



12-10-2021

New Orleans During A Pandemic: Engaging African American Community Stakeholders on COVID-19 Information, Prevention, Testing and Vaccination

Anthony Thompson
athomp26@xula.edu

Follow this and additional works at: <https://digitalcommons.xula.edu/xulanexus>

Recommended Citation

Thompson, Anthony (2021) "New Orleans During A Pandemic: Engaging African American Community Stakeholders on COVID-19 Information, Prevention, Testing and Vaccination," *XULAnEXUS*: Vol. 19 : Iss. 1 , Article 1.

Available at: <https://digitalcommons.xula.edu/xulanexus/vol19/iss1/1>

This Article is brought to you for free and open access by XULA Digital Commons. It has been accepted for inclusion in XULAnEXUS by an authorized editor of XULA Digital Commons. For more information, please contact ksiddell@xula.edu.

New Orleans During A Pandemic: Engaging African American Community Stakeholders on COVID-19 Information, Prevention, Testing and Vaccination

Cover Page Footnote

Faculty Advisor: Dr. Shearon Roberts

New Orleans During A Pandemic:
Engaging African American Community Stakeholders on COVID-19 Information, Prevention,
Testing and Vaccination

Anthony Thompson

Introduction

The coronavirus pandemic brought a nearly complete shuttering to the United States of America beginning in March 2020. This shutdown brought every facet of life in both America and across the world to a halt as the deadly SARS-CoV-2 burdened intensive care units and took the lives of alarming numbers of individuals. Among the communities enduring the worst of the coronavirus outbreak at the start of the pandemic was New Orleans, Louisiana. In March and April 2020, when the coronavirus broke out in the city of New Orleans, new cases were as high as 878 per day while deaths were as high as 32 per day in Orleans Parish (which includes New Orleans) (Louisiana Department of Health, 2021).

The coronavirus wreaked havoc on all communities, but unfortunately, the African American community was consistently among the most impacted segments of the population. African American deaths made up 76.8% of all COVID-19 deaths in Orleans Parish, at the start of the outbreak, lasting through June 5, 2020. Excluding long-term care facility deaths, African American deaths made up 87.5% of all COVID-19 deaths in Orleans Parish through June 5, 2020 (Weinstein & Plyer, 2020). This was especially troubling given that African Americans make up 60.1% of the Orleans Parish population (United States Census Bureau, 2019a). The fact that the coronavirus took the lives of African Americans at disproportionately higher rates, illuminated but did not suggest new discovery of, racial health disparities. Specifically, comorbidities that exist within the Black community played a clear role in raising the death rate related to the coronavirus in African American communities (Losh & Plyer, 2020). When New Orleans

emerged as a hotspot for the coronavirus early on in 2020, it called for interventions to mitigate racial health disparities.

As New Orleans became a case study of the racial disparities highlighted by the pandemic, the state of Louisiana became a testing ground for federal resources to better understand and reduce the high rates of infection and deaths among Black communities. In response, in September 2020, The National Institutes of Health launched the Community Engagement Alliance Against COVID-19 Disparities (CEAL) in eleven states, including Louisiana. This NIH initiative, led by the National Institute on Minority Health and Health Disparities (NIMHD) and the National Heart, Lung, and Blood Institute (NHLBI), and carried out by non-profit research institution RTI International (formerly Research Triangle Institute), seeks to bring about COVID-19 awareness and research in minority communities.

Specifically, CEAL focused on historically marginalized communities [African Americans, Hispanics/Latinos, and American Indians] (NIH, 2020b). CEAL began working to establish and expand community outreach and community networks in the eleven states being addressed. With regard to COVID-19 vaccine clinical trials, CEAL aimed to increase the diversity of minorities participating in clinical trials. This is particularly important when considering such figures as African Americans making up less than ten percent of total COVID-19 vaccine trial participants (Artiga et al., 2021). Most importantly, CEAL aimed to bring about change and improvement to the diversity seen in research of such diseases as COVID-19 (NIH, 2020a). The Louisiana Community Engagement Alliance Against COVID-19 Disparities (LA-CEAL) comprised Federally Qualified Health Centers (FQHCs), faith-based organizations, and community partners working alongside higher education institutions to provide timely COVID-

19-related resources, information, and awareness to communities disproportionately affected by COVID-19 (LA-CEAL, 2020).

This research paper outlines the ways in which Black communities can be effectively engaged and educated during a pandemic by illuminating the work of LA-CEAL in delivering health education to African American residents in New Orleans. Specifically, this work presents the scope of work executed on behalf of LA-CEAL in New Orleans, as observed by the author, who served for 12 months as a LA-CEAL project assistant. This paper presents a small section of findings on community health engagement and outreach that was a smaller Louisiana state-level component of the larger federally funded NIH study.

Specifically, the author directly managed social media platforms Twitter, Facebook and Instagram to engage community stakeholders. Additionally, the author worked with trusted community health experts to aid in disseminating trusted health information through digital platforms. The insights from both of those community engagement activities demonstrate how trusted stakeholders can work to intervene in health disparities. Through digital platforms, health information was distributed through virtual town hall events, pandemic-related government announcements, and testing and vaccination events that aimed to reach African American residents in the city. Ultimately, the goal of this paper is to outline how this approach took place in a pandemic, and the ways it can effectively encourage life-saving health behavior among a marginalized community.

