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

Immigrant and Refugee Communities in Ohio

Background

Terminology

Needs Assessment key populations are identified throughout this document using the terminology preferred by respondents. This section focuses on those who identified themselves as representing immigrant and refugee populations in Ohio.

The term 'immigrant' refers to "any person who changes their country of usual residence". "Usual residence" incorporates two components; it is a place where one lives and spends their daily period of rest. The term 'immigrant' does not refer to individuals who engage in temporary travel, including for recreation, business, holiday, medical care, or religious practices (International Organization for Migration, 2018). The terms 'first-generation immigrant' and 'second-generation immigrant' additional refer to individuals born in the U.S. but whose parents or grandparents are foreign-born.

The term 'refugee' refers to "any person who leaves their initial country of usual residence for fear of being harmed or harmed further because of their race/ethnicity, religion, nationality, political opinion, or membership of a particular social group" (International Organization for Migration, 2018).

Population

Over 550,000 (nearly 5%) of Ohio's total population are foreign-born immigrants or refugees. While Ohio's total population has experienced less than 10% growth since 1990, the number of immigrants and refugees in Ohio has more than doubled over these 30 years. An additional 5% of Ohio's population are native-born U.S. citizens with at least one immigrant parent (American Immigration Council, 2020; Migration Policy Institute, 2018). Today, immigrants and refugees in Ohio hail from many different countries (see Table 6), including India (11.8% of immigrants in Ohio), Mexico (8.6%), China (7.6%), the Philippines (2.9%), and Canada (2.5%) (American Immigration Council, 2020).

Table 6. Prevalence of Immigrants in Ohio, by Country of Origin

	N	Percent
Detailed Region/Country of Birth	**555,442**	**100%**
Europe	99,860	18.0%
Northern Europe	14,542	2.6%
United Kingdom	11,181	2.0%
Ireland	1,183	0.2%
Other Northern Europe	2,178	0.4%
Western Europe	20,465	3.7%
France	3,346	0.6%
Germany	13,580	2.4%
Other Western Europe	3,539	0.6%
Southern Europe	13,568	2.4%
Italy	8,188	1.5%
Portugal	618	0.1%
Other Southern Europe	4,762	0.9%
Eastern Europe	50,971	9.2%
Poland	4,888	0.9%
Russia	7,478	1.3%
Other Eastern Europe	38,605	7.0%
Other Europe (no country specified)	314	0.1%

	N	Percent
Asia	240,152	43.2%
Eastern Asia	66,785	12.0%
China	42,048	7.6%
China, excluding Taiwan	38,393	6.9%
Taiwan	3,655	0.7%
Japan	9,008	1.6%
Korea	15,729	2.8%
Other Eastern Asia	0	0.0%
South Central Asia	99,897	18.0%
India	65,338	11.8%
Iran	4,127	0.7%
Other South Central Asia	30,432	5.5%
Southeastern Asia	41,960	7.6%
Philippines	15,990	2.9%
Vietnam	11,789	2.1%
Other Southeastern Asia	14,181	2.6%
Western Asia	28,427	5.1%
Israel	1,497	0.3%
Lebanon	4,754	0.9%
Other Western Asia	22,176	4.0%
Other Asia (no country specified)	3,083	0.6%

	N	Percent
Africa	88,669	16.0%
Eastern Africa	32,190	5.8%
Northern Africa	9,610	1.7%
Western Africa	33,505	6.0%
Middle and Southern Africa	5,624	1.0%
Other Africa (no country specified)	7,740	1.4%
Oceania	4,133	0.7%
Australia and New Zealand subregion	1,904	0.3%
Oceania (no country specified)	2,229	0.4%

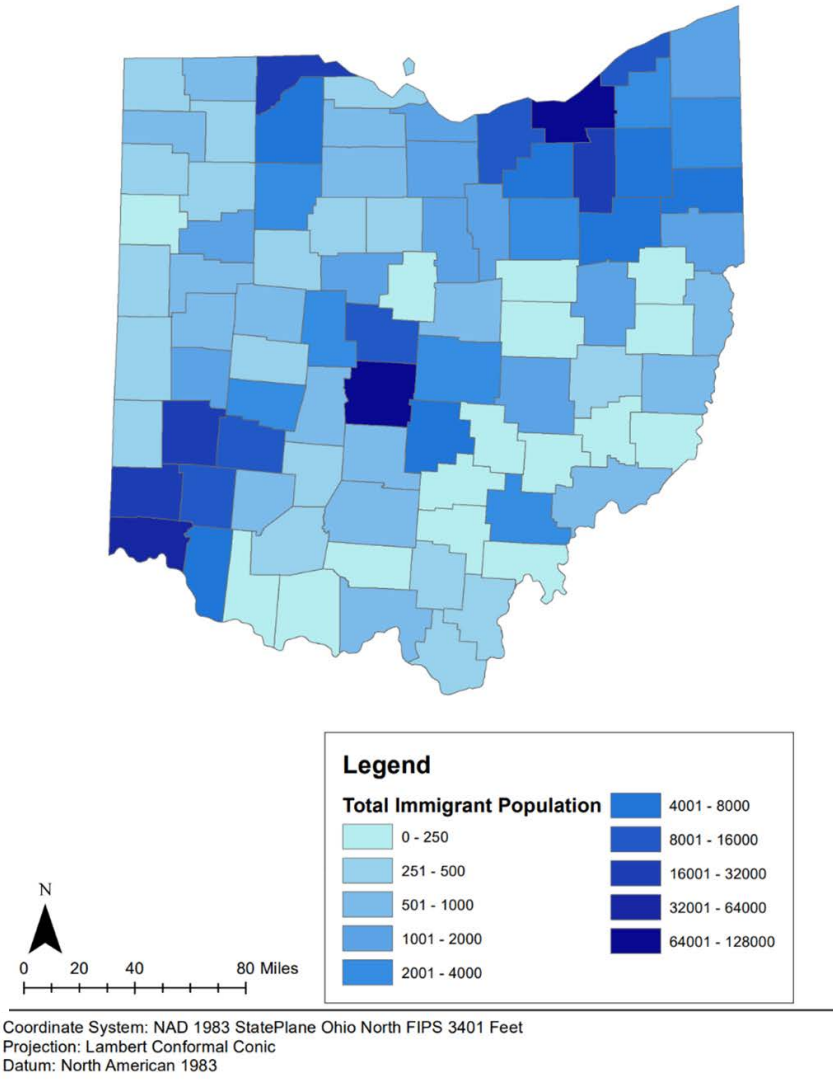
	N	Percent
Americas	122,628	22.1%
Latin America	108,648	19.6%
Caribbean	19,348	3.5%
Cuba	2,354	0.4%
Jamaica	4,386	0.8%
Other Caribbean	12,608	2.3%
Central America	70,731	12.7%
Mexico	47,853	8.6%
El Salvador	7,227	1.3%
Other Central America	15,651	2.8%
South America	18,569	3.3%
Brazil	3,081	0.6%
Colombia	3,801	0.7%
Other South America	11,687	2.1%
Northern America	13,980	2.5%
Canada	13,980	2.5%
Other Northern America	0	0.0%

