Reactions to COVID-19: A Public Health Critical Race

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Abstract: Since the spring of 2020, the pandemic has dominated public discourse. Using a public health critical race praxis research approach, our team interviewed a diverse group of individuals to elicit stories about their knowledge, attitudes, and responses to COVID-19. We used health belief model constructs and critical race theory tenets to evaluate race and ethnicity's influence and implications in reactions to the pandemic. Findings include the ordinariness of racism and colorblindness in assessing the susceptibility and severity of COVID-19 and its risk factors. Including social determinants of health in the core curriculum of cross-disciplinary education programs emphasizes the impact of public health disparities and may reduce colorblindness and ordinariness.

Keywords: COVID-19, community health education, public health critical race praxis, health belief model, critical race theory, social determinants of health

The World Health Organization (WHO) reports that as of November 1, 2020, almost 1.2 million people worldwide have died from SARS-CoV-2, the virus that causes COVID-19 worldwide, with 19.1% of recorded deaths occurring in the United States (WHO, 2020). The Centers for Disease and Control and Prevention (CDC) indicate that American Indian, Alaska Native, and Hispanic people are 2.8 times more likely to be infected and approximately five times more likely to be hospitalized due to COVID-19 than non-Hispanic Whites (CDC, 2020c). Non-Hispanic Black or African Americans are 2.6 times more likely to contract the virus, 4.7 times more likely to be hospitalized, and 2.1 times more likely to die of COVID-19 related illnesses (CDC, 2020c). Individuals with underlying obesity conditions, diabetes, and hypertension have higher morbidity and mortality rates (CDC, 2020d). Non-Hispanic Black and Hispanic populations have higher prevalence rates in each of these comorbidities (CDC, 2020a, 2020b; Fryar et al., 2017). The purpose of our study is to evaluate the impact of race and ethnicity on individuals' knowledge, beliefs, and behaviors during the pandemic; therefore, our research questions follow:

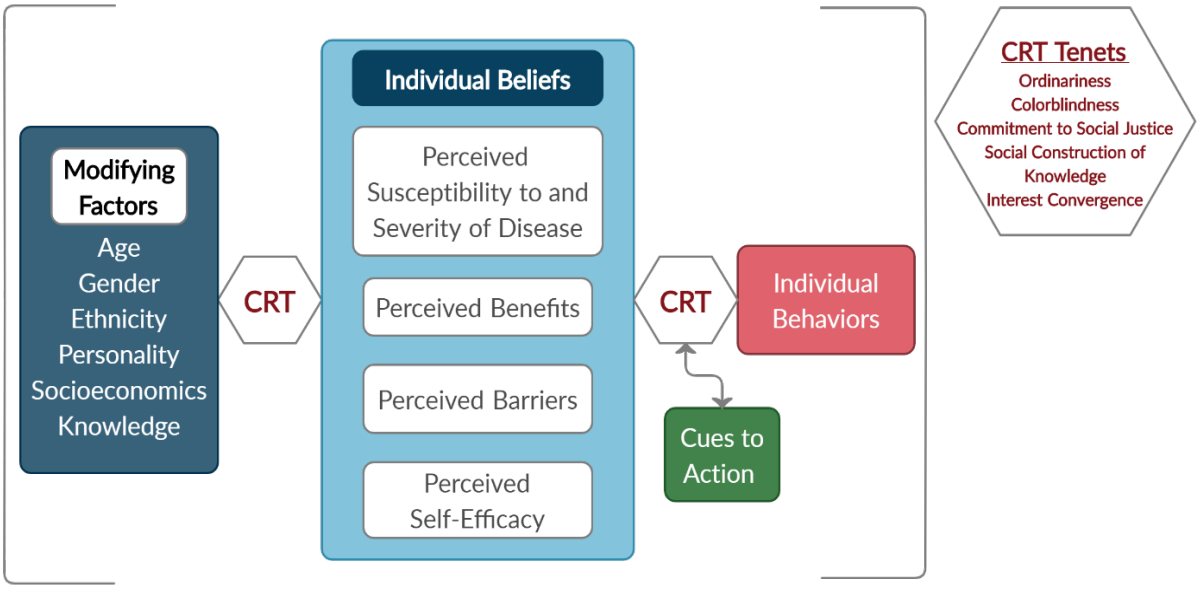
1. How does race/ethnicity impact the choice of sources and how individuals receive information about COVID-19?
2. What is their interpretation of the information learned about COVID-19?
3. How does race influence respondents' experience or the perception of others' experiences during the pandemic?

