and state government leaders, healthcare institutions, and other social systems.<sup>1</sup> At the societal level, public and elected officials have a leading role to play. This involves calling attention to racism, xenophobia, and misinformation whenever they are articulated in public spaces; strongly refuting such statements; substituting accurate information and statements reflecting inclusive values and goals; and advocating for anti-racism in all public policies.<sup>2</sup> COVID-specific examples include, for instance, public officials directly refuting the association of COVID-19 with Asian/Asian American communities and disseminating accurate information about how people of all racial-ethnic backgrounds can contract and transmit it. Public policy can also help convey these same messages.<sup>3</sup> Prosecution of COVID-related hate crimes may help counteract attitudes that blame communities of color for the pandemic. Mandatory mask ordinances can help reduce racial profiling and harassment (as well as reducing COVID-19 transmission) and can be publicly promoted as an expression of conscientiousness and community support instead of an indicator of illness.

Racism, implicit bias, and cultural barriers must all be acknowledged and eliminated within healthcare and social service institutions as well. Training programs for all staff are commonly articulated as a practical way to achieve this, but the content of these programs must be richer and more comprehensive than standard implicit bias and cultural competency trainings.<sup>4</sup> The content of these efforts must – at a minimum – build staff knowledge and skills in identifying and reversing discriminatory practices and habits, and in understanding and honoring cultural values and norms of the communities they serve (e.g.: familism and collectivism, which is central in many communities of color). More likely to be successful are multi-pronged initiatives that provide ongoing, multi-session staff trainings alongside deeper institutional work to address structural barriers and discrimination, including hiring healthcare employees reflective of the populations they serve.<sup>5</sup>

Beyond healthcare institutions, other systemic changes can be pursued in the immediate and longer term to decrease the widespread marginalization produced by racism – and its range of health-related impacts.<sup>6</sup> Government and private efforts to mitigate COVID-19 should routinely support and promote community-based businesses and organizations owned by people of color.

1. The need for multi-sector interventions involving partnerships with local communities to address structural racism has been explored in prior research (e.g.: Bailey et al., 2017).

2. Anti-racism in public policy requires examining and then actively countering existing racial inequity, the racist policies that produce it, and the racist ideas that veil it (Kendi 2019a and 2019b).

3. Government support for anti-xenophobic policies may actually be necessary for interventions meant to assist immigrant and refugee communities to be successful (Crush & Ramachandran, 2010; Onoma, 2020).

4. Brondolo et al. 2009; Jongen et al., 2018.

5. This involves diversifying healthcare and social service workforces to include more people from underrepresented communities, thorough mentorship and sponsorship of staff at all levels of the organization, and requiring all levels of organizational decision makers to engage with these goals (Dobbin & Kalev 2018).

6. For documentation of the health impacts of racism, discrimination, and xenophobia see Efird & Bith-Melander (2018), Finch et al. (2001), Suleman et al. (2018), Vestal (2020a), and Vestal (2020b).

Police departments should undertake the same multi-pronged institutional transformation initiatives described above, and hate crimes should be taken seriously and prosecuted. Racial inequities in the criminal justice system should be addressed to reduce mass incarceration, which carries both immediate COVID-related risks associated with congregate living and long-term health and economic effects that make communities of color more vulnerable in general and during pandemics.<sup>1</sup> Reparations or direct payments could be instituted to help reverse the limited access to resources that is a key upstream driver of health disparities affecting Black and African American communities.

1. On the many health-related and other impacts of mass incarceration, see Acker et al. (2018) and Alexander (2012).

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## Solutions that Address Immigration-Related Fears

Both policy-level changes and substantial dissemination of related information are necessary to allay the immigration-related fears that form a substantial barrier to the use of COVID-19 protections in many Ohio communities. Policies and processes must be put in place to ensure that personal information gathered through testing, contact tracing, healthcare, and any COVID-specific resource distribution cannot legally be transferred to any other government entities – including local police, U.S. Immigration & Customs Enforcement (ICE), U.S. Citizen & Immigration Services (USCIS), and immigration courts. These changes would free many members of Latino/Hispanic, Asian/Asian American, and immigrant/refugee communities to benefit from the full range of health-protective strategies without fear of detainment, deportation, or future penalties to immigration processes. These steps would positively impact the ability of both undocumented individuals and many legal residents and citizens to protect themselves and their communities from COVID-19.

Short of full legal separation between all health-related activities and immigration-related law enforcement, some lesser interventions could also have positive impacts. Offering COVID-19 interventions at trusted community sites (such as ethnic grocery stores or community-based organizations) and delivered by non-governmental, non-military personnel – instead of at governmental sites (such as local public health departments or other government locations) – would improve trust and engage more community members. Maintaining this trust, however, requires either that already existing health-information protections (such as HIPAA) be used effectively to prevent sharing of personal data, or that these sites operate entirely without collecting personal data that could be useful to immigration authorities. Allowing individuals to get a COVID-19 test without identification or referral from a healthcare provider could increase testing utilization in these communities.<sup>1</sup> Temporary suspension of all deportations during the pandemic and legislation guaranteeing that information gained through pandemic-related healthcare will never be conveyed to immigration authorities in the future could also help.

1.This could be done, for instance, through free testing sites that assign unique identifiers to each patient instead of identifying their test results by name. This approach would help with testing uptake and utilization in communities where immigration-related fears are common, but would limit the information that could be provided to surveillance efforts at the local or state level.

## KEY RECOMMENDATION #4: Strengthen employment policy and other relevant public policies

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### Work and Employment Barriers

Many members of the populations studied in this *Needs Assessment* face substantial work-related barriers that impede their use of all the recommended public health strategies to protect themselves against COVID-19. These barriers stem both from the need to work and from conditions at work, and they constitute essential challenges that must be addressed in order to alleviate the burden of COVID-19 in marginalized Ohio communities.