Source: *Table 6*. Prevalence of Immigrants in Ohio, by Country of Origin. Adapted from "Place of Birth for the Foreign-Born Population in the United States," by J. M. Macisco, 2020, *U.S. Census Bureau*. Retrieved July, 2020 from https://data.census.gov/cedsci/table?q=B05006&g=0400000US39&tid=ACSDT5Y2017.B05006. 2020 by U.S. Census Bureau.

Ohio's cities and metropolitan areas are home to a majority of the state's immigrants and refugees (see Map 6). Columbus has the largest percentage of immigrants (7.5% of the city's total population), followed by Cleveland (5.7%), Cincinnati (5.0%), and Dayton (4.3%) (National Immigrant Forum, 2019). Very few immigrants settle in Appalachian areas, but approximately 20% of Ohio's immigrant population resides in rural communities across the state (Chicago Council on Global Affairs, 2012).

About 5.0% of refugees in the U.S. are resettled in Ohio, such that between 1983 and 2013, 45,392 refugees were resettled in the state. There are refugee communities in all major Ohio cities, but most reside in five counties: Cuyahoga, Franklin, Hamilton, Montgomery, and Summit (ODJFS, 2018). The primary refugee communities in central Ohio include Afghani, Bhutanese-Nepali, Burmese, Congolese, Ethiopian, Eritrean, Iraqi, Somali, Syrian, and Ugandan peoples (Community Refugee & Immigration Services, 2020).

Map 6. Ohio Immigrant and Refugee Population, by County



Source: *Map 6*. Ohio Immigrant and Refugee Population, by County. Adapted from "U.S. Census Bureau," J. M. Macisco, 2017, *American Community Survey*. Retrieved September 2020, from https://data.census.gov/cedsci/table?q=Populations%20and%20People&g=0400000US39&tid=ACSST1Y2019.S0101&hidePreview=false

Income and Education

Immigrants make up about 6% of the total labor force in Ohio, and work in many different sectors of the economy (American Immigration Council, 2020).

Table 7. Primary Occupation Categories of Immigrants Living in Ohio

Occupation Category	Number of immigrant workers
Production	41,927
Transportation and Material Moving	39,135
Office and Administrative Support	30,204
Healthcare Practitioners and Technical	28,692
Management	27,632

Source: *Table 7.* Primary Occupation Categories of Immigrants Living in Ohio. Adapted from "Fact Sheet: Immigrants in Ohio," by J. M. Macisco, 2020, *American Immigration Council*. Retrieved September 2020, from https://www.americanimmigrationcouncil.org/research/immigrants-ohio. 2020 by American Immigration Council. Original source: analysis of the U.S. Census Bureau's 2018 American Community Survey 1-year PUMS data by the American Immigration Council.

In 2014, immigrants in Ohio earned an estimated $15.6 billion dollars in income – about 5.2% of the total income earned by all Ohioans. $4.5 billion dollars of these wages earned by immigrants in Ohio went to state and federal taxes (New American Economy, 2016).

Immigrants in Ohio experience poverty at higher rates (17.3%) than their U.S.-born counterparts (13.7%). Poverty rates among immigrants in Ohio have grown significantly in recent decades: more than twice as many immigrants were living in poverty in 2018 as in 2000 (poverty increase by about 30% among U.S.-born Ohioans during the same period). Undocumented immigrants are twice as likely as documented immigrants to experience poverty (Migration Policy Institute, 2018).

In the aggregate, immigrants in Ohio tend to be college-educated (see Table 8). It is important to note that educational opportunities are likely not available equitably across different immigrant communities.

Table 8. Education Levels of Foreign-Born and U.S.-Born Ohio Residents

Education Level	Foreign-Born, 1st Generation, or 2nd Generation Immigrant Residents (%)	U.S. Born Residents (%)
College degree or more	42	28
Some college	19	30
High school diploma only	22	33
Less than a high school diploma	17	9

Source: *Table 8*. Education Levels of Foreign-Born and U.S.-Born Ohio Residents. Adapted from "Fact Sheet: Immigrants in Ohio," by J. M. Macisco, 2020, *American Immigration Council*. Retrieved September 2020, from https://www.americanimmigrationcouncil.org/research/immigrants-ohio. 2020 by American Immigration Council. Original source: U.S. Census Bureau, 2018 American Community Survey 1-year Estimates.

Immigration History

Indigenous peoples inhabited the land that is now Ohio as early as 15,000 years ago. Indigenous and Native American tribes in Ohio in the 1600s included the Shawnee, Delaware, Miami, Seneca-Cayuga, Chippewa, Iroquois, and Wyandot. During the 1600s and 1700s, these Native American tribes lost the vast majority of their land to war and encroaching settlers. The last Native American reservations in Ohio were dismantled in the 1840s (Ohio History Connection, 2020b).

