Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Hannah Ranson Date

Community-Driven Advocacy: Addressing COVID-19 Health Inequities and Increased Institutional Mistrust in Historically Oppressed Communities in the United States

By

Hannah Ranson
Master of Public Health

Hubert Department of Global Health

_____

Mimi Kiser, DMin, MPH
Committee Chair

Community-Driven Advocacy: Addressing COVID-19 Health Inequities and Increased Institutional Mistrust in Historically Oppressed Communities in the United States

By

Hannah Ranson

B.S.
Clemson University
2019

Thesis Committee Chair: Mimi Kiser, DMin, MPH

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2021

ABSTRACT

Community-Driven Advocacy: Addressing COVID-19 Health Inequities and Increased Institutional Mistrust in Historically Oppressed Communities in the United States

By Hannah Ranson

Introduction: Communities of color have experienced centuries of historical and modern-day experiences with structural racism, health inequities, and lack of government accountability which has led to an innate institutional mistrust. There is considerable concern around people of color's COVID-19 vaccine uptake, which may be influenced by both personal hesitations related to mistrust, as well as inequitable social and environmental barriers to access.

Objectives: The goal for this project was to create an advocacy tool to leverage the voices and knowledge of experienced faith and community leaders around the United States in order to inform action that could mitigate COVID-19 health inequities and institutional mistrust in historically oppressed communities of color.

Methods: An advocacy interview guide, which was crafted from literature on community mobilization, was used to gather the insights and perspectives of faith and community leaders with experience in building trust in communities of color and increasing access to influenza prevention services. Interviews were conducted that helped shape six Community Leadership Voices Action Briefs that provide key insights to cultivating community trust, along with necessary action steps to reduce COVID-19 related health disparities.

Results: The findings that emerged from this project center around the content provided by community leaders in the Community Leadership Voices Action Briefs. Two categories from the briefs were examined for common themes across participants, they include Capacity & Successes: Cultivating Trust and Essential Principle-Based Actions. The main findings around cultivating trust included the following themes: authentic partnerships, provision of resources and services, leadership development and training, community engagement and collaboration, and cultural responsivity. Common action recommendations made by community leaders focused on centering the community, ensuring equitable access, prioritizing community and public health, addressing systemic racism, and engaging in a collective dialogue.

Implications & Recommendations: Foundational practices in public health continue to harm communities of color. Thus, in order to effectively address health inequities, we must adopt community-driven approaches and anti-racists frameworks that truly engage and build authentic relationships with communities that value equity and social justice.

Community-Driven Advocacy: Addressing COVID-19 Health Inequities and Increased Institutional Mistrust in Historically Oppressed Communities in the United States

By

Hannah Ranson

B.S.
Clemson University
2019

Thesis Committee Chair: Mimi Kiser, DMin, MPH

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2021

Table of Contents

CHAPTER ONE

INTRODUCTION

Introduction and Rationale

The COVID-19 pandemic has exposed the complex interconnected faults that exist between health, politics, economy and social well-being in a globally interdependent world. The challenge introduced by COVID-19 has highlighted the fragility that lies within our foundational institutions. It has exposed and amplified the egregious health inequities that have existed throughout America's history. Bearing the brunt of the burden, communities of color have faced stark disproportionate rates of morbidity and mortality from the COVID-19 virus. As of April 16th, 2021, the Center for Disease Control (CDC) has reported rate ratios for morbidity as compared to White, Non-Hispanic persons. These rate ratios showed a 2.4x for American Indian or Alaska Native persons, 1.0x for Asian persons, 1.9x for Black or African American persons, and 2.3x for Hispanic or Latino persons. [1] While recognizing these disparities may span globally, this paper will focus primarily on the United States.

Centuries of historical and modern-day experiences with structural racism, health inequities, and lack of government accountability have led to an innate sense of mistrust among communities of color and tribal communities. [2] This type of institutional mistrust can take many forms like mistrust in health providers, entire health care systems, the pharmaceutical industry, and government-lead health agencies. [3] It is created, sustained, and reinforced by systemic racism, economic disparities, social exclusion, and health stigma in these populations. The year 2020 has amplified disparities with the presence of a glaring polarization in our political system, social

justice issues, and most of all the COVID-19 pandemic. During the early stages of the disease outbreak, we continued to witness Black individuals die at the hands of law enforcement. The murder of George Floyd ignited Black Lives Matter protests across the nation in the summer of 2020. These protests were born in response to several systemic issues that have yet to be addressed by the US government. To name a few, there is the relentless attacks on Black and Brown communities by racism in police systems, the mass incarceration of Black and Brown persons, and disproportionate COVID-19 impacts due to health disparities. Persistent institutional oppression and exclusion has deepened mistrust in communities already burdened with overwhelming disparities related to their accompanying social determinants of health. This has created an even greater gap to providing these communities with the essential health care they need.

As vaccine hesitancy develops into a present-day reality, there is a heightened pressure on health entities to repair and rebuild systems trust. Distribution of the vaccine will begin taking place before community trust-building and vaccine education programs are implemented and proven effective. [2] Thus, vaccine distribution must fit within a framework that recognizes institutional mistrust is still very much a pervasive issue. [2] Ultimately, it is the responsibility of governmental institutions at all levels to address these challenges in ways that are deserving of trust in order to avoid further harm to vulnerable communities. [2] As institutional mistrust continues to expand, the public health sector must adopt new strategies that "recognize and engage the intrinsic strengths, agency, and capacity of communities."[4] Studies have found that the necessary next steps to dismantling distrust are to partner and collaborate with community members, involve faith-based organizations, build diverse and representative teams that are

involved in planning, designing and implementing public health programs, build on community strengths and priorities, work collectively and co-create with cross-sector partners, honor community's emotional and intellectual commitments, and create a "culture that fosters relationships, trust, and respect across participants." [3, 5] By using more community engagement strategies, we can recenter the conversation and learn from community knowledge and experiences.

It is imperative these public health strategies extend beyond short-term partnerships, and rather, focus on building long-term community-driven initiatives, like activities of the Interfaith Health Program (IHP) at Emory University. The aim of IHP is to overcome "systemic barriers to health equity" by addressing social structural factors across diverse organizations and participating communities. [6] In order to work towards their mission, IHP facilitates community collaboration, delivers trainings, creates networks, conducts research, and implements programs targeting health disparities both locally and around the globe. [6]

In its 2009 H1N1 prevention programming, IHP and the Center of Disease Control (CDC) were able to work together to extend health promotion and education throughout an existing IHP network in order to reach at-risk populations. [7] This network is comprised of 10 different organizations around the US, including faith-based, private, and public health groups. In the past, this group of organizations has come together to work on community programs that address and aim to prevent seasonal and pandemic influenza.

As integral voices of community health priorities, community and faith-based leaders in this network drive the conversation around how to address institutional mistrust, and subsequent vaccine hesitancy, within their communities. They will serve as an invaluable entry to understanding the nature of community beliefs and experiences, to which public health entities can then respond to appropriately. [3] It is through intersectoral and interorganizational relationships that the collaborating organizations of IHP are able to reach vulnerable populations and attain the capacity and resources to serve them appropriately. [7] IHP will assist in bridging the disconnect between community health needs and capacities and public health goals.

Additionally, tapping into the sources of community power and agency leads to sustainable solutions around health inequity. For example, capacity-strengthening partnerships allow for the collective aggregation of multileveled skills and assets, which empower communities to identify, mobilize, and actively participate in combatting their own public health priorities. [8] Through long-term community partnerships and facilitation of shared knowledge gains, we can identify community perspectives, experiences and challenges, and create more meaningful policies and interventions that can address the structural racism and health inequities facing these communities.[3, 6]

Problem Statement

An ongoing research study conducted on COVID-19 vaccination acceptance in the US found that as of December 2020, out of the 1,676 participants surveyed, about 73% would accept a recommended vaccine. [9] However, of those surveyed, 35% of Black individuals and 26% Hispanic individuals say they would not want the vaccine. The survey also found that of the

Black individuals who said they would refuse the vaccine 47% cited "not trusting vaccines in general" as the main reason as to why they would not accept it. Historical oppression of Black, Indigenous, and other people of color (BIPOC) communities and subsequent health inequities have caused an erosion of their trust in the healthcare system. [10] This mistrust leads to vaccine resistance, even as these communities have been hit the hardest with confirmed COVID-19 cases and mortality rates. [10] There is a critical need for new community-centric, public health strategies in order to gather essential community perspectives and goals. These new strategies should influence public health interventions in a way that has not been done before. By leveraging community voices, agency, and knowledge, public health organizations can more effectively address health disparities.

Purpose Statement

The goal of this project is to contribute to reducing COVID-19 health inequities and institutional mistrust in historically oppressed communities by leveraging the voices and knowledge of experienced, well-respected community leaders from diverse communities across the United States.

Objectives

The objectives of this special studies project are to include faith and community leaders in assessment and as decision-influencers on community needs and priorities to inform methods aimed at reducing or eliminating COVID-19 inequities. Secondly, to develop and implement a method for community-determined action recommendations in order to influence public health interventions.

Significance Statement

Community engagement and partnerships are essential for public health entities to appropriately and constructively serve disenfranchised populations. It is through co-learning and active participation that we can steadily earn trust within communities and chip away at health disparities. As of January 2021, there are several programs around the country testing different engagement strategies in order to minimize further damage and disparities brought about or exacerbated by the pandemic. For example, the NIH Community Engagement Alliance (CEAL) has launched 11 projects around the US to address COVID-19 disparities. The information gathered during this time about effective trust-building strategies is critical for the road forward. Although vaccine hesitancy is of primary concern for the public health sector, it is imperative we begin by meeting communities where they are; in other words, we must follow the lead of communities by focusing resources and advocating for their priorities in order to establish community agency and institutional accountability.

In order to rethink our public health intervention strategies, we must consider the systemic issues largely at play. It is essential to begin by identifying the root barriers to inclusion, diversity, and representation in order to respect and "engage the intrinsic strengths, agency and capacity of communities." [4] To cultivate trust, public health strategies must include asset-based approaches to leverage community power and agency, candid and transparent communication when relaying information about health research and risks, and a culturally relevant and distinct plan of action for each community. [2] Most importantly, the public health sector must practice accountability and hold ethical values, transparency and integrity to the highest standard in order to build sustainable, unwavering relationships with community members and their leaders. [2]

Policy changes directed by public health are imperative in the face of the health inequities made even more visible by COVID-19. These policies must address the historical oppression that has caused health disparities in communities of color and acknowledge the necessary expense of time and resources now required. Policy has the ability to ensure improved capacity of future interventions by providing infrastructure support for community-based programing. [2] In addition to policy change, government entities must acknowledge and be held accountable for the pain and persecution these communities have been forced to endure for hundreds of years.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

This review explores the intricate web of health inequity causalities, COVID-19 disparities, and marginalization processes that contribute to an expanding institutional mistrust in historically oppressed communities and the implications for vaccine uptake. This chapter begins by presenting current literature that examines disaggregated data on COVID-19 health disparities; followed by existing literature on underlying inequities in social determinants of health, which amplify vulnerabilities in communities of color. The following section examines literature on the history of expanding mistrust and misinformation, and its potential impacts on vaccine uptake. Presented next is a review of literature on the various community-centered public health strategies deemed essential for addressing institutional mistrust. The final section examines literature to determine an effective framework for community-driven advocacy.

As new information around COVID-19 and vaccine distribution is constantly pivoting, research studies pulled will reflect what is presently known as of January 2021. The issues described in this paper will center around health disparities present in the United States, although, relevant research may be analyzed from sources culturally similar when discussing community-centered public health approaches. The language in this paper aims to be as inclusive and intentional as possible in regard to community identity, while acknowledging identity reaches far beyond any boundaries certain terms may indicate. To limit any ambiguity, the following words may be used interchangeably throughout the review: community(ies) of color, Black, Indigenous, Multi-racial, People(s) of Color (BIMPOC) , historically oppressed, under-represented, marginalized,

disenfranchised, etc. The scientific community, from where much of my research is extracted, has shown to lag behind in applying the appropriate language around identity. Thus, these identifying terms were pulled from research articles and gray literature authored by BIMPOC cited in the text.

I . COVID-19 Disparities and Underlying SDOH

COVID-19 Health Disparities

The COVID-19 pandemic has sparked a global health response to a crisis felt around the world. Although the impacts are widespread, they are vastly unequal. Noted early in the pandemic, the disproportionate COVID-19 related morbidity and mortality rates were substantially higher in communities of color. As of January 13, 2021, the Centers of Disease Control (CDC) has reported provisional death counts for COVID-19 through several disaggregated data sets. A key indicator for disparities among this data is the difference between the percent of COVID-19 deaths and population distributions by race and Hispanic origin. These data found the following difference in deaths when accounting for population distribution, 18.6 for Hispanic/LatinX populations, 12.4 for Non-Hispanic Blacks, 2.3 for Native American and Alaskan Natives, and 0.5 for Native Hawaiian/Other Pacific Islanders. [11] These data are especially significant, when comparing these numbers to a -30.2 difference in percentage of death when adjusting for population distribution in Non-Hispanic Whites. [11]

Unfortunately, these disparities were predictable, preventable, and reflective of a country with widespread unjust social structures. Long before the outbreak, pervasive, and enduring health

inequities deeply impacted marginalized communities across the United States. The COVID-19 virus did not cause these disparities, rather it amplified them, and increased awareness of the underlying systems and structures of oppression that sustain their existence. In addition to disaggregated health data, the exacerbation of inequities related to COVID-19 can be seen in the undeniable measures of social vulnerability. Social vulnerability can loosely be defined as the resilience of a community after being confronted with external health threats, like environment-altering disasters, or infectious disease outbreaks. [12, 13] Social vulnerability is measured through a social vulnerability index (SVI) tool, created by the CDC, which collects data "on 15 variables across four individual and community measures: 1) socioeconomic status, 2) household composition and disability, 3) race, ethnicity, and language, and 4) housing and transportation". [12, 13] These variables are more commonly recognized as the social determinants of health, or environmental and social conditions that affect health and quality of life. The SVI measures community health risks by assessing impacts caused by the SDOH among individual community members. Influencing factors can be extensive and cut across several SVI variables, or SDOH, often leading to a feedback loop of poor health outcomes.

Understanding the infectious nature of COVID-19, public health protocols called for social distancing and sheltering-in-place. Although these regulations are presented as low-risk, feasible options to mitigate virus spread, they actually pose impossible obstacles for many individuals living in marginalized communities. For example, densely populated communities, lack of transportation options, multi-generational household structures, households with more people than rooms, and single parent households with children under 18 are all vulnerability indicators that are directly challenged by the call to socially distance. [13] Similarly, the shelter-in-place

mandates do not account for low socioeconomic households living on hourly wages, or essential workers who do not have the ability to work remotely and thus are prone to occupational exposure to the virus. Low-income households are at an even greater disadvantage because they do not have the luxury to buy items in bulk, which leads to an increased number of trips outside of the home for essentials items. [14] Essential positions, outside of healthcare, are often underfunded positions in food service/production, waste management, transportation or distribution. [15] Unlike essential clinical health employees, these service industries and their workers were not prepared, nor trained to work under public health constraints dealing with a highly infectious virus. [15]

The adoption of neoliberal policies in today's globalized world has increased the reliance on supply chains and exposed the vulnerability of these markets, especially in instances where economic inequality exists. [15] The pandemic has devastated the market causing many businesses to shut down, which has led to an unparalleled number of layoffs. Disenfranchised communities bore the brunt of this burden, as they often face higher levels of underemployment and unemployment due to structural barriers to education and hiring bias. According to the Bureau of Labor Statistics, a monthly report for the year of 2020, which has adjusted for race, closely mirrors the health disparities due to COVID-19. This monthly report found that Black Americans faced a peak unemployment rate of 16.7% in April 2020 and a current unemployment rate of 9.9% as of December 2020. [16] Similar trends for LatinX Americans show a peak unemployment rate of 18.9% and a current rate, as of December 2020, of 9.3%. [16] The inequity is staggering, when compared with White Americans, who had a peak unemployment rate of 14.1% in April 2020 and a current unemployment rate of 6.0%. [16] With unemployment rates

sky-rocketing many are left without an income or health insurance. Uninsured rates among nonelderly people are shown to be highest in Native Americans (22%), LatinX Americans (19%), and Black Americans (12%), with the lowest rates in whites (8%). [17] Without health insurance, individuals sick with COVID-19 are less likely to seek treatment for the disease, and thus increases the risk for mortality. The US government has sent out one $1200 stimulus check per single-family household, more or less depending on previous income and family structure, over the course of 11 months since the beginning of the pandemic. This equates to a little less than $4 a day for food, housing payments, medical bills, utilities, and any other essential items. As of January 2021, another stimulus check is in the works, however the damage has already been done in communities of color that have been without support for months.

Additional stress has been put on those disenfranchised communities that live with additional risk factors for COVID-19, such as those with co-morbidities or elderly age. It is well known that social vulnerability and the social determinants of health (SDOH) influence chronic stress and development of underlying health issues. [18] As a result, the risk of COVID-19 morbidity increases considerably for those with chronic respiratory conditions, like asthma or COPD. [19] These health conditions have been directly linked to detrimental social factors like poor housing conditions or smoke exposure. [19] Additional medical conditions that increase risk of morbidity due to the virus include cardiovascular disease or other “heart conditions, obesity, diabetes, chronic kidney disease, liver disease, and immunocompromised” individuals going through treatment for a chronic condition like cancer or HIV/AIDS. [20] These conditions, can again be drawn back to adverse social determinants like low socio-economic status (SES), poor quality education, community context, and health care access. [20] Hypertension is a leading risk factor of

disparities in heart conditions like ischemic heart disease, the top illness related to death and disability,[21] and the highest prevalence is found in African American adults. [22] This is exemplified in 40.8% of African American men and 41.5% of African American women who have been diagnosed with hypertension. [22, 23] Hypertension accounts for 30% of patients that experience poor health outcomes due to COVID-19. [22] These pressing health conditions coinciding with a decline in financial stability and lack of health insurance increases the strain on people of color's mental health and well-being amidst the pandemic and results in higher morbidity and mortality related to COVID-19.

Broken economic, justice, and health systems in conjunction with the pandemic has created additional challenges negatively impacting marginalized populations. The preventive measures established to mitigate virus spread has led to a deterioration of access to essential social services, like school lunch programs. [18] Concern for childhood malnutrition is an issue that expanded when schools closed down. Many of the children that participated in the school lunch program live in poverty and now face threats of food insecurity. [19] According to the National Center for Education Statistics, 45% of Black, 45% of Hispanic and 41% of Indigenous students attend schools where 50-75% of students are eligible for free or reduced priced lunch, compared to only 8% of white students who attend the same high-poverty schools. [24] Lack of adequate nutrition can lead to negative impacts on mental and physical growth, as well as a lower immune system defense to fight infectious diseases, like COVID-19. [19] Additionally, school closures produced several barriers for the access to education. The remote system of learning requires access to technology and Wi-fi. This poses an issue to the 34% of Black households and 39% of LatinX households who do not have broadband capability. [25] The divide in differential access is

evident when comparing these statistics to white households where only 21% do not have Wi-fi access. [25] Lack of broadband also creates obstacles to receiving adequate, up-to-date information regarding COVID-19 and health promotion materials. [14] Not only does this limit knowledge about potential risk factors, it also impedes healthcare access which includes COVID-19 testing and care. [14] Dependency is then turned to local news stations, which may limit access to health messages easily interpreted in all languages. [14]

The disproportionate risk of COVID-19 is also linked to circumstances exclusively experienced by BIMPOC, like the mass-incarceration of Black and Brown people, housing discrimination, immigration status, structural discrimination in employment, and heightened risk of police violence towards BIMPOC wearing masks. Mass incarceration is a public health epidemic on its own. To understand mass incarceration in America is to acknowledge that the US accounts for only 5% of the global population but holds about 25% of the world's prison population. [26] Black Americans and LatinX Americans make up about 32% of the population in the US, however, account for 56% of the US prison population. [26] Black Americans are at a five times greater risk to be arrested and have longer prison sentences than white individuals. [20] Incarcerated individuals are more likely to have adverse health issues associated with a greater susceptibility to disease, mental illness, negative tobacco habits, and are five times more likely to be infected with HIV. [26] The national case rate of incarcerated individuals with COVID-19 is about 5.5 times higher than the national average of the US population. [27] COVID-19 has instigated a greater vulnerability to prison populations and immigrants detained at US detention centers, as overcrowding inhibits the ability to socially distance, shared hygiene facilities increase the likelihood of virus spread, there is limited access to adequate nutrition and healthcare, and

provision of personal protective equipment (PPE) has been scarce. [20, 27] Social injustice creates and sustains several factors that make communities of color more vulnerable to the virus. For example, some BIMPOC hesitate to use face coverings due to the inherent fear police will mistake them for someone else and arrest them, which is perpetuated by a "longstanding conflation of race and criminality" in the US. [20] The structural injustices perpetuated by a lack of protection for incarcerated individuals, employees deemed "essential", immigrants, and people of color, expose deep vulnerabilities that heighten the risk of spread of COVID-19.

Underlying SDOH Inequities

Pandemics and epidemics invariably are most destructive in communities already facing other hurdles, such as co-morbidities, lack of health care access, and numerous systemic social vulnerabilities. [5] As was seen in past global health crises, an equitable response requires the role of public health to identify communities that are most at risk and provide equitable distribution of resources by focusing on both ingrained social risk factors and current unmet social needs. [5, 28] Subsequently this will aim to address the distinct SVI variables, better known as the SDOH, which spawn from environmental factors and inequitable environmental policies that fail to protect marginalized communities. [29] SDOH can be broken in to five domains: 1) economic stability, 2) education, 3) social and community context, 4) neighborhood and built environment, and 5) health and health care. [20] It is critical for public health strategies to address each domain and work across sectors to understand how existing health inequities transformed into COVID-19 disparities.

Economic Stability

Economic stability is controlled by the "distribution of resources, power, and money at local and global levels". [30] The key health equity concerns within this domain are poverty, employment, food security, and housing stability. [20] In examining economic status, it's important to understand what wealth is and how it circulates. Wealth can be defined as the total value of assets owned by an individual or their family. [20] It is attained over time and can impact several generations, which ultimately influences available opportunities in education and employment. [20] The obvious link to a stable income and ability to acquire wealth is employment status. Employment is directly influenced by education, which determines what field of work an individual enters. People of color are more likely to work in blue-collar service jobs and be under-employed (working at a job that does not amount to the skills, ability, or education level of the individual).[31] Even when BIMPOC enter the workforce with a well-esteemed academic standing, they still face hurdles of discrimination due to biased hiring and promotion practices. Sixty years after affirmative action was established, many individuals still struggle to find positions that meet and sufficiently compensate the level of work for which they are qualified. When an individual of color is placed in a role they deserve, the case for affirmative action is often weaponized and used as a justification for their achievements. Not only is this demeaning, but it also sustains the idea that people of color are undeserving of success no matter what lengths they go to prove their ability.