Literature Review

Scientific Racism

The goal of this paper is to describe how community stakeholders engaged African American residents to reduce the impact of COVID-19 in their community. To fully understand

why trusted community stakeholders are needed in health intervention, it is necessary to present the ways in which mistrust has become rooted in the Black community in the United States to the health/medical field, beginning with a review of scholarly research on scientific racism.

Scholar Louis Menand (2001) explored early cases of scientific racism in the United States, specifically, its presence in the studies of American physician Samuel Morton, who collected skulls of individuals of different races and measured interior capacity. Among those Morton found with the lowest interior skull capacity were American-born Negroes, a claim which is denied by Menand. Menand argued that Morton's studies and conclusions were invalid as Morton did not take such factors as body size into account, and manipulated his experiments by including or excluding certain skulls in order to reach generalizations such as Caucasian superiority. Menand ultimately concluded that Morton's racist work was unsound. Menand's exploration of Morton's work looks at the roots of the mistrust by Black Americans in medicine and medical research. The idea that Black Americans are inferior or less than through scientific research or experimentation provided support for their enslavement and treatment in society, and also extended to their treatment in medical and scientific research.

R.M. Dennis (1995) also outlined the use of Social Darwinist principles to human society, especially relating to racial differences. Dennis wrote that the use of IQ tests as a source of scientific racism in finding intellectual differences based on hereditary factors was originally asserted by Francis Galton, an 1800s anthropologist. Galton's claims about racial differences in IQ were found to not be factual, and Dennis argued in his work that the attempt to divide the human race based on race-related intellectual factors stemmed from hatred and not biology.

Other scholars examined the use of science in determining health in addition to IQ. The argument that medical mistreatment is rooted in the early establishment of racism in science is

strengthened in H.H. Fairchild's 1991 work. Fairchild determined the validity of J.P. Rushton's sociobiology of racial differences and hierarchical ranking of racial groups with "negroids" being last. Fairchild determines the assertions of J.P. Rushton to be invalid. As a result, the work calls for a shift in research to allow for a decrease in inequality and increase in research excellence and diversity. The conclusion of this work finds that Rushton's work was unscientific and can be classified as scientific racism.

The division of the human race based on unjust racial categorization is further critiqued by M.L. Blakey (1999). Blakey explores the idea that race is not determined by nature, but instead by science, and is therefore rooted in negative bias. Blakey's work concludes that the existence of racial categorization coupled with biological determinism proves the presence of racism in science. This conclusion is important in the study of engaging Black communities regarding disease in that it suggests there are obstacles that must be overcome because of race.

Trusted Black intellectuals have called out scientific racism from early on. Carol M. Taylor (1981) noted that W.E.B. DuBois believed that racist investigators manipulated facts in order to fulfill their bias. This, according to Taylor's interpretation of DuBois' views, resulted in the false scientific depiction of the Black American. Taylor concludes that DuBois was a key leader in refuting evidence used in scientific racism studies. The capturing of DuBois' perspective is important in that it shows the role that prominent Black scholars played in clarifying the mainstream scientific community's misuse of evidence to perpetuate biological truths about African Americans. This role of trusted Black intellectuals and scientists continues today, and was incorporated as a health intervention strategy as this paper will later describe.

African Americans and Mistrust of Medical Research

Racism in science then transferred to all other forms of research, including biomedical and health science research fields. It has been well documented by researchers the large scale ways in which African Americans were victims of medical research and experiments, but a few key medical research events have become popular knowledge, beyond just researchers, and ordinary citizens can point to them today as evidence of racism in medical research.

During enslavement, African Americans were the subjects of countless biomedical experiments on both men and women. They also did not have ready access to licensed physicians as enslaved people (Kennedy, Mathis & Woods, 2007). Any understanding of the mistrust of African Americans to medical research and medical care is rooted in their treatment since their forced arrival to the country.

In modern medicine, that trust was continually eroded. The largest noted medical research event that changed ethics in research today can be traced back to the Tuskegee Syphilis study. This idea is explored in the work of D.P. Scharff et al. (2010). Scharff et al. date the contemporary mistrust back to the Tuskegee Syphilis study started by the Public Health Service in 1932. The researchers surveyed African American adults on the reason for their reluctance toward research participation, and found that the Tuskegee experiment was among reasons for mistrust. The author's recommended that research on the Black community should include plans for reducing African American mistrust in order to increase research participation.

The issue of mistrust was particularly important in the 1980s as the HIV epidemic required more diverse participation from racial minority groups. Scholars researching HIV research inclusion noted a high level of governmental mistrust about the outbreak of diseases, particularly when Tuskegee, a government-funded study, also included a different sexually transmitted disease. In Ball, Lawson, and Alim's 2013 study, Black-surveyed participants

believed there was government secrecy surrounding the spread of HIV. Additionally, as a result of the disproportionate spread of HIV in the Black community, survey respondents indicated they had less satisfaction and trust in physicians, and the medical care they received. The scholars also recommended that as part of engaging Black communities around this disease, HIV falsehoods widely held by the Black community should be rebutted by the implementation of effective HIV-related education campaigns.