The first immigrants to Ohio were French and British colonialists (Ohio History Connection, 2020b). A second wave of immigration in the 1800s included settlers from western Europe (e.g.: Germany, Ireland, and Italy) and eastern Europe (e.g.: Russia, Poland, and Hungary). Starting in the 1940s in the wake of World War II, Ohio experienced an increase in immigrants with Jewish ancestry (Aumann et al., 2020), as well as an increase in immigration from a greater diversity of origin countries.

Health Profile

Early research on immigration and health documented the potential negative health consequences immigrants may experience during and after immigration. More recently, researchers have documented a phenomenon describing the generally greater quality of health immigrants experience compared to their U.S.-born counterparts. This "Immigrant Health Paradox" describes the pattern that immigrants experience lower incidence of chronic conditions – both physical and mental – as well as higher life expectancy compared to U.S.-born individuals of the same racial/ethnic group (Waters & Pineau, 2015). For example, immigrants from Mexico have a lower incidence of diabetes than Mexican-Americans born in the United States (Markides & Rote, 2015). Over time, however, immigrant health profiles begin to look more similar to their U.S.-born counterparts as time spent in the United States increases. While the full picture of factors that fuel this health paradox are yet unclear, socioeconomic factors, discrimination, and acculturation are all hypothesized to influence the health status of immigrants and their U.S.-born peers, and may jointly explain the immigrant health paradox (Markides & Rote, 2015; Waters & Pineau, 2015; Viruell-Fuentes, 2007; Viruell-Fuentes, et al., 2012).

It is important to note that exceptions to this paradox do exist. Diabetes, heart disease, and cancer are frequent concerns among immigrant communities in Ohio (Columbus Office of Minority Health, 2017). Although incidence rates of most cancers are higher among U.S.-born immigrants, foreign-born immigrants do experience higher incidence of stomach and liver cancers (Singh et al., 2013). Foreign-born Black, Latino/Hispanic, and Asian/Asian Americans also have higher rates of HIV than their U.S.-born counterparts (Singh et al., 2013). In addition, younger immigrants tend to experience better health outcomes than their U.S.-born counterparts; however, as immigrants age, their health may significantly deteriorate (Jasso et al., 2004). The capacity of communities to address these challenges varies by available social, economic, and healthcare resources, cultural norms, immigration status, language proficiency, location of residence, experiences of stigma and marginalization, and poverty status.

Access to health care is a major concern for all immigrant and refugee populations. Lack of health insurance is an important impediment to access. An estimated 100,000 immigrants in Ohio are undocumented and therefore cannot enroll in Medicaid or other public health insurance programs (National Immigrant Forum, 2019). Many immigrants also report feeling uncomfortable when speaking with healthcare professionals. Researchers recommend expanding health insurance and safety nets for aging immigrants, as well as providing language services (Derose et al., 2007).

Undocumented residents also have less access to a range of other social supports than U.S. citizens and documented immigrants in Ohio. According to a 2015 study by the University of California's Global Health Institute, Ohio is the single state with the most exclusionary set of policies affecting undocumented residents. Ohio excludes undocumented families from all of the following services: health insurance for children, supplementary nutrition programs like SNAP, financial aid for education, worker's compensation, employee work authorization, driver's license assistance, and the reduction of federal law enforcement in immigrant communities. All other U.S. states provide at least one of these public health or welfare benefits to undocumented families (Rodriguez et al., 2015).

Refugees in Ohio are usually eligible to receive state assistance. For the first eight months post-resettlement, refugees may have access to cash and medical assistance programs. For the first five years, refugees may be eligible to receive a variety of social services, including language training, job services, childcare, counseling, and more. Very few services are provided beyond five years. Some refugees might also be eligible to receive assistance through federal programming; eligibility depends on many factors and is not necessarily guaranteed. Recent state policy has made additional funds available for children of refugees to access some of these services more frequently (ODJFS, 2018).

The Somali community, which comprises a large proportion of refugees in Ohio, experiences specific healthcare access barriers, including limited language fluency, lack of healthcare insurance, and cultural practices that limit engagement with U.S. healthcare providers (e.g., female circumcision) (Banke-Thomas et al., 2019). Latino/Hispanic immigrants in Ohio also experience barriers to accessing healthcare. For example, Latino immigrants living in Cincinnati have described fear of seeking healthcare services due to discrimination and racism in the healthcare setting and, specifically, from healthcare providers (Jacquez et al., 2016). Their experiences highlight a need for more Spanish-speaking doctors, substantial cultural competency education for healthcare providers, and a pathway for insuring undocumented individuals.

Challenges Specific to COVID-19

While many immigrants are enrolled in employer-provided health insurance plans, rising unemployment in the context of COVID-19 jeopardizes this coverage. In a scenario outlined by the Migration Policy Institute, an estimated 88,000 immigrants in Ohio will lose their employer-provided healthcare during the pandemic (Capps & Gelatt, 2020). A spike in unemployment and uninsured status may lead to greater health inequities, as well as higher COVID-19 infection and mortality rates among immigrant and refugee populations. As the number of uninsured immigrants in Ohio continues to rise, it is critical that access to healthcare remains as open as possible.

Structural barriers to healthcare, including undocumented status and being uninsured, particularly affect the ability of immigrants and refugees to access affordable COVID-19 testing. Coupled with the fear of deportation, groups of immigrants and refugees – including undocumented individuals – may be less likely to seek COVID-19 testing and medical care even when needed. Fear of legal action can also influence many immigrants not to cooperate with contact tracing efforts. Left unchecked, these challenges will not only increase the spread of COVID-19 but may also exacerbate symptoms and lead to greater mortality (Ji et al., 2020).

Findings from Analysis of *Needs Assessment* Data from Respondents Representing Immigrant and Refugee Ohioans

Description of Respondents: 35 respondents representing immigrant and refugee communities in Ohio completed the *Needs Assessment* survey. This is not a general sample of immigrants and refugees, but a purposeful sample of individuals who represent organizations, agencies, and community groups that work with immigrant and refugee populations. They most commonly work in non-profit organizations. Just under half of these respondents identified as immigrants or refugees themselves; their origins were Somali, Kenyan, East African, Mauritanian, Bhutanese, and Latin American.

