

ACCOUNTABILITY AS A PUBLIC HEALTH RESPONSE: COVID-19's Impact on Communities of Color

NASTAD recognizes that institutional accountability in public health is needed to effectively address the health inequities exacerbated by COVID-19 and other pandemics. Focusing the public health response solely on individual behavior change overlooks the context in which existing health inequities arise. Infectious disease outbreaks place substantial health and economic burden on communities of color, resulting from systematically limiting access to resources such as unbiased healthcare, living wages, and legal protections. To achieve health equity and to better prepare for future outbreaks, we must address long-standing systemic issues, including medical racism, institutional stigma and trauma, discriminatory hiring practices, medical mistrust, and the inequitable distribution of public health resources. Accountability in public health also prioritizes the voices of public health professionals of color and impacted communities as the key experts needed to address these issues effectively. Therefore, NASTAD worked with members of the Minority Leadership Program to develop recommendations for health departments to implement in their responses to COVID-19, which you can find [here](#).

NASTAD acknowledges the diligent work of all institutions involved in the public health response to the current COVID-19 outbreak and encourages strategies that address the barriers that allow COVID-19 and other inequitable health outcomes to persist. Data on the effects of COVID-19 on specific racial and ethnic groups remain scarce. Still, available reports show that Black and African American communities are overrepresented in hospitalized patients and in

reported deaths across most geographic regions in the United States.^{1,2} Examples from New York City, Chicago, St. Louis, and others, highlight a death rate for Black and African American communities that is disproportionately higher than that of White communities.^{2,3,4} Similarly, a higher mortality rate has been identified in Latinx and Asian Americans across New York State and California, respectively.^{1,2}

“The latest available COVID-19 mortality rate for Black Americans is 2.4 times higher than the rate for Latinos, 2.5 times higher than the rate for Asians, and 2.7 times higher than the rate for Whites.”²

The existing data highlight how communities with limited access to healthcare and other resources continue to be impacted by poverty, classism, and racism. These inequities are perpetuated through differences in living conditions (e.g., densely populated housing, residential segregation, and overrepresentation in prisons and detention centers), working conditions (e.g., a quarter of Black, African Americans, and Latinx workers are employed by the service industry, Latinx people account for 53% of the agricultural workforce, and Black and African Americans represent 30% of vocational nurses)¹, and limited health insurance and paid sick leave (e.g., Latinx people are three times, and African Americans are two times as likely to be uninsured than Whites)¹.

COVID-19 surveillance and clinical research data must include racial, ethnic, and socioeconomic

¹ CDC. Coronavirus Disease 2019 (COVID-19) [Internet]. Centers for Disease Control and Prevention. 2020 [cited 2020 Apr 23]. Available from: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>

² COVID-19 deaths analyzed by race, 04-14-2020 [Internet]. APM Research Lab. [cited 2020 Apr 16]. Available from: <https://www.apmresearchlab.org/covid/deaths-by-race>

³ City of Chicago: Latest Data [Internet]. [cited 2020 Apr 23]. Available from: <https://www.chicago.gov/city/en/sites/covid-19/home/latest-data.html>

⁴ Demographic Data [Internet]. stlouis-mo.gov. [cited 2020 Apr 23]. Available from: <https://www.stlouis-mo.gov/covid-19/data/demographics.cfm>

⁵ Chen JT, Krieger N. Revealing the unequal burden of COVID-19 by income, race/ethnicity, and household crowding: US county vs ZIP code analyses. Harvard Center for Population and Development Studies Working Paper Series, Volume 19, Number 1. April 21, 2020. <https://tinyurl.com/y7v72446>

information to tailor prevention and treatment strategies. Yet only 21 states are currently reporting data disaggregated by race and ethnicity, and of those that do, about 50% of cases and deaths list race and ethnicity as unknown or missing.⁵ Additionally, 65% of cases in the CDC data available are missing race and ethnicity information.⁵ It is the responsibility of public health professionals, including NASTAD, not just to ensure data are being collected, but that swift action is taken. The time and resources spent during the crisis advocating for appropriate data collection and reporting measures only delay a targeted and culturally relevant response and further exasperate the devaluing of Black and Brown lives.