After HIV research, mistrust also showed up in biomedical research in cancer diseases that disproportionately impact the Black community. Colorectal cancer, and the screening of it, is a more recent area of mistrust for Black patients (Adams et al., 2017). Black individuals were found to be less likely to receive colorectal screenings than White patients. Even so, African Americans have higher rates of colorectal cancer (CRC) mortality than White patients. Adams et al. found that high medical mistrust rates were generally linked to low CRC screening. The study of the disproportionate occurrence of specific diseases in Black patients is continually found to be linked to mistrust. This is important in realizing that mistrust is not limited to a single event or disease, but spans across several centuries and is prevalent across the American healthcare system.

It is important then that at the point of recruitment of African Americans for biomedical research, research teams allow for collection of insight into the existing factors shaping mistrust for the Black community for a specific disease. Research that illuminates the recruiter perspective of African American participation in medical research is an important area of study into the process of biomedical research involving diverse communities (Barrett et al., 2017). While such barriers as psychosocial and financial factors can deter recruitment for biomedical research among Black populations, fear and mistrust were still dominant factors leading to low

African American participation in medical research. Barrett et al.'s work offers insight for future research projects that address patient needs and patients' lives outside of medical research, which may lead to better participation from those communities. This value of the recruiter's view of African American feelings towards medical research is important when engaging Black communities. This part of the research process can determine the successful inclusion of Black research participants in important research studies for diseases that disproportionately impact African Americans, just as the COVID-19 virus has.

Racial Health Disparities

The culmination of the negative impacts of scientific racism and mistrust in medicine and research has worsened racial health disparities. The idea that health disparity is rooted in racism is explored by J. Feagin and Z. Bennefield (2014). Feagin and Bennefield remind researchers that the infrastructure of American health sciences is still White-led, including the American Medical Association and the National Institutes of Health. The scholars recommend that racial health disparities in the American medical field be decreased by constantly reminding powerful, White decision-makers of the views of Black patients, physicians, and community members.

Throughout the development of health disparity research, factors other than an individual's inherited biological traits can also have an impact on health. One such factor is an individual's geographic location (Chandra and Skinner, 2003). Black communities typically receive lower quality healthcare, and simply increasing access to healthcare is not enough to mitigate healthcare disparities. Instead, according to Chandra and Skinner, the quality of the healthcare in Black communities should be enhanced. Exploring geographical impact on healthcare is important as it serves as a determinant for health disparities in a given community.

Discrimination and racism are often at the root of racial health disparities. S.L. Szanton et al. (2012) take a unique approach to this argument by linking the stress caused by experiences with racial discrimination to health complications that are labeled as disparities. Szanton et al.'s work examined the effect of an African American's experience with discrimination on red blood cell oxidative stress levels, which can subsequently lead to further health complications. The scholars determined correlations between the pressures of racial discrimination and high red blood cell oxidative stress levels that exacerbate the overall wellness of African Americans.

Despite the accumulation of knowledge and awareness surrounding racial health disparities, mitigation of racial health disparities remains a challenging task. J.K. Benz et al.'s 2011 work explores the lack of awareness held by African American communities regarding the specific racial health disparities impacting their own community. This work argues that better awareness would lead to action and change within communities that were previously unaware of specific disparities. The scholars conclude that a great deal of work remains in order to increase awareness of racial health disparities, which can be done through far-reaching community campaigns.

Specifically related to COVID-19, the 2020 work of Chowkwanyun and Reed Jr. explores the effectiveness of the provision of data regarding disparities linked to COVID-19. This study argues that data should be delivered with analysis, and that much of the data on COVID-19 disparities was not contextualized. This study concludes that COVID-19 disparities data should include such patterns as income and food insecurity in order to better contextualize the nature of the disparity. This argument is important because the communities from which data is being extracted are also the hardest hit economically by the COVID-19 pandemic, further

warranting the need for comprehensive collection of data and analysis. Such approaches may contribute to the recovery of such communities from the harsh toll endured during this pandemic.

Social Media Usage in Modern-Day Healthcare

One factor that is new to engaging communities to reduce health disparities, is the ways in which we can more easily connect in our digital world thanks to social media. Social media has become an important aspect of modern-day communication in a variety of fields, including healthcare. Social media has allowed community advocates, healthcare professionals, and other members of the medical arena to voice important messages for improvement of healthcare for all. Rozenblum and Bates' 2013 work looks into the use of social media in enhancing patient-centered care. Specifically, this work looks at the important role social media plays in increasing patient self-advocacy and engagement in healthcare. This is important in that it brings awareness to the previous lack of patients involvement in and knowledge of health care issues, and the ability of social media to mitigate this issue.

Social media has also allowed organizations to have a greater reach within and beyond their communities. Househ's 2013 work focuses on the impacts social media has had on healthcare organizations and their connections with patients. This work focuses on the benefits of social media in healthcare, including enhanced fundraising, gaining of new patients, improved company image, and overall cost-effective marketing. Househ notes that although social media has become widely used in healthcare, such use is not properly documented, which in some ways degrades the impact of social media. This lack of documentation is important in that it suggests social media use in healthcare is more important than discussed and should be continued for various reasons, one of which will be examined.

In addition to such popular social media sites as Facebook and Twitter, social networking through profession-specific forums and blogs is also an emerging area in online communication in healthcare. In Ventola's 2014 work, the usage of various social media and social networking sources by different types of healthcare professionals is examined. Ventola also looks at both the positive and negative impacts of social media as compared to profession-specific social networking sites, finding that social media is used by physicians for personal reasons more than professional reasons, though social media is still an important and growing method of effective communication in healthcare. These studies on the role of social media in healthcare and profession-specific social networking suggests the potential for social media to have the same professional and trustworthy image as profession-specific social networking. Many scholars have contributed to the idea that social media is needed today in order to properly include and engage all communities in healthcare issues. Additionally, given that much of the misinformation about SARS-CoV-2 was disseminated through social media, it centers this form of community engagement even more as a tool for the effective combating of mistrust and misinformation.