The covert nature of inherent biases, discrimination, and microaggressions has allowed racism to persist in settings where 'equity' is expected. Although some racist practices and policies have been historically challenged, these mere acts of progress should not be confounded for the

eradication of racism. Racism is carried out not only by individuals, but also in the systems and social structures of our country. Among many of its severe impacts, systemic racism directly limits wealth accumulation and results in a perpetual cycle of low SES in many communities of color. SES is determined by family wealth, education level, and job status. [32] The interaction between SES and poverty has been found to have direct links to poor health outcomes. [32] Poverty is defined by a threshold set by the US government, which for a family of four is set at $26,200. [33] In 2018 11.8% of the US population lived in poverty, of those 25.4% were Native Americans, 20.8% were Black, 17.6% were Hispanic, and only 10.1% were White. [33] Several factors can contribute to a lack of resources or opportunities that result in poverty, including marital status, education, social class, social status, income level, race or ethnicity, immigration status, and geographic location. [32] Communities living in poverty have higher instances of mental illness, increased mortality rates, chronic illness, and lower life expectancy. [32] Children born into poverty may also experience stunted development both mentally and physically depending on their surrounding environment and level of food security. Food insecurity is influenced by several of the same factors, as well as geographic region, neighborhood conditions, and access to public transportation. [34] Food deserts, areas void of affordable nutritious food, are more prominent in Black and Hispanic neighborhoods compared to White Non-Hispanic neighborhoods. [34] In addition to a lack of neighborhood resources, these same communities of color may also experience housing instability. It was found Black and Hispanic communities are twice as likely as White households to experience a cost burden when having to spend more than 50% of their income on housing costs. [35] Housing instability relates to challenges like struggling to pay rent, having more people than housing space, staying with relatives, moving from place to place frequently, and spending a majority of income on housing, all which leave

little money for other necessities. [35] This instability can cause individuals to live in a state of constant anxiety, which manifests in other forms of chronic disease. Additionally, the impact of moving frequently creates an absence of community bonds and relationships, which are ultimately associated with a positive impact on health. [32] Community ties offer support and resources which provide solace, strength, and hope in difficult times.

Education

An individual's education is one of the most valuable resources they can have. However, quality education across the lifespan is not equitably accessible. Early childhood education is crucial for avoiding delays and ensuring mental and physical development. [36] The factors influence early education opportunities include SES, parental or caregiver relationships, early life stressors and access to education programs. [36] Many children of color are disadvantaged even before the moment they are born. Specifically, being born in to poverty or stressful situations creates a space for trauma to influence cognitive development. [36] These formative years have been found to impact health behaviors and health risk development later on in life. [36] Manifestation of early development are noticed more prominently in secondary schooling, where students begin to plan for their future. A major milestone in education is graduating high-school and receiving a diploma, a standard requirement for most jobs and for applying to secondary education. [37] The public schools available for students are determined by the neighborhood they live in and their SES. Both of which can put students from low-income communities at a disadvantage, as the school they are predestined to go to may be underfunded and thus impact the quality of education provided. Public schools with lower funding are linked to detrimental effects on students like low test scores, poor academic progress, and higher drop-out rates. [37]

An additional issue felt by communities of color is the school to prison pipeline. This issue is caused by a strict zero-tolerance discipline on students of color often resulting in suspension or expulsion. This toxic cycle leads to a pattern in student absences and harsh discipline, which paves the path toward juvenile detention centers and ultimately prison. [38] Zero-tolerance policies play a factor in why more than a third of Black, LatinX, and Native American students do not graduate on time. [38] This delay in graduation and absence in schooling put students at a severe disadvantage when time comes to apply to higher education. Higher education, again, can directly influence the kind of job and income an individual has the ability to apply to. Thus, for students that struggled through high school due to a slew of factors, i.e. lack of faculty support, opportunities for advanced classes, and a quality education, the thought of applying to secondary education may feel unattainable. There is an added layer for first-generation college students, as they receive little support during the college admissions process and must navigate the convoluted application process for federal loans and financial aid on their own. Needless to say, there are many obstacles set in place by SDOH as it relates to an individual's early pathways to education and success, which has the potential to affect the rest of one's life.

Social and Community Context

Much of how we interact with the world depends on our social status, our connections and relationships, and to what degree we engage with our surrounding community. Within the SDOH factors of social and community context lies "social cohesion, discrimination, civic participation, and incarceration." [20] Race and ethnicity have long been identified as risk markers for underlying health conditions, although I would argue discrimination is the true marker.

America's founding principles, centered around white supremacy, capitalism, and patriarchal values, have led inequitable SDOH to become an intrinsic reality in our society. The complex web of health determinants largely stems from a public failure to protect specific communities and their built environments. Chronic health conditions, like hypertension and diabetes, are more prevalent in disenfranchised communities because of the social and environmental factors that fuel unhealthy habits and create barriers to basic health needs. As stated by Smedley, Stith, and Nelson, race is the number one determinant in predicting health and quality of health care of an individual. [39] However, it should be widely noted that race has *nothing* to do with health disparities, rather it is structural racism that fuels inequity. [40] The additive effects of racism on top of other harmful sociopolitical conditions have created an environment inherently toxic to the health of those who are marginalized. The structural component of racism and oppression is rooted in unequal power dynamics held in place by White-washed history books and perpetuation of factually incorrect assumptions and beliefs. Both structural and individual discrimination are social stressors that influence adverse physiological responses in people of color, which can develop into more serious health issues later in life. Discrimination and racism affect all BIMPOC, no matter their achievements or SES. Racism and discrimination pervade every sector of life, including economic stability, housing, education, employment, health care, protection under the law, etc.

Arguably one of the most egregious forms of racism is that in our criminal justice system and the impacts on social health of communities. This includes "policing, pre-trial detention, sentencing, parole, and post-parole." [20] In addition to mass-incarceration, racial injustice is boldly apparent through police brutality against communities of color, specifically Black and LatinX. Law

enforcement is more likely to use lethal force towards Black Americans when compared with any other race. [20] As seen with George Floyd, Breonna Taylor, Stephon Clark, Philando Castile, Sandra Blank, Alton Sterling, Walter Scott, Tamir Rice, Michael Brown, Eric Garner, and countless others who were ruthlessly and unjustly murdered by police officers, a vast majority of whom faced no legal repercussions for their actions. [41] High fatality rates and increased arrests can be attributed to the influx of police stationed in communities of color. Innocent Black Americans are more likely to have an unsolicited interaction with police by being stopped, questioned, or searched when compared to all other races. [42] Black citizens are also disproportionately charged and arrested for drug crimes, even though these offense are committed at equal rates across all races. [42] Awaiting trial, 65% of those arrested were being detained, which significantly increase the odds of conviction and likelihood of an individual to accept a disparaging plea deal, resulting in longer jail time. [42] Of pre-trial releases, 70% require a money bond, which are likely to be higher or denied all together to Black and LatinX citizens, forcing them to wait out their trial in jail. [42] Once caught in this cycle, many first-time offenders will re-enter the prison system, which perpetuates negative impacts on their individual health, family health, community health and societal health.[29]

Social cohesion signifies strength in community relationships, as well as perceived unity among community members. [43] This concept, along with social capital are imperative to examine community health and resilience. Social capital encompasses the following measures: perceived benefit, perceived fairness, group membership, and trust. [43] Relationships most often emerge from social ties and provide a common thread of support to both parties, on the level of emotional, social, or instrumental support. [43] This sense of support can also lead to a shared trust

and a realized communal capacity for change, also known as collective efficacy. This collective efficacy can influence better health outcomes, lower rates of violence in the community, and create better access to essential resources. [43] In many communities and cultures social cohesion is highly regarded and provides an essential outlet to members. As an example, religious gatherings held weekly are routine for many communities around the US. [44] Thus, disruption in routine gatherings, due to COVID-19 safety measures, can pose as a challenge for community members. [44] We see similar issues arise for social support programs that are no longer able to provide communities with essential services. However, a form of communal impact that has prevailed, even amidst the pandemic, is the act of civic participation. This coordination of a unified effort towards an array of areas creates a similar sense of connectedness among community members. Civic participation goes beyond voting, and extends to volunteering, joining special interest groups, community gardening, and engaging in community service projects. Community capacity and collective efficacy are drivers of positive change and their ability to respond to events such as pandemics, especially communities that face hardship brought on by disparate impacts.

Neighborhood & Built Environment

An individual's neighborhood and built environment are versatile in nature and thus can be considered modifiable risk factors, however, they contribute heavily to the deadliest non-communicable diseases in the US. This domain of SDOH focuses on access to nutritious foods, crime & violence, environmental conditions, and housing quality. [20] History of structural colonization, reservations, and oppressive policies, like Jim Crow laws, have shaped the segregated communities we label as low-income. [29] Structural racist policies ultimately drive

inequities in all four of these focus areas. Discriminatory housing and neighborhood segregation can essentially be drawn back to redlining, a policy established in the 1930s that refused lending and investment services to low-income and marginalized communities [20]. This disinvestment is directly exemplified in the lack of banking, health care, insurance, and retail services available in these communities. [20] To this day communities of color are more likely to be exposed to environmental hazards like poor air quality or lack of clean water. For example, the water crisis in Flint, Michigan, where 54% of the population is Black and 40% of the population lives in poverty. [20] In addition to these harmful exposures, poor housing conditions may also contribute to extreme health risks due to exposure to mold & mildew, poisonous toxins, and unsanitary conditions related to overcrowding. [45] These issues are compounded when neighborhoods have destitute resources and limited access to healthy foods and quality health care. The prevalence of food desserts, barriers to affordable nutritious meals, and limited access to safe outdoor environments fuel unhealthy behaviors which contribute to chronic diseases like diabetes, obesity, and cardiovascular disease. [45] These health issues will often go untreated when communities don't have access to a health care facility or the funds to pay for a visit.

Health & Health Care

The SDOH domain of health and health care is most notable in public health studies on racial disparities, however, it plays a similar role of importance in widespread inequities in marginalized health when looking across all domains. The key areas highlighted in this domain are health literacy, access to health care, and access to primary care. [20] Access to quality health facilities is always a top concern, however, is exponentially important when health crises like COVID-19 strike. Mitigating community transmission is dependent on access to quick testing

and care, both of which are scarce in communities of color. [14, 19] Inequities can also impact health systems themselves, resulting in under-resourced, under-funded, and under-staffed facilities which delays virus testing, testing results, and essential care for patients in need. [14] These disparities were felt in Native American reservations where federal funds were delayed, which negatively impacted the Indian Health Service's ability to respond to the virus. [46] The transition of health services to telemedicine further widens the gap for patients that do not have access to the required technology. [14] A rampant issue in US health systems is the influence of white-centric values on health care practices. [29] The values of eurocentrism include individualism, paternalism, objectivity, perfectionism, dualistic thinking; nationalism; English as the dominant language; Judeo-Christian beliefs; efficiency; power hoarding, etc. [47] White supremacist culture identifies the aforementioned values as norms or standards, which subsequently de-values characteristics that stray outside of these lines. In addition to an obliviousness to practices that create barriers for communities of color, this underlying system of values also instills bias and cultural aversion in health care professionals. This manifests in how doctors care for BIMPOC patients, often perpetuating a stigma that affects the health-efficacy in individuals or groups. [29] Health care provider implicit bias may also affect the clinical care a patient receives from diagnosis, treatment, pain management, and referrals. [20] White cultural values in health care also disregard accommodations for culturally and linguistically appropriate practices for patients from communities of color. [48] This contributes to an isolation that is especially felt by LatinX communities, where there is already a fear of sharing information with government officials. [48] Marginalized populations are more likely to experience barriers when it comes to health literacy due to lack of interpretation and translation services, but also as it relates to access of critical messages. Health messaging has constantly evolved over the course of the

pandemic and left communities, like Indigenous peoples and Immigrants, in the dark due to a lack of widespread, multi-lingual communications. [49] These barriers contribute to an expanding institutional mistrust in communities of color.

The underpinnings of all the SDOH listed above are rooted in historical, political, social, and economic systems all saturated in a history of oppression. The health inequities that stem from SDOH are a result of unfair policies and systemically racist and classist practices and ideologies. This structural oppression limits the ability of communities of color to withstand new devastations, like COVID-19, due to already established health barriers. The pandemic amplified inequities resulting from the lack of access to emergent disease-related knowledge, access to testing and treatment, unsafe working conditions, food insecurity, and ultimately an increase in COVID related morbidity and mortality in communities of color. By highlighting the associations between health disparities and upstream factors, we can prevent future institutional accusations framing the virus as solely a problem of communities of color. [50] Rather the issue of COVID-19 disparities is unjustly thrust upon disenfranchised communities, much like the racist systems that plague America. [13] It is these inequalities that contribute to the disruption of social cohesion, deepening political divide, and fueling institutional mistrust. [51]

II. Vaccine Hesitancy and Expanding Mistrust

Vaccine Hesitancy

The US government's failure to respond appropriately to the series of harmful events that took place in 2020 enveloped the population with an overwhelming sense of uncertainty and apprehension. The lack of political coherent direction and stability allowed for the development

and spread of conspiracy theories and inadequate information regarding medicinal cures, which were not backed by science. This spread of misinformation is not a threat to reducing the spread of the virus, but also to increasing population immunity gained from vaccine acceptance. The concept of vaccine hesitancy is not unique to the COVID-19 pandemic, however, its consequences are more pronounced in the wake of over 500 thousand COVID-19 related deaths, as of February 2021. The administration's turmoil compounded with modern day and historic injustices and attacks on Black, Indigenous, multiracial and other people of color (BIMPOC) has reinforced and amplified a sense of mistrust in these communities. This mistrust is evident in the disparate statistics of vaccine hesitancy in communities of color, when compared with white communities. In a survey conducted in January 2021, when asked about vaccine acceptance 43% of Black adults and 37% of Hispanic adults said they would want to "wait and see" how the vaccine is working for other people before they accepted it. [9] Whereas only 26% of white adults experienced the same hesitation.[9] The most concerning data is around individuals who would "definitely not" get the vaccine if it was offered to them, represented by 14% of Black adults and 11% of Hispanic adults.[9] The data shows that republicans (25%) and rural residents (21%) were the most reluctant groups to get the vaccine, however, the type of vaccine hesitancy I will be addressing is that fostered by institutional transgressions and structural racism. [9]

Vaccine hesitancy is recognized as one of the top ten most pressing health threats by the World Health Organization. [52] It is composed of three primary determinants: confidence, complacency, and convenience. [53] Although, all three determinants are relevant, confidence, or lack thereof, is the domain most directly linked to inherent mistrust in health care institutions. Systems mistrust, also known as institutional mistrust, includes several sectors and individuals, such as health care

providers, health care systems, the pharmaceutical industry, clinical researchers, government-lead health agencies, and the overall socio-political system. [3, 53] An important component of systems mistrust is medical mistrust, which is directly related to the biases in systems of health care. This can come from individual prejudices related to provider micro-aggressions and disregards for patient needs, as well as macro-level injustices such as underserving health care systems and lack of public health investment. [54] According to Bogart and colleagues, "mistrust has been conceptualized as a form of coping that fulfills epistemic (desire to understand), existential (desire to control), and social (desire to maintain a positive view of self or one's in-group) motivations under a state of threat or uncertainty," such as the COVID-19 pandemic compounded with a lifetime of pervasive injustice. [54] Thus, innate mistrust may serve as a self-protective response, which in turn influences health behaviors that aim to avoid extended discrimination in and outside of health care settings. [54, 55]

Institutional Mistrust

Nationwide, trust in systems did not start declining with the pandemic, but has remained at record level lows over the last several years.[56] Several surveys on attitudes about the federal government conducted by Pew Research Center have shown that on average only 20% of American adults say that they trust the federal government to "do the right thing" all or at least most of the time. [56] The roots of institutional mistrust differ across party lines, however, when discussing vaccine hesitancy specifically, there are several factors that influence public opinion. Based on a nationwide survey published in September 2020, results suggested at the state level, higher levels of trust in the Trump administration predicted lower rates of vaccine acceptance. [57] This type of mistrust has been gaining traction over the last several years and is contrived on

base-less conspiracy theories on subjects from climate change to the field of science in general. The social and political conditions surrounding the pandemic led to a plethora of new conspiracy theories about the virus and about the validity of any future vaccine that would eventually be produced. It did not help matters that at the beginning of the outbreak there was still a limited understanding around the virus itself, as well as how it traveled and how to know if you contracted it. These initial uncertainties and the conflicting messages that accompanied them fueled a deeper erosion of trust in institutions, like the federal government.

The damage was already done by the time there was new, more accurate information. Since then, social and political entities have provided almost no tactical motives to establish a dependable or trustworthy reputation. This is evident in the delayed sense of emergency and poor crisis-response communication delivered by the U.S. government, but also covertly in misrepresentative data collection and absences of support or resources in communities of color. Despite the National Institutes of Health 1993 Revitalization Act, which required the inclusion of communities of color in clinical research, many BIMPOC are still regularly excluded from research trials. [58] For instance, data for Native American and Alaskan Native morbidity and mortality were not included in federal COVID-19 census reports for several months. [59] Simultaneously, this exclusion led to delayed federal relief for Indigenous communities who have experienced devastating impacts of COVID-19 due to social determinants, such as barriers to healthcare access, poor housing conditions, and pre-existing co-morbidities. [59] This underrepresentation and disaggregation of racial data has also led to a complete absence of information on Native Americans', Native Hawaiians', and Pacific Islanders' receptivity to the COVID-19 vaccine. [2] Furthermore, public health and epidemiological research often exclude

disabled (physically, intellectually, and mentally) populations from their data collection by way of implicit and explicit restrictions, which further amplifies the intersectional dynamics of a data informed response. [59] This lack of representation significantly reduces the generalizability of research results or effectiveness of pharmaceutical products and vaccines, and thus deepens system mistrust felt by excluded communities. [58]

A vicious cycle exists between clinical research exclusion of BIMPOC and hesitation of these communities to participate in such studies. This rightful hesitation is fueled by past and present transgressions and oppressions both clinically and systemically. There lies a shared sentiment in communities of color, but especially in Black communities, that their lives do not matter in our society. [60] Manning shares that, "there is […] a justified fear that our human lives might be dispensable in exchange for scientific discovery benefiting those with privilege and who are white," and though mistrust and trepidation exist, "we should also consider the rightful anger against the establishment that dehumanized Black people over and over again." [60] There is a dark and complex history of American transgressions against people of color (POC) that must be acknowledged in order to understand how the road to reconciliation should be shaped. These series of injustices that lead to institutional mistrust will be analyzed through two differing, yet interconnected, frames: medical racism and societal oppression.

Medical Racism

The United States' history of slavery and white supremacy has influenced every sector of American life for the past 500+ years. The concepts of polygenesis and eugenics ultimately gave rise to medical racism, which was used early on to justify slavery and egregious mistreatment of

non-white folks. Biological racist theories were not denounced until as late as the mid-twentieth century, and to this day their long-lasting impressions still remain toxic to communities of color. The result of these ideologies has led to nonconsensual medical experimentation, weaponization of disease, forced sterilization, medical neglect, etc. Although the list of clinical harm in communities of color is too long to discuss here, I will touch on notable examples that have occurred throughout American history.

Since the colonization of America, Indigenous peoples have faced persecution in several forms, such as attempted genocide, stolen tribal lands, broken treaties, forced assimilation, and deprivation of natural resources. [61] There is a noted history of North American colonists using biological warfare against Native communities, such as the intentional gifting of blankets contaminated with smallpox, which decimated at least 30% of the Native population on the Northwest coast. [2] Ethnocidal policies and direct spread of communicable diseases, like whooping cough, dysentery, tuberculosis, influenza, and measles, on top of colonists' refusal to care for ill populations have long devasted Indigenous communities, like Native Hawaiian and Pacific Islanders. [2] As the concept of Westernized medicine gained more traction, unethical clinical treatments began to emerge. Instances of misinformation, medical neglect, and health providers deceptions resulted in a third of Puerto Rico's childbearing aged women to undergo non-consensual sterilizations from 1930-1970s. [2] It must be acknowledged that much of the foundations of modern-day medicine in the US were derived from unethical clinical experimentation and surgery dissections of African American slaves. [61] Lack of personal freedom and autonomy made it impossible for slaves to object to cruel and degrading experiments. Dehumanization of the Black body is seen in several examples throughout

American history. Throughout the 1800s unethical surgeries by early racist physicians, like J. Marion Sims, conducted unwarranted operations on enslaved women and children. These experiments included non-anesthetic cranial dissections of enslaved infants through rearranging their skull bones with cobbler tools, as well as conducting over 30 vaginal operations on Lucy, Anarcha, and Betsey, three enslaved women from Alabama, from 1845-1849, again without consent or anesthesia. [18, 62] These early practices of medical racism created a health system that profited off of the Black body. In 1951, Henrietta Lacks, a Black cancer patient being treated at Johns Hopkins University, unknowingly provided her cells for use by the university after her passing. [2] Johns Hopkins used her cells for clinical and genetic research for over forty years without acknowledgement or compensation to a deceased Lacks, or her family. [2] A blatant disregard for patient autonomy has caused a lasting, widespread mistrust in clinical, research, and public health practices

Tuskegee Syphilis Study

The most notorious violations that is often referred to as the quintessential, historical symbol of medical mistrust in Black communities is the U.S. Public Health Service Study of Untreated Syphilis in Tuskegee Alabama. [61] The study lasted from 1932 to 1972 where over 400 Black males with syphilis were observed and denied treatment, even after a cure was established for the illness.[61] Although promised free healthcare by public health officials, the study participants were given placebos and studied as the disease progressed, causing blindness, mental illness and death. [2] The prolonged study was widely reported among the health care community for over 40 years without any objection, which raises serious concern around “professional self-regulation and scientific bureaucracy” within all medical or health related institutions. [63] Today, the

grossly immoral study can be seen as a significant metaphor for medical racism, unethical misconduct in human research, lack of morality in health care providers, and institutional exploitation of Black people. [62, 63]

Modern-Day Medical Mistrust

Present day, medical mistrust is perpetuated through constant, yet less overt discrimination in healthcare, such as SDOH barriers to health care access, and eurocentric medical practices that fail to account for culturally or linguistically appropriate care. [2] In a study conducted in 2018, patients of different races and ethnicities were surveyed about their experiences in seeking services from hospitals or health clinics. [64] Of those who were surveyed, 32% of Black patients, 23% of Native American patients, and 20% of LatinX patients were said to have experienced racial discrimination during a visit to the doctor. [2, 64] A recent and poignant example of medical discrimination lies within the case of Susan Moore. Dr. Moore, a 52-year-old Black physician from Indiana, tested positive for coronavirus in late November of 2020. Shortly after, she sought treatment from Indiana University Health Hospital where she faced medical neglect, specifically the refusal to treat her pain, carried out by white health care providers.[65] Moore shared a viral Facebook video addressing the medical racism she was facing, and two weeks later died due to complications from the virus. [65] Dr. Moore's experience gained national attention because it emphasized a common experience felt by BIMPOC, no matter their education level or socio-economic status. [65] In addition to perpetuating vaccine hesitancy, biases in healthcare also fuel the under-utilization of available health care services and disease prevention practices, like mammograms, colorectal cancer screenings, cholesterol screenings, and HPV vaccinations. [3] This heightens potential risk of disease, but also excludes communities of color from having

autonomy over their health. In the age of COVID-19, medical mistrust is seen more and more as governmental institutions fail to make communities of color a priority, which would require increasing access to provision of resources, virus testing, health services and care, and support services. [2]

Societal Oppression

Although historical abuses are an important fragment to understanding expanding mistrust, the larger narrative at play is the structural oppression of racism in the United States. [66] Our country has a long and pervasive history of stifling the voices and rights of folks who do not fit in the white, straight, Christian, able-bodied and natural-born citizen category. [18] The disregard for cultures and values outside of eurocentrism gives rise to white-washed, exceptionalist beliefs, which have proven toxic and dangerous to disenfranchised communities. [67] One example, is the spike in xenophobic hate crimes against Asian Americans since the start of the pandemic. Over 1,800 incidents of physical or verbal violence against Americans of Asian descendent across the US occurred in a span of eight weeks, from March to May 2020. [68] This spike is assumed to be linked to the incessant hateful rhetoric spewed by the Trump administration faulting China for the uncontained outbreak of COVID-19. [68]

Mistrust has developed as a coping mechanism to the accumulation of centuries of injustice, including the brutal colonization of Indigenous peoples' lands, slavery, dehumanization of Black and Brown people, policy brutality, mass incarceration, the achievement gap, housing segregation, and social end economic exclusion. [54] Research has found that negative experiences and racism in one sector, like police brutality, can have spill-over effects into

another, like the healthcare environment. [69] The systems of racism are intertwined, and thus experiences of discrimination can accumulate across sectors. [69] Issues of marginalization are heightened within intersectionality's between race, gender, class, sexual orientation, citizenship, religion, and disability. These social categorizations create overlapping and collective frames of prejudice and privation [55], which along with white nationalism, classism, and racism, sustain the oppression of BIMPOC communities. [29]

Health inequities are often blamed on vaccine hesitancy and institutional mistrust, although it is the underlying systems of injustice that sustain an environment of fear, doubt, and inequity. [29] Distrust can be linked back to historical abuses and the perpetuated acts of racism in our society, however, at the same time it can amass and be transferred intergenerationally as a result of unresolved structural issues. [70] This may allow for the proliferation of harmful beliefs derived from misinformation, disinformation, and inequality-driven mistrust. [71] Over the course of the pandemic, these ideas have been referred to as "conspiracy theories," insinuating that the beliefs are unreasonable or paranoid. In repeating this rhetoric, institutions fail to acknowledge that these mis-informed beliefs stem from perpetual stigmatization and social exclusion. [71] When institutions do not take accountability, the burden of mistrust is once again placed on historically oppressed communities to repair. [70] Acknowledging institutional mistrust as justified by the institutions themselves will allow for more open and honest discussions about moving towards a path of reconciliation.[70] A sense of trust is "theoretically history-based, cumulative, and thicken and thins as individuals transact with individuals and systems," [72] which indicates that mistrust has the potential to be modified. [3] Trust is public health's most vital asset, and thus it is

imperative that we enact strategies that foster authentic, dependable relationships with communities of color in order to repair and rebuild it. [70]

III. Essential Public Health Practices

In understanding how the social determinants of health and systemic racism deeply underline institutional mistrust, public health practices must focus on the identified root causes of these issues in order to build an environment worthy of trust. There is a need to centralize the concepts of race, uneven power structures, and systemic injustice in public health interventions. Although some of these concepts are interwoven into public health practice, they are rarely the driving force, and thus fail to make any substantial impacts. Until the community is prioritized and centered in public health responses, interventions will remain unnoticed at the individual level. Although, in the last few decades, while there has been progress in attempts to increase community participation, the overarching entity of public health is more often disconnected from communities and the health issues they face. This disconnection is driven by foundational flaws not only in public health, but in all of our institutions. Before principles of meaningful engagement can be discussed, it's important to understand the deep-seated, pernicious values of the public health sector.

