

**PERCEPTIONS, NEEDS, CHALLENGES AND INSIGHTS
OF AN UNDERSERVED COMMUNITY
IN THE COVID-19 PANDEMIC**

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Foreword

The COVID-19 Pandemic has brought great change to lives around the globe. The suddenness and magnitude of that change will likely never be forgotten. It is safe to say that nearly all of the world's people have been impacted in some way, and, in the vast majority, that impact has been considerable. Similar to other disasters - and I think many will consider this pandemic to be a disaster - there are those who suffer more than others. The COVID-19 Pandemic has shone a bright light on the inequities of that suffering in the United States and other countries.

Understanding and reducing inequities in health, like those seen with the pandemic, have been and continue to be the focus of our work at the University of South Alabama Center for Healthy Communities (CHC). The CHC takes a community-engaged approach to our mission. Since our founding in 2003, we have been fortunate in developing numerous relationships and partnerships in the battle to achieve health equity. The dissemination of information and the telling of stories has been a foundation of our approach, and we realize that our partners have many stories to tell.

Early in the pandemic, it became evident that people of color and those who live in poverty were at higher risk for becoming infected with the virus and having a bad outcome, including death. It was clear to us at the CHC that the very populations with whom we partner in efforts to promote health equity would have a unique experience that should be documented, understood, and shared. Therefore, we sought to give voice to representatives of communities experiencing health disparities. This report is a vehicle for their voices to be heard more broadly. We hope that the information and insight provided will be useful to community leaders and other stakeholders as they work to address the stresses brought about by the pandemic, as well as other future challenges.

The CHC thanks the project's participant-partners for their time, cooperation, openness, and their dedication to improve the conditions of underserved communities. We hope that their accounts and recommendations are heard and **that action is taken** to render the inequities of suffering less dependent on skin color, income, wealth, and education.

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The present report is based on conversations with a group of fifteen community members who are valuable affiliates of the USA Health Center for Healthy Communities. They serve as members of Research Advisory Boards, as volunteers in the Community Health Advocates (CHA) program, or as staff members. We greatly appreciate their unwavering dedication to promote health equity in their community. We are thankful for the generous gift of their time and expertise in discussing issues of the pandemic in order to let the voice of their community be heard at this perilous junction.

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EXECUTIVE SUMMARY

The COVID-19 pandemic has affected every area of life for communities in terms of both disease burden and the need to adopt mitigation behaviors. Data clearly shows that minority communities experience more profound impacts in terms of disease severity and death if contracting COVID-19. They also experience economic and health hardship due to the mitigation steps taken to slow the spread of the virus.^{1,2}

To elucidate these impacts, the Center for Healthy Communities (CHC) undertook a qualitative research study to understand the lived experience of the pandemic among residents of its immediate service area, encompassing zip codes 36602-07, 36610 & 36617. Health disparities of the area were documented in 2008.³ From April 30 through May 19, we conducted interviews and focus group discussions with 15 community members, leaders, or advocates. The study sought to understand:

1. How community members experience the COVID-19 pandemic
2. How to address challenges specific to COVID-19, and
3. How to effectively communicate relevant information in the community.

In discussing the impact of the COVID-19 pandemic and the response to it in the community, it is important to acknowledge that some people living in the area do have resources to easily adjust to pandemic mitigation strategies. They were able to transition to remote work and to provide children with the devices and structured environment for remote learning. This group of residents can take advantage of the emphasis on staying at home to relax, strengthen family relationships, and decompress from “normal routines.”

However, persons living below the poverty line (an estimated 31.5% of the population)⁴ or with limited income have few resources to withstand the demands of the pandemic and resulting mitigation response. Such is the community the present report mainly relates to.

COMMUNITY EXPERIENCES

The pandemic and ensuing mitigation strategies brought about four major stressors for low resource families: increased childcare needs, added responsibility of remote education, economic peril, and intense disturbance of usual social network support.