For most, paid work is not optional. Many members of our communities are primary or critical sources of income for their households; low-wage jobs are common and families already in or close to poverty cannot afford to lose the income from these positions even if they involve COVID-related risks. Work within these communities is often in essential jobs: <sup>1</sup> in grocery and retail stores, and as care workers, health workers, and first responders. People of color and immigrants are over-represented in essential service industry and supply-chain positions, frequently working more than one such job each week and without access to other sources of income.<sup>2</sup> Essential jobs – both professional and working-class – often involve face-to-face and close contact with the public and fellow employees, making six feet of social distance impossible much of the day. Many essential work environments also make frequent hand washing impossible (e.g.: cashier jobs). In addition, many employers fail to provide

adequate cleaning supplies and PPE for the working conditions involved. Most workers have little control over such conditions at work, relying on employers to take appropriate precautions, follow state regulations, and enforce guidelines in their workplaces.

Daily attendance at work is also mandatory for many individuals. Remote work is impossible in many essential jobs, and employer policies and limited broadband access limit working from home for other employees as well. For many workers sick time is also not an option: their contracts have no provisions for paid sick leave and employers don't allow time off work. Many workers are reluctant to skip work even when they are sick or have been exposed to COVID-19 because they fear losing their benefits or their jobs altogether if they miss days. Furthermore, some individuals – particularly those in low-wage essential positions – worry about how getting a COVID-19 test or participating in contact tracing could affect their employment. Immigrants and refugees may be particularly likely to avoid risking their employment in any way, even to protect their health, because they qualify for neither stimulus funds nor unemployment benefits, or because they fear losing the ability to adjust their immigration status in the future if they utilize any public benefits (under the public charge rule).<sup>3</sup>

<sup>1</sup> Dyer, 2020.

<sup>2</sup> Dwyer, 2013.

<sup>3</sup> For details on the public charge rule and how it can impact immigration status adjustments, see U.S. Citizenship and Immigration Services (2020). The most stringent aspects of the public charge rule are under injunction due to COVID-19, but the extent to which this reassures immigrants is unclear and likely varies.

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## Employment-Related Policy Solutions

While policy change represents a critical route to alleviating many of the barriers described in this report, the deep and wide nature of COVID-related risks at work makes it particularly important to institute and enforce regulations that affect employers and workplaces.<sup>1</sup>

Members of all marginalized communities would benefit from a legal requirement that all businesses provide leave time to employees who need to isolate or self-quarantine, or need to stay home to care for an isolating or quarantining family member, without threat of job or benefit loss. Requiring that employees exhibiting COVID-19 symptoms take sick leave is also essential; this sick leave should be paid or accompanied by emergency financial supports for those who cannot afford to miss work without threat to their economic security. These policy recommendations build on evidence that paid leave policies reduce workplace transmission and improve quarantine compliance<sup>2</sup>. Given the risks of in-person work, employers should also be required to allow employees who can do their jobs from home to work remotely.

Within physical workplaces, employers must be required to follow current state

guidelines and utilize best practices for minimizing the spread of COVID-19, including providing masks, PPE, and hygiene supplies to employees as well as facilitating hand washing and social distancing.<sup>3</sup> In addition to regulatory requirements, incentives that assist and reward compliant employers can be an effective strategy in many cases. Many small and minority-owned businesses will require financial support to engage fully with safety requirements and stay in business.<sup>4</sup> Workplaces can also be important sites for employees to receive COVID-related information, and this information should be provided in multiple languages when substantial proportions of employees communicate most comfortably in languages other than English. Some businesses and industries have particularly egregious histories of unhealthy working conditions and coercion of employees; given the critical nature of COVID-related protections businesses should be monitored for regulatory violations that harm workers' health.<sup>5</sup>

1 See McLellan (2017) on the roles of employers in protecting and promoting employees' health and the benefits employers also gain from considering employee health.

2 Bodas & Peleg, 2020; Kumar et al., 2011; Kumar et al., 2013; Miyaki et al., 2011.

3 Hand washing and hand sanitizer have been shown to reduce the spread of infectious disease within workplaces (Zivich et al., 2018). Providing access to health resources can increase uptake among employees and provide further protection within the workplace (Kimura et al., 2007; Yue et al., 2017).

4 Hannon et al., 2012.

5 Linaker & Smedley, 2002.

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## Other Critical Policy Solutions

Beyond the realm of employment, several other policy issues emerged as uniquely critical to particular populations in Ohio.

In addition to the universalistic positive effect of reducing COVID-19 transmission in public places, enforcing guidelines about mandatory mask wearing may help reduce instances of discrimination and harassment against African American, Asian, and Asian American individuals wearing masks.<sup>1</sup>

Many COVID-related protections would be more available to immigrants with policy-level clarity and reassurance that educational events, testing sites, contact tracing, and health information are all kept strictly separate from immigration authorities. Unemployment compensation or direct financial supports would also help immigrants who have experienced job loss but cannot benefit from CARES Act funding.

In rural areas, strong incentives may be more effective than regulatory enforcement at gaining the cooperation of community members in mask wearing, limiting large events, and social distancing in public venues.

Within many hospitals and medical facilities policies such as triage protocols will need revision in order to ensure equitable care for people with disabilities. Ensuring that a formal or informal caregiver can always accompany an individual with a disability to doctor's appointments, during medical testing, within hospitals, and during hospitalizations will help ensure appropriate care and patient understanding.

1. For additional information on how COVID-19 is increasing instances of discrimination, harassment, and violence against Asian Americans, see Li & Galea (2020) and Kim (2020).

## KEY RECOMMENDATION #5: Increase access to affordable, low-density housing

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### Housing Barriers

Housing-related challenges – which vary somewhat in form across geographies and population groups – constitute key structural barriers to protecting individuals and families from the impacts of COVID-19. The COVID-related risks of dense, poor, or insecure housing reflect broader patterns of housing as a determinant of both short- and long-term health outcomes.<sup>1</sup> The dense and poor housing conditions faced by a significant proportion of Ohioans adversely affect their ability to utilize safe hygiene practices (such as frequent-enough cleaning of shared surfaces) and keep enough social distance to prevent rapid transmission of the virus if one member of the household contracts it.<sup>2 3</sup> Dense living conditions also directly impede the essential practices of isolating those diagnosed with COVID-19 and quarantining those who have been exposed, as there is not enough physical space for one or more household members to separate themselves from others in the household. Contact tracing is also severely inhibited by situations where individuals are housing insecure, move frequently, share phone lines, or can't maintain access to a phone line over time.