While several factors undergird a perpetual chasm, the engrained "white logic" , utilized as a public health standard, reinforces a white supremacist approach in our practices further deepening disconnection between the community and health institutions.[73] White logic is "a context in which white supremacy has defined the techniques and processes of reasoning about social facts." [73, 74] This kind of logic is seen in the research and health strategies (white methods) rooted in colonization and the positivist paradigm. [73, 74] The positivist paradigm

relies on methods that supports testing of a hypothesis through experimentation with "operationalized variables" in order to get a quantifiable result. [75] Ultimately this paradigm, along with epistemic logic, fuels the concept that deep-seated systemic inequities, power structures, and social conditions may be wholly understood with just the use of truth, or evidence by way of "experiments, variables, and effect estimates".[73]

Structural racism and white supremacy are not issues that can be resolved entirely by objectivity or logic. An individual's health is "fundamentally political," [73] and we cannot assume that it can be captured through the use of qualitative and quantitative methods. The path towards equity requires a deeper look at our systems and the elements that drive change (i.e. politics and social action). To really do the work required of health equity, we can't continue to use white methods, or positivist strategies, which cater to a system we are trying to dismantle.[73] Health equity, much like cultural humility and antiracism, is not something that can be "achieved," rather it is a state of continuous reflection and reformation fueled by justice and empathy.[73] Our public health strategies must have intentional outcomes that are "rooted in antiracist, critical race, and decolonizing frameworks,"[73] and encompass practices that center around community prioritized needs.[76] To irradicate harmful power dynamics and cultivate trust, principles and practices that ensure community engagement must be used more pervasively as a standard for public health strategies.

Principles of Community Engagement

Community engagement and participatory research are important practices that have long been recognized by the health community. Dating back to 1948, the World Health Organization's

Constitution stated the importance of incorporating public opinion and "active cooperation" in practice in order to improve population health.[8] Although these practices have been historically recognized as imperative to public health, they are still often under-utilized, or they fail to incorporate an anti-racist or decolonization framework, which acknowledge power-dynamics and center critical race theory in their approach. The absence of these critical frameworks perpetuates inequity and the exclusion of communities of color in public health interventions. The failure to appropriately engage communities leads to the collection of decontextualized information, which underserves the community in the ways that are most needed. [77] By cultivating relationships and fostering trust within communities, public health entities can improve overall community health, both long-term and in moments of crisis, like the COVID-19 pandemic. Rather than burdening communities with forceful or coercive tactics to increase vaccine acceptance, the public health community must engage in more holistic processes that are deliberate in understanding community mistrust, and respond to it accordingly.[3]

The key to building authentic relationships through public health practice involves the adoption of community centric principles. These principles include cultural humility and respect for community values; co-creation and the ability to work collectively; acknowledgment of power dynamics and leverage of intrinsic strengths of the community and its members; relationship building and fostering of multilevel cross-sector partnerships; critical consciousness raising; transparent communication; community inclusion; relevant and tailored interventions that meet community priorities; and investment in long-term solutions that cultivate sustainability. The process of fostering trust and the use of these principles requires adequate time, resources, communication, and accountability. [78] Thus, this process cannot be rushed or briefly carried out

to ‘resolve’ issues of COVID-19 vaccine hesitancy, rather it is a long-term commitment to improving community health. Due to the urgency of the pandemic, there is not adequate time to engage in strategies that build trust from the ground up. However, if carried out correctly, employing these principles can mitigate implications of perpetuating deeper mistrust. Presented next is a review of literature on the aforementioned principles, which are essential for addressing institutional mistrust.

Cultural Humility

All institutions established in America are underpinned by racist beliefs and practices, like white supremacy and colonization, and the public health sector is not an exception. This perpetuates health practices that are rooted in eurocentrism and, subsequently, ignore and disregard other cultures, races, ethnicities, or sets of beliefs.[79] These practices in health care and public health are seen in multicultural color-blind approaches that fail to acknowledge diversity and inequities that are linked to systemic racism.[79] In order to address institutionalized racism, discrimination, and health inequity, it’s critical we adopt an understanding of critical race theory (CRT). CRT allows us to not only acknowledge race and racism, but to centralize them in our health care systems so that we may better understand the pervasiveness of racist issues.[79] Public Health Critical Race Praxis draws on CRT by acknowledging issues of racial inequity, and also asserting methodology that aims to dismantle these issues.[80] These theoretical frameworks creates a way to see and subsequently challenge systems of oppression and call on health care practitioners and researchers to pay attention to issues of diversity, inclusion, equity, discrimination, power, and privilege.[79]

In order to utilize these frameworks in the most effective way, public health practitioners must be receptive towards all communities and cultures by honoring and respecting the values they bring forth. This will require that practitioners and researchers acknowledge subconscious biases and work to further educate themselves on antiracism. This is a "lifelong commitment to self-reflection and mutual exchange in engaging power imbalances along the lines of cultural differences,"[81] and requires substantial work and time, more than a one-off training course in cultural competency.[81] We should also note that cultural competency is an outdated concept, and, in its place experts in this field recommend adopting structural competency and cultural humility.[3] This centers ones focus on cultural, racial or ethnic, historical, and/or linguistic identities, [8] and underscores the importance of an individual's background in relation to their health. These approaches should be used to identify and incorporate cultural standards and health concerns in all stages of community interventions (i.e. planning, designing, and implementation),[5] while paying close attention to the depths of diversity that lie within each racial or ethnic group.[58] Additionally, structural competency and cultural humility should be integrated in to any and all public health outreach and health promotion campaigns to effectively communicate through linguistically and socio-culturally appropriate messages.[82] In order to productively engage communities in public health programs, the onus is on us to create open and inclusive spaces that accommodate community-centric priorities. In an article written by Ramos et al., it is stated that trust is not established on the false ability to "relate" to the stereotype of a culture through the language, vocal tone, or popular culture; rather, it is undergirded by authenticity through meaningful, consistent, and respectful interactions, as well as the provision of autonomy over their outcomes.[3]

Partnerships & Coalitions

Community engagement and cross-sector networks lie at the heart and core of public health,[5] and are essential for leveraging strengths and resources towards a commonly shared vision.[7] During the crisis of the pandemic, public health holds a significant leadership position, however, in order to effectively do its job, it must rely on partnerships and relationships with trusted community leaders and organizations to shape, communicate, implement and disseminate health promotion information and essential health practices.[5] In the interest of cultivating and sustaining authentic, trustworthy relationships, public health collaborators themselves must be trustworthy; meaning, upon engaging the community, interventions must prioritize community-stated needs over self-interests.[5] Partnerships should serve as "meaningful opportunities to work *in partnership*," specifically, working hand-in-hand to define and take part in every step of the process, from development of initial priorities to decisions for intervention strategies and dissemination of findings.[77] In addition to process and activity development, this equity-centered approach should also place a special focus on the outcomes of the project to ensure the community's goals are met.[5]

Cross-sector partnerships and coalitions are core community engagement strategies that strengthen community capacity and further develop a comprehensive approach to community health.[83] Cross-sector partnerships can include community based organizations, community health centers, state and local health departments, faith-based organizations, hospitals, indigenous organizations, academic and research institutions, policy-makers, health care providers, and most importantly, community members.[84] Coalitions represent a collective infrastructure of multiple partners working towards common community health goals. The

connected networks can range in size and capacity, however, when working in unison, coalitions have the ability to share resources, streamline efforts, and mobilize change at any level.[8] The dynamic structure of coalitions calls for continuous interaction and ever-evolving compromises in order to neutralize power dynamics and center equity.[7, 8] These community networks are effective in intermediate systems change, especially as it relates to health policy, community mobilization, and targeting specific health behaviors and outcomes.[83]

Leverage of Intrinsic Community Strengths & Co-Creation

Community partnerships and engagement practices that foster authenticity, trust, and equity are derived from relationships that value community beliefs, insight, and participation. Before any community collaboration can begin, outside partners must be prepared to relinquish control over activities or interventions, and acknowledge unequal power dynamics between themselves and the community.[5] The power imbalance shifts when an outside practitioner enters the community, and it is exacerbated with differences in class, race, spoken language, ethnicity, gender, and culture. [85] In order to overcome unequal power dynamics, all members must acknowledge the privilege and power they carry and agree on strategies that share power equally and ensure "access to practical, educational, and social resources" that are typically out of reach. [76] Other poignant strategies to uplifting community strengths and amplifying community voices is through the use of asset-based approaches and incorporating practices from a community empowerment framework.

The term community empowerment is used to describe the autonomy, mastery, or control individuals, organizations, or groups have over their livelihoods, in terms of influencing

structural institutions and their political and social environments, which affect their quality of life.[83] Although the framework itself includes important strategies, the term ‘empowerment’ may be interpreted as somewhat diminishing, as it implies that power must be surrendered in order for a community to enact their capabilities. Instead of discussing how power can be ‘given’, we should shift the conversation to what it means to refrain from stealing or hoarding power.

In describing the key strategies from the ‘empowerment’ framework for this special studies project, I will use language that speaks to the internalized power of communities, such as community mobilization, leverage of intrinsic strengths, or asset-based approach. The community ‘empowerment’ praxis focuses on transformation of power structures, while increasing a sense of community belonging and realized ability to affect systems change.[8] This strategy of identifying and leveraging assets allows communities to enact the change they see is needed.[2] Coming from an asset-based approach, rather than a deficit perspective, strengthens confidence and ownership in decisions, increases social cohesion, and is more effective in promoting enduring change.[8, 76]

The process of co-creation refers to engaging all stakeholders in the program process and ensures that everyone has the opportunity to equally contribute. In order to work collectively, all members must engage in the process of critical consciousness to develop a common understanding of community issues and concerns and identify the social determinants that drive inequities.[86] This, along with co-learning, promotes the cyclical exchange of diverse experiences, wisdom, and capacity of all involved, drawing on Freire’s theory on pedagogical

praxis.[8, 87, 88] This can lead to a better understanding of obstacles that limit community capacity, such as lack of time, transportation, or resources required to participate. Public health programs should account for these barriers by providing incentives, reimbursement, and/or required resources for participation,[58] as well as provide adequate trainings for community members to lead or co-lead research and advocacy efforts.[85] Community engagement projects, irrespective of the issue at hand, will always require clear communication, program flexibility, power sharing, intellectual and emotional commitments, cultural humility, accountability and adequate time and resources in order to build relationships that foster trust and respect.[5, 8, 78]

Transparency & Accountability

As the pandemic progressed, the institutional mistrust in communities of color grew, in part as a response to the lack of transparency and accountability of public health messaging delivered by the administration. This was compounded by erratic contradictory messaging around the virus and a continuation of systemic failures related to social justice. Effective health communication requires timely updates, full and total disclosure of available information, compassion for those most affected, acknowledgement and accountability of challenges and mistakes, and appropriate message dissemination that accommodates all populations.[89] A community-centric approach encourages bidirectional communication, in which, on top of disseminating information, public officials should also be listening to public input and concerns. [90] This discourse will help practitioners identify issues related to inequity and mistrust by further connecting public concerns with personal beliefs, cultural perspectives and guiding ideologies.[90] This information can be used to tailor future health messages, whether it addresses top concerns or accounts for more accessible dissemination. Specifically, this may incorporate strategies that address low

health literacy, linguistically appropriate messages, barriers to technology access, and cultural differences.[14] Finally, public officials and institutions should stick to their word and be held accountable for past transgressions and address clearly how mistakes will be avoided in in current and future practices.[3, 89]

Sustainability

Long-term community investments build sustainable outcomes and strengthen partnership trust. This requires that community engagement occurs early on and throughout public health interventions.[5] Community engagement, especially in communities of color, must follow an anti-racist framework that acknowledges structural racism and does not perpetuate inequities through public health practice.[5] To that effect, public health responses should not be monolithic, rather they should cater to the diverse history and culture of the partnering community.[2] Long-lasting community improvement frameworks require sturdy mechanisms that draw on community capacity, network resources, and partner investments. It is through these sustainable health initiatives that community health outcomes improve and health inequities are reduced.

Community-Centered Practices

The principles discussed above are the foundation for every community-centered public health practice. Community-engagement strategies center community, rather than only the population at large, in order to focus efforts on identifiable inequities, community priorities, and community assets through effective interventions. [83] These interventions have shown to be more sustainable than a top-down ‘problem-solving’ approach because they incorporate cultural strengths and local systems.[83] Community-engagement draws on traditions of social justice practices, like

community mobilization and systems-change advocacy.[8] Though there are several public health practices that draw on community-engaged interventions, I will focus on those most relevant to the current COVID-19 disparities and mistrust crises, such as partnerships with trusted messengers, community research advisory boards, community advocacy, and community-based participatory action research (CBPAR). Though some of these strategies are research-based, I will be drawing on the recommendations and practices specifically related to community engagement.

In an atmosphere where there is prevalent institutional mistrust, it is key to partner with trusted messengers and co-create evidence-based messaging that is effective, clear, consistent, and culturally and linguistically appropriate. These trusted messengers can be anyone, such as long-standing community leaders, beloved community members, faith-based leaders, or community health workers, etc. These messengers can serve as "cultural brokers and navigators between community members and fragmented systems of care" by acting as community advocates, as well as provide knowledge that addresses misinformation, fear, and stigma around COVID-19.[91] Additionally, we should not discount family members as trusted messengers, as upstream intergenerational communication may help families with elderly members receive adequate, up-to-date information.[70] The use of Community Research Advisory Boards (CRABs) may also help to reintegrate trust and equity in to the public health research process.[92] CRABs provide contextual insight about a community by reviewing public health project designs and detecting community-specific obstacles to participation.[92] CRABs serve to define the consent process and foster communication and relationships.[92] Lastly, CBPAR is an engagement approach that emphasizes addressing community health from an asset-based and environmental perspective.[77]

It ultimately ties all the principles of community engagement together by centering and amplifying community voices, neutralizing power imbalances, fostering authentic partnerships and co-creation, leveraging community strengths, utilizing findings to benefit all stakeholders, and invests in sustainable, long-term commitments.[93]

Nationwide Community Efforts Addressing COVID-19

Several community programs have launched in response to try and mitigate COVID-19 health disparities. Egede and Walker argue that community programs should be considered a part of pandemic-recovery efforts and federal funding should reflect this.[28] These programs must be incorporated into larger structural interventions that aim to dismantle discriminatory health structures instead of merely doing damage control.[28] In order to cultivate trust, these programs must invest in the communities they are serving and acknowledge that issues of health inequity existed long before a global health crisis occurred, and they will not be eliminated after one intervention.[28] Though numerous programs have been deployed, I will be speaking to the most prominent ones at this time.

The NIH Community Engagement Alliance (CEAL) Against COVID-19 Disparities is focused on addressing misinformation around COVID, educating communities about inclusion in clinical research on COVID through trusted community messengers, and addressing health disparities. CEAL, funded by the National Institutes of Health (NIH), is working in eleven states with communities of color around the US by engaging with community-based communication networks, led by local leaders, to build trust, increase awareness and education, and promote inclusion.[94] NIH has also partnered with the Centers for Disease Control and Prevention (CDC),

the National Academies of Sciences, Engineering, and Medicine and the National Academy of Medicine in an ad hoc committee that has created a framework for "Equitable Allocation of COVID-19 Vaccine". [95] This framework's goal is to reduce morbidity, mortality, and societal impact due to transmission of COVID-19, by guiding federal and state authorities in their COVID-19 vaccine allocation plans. [95] The framework is broken up in four phases of distribution with equity as a crosscutting consideration, with vaccine access prioritized for geographic areas identified by CDC's social vulnerability index.[95] Lastly, the U.S. Department of Health and Human Services (HHS) Office of Minority Health has partnered with Morehouse School of Medicine's National COVID-19 Resiliency Network (NCRN).[96] This network will share essential messages and links to healthcare and social services in communities across the US and areas most heavily affected by the pandemic.[96] The NCRN is collaborating across institutions and partner organizations to work towards identifying and engaging disproportionately impacted communities, nurture existing and develop new partnerships, educate and provide informational resources, disseminate culturally and linguistically appropriate information, leverage technology and connect communities to resources, and apply broad and comprehensive dissemination methods.[96] HHS has adopted NCRN in to a three year agreement as a part of a larger initiative aiming to mitigate the impact of COVID in communities of color. [96]

Future public health efforts must involve community-centric practices in order to make interventions meaningful and safe for participants, foster a culture of authentic relationships, and thus reduce the need for individuals to turn towards institutional "mistrust as a coping mechanism against stigma and discrimination"[3]. At their core, programs must use strategies that

are co-created and lead by the participating community.[3] We must invest time and resources into communities and partnerships, as trust is built on reciprocal relationships that are mutually beneficial to all parties.[58] We should continue to question the approaches we use in public health and create new strategies that do not rely on outdated theories and concepts. We need to continue to work towards health justice by cultivating compassion and mutuality to understand the gifts of our differences and how we may play a part in mitigating inequity.[73]

IV. Community-Driven Advocacy

The community engagement practices previously described aspire to center community priorities alongside 'outsider' collaboration and support. It is through these practices that power dynamics can be restructured, cultural values celebrated, "creativity fostered through deliberative, mediated processes," and community voices amplified. [97] The prioritization of community input can foster a community-driven design where community members serve as primary decision makers. [97] This design also promotes strengthened community capacity; a continuum of civic engagement; ownership; and leadership, [98] all of which are essential for community-driven action and advocacy. In order to truly honor primary stakeholders, their voices must be the central influential force, rather than a force to be influenced. As public health practitioners, we must also consider how we are "entering" the community and if we have their permission to be there. [99] If our presence is welcome, we should be constantly reflecting on our role and position as an 'outsider'. [99] The community should serve as a leading entity from the beginning stages of program development, as well as helping establish the goals and aspirations for long-term impacts.[100]

The underlying concepts of community collaboration guide the development of a framework and action-based tool that identifies community priorities, understands essential community-based principles, and leverages community's voice. The framework's structure is influenced by the principles utilized in various community advocacy resources, such as the guides to health equity, community action plans, and non-profit organizational toolkits. Although different in structure, these resources create a direction for community-driven change. This framework includes the following components: community interpreted context, community capacity and assets, and advocacy goals.

Community Context

The lived reality of community members is paramount to designing effective programs or policies. [100] This concept is a "basic democratic principle," [100] as it ensures all voices are used to create mutually beneficial solutions. Additionally, this incorporates community values, which not only supports successful implementation but also long-term sustainable outcomes. [100] The inclusion of community values, builds upon a community-asset based approach, which celebrates community identity by also acknowledging "traditions, historical events, art forms, [and] language structure." [100]

Community context is foundational to the framework because it sets the scene for community-change interventions. It is vital to understand the background and intricacies of the community that is being discussed in order to make a case for appropriate action. The framework should include information about the demographics of the community, such as race, community setting, poverty level, and reliance on public transportation. [101] Community health issues can be

influenced by a variety of factors and can often be a sensitive subject, especially if there are root causes that pose a higher priority for community members. Thus, the framework for change must research the health issues by gathering background and local thoughts and feelings on who may be affected, divisiveness of the issue, barriers to addressing the issue, and history of the issue in the community.[76]

Community Capacity and Assets

Communities are deeply cognizant of the barriers they face, and thus, re-focusing on their internal capacities can energize confidence and willingness to participate in mobilization. In order to address community issues of concern, community and organization capacity, relevant skills, and experiences must be a part of the action change framework. [86] Instead of starting from a deficit approach, highlighting internal community assets will serve as influential catalysts for motivation. [102] Effective advocacy efforts require taking in to account what resources the community already has.[103] This necessitates understanding the background of the organization, past program experience, successes in their work, leadership capacities, partnerships or alliances, and the relationship they have with their community. This additional information gives the organization's proposed advocacy action plan credibility and showcases their ability to make an impact. It also highlights gaps where partner organizations or outside entities may be of assistance in providing resources or additional support. UNICEF's ACT-ON model uses this information in a sequential strategy planning tool to connect internal and external capacities and risks. [103] ACT-ON is an acronym for each of the topics and creates a process of understanding for engagement. This includes A- Advantages, C- Challenges, T- Threats, O-Opportunities, N-Next Steps. This method is useful for assessing advocacy capacity. [103]

Advocacy Goals

The action change framework should include a section that addresses community health goals and long-term outcomes. Identifying immediate and long-term goals leads to a plan of action for the desired change. This strategic plan must factor in the kinds of activities requires, responsible stakeholders, their timeline for completion and the resources required to carry out the activities. [103] Specificity in both action and naming key-change institutions strengthens the framework, leveraging community voice, as well as the overall action plan itself. However, it is important to also consider the obstacles to achieving goals and incentives for stakeholders to act. Counteracting barriers to the goals require community insight, as it has the ability to target upstream factors, which are often precursors to the larger issues. Thus, collaboration and shared power can help target issues in a nuanced way and lead to more effective and wide-spread solutions. [100]

An advocacy change framework should come from concepts rooted in community engagement practices. Using these strategies can leverage community power and help them advocate for themselves. It should be assumed that communities often are already equipped with knowledge, voice, and a sense of community priorities. Rather than disrupting their intrinsic power, public health entities should be asking communities how they can support their community-driven action. Thus, crafting a framework around a community organization's voice, capacity, and population health aspirations, we can strengthen ties and re-build trust within the public health sector.