Based on scholarly discussion in these four key areas related to the process of including Black communities in biomedical research, this paper proposed the following four research questions:

Research Questions

RQ1: Why are African Americans hesitant with regards to COVID-19 treatment and vaccination?

RQ2: How can African Americans be engaged with regards to COVID-19 vaccination?

RQ3: How can African Americans be engaged with regards to COVID-19 clinical trial research?

RQ4: How should African Americans be included in research conducted during a pandemic?

Methodology

The Louisiana Community Engagement Alliance Against COVID-19 Disparities (LA-CEAL) worked in many ways to provide resources for communities of color regarding COVID-19 facts, COVID-19 testing, and eventually COVID-19 vaccination. One of the early primary areas of focus for LA-CEAL was access to testing for underserved communities of color. The project collaborated with over 100 community partners that included pharmacies, clinics, faith-based organizations, tribal nations, and community groups.

The analysis in this paper examined a select subset of the wider group of LA-CEAL stakeholders/partners, that the author engaged directly as a research assistant and recruiter. The author conducted in-depth research interviews with the selected partners below and collected research field notes while supporting the work of the selected study partners below to answer the research questions.

Sample and Procedure

Select Study Partners

Several New Orleans' Federally Qualified Health Centers (FQHCs) served as an essential avenue for the provision of COVID-19 testing access used by LA-CEAL. New Orleans FQHC InclusivCare, for example, provided drive-through testing in New Orleans area communities such as Marrero. Additionally, LA-CEAL worked with New Orleans churches such as Baptist Community Ministries to help spread COVID-19-related information. These churches were able to further access testing provided by the FQHCs because churches were able to pass on information by word of mouth. Partnering with both FQHCs and church organizations was important in that it allowed for further distribution of information and overlap of communication to stakeholders involved with the partner FQHCs and church organizations.

Furthermore, the social media platforms Twitter, Facebook, and Instagram were used in several ways by LA-CEAL to engage community partners and residents.. First, LA-CEAL used social media to distribute information on COVID-19 testing, COVID-19 case numbers, and governmental updates important for the focus communities. Once COVID-19 vaccine trials began, LA-CEAL also worked with local healthcare providers to host community events as virtual town halls on vaccination trial safety and vaccine efficacy once the first COVID-19 vaccines became available. The broad avenues taken by LA-CEAL were accompanied by direct conversation with community leaders, many of which were healthcare providers or leaders at LA-CEAL partner organizations.

The project also leveraged local African American medical physicians, researchers and scientists as part of its efforts to recruit Black participants for clinical trial research and to deliver messages in support of widespread community vaccination uptake. The author conducted interviews with the scientists involved in this approach to answer the study's research questions.

Selected Study Scientists

The following scientists and physicians were selected for this paper based on their understanding of their own communities and their knowledge of scientific racism, medical mistrust and health disparities.

Dr. Keith C. Ferdinand, MD, is the Gerald S. Berenson Endowed Chair in Preventive Cardiology and Professor of Medicine at Tulane University School of Medicine. In February 2021, Dr. Ferdinand was interviewed by the author. Dr. Ferdinand explained that the cause of the increased hospitalization and death rates in communities of color are “related to the social determinants of health: where people live, work, and play” (Thompson, 2021a). This was important in highlighting the plight of Black communities during this pandemic. Dr. Ferdinand

also alluded to the more general issue of the lack of diversity in medicine, recalling instances in his career at which he could tell his patients had not received care properly adjusted for a Black patient (Thompson, 2021a). Such experiences for Black patients are unfortunate during regular times, and become worsened during such a time as a pandemic. Dr. Ferdinand's medical perspective has clear implications for the approaches which should be taken in order to support Black communities during this pandemic. Dr. Ferdinand's role as a physician conducting research and practicing medicine is important because Dr. Ferdinand was able to serve as a trusted advocate for the desired African American community engagement of LA-CEAL on multiple fronts, including influencing clinical research trial participation and vaccine uptake.

Dr. Gary Wiltz, MD, Chief Executive Officer of Teche Action Clinic, was interviewed by the author in February 2021. Teche Action Clinic is an FQHC consisting of a network of clinics in surrounding parishes of Greater New Orleans. The primary location of Teche Action Clinic is in Franklin, Louisiana, whose population is approximately 59% Black/African American (World Population Review, 2021). Dr. Wiltz offered this study a unique perspective as a healthcare provider and leader in a rural Black community. Dr. Wiltz explained that "we had all these underlying conditions: the highest rates of obesity, diabetes, hypertension, all these comorbid conditions. When COVID came along, it just exposed an already predisposed population" (Thompson, 2021b). As one of the sites that provided vaccines to underserved populations, Teche Action Clinic was a prime example of the importance of FQHCs in engaging and better supporting pandemic-stricken Black communities. The insight gleaned from Dr. Wiltz for answering the research questions also was a key resource in seeking to find ways to properly engage suffering Black communities in a pandemic.