Furthermore, the consistent need for advocacy places a burden and negative mental health impact on public health professionals of color who are experiencing grief firsthand, while having to persuade institutions to respond appropriately. Long-term public health accountability includes diversifying the workforce, but also supporting the diverse workforce currently in place comprised of those directly impacted by loss of life, illness, and systemic disregard. Accountability strategies must include listening to, prioritizing, and operationalizing responses to the concerns of public health professionals of color. Diverse workforces also have the rich understanding needed to tailor protective measures and guidance for communities with limited options. This can include adapting COVID safety guidelines for communities lacking access to clean water (e.g., the Navajo Nation or residents of Flint, MI), for essential workers with limited “staying at home” options, or for people who are incarcerated and immigrants in detention centers where social distancing practices are not feasible. Public health professionals of color can also provide a clear vision that addresses the contexts in which people find themselves unwell. This vision could include a reimagining of funding strategies that redirect resources to organizations and health centers in areas impacted by redlining, or ideas on how to contextualize surveillance data in ways that tell a bigger picture to explain the causes of inequities.

To ensure public health professionals of color are prioritized in determining culturally appropriate responses to COVID-19, NASTAD harnessed

the collective wisdom of its [Minority Leadership Program](#) participants to develop recommendations to aid Health Departments in achieving equitable outcomes. The Minority Leadership Program (MLP) is a leadership development and investment program for persons of color working in state or CDC funded health department positions in HIV and viral hepatitis programs. MLP serves as a space rooted in social justice for health department staff of color to engage in critical conversations about institutional barriers, managing emotions and burnout, racial and gender-based microaggressions, communication, and project management. NASTAD recognizes the need to prioritize the voices of emerging leaders of color in public health and, as such, prioritized their expertise to develop the following recommendations:

DATA COLLECTION AND REPORTING

- Advocate for demographic information to be complete and comprehensive to ensure we understand how COVID-19 and other diseases that disproportionately impact communities of color can be effectively addressed in a culturally responsive manner.
 - *Address underreporting of Native American communities and cease the practice of reporting available data on Native Americans as “other.”*
- Address inequitable distribution of public health resources by ensuring that disaggregated data by race, ethnicity, and zip code are collected. Comprehensive data collection will allow health departments to look at and prioritize the groups and areas disproportionately impacted by COVID-19 to ensure that healthcare staff have the data and information needed to improve patient care. The data will also allow the proper allocation of resources and a targeted approach to disseminating public health information.
- Information about a person’s race, ethnicity, and other demographics should be collected at the point of service, self-reported by the individual, and either confirmed or collected if it is missing as the data move through the public health surveillance system.
 - *It is important never to make assumptions about race and ethnicity and to appropriately ask, record, and report this information while maintaining the highest level of patient confidentiality and data security.*