Childcare: The abrupt closing of schools resulted in profound disruption of family routines as well as loss of a major source of childcare for the workday and of meals for children; while parents with “essential jobs” had to continue to work. Mostly, grandparents assumed the care of children. However, families lacking such support had to make other arrangements, with concern of heightened exposure risk for the child at someone else’s home and increased financial strain in paying for the caretaker.

Remote education: The move to at-home education assumed widespread access to technology not present in low resource communities. It shifted the provision of a structured environment for learning and of assistance for subject matter understanding to parents and guardians who, in many instances, had to continue working full time and lacked resources (i.e.; ease of accommodations at home, internet ready devices, connectivity, technological know-how, knowledge of school subjects). At home educational responsibilities were even more difficult to fulfill for children with special needs. Overall, the shift to remote education was very stressful for parents, and learning was difficult for children. The likely long-term impact will be a net deficit in children's educational achievement.

Economic Stress and Sources of Relief: The economic fallout from the mitigation strategies was considered a major problem in the community. Individuals in positions not amenable to remote work or who were not considered essential employees lost their jobs. Others saw a reduction in their work hours. Both situations worsened hardships in households already living paycheck-to-paycheck. In addition, day jobs or manual labor side hustles abruptly stopped, preventing individuals in the informal job market from earning their livelihood.

Governmental assistance has provided relief, although receipt has been uneven. The \$1,200 stimulus payment met immediate needs, but the amount is not sufficient to carry families through the extended pandemic period. The expanded unemployment supplement of \$600 per week has served to maintain and stabilize families, but its temporary nature means that families will face steep struggles when the program ends. It is feared that a combination of lost income and the lifting of eviction bans will lead to an increase in homeless individuals and families.

Community-based relief has included discounts on utility bills and leniency in making payments on bank loans. Social service agencies continue their work by phone offering access to food banks and communal pantries. Many churches also provide food assistance. Some small businesses continued to be supported by customers, even if services were not provided (e.g.; beauty salons).

Adoption of mitigation behaviors: There was a clear divide between the younger and older segments of the community with regards to adherence to stay at home orders and social distancing. For the most part, seniors heeded the advice and limited social interactions as well as excursions outside their homes. Younger residents were not as compliant, staging large gatherings or continuing to go out. At the early stages of the pandemic, some questioned whether the virus was real. As community spread resulted in more persons witnessing relatives, friends, or neighbors being affected, the need to comply with mitigation behaviors has become more relevant. Direct experience with the disease is a powerful motivator.

Many in the community lack resources to implement mitigation behaviors. Essential workers living in crowded quarters have no way to self-isolate if exposed at work. Homeless individuals or families have difficulty implementing preventive hygiene practices.

Disruption of Social networks: Family, friends, neighbors, and churches are the pillars of a web of social networks in the community. Such networks have played a critical role in the response to the pandemic, through the sharing of resources and provision of support. However, the mitigation requirements (i.e.; stay at home and social distancing) are straining the connections. For families, there is concern of whether or not to visit elderly relatives, resulting in a net loss of support and resources for them. There is heightened concern for neighbors who need to self-isolate due to risk of severe disease. Support is provided through grocery runs and generally “checking in.” However, loss of the usual physical closeness with vulnerable family members and neighbors places them at risk for loneliness and isolation.

Church activities that brought people together for interaction and fellowship have been curtailed. Common interactions of individuals in the streets have decreased. Weekly extended family gatherings, as well as traditionally held family reunions are now seriously restricted. The disruption of such rich social milieu threatens emotional wellbeing and undermines the effectiveness of social networks in ameliorating the physical and economic hardships exacerbated by the pandemic.

Mental health strain: The pandemic inflicts trauma in multiple ways. It breeds anxiety through the loss of usual routines and the uncertainty of how long the situation will last, it adds a heightened layer of economic stress, it generates grief by the loss of family members—in many cases the matriarchs and leaders of families, and it curtails the capacity to deal with the stressors through social support. There is concern that drug and alcohol use will increase as mechanisms to cope with stress.

Access to healthcare and testing: Individuals who received regular care prior to the pandemic had the ability to contact their primary care health providers for COVID-19 or other health concerns. For the uninsured without a medical home, the same pre-pandemic care options remained: seeking advice from friends and family, using home remedies, and the emergency room as a last resort.