Housing challenges stem from the high cost of housing throughout both urban and rural areas of Ohio. Unaffordable housing results in many occupants living together in single and/or small housing units. Across all the marginalized groups studied in this *Needs Assessment*, multi-generational and multi-family housing arrangements are common. While such arrangements can offer a range of benefits in the forms of cost-sharing and familial or social support, these crowded homes also involve many people sharing space, including bathrooms, bedrooms, and beds. Apartments and houses can also be densely clustered in the neighborhoods of mid-range and large cities, contributing to challenges related to social distancing and high-touch surface cleaning in shared community spaces such as elevators and neighborhood markets. Congregate arrangements are relevant for some population subgroups, particularly those living in nursing care facilities or halfway houses, migrant workers living in camps, and incarcerated individuals. Housing instability adds further challenges. Individuals' ability to control hygiene and social distancing are dramatically reduced in shelters and outdoor living situations. These housing conditions

1 Thomson et al., 2009; Bashir, 2002.

2 Overcrowding also has negative impacts on mental health, child development, heart disease, and other health outcomes (Bashir, 2002).

3 In addition to the general and widespread barriers caused by dense, poor, or insecure housing among marginalized populations, prior research has suggested that older individuals and those with disabilities are among those groups additionally burdened. Around 52% of Ohioans aged 65 and older are cost-burdened by rent, and Ohioans with disabilities spend roughly 82% of their income on housing. Additionally, nearly two-thirds of homes in Ohio are inaccessible by wheelchair (Fallon & Price, 2020).

also have negative impacts on overall health status and impede individuals from maintaining healthcare relationships that are critical to both general and COVID-related medical testing, diagnosis, and treatment.<sup>1</sup> In addition, close caregiving relationships can pose challenges when individuals need to isolate or quarantine, since neither those providing care nor the individuals they care for (children, individuals with disabilities, elderly family members) can live physically separate from one another. Challenges related to caregiving are concentrated among women and low-income people of color, who perform the majority of both informal and formal daily caregiving work.<sup>2</sup>

1 Data from the National Survey of American Families indicates that 23.6% of Americans had unstable housing prior to the 2008 housing crisis (Kushel et al., 2006); the rate of housing insecurity is likely even higher among Ohio's marginalized populations who commonly work in low-wage industries. Poor housing conditions have negative impacts on health status (Stahre, 2015), and homelessness is significantly associated with emergency room care (Wolitski et al., 2010).

2 Dwyer, 2013; Hodges, 2019.

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## Housing Solutions

Short-term solutions to housing-related challenges would immediately improve the ability of vulnerable communities to utilize hygiene, physical distancing, isolation, and quarantine strategies to minimize the impacts of COVID-19.

Across communities where dense housing conditions are common, there is an urgent need for affordable and culturally acceptable interim housing options for individuals who need to quarantine or isolate. Sponsored and/or provided through private, local, state, or federal funding, such alternatives would directly reduce the spread of disease along with its long-term health and economic effects. There are many prospects for temporary housing locations and the appropriateness of each varies across geographies and communities; overall they include hotels, motels, RVs, mobile homes, and public sites not currently in use, such as schools, convention centers, emergency evacuation sites, and National Guard Armories. Since financial insecurity and poverty are primary underlying constraints for many members of marginalized communities, it is essential that these temporary housing options be offered free of charge, or paid for through vouchers and emergency funding programs that are easy to apply for and well publicized.<sup>1</sup> Plans to establish such temporary options should also include ways to ensure that individuals who utilize them will be able to safely procure food and supplies, that Internet and communications technology will be functional, that interpretive and supportive

technologies will be available for people with disabilities, and that caregivers will be allowed to stay with isolating and quarantining individuals when necessary.

Steps should also be taken to reduce the likelihood that the economic strains of the pandemic will cause further increases in housing density and housing insecurity.<sup>2</sup> Suspending evictions, providing rental assistance, and pausing utility payments are all strategies that can help keep housed individuals in their current residences. Those who need to stay safe in crowded homes would benefit from financial assistance to obtain cleaning and hygiene supplies, provision of partitions and mats to help create separation between living and sleeping quarters, and feasible guidelines for isolation within homes. Particular attention should be paid to creating tailored precautions to prevent COVID-19 transmission from caregivers to those they care for, or vice versa. Oversight of migrant worker camps and urban apartment complexes known to have predatory landlords could help ensure COVID-safe (and generally improved) living conditions for individuals in these residences. Improving living conditions and minimizing the additional housing instability COVID-19 causes will not only reduce COVID-19 transmission. These steps are; it is also likely to reduce rates of food insecurity (Mykta, 2015) and medical care utilization.<sup>3</sup>

1 Jacobs et al. (2010) note that there is sufficient evidence of effectiveness to recommend rental vouchers as a community-level housing intervention.

2 Mykta (2015) notes that families facing foreclosure or eviction are likely to “double up” or join multi-family housing units.

3 Anderson et al., 2003; Baxter et al., 2019; Desmond & Kimbro, 2015; Mykta, 2015; Wolitski et al., 2010.

COVID-19 spreads quickly within congregate settings, so it is essential that both residents and employees in these locations have adequate masks, PPE, and hygiene supplies. These facilities would also benefit from customized guidance and resources to temporarily separate individuals who are sick or have been exposed from others. Jail and prison overcrowding can be eased by reducing or avoiding sentences for minor offenses. <sup>1</sup> Increased investment in shelters and low-income housing could help provide COVID-safe accommodations for homeless and transitionally housed populations, including those fleeing domestic violence (Baggett, Tobey, and Rigotti, 2013). <sup>2</sup>

To improve the long-term health of marginalized communities beyond COVID-19, it will be necessary to find methods to bring housing costs down and keep families stably housed. Key strategies include converting existing housing to affordable units, as well as subsidizing and incentivizing private enterprises to build more affordable or mixed-income housing. <sup>3</sup> For migrant workers and prison populations, more humane living conditions (involving even such basic features as having adequate air flow and hand soap available) will likely require policy changes and increased regulation. <sup>4</sup> For people with disabilities, community-based living alternatives could help reduce the proportion in congregate care settings that run higher risks for infectious and institution-acquired illnesses.