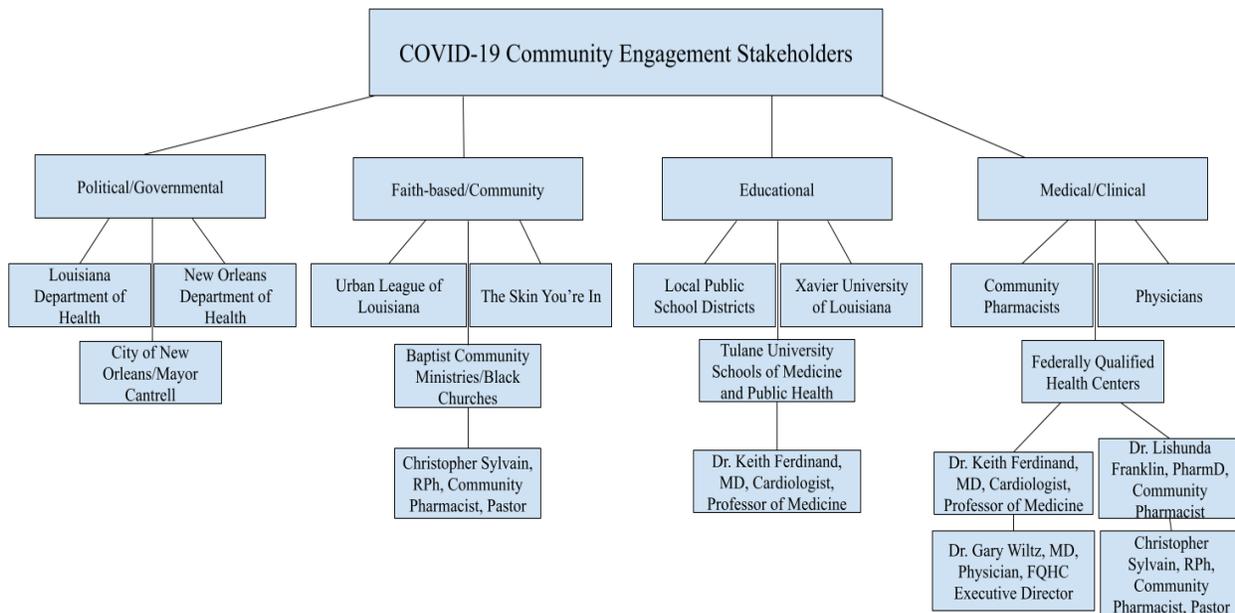
LA-CEAL also sought to supply Black residents with resources for enduring the pandemic through community pharmacies. Two New Orleans community pharmacies were included in this study. The Best Life Pharmacy and Crescent City Pharmacy and their owners' insight were included in this study. Christopher Sylvain, RPh, is the owner and pharmacist of Best Life Pharmacy, which serves the underserved in the Mid-City and downtown areas of New Orleans. In conversation with the author, Sylvain spoke about the need for institutions that are focused on those who cannot otherwise acquire such necessities as medication. Above all else, Sylvain emphasized the fact that those being impacted most by this pandemic were not deserving of such treatment, and that this was largely due to failures of a health system beyond their control. Sylvain expressed the importance of the dedication shown by such providers as himself specifically to underserved communities such as the Black communities being referred to in this work (Thompson, 2021c). Along with his work as a pharmacist, Sylvain is also a pastor for Faith Full Baptist Gospel Church, where he is able to extend his advocacy for LA-CEAL's community engagement efforts to members of his church community. This is important for building trust in that Sylvain's advocacy can be heard by stakeholders from both a professional view as a pharmacist and a more personal/spiritual view as a pastor.

Dr. Lishunda Franklin, PharmD, is the owner and pharmacist of Crescent City Pharmacy, which has been a partner of LA-CEAL in the provision of resources to underserved Black New Orleans communities during the pandemic. Specifically, Crescent City Pharmacy was crucial for these communities in that it is one of the sites providing COVID-19 vaccination to the underserved inner-city population of New Orleans. Dr. Franklin shared her views as a key provider to underserved New Orleans residents with the author. In doing so, Dr. Franklin noted the ways in which Black underserved communities of New Orleans are inadequately resourced

and particularly so during the pandemic. Dr. Franklin pointed out that she has directly observed this lack in resources simply by the overwhelming nature of individuals seeking vaccination at her pharmacy, which is offered to Black residents, even on weekends (Thompson, 2021d).

From information distribution on social media to partnership with local providers for testing and vaccination, the LA-CEAL project used community partners and Black scientists in unique and varied approaches to provide proper resources for Black communities in New Orleans being impacted by this pandemic. These approaches for the provision of health resources were analyzed by the author in seeking to reach this work’s goal: finding ways to properly engage underserved Black communities to decrease disproportionately negative impacts of a pandemic. Therefore, the key informants the author interviewed for this paper reflect the full cross-section of community engagement that was the main objective of LA-CEAL. Their insights spanned all forms of engagement across the city and state as illustrated in the figure below.

Figure 1: Louisiana COVID-19 Community Engagement Stakeholders



Results

This study summarized research interviews and project field notes to answer the research questions below that illustrate the ways in which this COVID-19 community engagement alliance worked to engage local African American residents. The study aimed to examine how a local African American community could be best engaged in medical research and medical treatments when mistrust, hesitancy and lack of access and quality of care are prevalent in their community. Research Question 1 asked:

Why are African Americans hesitant with regards to COVID-19 treatment and vaccination?