Conceptual Framework

Ford and Airhihenbuwa (2010) describe public health critical race praxis (PHCRP) as a semi-structured research approach that informs the racialization of public health conventions such as modes of knowledge production. We used PHCRP as a guide to create our conceptual framework. To assess the public health implications of reactions to the pandemic, we used health

belief model (HBM) constructs such as perceived susceptibility and severity of COVID-19 and perceived barriers to positive behavior changes. As Closson (2010) suggests, we used critical race theory (CRT) as part of our framework to "cast light on aspects of the dialogue on race in the field that have been left out of earlier discussions" (p. 280). In our combined conceptual framework, visualized in Figure 1, we sought to find CRT tenets (shown in the upper right corner) that influenced HBM constructs (seen within the brackets). PHCRP includes transparent researcher positionality and encourages scholars to address identified racial hierarchies in health disparities (Ford & Airhihenbuwa, 2010). Therefore, CRT's central tenets are presented as an exponent to raise our 'study's findings to the power of CRT.

Figure 1: *Study Conceptual Framework*



Methods

Study Design and Sample Selection

This is a basic qualitative inquiry. We used the constant comparative method to analyze our data. We conducted semi-structured interviews to solicit information on participants' knowledge about COVID-19 using questions designed to elicit HBM constructs of perceived susceptibility, severity, benefits, barriers, and cues to action (Glanz et al., 2008).

We recruited participants using purposeful and snowball sampling through social media. In keeping with CRT's focus on including narratives from people of color (Ladson-Billings, 1998), we recruited racially and ethnically diverse participants. Study participant demographics are seen in Table 1. In addition, we sought participants of various ages and educational backgrounds. Participants were aged 18-75 with education levels ranging from high school to doctoral degree, with the majority holding bachelor's degrees.

Table 1: *Study Participant Demographics*

Gender	Non-Hispanic Black/African American	Non-Hispanic Asian	Hispanic/Latino White	Non-Hispanic White
Female (n=16)	1	3	6	6
Male (n=12)	1	2	5	4

Data Collection and Analysis

We conducted interviews in April 2020 (n=14) and June-July 2020 (n=14) by phone or through Zoom, a video conferencing platform, and recorded with participants' permission. Follow-up questions were asked during the interview to solicit clarifying information when appropriate. We Interviews were transcribed. To ensure credibility, we engaged in peer review of the findings and adequate engagement in data collection. We used the constant comparative method (Glaser & Strauss, 1990) to look within and between transcripts for themes aligned with HBM constructs or CRT tenets.

Findings

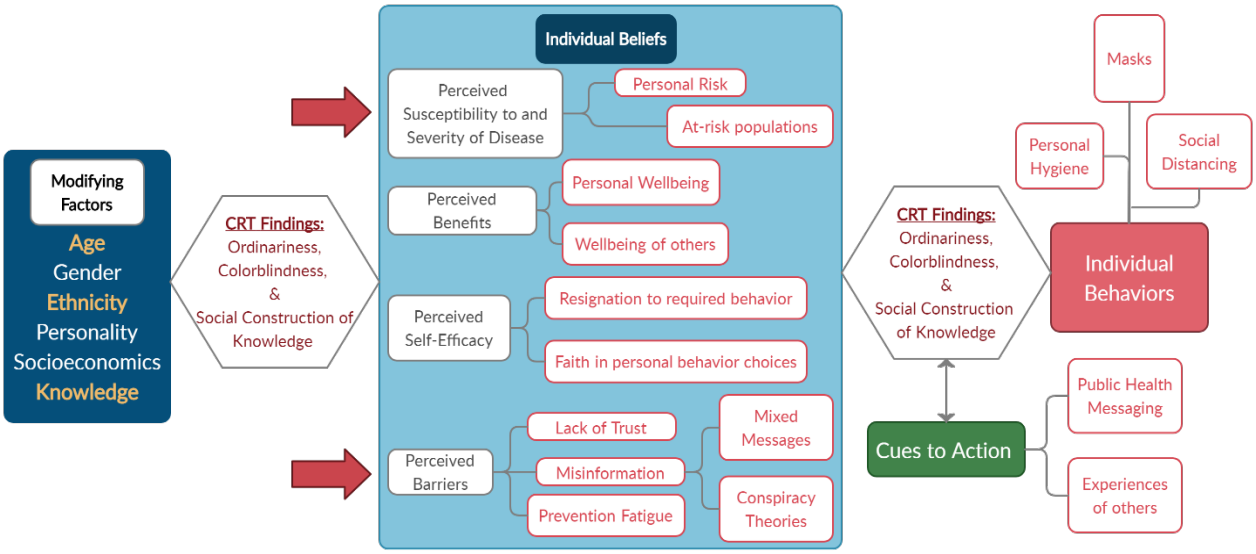
As seen in Figure 2, the HBM constructs most influenced by CRT tenets were perceived susceptibility and severity of disease and perceived barriers. We identified the following CRT themes: colorblindness (Bonilla-Silva, 2015), ordinariness (Bowman et al., 2009), structural/systemic racism (Ladson-Billings, 1998), social construction of knowledge (Ford & Airhihenbuwa, 2010), and interest convergence (Bell, 1980).