I. Strengths of the Community

Respondents identified a broad range of community strengths that are resources for Ohio's COVID-19 response within its immigrant and refugee communities. These included:

- Culturally-specific communities already have the capacity to organize in a culturally responsive way
- Culturally-specific community organizations are seen as advocates for the needs of the population; they have established infrastructures to deliver COVID-19 response because they are already trusted by the community
- Small, community-specific organizations fill gaps that larger organizations cannot necessarily reach
- Communities have resilience and experience living through trauma
- Communities have the ability to adapt
- These are close knit communities with community-oriented cultures
- Many health professionals exist in the community
- Faith leaders within the community are willing to help
- There are many community organizations
- Multigenerational families are common
- There is motivation and readiness to minimize the impact of COVID-19
- There is a culture of volunteerism – e.g.: women in the Lao community make home-made face masks
- Mask wearing is culturally acceptable in some immigrant and refugee populations
- Immigrants are largely healthier than the native-born population (the 'immigrant health paradox')

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

These categories represent the most common barriers to immigrant and refugee communities using public health strategies to minimize the impact of COVID-19. These key barriers were mentioned by multiple respondents (ranging from 5 to 15), and they affect communities' ability to use multiple public health strategies. A summary of each barrier is followed by bullets which 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. Language barriers

Several types of language barriers limit the ability of immigrants and refugees to use public health strategies to minimize the impact of COVID-19. Strategies affected by language-related barriers include use of protective hygiene, social distancing, PPE, COVID-19 testing, contact tracing, isolation, self-quarantining, and healthcare (Topics ABCDEFGH).

- Information and resources are not available in multiple languages
- Individuals may have limited English proficiency and limited English literacy
- Individuals may have limited literacy in their native language
- Interpreters and translation services are lacking in many situations
- A lack of interpretation services has led to an increase in for-profit interpreter services that are not culturally sensitive or appropriate (i.e.: translating words alone is not linguistically complete translation)
- Phone interpretation services are low quality
- Testing sites lack language/translation support
- Technology is needed to access information not in English, and may be unavailable
- Some are unable to complete forms – such as unemployment applications – due to limited English literacy

"The immigrant community in the United States today is facing the most unwelcoming environment many have ever faced in their lifetime in this country."

"Furthermore, although state and local public health agencies regularly disseminate COVID-19 public awareness information and alerts, the information is not culturally and linguistically specific enough to reach vulnerable immigrant households. Moreover, immigrant communities in general are prone to misinformation, misinterpretation of public health announcements, and scams."

"[Some community members do] not know how to read or write in any language."

"The government should have allocated money to various non-profits specifically for translating and disseminating materials and education to vulnerable communities about the virus."

2. Housing challenges

Housing conditions within immigrant and refugee communities affect the ability of members to use protective hygiene practices and social distancing, and to practice isolation and self-quarantining when needed (Topics ABFG)

- Close living quarters
- Large, extended families
- Multi-generational households
- Large households
- One bathroom per household
- Multiple people sharing a room or bed
- Substandard living conditions
- Difficulty affording housing
- No space in the home to isolate/quarantine

"A single household could be occupied by 3 to 4 families."

"Landlords [should] be asked to [give] grace for unpaid rent dues."

"[Isolation] could be a challenge in many families, as they are economically constrained so they tend to live in clusters and the availability of enough space for isolation is hard."

3. Lack of access, availability, and cost

Lack of access to needed resources stems from poverty, unaffordability of needed resources, and lack of available stock of needed resources. This barrier limits the ability of community members to use protective hygiene practices, utilize PPE and COVID-19 testing, participate in contact tracing, practice isolation and self-quarantining when necessary, and access healthcare (Topics ACDEFGH).

- Lack of access to disinfecting and hygiene products
- Lack of access to PPE
  - Expensive
  - Hard to locate
  - Limited even among workers with specific PPE needs – healthcare workers and care providers
  - Hard to get elastic to make masks
- Lack of access to clean water
- Lack of healthcare, both in general and specific to COVID-19
  - Lack of health insurance
  - No available primary care providers

"You can't find PPE at the store and it's not cheap. [Members of] my population cannot afford it if it is available."

"I think that the health centers need to do a lot to provide better services to refugee & immigrant communities. Many [members of these communities] frequently express feeling unheard by providers and disrespected by phone and reception staff. Their interpretation services are unreliable so patients get rescheduled often but aren't informed that they've been rescheduled, so they waste time and resources getting to a clinic when they don't have an appointment, etc."

"Families do not have insurance - so they can't get to doctor to get [an] order for a [COVID] test."

- Lack of access to testing
  - Most testing is available only through major health providers, to whom immigrants and refugees don't have access
  - There is a lack of testing in many other healthcare centers within minority communities
- Lack of access to phones, cell service, digital communication devices and platforms
- General financial need
  - Inability to pay rent
  - Inability to buy resources like PPE
  - Inability to stay home from work
  - Inability to cover basic needs
- Immigration status is a barrier to accessing public funds and benefits
  - Ineligible for unemployment
  - Lack of ID impedes ability to get tested

"Immigrants are going to Emergency Rooms seeking testing because they don't know what else to do."

"Many individuals in these populations are unable to receive public benefits or… stimulus checks and are struggling for money – their main concern is maintaining food and rent and not 'safe practices'."

4. Work-related challenges

The necessity of going to work and keeping one's job, and lack of protections at work, limit the ability of immigrants and refugees to practice protective hygiene, social distancing, participate in contact tracing, or practice isolation or self-quarantining when necessary (Topics ABEFG).