The scientists interviewed in this study affirmed that African Americans have long been the subject, and victims of unjust and unethical biomedical experimentation. This is not the single cause of African American hesitancy, but is simply one long, continuous and complex cause of mistrust that leads to hesitancy.

In examining the local outreach work of LA-CEAL through research interviews with select scientists, this study found that there was still a need today for customized and culturally responsive medical information related to the pandemic. Underserved communities of color may receive information through mainstream communication such as television and radio news. Since the pandemic waged disproportionate death in these communities, mainstream communication was identified as being insufficient. Black communities did not receive mainstream communication well because it was not tailored to the often disregarded social, financial, and cultural issues found in underserved Black communities.

The scientists shared that when a community is not being spoken to directly with information in a way that is suited to them, as a community often deprived of basic resources,

skepticism remained high, not only toward types of treatment during this pandemic, but also toward the larger health system.

Dr. Gary Wiltz suggested that “misinformation and fear and hesitancy in getting into the system and getting the care that our folks need exacerbated an already existing condition,” (Thompson, 2021b). Additionally, despite many programs and initiatives that make Black communities a priority on the surface, there is a disconnect between existence of and impactful implementation of such programs, the scientists noted. This is often due to a lack of diversity and representation from the community in the design and planning of studies that aim to treat and vaccinate underserved communities.

The second research question asked community stakeholders about the approaches to reducing vaccine hesitancy in a local African American community. Research Question 2 stated: *How can African Americans be engaged with regards to COVID-19 vaccination?*

Medical professionals from LA-CEAL partner organizations made it clear with regards to African Americans’ willingness to be vaccinated, that this was an initial obstacle to overcome in the general perspective of the African American community. In order to overcome this obstacle and improve attitudes specifically about vaccination, medical research studies must amplify voices of Black medical providers to advocate for vaccination.

Firstly, attitudes by African Americans about vaccination can be improved by selecting Black medical providers as vaccination advocates because of the shared experience held by Black providers and Black community members. This resonates with underserved Black communities because it indicates that there are individuals who understand the complexity and vulnerability of life as a Black American.

Such advocacy is perceived within Black communities as assurances of checks and balances by trusted community members who can vouch for medical breakthroughs. The reach of this kind of representation of ambassadors from the community in support of vaccination is hampered by the fact that diversity in medicine remains astonishingly low. According to Dr. Gary Wiltz, “a big challenge is having culturally competent people to deliver care,” (Thompson, 2021b). The Association of American Medical Colleges states that a mere 5 % of all physicians in America are Black or African American (AAMC, 2018). Coupled with the fact that 13.4% of all Americans are Black or African American, the need for diversity in medicine is clear (United States Census Bureau, 2019b).

Without diversity, there are not enough voices to serve in this advocacy role, thereby decreasing the widespread engagement of Black communities in promoting COVID-19 vaccination. In addition to the closely-related factors of Black provider advocacy amplification and diversity in medicine, vaccination engagement can also be positively influenced by better delivery of communication from prominent community public figures.

Underserved Black communities should therefore receive vaccination-related messages from local and national Black leadership in medicine and government, as both play a crucial role in COVID-19 vaccination. Of the areas needed for African American COVID-19 vaccination, engagement and communication from Black leadership has been one of the more effective approaches used locally during this pandemic, but is still not enough for a greater shift in the general attitudes of Black Americans toward vaccination. Therefore, amplification of Black medical providers’ voices, improved diversity in medicine, and encouraging communication from Black officials must all be present in order to better engage Black communities in COVID-19 vaccination.

The research that led to the creation of the COVID-19 vaccine was also another area where mistrust was high for local Black communities. Therefore, Research Question 3 asked the community stakeholders:

How can African Americans be engaged with regards to COVID-19 clinical trial research?

African American engagement in clinical trials is also an area that needed improvement during the pandemic largely because of the hesitancy of Black communities discussed earlier. It is important that African Americans be part of clinical trial research in order for research to represent a realistic distribution of the total population. This cannot be done without African American participants, therefore underscoring the need for better engagement efforts to improve recruitment and participation.

In order to improve engagement of underserved Black Americans in clinical trial research, the community stakeholders shared that the distribution of information in locations deeply-rooted in Black communities, and inclusion of information with benefits specific to Black communities must both be accomplished.

With regard to places deeply-rooted in Black communities, churches serve as a prime example of such a site. Though many churches operated virtually during the pandemic, there still exists a close tight knit church family that communicates through social media, telephone and direct communication.

The church is also a space for education, dialogue and conversation that engages members about disease, health practices and prevention. The nature of churches within Black communities allow for a conversation beyond commonly expected religious topics. Additionally, as observed by the author, deeply rooted community spaces such as churches serve as coordination points for testing, vaccination, and resource distribution. As stated by Dr. Keith

Ferdinand about underserved Black communities, “many people lived in communities where they were not even close to a testing site” (Thompson, 2021a). This verifies the need to use such sites as churches as logistical points for pandemic-related items.

The coronavirus pandemic was not an off-limits topic in the churches observed in this study. As calls for African American participants and coronavirus clinical trials began, conversation specific to clinical trials could be discussed amongst Black church families. Therefore, delivery of communication for Black communities on COVID-19 clinical trials to such deeply rooted Black community locations as the Black church, served as the first prong in successfully engaging Black communities on clinical trials.

