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

The Ohio State University
College of Public Health

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Findings and Recommendations for *Needs Assessment* Populations

Black and African American Communities in Ohio

Background

Terminology

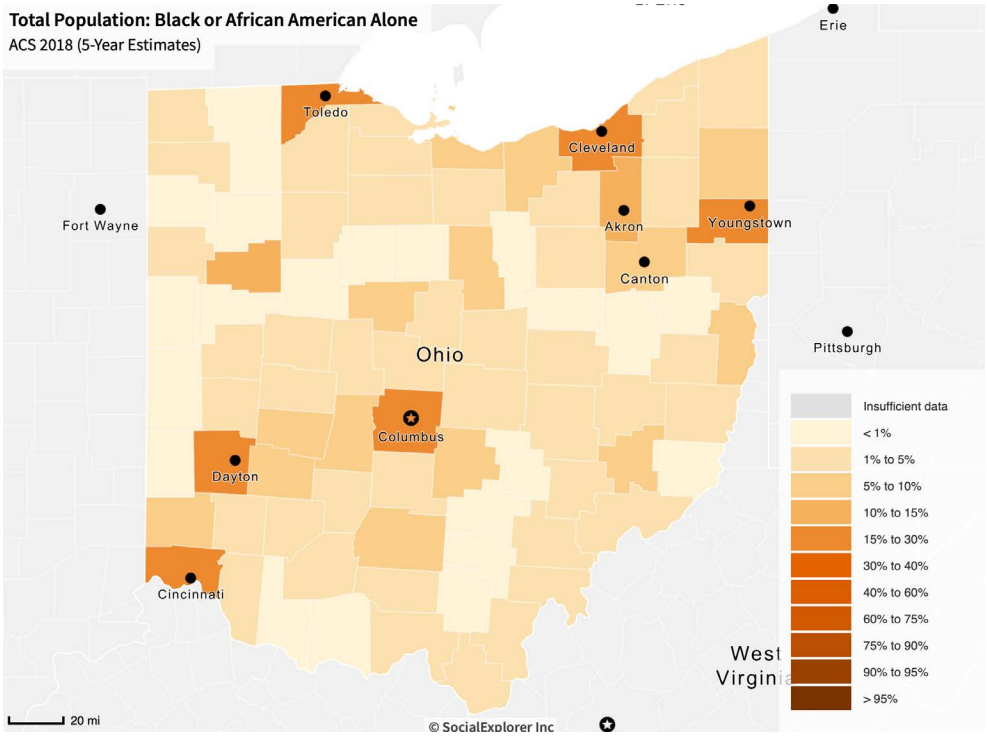
Needs Assessment key populations are identified throughout this document using the terminology preferred by respondents. This section focuses on Black and African Americans.

The terms 'African American' and 'Black' are both used to name cultural and lived experiences. Up until the 1960s when there was increased migration to the United States from places including the Caribbean, Africa and Europe, most people who identified as 'black' in the U.S. were descendants of enslaved Africans (Adams, 2020). In the late 1980's, Jesse Jackson popularized the use of the term 'African American' over 'black ' – a deliberate move on the part of Black communities to move away from race and towards a shared ethnicity and cultural claims to African heritage and American citizenship (Martin, 1991). Although some recent immigrants may claim an African American identity, many may identify instead as Black, as African, or as both. Though the word 'black' has been used by traffickers of human slaves since colonial days, a move towards the claim of 'Black', with a capital "B," designates for many making visible race as a historically-created cultural construct, and claiming Black as an identity of shared power and lived experience regardless of country of origin (Adams, 2020). This meaning is seen in both the Black Power and Black Lives Matter movements, although capitalization of Black in all usages is still under debate (Appiah, 2020).

Population

The U.S. Census Bureau uses the term 'Black Americans' to describe individuals with ancestral origins tied to any of the Black racial groups in Africa (U.S. Census Bureau, 2020a). Black and African Americans represent 13.1% of Ohio's population, including more than 1.5 million residents (U.S. Census Bureau, 2020b). Black and African American residents are scattered throughout the state, with the largest populations residing in Cuyahoga (371,298), Franklin (283,279), Hamilton (208,770), and Montgomery (109,355) counties. The median age of Black and African American Ohioans is 34.1 years, compared to 39.1 years for all Ohio residents (Ohio Development Services Agency, 2019a).