- Over-representation of immigrants & refugees as low-wage, frontline essential workers
- Many are the primary source of income for the household and cannot afford to stay home or quit work
- No alternative sources of income exist; immigrants and refugees often work multiple essential jobs
- Importance of doing what you are told to keep your job
- Inability to socially distance in caregiving jobs
- No control over employer-implemented guidelines, and to what extent employers are taking precautionary measures and protecting employees from COVID-19
- Inability of immigrants and refugees to qualify for stimulus money and unemployment benefits, and fear of losing the ability to adjust immigration status under the public charge rule if any benefits are used

"Many [immigrants and refugees] work in essential and low-level jobs (e.g.: groceries, nursing homes, home health aides, etc.) and it is hard for them to stay home."

"A number of [community] members work in nursing homes, home health, or essential services distribution centers. Some have indicated that protective [equipment] is not available in a consistent basis or [of] good quality."

"If the primary source of income is from the person that needs to isolate, that family member will not rest if they know their family does not have the means to survive with them not working."

"[Individuals] hesitate to take time away from work due to huge family income needs domestically and [in their countries] of origin."

"Many [are] undocumented and work in manual labor jobs, such as construction sites, meat packing, and processing industries [that] have a history of worker violations."

"Undocumented individuals [are] out of jobs or underemployed and have no access to government supplemental funds."

5. Insufficient and inappropriate education

This barrier encompasses lack of education about issues related to COVID-19 and self-protection, as well as a lack of culturally-appropriate educational materials. These problems limit the ability of immigrants and refugees to use all the public health strategies that can mitigate the impact of COVID-19: hygiene, social distancing, PPE, testing, contact tracing, isolation, self-quarantining, and healthcare access (Topics ABCDEFGH)

- Awareness of the severity and significance of COVID-19 is lacking
  - Refugees who have survived other communicable diseases may feel COVID-19 is unlikely to be a significant threat
- Understanding of specific protective measures is lacking:
  - How to disinfect properly
  - Why good hygiene practices are important, what they involve
  - Why social distancing is important
  - How to wear a mask properly, use PPE, keep PPE clean
  - Why PPE is important
  - Where to get tested
  - How to isolate properly within the household
  - The importance of contact tracing, even when self-quarantining
  - The danger of asymptomatic people
  - How to contact providers
  - How to use telehealth
  - Part of the problem is inconsistent policies and messaging from public leaders

"[Some] members of the community have lived years in confined refugee camps and have faced [many] communicable diseases and survived and they [feel] that they have the immunity in them…"

"Many refugees spent decades in camps and aren't familiar with [or] accustomed to hygiene practices."

"[Some] individuals in self-quarantine are still getting out and doing their regular chores, thinking that putting [on a] mask is enough, so… intensive educational and awareness is… very important."

"Policies are not clear to most of this community since they are hearing it from second and third[-hand] sources. This creates disconnect and lack of understanding of Governor's orders, recommendations, benefits and support, etc."

- Culturally-aware and culturally-cognizant education about social distancing is lacking
- Educational materials assume too high a level of literacy and education
- Information about health and prevention is generally lacking
- Misinformation spreads because accurate information is inaccessible

6. Lack of personal transportation

This barrier limits the ability of members of these communities to practice social distancing, use PPE, get testing, and access healthcare (Topics BCDH).

- There is no accessible COVID-safe transportation
- Drive-through testing isn't usable without a car

> *"Refugees and immigrants carpool for everything due to lack to transportation resources."*

7. Stigma, fear, and mental health challenges

Mental health concerns, as well as stigma and fear, are triggered by COVID-19. This impedes the ability of community members to practice protective hygiene or social distancing, use COVID-19 testing or contact tracing, isolate when needed, and access healthcare (Topics ABDEFH).

- Many have a history of trauma
  - Fear of isolation
  - Fear of dying alone
- Significant unmet mental health needs exist in these populations
- Mask-wearing can trigger trauma
- Some are afraid to leave the home
- Social distancing is challenging for mental health, particularly for refugees
- Some fear getting in trouble for not social distancing
- Some fear contamination
- There is fear and stigma around testing, COVID-19
- There is a stigma surrounding mental health services
- Many COVID-19 survivors may face traumatic stress in the aftermath of local outbreaks

"With this population, you need to understand their own experiences in a 'crisis' supersede what the CDC is asking them to do. They have experienced real trauma and this doesn't appear to be a war or threat to them. It is invisible. No blockades, no gunfire, no electricity turning off. It seems made up of American panic."

"Refugee trauma may make it more difficult to isolate from the few family/ community you have contact with."

"[Individuals] fear that going to a hospital for a test might cause one to contract the disease."

8. Mistrust of government and healthcare systems

This barrier impedes use of COVID-19 protective advice in general, use of testing and healthcare, use of contact tracing and isolation (Topics ADEFH).

- Mistrust of the healthcare system given its history with Black people
- Miscommunication/misinformation about testing from/about healthcare providers and facilities
- Mistrust of modern medicine
- Fear of infection at healthcare facilities
- Lack of racial and ethnic diversity among healthcare providers
- Limited information sharing due to a mistrust of government authorities
- Concerns about immigration status
  - Fear of exposure to law enforcement or ICE/immigration authorities through testing or contact tracing, or reporting concerns or symptoms
  - Fear of getting other families in trouble

"[There is] some distrust of the healthcare system because of the medical establishment's history of mistreating African Americans."

"A well-educated family that has no language issue could [not] access their mother for over a month after she was admitted to one of the hospitals; they were not consulted about her treatment and at some point they were told she was dead. However, when they came to the hospital they were told it was a mistake and she was alive."

"[Some are] afraid to report due to fear of ICE."

9. Cultural and religious norms and practices

Cultural and religious norms and practices important to immigrant and refugee communities also constitute barriers to protective strategies including hygiene, social distancing, PPE, contact tracing, isolation, self-quarantining, and healthcare (Topics ABCEFGH).