V. Literature Review Summary

As of early March 2021 the first couple of phases for vaccine rollout are underway, with about 10% of the US population fully vaccinated. [104] However, a recent analysis showed that the vaccination rate among white people is two times higher than Black people and two and a half times higher than Hispanic people. [105] Even with several national programs aimed at mitigating disparities perpetuated by COVID-19, the disproportionate rates of vaccinations prove the issue to still be rampant. Even with local entities doing all they can, it is apparent the structure of the system does not support equitable distribution. [106] Another concern revolves around the heightened pressure to distribute vaccines quickly with little attention in how to do so equitably.[106] Although we cannot completely make up for lost time, we can focus public health efforts to support communities that need it the most. This requires that we act and provide resources to key areas with high social vulnerability indexes, where SDOH perpetuate inequities in communities of color and empathize with their justifiable reasons for mistrust. Specifically, addressing the domains of the SDOH that impact direct barriers to healthcare access. Mistrust is rooted in systemic racism prevalent in all institutions in the US, but especially in medicine and healthcare. Although historical transgressions and intergenerational trauma play a part, the perpetuation of mistrust comes from lived experiences of bias, racism, and harm inflicted on communities of color. These systemic injustices require public health to re-evaluate the current systems we are a part of, and challenge existing frameworks that perpetuate oppression of BIMPOC. This is evident in how we address issues of low vaccine uptake, shifting the conversation from vaccine hesitancy to social injustice and barriers to access.

Instead of coming into communities and trying to convince people *why* they should get the

vaccine, we should be working through partnerships to provide resources and COVID-19 education essential to building vaccine confidence. It is not the responsibility of historically oppressed communities to blindly trust institutions that have wronged them in the past. We need to decolonize our public health strategies to ensure we are not perpetuating the systemic effects of racism. This means providing transparency and accountability in all messaging and program strategies, while also prioritizing community needs and advocating for equitable access to resources. In addition, community strengths should be leveraged as a measure to neutralize power dynamics and co-create plans of action. In order to respond to the urgent need for understanding and shaping an effective public health response to inequities in vaccine uptake and hesitancy, perspectives from experienced local faith and community leaders must be centered. The process of community engagement and centering community voice will require authentic rapport building, pro-longed support, a shift in power dynamics, and redistribution of resources.

The literature reviewed covered a range of topics from SDOH to community driven action. Although the research used was current or written within the last few years, I found that the language around social justice and equitable interventions is constantly evolving, and thus I do not expect my review to be an evergreen piece in terms of language. However, I do believe many of the principles I discussed, especially as it relates to community-centered public health practices, will remain relevant as we begin working towards dismantling systemic oppression. Because the nature of this piece is on current issues, the literature that surrounded topics related to COVID-19 may be outdated within a couple of months. Thus, it is important that the approaches taken in my study not only address current issues related to COVID-19 but are also

future oriented in scope. Public health is an evolving field and must be community-oriented in order to break down barriers to health equity.

CHAPTER THREE

METHODOLOGY

Introduction

The goal of this project was to contribute to reducing COVID-19 health inequities and institutional mistrust in historically oppressed communities by leveraging the voices and knowledge of experienced, well-respected community leaders across the United States. In order to work towards this goal, several strategies were considered for tools that would help amplify community voice. As there were no tools like this already published, the research analyzed community and practitioner guides to community action against social disparities; gray literature on community mobilization and advocacy; and policy briefs on the community action against COVID-19 health disparities.

Each participating site received a final deliverable in the shape of the Community Leadership Voices Action Brief, which was intended to be used as a way to advocate for community needs and priorities through leadership perspectives and recommendations. Though the implementation of this tool is not included in this methods section, it is an important element to the process in reaching the overall goal of this project. The results derived from this project revolve around the content collected from the creation of the Community Leadership Voices Action Brief itself.

Population and Sample

The Interfaith Health Program (IHP) at Emory University was formed in 1992 at The Carter Center to engage the strengths of faith-based organizations in achieving public health goals of eliminating health disparities. One initiative that has grown out of that is a ten-site network of

faith and health collaboratives to address influenza prevention challenges in minority and hard to reach populations. Over a number of years this network has worked closely to cultivate trustworthy, authentic relationships amongst one another, with national partners, and within their communities. Having had more than 10 years of shared learning and program experience, the sites were selected for this initiative based on their community involvement and intervention expertise.

The IHP network is composed of 10 different organizations around the United States, 6 of which participated in this project. The participating sites included the Center for Faith and Community Health Transformation located in Chicago, IL, Penrose-St. Frances Mission Outreach located in Colorado Springs, CO, United Health Organization located in Detroit, MI, Buddhist Tzu Chi Foundation located in Los Angeles, CA, Lowell Community Health Center located in Lowell, MA, and Methodist LeBonheur Center of Excellence in Faith and Health located in Memphis, TN. Each site was represented by one to two organization leaders who participated in qualitative interviews that formed the content of the Community Leadership Voices Action Briefs.

Procedures

Literature Review Preliminary Process

The literature review helped build the foundation for the interview guide, both in the framework and the questions used. The sources used ranged from journal articles to gray literature and used the following search terms: advocacy tool, community change process, community advocacy tool, community action plan, and community action brief.

Special attention was given to literature that included potential questions that could help influence the interview guide and thus the structure of the action briefs.

Qualitative Interview Design

After initial research on community action a framework for a qualitative interview guide for the participating sites was constructed. This first step addressed the first objective, which was to include community leaders in assessment and as decision-influencers on community needs and priorities aimed at reducing or eliminating COVID-19 inequities. The interview guide was broken in to four sections with 18 questions total (See Appendix 7). The sections included: Identifying Community Make-Up, Organization and Community Leader, Understanding Root Challenges, and Proposed Solutions & Calls to Action. The sections followed a sequence that would allow for participants to build from one topic to the next. The goal of inquiry for each section is described below.

Identifying Community Make-Up—This section was designed to better understand the community being served and identify any characteristics the organization leader felt were relevant.

Organization and Community Leader – Questions in this section were aimed at gathering information about the organization from the perspective of the organizational leader and discussing the overall goals and successes the organization held. Included were questions designed to understand the organizational leader, their role in both the organization and community, and what they felt made them successful in their position.

Understanding Root Challenges – This set of questions aimed to get to the root causes of health challenges that faced each participating site's community. It also was used to prompt organization leaders to think about the systemic health inequities that undergird those issues.

Proposed Solutions & Calls to Action – This final section was aimed at gathering information from community and faith leaders to provide recommendations for institutional stakeholders, within public health sectors and beyond. It also served to identify what actions from these stakeholders were needed to restore and build trust with the community.

After the interview, sites were asked for follow up materials mentioned in the interview such as community needs assessments and organization documents. The recorded interviews were then transcribed for analysis and for the construction of a Community Leadership Voices Action Brief. They underwent a first round of edits to fit in a design template, cutting them all down to three pages. The second round of edits was made after feedback from the sites themselves was given.

Community Leadership Voices Action Brief

The Community Leadership Voices Action Brief followed the framework of the interview guide; however, the final version was influenced by the responses and themes that arose. Each brief was three pages in length with the following sections: Key

Messages; Community of Concern; Priority Community Issues & Challenges, Trusted Community Leadership Experience and Voices, Organization Commitments and Services, Capacity & Successes: Cultivating Trust, and Essential Principle-Based Actions. These sections, although based on the interview guide, were also shaped by the common responses amongst the different participants. An explanation of each section is described below.

Key Messages – This initial section serves as an executive summary for the brief. It gives a short description of the organization, it's capacities, strategies for trust building, and action recommendations.

Community of Concern—This section gathered demographic information and characteristics about the population served. It also included information that covered community health concerns and information from community needs assessments.

Priority Community Issues & Challenges – This section summarized the root challenges for the previously mentioned health issues facing the community of concern. It is here that leaders gave their views of the inequities that undergirded these issues.

Trusted Community Leadership Experience and Voices – A summary of the organizational leader(s) position in the organization, their successes, and insight into what contributes to success in their work.

Organization Commitments and Services – A description about current and past community programs carried out by the organization. This section included the most relevant programs, interventions, and experiences to the organization's mission and related work.

Capacity & Successes: Cultivating Trust – This section summarized information from the organizational leader's experience and recommendations with community trust building.

Essential Principle-Based Actions – This section articulated recommendations made by the organization leaders for institutional stakeholders in areas cultivating trust and public health strategies for both immediate and long-term action.

Based on community leader responses, the final Community Leadership Voices Action Brief deliverable was crafted as a method, or vehicle, to leverage community voices, setting the stage for principle-based actions essential to addressing COVID-19 inequities and mistrust. This aimed to address objective two, which was to develop and implement a method for community-determined action recommendations aimed to influence public health interventions. Although these briefs were developed, the final crafted deliverable has not yet been implemented. Due to the time constraints of this special studies project, understanding the tool's effectiveness on community-based action cannot be determined. However, data collected from the interviews was analyzed for themes around common responses that emerged with each section of the tool. An intentional effort was made to identify themes about cultivating trust and action recommendations.

Instrument

The data collection instrument used was an 18-question qualitative in-depth-interview guide. The guide was crafted to allow the participants to elaborate and become more comfortable with the sequence of topics covered. Each site participated in an hour to hour and a half long recorded Zoom interview.

Ethical Considerations

IRB approval was waived for this project given that it is an evaluation that is not meant to generalize findings to a broader population.

Limitations

This project contained various limitations related to both the urgency and evolving nature of the topic being analyzed, as well as the limited number of IHP site participants. The sample of participants resulted in findings specific to each site, therefore these findings are less generalizable to a broader national application. The action recommendations made by the sites were particular to historical and present experiences, and thus are not evergreen in terms of future application. The current relevancy of this project limits the future implications related to its findings.

Due to time constraints, the Community Leadership Voices Action Briefs have not yet been used to influence public health approaches, thus no conclusions can be drawn about its effectiveness.

CHAPTER FOUR

RESULTS

Introduction

The end results for this project are twofold: one is the framework for a Community Leadership Voices Action Brief that serves as an advocacy tool for organizations to amplify their recommendations to mitigate future health disparities related to COVID-19. Second, are actual action briefs shaped by the experiences and perspectives of faith and community leaders from six different national sites. Due to time constraints, this tool has not yet been implemented to evaluate effects on bringing about changes that impact health disparities. Thus, the presented results focus on themes and commonalities that arose from an analysis of the six action briefs. The brief contains six sections: Community of Concern, Priority Community Issues & Challenges, Trusted Community Leadership Experience and Voices, Organization Commitments and Services, Capacity & Successes, and Essential Principle-Based Actions. The following analysis is an examination of each of these sections and common elements across the six organization action briefs.

Community of Concern

This section contains information about the community that the organization serves. It includes statistics around demographics, like race, ethnicity, socioeconomic status, and other related factors. The participating sites span the United States, thus each community had very distinct characteristics. However, there are several similarities across the participating site's communities. These emerging themes are separated into the categories of race & ethnicity and socioeconomic-related demographics.

Race, Ethnicity, and Migrant Status

Each of the six participating sites work within communities that are at least 20% made up by persons of color. The predominant racial and ethnic groups residing in these communities were Black, Latino, or Asian. However, communities also included a percentage of Native American populations, and persons from Greece, Poland, eastern Ireland, eastern India, southeast Asia, Africa. In 4 out of the 6 sites, community leaders mentioned that immigrant and refugee populations represented a significant portion of the community they served (see Appendices 2,3,4,6).

Socioeconomic- Related Demographics

A majority of the populations served by the participating organizations experience low socioeconomic status, lack of health insurance, barriers to healthcare, homelessness, language barriers, and/or social barriers related to old age.

Priority Community Issues & Challenges

This segment summarizes the community health priorities identified through past community health needs assessments (CHNAs) and organization leadership recommendations. There are several overlapping health priorities in the six communities of focus. Beginning with top priorities identified by CHNAs, common issues that emerged were chronic disease, substance abuse, affordable housing, education, mental health, access to care, community safety, poverty, healthy food access, and social determinants of health. Additionally, the community leaders expanded on these priorities and gave updates about current issues due to the pandemic. These current issues include systemic barriers to healthcare access, equitable access to COVID-19

related services (testing, treatment, and vaccines), COVID-19 vaccine mistrust, institutional racism, inherent biases, lack of health insurance, and overcomplicated processes for health service access. In all cases, each site remarked that existing health priorities had been exacerbated in the presence of COVID-19.

Trusted Community Leadership Experience and Voices

This section summarizes community leader roles and responsibilities while aiming to expand on their experiences and establish credibility. Every leader's experience was different, thus few commonalities emerged. The time the leaders spent working with the community ranged from 2 to 30 years, with the average time invested of 15 years. These community leadership positions included: roles of community organizers include Assistant-Directors; Community Outreach Coordinators, Community Nurses, Directors, Vice-Presidents, and Presidents of community or faith-based related programming and organizations.

Organization Commitments and Services

This section showcases the mission, values, and program activities of the organization, while also drawing on their capacity and past achievements. Of the six organizations that participated in this project, three are faith-based healthcare systems with faith-community outreach programs attached (see Appendices 1,5,6), one is a federally qualified health center (see Appendices 4), one is a local community-based nonprofit (see Appendices 3), and one is a faith-based international humanitarian organization (see Appendices 2). All of the organizations are either faith-based or offer a faith-based component as a part of their community outreach.

The commonalities that emerged among organization services include free or low-cost non-discriminatory care to vulnerable populations, health screenings, patient-centered care, culturally competent care, and health education. Similar program activities across participating organizations include professional and leadership development, health education, cross-training, faith-based partnership initiatives, health equity initiatives that target the social determinants of health, and consistent community outreach.

Capacity & Successes: Cultivating Trust

This section gathered insight and experience from community leaders about strategies that cultivate community trust. Several themes emerged from this section that centered around authentic partnerships, provision of resources and services, leadership development and training, community engagement and collaboration, and cultural responsivity. These emerging themes are discussed in further detail below.

Authentic Partnerships

The theme of partnerships emerged with all six participating sites. The types of community partners included various entities such as faith-based organizations, churches, interfaith networks, educational institutions, public health entities, local government offices, federal government agencies, local health advocacy groups, and national coalitions. The main theme consistent among the creation of authentic partnership is extended amounts of time and resources invested in the community and genuine connection around shared goals. Evidence supporting partnerships includes increased organizational capacity, transfer of trust within the community, de-stigmatization around

certain health topics, identification of trusted messengers, and broadened community reach.

Provision of Resources and Services

Every participating organization has engaged in activities that involve providing resources or services to address community health needs. These services provided by the organizations are free of charge or low cost. The support of this theme incorporates the reasoning that tangible support and services directly impact community health and help build a consistent foundation of care from which the community benefits.

Leadership Development and Training

Of the six organizations, four identified leadership development or training as a main focus for program activities (see Appendices 1, 3, 4, 5). The kind of leadership development differed among sites and ranged from training on technical skills and strengthening capacities, to nurturing faith and health leaders around interconnected work. Development activities mentioned by sites include community health worker trainings on cultural sensitivity, workshops on mobilization and advocacy, education on specific health topics, and leveraging people's talents and wisdom. Leadership development is said to build trust because it fosters collaborative work, supports community autonomy, and neutralizes power dynamics.

Community Engagement and Collaboration

The theme of community engagement was consistent across sites, and occurred through several different activities, such as targeted outreach utilizing health communication and promotion strategies; directed efforts to address social determinants of health; educational workshops; consistent fostering of authentic relationships and support; action in restorative justice; interactive community meetings; community member autonomy building; transparent health communication; and cultural responsivity that centers community context. These strategies centered around the community's context, as linguistically, culturally, and environmentally responsive care, an acknowledgement of barriers to access, and amplifying the community's voice, which in turn is said to cultivate trust.

Essential Principle-Based Actions

The final section of the Community Leadership Voices Action Brief reflects the organizational leader's recommendations for both immediate and long-term actions, and the results for this section are presented within these two categories.

Immediate Action

This sub-category focuses on action that should be taken instantly regarding COVID-19 health disparities in communities of color. The two most prevalent categories are centering the community and commitment to access.

Centering the Community

The most common immediate action theme that arose in 4 of the 6 participating site's briefs is centering community voice (see Appendices 1,2,4,5). This concept encompasses several factors, including prioritizing community context; patient-centered care; cultivating environments worthy of trust; identifying trusted voices to amplify; focusing on BIMPOC communities who have been hardest hit by the pandemic; co-creation and working alongside communities; and focusing on community priorities.

Commitment to Access

The theme of access is present in 3 of 6 briefs (See Appendices 1,2,6). This call to action includes calling on outside stakeholders to follow through with promised services in a reasonable timeframe; prioritizing communities of color in vaccine distribution; and addressing systemic disparities that may prevent access.

Long-term Action

This sub-category of themes represents actions that should be prioritized now and long past the pandemic to build community trust open-endedly and mitigate further health disparities. Themes that were most prominent include prioritizing community and public health, addressing systemic racism, and establishing a collective dialogue.

Prioritizing Community and Public Health

This long-term action item emerged in two briefs (See Appendices 4 and 5). This recommendation calls for promoting health for everyone as a collective by addressing systemic barriers to health. In addition, it recommends prioritizing preventative care and public health through adequate funding, as well as recognizing public health as a central voice.

Addressing Systemic Racism

Addressing systemic barriers, such as racism, is a consistent theme throughout every brief. This action item includes several recommendations, like diversity, equity, and inclusion in places where community decisions are being made; acknowledgment of systemic transgressions; mandatory trainings and educational workshops on systemic racism and white supremacy; reparations given to people of color; and investments in disenfranchised communities.

Collective Dialogue

This call to action recommends that all local, federal, faith-based, public health, and academic leaders engage in conversation in order to shape health promotion messages and strategies that best fit best the community's context.

Summary

The key findings that emerged from these results include priorities that arose in the presence of COVID-19, including systemic barriers to healthcare access, equitable access to COVID-19

related services (testing, treatment, and vaccines), COVID-19 vaccine mistrust, institutional racism, inherent biases, lack of health insurance, and overcomplicated processes for health service access. Emerging themes drawn back to cultivating trust include authentic partnerships, provision of resources and services, and leadership development and training, and community engagement and collaboration. Essential principle-based actions gathered from community leader recommendations include centering the community, making a commitment to access, prioritizing community and public health, addressing systemic racism, and engaging in collective dialogue.

Although the tool itself has not yet been implemented, the findings from the creation of the briefs provide important content related to community trust building and action recommendations from community leaders. This content can provide key insights for equitable programming around COVID-19 in communities of color in future efforts.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

Introduction

The purpose of this special studies project is to develop an advocacy tool that leverages the voices and wisdom of faith and community leaders from multiple sites across the United States in order to contribute to the reduction of COVID-19 health inequities and institutional mistrust in historically oppressed communities. To achieve this goal, a review of past and present literature was carried out on inequities in marginalized health, including an analysis on COVID-19 disparities in communities of color, followed by existing literature on underlying inequities fueled by the social determinants of health (SDOH). Additionally, the literature reviewed was on the roots of mistrust and misinformation, followed by essential health practices needed to combat mistrust, and followed with a review on advocacy tactics that influence a community-led action framework. The review of the literature helped establish a foundation for creating an initial framework for gathering leadership perspectives. After interviews with each of the participating community leaders, a Community Leadership Voices Action Brief was created to act as a tool that can help mitigate COVID-19 disparities in disenfranchised communities.

The objectives of the project are to engage community leaders as decision-influencers on community needs and priorities aimed at reducing COVID-19 inequities, and to develop and implement a method for community-driven action recommendations to influence public health interventions. Although a method, or tool, did come out of this process, implementation of the tool to eliminate or diminish health inequities related to COVID-19 was not carried out due to

time constraints. Even though this tool has not yet produced the results from implementation, the content generated cultivating trust and action recommendations from the briefs themselves is valuable for future health inequity interventions. The importance of these results in relation to current literature will be discussed in further detail below.

Results Analysis

The results from this project emerged from the themes and commonalities across the various Community Leadership Voices Action Briefs themselves. Although valuable evidence was derived from each section of the action brief, the most significant findings are found in the two sections, *Capacity & Successes: Cultivating Trust* and *Essential Principle-Based Actions*.

Capacity & Successes: Cultivating Trust

The themes that emerged from this section describe the organizations' path towards gaining and sustaining community trust. One commonality that strengthened the organizations' ability to sustain trust and carry out the aforementioned practices occurs with the amount of time and enduring dedication they invested into their community. The community leaders also re-iterated the importance of a strong foundation that was steadfast to their mission in addressing health disparities and promoting health equity. It was made clear that trust is not given haphazardly, it is something to be earned through consistent support and mutual respect. Institutional stakeholders cannot wait until a crisis, like the COVID-19 pandemic, occurs to engage or cultivate relationships with communities.

The variety of both community leader responses and organization experience in building trust creates a breadth of practical opportunities for institutional stakeholders to consider. Although the range of activities among organizations is diverse, common themes of authentic partnerships, provision of resources and services, leadership development and training, and community engagement and collaboration all emerged. Each of these overarching themes encompasses more of the following specific public health practices.

The concept of authentic partnership is a repeated theme amongst every community organization. This is not a surprise as the participating sites were all chosen from the IHP network, which fosters collaboration between multi-sectoral partners. The capacity and support behind the engagement in partnerships was said to serve as a way to cultivate more personal relationships with the community members themselves, build program capacity, increase access to resources, and act as an efficient vehicle to transfer trust between outside entities and credible community messengers. Additionally, partnering across sectors allowed for a broader reach into vulnerable communities, this included collaboration between faith-based groups, academic institutions, healthcare systems, advocacy groups, community-led initiatives, local government, federal government, etc. This widespread network allows partners to build comradery over similar struggles and heightens confidence for planning a response to a more complex issue. However, additional information about sustaining these relationships was also highlighted in the results. Oftentimes when partnerships are forged there is potential for an outside entity to prioritize a hidden agenda over the community's needs. Thus, partnerships that are truly authentic must come from open, honest, and consistent communication and shares goals.

These kinds of partnerships prioritize community needs and value the relationship more than an institutionally driven desired outcome. The current national response for building and maintaining community trust is consistent with the prioritization of community partnerships. As seen in National Institute of Health's (NIH) Community Engagement Alliance's tip sheet for building community trust, the first action item is to "invest in long-term relationships with community partners," by building on previous partnerships, having flexible community-led meetings, and asking communities to share their needs first. [89]

The essential practice of providing equitable community access to resources and services is another common theme reported by all participating sites. This practice is also expected, as the participating organizations all conduct community-engagement programming that aims to address barriers related to the SDOH. The foundational approaches consistent across the collective participating sites ensure free or low-cost services and resources that aim to improve community health and prevent illness. The essential factor that underscores this practice is to ensure community context is built into dissemination. As a key health domain of the SDOH, community context represents aspects of "social cohesion, discrimination, civic participation, and incarceration." [20] This domain is crucial to creating equitable programs and resources. As echoed by the participating community leaders, the 'free' programs offered by organizations are often engrained with convoluted stipulations that create barriers to access. Centering community context goes beyond considering barriers to access, it also takes into account community-values, faith-based beliefs, cultural background, and possible historical and

personal experience with institutional transgressions. By working to incorporate these values in to our community health interventions, we can strengthen relationships, social cohesion, and collective efficacy. [43] These practices of cultural responsivity should be enacted in all forms of service and resource provisions, along with community engagement and collaboration.

Community engagement looks a little different across the six participating sites, however, the practices are all rooted in equitable, social justice, and empowering frames. The major activities that leverage community power are educational workshops, leadership trainings, interactive community meetings, and centering community voice. This co-collaboration allows community members to be the central decision makers in taking charge of their own health, but also in leading a response that can impact the health of their entire community. Leveraging internal power can create positive, sustainable changes that mitigates future health inequities. All of these aspects underline the concept of collective efficacy, which relies on "social capital and social cohesion" to increase a community's ability to instigate change and "exercise informal social control." [43] The overarching goal of engagement should be to assist communities in re-energizing their power, so the intervening entity may exit once their assistance is no longer needed. This is not to say that intervening entities cannot provide long-term partnership support, but rather their interventions and decision-making power should have a limited presence over time. This concept re-establishes transparency behind intervening agencies and cultivates trust through neutralized power structures.