Map 1. Percent Black and African American Residents in Ohio, By County



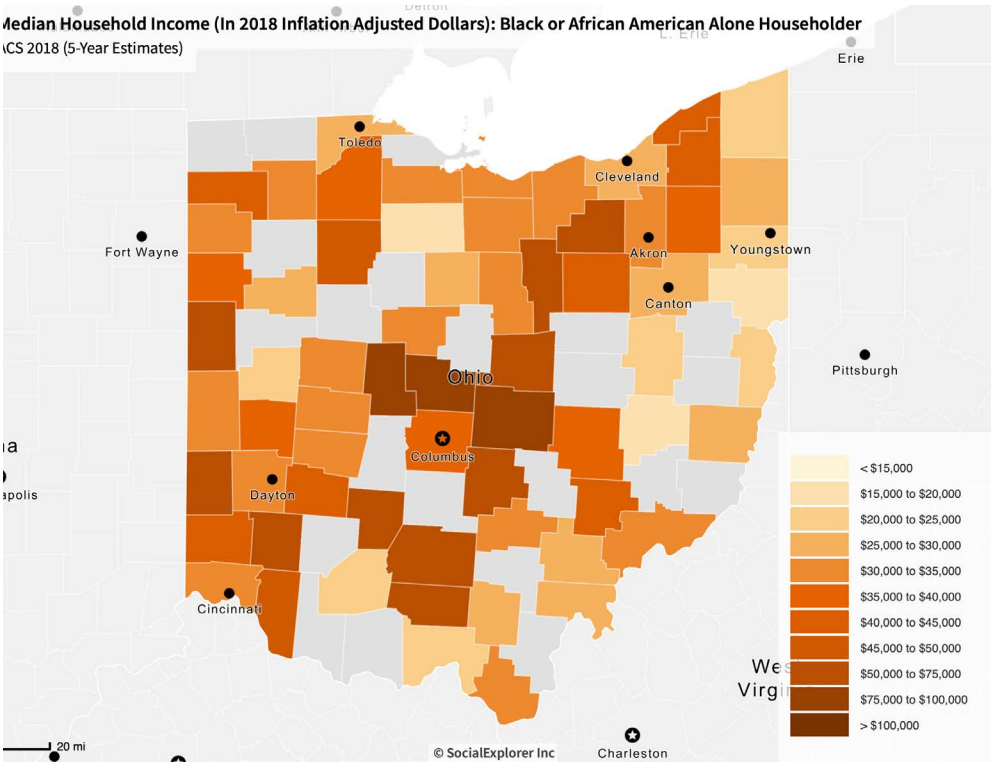
Source: *Map 1.* Percent Black and African American Residents in Ohio, By County. Adapted from "Social Explorer," by C. M. Bijou, 2020, *Social Explorer.* Retrieved July 2020, from https://www.socialexplorer.com/db7e5fe34d/view. 2020 by Social Explorer Inc.

As of 2018, there were 92,782 foreign born Black individuals living in Ohio (Migration Policy Institute, 2018). While most foreign-born Black populations in the U.S. are from the Caribbean, including Jamaica and Haiti, a majority of recent Black immigrants to Ohio come from Africa – including Somalia, Ghana, Ethiopia, Kenya and other countries (Anderson, 2015; New African Immigrants Commission, 2018). African immigrants account for 16.7% of Ohio's foreign-born population (Migration Policy Institute, 2018).

Income and Education

The median household income of Black and African American Ohioans is $31,699, substantially lower than the general Ohio population median of $56,000. Household income among Black and African Americans varies widely by county. Median household income is relatively high in Franklin County ($37,130), for instance, and lower in other counties such as Cuyahoga ($29,295) and Seneca ($18,125). In 2017, 14.3% of Black and African American Ohioans were living below the poverty line, compared to 11.1% of all Ohioans (Larrick, 2019). Approximately 26.0% of Black and African American Ohioans have obtained a post-secondary degree, compared to 38.0% of all Ohioans (Ohio Development Services Agency, 2019a).

Map 2. Median Household Income among Black and African American Ohioans*



*Gray counties indicate that sufficient data are not available

Source: *Map 2.* Median Household Income among Black and African American Ohioans. Adapted from "Social Explorer," by C. M. Bijou, 2020, *Social Explorer*. Retrieved July 2020, from https://www.socialexplorer.com/394dee327f/view. 2020 by Social Explorer Inc.

Historical and Systemic Racism

Black and African Americans have been part of Ohio's history since the state's creation in 1787 (University of Akron, 2008). In 1830, approximately 9,600 Black and African Americans resided in Ohio; by 1950 this group represented 6% of the state's total population. Black and African American Ohioans have always faced considerable racism, discrimination, and violence. In the early 1800s, Ohio legislators passed the "Black laws", which required any Black person to post a $500 bond to gain entry into the state. These laws also restricted employment opportunities for Black Americans and prevented them from voting, serving on juries, testifying against Whites, and enrolling their children in public school (Middleton, 2005). A hundred years later – in the 1920s – support for the Ku Klux Klan (KKK) rose in Ohio, and Klan members were elected to public office in some major cities, including Akron (Ohio History Connection, 2020a). At the same time, Black Americans were actively prohibited from living in White neighborhoods (by redlining and other widespread discriminatory policies) and were frequently subjected to discrimination in public spaces (WOSU Public Media, 2017). These and other forms of historical and systemic oppression in Ohio – as in the country at large – have had long-term health, economic, and social impacts on Black and African American communities.

Black and African Americans have also been subject to state-sponsored racism in the form of medical experiments. Throughout the 20th century, the U.S. government sponsored several unethical research studies on Black Americans (Washington, 2006). The most famous of these was the Tuskegee experiment, which took place from 1932 to 1972 in Tuskegee, Alabama. The U.S. Public Health Service (PHS) funded the Tuskegee experiment to study the natural progression of syphilis, recruiting 600 Black men with promises of free health care for various ailments (Nix, 2019). PHS doctors lied to participants about the goals of the study throughout its duration, and actively prevented them from receiving syphilis treatment. By the end of the study, 138 participants had died from syphilis or related complications.

Unfortunately, similar unethical experiments also took place in Ohio. In 1952, more than 180 healthy Black inmates at the Ohio State Prison were injected with live cancer cells as part of a clinical study funded by the National Institutes of Health (NIH) (Johnson, 2018). Study leader Dr. Chester M. Southam of the Sloan-Kettering Institute misinformed inmates about the potential dangers of participating in the experiment (Alliance for Human Research Protection, 2014). Two decades later, Dr. Eugene L. Saegner of the University of Cincinnati exposed 88 cancer patients – of whom 60% were Black, and 3 were children - to high doses of radiation in a study funded by the Department of Defense. 25 patients died within the first two months of the experiment (Healy, 1994; Advisory Committee on Human Radiation Experiments, 1996).