Race and Information

Individuals learned behaviors such as mask-wearing and social distancing from major media sources, including networks like ABC, CNN, and local news affiliates. Many participants noted the importance of receiving information from established media sources they perceived to be reliable and legitimate. When trusted, these instructions fell within the HBM construct of cues to action. The reach of public health messaging across racial and ethnic groups to prevent the spread of this disease appeared to mitigate the critique of the HBM that assumes messages are widespread and equitably distributed (LaMorte, 2019); however, lack of representation in newsrooms limits or excludes counter-narratives of communities of color (Greico, 2018). A structural change is necessary to adequately represent these stories.

Misinformation that included conspiracy theories and mixed messages were among the most common themes in the HBM construct of perceived barriers. The importance of "mainstream" media sources during a pandemic was made clear during our interviews. Changing recommendations and elected officials openly questioning these outlets' legitimacy presents a perceived barrier to positive behavior changes. All participants mentioned their distrust of the government except for non-Hispanic White males, who overwhelmingly indicated high levels of trust in government at all levels. Respondents of color relied heavily on the social construction of knowledge, demonstrating higher levels of trust in community members' experiences and information than the government.

Figure 2: *Conceptual Framework with Study Themes*



Race and Experience

Regardless of their race/ethnicity, most participants (75%) did not state the differential impact of this disease on racial and ethnic groups. When asked about populations most at risk for COVID-19, respondents overwhelmingly echoed public health messaging talking points, identifying the elderly and those with pre-existing or underlying health conditions at greatest risk. In comparison to non-Hispanic White participants, the people of color in our study indicated a lower perceived susceptibility and severity despite widespread news coverage of COVID-19 outcome disparities in non-Hispanic Black and Hispanic populations. Only two individuals indicated awareness of people of color as higher risk, one of whom stated, "it is interesting that the Black population is more impacted with severe infections because of higher rates of hypertension and diabetes." Obesity and diabetes were mentioned 29 times but only once in conjunction with race despite the higher prevalence rates of both conditions in Black and Hispanic populations. No person of color mentioned the racial disparity in these comorbidities. It is possible that individuals are socialized to expect poorer health outcomes among people of color. If examined at all, these poor outcomes are often attributed to the social determinants of health (SDOH), ignoring their link to structural racism (Ford & Airhihenbuwa, 2010). This is a crystallization of the CRT tenet of ordinariness (normal and integral) nature of racism in the United States (Ford & Airhihenbuwa, 2010). A virus may not discriminate, but people and societal systems do.

When asked about how their race impacted their experiences during the pandemic or how those from other races might have different experiences, most participants used phrases such as "lesser means," lack of resources," and "less access to care. One participant mentioned "systematic oppression . . . White people have a bit of a leg up"; however, most indicated that they did not feel that race would make a significant difference in the experiences of people during the pandemic. One participant stated, "COVID sees no race; that's how I see it. We all bleed red. On the inside, we all bleed red." Intentional deviance from using racial terminology is an indicator

of the CRT tenet of colorblindness (Bonilla-Silva, 2015). Closson (2010) asserts, “Society is structured with systemic racism. . . . We accept that everyone is infected with a disease to greater or lesser degrees. . . . To claim to be colorblind allows the disease to spread unchecked” (p. 279).