1 Akiyama et al., 2020; Cloud et al., 2020.

2 Homeless and housing-insecure individuals are also more likely to smoke tobacco than the general population (Stahre et al., 2015); new shelters and temporary housing arrangements must consider accommodating this behavior with a risk-reduction orientation in order to properly protect low-income individuals from COVID-19. See also Baggett et al. (2013).

3 Kelleher, Reece, & Sandel (2018) found that a mixed-income approach to housing improvements as well as involvement by hospitals and community stakeholders works best for neighborhoods in Columbus, Ohio.

4 Prost et al., 2020; Shah, 2020; Kelleher et al., (2018).

## KEY RECOMMENDATION #6: Improve public and shared transportation services

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### **Transportation Barriers**

Marginalized communities across the state face frequent gaps in availability of affordable and COVID-safe transportation. The impact of transportation barriers on individuals' ability to protect themselves from COVID-19 echoes broader patterns of delayed medical care and poorer health outcomes among those who lack transportation.<sup>1</sup> Many families and individuals with limited incomes do not have access to personal vehicles and thus rely on public transit or other forms of communal transportation to get to work, shop for groceries and supplies, and move around the community – as well as to seek healthcare or a COVID-19 test. Existing transit networks are limited, however, often lacking routes to transport people from their neighborhoods to grocery stores or healthcare sites. In some regions, public transit networks purposefully do not provide service to COVID-19 testing sites due to concerns about viral transmission on buses. Carpooling to work and shopping is common in some communities. Ride-share services offer another alternative for individuals who can afford them, but do not serve some rural areas of the state.

Using public transportation exposes individuals to risk of COVID-19 transmission through lack of social distancing on buses; unless buses are cleaned frequently, they also pose a risk for transmission through high-touch surfaces. When public transportation cannot be used, however, many community members lack any way to buy essential supplies or cleaning products, or to get to a COVID-19 testing center or healthcare site unless they are located very close to home. Drive-through testing sites are also usually inaccessible without a car.

<sup>1</sup> Peters, 2020; Pineda & Corburn, 2020; Syed et al., 2013; Wolfe et al., 2020.

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## Transportation Solutions

Increasing access to COVID-safe transportation would substantially improve individuals' ability to procure the basic and sanitizing supplies necessary to prevent disease and maintain health, and to utilize COVID-19 testing and healthcare to minimize the impact of disease in their communities.<sup>1</sup>

Additional investment in public transit systems could facilitate several important improvements. Buses and other vehicles could be made safer by adding plexiglass barriers, distributing masks to riders, and cleaning more frequently. Infrastructure could be improved by adding routes that go to work, healthcare, and shopping sites (including to culturally-specific groceries); increasing the frequency of buses on routes; reducing costs to riders; and issuing free bus passes to those otherwise unable to use them.

In some areas, community agencies already provide transportation to healthcare sites and other social services; additional investment in these networks would allow them to serve more individuals more regularly during the pandemic.<sup>2</sup> Financial incentives could help bring rideshare companies into rural areas and outfit cars to provide transportation to essential shopping, testing, and healthcare sites in ways that are safe for both riders and drivers.

1 Transportation interventions – including subsidies and free services – have been shown to alleviate delayed or missed medical care (Solomon et al., 2020; Starbird et al., 2019; Wolfe & McDonald, 2020).

2 Starbird et al., 2019; Vias et al., 2020; Wolfe & McDonald, 2020.

## KEY RECOMMENDATION #7: Improve the quality of COVID-related education and increase its dissemination

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### Education-Related Barriers

Lack of accurate, up-to-date, relevant, and comprehensible education about COVID-19 is widespread throughout the communities studied in this *Needs Assessment*, and this dearth of education undermines the effectiveness of all the public health strategies that could minimize the pandemic's effects on individuals and groups. Critical gaps in information about the disease encompass a range of topics, including: the risks of COVID-19 and how it is transmitted; the fact that one can have and transmit COVID-19 without symptoms; recommended hygiene practices and products; when and how to practice social distancing; the importance of masks, how to wear masks properly, and when other PPE is needed; when and how to get tested; how contact tracing works and why to participate in it; when and why to isolate or self-quarantine; and where to get healthcare and what facilities are open. Many communities also experience other unmet information needs that stand in the way of COVID-protective information and health-oriented behavior. These include, for instance: how to adapt preventive behaviors to specific disabilities or living conditions; how to talk to children and other family members about the disease, mask-wearing, and other protective strategies; how to communicate with doctors; and how and when to access care for mental health or drug use issues.

These specific information gaps often exist within broader contexts where basic health education – which sets the stage for comprehension of COVID-specific messaging – is missing or ineffective. Individuals with low literacy, low education levels, and limited

English proficiency often lack understanding of how the healthcare system works in general, as well as exposure to core concepts related to health-promoting habits and healthcare usage. COVID-specific educational messages can also be undermined when they are not delivered in a person's native language, in culturally appropriate terms, or at an inappropriate reading level.<sup>1</sup> Misconceptions and misinformation constitute another substantial problem – in communities that have come to believe that COVID-19 is not real or that masks cannot reduce transmission, for instance, substantial exposure to carefully crafted and accurate information from trusted sources would be necessary to increase the use of protective strategies.<sup>2</sup>

The consequences of information gaps and lack of effective COVID-related education are manifold. At the most basic level, individuals lacking information about COVID-protective behaviors are unlikely to use them, and more likely to engage in high-risk behaviors. In some rural and other communities, individuals may think they are not susceptible to COVID-19 or feel unconcerned about contracting the virus. Others believe there is little point in protective behavior because their pre-existing conditions or the large number of cases around them mean that they will contract the disease no matter what, or that people like them will be given last priority for treatment. Relying on whether someone 'looks sick' to decide whether it is necessary to social distance, wear a mask, or clean surfaces is also a commonly reported problem.