- Cultural norms and religious practices that require gathering and proximity
  - Physical touch to greet, human touch as a cultural value
  - Cultural norms of gatherings
  - Physical proximity norms
    - Within the family
    - At ethnic stores
  - Social norms of members of the same sex gathering
  - Mourning and visiting the sick
  - Prayer times and requirements
- Cultural norms of family proximity to each other within the household
- Lack of culturally accommodating healthcare providers
- Challenges of making PPE compatible with traditional cultural/religious garb
- Social and cultural barriers preventing men from wearing PPE
  - Gender barriers
  - Men may not answer to women
- Women may be expected to continue culturally gender defined role – i.e., 'duties'
- Lack of availability for contact tracing phone calls due to spiritual practices
- Fear of testing
  - Being ostracized by family, community shaming
  - Fear of isolation

"How [can] communities that are communal rather than individualistic [be] expected to social isolate? How do they feel connected while social isolating?"

"Have [testing] hours available for a wide range [of times]. Muslims pray several times a day."

"This is a serious issue. Families will not leave each other, only to go to the hospital."

"Family roles [may be a barrier] – in several cultures, women are expected to continue with their 'duties'."

Other Barriers

These additional barriers represent separate issues reported by multiple respondents, but not as frequently as the 9 key barriers described above.

- Topic B – Social Distancing
  - Caregiving responsibilities (particularly for children, but also for seniors) impede social distancing
- Topics A & C – Hygiene & PPE
  - Challenges of wearing masks
    - Particularly for Black immigrants
    - Among those with disabilities and in hot weather

"People of color are perceived as 'dangerous' and 'untrustworthy' among other derogatory terms. Wearing a mask may be [a cause] of concern for personal safety."

"[For some it is a problem to be] not able to see [a] person's mouth (i.e., lip read). [This] may be triggered by masks. [Individuals] may have significant mental and emotional disabilities that might [make it] challenging to follow [these rules]."

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

These categories represent the most common solutions suggested to help immigrant and refugee communities use public health strategies to minimize the impact of COVID-19. These key ideas were mentioned by multiple respondents (ranging from 5 to 15) and would facilitate communities' ability to use multiple public health strategies. A summary of each proposed solution is followed by bullets that list details and specifics commonly mentioned by respondents. Selected quotes exemplify the stories and ideas of *Needs Assessment* respondents.

1. Provide multilingual information and support

This would improve the ability of immigrants and refugees to use all recommended measures to minimize the impact of COVID-19, including protective hygiene, social distancing, use of PPE, testing, contact tracing, isolation and self-quarantining when needed, and using healthcare (Topics ABCDEFGH).

- Provide long-term English education
- Promptly translate updates from the Governor's office
- Create visual aids
- Make quality face-to-face interpretation and translation more widely available

"Translate materials – [in both] written and verbal [forms] – as many refugees are illiterate."

"[For members of these communities, use] proper interpreter[s] who understand their cultural background. Someone who can relate to them and educate them properly."

- Create educational materials in multiple native languages of our immigrant and refugee groups
  - PSA (public service announcement) videos and commercials
  - Social media content
  - Mailed information
- Create more multilingual testing sites, hire contact tracers who can work in languages other than English

"Ensure that all service providers are providing multilingual access to information in various mediums (e.g.: written; audio-visual)."

"Provide workshops or webinar presentations, as well as distribution of information thru Spanish media outlets... Also distribute to organizations like LULAC, OCHLA, PACO, local churches, schools, public libraries, and community virtual festivals or current community 'safe' gathering events and essential worker worksites."

2. Create housing options

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

- Offer alternative housing for infected individuals who need to isolate or self-quarantine
  - Empty apartment complexes, hotels
  - Safe, stable housing
- Create more feasible guidelines on isolation in close quarters
  - Allow a family member to isolate with the infected individual
  - Provide PPE/sanitation supplies for isolating household members

"Create communal social isolation/ quarantine centers where people can be provided with basics like food if necessary. This is likely to work best in COVID-19 hotspots."

"Suggest ways to isolate sick members of [the] family within homes where multiple people live."

3. Create more, varied, culturally-appropriate educational materials

This approach will improve the ability of community members to practice protective hygiene and social distancing; use PPE, testing, and contact tracing; isolate when needed, and access healthcare (Topics ABCDEFH).

- Culturally-cognizant education should be developed and continuously shared, about:
  - Severity of COVID-19
  - Basic hygiene
  - Where to get resources
  - How to care for sick family members safely
  - Why PPE is important, how to obtain and use it
  - Dispelling false information, misinformation
  - Significance of testing
  - Importance and methods for isolation, self-quarantining
  - How accessing COVID-19 support will (not) affect immigration cases
  - How to communicate with doctors
  - Mental health and drug abuse issues
  - Addressing stigma
- Make sure education is culturally appropriate
  - Be sensitive to contradictory teachings from religious leaders
- Provide culturally responsive training for intake and healthcare personnel
- Make sure interpreters and translators are culturally aware

"[Offer] explanation of what [each protective] process is and why it is being done."

"[Provide] education to the family as to why it is important to stay away from the infected person."

"Allow…a family member to 'be in the room' with the client via Facetime, Skyping, etc."

"As much as possible, [hire] enough minority doctors and nurses to do the tests."

4. Actively involve community and religious groups

Local community leaders can help with distribution of information and supplies, and facilitate community access that will allow immigrants and refugees to make better use of all recommended public health strategies to minimize the impact of COVID-19. These strategies include protective hygiene, social distancing, use of PPE, testing, contact tracing, isolation and self-quarantining when needed, and using healthcare (Topics ABCDEFGH).

- Community organizations and religious organizations within and connected to immigrant and refugee communities should be utilized as key partners
- Trusted individual community members – who come from/look like the communities they serve – can provide critical linkages between communities, information, and resources. This can include:
  - Community leaders
  - Religious leaders
  - Youth in the community
- These individuals and organizations can:
  - Disseminate information
  - Disseminate supplies
  - Contribute to decision-making
  - Conduct outreach and education
  - Model protective behaviors
  - Help shape policy geared toward these communities
  - Conduct testing and contact tracing
  - Bring providers to the community
  - Share stories from community members who have successfully used services

"There should be a partnership with community organizations that already have a trusted relationship with community members."