- Data should be collected in synchronous time as other related issues such as healthcare access, insurance status, income, poverty, food insecurity, domestic violence, sexual assault, incarceration, safe and secure housing, homelessness, etc. These ancillary issues should also be aggregated by race and ethnicity.
 - *Expand the collection of additional variables that may expose or make clear other inequities, such as sexual orientation, gender identity, and co-morbidities.*
- It is imperative that we make every effort to retroactively collect data that were not collected during the height of the pandemic.
- Utilize the data collected to identify inequities, infection rates, morbidity rates, mortality rates, and access to testing. Use data to inform targeted, thoughtful action, and disseminate the data in a way that is community-focused and does not seek to disparage or further widen existing inequities.
- Work that is informed by data or utilizes data to monitor or evaluate impact should expand beyond traditional sources and recognize that traditional data collection has often left marginalized communities invisible.
 - *Consider less traditional data collection processes, such as qualitative data processes (virtual focus groups and interviews) and art-based data collection (story-work, digital storytelling, and photovoice), to help humanize the impact of the pandemic.*
- enforcement in a way that increases access to care without creating unnecessary barriers or fear.
- Work should center needs and voices of communities of concern, particularly communities of color and other communities that have been historically marginalized.
- Work to establish culturally sensitive approaches to collaborating with, and supporting, Native American and indigenous communities, whether urban or reservation based. Plans should be in place to quickly ramp up this support in times of crisis. These efforts must be rooted in respect for the autonomy and unique cultural traditions of each community.
- Ensure that testing is available, accessible, and known of in communities of color, especially in rural areas, before moving patients to metropolitan areas as many hospitals are facing bed, ventilator, or other shortages.
 - *Due to hospital and health department closures along with a reduction in hours before COVID, people in rural communities have had to drive 45 minutes or more to seek medical attention. Access to healthcare in rural communities should be prioritized, and hospital closures ceased to ensure equitable health outcomes beyond the pandemic.*
- Focus clear efforts on relationship and trust-building between community and public health institutions as key process and outcome measures.
- Develop a solid plan to address the need for adequate prenatal care for vulnerable populations during times of mass trauma when such care cannot be provided in a hospital setting. The first step could be to adequately investigate and analyze the inequalities related to why vulnerable groups primarily seek care in hospital settings rather than private practices. Prioritize creating alternatives and standardized responses for doctors to address these issues in times of mass medical emergencies.
- Actively seek out, encourage, and financially support innovative approaches by subrecipient agencies providing community engagement activities to those greatly impacted by COVID-19.
- Learn what issues communities are facing and work to provide solutions. Host weekly calls and meetings, develop a health equity webpage with resources, etc.

EXPAND ACCESS TO TESTING AND TREATMENT

- Ensure that access to COVID-19 testing is expanded to the communities impacted the most, especially those who are immigrants, incarcerated, and vulnerably housed.
- Value the principles of health equity by ensuring that adequate access to COVID testing, resources, tools, and information is made available in diverse languages and for differently abled communities (e.g., people who are deaf and hard of hearing or need ASL services).
- Work with law enforcement to stop over-policing in communities of color during the pandemic. Offer training and guidance to ensure public health responses are appropriately implemented by law

- Address community concerns about discrimination in healthcare access, services, information, and education.
- Gather feedback in real-time during the response rather than utilizing traditional after-action feedback loops, which are slow and constricting in a long-term pandemic.

CULTURALLY RESPONSIVE MARKETING AND OUTREACH

- Invest in marketing tools that adequately inform communities of color of readily available resources, especially in those neighborhoods that have fewer institutional anchors.
- Actively seek input from communities of color before making any blanket statements regarding how these communities will best rebound and the tools necessary to recover from the devastating impact of COVID 19.
- Messaging should be vetted through community voices, disseminated through culturally appropriate means, and evaluated for understanding, reach, and impact.
- Ensure that messaging about the COVID response is equitable and thoughtful and does not exacerbate prejudices by using discriminatory language and terminology.
- Information should be provided in multiple languages and crafted to ensure literacy levels are not a barrier to understanding. Make sure to vet it before distributing even after it has gone through a translation agency.
- Create culturally and linguistically appropriate content. All messaging should be multilingual, multicultural, clear, transparent, and credible. Health Departments should utilize different media platforms most accessed by communities of color and incorporate social media to increase the frequency of messaging.

COLLABORATE WITH DIVERSE PARTNERS

- Collaborate with faith-based organizations and other trustworthy institutions who have developed virtual platforms to connect with their communities and who can provide cultural, linguistic, and consistent public health information.
- Have a community liaison for each underrepresented

community that can act as a bridge between health departments and the public.

- Partner with communities to disseminate linguistically and culturally appropriate messaging, including community-based organizations, influencers, and ethnic media.
- Take explicit care not to co-opt work created by communities of color or other historically marginalized communities. Information and education should clearly credit their work and communities should be compensated for their time, effort, and expertise.
- Continue to be connected to communities at the intersectional impact of other social, structural determinants and factors related to COVID-19. This can include people working in the gig economy (e.g., sex workers, nannies) who are not supported by unemployment services, those experiencing food insecurity, unstable housing, homelessness, domestic and family violence, or the inability to continue school due to lack of technology.
- Develop task forces to identify unique obstacles that underserved racial and ethnic minority communities face (e.g., migrant/farm workers, Native Americans, and rural communities). Utilize task forces to identify the causes of health inequities and to develop plans to address obstacles at state and local levels.