Essential Principle-Based Actions

Although the pandemic continues to change and evolve, the recommendations made by the organizations are cognizant of this and align their proposals with systemic issues that have yet to be addressed. This is notably found in the immediate versus long-term action items described in the results.

Immediate actions called for centering the community and committing to equitable access. This employs many of the community engagement practices already discussed, however, also includes cultivating systems worthy of trust, focusing on BIMPOC communities who have been disproportionately impacted by the COVID-19 virus, and ensuring equitable access to virus-related services (i.e. vaccines, testing, general healthcare). The vaccine roll-out response has already shown to be widely inequitable in many places, for example appointment registration is occurring mostly online and many vaccine distribution sites are located outside of disenfranchised communities. This perpetual lack of consideration when it comes to community context and systemic inequities further increases health disparities in communities of color. Thus, prioritizing these communities in the response is vital to increase vaccine uptake.

The long-term action items include prioritizing community and public health, addressing systemic racism, and engaging in a collective cross-sector dialogue. The public health sector has long-been undervalued and underfunded, even though it is a major force for our nation's health. The US as a whole values curative care over prevention, which leads to neglecting root cause of issues that drive health disparities. Addressing root causes

upstream would save time, money, and lives from avoidable chronic diseases. Root causes stem from systemic injustice and oppression, which are often ignored in institutional health responses. Systemic racism is an underlying toxicity to the population's health, and until we address it, we are merely putting a bandage on an issue that is internally cancerous. NIH's UNITE is a current initiative that is fighting to end structural racism. The initiative has employed five committees to address separate issues related to bias and discrimination, including systematic self-evaluation in the science community, expanded research on health disparities and health equity, improving internal structures for diversity, equity, and inclusion, coordinating NIH-wide efforts to ensure transparency, accountability, and communication with all stakeholders, and changing policy and work place structure in the research ecosystem to promote diversity. [107] Although initiatives like these are needed, systemic change cannot occur with one initiative at a time. Fighting systemic racism requires a collective approach that stems from cross-sector dialogue. As re-iterated by the participating sites in this project, emphasizing this dialogue can provide rich information from various perspectives, give insight to distinct barriers in different settings, and help create a well-rounded and streamlined plan of action. This conversation allows all stakeholders to come to terms with blatant issues that plague our systems. Addressing issues of white supremacy and structural racism will require that all systems take collective anti-racist action, acknowledge past transgression, and work alongside communities to restore justice.

Applying Results to Current Realities

The dynamic state of the pandemic has produced new information regarding vaccine roll-out, health disparity statistics, rates of vaccine acceptance, and relevant programs targeting community health issues. In order to discuss how the findings from this project are applicable to current and future public health practice, it's important to understand the present state of the pandemic and anticipate possible health challenges that could occur in the future. As of mid-April 2021, deaths from COVID-19 in the US have reached 566k, with an average of 70k new virus cases a day, over 10% of which are currently contributed by the state of Michigan alone. [108] Michigan's current surge in cases is thought to be in part due to virus' variants, and the state's cases are being widely detected in children and young people. [109] To make matters even more challenging, of the three vaccines approved for distribution in the US, the rollout of the Johnson & Johnson vaccine has been paused to study its possible health risks. [108] Among all of these issues, federal responses have been accommodating in some regards, but are still falling behind the equity threshold. For example, the appeals for increased vaccine supply for Michigan have been denied due to the inflexible nature of the federal vaccine rollout, which determines vaccine supply solely by population size. [110] The federal government made the compromise to expand vaccine availability to community health centers, allowing some to be added to the "government's retail pharmacy partnership". [110] Although, it can be argued that this 'expansion' should have been standard to the initial roll-out, as federal vaccine locations are not accessible to all communities nor are all of them trusted. In applying the results from this project, the push for equitable access is most notable in this scenario of expanding roll-out to vulnerable communities.

The sites that participated in this project are working with a number of marginalized populations,

however, one vulnerable community that was often left out of the conversation was the prison population. Given the nature of the participating organizations, their outreach is bound to the capacities of local outreach or clinical settings, which often centers around needs identified in community health assessments. Although, their work does not explicitly target incarcerated communities, many of the organizations utilize social justice frameworks in their outreach to address the systemic issues, some of which may be related to the criminal justice system. Additionally, implementation focused on communities of color may also aim to engage community members who have been affected by the prison pipeline in one way or another.

Although incarcerated communities were not a major highlight of this paper, they do make up a significant portion of vulnerable populations, and are disproportionately made up of people of color. [111] In recent months the Federal Bureau of Prison has removed COVID-19 cases and deaths from its regular reports. [112] This makes it impossible to know the exact toll the virus is currently having in these systems, although we do know they have had more infections than any other institution. [112] As of mid-April 2020, there has been a total of nearly 400k COVID-19 cases in local and federal prisons, with at least 2,564 virus related deaths among prisoners.[112] Given the disparities of testing among different prison populations, the data reported varies widely among state penitentiaries. [112] In areas like Michigan, where there are virus hotspots, there is an increased burden in incarcerated communities. The data shows that 2 in 3 prisoners have tested positive in Michigan, while 1 in 269 prisoners has died.[112] Incarcerated populations are grossly underprioritized when it comes to health responses. The heightened risk of virus spread in prisons is tied to overcrowding, limited testing availability, lack of personal protective equipment, and inadequate vaccine access. [113]

Apathy towards these population fuels insufficient responses which fail to provide proper or dignified approaches to limit virus spread and care for infected individuals. This idea that incarcerated individuals' lives are dispensable and unworthy of basic life-essentials re-enforces the concept of necropolitics. The pandemic has forced us to confront the concept of necropolitics, or the politics of life and death, due to the infectious nature of the virus and limited capacity of healthcare systems. [114] The idea behind necropolitics is that the government makes silent decisions that value certain lives over others, especially in moments of mass crisis. [114] As we know, our institutions are inundated with racism, which provides a pivotal connection between white supremacy and necropolitics. Again, applying our results to these underlying issues forces us to utilize anti-racist frameworks to understand the different theories and concepts currently fueling disparities. In accepting surface-level ideas around barriers to access and health inequities, we perpetuate underlying corrupt frameworks that forces disenfranchised communities to deal with these issues on their own. Public health entities have to respond in a nature that acknowledges their role in these foundationally flawed systems and work to dismantle them.

Presently, 38.9% of the population has received one dose of the vaccine, and among those 64.6% are white, 11.5% are Latino or Hispanic, 8.5% are Black, and 5.4% are Asian. [115] These results show that of those who have received the vaccine, people of color are behind their represented percentage as a part of the total population while white people are currently receiving the vaccine at a greater percentage than their total population. In short, this shows that white individuals are receiving the vaccine at higher rates than communities of color. Although several factors may contribute to this, it is assumed that the major contributor to disparities in vaccine uptake is

barriers to access. [105] According to the Kaiser Family Foundation's (KFF) COVID-19 Vaccine Monitor, which tracks feelings around the vaccine, a release of data from March 2021 shows that the decision around vaccine uptake is fluid for a majority of people. Of the various responses recorded, only 10% of Black adults and 18% of Hispanic adults said they would definitely not get the vaccine. [9] These refusal rates are seemingly low compared to the highest prevalence in vaccine refusal in people who identify with the Republican party at 32%. [9] The notion that vaccine hesitancy is the number one contributor to lack of vaccine uptake in communities of color presents a harmful belief that ignores the real issue of systemic barriers to vaccine access.

Implications and Recommendations

The future public health implications of this project focus on two things, assumptions about what could strengthen the tool for future use and actual implementation of the action briefs. This project remains open-ended, as the ever-evolving nature of the pandemic does not provide a definitive end point. Thus, the proposal for the best way forward that follows includes assumptions based on what is currently known.

The Community Voices Action Brief was initially crafted with both local and nation-wide implementation in mind. The development of the final tool was influenced by the leaders' experiences and the community contexts of the six participating sites across the US. The participating sites had several similarities, but it's important to note that their community context and population demographics guided distinctive program activities and they addressed barriers to prevention of influenza. While together these perspectives on effective actions represents a wide variety of successes in responding to the needs of those experiencing health inequities, this body

of work could be strengthened by further community input from additional organizations. The organizations that influenced the content of the action briefs were either faith-based health systems, faith- or community-based organizations. Including indigenous groups, advocacy groups, thinktanks, and other local non-profits or non-governmental agencies would help shape these recommendations to represent a wider array of different communities in the US. The structure of the tool is flexible, however, it's foundation should remain rigorous around three main concepts. These concepts include identifying community context, key-change institution(s), and concrete actions that key-change institution(s) have the capacity to leverage.

For this tool to be implemented locally, it should be aimed at promoting collaboration among community stakeholders, setting the stage for equity-based frameworks, and advocating for support and resources from local key change institutions. To be most effective, the local use of this tool should incorporate voices of other local community leaders to help build a collective response to community health inequities. This collective response integrates a variety of perspectives to combat these issues, however, it also strengthens credibility behind recommendations through the establishment of a unified front.

Implementing this tool nationwide would be most useful in initiatives such as that in the COVID-19 federal vaccine rollout led by the CDC and HHS to engage faith and community-based organizations. As previously mentioned, these efforts have tried to center part of their response around partnerships with community health centers, and the use of this tool could help streamline a more concerted effort towards equity. A common concern among participating community leaders is the lack of a collective dialogue around a centralized plan of action. An

organized, collective use of this tool can help efficiently and effectively identify community concerns around interventions in regard to community context and identify necessary, feasible action steps to work around these boundaries. The overall flexibility the tool makes it useful to any and all communities, again highlighting its foundation in equity and inclusion.

The foundational elements of this tool re-emphasize the importance of community engagement, cultural responsivity, and structural competency. Even if this tool is not applied nationally, its framework and aims provide an essential guide for future public health interventions. The public health sector has the ability to grow and transform into an entity guided by community-driven frameworks. However, this requires us to work alongside communities and learn from their tactics that center equity, cohesion, and mutual trust.

Conclusion

This project set out to advocate for communities of color that have been disproportionately impacted by COVID-19 and systemic health disparities. The literature review helped capture research that served as a framework for a tool that will be used to leverage community-leader voices. During the creation of this tool, important content emerged from faith and community leader responses, specifically around cultivating trust and action steps forward. Although the tool itself has not yet been implemented, the results that came from the development of the action briefs provide foundational direction to achieving an equitable COVID-19 response. The framework in the tool makes it possible to learn community-centric strategies that value cultural differences, address social barriers to health, and support authentic partnerships. These approaches are necessary in building community trust, but ultimately, they should strive to

leverage overall community health and mitigate disparities. While the nature of the pandemic may continue to vary in its path (see Appendix 8), the imperative call for systemic change in response to health disparities is long over-due and will require a steadfast dedication to more equitable strategies. Future public health advocacy efforts should remain focused on dismantling systems of oppression in order to rebuild environments rooted in solidarity, justice, and equity.

REFERENCES

1. *Hospitalization and Death by Race/Ethnicity*. Centers for Disease Control and Prevention : Coronavirus Disease November, 2020 [cited 2020 December 20]; Available from: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.
2. Farberman, R., *Building Trust in and Access to a COVID-19 Vaccine Among People of Color and Tribal Nations : A Framework for Action Convening*. 2020, Trust for America's Health.
3. Jaiswal, J., *Whose Responsibility Is It to Dismantle Medical Mistrust? Future Directions for Researchers and Health Care Providers.* Behavioral Medicine, 2019. **45**(2): p. 188-196.
4. *Interfaith Health Learning Network: Action Concerns*. September 2020.
5. Lloyd Micheener, S.A.-G., PM Alberti, MJ Castaneda, BC Castrucci, LM Harrison, et al., *Engaging With Communities — Lessons (Re)Learned From COVID-19.* Preventing Chronic Disease, 2020. **17**.
6. *Faith-based and Public Health Partnerships: Reaching Vulnerable Populations.* [cited 2020; Available from: https://ihpemory.org/ihp-programs/faith-based-community-partnerships-reaching-vulnerable-populations/.
7. Kiser, M. and K. Lovelace, *A National Network of Public Health and Faith-Based Organizations to Increase Influenza Prevention Among Hard-to-Reach Populations.* American Journal of Public Health, 2019. **109**(3): p. 371-377.
8. Minkler, M., N. Wallerstein, and N. Wilson, *Improving health through community organization and community building*, in *Health behavior and health education: Theory, research, and practice, 4th ed.* 2008, Jossey-Bass: San Francisco, CA, US. p. 287-312.
9. Hamel, L., Kirzinger, A., Munana, C., Brodie, M.A. , *KFF Health Tracking Poll/ KFF COVID-19 Vaccine Monitor*. 2021, Kaiser Family Foundation.
10. Malik, A.A., et al., *Determinants of COVID-19 vaccine acceptance in the US.* EClinicalMedicine, 2020. **26**.
11. CDC, *Figure 2. Difference between the percent of COVID-19 deaths and the population distributions by race and Hispanic origin: the impact of adjusting for age*, in *Health Disparities: Race and Hispanic Origin*. 2021.
12. CDC, *CDC Social Vulnerability Index*, ATSDR, Editor. 2020.
13. Gaynor, T.S. and M.E. Wilson, *Social Vulnerability and Equity: The Disproportionate Impact of COVID -19.* Public Administration Review, 2020. **80**(5): p. 832-838.
14. Thakur, N., et al., *The Structural and Social Determinants of the Racial/Ethnic Disparities in the U.S. COVID-19 Pandemic. What's Our Role?* American Journal of Respiratory and Critical Care Medicine, 2020. **202**(7): p. 943-949.
15. Quinlan, M., *COVID-19, Health and Vulnerable Societies.* Annals of Work Exposures and Health, 2021.
16. Statistics, B.o.L., *A-4. Employment status of the civilian noninstitutional population by race, Hispanic or Latino ethnicity, sex,and age, seasonally adjusted*. December 2020: Washington, DC.
17. Tai, D.B.G., et al., *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States.* Clinical Infectious Diseases, 2020.

18. Burton, É.C., D.H. Bennett, and L.M. Burton, *COVID-19: Health disparities and social determinants of health.* International Social Work, 2020. **63**(6): p. 771-776.
19. Abrams, E.M. and S.J. Szefler, *COVID-19 and the impact of social determinants of health.* The Lancet Respiratory Medicine, 2020. **8**(7): p. 659-661.
20. Maness, S.B., et al., *Social Determinants of Health and Health Disparities: COVID-19 Exposures and Mortality Among African American People in the United States.* Public Health Reports, 2020: p. 003335492096916.
21. WHO, *The top 10 causes of death*. 2020.
22. Alcendor, D.J., *Racial Disparities-Associated COVID-19 Mortality among Minority Populations in the US.* Journal of Clinical Medicine, 2020. **9**(8): p. 2442.
23. Laurencin, C.T. and A. McClinton, *The COVID-19 Pandemic: a Call to Action to Identify and Address Racial and Ethnic Disparities.* Journal of Racial and Ethnic Health Disparities, 2020. **7**(3): p. 398-402.
24. U.S. Department of Education, *The Condition of Education 2020 (NCES 2020-144), Concentration of Public School Students Eligible for Free or Reduced-Price Lunch.*, in *U.S. Department of Education, National Center for Education Statistics.* 2020.
25. Havele, S. and D. Mashall, *Brroadband Internet Access, Education & Child Health: From Difference to Disparities, Part 1*, in *Children's Hospital of Philadelphia - Policy Lab*. 2020: Philadelphia, PA.
26. NAACP, *Criminal Justice Fact Sheet*, N.N.A.f.t.A.o.C. People, Editor. 2020.
27. Novisky, M.A., C.S. Narvey, and D.C. Semenza, *Institutional Responses to the COVID-19 Pandemic in American Prisons.* Victims & Offenders, 2020. **15**(7-8): p. 1244-1261.
28. Egede, L.E. and R.J. Walker, *Structural Racism, Social Risk Factors, and Covid-19 — A Dangerous Convergence for Black Americans.* New England Journal of Medicine, 2020. **383**(12): p. e77.
29. Watson, M.F., et al., *COVID-19 Interconnectedness: Health Inequity, the Climate Crisis, and Collective Trauma.* Family Process, 2020. **59**(3): p. 832-846.
30. Yaya, S., et al., *Ethnic and racial disparities in COVID-19-related deaths: counting the trees, hiding the forest.* BMJ Global Health, 2020. **5**(6): p. e002913.
31. Promotion), O.O.o.D.P.a.H. *Employment*. 2020 [cited 2021 January 23]; Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/employment.
32. Promotion), O.O.o.D.P.a.H. *Poverty*. 2020 [cited 2020 January 23]; Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty.
33. USA, P. *Income and Poverty in the United States*. 2019; Available from: https://www.povertyusa.org/facts.
34. Promotion), O.O.o.D.P.a.H. *Food Insecurity*. 2020 [cited 2021 January 23]; Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity.
35. Promotion), O.O.o.D.P.a.H. *Housing Instability*. 2020 [cited 2021 January 23]; Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability.
36. Promotion), O.O.o.D.P.a.H. *Early Childhood Development and Education*. 2020 [cited 2021 January 23]; Available from: https://www.healthypeople.gov/2020/topics-

objectives/topic/social-determinants-health/interventions-resources/early-childhood-development-and-education.
37. Promotion), O.O.o.D.P.a.H. *High School Graduation*. 2020 [cited 2021 January 23]; Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/high-school-graduation.
38. APHA, *Address Social Determinant to ensure on-time graduation*, in *Policy Statements*, A.P.H. Association, Editor. 2016.
39. Smedley, B.D., Stith, A. Y., Nelson, A. R., *Institute of Medicine Committee on, Understanding, Eliminating, Racial Ethnic Disparities in Health Care*, in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. 2003, National Academies Press (US) Copyright 2002 by the National Academy of Sciences. All rights reserved.: Washington (DC).
40. Nephew, L.D., *Systemic racism and overcoming my COVID-19 vaccine hesitancy.* EClinicalMedicine, 2021: p. 100713.
41. News, B. *Breonna Taylor: Timeline of black deaths caused by police*. 2020; Available from: https://www.bbc.com/news/world-us-canada-52905408.
42. *Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System*, T.S. Project, Editor. 2018.
43. ODPHP. *Social Cohesion*. 2020 [cited 2021; Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/social-cohesion.
44. Turner-Musa, J., O. Ajayi, and L. Kemp, *Examining Social Determinants of Health, Stigma, and COVID-19 Disparities.* Healthcare, 2020. **8**(2): p. 168.
45. Rollston, R. and S. Galea, *COVID-19 and the Social Determinants of Health.* American Journal of Health Promotion, 2020. **34**(6): p. 687-689.
46. Nguemeni Tiako, M.J., H.P. Forman, and M. Nunez-Smith, *Racial Health Disparities, COVID-19, and a Way Forward for US Health Systems.* Journal of Hospital Medicine, 2020. **16**(1): p. 50-52.
47. Okun, T., *white supremacy culture*, in *dRworks*.
48. Martínez, M.E., J.N. Nodora, and L.G. Carvajal-Carmona, *The dual pandemic of COVID-19 and systemic inequities in US Latino communities.* Cancer, 2021.
49. Rozenfeld, Y., et al., *A model of disparities: risk factors associated with COVID-19 infection.* International Journal for Equity in Health, 2020. **19**(1).
50. Chowkwanyun, M. and A.L. Reed, *Racial Health Disparities and Covid-19 — Caution and Context.* New England Journal of Medicine, 2020. **383**(3): p. 201-203.
51. Vadlamannati, K.C., A. Cooray, and I. De Soysa, *Health-system equity, egalitarian democracy and COVID-19 outcomes: An empirical analysis.* Scandinavian Journal of Public Health, 2021: p. 140349482098210.
52. WHO. *Ten threats to global health in 2019*. 2019 [cited 2020; Available from: https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019.
53. Verger, P. and E. Dubé, *Restoring confidence in vaccines in the COVID-19 era.* Expert Review of Vaccines, 2020: p. 1-3.
54. Bogart, L.M., et al., *COVID-19 Related Medical Mistrust, Health Impacts, and Potential Vaccine Hesitancy Among Black Americans Living With HIV.* Journal of acquired immune deficiency syndromes (1999), 2021. **86**(2): p. 200-207.
55. Benkert, R., et al., *Ubiquitous Yet Unclear: A Systematic Review of Medical Mistrust.* Behavioral Medicine, 2019. **45**(2): p. 86-101.

56. Doherty, C., Kiley, J., Daniller, A., Jones, B., Hartig, H., Dunn, A., Gilberstadt, H., Green, T.V., Gomez, V., Kent, D., Bertoni, N., *Americans' Views of Government: Low Trust, but Some Positive Performance Ratings*. 2020, Pew Research Center: U.S. Politics & Policy.
57. Kulke, S., *National Survey: Public trust and Americans' willingness to vaccinate for COVID-19*. 2020, Northwestern: Northwestern Now.
58. Moreno-John, G., et al., *Ethnic Minority Older Adults Participating in Clinical Research.* Journal of Aging and Health, 2004. **16**(5_suppl): p. 93S-123S.
59. *Building Community Trust to Improve Participation in COVID-19 Testing and Contact Tracing*, A.P. Association, Editor. 2020.
60. Manning, K.D., *More than medical mistrust.* The Lancet, 2020. **396**(10261): p. 1481-1482.
61. Trinh, N.-H.T., et al., *Addressing Cultural Mistrust: Strategies for Alliance Building*. 2019, Springer International Publishing. p. 157-179.
62. Gamble, V.N., *Under the shadow of Tuskegee: African Americans and health care.* American Journal of Public Health, 1997. **87**(11): p. 1773-1778.
63. Brandt, A.M., *Racism and research: the case of the Tuskegee Syphilis Study.* Hastings Cent Rep, 1978. **8**(6): p. 21-9.
64. *Discrimination in America: Final Summary*. 2018, NPR, Robert Wood Johnson Foundation, Harvard T.H. Chan School of Public Health.
65. Eligon, J., *Black Doctor Dies of Covid-19 After Complaining of Racist Treatment*, in *The New York Times*. 2020.
66. Bajaj, S.S. and F.C. Stanford, *Beyond Tuskegee — Vaccine Distrust and Everyday Racism.* New England Journal of Medicine, 2021: p. e11.
67. James, R.D., K. McGlone West, and T.M. Madrid, *Launching native health leaders: reducing mistrust of research through student peer mentorship.* American journal of public health, 2013. **103**(12): p. 2215-2219.
68. UN, *Mandates of the Special Rapporteur on contemporary forms of racism, racial discrimination,*
xenophobia and related intolerance; the Special Rapporteur on the human rights of migrants; and
the Working Group on discrimination against women and girls. 2020, United Nations: Geneva, Switzerland.
69. Alang, S., D.D. McAlpine, and R. Hardeman, *Police Brutality and Mistrust in Medical Institutions.* Journal of Racial and Ethnic Health Disparities, 2020. **7**(4): p. 760-768.
70. Alicia L. Best, F.E.F., Mika Kadono, Rueben C. Warren, *Institutional Distrust among African Americans and Building Trustworthiness in the COVID-19 Response: Implications for Ethical Public Health Practice*. November 19, 2020, Meharry Medical College: Journal of Health Care for the Poor and Underserved.
71. Jaiswal, J., C. Loschiavo, and D.C. Perlman, *Disinformation, Misinformation and Inequality-Driven Mistrust in the Time of COVID-19: Lessons Unlearned from AIDS Denialism.* AIDS and Behavior, 2020. **24**(10): p. 2776-2780.
72. Hammond, W.P., *Psychosocial Correlates of Medical Mistrust Among African American Men.* American Journal of Community Psychology, 2010. **45**(1-2): p. 87-106.
73. Petteway, R.J., *"Dreams Of A Beloved Public Health: Confronting White Supremacy In Our Field"*, in *Health Affairs Blog*. 2021, Health Affairs Blog: Health Affairs Blog.