"[An] introduction from a respected community member reduces suspicion of the source of information."

"Educate the community through some community ambassadors."

"Use churches and mosques as points of contact."

"Include younger residents as influencers capable of disseminating information."

"Trust is a major factor in getting information disseminated. My suggestion is a centralized approach to information from a trusted source."

"[Establish] distribution sites at local Hispanic/Latino and other immigrant groups' market places and businesses."

5. Provide supplies and resources directly

This solution involves direct provision of supplies, resources, and services within communities. This would help immigrant and refugee communities better utilize hygiene, social distancing, PPE, testing, isolation, self-quarantining, and healthcare (Topics ABCDFGH).

- Use community sites to distribute cleaning and hygiene supplies, PPE
- Increase accessibility of PPE through nonprofits, workplaces, schools, local stores, public health departments
- Increase testing accessibility in neighborhood and community sites, using already-frequented organizations and facilities
  - Increase daily testing window to accommodate religious needs
  - Remove requirement for a physician's order to be tested
  - Reduce testing cost or make it free
- Provide direct financial support
  - Improve accessibility of public assistance, unemployment, stimulus checks
  - Cash assistance
- Provide for basic needs
  - Food
  - Grace for unpaid rent
- Provide access to phones, technology

"People that cannot qualify for unemployment need local financial help from the city to be able to pay rent and bills."

"[Create] public policy to ensure [that] during COVID recovery and during pandemic closure all housing occupants have access to clean water and utilities to maintain a healthy living environment, as well as incarcerated populations and staff regardless of immigration status."

6. Improve access to healthcare and social services

This intervention would help improve use of hygiene, social distancing, testing, isolation, self-quarantining, and healthcare (Topics ABDFGH).

- Fund community nonprofits and social services
- Supply emotional and mental health support for those in isolation
- Provide assistance for those who are sick
- Provide alternative care for children and seniors
- Conduct active outreach
- Increase telehealth accessibility
- Re-open in-person healthcare providers
- Educate healthcare providers on how to provide services and outreach

"[Provide individuals] with emotional support while in isolation."

"[Members of this community] would normally go to the hospital, [but are] now just not going [for care] at all."

"This population is very much used to this system. [E]specially those with under[lying] conditions feel comfortable seeing their providers in person. Therefore they feel [telehealth] is just a phone call and do not really take that as their real appointment."

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 D & H – Testing & Healthcare Access
  - Provide transportation
- Topics A & B – Hygiene & Social Distancing
  - Pursue policies and initiatives to improve workers' rights and safety
- Topic D & E – Testing & Contact Tracing
  - Reduce worries about law enforcement by emphasizing confidentiality and distance from police and ICE/immigration authorities
    - Train law enforcement to reduce hostility
    - Allow for testing without identification

IV. Trusted Community Resources and Linkages

Respondents identified a long list of varied and trusted community resources: healthcare organizations (including clinics and hospitals), churches, non-profit organizations, refugee organizations, and charities.

Final Recommendations to Minimize the Impact of COVID-19 on Immigrant and Refugee Populations in Ohio

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

Mobilize ethnic and religious organizations trusted by the community to guide and execute all aspects of the COVID-19 response, including: creating educational material; disseminating information; distributing cleaning supplies, masks and PPE; testing; contact tracing; and facilitating isolation & self-quarantine arrangements.

Provide grant dollars to community-based organizations, led by immigrant and refugee leaders, to guide the COVID-19 response and recovery in culturally responsive ways.

Foster multi-sectoral support for a holistic COVID-19 response, by assuring that community leaders and community-based organizations are networked with community health organizations, local public health, faith-based organizations, business, and social service organizations.

Empower community leaders to model protective behaviors and communicate the importance of social distancing, hygiene, and participating in testing/contact tracing/isolation to their communities.

Train community health workers to actively connect community members to resources.

Employ highly trusted members of the community, or trusted individuals who already serve the community through immigrant and refugee resettlement organizations, to work as contact tracers.

Immediate recommendations to improve the health of communities:

Include community-based leaders in the committees and organizations that shape policies affecting these communities.

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:

Facilitate ready access to masks, disinfecting/cleaning supplies, and other essential supplies.

- Provide low-income communities with free or low-cost resources to deal with the pandemic, including cleaning and hygiene supplies, masks, and PPE.
- Distribute supplies through trusted community leaders, organizations, and sites.
- Utilize non-profits, workplaces, schools, local stores, and public health departments to increase accessibility of PPE.
- Provide basic supplies, cleaning supplies, and PPE for individuals and caregivers who are isolating or self-quarantining.
- Develop and distribute alternate protective methods for individuals who work in outdoor labor and other conditions that make standard PPE difficult to use.

Increase testing accessibility in neighborhood and community sites, using already-frequented organizations and facilities.

- Increase daily testing window to accommodate religious needs.
- Remove requirement for a physician's order to be tested.
- Reduce testing cost or make it free.

Provide social supports to facilitate isolating and self-quarantining when needed.

- Provide food, medicine, and other resources directly to places where individuals are self-quarantining or isolating.
- Provide emotional support to individuals who are isolating or self-quarantining.
- Set up these services as part of the contact tracing process and provide daily check-ins.
- Provide alternative arrangements for children and elderly individuals when their caregiver is isolating or self-quarantining.

Improve healthcare access to ensure that those who test positive can be effectively linked to ongoing and culturally-appropriate care. [1]

- Provide funding for free clinics serving culturally-specific groups.
- Ensure that translation/interpretation services are provided in clinics.
- Ensure that provision of healthcare has no repercussions for immigration processes. [2]
- Ensure that female providers are available to provide all aspects of testing or medical care to female clients when preferred.
- Re-open in-person healthcare providers, because face-to-face care is often preferred.

- Extend and improve telehealth services, including increased access to WiFi, translation services, and culturally sensitive providers.