These state-sanctioned scientific abuses have led to deep-seated and widespread distrust of public health and the medical system within the American Black/African American communities. Well documented by a range of studies, Black Americans are more likely to distrust medical professionals than Hispanics and Whites (Armstrong et al., 2007). This distrust is largely driven by the perception that the healthcare system values profit and reputation over the health of patients (Armstrong et al., 2008; Shoff & Yang, 2012). Furthermore, Black Americans are more likely than others to report experiencing racial discrimination from their own healthcare providers (Armstrong et al., 2013; Bird & Bogart, 2001; Hausmann et al., 2008).

Health Profile

Black and African Americans have a lower life expectancy than other major racial/ethnic groups in Ohio. At birth, Black Ohioans can expect to live approximately 73 years, which is 4 years less than the life expectancy for White Ohioans and 9 years less than for Hispanic Ohioans (Ohio Department of Health, 2019).

Infant mortality is also substantially higher among Black Ohioans than other groups. In 2017, the infant mortality rate for Black Ohioans was triple the rate for White Ohioans and double the rate for Hispanic Ohioans. Ninety percent of all Black infant deaths in Ohio occurred in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit counties (Ohio Department of Health, 2018a). Furthermore, 14.1% of all Black infants born in Ohio have low birth weights (less than 5lbs 8 oz.), compared to 7.4% of White infants, 8.7% of Hispanic infants, 8.9% of Asian infants, and 6.9% of Native American infants (Ohio Department of Health, 2019).

Blacks and African Americans also suffer higher rates of chronic disease than most other racial groups in Ohio. Almost 40% of Black Ohioans have been diagnosed with hypertension, compared to 34.9% of Whites, 28.1% of Hispanics, 13.8% of Asians, and 43.5% of Native Americans (Ohio Department of Health, 2019). Black Ohioans also suffer from diabetes at higher rates than Whites and Hispanics (Ohio Department of Health, 2019). Similarly, 17.2% of Black children in Ohio are suffering from asthma, compared to 6.3% of White children and 8.4% of Hispanic children. Black and African American Ohioans more often die of heart disease, stroke, diabetes, and cancer deaths compared than members of all other racial and ethnic groups (Ohio Department of Health, 2018b).

Challenges Specific to COVID-19

Similar racial disparities have appeared in the midst of the novel coronavirus (COVID-19) pandemic. Since the start of the pandemic in Ohio, 19.6% of COVID-19 cases, 28.4% of deaths, and 17.9% of hospitalizations have been among Blacks and African Americans, despite the fact that they represent less than 15.0% of Ohio's total population (Ohio Department of Health, 2020b). The racial disparities in COVID-19 cases, deaths, and hospitalizations are related to limited access to healthcare within Black communities and disproportionate rates of underlying health conditions among Blacks and African Americans (Godoy, 2020)

Compared to other groups, Black Americans are overrepresented among essential workers, increasing their risk of COVID-19 exposure (Rho et al., 2020). Across the U.S., Black Americans represent 13% of the population but 17% of all essential workers (Rho et al., 2020; U.S. Census Bureau, 2020c). Blacks and African Americans represent 26% of all public transit workers, 19.3% of childcare workers, and 17.5% of health care workers (Rho et al., 2020). Not only are Black Americans overrepresented among essential workers, they are also amongst the hardest hit when it comes to job and wage loss. Forty-four percent of Black Americans report that someone in their household has lost a job or income as a result of the pandemic, compared to 38% of Whites and 61% of Hispanics. Furthermore, 73% of Black Americans report that they do not have emergency funds, compared to 17% of Whites and 70% of Hispanics (Lopez et al., 2020).

Religion, Family, and Health

Religion has been a centerpiece of Black and African American culture for centuries and Black Americans remain somewhat more religious than other groups today. Eighty-two percent of Black/African Americans report a religious affiliation, compared to 80% of Hispanics, 76% of Whites, and 69% of Asians. While most Black Americans identify as Christians (79%), Black Muslims account for 20% of all Muslims living in the U.S. (Masci et al., 2018). Black Americans' religious beliefs play an important role in their healthcare beliefs and decisions (Holt et al., 2014; Levin et al., 2005; Robinson et al., 2014).

Religious communities and family networks play important roles in the lives of Blacks and African Americans, as sources of social, emotional, and financial support (Taylor et al., 2017). African Americans have a strong sense of community and turn to their social networks for informal support related to transportation, finances, illness, and a range of stressors (Benin & Keith 1995; Taylor et al., 2015). Strong social ties and social support have been linked to improved mental and physical health outcomes, and therefore represent a point of strength within the African American community (Berkman & Kawachi, 2014; George, 2011).

Findings from Analysis of *Needs Assessment* Data from Respondents Representing Black & African American Ohioans

Description of Respondents: 79 respondents representing Black and African American communities in Ohio completed the *Needs Assessment* survey. This is not a general sample of African Americans, but a purposeful sample of individuals who represent organizations, agencies, and community groups that work with Black and African American populations. About two thirds of respondents identified as Black or African American themselves. Working in community health centers seemed to be the most frequent way (but not the only way) respondents have contact with this population. The majority of respondents were employed in the health care and social assistance category. Our respondents generally serve high-need groups, so the findings below apply most clearly to that subset of African Americans in Ohio.