The same pattern was at play with regards to access to testing for the novel coronavirus. Barriers to testing included the need for a medical provider’s referral, confusion in the community over whether or not payment was required, lack of information regarding testing sites, and transportation—even to community based sites, which remain beyond walking distance for many.

A positive development in healthcare brought about by the pandemic has been the substantive growth of telehealth as a viable care provision option.

Access to technology: Technology was considered the most valuable tool to address many of the challenges posed by the pandemic. It provided the means for remote activities, such as at home education or work, continuity of business interactions, and provision of and accessibility to services, e.g.; telehealth. It was critical to the viability of fundamental aspects of the social network, such as interpersonal and family connectedness; as well as the continuity of church

services, gatherings and personal ministry. However, technology access is uneven and limited by location, financial and digital literacy constraints.

Cell phones are the most affordable devices available, yet the degree of Internet access they allow is cost-dependent. Hotspot access is limited. Ownership of multiple internet ready devices is uncommon, and families with several children struggled to provide each child with the device-time combination necessary for online education, even though Mobile County Public School System provided equipment. Beyond the lack of devices and connectivity, low familiarity with online tools (e.g.; the education platform used by the school system, videoconferencing applications, etc.) posed an additional barrier for many.

EXPERIENCES OF INEQUALITY

The pandemic brought to the forefront longstanding disparities in resources and health outcomes experienced by communities of color, now exacerbated. Disparities made starkly evident included differential capacity to accommodate remote education, disproportionate number of essential workers facing increased exposure with lower resources to protect themselves and their families if affected with COVID-19, substantive number of persons dependent on informal labor facing complete loss of income without recourse to benefits such as unemployment, overall reduced ability to meet day-to-day needs as people often depend on community and personal social networks for support, limited capacity to accrue the benefits of technology to circumvent disruptions brought about by the pandemic, and differential access to healthcare as well as barriers to testing.

The history of discrimination and harm experienced by persons of African American descent means that many in the community are not surprised that African Americans are dying at higher rates than whites. Enduring distrust in the medical establishment leads to questions of what is really happening and may keep some persons resorting to home remedies instead of going to the hospital for fear of receiving subpar treatment simply because they are Black. Many, especially advocates, are frustrated with the continued documentation that certain comorbidities (e.g. diabetes, obesity) make the virus's impact worse without adequate discussion or addressing of the impact of the social determinants of health that lead to the higher prevalence of these comorbidities in Blacks.

Injustice and disparity form a routine part of the community's experience. These stresses were described as "a storm" that the community lived with constantly. The COVID-19 pandemic hit the low-resource community as an additional storm to be weathered and navigated even as the level of hardship is further increased by the demands of the pandemic.

SUPPORT NEEDED TO WITHSTAND THE PANDEMIC

The threat of infection, the economic fallout, the stress of social networks, and the profound disruption of usual coping strategies affect all segments of the community, however, three population sub-groups were identified as the most vulnerable: 1) persons and families who are

homeless and have extremely limited ability to implement preventive hygiene as well as shelter in place or social distancing mitigation behaviors, 2) children with special needs who were severed from the structured educational environment and skilled instruction by the shift to remote education, and 3) persons struggling with mental health issues who now face heightened stress and alteration of routines, as well as difficulties in accessing mental health services. Other groups especially affected include essential workers who require support with childcare; school-age children overall who have been placed at risk of deficit in their education; and seniors affected by diminished social interaction as well as from limitations in the support received from relatives or neighbors.

Overall, the community requires support through: 1) economic relief, 2) food assistance, 3) provision of resources to facilitate mitigation behaviors, and 4) training of parents to support remote education. It is also necessary to increase access to technology, to reliable information on COVID-19, to mental health support and to COVID-19 testing and adequate follow up.

RECOMMENDATIONS FOR AN ACTION PLAN

Participants outlined three components of the process to accommodate the demands of the pandemic: adaptation, response and preparedness.