1 Rimer & Kreuter, 2006.

2 Although the barriers highlighted in this paragraph pertain specifically to education- and information-related gaps, they are profoundly intertwined with – and in many cases secondary to – structural barriers such as lack of resources. Not understanding how to wear a mask or which foods contribute to a healthy diet are real challenges for some, but in other cases the more prominent problems are lack of funds to purchase masks or access to markets that sell fresh produce.

Some populations also have specific additional information and educational needs. Refugees, some groups of recent immigrants, and older members of other marginalized communities may lack experience with computers and the technical skills necessary to access educational information or use telehealth. Immigrants and refugees often do not understand complex healthcare and social systems well enough to navigate them during the pandemic. Refugees who have survived harsh life conditions or other communicable diseases may feel that COVID-19 is unlikely to be a significant threat. Residents of rural communities particularly suffer from 'safety fatigue'; this is a result of over-exposure to inconsistent information from various official sources and social media while simultaneously receiving no information from local sources they trust, and can be exacerbated by low health literacy.

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## Education-Related Solutions

To facilitate the ability of all of Ohio's populations to protect themselves from COVID-19, it is essential that educational messaging is culturally tailored; developed in consultation with community members and leaders; presented in all the languages each community speaks and in terms appropriate for individuals with low literacy and numeracy; includes plentiful visual aids; features diverse graphics centered on members of all relevant communities; and delivered on an ongoing basis. These recommendations are consistent with the literature demonstrating that tailored health messages and community engagement are key to effective health promotion education.<sup>1</sup> A comprehensive mass media campaign to continually disseminate clear, credible, consistent information from public health experts could provide a critical foundational layer of understanding on which more detailed, tailored campaigns can build.

To establish and maintain the necessary level of COVID-related understanding, informational materials must cover a broad range of topics.<sup>2</sup> Chief among these are:

- The severity and threat of COVID-19
- The efficacy of protective measures including hand washing, surface cleaning, mask wearing, other PPE, and social distancing
- When and how to use all these protective measures effectively
- Where to affordably obtain necessary supplies and resources such as cleaning supplies, masks, and PPE
- When, where, and how to get a COVID-19 test including without insurance or a doctor's referral
- Why contact tracing is important and how it works
- When and how to isolate and quarantine including within the home
- How to access COVID-related healthcare including without insurance

<sup>1</sup> Finset et al., 2020; Rimer & Kreuter, 2006; Van Bavel et al., 2020; WHO, 2020.

<sup>2</sup> The World Health Organization (WHO, 2020) has developed a qualitative assessment tool that can be used to assess community understanding of COVID-19 risk and how communities are informing themselves about COVID-19.

For many of the populations studied in this *Needs Assessment*, publicly disseminated information about additional topics would also facilitate COVID-19 prevention behavior within households and communities. These include:

- How to use COVID-related protections while at work, in religious spaces, and when in caregiving roles <sup>1</sup>
- How hygiene practices, facial coverings, use of PPE, and other COVID protections can be adapted appropriately to the needs of individuals with a range of disabilities
- How to adapt guidelines to individuals living in urban, suburban, and rural communities
- Community-specific suggestions for staying safely connected with family and community during the pandemic
- How to care for sick family members safely
- How to communicate effectively with healthcare providers
- Specific, tailored information designed to dispel false information and misinformation circulating within the community
- How to manage social distancing and mask-wearing with family and friends, including content about how these behaviors can communicate respect and the value of protecting one another <sup>2</sup>
- How to adapt community traditions, greetings, and ceremonies to be COVID-safe
- The personal- and community-level benefits of following public health advice and how this can be consistent with preservation of individual rights
- Strategies that help inoculate communities to harmful misinformation related to COVID-19
- Public assistance that is available to individuals in isolation or quarantine, caring for such individuals, and suffering from lost income due to COVID-19
- The confidentiality of COVID-19 testing and contact tracing; specific and accurate guarantees that information gained through these health-protective measures will not be communicated to law enforcement or immigration authorities

<sup>1</sup> This and other suggestions about recommending replacement or adapted behaviors are consistent with evidence-based health promotion concepts (Finset et al., 2020; Michie et al., 2020).

<sup>2</sup> Modeling pro-social behaviors and appealing to collective action, especially in communities with cultures that value collectivism, improves health message uptake (Finset et al., 2020; Van Bavel et al., 2020).

Educational materials should be widely distributed using a range of modes, including flyers and posters, household mailings, pamphlets, yard signs and other community signage, ethnic and other social media, webinars and video events, video testimonials or demonstrations featuring community members, TV, and radio. Many of these vehicles for accurate information can also be used to mitigate misinformation individuals have received, or to ‘inoculate’ them against circulating misinformation.<sup>1</sup>

Utilizing local community expertise to develop tailored educational materials, and delivering these materials through trusted local sources, are both essential to ensuring that they will be well received and accepted by the audiences for whom they are designed. Some forms of content and delivery are particularly appropriate for specific communities. For example, storytelling may be an especially effective method of demonstrating to Latino/Hispanic groups that public health strategies can be made consistent with cultural norms, values, and traditions.<sup>2</sup> Educational messaging must also be made accessible to the broadest-possible range of ability levels by using materials written in simple language, interpretive services, and communication technologies.

Education-related solutions must also be directed at healthcare, public sector, and social service workers. Ongoing training for all such employees could help them provide culturally responsive services and outreach to all of Ohio’s communities. This broad education must encompass implicit bias and cultural sensitivity training but must also move beyond these traditional forms to deeper content delivered through multi-session programs more able to generate individual and institutional behavior change. Contact tracers, testing-site staff, and healthcare providers must be educated about how to deliver services effectively to people with disabilities. Disability service providers and formal and informal caregivers would also benefit from COVID-specific trainings.

In the long run, broad improvements in health education would build stronger foundations for understanding the need for health behavior changes to respond to infectious disease epidemics and other health crises. This would require a racially equitable education system that serves members of all communities to the highest standard, more comprehensive school-based health education, and a more diverse pool of educators in primary and secondary educational settings.