Limitations

To protect participants and interviewers' health and safety alike, the Institutional Review Board prohibited recruiting or interviewing participants in person; therefore, it was difficult to recruit participants through personal social media from a variety of backgrounds with a high school education or less. Further, when discussing how identity influenced their experience with the pandemic, we, like Cunningham and Scarlato (2018), found “race did not organically emerge in the discussion” (p. 237). Although we centered our study in the margins, as White and Hispanic female recruiters and interviewers, we struggled to recruit adequate non-Hispanic Black or African American participants and observed difficulty eliciting an organic discussion of racial implications. Additionally, COVID-19 is an unprecedented occurrence. The ever-evolving nature of public health guidance and local and federal direction related to preventing the disease presented a challenge when comparing responses over time.

Conclusions and Implications

Unlike other health issues impacting the United States, the ease of transmission and severity of infection with the virus makes dissemination and accessibility of information critical for public health. The CRT tenet of interest convergence asserts that the interests of communities of color are addressed when they converge with the interests of Whites (Bell, 1980). Closson (2010) posits that “interest convergence both explains a racial reality and offers a strategy for surmounting racial obstacles” (p. 273). The messages of hand-washing and social distancing recommended by the CDC have been repeated by major news outlets, permeating the collective consciousness. Based on interview responses, this was determined to be an area of interest convergence as all study participants reported making at least one behavior change. The CRT implications of interest convergence indicate that educators must acknowledge this hegemonic hierarchy of interests and proactively intercede to address marginalized groups' needs before it serves the dominant group.

To reduce the ordinariness and colorblindness in health disparities, educators in all disciplines should be aware of the racial impact of SDOH on their learner population. A person’s health affects every aspect of their life. Hence, SDOH will make an impact on learning across disciplines. We recommend that all educators familiarize themselves with the five critical elements of SDOH: economic stability, education, social and community context, health and health care, and neighborhood/built environment. With knowledge of the racial aspects of SDOH, educators can create curricula that are appropriate across disciplines with applications in a variety of programs. Educators from different backgrounds should introduce SDOH in communities of color into their professions’ dialogue through guest speakers, SDOH training, professional conference presentations, and interprofessional research.

References

Bell, D. (1980). *Brown* and the interest-convergence dilemma. In D. Bell (Ed.), *Shades of Brown: New perspectives on school desegregation* (pp. 90-106). Teachers College Press.

Bonilla-Silva, E. (2015). The structure of racism in color-blind, "post-racial" America. *American Behavioral Scientist*. 59(11), 1358-1376.

Bowman, L., Rocco, T. S., Peterson, E., & Adker, W. A. (2009, June 6-9). *Utilizing the lens of critical race theory to analyze stories of race* [Paper presentation]. Adult Education Research Conference, Chicago, IL, United States. https://newprairiepress.org/aerc/2009/papers/7

Centers for Disease Control and Prevention. (2020a). *National diabetes statistics report, 2020*. U.S. Department of Health and Human Services. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

Centers for Disease Control and Prevention. (2020b). *Adult obesity facts*. https://www.cdc.gov/obesity/data/adult.html

Centers for Disease Control and Prevention. (2020c). *COVID-19 hospitalization and death by race/ethnicity*. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

Centers for Disease Control and Prevention. (2020d). *People with certain medical conditions.* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

Closson, R. B. (2010). Critical race theory and adult education. *Adult Education Quarterly, 60*(3), 261-283.

Cunningham, B. A., & Scarlato, A. S. M. (2018). Ensnared by colorblindness: Discourse on health care disparities. *Ethnicity & Disease*, *28*(Supplement 1), 235–240.

Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health*, *100*(S1), S30-S35.

Fryar, C. D., Ostchega, Y., Hales, C. M., Zhang, G., & Kruszon-Moran, D. (2017). *Hypertension prevalence and control among adults: United States, 2015–2016* (Report No. 289). National Center for Health Statistics. https://www.cdc.gov/nchs/data/databriefs/db289.pdf

Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behavior and health education: Theory, research, and practice* (4th ed.). Jossey-Bass.

Greico, E. (2018, November 2). *Newsroom employees are less diverse than U.S. workers overall.* Pew Research Center. https://www.pewresearch.org/fact-tank/2018/11/02/newsroom-employees-are-less-diverse-than-u-s-workers-overall/

Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education? *Qualitative Studies in Education, 11*(1), 7-24.

LaMorte, W. W. (2019, September 9). *Behavioral change models* [PowerPoint slides]. Boston University School of Public Health. https://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories2.html