I. Strengths of the Community

Respondents identified a broad range of community strengths that should be used as part of the COVID-19 response within Ohio's Black and African American communities. These commonly included:

- Churches and faith organizations, Black ministers, reliance on faith
- A connected community that is culturally strong, trusting, with many gatekeepers, strong kinship ties, sense of collectivism, and value on supporting one another
- Community attributes: resilience, protecting one-another, loving, giving, committed
- Volunteerism – for instance, a lot of mask-making groups and individuals
- Trusted leaders, who know the communities' needs
- Organizations that work in the community, including public schools and community colleges, integrated health departments and primary care, food distribution sites
- Significant social networks
- Organized protests
- Barber shops and hair salons

II. Key Barriers to Using Public Health Strategies to Minimize the Impact of COVID-19

These categories represent the most common barriers to Black and African American communities using public health strategies to minimize the impact of COVID-19. These key barriers were mentioned by multiple respondents (ranging from 5 to 30), and they affect communities' ability to use multiple public health strategies. A summary of each barrier is followed by bullets that detail specific instances and problems commonly mentioned by respondents. Selected quotes exemplify the stories and ideas of *Needs Assessment* respondents.

Topic A: Hygiene
Topic B: Social Distancing
Topic C: Mask-Wearing and Personal Protective Equipment (PPE)
Topic D: COVID-19 Testing
Topic E: Contract Tracing
Topic F: Isolation
Topic G: Self-Quarantining
Topic H: Healthcare Access

1. Lack of access, availability, and cost

This barrier limits the ability of community members to use protective hygiene practices, utilize PPE and COVID-19 testing, and self-quarantine when necessary (Topics ACDG).

- Community members lack access to masks, cleaning agents, disinfecting supplies, gloves, laundry facilities, and warm running water.
- These resources are often expensive, and general un-affordability is exacerbated by
  - price gouging
  - lack of credit cards (to enable purchasing items online)
- Individuals don't always know where to get necessary self-protection items
- Stores often don't have these items in stock
- Testing is unavailable in general, and specifically unavailable in community neighborhoods. People would use it if it was available.

"Several families we contacted to discuss needs said they did not have access to masks or cleaning supplies and that they were concerned about not being safe from the virus because of this."

"Many [people] do not have the money or funds to buy face masks; many do not have washers or dryers to wash face masks on a daily basis."

"[Individuals are unable] to pay if there is a cost associated with testing."

2. Racism and lack of trust in public entities

The history of racist public policy, lack of trust in government officials, and fear of being targeted by the police or perceived of as a criminal limit individuals' use of protective advice, hygiene practices, PPE, and contact tracing (Topics ACE).

- Black people are historically mistreated in general, and specifically during a crisis
- Black people have been particularly mistreated by medical professionals and researchers.
- Black people fear police brutality, being perceived as criminals when wearing a mask
- These fears are particularly acute for men

"This community has been through slavery, government institutions of racism, and medical apartheid. They are very resistant to government orders while experiencing differential treatment."

"Many tests and studies already use African-Americans as 'guinea pigs'."

"Wearing masks is dangerous for many in the Black community who already experience racial profiling while shopping and completing other daily activities. Many fear being mistaken for criminals/robbers while wearing masks in grocery stores and gas stations."

3. Lack of personal transportation

Lack of personal transportation means that many members of the community rely on public transportation to get to work and move around the community, as well as to seek healthcare or a COVID-19 test. This necessity impedes the use of protective hygiene practices and social distancing (Topics ABDH).

"I know a single mother of four young children that has had an extremely difficult time accessing cleaning products and masks for her children. Clearly, she has not wanted to take public transportation, nor ride in a car with anyone because of the lack of ability to social distance in a car with her children. Her financial resources are very limited, and without Internet access she lacks the necessary resource base to locate where to purchase masks or access online grocery delivery services. She has had to rely on organizations such as ours, or friends and family, to shop for her in the midst of shortages and deliver items."

"Even if your doctor says to get a test, and orders one, if [someone] lack[s] a car, they can't get there."

4. Housing challenges

Housing conditions within Black and African American communities affect members' ability to use protective hygiene practices and social distancing, to practice isolation and self-quarantining when needed, and to participate in contact tracing (Topics ABEFG).

- Crowded, dense, or small housing units
- Multi-generational and multi-family housing units
- Congregate housing arrangements, such as apartments, prisons, halfway houses
- Shelters and public housing
- Homelessness and housing instability
- Densely populated neighborhoods
- Lack of separate temporary shelter for confirmed cases
- Many people must share each bathroom
- Transient individuals change phone and address frequently, don't know others' contact information

"Multiple generations [are often] in one household, with different perceptions of being safe (i.e. coughing into elbow instead of hands)."

"[Many people] lack…access to multiple bathrooms in a house."

"[Some groups are] very transient. Switching of cell numbers and addresses are common. This makes [contact] tracing difficult."