1 Van Bavel et al., 2020.

2 Storytelling emerged as particularly important for Latino/Hispanic groups in this *Needs Assessment*; prior research has also demonstrated that narrative may improve message uptake by low health literacy groups (Moran et al., 2016).

## KEY RECOMMENDATION #8: Address Language and Communication Barriers

### Language and Communication Barriers

Where language or communication barriers exist, they can render all the strategies available to protect individuals and communities from COVID-19 inaccessible, standing in the way of obtaining COVID-related information or education, engaging with COVID-19 testing or contact tracing processes, and accessing physical healthcare, mental healthcare, substance abuse treatment, or social services. Language barriers are common across the Latino/Hispanic, Asian/Asian American, and immigrant/refugee communities studied in this *Needs Assessment*, affecting not only individuals who speak no English at all, but also those with low English proficiency and dependent family members who rely on them to access information or healthcare.

COVID-related information is often provided only in English, contributing to a lack of understanding of the disease, how to prevent it, and how to cope with it within communities where English is not the dominant language. This problem pertains not only to written educational materials, but also to local signage (such as signs indicating direction-of-flow or social distancing guidelines in grocery stores), press conferences in which public officials provide important COVID-related updates, public service announcements, and more.

Many healthcare services operate only in English, even when serving communities most comfortable communicating in another language. In healthcare settings where translation is available, services sometimes provide poor-quality translation or take a long time to connect patients to translators.

In many situations, individuals who need help communicating with a healthcare provider are forced to rely on the limited translational capabilities of children or other family members. Furthermore, lack of comprehension is not the only problem caused by these language barriers. Anticipated difficulties communicating with one's healthcare provider, understanding a contact tracer's questions, or filling out required forms can cause fear and anxiety – further curtailing individuals' engagement with healthcare. These *Needs Assessment* findings echo those of prior research on the limitations and consequences of lack of language-concordant healthcare for individuals with low English proficiency.<sup>1</sup> These barriers limit the ability of many members of Ohio's communities to get a COVID-19 test, participate in contact tracing, or access effective healthcare when ill.

For people with disabilities, other types of communication barriers can also impede use of the strategies that protect individuals and communities from COVID-19. Deaf/blind persons, for instance, require touch to communicate, and thus need assistance from an interpreter to absorb COVID-related information or participate in COVID-19 testing, contact tracing, or healthcare. Masks can make communication difficult for deaf individuals and others who utilize lip-reading strategies. Restrictions that prohibit interpreters from accompanying individuals to healthcare appointments and not having interpretive technology available further contribute to communication challenges faced by many Ohioans.

<sup>1</sup> Diamond et al., 2019; Flores, 2005; Jaeger et al., 2019; Karliner et al., 2007.

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## Language and Communication Solutions

Multilingual and community-tailored information and services would substantially improve the ability of many of Ohio's communities to use all methods of COVID-19 protection. Educational information should be presented in all the languages spoken by distinct population groups within Ohio; these include Spanish, Mandarin, Arabic, Somali, and many others.<sup>1</sup> Doing so most effectively will require that guidance provided by the State of Ohio, as well as updates from the Governor's office, materials from the CDC, and other government-authored documents be translated promptly into these languages. Local and community-based organizations providing COVID-related information will also need to identify the languages relevant to their target populations and provide information in each of these languages. At a minimum, multilingual information should be available about each of the public health strategies to combat COVID-19; when, why, and how to use them; and how to locate COVID-19 testing and healthcare.

Writing English-language originals of educational materials in plain, accessible language has many benefits. Simple language information is not only easier to for individuals with low English proficiency to understand and utilize, but also more effective for native English speakers with low literacy or low health literacy. Translated versions that accurately convey consistent information may be easier to write based on simpler original versions. High-quality translation will go beyond translation of words to consider full communication of meaning; "six feet", for instance, is not easily understandable as a unit of distance for some immigrant populations. Utilizing members of

the communities intended to receive translated information to do the translation work may be the most effective way to guarantee complete, meaningful, culturally appropriate translated products.<sup>2</sup> Visual aids are also essential in educational material, assisting low-literacy English speakers, individuals who are not literate in any language, and individuals who must read materials in a language in which there are not fluent.

Multilingual personnel are an equally critical component of addressing the language barriers common across Ohio. All testing, contact tracing, and healthcare service locations must employ bilingual or multilingual practitioners, have translators on staff, utilize shared staffing models to share translators with other sites, or have phone access to translation services when needed.<sup>3</sup> Publicizing the availability of multilingual services could help to reduce fear and anxiety, helping more individuals become willing to come forward for testing, answer contact tracing calls, and engage with healthcare. High-quality translation services must be used; some for-profit companies employ workers who lack the skills to fully translate meaning in a culturally competent way. Hiring individuals from within the communities being served could help ensure that testing, contact tracing, and healthcare interactions are both linguistically fluent and culturally competent, and could help build trust and connection with these communities. Funding translator trainings could also help expand the pool of native-language speakers with the health-specific language skills necessary to be hired into these testing, contact tracing, and healthcare positions.

1 Spanish is the mostly commonly spoken non-English language in Ohio, but several others are spoken as well. (Limited English Proficiency, 2015).

2 Brunette, 2005; Jones et al., 2011.

3 Multiple studies show that trained, professional interpreters and language-concordant care positively affect the satisfaction, quality of care, and outcomes of patients with low English proficiency (Flores, 2005; Karliner et al., 2007).

For individuals with disabilities that affect communication, several measures can help ensure access to COVID-related information and services. Using ASL (American Sign Language) and other interpreters, interpretive technology, screen readers, closed captioning, and audio descriptions are all effective options for ensuring communication of COVID-related information.<sup>1</sup> Classifying ASL and other interpreters as essential employees can preserve their presence to assist with both the COVID-19 response and broader healthcare interactions. Interpretation services and technologies must be provided throughout the healthcare landscape, including during contact tracing and at testing sites, in healthcare facilities and hospitals. Formal interpreters or trusted companions must be permitted to be involved in contact tracing and allowed to accompany people with disabilities to testing and healthcare. Hiring people with disabilities – or already connected to disability communities – to do this work can both help relieve financial insecurity in these communities and ensure that interpretation services meet the needs of community members. Finally, presenting educational information and asking contact tracing questions in plain language can help facilitate accurate interpretation of this information for individuals with disabilities.