Improve the accessibility of public assistance, cash assistance, unemployment, and stimulus checks.

Provide widespread access to Internet services and cell phones.

1. Migration Policy Institute, 2020.

2. Capps & Gelatt, 2020.

Immediate recommendations to improve the health of communities:

Provide supplemental supports to cover basic needs, including food and medicine.

Create a grace period for unpaid rent.

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

Ensure that all people, regardless of immigration status, have continuous access to quality healthcare – including physical healthcare, mental healthcare, and substance use treatment.

3. **Directly address the impacts of historical racism and immigration-related fears through policy change and ongoing training; create strong separation between health-related institutions and immigration authorities.**

Immediate, COVID-19 specific, recommendations:

Put processes in place to ensure that personal information gathered through testing, contact tracing, or any resource distribution is not transferred to U.S. Immigration & Customs Enforcement (ICE)/U.S. Citizen & Immigration Services (USCIS)/immigration courts. [1]

Ensure that ICE is disconnected from COVID-19 interventions such as testing and contact tracing, and from the use of healthcare.

Allow for COVID-19 testing without providing identification.

Ensure that individuals who access COVID-19 testing and/or healthcare are not subject to future penalties under the public charge rule. [2]

Allow a trusted family member to assist or accompany individuals who need to isolate or self-quarantine, to address cultural concerns and mistrust of government.

Immediate recommendations to improve the health of communities:

Provide all healthcare providers with mandatory, ongoing implicit bias training, as well as training in providing appropriate interpretation services to patients.

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

Proactively recruit and train ethnic and racial minorities to work in all sectors of the medical field.

Formally separate immigration status from utilization of healthcare.

1. For an example, see California's process and reassurance that contact tracing processes do not entail risk of contact with immigration authorities, at: https://covid19.ca.gov/contact-tracing/

2. 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.

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:

Require 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.[1]

Implement unemployment compensation or direct financial supports to immigrants who have experienced job loss and have not been able to benefit from CARES Act funding. [2]

Improve workers' understanding of their rights, safety, and sick leave policies.

Supplement the capacity of local health departments to enforce public guidelines.

1 Gelatt, 2020.

2 Capps et al., 2020

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 free, community-specific housing options for those who need to self-quarantine and isolate. Utilize hotel rooms, empty apartments.

Create feasible guidelines for isolation in close quarters. Provide partitions and mats for those who cannot fully isolate or self-quarantine because they are living in cramped quarters or sharing beds.

For multigenerational families, provide alternative care options for children and seniors to allow caregivers to quarantine or isolate.

Provide rental assistance, and work with landlords to allow families a discount or extra time to make payments for rent.

Identify and work with predatory landlords of apartment complexes/camps where immigrant and refugee communities live, to assure basic standards required by city codes are maintained.

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

Increase availability of stable, safe, affordable housing to reduce dense living conditions.

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

Immediate, COVID-19 specific, recommendations:

Provide funding for socially distanced transportation options from locations where immigrants and refugees live to specific places of employment and healthcare facilities.

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

Immediate, COVID-19 specific, recommendations:

Create varied, culturally appropriate educational materials that use simple terms to communicate in multiple languages, and contain many visual aids.

Feature community members in videos, enacting COVID-19 prevention behaviors while also featuring cultural practices (e.g.: family meals) that are valued in settings familiar to people (e.g.: living spaces). Use storytelling to show that public health practices are not incompatible with cultural values and norms.

Equip local leaders to communicate with their own communities, stressing the importance of social distancing, mask wearing, hygiene, testing, contact tracing, and isolation.

Distribute educational information and campaigns through local, trusted community organizations (e.g.: resettlement organizations , churches/ mosques) and WhatsApp/Viber/Facebook.

Take account of information and misinformation from immigrants' countries of origin, as well as guidance from religious leaders, that is relevant to uptake of public health interventions.

Design communication strategies that will be effective by ensuring that they:

- Provide accurate information to immigrants about eligibility for various programs/ interventions
- Defuse concerns about potential immigration consequences of seeking coverage or care
- Encourage individuals to seek care at early stages when symptoms are milder and thus less costly to treat. [1]

Develop culturally-relevant educational materials that cover a broad range of COVID-related topics, including: severity of COVID-19; where to obtain supplies and resources; how to sanitize a home; why PPE is important and how to obtain and use it; when, where, and how to get a COVID-19 test; importance of isolation and quarantine; when and how to isolate or self-quarantine; how to care for sick family members safely; how to communicate with healthcare providers; accurate information to dispel false information and misinformation.

Directly communicate the message that accessing COVID-19 support will not affect immigration cases.

Provide training for all healthcare providers and a wide range of health and social service staff serving immigrant and refugee communities, about how to provide culturally-responsive services and outreach to these communities.

1 Capps & Gelatt, 2020.

Immediate recommendations to improve the health of communities:

Provide information about mental health challenges, drug abuse issues, stigma, and how to accesses services relevant to these topics.

8. Provide services and hire multilingual workers to resolve language barriers.

Immediate, COVID-19 specific, recommendations:

Create educational materials in multiple languages (and multiple dialects) spoken by local communities, using multiple modes of delivery including social media content, written information for flyers or mailers, PSA (public service announcement) videos and commercials.

Utilize visual aids in all educational materials to ensure clear communication regardless of literacy level.

Ensure that updates and guidance from the Governor's office and public health leaders are promptly translated into multiple languages.

Hire contact tracers, testers, and support staff at these sites who can work in many relevant languages

Immediate recommendations to improve the health of communities:

Ensure that high-quality face-to-face translation and telephonic or online interpretation services are widely available in healthcare and social service settings.

Educate interpreters and translators to ensure that they can operate in culturally-appropriate ways.

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

Increase the number of healthcare workers who speak multiple languages and can work at least partially in the languages spoken by all local communities.

Create documents explaining common healthcare recommendations in many languages spoken by immigrant and refugee communities, and make these widely available to healthcare providers in all settings and in community organizations.

Provide long-term English education for individuals and families new to the U.S.