WORKFORCE EXPANSION AND STAFF SUPPORT

Workforce Expansion:

- Designate essential worker status for harm reduction and other programs serving disproportionately marginalized communities.
- Include infectious disease and health equity program staff in internal COVID-19 response workgroups to avoid unintended harm to communities of color and other marginalized people.
- Evaluate divisions, units, and bureaus at health departments to ensure that there is diversity at every level. While leadership may likely direct staff to tailor actions to respond to data, there is value in having the insight to help shape the response from individuals who are both qualified and members of the affected communities we serve. A clear majority of impacted communities should also be reflected in leadership positions.

- Work must be community-driven and community-led and include expertise in race, gender identity and expression, sexual orientation, equity, minority health, cross-cultural research, and community participatory methodologies.
- Embrace and immediately implement a “health in all” policies approach. Expand reach by creating working partnerships with non-medical sectors to address the social determinants of health, thereby addressing the underlying factors that allow for poor health. We can no longer afford to work in a vacuum. This approach may also help reduce the silos we work in due to categorical federal funding.
- Define and address underlying health inequities in asthma, heart disease, high blood pressure, smoking rates, diabetes, access to quality health care, and unhealthy living conditions. Left unaddressed, these inequities will always be exacerbated by emerging epidemics, crises, and traumatic community-wide events.

Staff Support:

- Acknowledge that health department staff are experiencing loss, death, and challenging times where flexibility, compassion, and support must be provided.
- Consider providing trauma-focused care to staff that are experiencing the effects of both living through and working during a crisis in frontline sectors.
- Allow staff at all levels and areas of the organization to have their voice heard and have their time and effort fairly and equitably compensated with hazard pay or additional paid time off.
- Provide fair, and liberal family and personal paid leave and extended sick time.
- Fully evaluate actions prior to, during, and post-response, including:
 - *Internal policies and protocols and how they impacted staff at every level of the organization.*
 - *Issues of parity, equity, and fairness in organizations.*

INSTITUTIONAL CHANGE TO DISMANTLE SYSTEMIC RACISM

- We know there are long-standing existing policies that support the systems we work in and thereby

support structural and systemic racism. Examine existing policies to determine if they perpetuate racism, whether intentionally or inadvertently. When creating new policies, there should be an intentional focus on ensuring that they are inclusive and equitable.

- Consider power hierarchies and status quo norms (e.g., values of White supremacy, patriarchy, pathologizing, racializing, and criminalizing) which contribute to the ways in which health inequities are perpetuated among communities of color.
- Address funding structures that continue to prioritize well-resourced organizations and divert funding to organizations and clinics located in neighborhoods impacted by historical redlining and limited access to care.
- Be willing to speak truth to power whenever needed to keep work honest and clear in its integrity and authenticity.
- Support research that examines the impact of internal bias and institutional racism on communities of concern, particularly persons of color.
- Name racism rather than couching it in terminology intended to value dominant comfort over people of color's health and wellbeing.
- Consider the epigenetic impact of intergenerational stress, trauma, and oppression on communities of color and how that aligns with health inequities and vulnerabilities experienced during a pandemic.
- Racism – we have to call it out, name it specifically, and then work to address it. We do not have the power to change the hearts and the minds of those who exhibit racist behaviors or implicit bias but, we have the responsibility to question unequal treatment and enforce treatment standards across all providers for all patients.

NASTAD is committed to continuing to support Health Departments navigate accountability measures in public health responses to address the root causes of health inequities. Please do not hesitate to reach out with technical assistance needed or additional resources to share across our membership by emailing [Rosy Galván](#), Director, Health Equity.