<sup>1</sup> For additional reflections on recommendations about interpretive services and communications accessibility, see Courtenay (2020); Courtenay & Perera (2020); Goggin & Ellis (2020); and Jumreornvong et al. (2020).

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## Achieving the Top-Level Recommendations from *Ohio's COVID-19 Populations Needs Assessment*

Taken together, the eight top-level recommendations described above represent a vision for essential next steps in Ohio's COVID-19 response strategy. Designed to alleviate powerful barriers that currently prevent a significant number of Ohioans from using existing COVID-19 prevention measures, these steps would constitute substantial progress toward slowing or preventing the disparate impacts of COVID-19 on people of color, rural residents, and Ohioans with disabilities. Achieving these goals will require contributions from many individuals, groups, and organizations across the state, as well as the integration of new resources. The most promising approach to advancing these objectives will involve [multi-sectoral, multi-level community-based collaborations working with well-aligned goals and strategies to advance health equity](#). The components of this approach are described briefly below.

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### **Take a multi-sectoral community-based approach**

Alleviating widespread barriers to the use of COVID-19 protective behavior will require the cooperation of state-level leaders, local public health entities and social service agencies, community-based organizations and leaders, healthcare providers and institutions, public and private funders, and subject matter experts based at academic and other institutions. Teams assembled to address specific local challenges will need to draw in contributors from all the relevant sectors.

For example, an initiative to prevent COVID-19 infection at home and work within a Spanish-dominant urban community might be based in a local Latino community center and benefit from multiple collaborative contributions. A health communications scholar with expertise in Latino community health might team up with a local public health educator providing up-to-date knowledge and COVID-related educational materials originally written in English. Several local community members willing to provide their stories could be featured in the educational flyers and videos.

A Spanish-speaking community health worker could distribute materials and talk to community members about making preventive behaviors work in their own lives. A local employer could contribute by disseminating educational materials, cleaning supplies, and masks in the workplace, and a foundation interested in funding health equity work in Ohio could provide financial support for these efforts.

Collaborative multi-sectoral teams are essential to COVID-related initiatives, and it is critical that community members trust and feel willing to connect with these efforts. As such, these teams will usually benefit from being led (or co-led) by members or leaders of the community they aim to serve.

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## **Integrate interventions across COVID-19 protective strategies**

Most of the barriers detailed by *Needs Assessment* respondents affect the ability of community members to access multiple CDC-recommended protective strategies. Densely crowded conditions, for instance, impede the effective use of hygiene, social distancing, isolation, and quarantine. Solutions that provide people more living space would increase access to all these prevention methods simultaneously.

In addition, effectively improving access to one prevention method can require alleviating multiple barriers. For example, instituting an effective testing program for migrant workers would require not only creating geographically convenient testing sites, but also ensuring that testing site staff speak the preferred language(s) of workers; educating workers about when and why to be tested; creating methods to link those who test positive to healthcare and temporary isolation housing; and guaranteeing that personal information during testing or contact tracing will not be shared with immigration authorities.

Integrative thinking is therefore an essential component of any effort to alleviate barriers to COVID-protective behavior within marginalized communities. Initiatives should aim to solve interconnected problems through common interventions and alleviate multiple barriers to a target problem simultaneously.

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## **Launch interventions at multiple levels**

Disparate health outcomes result from a wide range of determinants of health that operate at multiple levels. These include:

- Upstream social conditions such as economic insecurity
- Mid-level physical contexts such as dense housing and lack of transportation
- Mid-level social contexts such as unsafe essential workplaces
- Downstream biological pathways, such as the more severe responses to COVID-19 among individuals with certain comorbidities

It is therefore necessary to launch interventions at all these levels in order to effectively stem the disparate impact of COVID-19 on Ohio's communities of color, rural residents, and people with disabilities. These interventions must include, for instance, implementing state-level regulations, improving city transit systems, and providing appropriate PPE in local workplaces.