The second prong of the task of engagement is ensuring that such communication to deeply rooted Black community spaces emphasize how the Black community will benefit from clinical trials, which are often seen as experimentation similar to the racism-fueled studies of the past. If these communities know that they may have personal benefit through these clinical trials, as explained in clear, specific, and direct communication, engagement is expected to be more favorable.

Finally, the study examined ways in which under-represented communities can be integrated better into medical research. Research Question 4 asked:

How should African Americans be included in research conducted during a pandemic?

Both interviews and study field notes indicated the importance of personal, one-on-one engagement of Black residents by those to whom they feel connected. This underscores the need to ensure that healthcare providers have the proper means to practice to the best of their ability, even in underserved communities. This approach to improved research inclusion is an extension of the need for diversity in medicine in that it claims diversity alone is not enough if the diverse

healthcare provider workforce is not equipped to serve in the role so heavily needed by suffering Black communities.

When members of these communities see and are able to have in-person communication with medical professionals they relate to on a racial and cultural level, the idea of research participation coincides with the belief that medical and research fields have trusted individuals of color. For example, both pharmacists interviewed in this study emphasized the importance of their daily interactions with community members as a starting point for engaging patients about participation in medical research studies (Thompson, 2021c,d). They navigated from conversations about the well-being and overall health of their patients as they visited the pharmacy for recurring prescriptions. They were then able to share the facts with their patients on the ways that participation in research can ensure that as a community there is representation in biomedical research.

Discussion and Conclusion

The results highlight that intentional inclusion at all points of medical research and intervention can work to decrease hesitancy in a local African American community toward medical research, vaccination and clinical trials. It can also work to reduce the mistrust from historical medical abuse in research that fuels hesitancy towards uptake of medical interventions. Reducing hesitancy among African Americans often means taking the time to build trust. It must be noted that during this time, trust can only be built with the proper resources needed in order for a strong relationship between the African American community and the American medical and healthcare system. These resources for the solidification of this relationship will be further analyzed.

The first resource to build trust between Black Americans and the American medical and healthcare system is diversity in medicine. This work aims to show that even on a local level, this can be done when medical professionals are representative of the community they engage with, as was the case with the community stakeholders observed in this study.

The next resource to improve trust is the continuation and improvement of communication channels from both medical and governmental leadership that is specific to the complex issues Black Americans faced long before the pandemic and that will persist afterwards. Such communication, especially during this pandemic, was accomplished through the Centers for Disease Control and Prevention, National Institutes of Health, and such state level bodies as the Louisiana Department of Health. The Louisiana Community Engagement Alliance Against COVID-19 Disparities, which served as one local part of the larger national NIH initiative, is a fine model for the way that America's nationwide medical institutions should provide communication tailored specifically to the daily and disproportionately heavy burdens carried by Black Americans. Projects such as LA-CEAL were created to support Black communities hard hit in New Orleans and across the state, allowing Black residents to receive clear, specific communication on vaccination locations, availability, efficacy, along with testing and infection data. This was a pandemic-related initiative, but projects like these are needed going forward to continue with targeted flows of information.

Finally, there needs to be more robust approaches to targeting misinformation. From a public health standpoint, social media serves as a crucial avenue for the specific communication being called for by this work. It also is a challenge for health professionals in ensuring the right types of information reach intended populations. Therefore, community engagement initiatives

will need to begin considering the role of social media as a means of directly communicating with hard-hit Black communities and combating false pandemic-related information.

As discussed earlier, this targeted communication can increase trust and ultimately decrease racial health disparities both during and beyond this pandemic. Future research can compare local community efforts that are culturally specific and the ways they modify these takeaways. For instance, how African American residents are engaged differs from Native residents and even Spanish-speaking residents whose communication and community structures may differ slightly from African Americans.

This study's analysis is limited in that its direct insights were restricted to a few New Orleans' Black physicians and medical providers who were partners of this specific COVID-19 project. Future research can look at what happens when ordinary residents can then serve as the word-of-mouth or non-scientific advocates for treatment, and inclusion in clinical research, and not the scientists alone.

Ultimately, the engagement of Black communities to mitigate and eventually eliminate disproportionate suffering can be accomplished through increased diversity in medicine, widespread acknowledgement of a scientific history rooted in racism, and clear, specific, and direct communication to Black communities. This can be achieved through a nationally funded hyper-local community engagement project that uses trusted community voices to advocate for medical research and intervention. This approach, as outlined in this case study, can certainly be a model going forward to reduce decades of medical mistrust within Black communities. Therefore, as established by this study of Black New Orleans during the coronavirus pandemic, the disproportionate burdens long carried by Black Americans, inclusive of the right to health access and care, has no need to exist in perpetuity.