Adaptation anchors on the recognition that the pandemic is a lengthy crisis, and the frame of reference provided by the experience with hurricanes is not helpful. A different frame of reference has to be created that acknowledges the sustained threat in order to make the needed shift to consistently implement mitigation strategies and provides a vision for how the everyday will change permanently going forward. A roadmap to navigate the pandemic requires information on what is needed for prevention and protection as well as what support is available from government and other sources, along with clear guidelines for how to access such support.

The first pillar of a pandemic response plan is economic relief, provided through mechanisms that ensure quick access and reach persons with weak ties to the formal economy. The second pillar is food provision, particularly ensuring that all children are fed. A reliable system for economic relief and food provision should be established, capable of matching the magnitude of the need and the length of the pandemic. The third pillar is increased technology access, including: 1) enhanced infrastructure to boost connectivity, 2) facilitation of access to digital devices, 3) promotion of digital literacy, and 4) sustained and safe access to community-based computer portals, such as those provided by public libraries. Finally, provision of mental health support to counteract anxiety, depression, and hopelessness was considered critical to a response plan.

In regards to healthcare, study participants urged the inclusion of all local primary care clinics in pandemic response plans in order to facilitate their access to personal protective equipment and other supplies necessary to support their continued operation. With adequate supplies, primary care clinics could play a key role in the provision of care to persons with mild or moderate

COVID-19 symptoms, allowing hospitals to focus their resources on patients requiring inpatient care.

Recommendations to facilitate community-wide access to testing for the novel coronavirus include: 1) Clear and uniform criteria of who should be tested, 2) Simple decision aids to help persons decide when testing is needed, 3) complete removal of payment barriers, 4) establishment of multiple community-based testing sites.

Long-term community preparedness should hinge on the assessment of overall community needs as well as assets, approached via a coalition of institutions and organizations able to formulate and implement plans addressing the needs of underserved communities. Outreach should include three basic functions: education on the pandemic, information on the alternatives available to meet community needs, and the provision of resources to comply with mitigation strategies.

RECOMMENDATIONS FOR AN INFORMATION PLAN

An unclear understanding of the pandemic exists due to the presence of inconsistent information, absence of a unified message, and lack of consensus among leaders concerning how to handle the pandemic. As a result, it is easy to entertain conspiracy theories, disregard mitigation recommendations, and fall prey to apathy; leading to inconsistent thought processes regarding information about the pandemic. Nevertheless, perceptions of COVID-19 in this predominantly Black community are evolving as the pandemic unfolds. Messages that have penetrated the community include the need to: 1) keep a distance of at least six feet when interacting with individuals beyond the immediate household, 2) stay at home or take shelter to reduce risk of exposure, 3) practice safe hygiene routines to reduce spread of the virus, 4) prevent individuals at high risk for severe disease (i.e.; the elderly, and persons diagnosed with diabetes, asthma or cancer) from being exposed. Still, individuals younger than forty, who consider themselves “indestructible” or “invincible,” may disregard mitigation behaviors.

The community is also in need of clear and concise information about: 1) symptoms of COVID-19, 2) course and complications of the disease, 3) the ways the disease is transmitted, 4) the presence of asymptomatic carriers, 4) the risk for reinfection, 5) the safety of vaccines, 6) the length of the pandemic, and 7) how to dispose properly of protective equipment (gloves, masks, etc.).

Messages should be direct and practical, e.g.; when describing the symptoms of COVID-19, include what a person should do if experiencing them, information on where to get tested, and the cost or requirements for testing. The sub-groups vulnerable to severe disease should be further described in ways that help people identify themselves as vulnerable. Clear explanation of what the mitigation strategies consist of and why they are important will help people to adopt them. Overall, messages should acknowledge the changing situation and provide comfort through dissemination of positive stories of recovery. Finally, in view of the

going to a hospital or healthcare source, it is necessary to encourage people to keep up with their routine appointments.

Messages should be conveyed by community leaders, including state as well as local political and public health officials, medical professionals, scientists, pastors, and heads of community-based organizations. Channels of communication should be varied, including yard signs, flyers, post cards, mailers, news media, social media, email, websites, newspapers, and, particularly, radio. Consideration should be given to the fact that word of mouth is one of the most effective, if not always accurate, ways in which information is disseminated in the community.