5. Need to work

Many members of these communities must go to work, often in low-wage jobs, to provide for their families and maintain a basic income. This necessity limits individuals' ability to use protective hygiene practices and social distancing, and to practice isolation and self-quarantining when needed (Topics ABFG)

- Working as essential workers
- Working face-to-face with the public
- No option to work remotely or from home
- Working in low-wage jobs and living in poverty even with those jobs
- Must work to be able to provide for the family/ household
- Mandatory attendance at work
- Fear of losing benefits if one stays home from work
- No sick time arrangements, employer doesn't allow time off work
- Working in environments that do not reinforce social distancing or other guidelines

"Inability to work from home; many in this population work in essential jobs like food service, retail, janitorial, etc."

"Some people have very low income and may fear losing needed economic security benefits (SNAP) if they don't keep going to work."

"Most people in the Black community can't afford to miss work and their jobs are often on the line if they miss."

"[Many people are] working in environments where management either does not advocate or provide protective barriers, and where 6 feet of social distancing is not possible (i.e. cashiers)."

6. Socialization and Values

The strong need to maintain social contact and activities, based in community values, is a barrier that impedes the use of protective hygiene practices and social distancing (Topics AB).

- There is social pressure to socialize – collective, communal culture
- Social distance is counter to cultural values
- There is an expanded definition of family
- There is a desire to maintain in-person contact
- There is a need for social support and contact, particularly during certain times such as pregnancy, funerals, celebrations
- There is a desire to attend church and maintain religious traditions

"It is perceived as rude for me to drop items off at my grandfather's house and not come in and visit. I have to do that anyway and he just has to be mad."

"Hugging and kissing others is a natural way of showing family/ friends they are cared for."

"Religion is important and people will tend to gather despite rules."

7. Caregiving responsibilities

Caregiving responsibilities impede the use of protective hygiene practices and social distancing, as well as isolation and self-quarantining when needed (Topics ABFG).

- Some individuals are single parents and lack alternate childcare options
- Children don't understand distancing
- Some are caring for and supporting the elderly
- Distancing is against cultural values and practices

> *"[Many lack] availability of alternate caregivers (childcare, elder care, disabled person care)."*

> *"African Americans are very nurturing and will not leave a sick person alone to fend for themselves."*

8. Lack of health information and limiting health beliefs

Community members often lack up-to-date health information relevant to COVID-19. This can impede the use of protective hygiene practices, social distancing, PPE, COVID-19 testing, and appropriate participation in contact tracing (Topics ABCDE).

- Limited access to updated health information
- Inconsistent and confusing messaging
- Misconceptions and lack of comprehension
- Misinformation
- Lack of culturally relevant information
- Information not presented at an appropriate reading level
- Language barriers – lack of translated health information.

These information gaps, as well as some health beliefs, limit understanding and ability to act on accurate information related to COVID-19.

- Not taking the virus seriously
- Community members do not think they are susceptible to COVID-19
- Community members are too reliant on whether someone "looks sick"
- Community engages in risky health behaviors
- Some believe they will contract COVID-19 no matter what because of high-risk, pre-existing conditions
- Poor understanding of what PPE is, how to use it, or why it's necessary
- Not knowing where to be tested, or who can be tested
- Changing habits is difficult
- Witnessing many people not wearing masks, keeping socially distant

"[Communities need] more details that [deliver] health messages at [a] lower grade level."

"[There is a] lack of understanding of how face coverings help prevent spread of disease."

"[Many] lack…clarity on what testing will result in. Is it just verification or do you get treatment?"

9. Lack of technology

Lack of access to smart phones, computers, and Internet limits community members' ability to practice social distancing, participate in contact tracing, and use telehealth substitutes for in-person healthcare (Topics BEH).

- Impairs remote activities
- Many want to use remote means to attend church (for instance), but do not have the means

"Most healthcare practices are using telehealth, which may be a foreign and impersonal way of "seeing" a patient. [Individuals may] lack…understanding of the technology, privacy [issues], and [may be] without access to home computer, Internet or Smartphone."

"[Some have] limited ability to shop online. Many folks in this community do not have the credit cards or ability to purchase items online instead."

10. Lack of health insurance, lack of access to trusted healthcare

This barrier impedes use of PPE, COVID-19 testing, and healthcare related to COVID-19 (Topics CDH).

- No health insurance at all
- Loss of health insurance with loss of job
- Unaffordability of healthcare
- Lack of access to primary care providers
- Don't know where to get healthcare without insurance
- Lack of trust in healthcare system, racism, and poor treatment by providers
- Medical professionals refusing to test or not recommending testing, despite symptoms
- Unable to get a test without a source of healthcare (for a testing referral)
- Too much experimental testing on poor people already

"[There is] inconsistent access to health care due to lack of insurance or underinsurance."

"Distrust of the government. Young black men: "They are planning on killing us all, so why listen?" Young Latino men: "I have to work and I am willing to take the chance and besides I most likely will not live to be old.'"

Other Barriers

These additional barriers represent separate issues reported by multiple respondents, but not as frequently as the 10 key barriers described above.