References

- Adams, L. B., Richmond, J., Corbie-Smith, G., & Powell, W. (2017). Medical mistrust and colorectal cancer screening among African Americans. *Journal of community health, 42*(5), 1044-1061.
- Artiga, S., Kates, J., Michaud, J., & Hill, L. (2021, January 26). Racial diversity within covid-19 vaccine clinical trials: Key questions and answers. Retrieved March 12, 2021, from <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-diversity-within-covid-19-vaccine-clinical-trials-key-questions-and-answers/>
- Ball, K., Lawson, W., & Alim, T. (2013). Medical mistrust, conspiracy beliefs & HIV-related behavior among African Americans. *J Psychol Behav Sci, 1*(1), 1-7.
- Barrett, N. J., Ingraham, K. L., Hawkins, T. V., & Moorman, P. G. (2017). Engaging African Americans in research: The recruiter's perspective. *Ethnicity & Disease, 27*(4), 453.
- Benz, J. K., Espinosa, O., Welsh, V., & Fontes, A. (2011). Awareness of racial and ethnic health disparities has improved only modestly over a decade. *Health Affairs, 30*(10), 1860-1867.
- Blakey, M. L. (1999). Scientific racism and the biological concept of race. *Literature and Psychology, 45*(1/2), 29.
- Chandra, A., & Skinner, J. (2003). *Geography and racial health disparities* (No. w9513). National bureau of economic research.
- Chowkwanyun, M., & Reed Jr, A. L. (2020). Racial health disparities and Covid-19—caution and context. *New England Journal of Medicine, 383*(3), 201-203.
- Community engagement Alliance (CEAL) Against Covid-19 Disparities. (n.d.). Retrieved March 14, 2021, from <https://covid19community.nih.gov/>
- Dennis, R. M. (1995). Social Darwinism, scientific racism, and the metaphysics of race. *Journal of Negro Education, 243-252*.

Fairchild, H. H. (1991). Scientific racism: The cloak of objectivity. *Journal of social issues*, 47(3), 101-115.

Feagin, J., & Bennefield, Z. (2014). Systemic racism and US health care. *Social science & medicine*, 103, 7-14.

Figure 18. percentage of all ACTIVE physicians by race/ethnicity, 2018. (n.d.). Retrieved March 14, 2021, from <https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>

Franklin, Louisiana population 2021. (n.d.). Retrieved March 11, 2021, from <https://worldpopulationreview.com/us-cities/franklin-la-population>

Househ, M. (2013). The use of social media in healthcare: organizational, clinical, and patient perspectives. *Studies in health technology and informatics*, 183, 244–248.

Kennedy, B. R., Mathis, C. C., & Woods, A. K. (2007). African Americans and their distrust of the health care system: healthcare for diverse populations. *Journal of cultural diversity*, 14(2).

LA-CEAL. (2021). “About LA-CEAL,” Retrieved March 14, 2021, from <https://haltcovidla.com/about/>

Losh, J., & Plyer, A. (2020, March 25). Demographics of New Orleans and early COVID-19 hot spots in the U.S. Retrieved March 10, 2021, from <https://www.datacenterresearch.org/covid-19-data-and-information/demographic-data/>

Menand, L. (2001). Morton, Agassiz, and the origins of scientific racism in the United States. *The Journal of Blacks in Higher Education*, (34), 110-113.

NIH funds community engagement research efforts in areas hardest hit BY COVID-19. (2020, September 16). Retrieved March 9, 2021, from <https://www.nih.gov/news-events/news-releases/nih-funds-community-engagement-research-efforts-areas-hardest-hit-covid-19>

Orleans Parish COVID-19 Dashboard. (n.d.). Retrieved March 10, 2021, from <https://experience.arcgis.com/experience/746f03e88d204a2b82a7b958ea744bba/>

Rozenblum, R., & Bates, D. W. (2013). Patient-centred healthcare, social media and the internet: the perfect storm?. *BMJ quality & safety*, 22(3), 183–186. <https://doi.org/10.1136/bmjqs-2012-001744>

Scharff, D. P., Mathews, K. J., Jackson, P., Hoffsummer, J., Martin, E., & Edwards, D. (2010). More than Tuskegee: understanding mistrust about research participation. *Journal of health care for the poor and underserved*, 21(3), 879.

- Szanton, S. L., Rifkind, J. M., Mohanty, J. G., Miller, E. R., Thorpe, R. J., Nagababu, E., ... & Evans, M. K. (2012). Racial discrimination is associated with a measure of red blood cell oxidative stress: a potential pathway for racial health disparities. *International journal of behavioral medicine*, 19(4), 489-495.
- Taylor, C. M. (1981). WEB DuBois's challenge to scientific racism. *Journal of Black Studies*, 11(4), 449-460.
- Thompson, A. (2021, February 15). Personal Research Interview via Zoom with Dr. Keith Ferdinand, MD.
- Thompson, A. (2021, February 4). Personal Research Interview via Zoom with Dr. Gary Wiltz, MD.
- Thompson, A. (2021, February 11). Personal Research Interview via Telephone with Christopher Sylvain, RPh.
- Thompson, A. (2021, February 9). Personal Research Interview via Telephone with Dr. Lishunda Franklin, PharmD.
- U.S. Census Bureau Quickfacts: Orleans Parish, Louisiana. (n.d.). Retrieved March 9, 2021, from <https://www.census.gov/quickfacts/orleansparishlouisiana>
- U.S. Census Bureau QUICKFACTS: United States. (n.d.). Retrieved March 14, 2021, from <https://www.census.gov/quickfacts/fact/table/US/PST045219>
- Ventola, C. L. (2014). Social media and health care professionals: benefits, risks, and best practices. *P & T: a peer-reviewed journal for formulary management*, 39(7), 491–520.
- Weinstein, R., & Plyer, A. (2020, June 25). Detailed data sheds new light on racial disparities IN COVID-19 deaths. Retrieved March 14, 2021, from https://www.datacenterresearch.org/reports_analysis/lack-of-data-obscures-true-levels-of-racial-inequity-in-covid-deaths/