74. Zuberi, T. and E. Bonilla-Silva, *White Logic, White Methods : Racism and Methodology*. 2008, Lanham, MD, UNITED STATES: Rowman & Littlefield Publishers.
75. Park, Y.S., L. Konge, and A.R.J. Artino, *The Positivism Paradigm of Research.* Academic Medicine, 2020. **95**(5): p. 690-694.
76. *Community Engagement Toolkit: Guidance and Resources for Engaging Community Planning and Policy Development*, Futerwise, Editor. 2014.
77. Schulz, A.J., J. Krieger, and S. Galea, *Addressing Social Determinants of Health: Community-Based Participatory Approaches to Research and Practice.* Health Education & Behavior, 2002. **29**(3): p. 287-295.
78. Krieger, J., et al., *Using Community-Based Participatory Research to Address Social Determinants of Health: Lessons Learned from Seattle Partners for Healthy Communities.* Health Education & Behavior, 2002. **29**(3): p. 361-382.
79. D.Reed, D., *Racial Disparities in Healthcare: How COVID-19 Ravaged One of the Wealthiest African American Counties in the United States.* Social Work in Public Health, 2020: p. 1-10.
80. Ford, C.L. and C.O. Airhihenbuwa, *The public health critical race methodology: Praxis for antiracism research.* Social Science & Medicine, 2010. **71**(8): p. 1390-1398.
81. Bailey, Z.D., et al., *Structural racism and health inequities in the USA: evidence and interventions.* The Lancet, 2017. **389**(10077): p. 1453-1463.
82. Peek, M.E., et al., *COVID-19 Among African Americans: An Action Plan for Mitigating Disparities.* American Journal of Public Health, 2021. **111**(2): p. 286-292.
83. Wallerstein, N.B., I.H. Yen, and S.L. Syme, *Integration of Social Epidemiology and Community-Engaged Interventions to Improve Health Equity.* American Journal of Public Health, 2011. **101**(5): p. 822-830.
84. *Reaching across the divide; finding solutions to health disparities.* 2007.
85. *Meaningfully Connecting with Communities in Advocacy and Policy Work*. 2019, Aspen Planning and Evaluation Program.
86. Brennan Ramirez LK, B.E., Metzler M., *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.*, U.D.o.H.a.H. Services, Editor. 2008, Centers for Disease Control and Prevention: Atlanta.
87. Israel, B.A., et al., *Review of community-based research: assessing partnership approaches to improve public health.* Annu Rev Public Health, 1998. **19**: p. 173-202.
88. Wallerstein, N., & Auerbach, E., *Problem-posing at work: Popular educators guide (2nd ed.).* Edmonton: Grass Roots Press., 2004.
89. Disparities, C.W.G.o.t.N.C.E.A.C.A.C.-. *Tips for Building and Maintaining Community Trust in COVID-19 Resources*, N.I.o. Health, Editor. 2020.
90. Savoia, E., et al., *Predictors of COVID-19 Vaccine Hesitancy: Socio-demographics, Co-Morbidity and Past Experience of Racial Discrimination.* medRxiv, 2021: p. 2021.01.12.21249152.
91. Peretz, P.J., N. Islam, and L.A. Matiz, *Community Health Workers and Covid-19 — Addressing Social Determinants of Health in Times of Crisis and Beyond.* New England Journal of Medicine, 2020. **383**(19): p. e108.
92. Scharff, D.P., et al., *More than Tuskegee: understanding mistrust about research participation.* Journal of health care for the poor and underserved, 2010. **21**(3): p. 879-897.

93. Wallerstein, N. and B. Duran, *Community-Based Participatory Research Contributions to Intervention Research: The Intersection of Science and Practice to Improve Health Equity.* American Journal of Public Health, 2010. **100**(S1): p. S40-S46.
94. *Partnering with Communities to Address COVID-19 : The NIH Community Engagement Alliance (CEAL) Against COVID-19 Disparities*, N.I.o. Health, Editor. 2020.
95. *Framework for Equitable Allocation of COVID-19 Vaccine*. 2020: Washington, DC.
96. *MOREHOUSE SCHOOL OF MEDICINE*. National Covid-19 Resiliency Network 2020; Available from: https://ncrn.msm.edu/s/about-us?defaultFieldValues=pageName%3DAboutUs&language=en_US&targetlanguage=en_US.
97. Wilson, B.B., *Resilience for All: Striving for Equity Through Community-Driven Design*. 2018: Island Press.
98. Gibson, C.M., *Citizens at the Center: A new approach to civic engagement*. 2006, The Case Foundation.
99. Foundation, K. *Community Democracy Workshop*. May 21-22, 2014; Available from: https://philanthropynw.org/sites/default/files/resources/Notes%20CDW%20at%20Kettering-2014-05.pdf.
100. Development, C.f.C.H. *Community Tool Box.* [cited 2021 March 7]; Available from: https://ctb.ku.edu/en/table-of-contents.
101. *Community-At-Large Sector Questions An excerpt from the Community Health Assessment aNd Group Evaluation (CHANGE) Tool*, C.f.D.C.a. Prevention, Editor.
102. Harwood, R.C., *Putting Community in Collective Impact*, in *Collective Impact Forum*. 2016, Harwood: The Institution for Public Innovation. , Charles F. Kettering Foundation.
103. UNICEF, *Advocacy Toolkit: A guide to influencing decisions that improve children's lives*. 2010: New York.
104. Times, T.N.Y. *See How the Vaccine Rollout Is Going In Your State*. 2021; Available from: https://www.nytimes.com/interactive/2020/us/covid-19-vaccine-doses.html.
105. Nambi Ndugga, O.P., Latoya Hill, Samantha Arrtiga, Salem Mengistu, *Latest Data on COVID-19 Vaccinations Race/ Ethnicity*, KFF, Editor. 2021, KFF.
106. Nada Hassanein, G.H., Jayme Fraser, Aleszu Bajak, *'Just not equal at all': Vaccine rollout in Chicago a microcosm of racial disparities nationwide*, in *USA Today News*. 2021: Online.
107. NIH. *Ending Structural Racism — UNITE*. 2021; Available from: https://www.nih.gov/ending-structural-racism/unite.
108. *Coronavirus in the U.S. Latest Map and Case Count*. 2021 [cited 2021 April 17]; Available from: https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html.
109. Simon, S., *Michigan Sees Surge In COVID-19 Among Children*, in *NPR*. 2021.
110. Facher, L., *Biden officials rebuff appeals to surge Covid-19 vaccine to Michigan amid growing crisis*, in *STAT*. 2021.
111. Prisons, F.B.o., *Inmate Race*. 2021.
112. Project, T.M. *A State-by-State Look at Coronavirus in Prisons*. 2021; Available from: https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons.
113. Beusekom, M.V., *Studies detail large COVID outbreaks at US prisons, jails*, in *Center for Infectious Disease Research and Policy*. 2021.
114. Hamish Robertson, J.T., *The Necropolitics of COVID-19: Will the COVID-19 pandemic reshape national healthcare systems?* 2020.

115. CDC, *COVID Data Tracker — Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States*. 2021.
116. Yuko, E., *Why Are Black Communities Being Singled Out as Vaccine Hesitant?*, in *Rollingstone*. 2021.
117. Reverby, S., *Racism, disease, and vaccine refusal: People of color are dying for access to COVID-19 vaccines.* PLos Biol, 2021. **19 (3) : e3001167**.
118. Reverby, S., Hammonds, EM., *Taking a Medical History: COVID, "Mistrust," and Racism*, in *The Mudsill*. 2021.
119. Corallo, B., Artiga, S., Tolbert, J., *Are Health Centers Facilitating Equitable Access to COVID-19 Vaccinations? An April 2021 Update.* 2021, Kaiser Family Foundation.

APPENDICES

Appendix 1: AdvocateAurora Healthcare System & The Center for Faith & Community Health Transformation Community Leadership Voices Action Brief

Community Leadership Voices Action Brief

Trust, Social Determinants, and Vaccine Acceptance: Lessons Learned from 10 Years of Influenza Prevention Outreach

AdvocateAurora Healthcare System & The Center for Faith & Community Health Transformation

Key Message AdvocateAurora Health and their partner, The Center for Faith & Community Health Transformation (The Center), both serve communities facing health disparities in northern Illinois. Both entities engage in community engagement initiatives that are dedicated towards improving health and cultivating authentic trust. Their work relies heavily on partnerships with other community-based and faith-based organizations that also work to reduce health inequities. In response to tremendous hardship related to COVID-19, action recommendations revolve around using an asset-based approach, addressing systemic issues, and creating authentic community partnerships.

Community of Concern The communities served by AdvocateAurora and The Center reside in low-income, communities of color in Chicago's South Side, Kenosha, the greater Milwaukee area, and the Green Bay neighborhood in Milwaukee. These areas make up a diverse population with varying cultures, and largely include African Americans, Latinos, and different religious groups, such as the Muslim community. All of these residential areas face high community hardship scores, low socioeconomic issues, and high inequities in life expectancy.

Priority Community Issues & Challenges Based on 2020-2022 Community Health Implementation Plans created by Advocate Healthcare, the top community priorities from 2019 include healthy lifestyles/obesity, behavioral health, social determinants of health**,** mental health, diabetes, and food insecurity. [1,2] As of 2021, these priorities have expanded to include COVID-19 related services (i.e. testing, vaccines, and education). AdvocateAurora Health has identified specific SDOH that widen the gap in terms of life expectancy. These SDOH include housing, community safety, workforce development, food security, access to mental health services, and access to primary care services. In response to the pandemic, these SDOH have been amplified in communities already dealing with sever disparities. There is heightened concern for the health of these communities especially as it relates to COVID-19 vaccine hesitancy and mistrust.

Trusted Community Leadership Experience and Voices Kirsten Peachy has been working with Aurora Health in Faith and Partnership for 20 years and has been with The Center since its inception 11 years ago. In her role at AdvocateAurora Health, Kirsten is the Vice President of Faith Outreach, Mission and Spiritual Care, where she supervises the Community Faith Based Nursing Program, and does program management, staff management, co-building and collaboration with community partners. Kirsten is also a Co-Director at The Center where she carries out administrative tasks and acts as a convener to bring people together to identify where communal issues lie. Success in both of her roles requires her to take a deeply relational approach in her work, be committed to collaboration, and value the power and wisdom that come from inclusive spaces.

Over the years, The Center has proven to be a leader in defining faith and health work around engaging the root causes of health disparities, focusing on health equity, and integrating powerful, theological, and spirit-based frameworks into their work. The vision of this collaborative body is to promote loving communities through love, justice, and wholeness, where all people can be healthy. This is carried out by their mission to engage faith communities around social conditions

[1] Advocacy Trinity Hospital, "Community Health Implementation Plan (2020-2022)."

[2] Advocate Illinois Masonic Medical Center, "Community Health Implementation Plan (2020-2022)."

that directly impact people's health. Through leadership development, community building and mobilizing the unique spirit and power of people of faith, The Center has cultivated a trusted environment that is accessible and collaborative.

Organization Commitments and Services

AdvocateAurora Healthcare System is a not-for-profit health system that houses several hospitals in northern Illinois and the eastern parts of Wisconsin. It is one of the ten largest health care systems in the country. Aurora Healthcare, a Wisconsin health system, merged with Advocate Health, an Illinois faith-based healthcare system affiliated with the Lutheran church, about three years ago. Although the AdvocateAurora Healthcare System itself is not faith-based, it does encompass several hospitals and programs that maintain their original identity. One of these programs is the Community Faith Based Nurse Program within Advocate Health that addresses community needs in the mental health and HIV sectors. The community strategy lead by AdvocateAurora Health is to identify and address the social determinants of health (SDOH) that can reduce disparities in life expectancy. The healthcare system is guided by mission, justice, excellence, and caring for the surrounding communities.

The Center for Faith & Community Health Transformation (The Center) is a partnership initiative that began with Advocate Health in Illinois. The collaborative body works with other healthcare organizations, community-based organizations, and faith networks to address social conditions that impact people's health. The Center arose from major collaboration between the University of Illinois and the Chicago Department of Public Health and has since brought together other organizations, healthcare systems, faith communities, and churches who are doing similar work. In a commitment to be a more fluid entity, The Center largely identifies as a collaborative movement rather than a specific organization.

Capacity & Successes: Cultivating Trust

In order to build an environment rooted in authenticity and community receptivity, the goal should not be centered simply around cultivating trust, rather it should be focused on building meaningful connections that lead to improving community health. The community strategies carried out by the Community Faith Based Nurse Program and The Center highlight actions that focus on community wellbeing, and incidentally develop trust. These strategies include building a loving community, engaging in committed partnerships and developing community leadership.

Building A Loving Community The Center focuses on building communities where there is love being expressed, not only through caring relationships, but also through structural components that help improve health and wellness. Love is seen as a commitment to caring for people as dignified, whole, and worthy individuals. The Center looks at how this kind of love can impact policies at the community level and in what ways it can foster a feeling of connection and trust. It is through this type of love that the community can work towards building social cohesion, encourage restorative justice, and foster a space that provides adequate resources and services for the community's health needs.

Committed Partnerships As a body that is built on collaboration and partnerships, The Center's work would not be possible without community relationships. These partnerships have been invaluable to expanding the capacity of The Center and addressing community health needs. A good partnership requires the collaborating entity to remain present and committed to the relationship, even if it's not always in their interest to do so. Intervening entities should not wait until they need the community's help to meet or cultivate a relationship with them.

Leadership Development One of the primary areas where The Center focuses its efforts is in nurturing leaders. They do this through "bringing together leaders from congregations, health providers, universities, and community organizations to connect with their own wisdom and calling, to learn others' languages and to foster collaborative work." [3] Depending on where the communities needs lie, The Center provides educational material

[3]"About the Center," https://www.faithhealthtransformation.org/who-we-are/.

for leaders to build more knowledge around the complexities of the issue. As their focus over the last couple of years has shifted to trauma and resilience, the education materials center on integrating these topics with faith. These educational opportunities teach faith leaders what these mental health concepts are or what implication that have on their own communities. Additionally, these programs help identify what skills and resources the community can use to address the issues in their congregation and the community at large. Other activities include providing interactive community meetings around specific topics and offering a training curriculum that allows leaders to teach other people about the material. These different practices promote congregational dialogue that encourages community members to think about their social conditions and teaches them how to take action to address issues themselves.

Essential Principle-Based Actions In addressing all future health challenges, there is an opportunity to approach them through a life perspective, as opposed to a deficit approach. An asset-based lens can fundamentally shape the approach that is taken. There are countless ways in which social structures can harm or uplift health, especially when discussing the malleability of the social determinants of health. It's important to keep bringing the conversation back to what is working or thriving, so that those structures can be built upon.

While taking an asset-based approach, calls to action should be rooted in systemic thinking to address social and environmental conditions. There is a need to actively work towards addressing the root causes of the disparities in life expectancy. This means focusing on disenfranchised communities that have been hardest hit by the pandemic and working with them to address their priorities. Many of these communities are dealing with concrete issues of food insecurity, lack of transportation, or are struggling to provide for their families. Asking them to go out of their way to get a vaccine is going to be low on their list of priorities. Even so, there should be conversations with community members to discuss what the COVID vaccine means to them and what influences their decision one way or another. For many populations, the decision behind declining the vaccine is very fluid and nuanced. It's important that providers honor and respect this decision and be receptive to the community member's concerns.

Finally, there should be an overall emphasis on working with and alongside communities and their leaders. Especially in a time where mistrust is rampant, there needs to be a push to engage community members or leaders to transmit messages and act as sources of credible information. These roles can be filled by anyone from the community, however, it's best if the individual already speaks the language and has a network of communal relationships. This ambassador can provide accurate information to the community they are serving, as well as connect them to COVID services, such as testing or vaccine sites. In order to maintain a reciprocal relationship, community liaisons should be compensated. To truly maintain a relationship rooted in trust and reliance, it's critical to invest in the community by providing concrete and tangible resources.

References

Center, Advocate Illinois Masonic Medical. "Community Health Implementation Plan (2020-2022)."

Hospital, Advocacy Trinity. "Community Health Implementation Plan (2020-2022)."

Peachey, Kirsten. "Advocacy Tool Interview Guide - Advocateaurora Health & the Center for Faith and Community Health Transformation." By H. Ranson (February 2nd 2021).

Appendix 2: Buddhist Tzu Chi Medical Foundation – National Headquarter Community Leadership Voices Action Brief

Community Leadership Voices Action Brief

Trust, Social Determinants, and Vaccine Acceptance: Lessons Learned from 10 Years of Influenza Prevention Outreach

Buddhist Tzu Chi Medical Foundation – National Headquarters

Key Messages Buddhist Tzu Chi Medical Foundation is considered a trusted messenger for the community, as a provider that honors and respects the cultural background of each of the individuals it serves. It provides a safe space where vulnerable populations can access services without having to worry about their ability to pay. The organization has earned the community's trust through program outreach and messaging that works around social and environmental barriers to health. Their immediate action recommendations are to prioritize community context and commit to equity, while long-term, they recommend participating in a collective dialogue.

Community of Concern Buddhist Tzu Chi Medical Foundation's National Headquarters is located in San Dimas, California and serves 6 of the 8 service planning areas that make up Los Angeles County. LA County's population is 48.6% Hispanic or Latino, 15.4% Asian, 9.0% Black or African American, and 26.1% white,[1] with Los Angeles County being home to the largest Asian population in the U.S. Those who seek services from Tzu Chi are mainly vulnerable populations that face barriers to access due to underlying social determinants of health. These populations include individuals with a low socioeconomic status (SES), homeless persons, refugees, elderly, and individuals who face language barriers.

A 2019 Community Health Needs Assessment carried out in Baldwin Park, a city in service planning area #3 of LA County, determined the city to be in the 42nd percentile for health opportunity in California. This meant nearly 6 in 10 Californians had the opportunity to live a longer, healthier life than the residents living in Baldwin Park.[2] Based on a 2015-2020 Community Health Improvement Plan for LA County, health priorities included chronic disease, access to care, community safety, substance abuse, education, and affordable housing.[3] As of 2021, priorities mentioned by community leader, Debra Boudreaux, have expanded to also include COVID-19 related services.

All of the priorities mentioned are underlined in communities of color, especially for those who are undocumented, as there is a hesitancy to seek services due to the threat of being deported.

Priority Community Issues & Challenges
The health priorities recognized by community needs assessments and community leader Debra Boudreaux are all interconnected and can be discussed in relation to the overall category of accessibility.

The barriers to healthcare access are expansive and are often tied to the social determinants of health. The COVID-19 vaccine distribution plan has largely maintained an online platform. This technology and broadband requirement cuts off many low-income, vulnerable populations from being able to register for a vaccine appointment. This is especially prevalent for elderly populations that live alone and require technical assistance. Additional factors that contribute to accessibility include compromised vision, disability, lack of transportation, lack of time or capacity to continuously check for open appointments, confusing terminology used in mandated appointment forms, lack of education around the vaccine, and a complicated user-base that only provides information in English. The entire distribution process is over complicated, and it creates endless hurdles for disenfranchised communities. These communities are often left out of process development, which further excludes them from health services.

[1] "Los Angeles County, California," (United States Census Bureau, 2019).
[2] "2019 Community Health Needs Assessment," (Kaiser Permanente, 2019).
[3] Los Angeles County Department of Public Health, "Community Health Improvement Plan " (County of Los Angeles Public Health 2015-2020).

Trusted Community Leadership Experience and Voices

Community liaison and organization leader, Debra Boudreaux, has been working with the public health sector and the homeless consortium for more than 25 years. She currently sits as the Executive Vice President for Buddhist Tzu Chi Foundation, in which she volunteers her time as a Buddhist, faith-based commissioner. In her role she acts as an informant for both the community and government representatives in order to showcase what resources are needed to improve the capacity of community grassroots. Debra is driven by her innate sense of compassion and determined curiosity to improve her community's health. It is through years of experience that she has developed the wisdom to overcome barriers and identify root causes in order to build more equitable solutions.

Organization Commitments and Services

Buddhist Tzu Chi Medical Foundation is an international humanitarian organization with 9 regional centers in major hubs across the US. These include New York, New Jersey, District of Columbia (DC), Chicago, Houston & Dallas TX, Northern California, Southern California, San Dimas, and Hawaii. The organization has been serving these communities for over 32 years and is well-known among the Asian immigrant population. The mission of the organization is to "help those in need with love and care."[4] In Chinese, the organization's name "tzu" means compassion and "chi" meaning relief. The values of the organization are to serve with compassion, relieve with joy, leave no one behind, and give without asking for anything in return.

The National Headquarters office in San Dimas, California juggles a unique set of responsibilities caring for the surrounding communities, as well as responding to issues raised by other regional hubs. The success of the organization comes from collaboration with other community faith-based and non-profit organizations.

Capacity & Successes: Cultivating Trust

Over the years the organization has provided consistent and invaluable support to the surrounding populations which has created an environment of trust. The past year has not proven to be any different, as the organization has participated in endless engagement with the community in attempts to mitigate COVID-19 spread. The various ways the organization has developed and maintained trust can be discussed in the themes of community outreach and communication, partnerships and collaboration, and provision of resources and services.

Community Outreach & Communication Tzu Chi uses a multicultural perspective to center community context in all of their programs. Their outreach caters to all populations, languages, and cultures. They do this by hiring diverse staff that is representative of the communities they serve.

Tzu Chi has had to adjust and pivot engagement and communication strategies with social distancing constraints in place. The National Headquarters clinic published a Chinese newsletter that shares up-to-date information regarding COVID-19 and information about vaccine registration. The newsletter is accessible online and through social media where the information can be shared with friends, family members, and elders. The organization also uses WhatsApp to connect with the Asian population to share information quickly. For those populations without smartphones, they have used the Asian radio station and local TV stations for message dissemination. They have also largely participated in grassroots communication, asking people to share information with their next-door neighbors. This communication uses the assets of relationships, connections, and friendships to help spread messaging.

Partnerships & Collaboration Tzu Chi is in a unique position as a faith-based organization, as they have a strong network of ties to both community organizations and the interfaith community. The organization is a part of an interfaith dialogue that brings Buddhists, Catholics, and Jewish faith leaders together every month to discuss and share information around COVID-19. After the meetings, faith leaders use their own platforms to communicate with their congregations to update them and answer any questions they may have. Outside establishments,

[4] Tzu Chi USA, "Our Mission," https://tzuchi.us/offices/hq.

like the CDC, have also reached out to Tzu Chi to partner in sharing informative messaging with the community. By joining CDC in the stakeholder team, the Tzu Chi has a voice in guiding a response that is motivated by compassion.

Provision of Resources & Services Tzu Chi National Headquarters has been involved in local, national, and global response to the COVID-19 crisis. The organization has provided more than 23 million masks to 119 countries, and continues to distribute PPE to churches, temples, and to communities living on the Navajo reservations in Arizona. Tzu Chi has also provided PPE and essential supplies to refugees at the Tijuana border. They have had 7 different sites where every month 500-800 food packages are distributed to individuals of low SES.

As well as providing resources, Tzu Chi also engages in delivering health services. Many of the volunteers that work at the foundation are trained under the Medical Reserve Corps and are considered a National Medical Association Volunteer. In the case their assistance is needed, they are qualified to provide medical services. These volunteers are a huge asset in sustaining the organization's credibility.

Essential Principle-Based Actions

Recommendations proposed by the Buddhist Tzu Chi are based both in past organizational practice, as well as in key insights from organizational leader Debra Boudreaux. The immediate actions that should be taken lie within prioritizing community needs and committing to access, whereas long-term actions revolve around collective dialogue.

Immediate Action: Prioritizing Community Needs The pandemic affected communities of color most disproportionately due to social and environmental factors that put them more at risk. The vaccine distribution plan should have considered these risk factors in tailoring the response. However, the complex and inefficient roll-out process has perpetuated inequitable access to the vaccine. At this point, the monitoring and evaluation process should be standardized, so that counties can at least compare statistics. With each state having their own agenda and roll out process, it creates further issues of inequity. A unified system that eliminates hurdles for widespread aid must be developed. Policy makers and administrators creating roll-out programs for vaccine allocation must be more connected to what the community needs and how community context will affect their intervention.