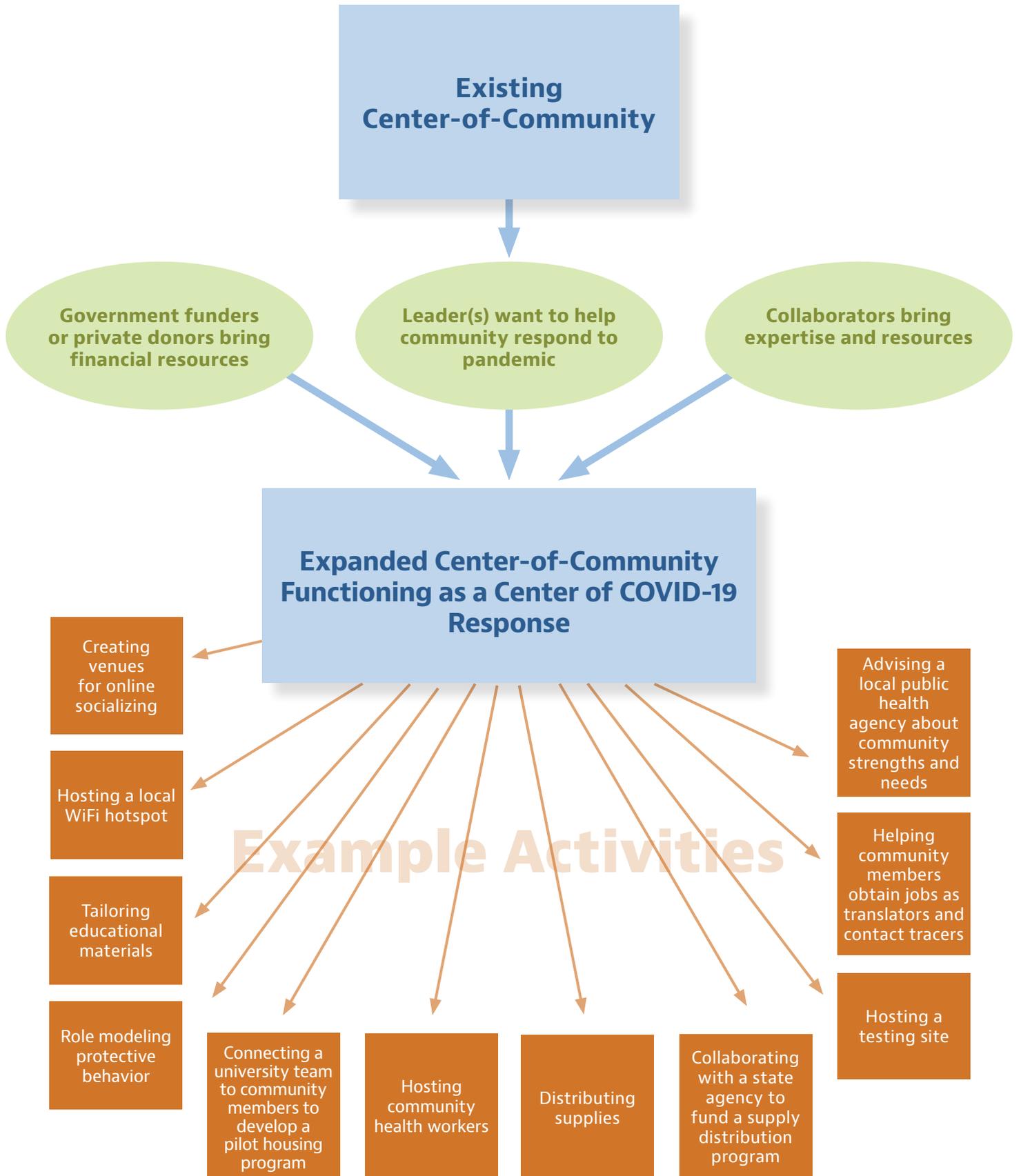
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## **Expand existing centers-of-community into centers of COVID-19 response**

Alongside the barriers they face, all the populations studied in this *Needs Assessment* house substantial community assets. These assets include not only respected individual leaders, but also local groups, institutions, and retail sites that are trusted and relied upon by community members. As described above, these 'centers-of-community' include ethnic and neighborhood organizations, community centers, places of worship, schools, free clinics, ethnic grocers and restaurants, 4H clubs,

university extension offices, barber shops, locally owned gas stations, dollar stores, and more. Expanding these centers-of-community to also serve as centers of COVID-19 response is an idea commonly suggested by *Needs Assessment* respondents (see Figure 5). With collaborative assistance from other sectors, these centers-of-community can fulfill a variety of crucial roles in the COVID-19 response.

**Figure 5. Expanding Existing Centers-of-Community into Centers of COVID-19 Response**



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## Create and expand community health worker capacity

COVID-19 is a pandemic having not only substantial impacts across Ohio but also substantially disparate impacts, which systematically disadvantage populations that are already marginalized across the state. Community health workers (CHWs) have been identified as a critical component of the COVID-19 response by the U.S. Department of Homeland Security and agencies in several other countries.<sup>1</sup> CHWs are “frontline public health staff who conduct outreach and build trust with vulnerable populations in federally qualified health centers (FQHCs), hospitals, public health agencies, and through community-based organizations (Smith & Wennerstrom, 2020).” Community health workers can serve a range of critical functions, including: providing links to community members they get to know over time; educating individuals and families about COVID-19 protections; helping people adapt these protections to their own life circumstances; translating written materials and providing interpretation services remotely; serving as contact tracers; helping people apply for public benefit programs; and helping to staff shelters and food pantries.

Expanding CHW capacity is thus an important mechanism for implementing the recommendations of this *Needs Assessment*. Existing CHW programs should be fully utilized to alleviate barriers to use of COVID-19 protections in the communities studied here.<sup>2</sup> Additional CHWs can be hired and trained from within marginalized communities across Ohio to solve COVID-protection challenges among people of color, rural residents, and people with disabilities. New CHW programs should be established with careful reference to the established procedures for doing so successfully,<sup>3</sup> and extra precautions should be taken to ensure that CHWs themselves have access to PPE and COVID-safe working conditions.

1 See, for example, Bhaumik et al. (2020) and Smith & Wennerstrom (2020).

2 There is evidence that this has not happened during the first months of the pandemic within the U.S.; CHWs have instead been laid off as a cost-saving measure in some locations (Smith & Wennerstrom, 2020).

3 Bhaumik et al., 2020.

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## **Align goals and strategies, and collaborate to maximize progress toward health equity**

Together, the elements above suggest the potential efficacy of multi-sectoral, community-based collaborations instituting multi-level interventions to help communities protect themselves from COVID-19. Diverse contributors to such an effort will need to align their goals and strategies in order to advance health equity, through an approach such as that articulated by the “Collaborating for Equity and Justice” framework.<sup>1</sup> The original collective impact concept on which this framework builds stressed that collaborators must agree on a common agenda, agree early on what constitutes success, contribute their individual strengths to the common agenda, remain connected through close communication, and coordinate their efforts through an infrastructure.<sup>2</sup> These basic tenets of impact-oriented collaborations must be supplemented by additional principles that facilitate collaboration to advance equity and justice. These include explicitly addressing social and economic injustice and racism; ensuring that community residents have equal power in determining the collaboration’s agenda; building community ownership and leadership; and focusing on policies, systems, and structural change.<sup>3</sup>

The Key Recommendations of this *Needs Assessment* and the suggested strategies for achieving these objectives are consistent with these broader goals. Building community-based collaborations to alleviate barriers to COVID-19 protections experienced across the state is a strategy with significant potential: both to minimize the impact of COVID-19 on Ohio’s communities, and to lay the groundwork for reduced disparities and better health across Ohio in the future.

1 Wolff et al., 2017.

2 Center for Community Health and Development, 2020; Kania & Kramer, 2011.

3 Kegler et al., 2019; Wolff et al., 2017.