- Topic A – Hygiene
  - Schools – some do not let students wash hands; they have crowded classrooms; children are coming to school sick because parents have to work; high school students have to change classrooms throughout the day; school does not share sufficient health information
- Topic B – Social Distancing
  - Needing to access overcrowded social service agencies
  - Black men in particular may discount the threat of the virus as they do not want to appear weak
- Topic C – PPE
  - Discomfort
  - Not liking how masks look
  - Having a disability – unable to breathe in mask; masks hinder deaf peoples' ability to communicate
  - Reusing masks too much until they are dirty
- Topic D - Testing
  - Fear of test – swab is a deterrent, rapid testing would help
- Topic E – Contact Tracing
  - Concerns about privacy, uncomfortable speaking to a stranger
  - Not sure how their information will be used
  - Worried about effects on employment
- Topic H – Healthcare Access
  - Fear of being exposed to COVID-19 at the doctor's office

> *"[This] population [is] uncomfortable with strangers asking questions and 'getting in their business'."*

III. Key Ideas (Solutions) to Address Barriers and Minimize the Impact of COVID-19

These categories represent the most common solutions suggested to help Black and African American communities use public health strategies to minimize the impact of COVID-19. These key ideas were mentioned by multiple respondents (ranging from 5 to 30) and would facilitate communities' ability to use multiple public health strategies. A summary of each proposed solution is followed by bullets which list details and specifics commonly mentioned by respondents. Selected quotes exemplify the stories and ideas of *Needs Assessment* respondents.

1. Provide resources directly

The most commonly suggested ideas to address the barriers described above focus on direct provision of resources. These approaches would help improve community members' ability to utilize protective hygiene, social distancing, PPE, COVID-19 testing, isolation, and self-quarantining (Topics ABCDFG).

- Free or low-cost supplies, including masks, gloves, cleaning products
- General supplies including meals and Internet service
- General resources including support groups, social support for elderly and children
- Free, community-based COVID-19 testing, including mobile-van testing, walk-through testing, testing at work, drive-through testing
- Direct financial support and in-kind support such as housing assistance
- Emergency pay, unemployment; facilitated stimulus payments
- Use of community organizations and members to distribute supplies and resources
- Delivery of supplies and resources directly to homes when necessary
- Availability of touchless sanitizer in public places

"Distribute free disposable white or multi-colored masks at neighborhood churches, stores, playgrounds and barbershops. Do not distribute or encourage black masks."

"[Institute] door drop distribution of disinfecting and personal care products that cannot be purchased with SNAP/WIC benefits."

"[Provide] hygiene stations at the neighborhood level."

2. Create housing options

Housing support and options would help improve use of hygiene, social distancing, isolation, and self-quarantining (Topics ABFG).

- Identify housing where sick people can go
- Create a pause in rent, utilities, other major expenses
- Utilize hotels and motels, unfilled public housing, other interim housing
- Utilize convention centers, schools, emergency evacuation locations
- Ease prison overcrowding by reducing sentences for minor offenses

"[Have] a community worker help [sick individuals] figure out…the best way to isolate in their home; give them a concrete plan to help them understand."

"[Provide] temporary housing for confirmed or suspected cases of COVID-19."

"Use hotels as options for non-ill family members to quarantine, for free."

"Release prisoners [who are in jails/prisons] for minor offenses. Quit privatizing prisons as a business. [The] profit motive encourages more inmates. Major policy changes [are] needed to ease [prison] overcrowding."

3. Increase and improve COVID-related education

High-quality education about a range of topics could be developed and used to improve use of protective hygiene, social distancing, PPE, testing, contact tracing, isolation, and self-quarantining. Education should be community-appropriate and tailored (Topics ABCDEFG).

- Possible topics for community education
  - The severity and real threat of COVID-19
  - Mask efficacy
  - Proper hand washing
  - Importance of cleaning
  - How to distance within the home
  - Guidelines for sharing meals and worship
  - Staying connected
  - Creative ideas for spending time together
  - Staying on course for the long term
  - Plans for leaving the house
  - How contact tracing works
  - Why contact tracing is important
  - Isolation vs. social distancing
  - When & why isolation is important
  - How to isolate
- Modes of delivery
  - Flyers
  - Pamphlets
  - Social media
  - Yard signs
  - Community signage
  - Demonstrations
  - YouTube videos
- Culturally relevant messaging with diverse graphics
- Low literacy level, lots of visuals
- Make materials available in multiple languages, offer translation services
- Use validated messaging
- Use entertainment
- Also educate police, EMS, and schools
- Provide incentives for education

> *"Utilize church platforms to communicate safety practices. Have other community influencers do short videos or share on social media."*

4. Improve transportation options

Creating safe transportation options would help address hygiene, social distancing, and testing barriers (Topics ABD).

- Increase frequency of public transportation
- Issue free bus passes
- Clean public transportation vehicles more frequently
- Increase safety of buses by adding plexiglass barriers, etc.
- Provide free transportation to testing

"[Provide] free individual transportation to stores."

"Increase markers and reminders for social distancing at bus stops and other public services/ facilities."

5. Improve employment policies

Improving policies in workplaces could make them safer, and address barriers to hygiene, social distancing, isolation, and self-quarantining (Topics ABFG).

- Ensure workplaces are following state and public health guidelines
- Ensure that employers accept healthcare provider recommendations
- Ensure that individuals can maintain their jobs if they have to isolate or self-quarantine

"Make masks available through employers."

"[Institute] uniform policies about employer acceptance of practitioners' recommendations."

6. Use trusted community members and resources

Services, information, and resources should be provided by trusted community members and sites, to help address barriers to hygiene, use of PPE, and testing (Topics ACD).

- Use trusted messengers from within communities to deliver educational messages
- Engage churches, community centers, dollar stores, gas stations, support organizations, and key community members to deliver supplies and as distribution sites
- Utilize community health workers, individuals who look and speak like the community
- Increase support to organizations who are already distributing and delivering needed supplies
- Identify where people are comfortable going (trusted community centers or churches) and make those the testing sites
- Train and use members of the community as much as possible (except, per some respondents, as contact tracers)

"Provide the needed assistance to the community by utilizing persons that look and speak like the people in that community."