Immediate Action: Commitment to Access In order to foster credibility and build community participation, entities must follow through with promised services in a reasonable timeframe. They cannot say they are providing the vaccine to anyone who wants it, and then turn their back on people that are facing barriers to access.

As a greater collective, everyone should be working together on the county, city, and community level. There needs to be clear communication and an agreed upon goal that everyone can work towards—no matter their knowledge or experience.

Long-term Action: Collective Dialogue In the time of governmental transition, there happens to be a lot of positive change, however, this change can also disrupt the status quo of government agencies, public health, state health, and grassroot initiatives. Although this is inevitable, the negative consequences can be mitigated through a standard operating procedure that does not change with new leadership. There is a need to really communicate with one another and share personal wisdoms, so that everyone may learn from one another.

The leaders of these conversations must include public health, state health officials, medical institutions, organization leaders, and hospital associations. These conversations can help shape health promotion messaging to fit the needs and context of the community, while also providing relevant, and accurate information. Rather than using confusing language around technicalities and policy, community health communication and messaging needs to be streamlined and transparent. All the best services can be provided, but without simple, informative messaging, that prioritizes community context, these services will go unused.

References

"2019 Community Health Needs Assessment." Kaiser Permanente, 2019.

Boudreaux, Debra. "Advocacy Memorandum: Buddhist Tzu Chi Medical Foundation – La, Ca." By H. Ranson (2/4/21 2021).

Health, Los Angeles County Department of Public. "Community Health Improvement Plan ": County of Los Angeles Public Health 2015-2020

"Los Angeles County, California." United States Census Bureau, 2019.

USA, Tzu Chi. "Our Mission." https://tzuchi.us/offices/hq.

Appendix 3: Detroit United Health Organization Community Leadership Voices Action Brief

Community Leadership Voices Action Brief

Trust, Social Determinants, and Vaccine Acceptance: Lessons Learned from 10 Years of Influenza Prevention Outreach

United Health Organization

Key Messages United Health Organization (UHO) has served the Detroit community for 54 years through various program iniatives directed at improving health. With a heavy focus on disease prevention, health education, and community engagement, the organization helps fight against systemic disparities. A current program, Christ Over COVID Antibody Prevalence Project, is directed at removing barriers to access for COVID related services, like testing and immunization. The organization's immediate action recommendation calls on outside entities to engage in transparent partnerships, while the long-term recommendation focuses on addressing systemic racism.

Community of Concern The communities served by UHO mostly reside in Wayne County, Detroit where there is a rich diversity of populations, including African Americans, Hispanics, Greeks, Asians, Polish, eastern Irish, eastern Indians, and Native Americans. The populations that seek services from UHO are on average between ages 35 and 45. Of the 1.75M residents that live in Wayne County, 22.7% were said to have been living in poverty and 9.7% were without health insurance in 2019. [1] In the city of Detroit, the disparity in individuals without insurance is even higher at 13.7%.[2]

Based on a Community Needs Assessment conducted in 2019, the top community priorities were transportation, housing availability, financial capacity, early education, and substance abuse.[2] As of 2021, community leaders Velisa Perry and Sekani Johnson, expanded on those priorities to include health care access, food access, COVID-19 related services, systemic inequities, and deep-rooted systems mistrust.

Priority Community Issues & Challenges Several of health priorities overlap and can be discussed under the systemic inequities and social determinants of health.

Systemic Inequities The issue of structural racism is persistent in all health disparities facing communities of color. As an institutional issue, it impacts everything, and is most apparent in sectors like transportation, finance, health care access, etc. Issues of institutional mistrust relates back to issues perpetuated by structural racism, specifically relating to poor community support and lack of resources provided by the government. Before the pandemic hit, Wayne County was dealing with chronic diseases, like heart disease and diabetes. They were an easy target for COVID-19 to affect those living with pre-existing conditions. COVID-19 has devasted these communities, however, it is nothing compared to what institutional racism has done.

When generational, systemic, and lived-experience mistrust is inherent, anything the government presents as "aid" won't look like aid to these communities. Without recognition and acknowledgement that these issues exist, the internal biases and subconscious racism will continue to fuel white supremacy. The dehumanization of populations of color engrains in them that they must bury their voice and be subservient instead of powerful. It demolishes people's sense of self-worth and agency for change.

Social Determinants of Health The social determinants of health (SDOH) can directly challenge access to basic human rights like food, health care, education, and housing. Food desserts are prevalent across Wayne County and negatively impact the health of community members. Lack of access to oral or general health care compounds these issues of nutrition-related morbidity.

Trusted Community Leadership Experience and Voices Velisa Perry and

[1] Thomas P. Miller & Associates, "Community Needs Assesment : Wayne County, Michigan," (Wayne Metropolitan Community Action Agency, 2019).

Sekani Johnson are invaluable staff members of UHO. Velisa is the Executive Director of the United Health Organization and facilitator of Project Healthy Living and the Wayne County Oral Health Coalition. She has been in this specific position for about a year but has been with UHO for about 12 years. Since she was a little girl, Velisa has been working with the Detroit community. Her experiences of losing loved ones to preventable diseases has propelled her in her work of centering prevention and knocking down barriers to access. As a visionary for her community, Velisa helps shape the future of Detroit with her resilient spirit and commitment to exceed expectations.

Sekani Johnson is the Assistant Director for UHO, in which he serves as a liaison for communications and as a convenor between partners. He has been in this position for about 3 years but has been informally associated with UHO for about 12 years. Sekani provides a generational bridge for UHO, as he is instrumental in reaching the younger generation through relational communication. Sekani's passion for helping others fuels him in his work. He leads by the principle that 'nothing about yourself matters more than the result you're able to give to your community.' His outlook and ability to work with younger populations makes him a key component in paving the path for UHO's future.

Organization Commitments and Services

UHO is a Detroit-based nonprofit that provides services to areas in southeast Michigan. UHO has been working to reduce preventable morbidity and mortality within these communities since 1967. Their mission is to encourage empowerment in community voice and expand access to services and resource in order to improve the health and quality of life in southeast Michigan. The organization further works towards their goals through the detection of asymptomatic diseases, health education and community engagement. Other key areas of focus include SDOH, social justice, and fighting systemic disparities.

One of UHO's longest running initiatives, Project Healthy Living (PHL), provides free and low-cost health screenings, or services, to about 10,000 participants annually.[2] This long-term program has provided a gateway for community-based and health-based organizations to connect with hard-to-reach populations. UHO's decades of community commitment has allowed it to become a resounding beacon of trust and support. In building partnerships, UHO is able to expand its capacity by transferring trust to other partners. Another central program of UHO is the Wayne County Oral Health Coalition. It was created to act as a convener for resources across partners. The Oral Health Coalition helps amplify the voice of the organization by pushing out information to local partners. The focus of this program is to improve access to oral health and subsequently improve overall health and wellness.

Capacity & Successes: Cultivating Trust

After over 50 years of providing services to the surrounding communities, UHO has established numerous partnerships, nurtured long-term relationships, and fostered a space worthy of trust. UHO relied on several key strategies to build and maintain an authentic environment grounded in fidelity, including building partnerships, providing resources & services, and engaging the community.

Partnerships Well known for its collaborative background, UHO has maintained an influence in the communities it serves by building relationships with local organizations and faith-based entities. Their partnerships have helped them identify trusted messengers and gather enormous amounts of resources to share with underserved communities. These partnerships thrive from open, honest, and consistent communication.

Resources & Services The coalitions and programs initiated by UHO provide communities with tangible services and resources that directly impact health. The Project Health Living initiative has helped save people's lives through health screenings and services that many people would lack access to in a hospital setting. Through pop-up clinics, PHL has worked hard to reach vulnerable communities and provide resources.

A more recent program carried out by UHO, Christ Over COVID Antibody Prevalence Project (COCAPP), serves as a foundational vehicle for the

[2] "Uho Historical Background Overview," ed. United Health Organization (2021).

V. Perry, Johnson, S. , interview by H. Ranson, February 16th, 2021.

organization to provide communities with resources, educational information, and access to COVID-19 services. COCAPP has partnered with faith-based organizations and African American churches around Detroit to share accurate information through trusted messengers. This information is integrated with a faith-based component to give congregates a comprehensive understanding of how COVID-19 works and why it should matter to them. Through this program, UHO's Wayne County Oral Health Coalition is also able to provide these populations with interactive educational material around oral health.

Engage the Community The work of community-based organization would be obsolete without community members participating in the action. UHO has curated an expertise for designing community interventions that cater to the exact needs of the community at that time. In their long history of service, UHO has delivered on all of their promises—making them a dependable and trustworthy community presence.

The volunteers and staff of UHO all started out as community members who wanted to give back and make a change in their community. A sense of agency among participants is often built from members being able to see themselves represented in leadership positions. UHO sets out to leverage people's talents and provide a vehicle for them to make their own informed decisions. It's through building confidence and engaging members in programs that UHO has empowered their communities to take action in change and build a sustainable future.

Essential Principle-Based Actions

Recommendations proposed by the UHO are based both in past organizational practice, as well as from lived experiences from organization leaders Velisa Perry and Sekani Johnson. The immediate action that should be taken is transparency in community partnerships, whereas long-term actions revolve around addressing systemic racism

Immediate Action: Transparent Partnerships In order to effectively communicate, partners should feel like they are able to relate to one another, whether it's through facing similar issues in their community or taking on similar strategies in handling those issues. Sharing vulnerabilities allows partners to build a deeper connection through recognition of an authentic voice. This authenticity provides transparency to the conversation and eliminates the need for a hidden agenda, which can be toxic to trust. A community leader acts as the gatekeeper for protecting community health, which requires them to be highly selective when engaging with new partners. Thus, it's important for partners to build an authentic rapport and foster trust through consistency of communication and actions.

Long-term Action: Addressing Systemic Racism The issues of the pandemic reach far beyond the virus and lie on a structural level. Health inequities are driven by systemic racism. These issues must be addressed at the policy level to dismantle the oppressive systems at play. It's important that there is representation of people of color at the political level where decisions are being made.

There must be a reckoning that acknowledges the covert and overt systems that dehumanize Black, Indigenous, multi-racial, people of color (BIMPOC). There should be more mandatory trainings and educational opportunities to address issues of systemic racism and white supremacy, as a portion of the country is blind to these problems. Addressing these issues requires a broadened approach, which means incorporating voices, young and old, from different backgrounds and races to engage in dialogue around racial equity. White individuals need to use their power to amplify BIMPOC voices and act in partnership to dismantle the system of white supremacy.

Lastly, in addition to past transgressions being acknowledged, there must be reparations paid to communities of color. Generational wealth has been stripped from people of color, leaving many families in cycles of debt that inhibit future opportunity. The investment BIMPOC and their ancestors have put in to creating this country should be monetized. This includes putting money back into low-income communities of color through funding and grants. This investment should contribute to infrastructure, supply resources, and provide communities with the services they need.

References

Associates, Thomas P. Miller &. "Community Needs Assesment : Wayne County, Michigan." Wayne Metropolitan Community Action Agency, 2019.

Perry, V., Johnson, S. . "Advocacy Tool - Detroit United Health Organization." By H. Ranson (February 16th 2021).

"Uho Historical Background Overview." edited by United Health Organization, 2021.

Appendix 4: Lowell Community Health Center Community Leadership Voices Action Brief

Community Leadership Voices Action Brief

Trust, Social Determinants, and Vaccine Acceptance: Lessons Learned from 10 Years of Influenza Prevention Outreach

Lowell Community Health Center

Key Message Lowell Community Health Center is a federally qualified health center in Lowell, Massachusetts. They provide quality, culturally competent, patient-centered care to communities in the Greater Lowell area, regardless of their ability to pay. Their work in reducing health disparities and empowering individual's autonomy over health is made easier with the authentic trust they have built with their community. In response to tremendous health disparities related to COVID-19, the Health Center's immediate call to action is to center the community in response efforts, while their long-term action recommendation is to prioritize public health.

Community of Concern Lowell community has a large immigrant presence that makes up 26.7% of the population.[1] The patients who seek care from Lowell Community Health Center (LCHC) are predominantly white, however, 40-45% are people of color, and include populations that are Southeast Asian, African-born immigrants, and Hispanic or Latino. LCHC provides services all the way from pre-birth to geriatrics.

Based on a Community Health Needs Assessment conducted in 2019, the top community priorities were mental health issues, substance addiction, alcohol abuse/addiction, cancer and nutrition.[1] As of 2021, community leaders Mercy Anampiu and Jeanmerli Gonzalez expanded on these priorities to also include systemic barriers to health care access and equitable access to COVID-19 services.

Priority Community Issues & Challenges Foundational flaws in U.S. systems perpetuate institutional barriers that limit access to essential services. In considering barriers, factors from the most basic level must be prioritized. Addressing systemic issues requires looking at the root causes and acknowledging the stream of barriers that comes from poor socioeconomic status, immigration status, literacy, and institutional racism. Issues related to utility needs, food supply, toiletries, housing, employment, and transportation all have direct impacts on health care access and personal wellbeing. The pandemic has exacerbated these issues, especially with a new sole reliance on technology to provide services. This reliance creates challenges for those who do not have access to the internet or technology. However, it is also compounded for those individuals who face language barriers or illiteracy.

Trusted Community Leadership Experience and Voices As invaluable leaders of the LCHC, Mercy Anampiu and Jeanmerli Gonzalez have curated an environment dedicated to community wellbeing. Mercy Anampiu is the Director of Community Health Programs and has been with LCHC for over 16 years. During her time at the Health Center, Mercy has served in several roles, including as a medic, community health worker, medical interpreter, coordinator, and manager. In her current role she oversees different aspects of the health center, including language access, community health worker trainings in the Community Health Education Center, and community-based interventions. As a member of several task forces and boards in the Lowell area, Mercy also serves as a convenor to bring organizations and resources together. Knowing LCHC and the broader community depend on her, Mercy is driven in her work to provide patient centered care and advocate for community health needs.

Jeanmerli has been with LCHC for about two years. She currently serves as the Community Outreach Coordinator in which she connects the Health Center to the community by providing resources, services, and general information about LCHC's health initiatives. In attempts to meet the

[1] D. Turcotte, Adejumo, K., Leon, C., You, K.J. , "2019 Greater Lowell Community Health Needs Assessment," (Lowell General Hospital, 2019).

M. Anampiu, Gonzalez, J. , interview by H. Ranson, February 17, 2021.

community where they are at, the Health Center participates in community-based events where they can interact with hard-to-reach populations. Jeanmerli builds connections with community members and shares information with them about LCHC's accessible health services. Jeanmerli is inspired by the dedication and passion shown by other LCHC staff and is driven to go farther in her work to match that level of commitment.

Mercy and Jeanmerli are the face of LCHC for so many people. They work on the frontlines of community health and are the voices that participants trust. As members of the community themselves, they are truly invested in their work to leverage health equity and improve health for all members.

Organization Commitments and Services

LCHC is a federally qualified health center that serves the northeast region of Massachusetts. The organization is focused on both primary and community health extension to try and reach populations who face disadvantages for health care. The mission of Lowell Community Health Center is to provide caring, quality, and culturally competent health services to people of Greater Lowell, regardless of their financial status; to reduce health disparities and enhance the health of the Greater Lowell community; and to empower each individual to maximize their overall well-being. Their values are empathy, patience, and cultural responsivity.

One of LCHC's key sites is the Metta Health Center, which follows an East meets West model of care. The Metta Center, "Metta" meaning loving kindness in the Buddhist Pali language, is one of the nation's first fully integrated sites to take this kind of cultural approach. The site offers western medicine, multi-lingual health care providers, and a diverse staff that represents the population it serves. The staff on site speak a range of 28 languages, which helps bridge the gap between the provider and patients, who are largely from refugee and immigrant populations. Their services include primary care for all ages, chronic disease management, nutrition counseling, mental health services, traditional healing advice, social services, health education, etc.

Another key division of LCHC is the Community Health Education Center (CHEC). The center provides cross-training, education, and professional development, a comprehensive certification programs, health modules, and advanced seminars and workshops for community health workers.[2] They are 1 of 3 public health education training centers in the state. CHEC is a vehicle for collaboration and partnerships, bringing together regional advisory boards, outreach educators, and other constituencies to learn together how to target community health needs. [2]

The aim of LCHC is to provide culturally appropriate services for everybody, regardless of immigration or financial status. In providing compassion-driven care, which goes beyond meeting primary needs of the patient to also address broader social needs, LCHC has fostered an environment worthy of community trust.

Capacity & Successes: Cultivating Trust

LCHC has built a trusting and authentic relationship with Lowell community by engaging in several community-based initiatives, providing accessible patient centered care, and building partnerships with other trusted community messengers. The Health Center started with the basics, beginning with grassroots led initiatives and a community-based method in targeting their interventions, they then built a network of trust by bringing in partners to expand capacity. The strategies discussed below will touch on LCHC's main ways of cultivating trust through a community-based approach and building partnerships.

Community-Based Approach A community-centered approach calls on all community leaders and community health workers to meet people where they are physically, mentally, socially, and emotionally. It's about arriving at a place where providers understand community context and can deliver accommodating care. This method requires cultural responsivity, which includes linguistically appropriate care and cultural cognizance of social

[2] "Community Health Education Center," Lowell Community Health Center, https://www.lchealth.org/professionals/community-health-education-center.

and medical practices. At LCHC, community health workers are offered trainings on cultural sensitivity to ensure they are meeting the needs of participants. Most importantly, staff takes the time to listen to the patient's concerns and explain the context behind healthcare forms or processes.

These practices are also utilized in the education and communication strategies deployed by LCHC. The organization's current education strategy is to engage in street outreach and target small groups of trusted messengers, like faith leaders, community-based leaders, and small businesses, to promote information around the COVID-19 vaccine. They are providing educational materials in English, Spanish, Portuguese, Cambodian, Swahili, and Arabic to cater to the entire population. Education around the vaccine and engaging in community conversations has raised enough awareness that the majority of people in the population want to receive it.

Partnerships LCHC's partnerships have helped them carry out their mission in a deeper capacity. In light of the pandemic LCHC has initiated a task force within the mayor's office to target COVID-19 in Lowell. This local government-based partnership was created to make sure Lowell is being considered in the COVID-19 response and that their voice is being heard.

Essential Principle-Based Actions

The issues of the pandemic only highlight the structural health issues that have weighted down communities for decades. Though the issues faced today are largely systemic, there are still practices that can be carried out to mitigate community health disparities. This requires immediate action of centering communities and a long-term action of prioritizing public health.

Immediate Action: Centering the Community
Community context should be at the forefront of any intervention, activity or health program. The target audience and their barriers to access must inform decisions around how health services are provided. To ensure equitable health care access for all, process barriers and bureaucracy must be removed. If systems were less complicated, it would help people recognize their eligibility for certain programs that could increase health care access. If these systems are meant to provide benefits to those who need it most, there should not be additional obstacles impeding this access.

As a system, there is often a rush to solve problems quickly rather than taking the time to understand the larger picture. This negates root causes and leads to apathetic practices that are not patient centered. If building trust is the goal, providers can't rush through processes and expect a patient to understand and accept the lack of context provided. There must be explanations behind required health forms, as lack of comprehension fuels patient's insecurities and reinforces the idea that health care is unattainable for them. There is power in vulnerability and authenticity. Providers should be open, honest, and real with participants if they want to build a rapport rooted in trust.

Along with systemic and provider bias, lack of empathy in these systems fuels' inequity. It takes listening to community members to identify what the best path forward looks like. There needs to be a collective step back to center voices of community members and the leaders they trust. Vaccine hesitancy should be recognized as a justified coping mechanism that is used prevent from past and current transgressions. Rather than putting the onus on communities to overcome this hesitancy, system should be cultivating environments worthy of trust.

Long-term Action: Prioritizing Public Health
Prior to the pandemic, public health and health prevention strategies were underappreciated and underfunded. Systemic issues often minimize concern around public health and health care prevention, which are both instrumental to correcting the system. Even though these sectors may not seem as pressing as issues of disease and food insecurity in critical moments, they are essential to remedying the cycle of health disparities. Public health is central to community health – it cannot take a backseat.

The COVID-19 virus has made it apparent that public health is a field that affects everyone. If one person, family, or community isn't vaccinated that problem is going to persist and threaten the entire population. The key is to promote health for everyone as a collective. This issue isn't singular, it is all encompassing. It requires people to find empathy and act in the interest of others.

References

Anampiu, M., Gonzalez, J. . "Advocacy Memorandum - Lowell Community Health Center." By H. Ranson (February 17 2021).

"Community Health Education Center." Lowell Community Health Center, https://www.lchealth.org/professionals/community-health-education-center.

Turcotte, D., Adejumo, K., Leon, C., You, K.J. . "2019 Greater Lowell Community Health Needs Assessment." Lowell General Hospital, 2019.

Appendix 5: Methodist Le Bonheur Healthcare & the Congregational Health Network Community Leadership Voices Action Brief

Community Leadership Voices Action Brief

Trust, Social Determinants, and Vaccine Acceptance: Lessons Learned from 10 Years of Influenza Prevention Outreach

Methodist Le Bonheur Healthcare & the Congregational Health Network

Key Messages Methodist Le Bonheur Healthcare System, their Mission Integration Division and their Congregational Health Network program have established and nurtured community trust through active community partnerships, engagement with faith-based leaders, and community-centered programs. By addressing the social determinants of health and putting an emphasis on commitment to care, their system has worked in partnership to mitigate health disparities. Their immediate call to action is to center community needs, while their long-term recommendation is to prioritize public health through adequate funding and shared power.

Community of Concern Methodist Le Bonheur Healthcare System serves Memphis and the surrounding area of Shelby County, Tennessee. Shelby County's population is 38.2% white, 56.6% African American, 2.7% Asian, 6.1% Hispanic, and 1.6% mixed race.[1] Although well known for its charitable giving, Memphis faces tremendous disparities and health challenges, especially in areas like poverty, crime, chronic disease, education, healthy food access, transportation, and housing. A 2019 Community Health Needs Assessment conducted by Methodist Health found the health priorities to be cardiovascular health, adult cancer care, maternal/infant/child health, access to health care, behavioral health, and addressing barriers to health.[1] As of 2021, priorities mentioned by community leaders, Niels French and Jonathan Lewis, have expanded to also include addressing social determinants of health (SDOH) and COVID-19 vaccine mistrust.

Priority Community Issues & Challenges Inequities in the SDOH drive the high rates of chronic diseases, poverty, education and health care access that occur in Memphis. The root challenges of inequities trickle down and lead to acute issues that directly impact health care access. Many patients come in with late-stage issues because they were unable to access the resources to address their initial concerns. This accumulation of chronic diseases causes healthcare systems to prioritize curative care versus preventive. Whereas the issue of health inequities are very much systemic and will not be eliminated with just one vector of strategies.

Although on the surface the issue of mistrust is around vaccine hesitancy, it stems far deeper. Distrust in the health care system accumulates over time due to a general lack of access, support, and inherent biases that affect people of color. Outside of healthcare mistrust, there is a greater sense of institutional mistrust that targets the government and other related industries. This issue has largely grown in the last year due to the spread of misinformation on the internet and a political failure to correct the spread of falsities. The issue of mistrust is a major concern because low vaccine acceptance will inevitably lead to higher morbidity and mortality from COVID-19.

Trusted Community Leadership Experience and Voices As invaluable assets to the Mission Integration Division at Methodist Health, Niels French and Jonathan Lewis have helped to curate an environment that supports and honors the communities they serve. Niels is the Director of Operations for the Division, in which he works directly with budgets, foundation grants, and keeping the division connected to the other sectors of the health care system. Over the past 15 years at Methodist Health Niels has helped run the humanitarian fund, which assists fellow associates in crisis situations, as well as with the family care center, a space where patient's families can stay overnight.

[1] "2019 Community Health Needs Assessment," (Methodist Le Bonheur Healthcare2019).

Another key player of the Mission Integration Division, Jonathan is the Director of Community Partnerships. He has been with the hospital system since 2008 where he began as a clinical chaplain and has since moved into community-based work. As an ordained United Methodist Minister, Jonathan has been successful in building and maintain relationships with faith-based members of the Methodist community for the Congregational Health Network. In addition to faith-based relationships, Jonathan also works to build educational partnerships with universities that focus on research, intervention, and facilitating community programs.

Organization Commitments and Services

Methodist Le Bonheur Healthcare is a large health care system in Memphis, Tennessee, which consists of six hospitals, including a children's hospital and a teaching hospital. The system is driven to serve everyone in Memphis, regardless of their ability to pay. The overall mission of this health care system is to be the leader in providing high quality, cost effective, patient-and-family-centered care, with services "provided in a manner which supports the health ministries and Social Principles of The United Methodist Church to benefit the communities [they] serve." [2]

Within the hospital lies the Mission Integration Division, which is best known for its chaplaincy. This division focuses on charity care, providing chaplains for all the hospitals, special projects, a humanitarian fund, a family care center, and an employee assistance program. It also facilitates volunteer services and community outreach that focuses on the grant funded programs through the hospital. The Health System's desire to push resources out into the community to improve healthcare outcomes and build trust with residents of Memphis created the Congregational Health Network (CHN). CHN is a collaborative partnership between the hospital system and the surrounding faith communities. Their role is to serve as a credible source for health-related information and education for the surrounding community.

The Methodist Healthcare system returns many of their corporate sponsorships to various non-profits and causes in the area, which in turn helps build and maintain community partnerships. Over its lifespan, the CHN has built nearly 700 different covenant partnerships with churches in the area. These partnerships represent a large percent of the community and its leaders. Methodist Health and the CHN are targeting root causes of health disparities by acknowledging systemic issues and engaging with the community to help address their concerns.

Capacity & Successes: Cultivating Trust

Methodist Le Bonheur Health and CHN have created and maintained community trust through partnerships and programs. They have done this in providing consistent support, building authentic relationships, and meaningfully engaging with the communities they serve. The various ways CHN and the Mission Integration Division have adopted these principles will be discussed in the following three categories: community programs, authentic partnerships, and resources & support.

Community Programs – Founded a few years ago in partnership with the Mission Integration Division, My Sister's Keeper was created to address the specific health disparities facing Black women. This program is devoted to amplifying the voices and health needs of Black women by promoting accessible health services, leveraging the power of these women by offering educational workshops on mobilization and outreach, providing health education services, and conducting and sharing research on Black women's health.[3] These concrete actions, along with solidarity in addressing key social and environmental needs has turned My Sister's Keeper into a trusted community source.

CHN has also initiated community outreach programs that focus on targeting the social determinants of health and promoting education and opportunity. The BookNook partnership program targets childhood literacy among at-risk

[2] Methodist Le Bonheur Healthcare, "A Culture of Compassion," Methodist Le Bonheur Healthcare, https://www.methodisthealth.org/about-us/our-culture/.

[3] "About My Sister's Keeper," https://www.methodisthealth.org/about-us/faith-and-health/my-sisters-keeper/about.dot.

and underserved Memphis students.[4] Engaging in meaningful partnerships and addressing SDOH through outreach helps the hospital build credibility to engage in other community-centered programs. An example of this is the partnership program created between Methodist Le Bonheur Healthcare, Church Health, and the University of Tennessee. This program, Serving the Underserved, is a certificate course that educates medical students on SDOH and teaches them how to provide healthcare to underserved populations.

Authentic Partnerships – The faith community is a large part of the fabric of Memphis; thus, churches and faith-based leaders play a vital role in Methodist Health's partnerships. Much of the trust building around the COVID vaccine has been facilitated by these community leaders. Bringing in their voices has helped re-center the conversation around the community and provided accountability for transparent communication.

Resources and Support – In addition to providing social support, it's important to provide tangible support and resources for the community to benefit from. An example of this is the Living Well Network, a free mental health referral service that responds directly to needs in the community. In another sector, Le Bonheur's children's hospital funds the Changing High-Risk Asthma in Memphis through Partnership program. This program improves coordination of care between providers, teaches asthma self-management, and engages the community in caring for high-risk patients. These direct services are free for patients and directly impact community needs.

Essential Principle-Based Actions

To mitigate further health impacts caused by COVID-19, and to repair trust, systems need to re-evaluate health strategies and re-center the community. This requires ensuring equity, addressing systemic barriers, providing transparent communication, leveraging trusted voices, and prioritizing prevention and public health. The following recommendations will touch on each of these measures by focusing on the immediate and long-term recommendations.

Immediate Action—Centering Community Voice The politicization of the virus has increased mistrust among experts from the scientific and medical communities. This makes it difficult to share accurate information without it being questioned. Through this process, it has revealed that experts are not always the disseminator that everyone trusts. Thus, it is essential to turn to the community and identify trusted voices to amplify. This is done by creating an atmosphere of leaders, executives, doctors, and public health experts that represent the community they are serving. Faith based leaders and community organizers are seen as the protectors for populations who are neglected by the larger systems. Leaders can help change the narrative around health stigma, health disparities, and the COVID-19 vaccine.

Action for the Long Term—Prioritizing Community Health Putting the health of communities at the forefront inevitably necessitates addressing inequitable systemic barriers. Black, Indigenous, Multi-Racial, People of Color should be present and centered in conversations around community health interventions. Vaccine distribution needs to be brought to the community versus requiring members to come find it. Barriers to care must be acknowledged so an entire population is not excluded from essential health services. This also means providing the necessary educational resources, so that individuals can make an informed decision around their health. There will never be trust if there isn't transparency and accountability in health messaging.

In order to address SDOH and community needs, public health and prevention must be a priority moving forward. When a crisis occurs, the public health sector is expected to deliver beyond the resources they have been given. The solution is pushing the issues upstream, to address the root causes in a way that a healthcare system cannot. This includes making public health a central leader, but also calls on agents of change like educators, government officials, pastors, churches and families.

---

[4] "Methodist Healthcare Working to Increase Literacy among Memphis Children," https://www.methodisthealth.org/newsroom/news-article/methodist-healthcare-working-to-increase-literacy-among-memphis-children.
N. French J. Lewis, interview by H. Ranson, February 5, 2021.

Appendix 6: Centura Health & Penrose St. Francis Health Services Mission Outreach Community Leadership Voices Action Brief

Community Leadership Voices Action Brief

Trust, Social Determinants, and Vaccine Acceptance: Lessons Learned from 10 Years of Influenza Prevention Outreach

Centura Health & Penrose St. Francis Health Services Mission Outreach

Key Messages Centura Health & Penrose St. Francis Health Services Mission Outreach have cultivated community trust by way of a Mission Outreach Program facilitated by four community nurses. Each nurse works with a different population, building relationships and rapport with community members by catering to their health needs and providing essential health services. The Mission Outreach Program has found success in partnering with faith-based and community-based organizations to carry out vaccination and education programs. Their immediate call to action is to increase vaccine accessibility by acknowledging social barriers, and their long-term recommendation is to prioritize community context in future program intervention planning.

Community of Concern Centura Health & Penrose St. Francis Health Services Mission Outreach serves the Greater Colorado Springs area in El Paso County, Colorado. The population served is 78.5% white, 16.9% Hispanic or Latino, 6.3% Black, 2.8% Asian, 1.0% Native American/Alaskan Native, 0.4% native Hawaiian/Pacific Islander, 5.5% some other race, and 5.6% multiple races.[1] Those who seek care through the Mission Outreach Program are individuals who face insurance barriers and have trouble accessing health care. These include the homeless population, recent immigrants, and communities of working people that live-in poverty and don't have access to economic resources.

Based on a Community Health Needs Assessment carried out in 2019, the top priorities identified were mental health, healthy lifestyle, and access to care. [1] As of 2021, priorities mentioned by community leaders, Fiona Hahn and Cyndy Wacker, have been expanded to also include healthcare affordability and COVID-19 related services (i.e. testing, vaccines, and treatment). These priorities are all connected in one way or another and are compounded with systems mistrust.

Priority Community Issues & Challenges Affordability and access to care differ for each of the populations that the community nurses serve. Although the homeless population is covered under Medicaid in the state of Colorado, they are often unable to utilize health services.

The immigrant population, and those who are undocumented, are often uninsured and cannot cover the cost for visits. This issue along with a general fear to interact with government services which could lead to deportation have deterred this population from seeking essential healthcare services. The issue of affordability also impacts the working class that lives in poverty. This population makes an income that exceeds the threshold to be covered under Medicaid, however, they are still largely unable to pay for medical services.

The lack of affordability and coverage under insurance, like Medicaid, is devasting to underserved populations. The absence of government support creates an atmosphere of mistrust related to the system's inability to help those that need it most. In light of the pandemic, this mistrust is amplified for those communities unable to access adequate, up-to-date information on the virus. Populations of color carry the weight of historical transgressions from government and hospital institutions, enveloping another layer of distrust. This worldwide crisis is much different from flu seasons in the past, as there is no experience on how to severely mitigate impacts or a timeframe to when it will end. The uncertainty around the pandemic decreases the sense of security and trust within communities.

[1] "Community Health Needs Assessment : Penrose- St. Francis Health Services," (Centura Health, 2019).

Trusted Community Leadership Experience and Voices The commitment to community that Fiona Hahn and Cyndy Wacker have given has established a sense of credibility beyond their individual roles and to all aspects of the Mission Outreach Program. Fiona has been with the hospital for about two and a half years and serves as one of the faith community nurses in the Mission Outreach Program. In this role she works with immigrant clients who are on the margins of the health system. Fiona's ability to build relationships with community members comes from her cross-cultural experience. Growing up in Mexico and living in Ecuador, Fiona is fluent in Spanish, and has a shared worldview that helps build trust and understanding. Although now retired, Cyndy was with hospital for 30 years. She was also a faith community nurse in the Mission Outreach Program, until the end of her career when she became an administrator for mission and ministry. Cyndy relayed that the success in her role came from the support of the organization that continues to allow the program to function.

Organization Commitments and Services The mission of Centura Health is to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in [their] communities. In all of their work they uphold the values of compassion, integrity, stewardship, excellence, respect, spirituality, and imagination. The hospital is well-known for its faith-based affiliation, and thus provides a bridge to community churches and parishioners in the area. This extends into partnerships with community coalitions, like the Healthy Community Collaborative, a program among community partners that aims to address community needs in El Paso, as well as the Community Health Partnership program, which serves as another collaboration among health partners in town that focuses on removing the barriers of access to care.

As a part of the health system community engagement, the Mission Outreach Program facilitates services to the surrounding vulnerable populations. The program is led by four community health nurses who each work with a different population and the well-established social agencies, or faith-based organizations, that reside in the area. These social agencies have served these communities for a long time, and people trust that they are genuinely looking out for their wellbeing. The nurses that connect with these sites create individual and personal relationships with community members, which cultivates a sense of trust that allows individuals to open up and share information with the nurses. This in turn can help break down the barriers to access of health services.

Capacity & Successes: Cultivating Trust It's important to have a baseline understanding of mistrust in order to engage in discussions with communities and organization leaders. For instance, during a recent drive-thru flu vaccine clinic calls were made to community members in order to discuss their hesitancy. The Hispanic, immigrant community raised questions and concerns, such as "how do we know they aren't experimenting on us? We don't have a voice. They can do anything they want; we have no recourse to work against that." It is also crucial to note, that not all concerns from different communities are going to be the same. It requires a lot of work to access several small congregations and build trust with each of them. This raises more challenges than working with a large population where there are several opportunities to expand on networks.

The community partners established through the Mission Outreach Program have been essential to the program's success. One example of this is the faith-based partnership with Our Lady of Guadalupe Catholic Church. The church hosts the Mission Outreach Program for flu vaccines every year, and largely draws on faith-based leaders to set a precedent for their congregation. The participation of the faith-based leader in the vaccine process shows that they trust the community health workers and the vaccine itself. This has been successful in reaching more vulnerable populations, as the church's congregation is made up of 95% immigrants. The most effective strategy in health promotion is educating faith-based leaders and co-developing a targeted strategy to disseminate information to their communities.

Partnerships are important to bridge the gap between mission outreach practitioners and the community at large. They help establish a

foundation for individual relationships between the nurses and community members. Consistency of programming and responding to community context allow the nurses to build upon a relational aspect in their work. This comes from being intentional about relevance to community health needs and speaking the proper language when conversing with community members. It's about making members feel comfortable and creating a space where they feel open to ask questions. This relationship expands beyond individual bounds and reverberates to trust in the larger program. This is especially seen within the Spiritual Care Department located within the hospital, as it is understood to be a "sanctuary", or a safe space for anyone to come in and share honest information about their conditions.

The hospital and Mission Outreach Program are at an advantage for information dissemination, as they aren't considered "the government" who are just there to distribute vaccines. In response to COVID-19, the Mission Outreach Program has been intentional about centering educational materials and programs around common vaccine questions and the efficacy behind it. Providing complete transparency and making it clear that there is no hidden agenda allows the community to make their own educated decisions around receiving the vaccine.

The adoption of a social justice framework has helped the hospital and the outreach programs shape a community health response that acknowledges the social determinants of health, discrimination, racism, and social disenfranchisement. [2] Through embracing this model, the community impact reaches beyond surface level health promotion. The ability to build trusted relationships and work without technical regulations has allowed the Mission Outreach Program to make resounding impacts. A direct example being the ability of a small group of nurses and medical volunteers to deliver flu shots at the same rate of the larger health department. The programs that reach people don't have to be widespread, but they do require a level of trust.

Essential Principle-Based Actions Calls to action target the federal level, as work that is carried out locally is dependent on the trickle down of policies and resources. Everyone is doing the best they can with what they have at the community level. Ethos is a built part of the community, and everyone is willing to support each other across sectors. However, resources are scarce, and the budget is limited. Therefore, the recommendations are targeted at the higher level(s) to address the following immediate and long-term action recommendations:

Immediate Response: Vaccine Accessibility The homeless, immigrant, and poor communities that the mission outreach program targets, are often left behind when planning for vaccine rollout. There needs to be better advanced planning that promotes widespread public awareness about the process. Additionally, communities of color need to be prioritized, even if they make up just a small percent of the population. These communities have been disproportionately affected by COVID-19 and should be considered as a major part of the vaccine distribution plan.

Long-term Response: Centering Community Context Access will not be equitable until community context is considered. The interventions must be targeted to the needs of the community and work outside of the "standard" parameters. Vulnerable communities and the barriers they face have to be understood in order to mitigate further exclusion.

References

"Centura Health Social Justice Framework." Centura Health, 2020.

"Community Health Needs Assessment : Penrose- St. Francis Health Services." Centura Health, 2019.

F. Hahn , C. Wacker. "Advocacy Tool – Interview Guide : Penrose- St. Francis Health Services Mission Outreach (Colorado Springs, Co)." By H. Ranson (2.3.21 2021).

[2] "Centura Health Social Justice Framework," (Centura Health, 2020).

C. Wacker F. Hahn interview by H. Ranson, 2.3.21, 2021.

Appendix 7: Advocacy Tool In-depth Interview Guide

Advocacy Tool – Interview Guide

Person Being Interviewed:
Organization:
Time:
Date:

Introduction:
Thank you for joining me to share your community perspectives and insight. [redacted] *The purpose of us sitting down today is to identify your top priorities for your community, develop action recommendations, and identify key change institutions or leaders who can leverage these actions. The goal of this project is to reduce COVID-19 health disparities and the expanding institutional mistrust in communities of color by leveraging the voices and knowledge of experienced, well respected community leaders across the United States. If you do not wish to answer any question or want to end the interview at any time, please let me know. I would like to record our discussion, if this is okay with you, in order to fully transcribe your responses. Do you have any questions on this? Do I have your permission to tape-record our discussion?*

Today we will begin by talking about your community, we will then move in to discussing your organization and the role you play, next we'll discuss the challenges your community faces, and finally we will talk about calls to action and next steps.

Although I have these topics listed out, I want to honor the space you are stepping into today and encourage you to share any other topics that you see relevant. At the end of our discussion, I will open the space for additional questions or feedback, but feel free to stop me at any point to add your thoughts. It is important that you shape this so that it can be effective in bringing about the change that you see is needed.

This interview will take around one hour to complete. Are you ready to begin?

A. Identifying Community Make-Up

I'd like to begin by talking about the communities you serve. Please feel free to include any identifying characteristics that my questions do not touch on.

1. Can you tell me give me an overview of your community? (Who makes it up? Where is it?)
    - If your work focuses on many communities, focus on one where there may be the greatest inequity around COVID (incidence & potential vaccine mistrust).
    - Probe for demographics (race / ethnicity / SES), size, community setting

2. Has this particular community ever gone through any kind of community health assessment? If so, do you have links or resources that may provide additional information?

3. What would you say are the biggest struggles and health challenges that face your community? *We will touch on this topic again later, but right now I'd just like you to identify what these problems are.*

    Probe:

- What health promotion strategies are you currently focused on?

B. Organization and Community Leader

Next, we'll transition in to talking about your organization and what part it plays in your community.

4. Can you please describe who your organization is? (i.e. team make-up, driving forces)

Probe:

- What makes your organization different from other community organizations in the area?

5. What is your organization's mission? Can you tell me the values of your organization?

6. In what ways is your organization working towards its goals?

Probe:

- What have been your key program activities?
- Who or what makes your work happen? (staff / volunteers)
- Do you have any links or resources that may provide additional information?

Now I'd like to transition to talk a little about you and your role in your community.

7. Can you tell me about your position in your organization and/or community?

Probe:

- How long have you been working in this community?

8. Can you describe what you consider as significant successes held by the organization in the past?

- What about your organization has made that possible?

9. What about <u>you</u> enables <u>you</u> to successfully achieve what you do?

10. What would other leaders in your community say about you, or the importance of your role?

C. Understanding Root Challenges

I'd like to transition back to understanding more about your community and what they are facing.

10.What needs to be understood in order to address the <u>*challenges (Probe from #2)*</u> of mistrust and vaccine hesitancy in your community?

Probe:

- What is the history of the issue in this community?
- What are the consequences (social, economic) of the issue?
- Who is affected most by the issue?

11. What specific health inequities fuel and under gird the issues you are most concerned about?

D. Proposed Solutions & Calls to Action

Based on these challenges, I'd like to discuss proposed solutions and calls to action.

12. What are the long-term changes you would like to see come from an intervention strategy?

- What short term changes do you think could help get you there?

13. What successes and lessons learned from the influenza promotion project can be useful in promoting the COVID vaccine?
    - What has changed/ what differs?

14. In this current time and environment, what are the essential steps to restore and build trust in your community?

15. What do you feel are the key actions that are essential to slow and end the spread of COVID-19?
    Probe:
    - Specificity of actions
    - How do these actions make use of available resources/allies?
    - Who, if anyone, might be adversely affected by the proposed change?
    - What would be an ideal time frame for when this/these actions would be carried?

16. What is your call to action for public health entities?
    - In what ways is this action feasible?

17. Who are the key change institutions and leaders who can leverage this action?
    - What kind of benefits and/or accountability would that entity have/perceive for this issue that would motivate them to act?

18. Are there any other questions or comment you would like to share?

I want to thank you again for sitting down with me today and sharing your honest responses with me.

Appendix 8: ***Shifting the Conversation: Vaccine Hesitancy to Vaccine Access***

Beginning with dismantling harmful public health foundational theory, we must address the agenda set forth in the majority of public health research around COVID-19 vaccine acceptance over the last 7-8 months. The ideas set forth by the public health community re-enforced the narrative that vaccine hesitancy is 1) the leading concern amongst communities of colors' health in relation to COVID-19 and 2) vaccine hesitancy is fueled solely by historical transgressions like the Tuskegee Syphilis Study. Not only are these agendas set forth false, but they also limit our approaches to addressing the real underlying issues. The iterative nature of this project has allowed me to recognize the inadequacies of several of the issues highlighted in the beginning portions of this paper. I will address these gaps by referring to current literature and ideas put forth by BIMPOC health practitioners.

The initial narrative that centers vaccine hesitancy above all else lacks a social determinants of health lens, which would reframe the conversation to focus more heavily on barriers to access. Vaccine hesitancy exists, but it is not the leading cause for limited vaccine uptake. A more well-rounded understanding about vaccine hesitancy, COVID-19 vaccine rollout, and intuitional mistrust in communities of color has led me to recognize the importance in what order we address these issues. The concerns around vaccine hesitancy emerged before vaccines were even approved. The heightened significance placed on vaccine apprehension in communities of color was pre-mature considering equitable roll-out was not yet in action, let alone streamlined. Public health's anticipation around COVID-19 vaccine hesitancy can be said to have stemmed in part from previous immunization's data, like that of seasonal influenza. Projections fail to take in to account the fluidity of decision making, especially when considering factors like the risks

associated with infection and politicization of scientific evidence. Centralizing vaccine hesitancy as the core barrier to vaccine uptake insinuates that practitioners have little responsibility of the outcome. This covers inadequate recruitment for practitioners who are persons of color, and inevitably puts the responsibility back on communities who are already burdened with systemic issues. The idea that vaccine hesitancy is universal among communities of color perpetuates monolithic, racist ideologies that everyone from these populations is mistrusting of the vaccine and is "hard-to-reach". [116] It should be fully acknowledged that much of the uncertainty around the vaccine is related to how fast it was developed and the role that certain political figures may have had in overseeing the process. [116] Institutional mistrust should be acknowledged in public health response, but attention should specifically be given to the "structures of racism that cause mistrust". [117]

The other false idea promoted by many health experts is that institutional mistrust is fueled solely by historical transgressions in relation to medical racism inflicted on persons of color. This idea completely hides the existence of present-day racism and lived experiences. Rather than continuously using notable events of medical abuse to explain contemporary fears, we should be focused on personal experiences that fuel distrust. [118] A recent example of modern, racist medical practices can be seen in the development of technologies like the pulse oximeter. In February, it was realized that this device was giving inaccurate readings to persons of color. [116] This was due to the lack of representation of participants of color in the development of the device. [116] In addition, even if historical malpractice is provided as a significant reason for an individual's mistrust, this is still *valid.* As multiple, extensive racist events have occurred throughout history, it is important to think about the longevity and "accumulation of injustice"

associated with these events. [116] Additionally, these events are positioned in a context of continuous, "intersecting, and unreconciled injustices which accumulate and continue to reinforce mistrust." [116] The various reasons individuals may give for institutional mistrust are justified, and instead of perpetuating an insufficient narrative, we must listen and acknowledge the pain institutions have caused and continue to inflict.

Addressing the flaws in public health strategies is essential to self-reflection. However, with that acknowledgement, it's important to tie it to action, meaning engaging in successful, equitable and community-led vaccine rollouts. A prime example of this rollout was the Black Doctors COVID-19 Consortium in Philadelphia held in early March. The Consortium engaged with the community by meeting them where they were and provided a walk-up vaccination site where over 4,000 people received vaccines. [116] KFF released a report in early March that examined state-led efforts in providing equitable access to the vaccine. There are numerous accounts of equitable accommodations being made for communities of color, including prioritization of broader groups living in geographic locations at a heightened risk for COVID in Rhode Island, incorporating people of color in initial vaccine priority groups in Montana and Utah, and working with community clinics to coordinate roll out efforts in communities of color in Colorado. [105] As indicated by COVID-19 Vaccine Data shared by KFF in early April, evidence supports that community-led health centers are more rapidly vaccinating people than that of the overall national vaccination effort. [119] Although the data shared examines equitable vaccine efforts at the state level, there has also been progress at both the local level and private sector as well.[105] As previously mentioned, federal efforts have incorporated equity into their plan of

action, including through a Health Equity task force, and more recently HHS's We Can Do This campaign that strives to increase vaccine confidence in vulnerable communities. [105]