"Provide PPE (particularly face masks) to area agencies and churches to distribute to residents."

"Provide access to health professionals and health education through trusted community partners."

Other Ideas

These additional ideas represent separate potential solutions reported by multiple respondents, but not as frequently as the 6 key ideas described above.

- Topics F&G – Isolation & Self-Quarantining
  - Provide alternate caregivers, and/or caregiver assistance
- Topic B – Social Distancing
  - Keep businesses closed until there is a vaccine
  - Require stay-at-home
  - Don't re-open until we are truly ready
- Topic C – PPE
  - Have public conversations about racism, reduce racism
  - Penalize unnecessary calls to the police on Black people
  - Reduce racial profiling
- Topic D – Testing
  - Come up with plans to provide treatment before testing people
- Topic E – Contact Tracing
  - Do in-person contact tracing
- Topic F – Isolation
  - Have community health workers develop isolation plans for different housing situations
  - Include home visits

> *"Identify the social determinants of health that mostly affect that community and begin to implement a "sustainable" approach to reducing barriers to care."*

IV. Trusted Community Resources and Linkages

Respondents also identified many trusted community resources – including categories of organizations, individual organizations, and individuals. Categories of organizations most commonly included:

- For health information:
  - Local health departments
  - Community health centers and workers
  - Local hospitals
  - Friends and neighbors
  - Churches
  - Community-based social services agencies
  - Trusted community members and leaders
  - Schools
- For medical care:
  - Emergency departments
  - FQHCs and community health centers
  - Area health centers
  - Health departments
- For social service information & resources:
  - Churches and pastors
  - Food pantries
  - A wide range of social service agencies and non-profit organizations

Final Recommendations to Minimize the Impact of COVID-19 on Black and African American Populations in Ohio

These recommendations reflect the data provided by respondents representing Black and African American communities as well as additional context and insight provided by our panel of expert researchers, public leaders, and practitioners with expertise focused on Black and African American communities.

1. **Center the COVID-19 response in the organizations and cultures of local communities, implementing public health activity through partnerships with trusted community groups, empowering local organizations to lead this work, and providing them with resources to do so.**

Immediate, COVID-19 specific, recommendations:

Engage churches, mosques, community centers, schools, dollar stores, gas stations, support organizations, and key community members to act as distribution sites and delivery coordinators for masks and cleaning/ disinfecting supplies.

Increase support to community organizations and institutions that are already distributing and delivering needed supplies.

Partner with trusted community organizations and institutions to disseminate COVID-related information to community members.

Partner with and promote Black-owned businesses that also distribute COVID-related supplies and information, and that model social distancing, cleaning, and mask-wearing.

Identify the community sites where people are most comfortable going and host testing sites there; hire individuals from the community to help staff these locations.

Hire and train local community members to work as contact tracers, increasing trust in contact tracing services. Local tracers can also (a) conduct contact tracing interviews in-person with individuals uncomfortable with or unable to participate by phone, and (b) provide tools to help people uncomfortable sharing information use "self-serve" contact tracing to educate their contacts about COVID-19 exposure and refer them to contact tracers.

Partner with community organizations and local businesses to create COVID-safe Wi-Fi hot spots to increase access to telehealth and other remote resources.

Partner with Pathways HUBs and community health worker organizations to connect individuals who show up for COVID-19 testing or participate in contact tracing with primary care and community resources.

Immediate recommendations to improve the health of communities:

Cultivate new trusting relationships between local communities and specific public health agencies and higher education institutions.

2. **Explicitly address economic injustice and its widespread health and social impacts by directly improving access to resources to support disease prevention, COVID-19 response, and necessities of daily living.**

Immediate, COVID-19 specific, recommendations:

Create new retail opportunities and public distribution sites to facilitate ready access to masks, disinfecting/cleaning supplies, and other essential supplies.

- Place semi-permanent COVID supply storefronts or pop-up shops selling supplies at reasonable cost in neighborhoods that residents can access on foot; this is particularly important in food/shopping deserts.
- Use government/private partnerships to incentivize improved availability of products and services in urban areas.
- Use community organizations to facilitate distribution of free supplies and delivery to homes when necessary.

Create free testing sites where people live and work, ensure that they are easily accessible, and integrate COVID-related education and services at these sites.

- Create new stable testing sites in neighborhoods.
- Use a range of mobile-van and pop-up testing sites to allow for both walk-up and drive-up testing.
- Conduct testing in workplaces, including at employment locations for essential workers.
- Make testing free.
- Provide accurate, culturally-tailored information at testing sites, presented in the languages of each community, to educate individuals who present for testing and others about COVID-19 how to minimize its spread.
- Integrate health and social support navigators into testing sites, to provide those who test positive with income support, other resources to make self-quarantine attainable, cleaning and disinfecting supplies, education about self-quarantine, and assistance in obtaining healthcare services.

Improve healthcare access to ensure that those who test positive can be effectively linked to ongoing care.

- Place free and low-cost health clinics in high-need neighborhoods – through or in partnership with existing FQHCs, public health authorities, and private healthcare systems – to provide COVID testing, primary care, preventive services, and social supports.
- Expand access to telehealth using community-based health centers with low payment requirements; make temporary HIPAA adjustments to ease access through multiple electronic platforms.
- Mandate strong charity care programs across all hospitals and appropriate funds to covers hospital costs of uninsured individuals with COVID-19.

Improve supportive community services by paying family or community members to serve as home health aides, expanding support groups and services for children and elderly community members.

Provide free municipal broadband and long-term public WiFi hot spots in low-income neighborhoods.

Improve and speed access to emergency pay, unemployment, and stimulus payments.

Immediate recommendations to improve the health of communities:

Increase direct financial support to low-income households, as well as in-kind supports such as housing and food assistance.

Recommendations to create a social context for long-term health and wellness:

Institute universal health insurance, including publicly-funded basic insurance coverage for all Americans.

Ensure ongoing access to primary care, mental health care, and substance use treatment.

3. **Directly address the impacts of historical, institutional, and everyday racism through policy change, strong statements by public leaders, and anti-racism education and training.**

Immediate, COVID-19 specific, recommendations:

Government and private efforts to mitigate COVID-19 should routinely support and promote community-based and Black-owned businesses and organizations.

Public leaders and elected officials should explicitly and publicly refute misinformation, racism, and xenophobia whenever they are articulated or disseminated in public spaces.

Immediate recommendations to improve the health of communities:

To eliminate bias and cultural barriers to healthcare and social services, ongoing implicit bias and cultural competency training sessions should be mandatory for all state employees, police, teachers, healthcare providers, social service providers, and trainees for these positions.

Policy makers and stakeholders should advocate for anti-racism in all policies.

Recommendations to create a social context for long-term health and wellness:

Racial inequities in the criminal justice system should be addressed to reduce mass incarceration and its long-term health and economic effects in communities. [1]

Reparations or direct payments should 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 Acker et al., 2018.

4. **Improve and enforce employment policies to reduce the spread of COVID-19 in workplaces and protect businesses and workers coping with the impacts of the pandemic.**

Immediate, COVID-19 specific, recommendations:

Ensure and enforce that all workplaces are following current state and public health guidelines.

Require large employers to use best practices for minimizing the spread of COVID-19, including providing masks, PPE, and hygiene supplies to employees, and develop an enforcement structure for these requirements.

Incentivize all employers to use these same best practices; highlight compliant employers and penalize non-compliant ones.

Provide financial support to small and minority-owned businesses to help them engage fully with safety requirements and stay in business.

Require that all businesses (including temp agencies) provide leave time to employees who need to isolate or quarantine themselves or a family member, without threat of job loss or benefit loss.

Expand emergency paid sick leave provisions in legislation, to cover employees in businesses of all sizes, make benefits retroactive, and hasten payout of benefits.

Recommendations to create a social context for long-term health and wellness:

Prohibit employers from asking about criminal history on initial job applications, to improve placement in positions offering health insurance and sick time.

5. **Reduce the substantial COVID-19 transmission risks associated with dense living conditions by increasing access to affordable housing, alleviating crowding in congregate situations, and creating new options for isolation and self-quarantine.**

Immediate, COVID-19 specific, recommendations:

Create a pause in rent, utilities, and other major expenses.

Identify and fund temporary housing units to shelter isolating and quarantining individuals and their caregivers away from others. Consider schools, conference centers, hotels, motels, and emergency evacuation locations for this use.

Increase investment in shelters and low-income housing to provide COVID-safe accommodations for homeless and transitional housing populations.

Reduce congregate living in prisons and jails by creating new options to reduce incarceration of non-violent offenders, ramping up release of low-risk non-violent offenders already in prison, providing appropriate supports for post-release re-integration, and ending the use of cash bonds for low-risk, non-violent individuals in jails awaiting trial.

Immediate recommendations to improve the health of communities:

Create more affordable housing by converting existing housing to affordable units, and by funding, subsidizing, and incentivizing new low-income housing development.

6. Improve access to COVID-safe, affordable transportation.

Immediate, COVID-19 specific, recommendations:

Improve public transportation infrastructure by adding routes that go to testing and healthcare sites, increasing the frequency of routes, and reducing cost to riders.

Make public transportation safer by cleaning vehicles more frequently, distributing masks to riders, and adding plexiglass barriers in buses.

7. Increase and improve the dissemination of high-quality, culturally-connected COVID-related education throughout communities.

Immediate, COVID-19 specific, recommendations:

Prioritize frequent clear, credible, and tailored communication about COVID-19 and its impact on the community.

Develop culturally-relevant educational materials that cover a broad range of COVID-related topics, including the severity and threat of COVID-19; the efficacy of protective measures including hand washing, surface cleaning, mask wearing, and social distancing; suggestions for staying safely connected with family and community; when, where, and how to get a COVID-19 test; why contact tracing is important and how it works; when and how to isolate and quarantine; how to use COVID-related protections while at work and when in caregiving roles.

Ensure that educational messaging is culturally-tailored, presented in all the languages each community speaks and in terms appropriate for individuals with low literacy, includes lots of visual aids, and features diverse graphics centered on members of the community.

Disseminate culturally-relevant educational materials through a range of modes, including flyers, pamphlets, yard signs and other community signage, social media, and YouTube videos.

Develop culturally-tailored materials to deliver standardized pre-test counseling, post-test counseling, and contact tracing conversations, to ensure that all patients and contacts receive thorough and consistent information.

Recommendations to create a social context for long-term health and wellness:

Improve school-based health education.

Create a racially equitable education system that serves members of all communities at the highest levels.