Five information dissemination strategies were stressed: 1) formulation of a unified message to be conveyed by multiple voices, 2) saturation of the community with messages regarding actions to take and why they are important, 3) approaching dissemination of information as a community project involving community members as partners, 4) pastors are particularly valuable allies and churches could function as resource sites for the passing of information, provision of mitigation supplies, and testing outposts, and 5) information toolkits should be produced that can be distributed to local business owners and other community-based organizations who in turn can help the information penetrate the community and touch those hardest to reach.

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INTRODUCTION

The COVID-19 pandemic has affected every area of life for communities in terms of disease burden and in the need to adopt mitigation behaviors to limit disease spread. The state of Alabama declared a public health emergency on March 13th, 2020. Closure of schools and daycare centers with 12 or more children per room was mandated on March 20th, along with the suspension of visitation of inpatients at hospitals or nursing homes, and persons in long-term care facilities. A “stay-at-home” order was issued on April 3rd, lasting until April 30th. During this period, all but essential businesses were closed.⁵ Effective May 1st through July 3rd, a “safer-at-home”⁶ order was issued, which encouraged but did not mandate pandemic mitigation behaviors. The order allowed most non-essential businesses to renew operations. Allowances for social distancing were a requisite, along with occupancy rates of 50 percent or less. While writing the present report, the safer at home order has been amended in several instances and currently extended through January 22, 2021⁷.

Data shows that minority individuals experience greater disease severity and higher risk of death if contracting COVID-19. Minority communities also experience heightened economic and health hardship due to the mitigation steps to slow the spread of the virus.^{1,2} Given this reality, it is necessary to understand the needs of underserved minority residents to inform the response of health care systems as well as of social services and other organizations, with the ultimate goal of lessening the spread of COVID-19 and fostering the provision of equitable healthcare. The Center for Healthy Communities (CHC) undertook a qualitative research study to learn from community leaders, advocates, and members what the experience of the pandemic was at the community level and what steps could be taken to ameliorate its impact.

This study focuses on a geographically contiguous area, including zip codes 36602-07, 36610 & 36617, with a total population of 96,388. Health disparities in the area were documented in 2008.³ According to the American Community Survey,⁸ the percentage of residents living below the poverty line across the eight zip codes ranges from 17.5 to 39 percent, with a median of 31.9 percent. The area is also majority minority, with the percentage of African American residents per zip code ranging from 36.3 percent to 94.4 percent (median of 66.35 percent).

The study seeks to understand:

1. How community members are experiencing the COVID-19 pandemic
2. How to address challenges specific to COVID-19
3. How to effectively communicate relevant information

The project’s protocol was reviewed and approved by the University of South Alabama Institutional Review Board. The data collection activities occurred between April 30th and May 19th, 2020. Therefore, the information gathered references the experiences of study participants during the “stay-at-home” period and through the initial weeks of the “safer-at-home” order.

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METHODOLOGY

Data collection procedures

To inform the three fundamental queries that were the object of the study, we designed an interview guide (see Appendix 1) to facilitate a conversation focusing on the information needed to answer the study questions. We then invited 19 community members affiliated with the Center for Healthy Communities to participate in either a key informant interview or a focus group (based on their time availability). Four key informant interviews and four focus groups were conducted, referred to as “data collection events,” where a guided discussion took place, as outlined in the interview guide.

The research team conducted conversations via the Zoom videoconferencing platform.⁹ The team consisted of an interviewer, a scribe, and an observer. The interviewer led the discussion while also taking brief notes of key information garnered. The scribe kept the formal record of the conversation. The observer both took detailed notes and, on occasion, interjected some questions for clarification or expansion of points made by the study participants. In addition, the complete conversation was audio-recorded and an electronic transcript was generated through the video conferencing platform.

After each data collection event, there were four sets of distinct records of the information: 1) the scribe’s detailed notes, 2) the personal notes by the interviewer and the observer, 3) the electronic recording of the conversation, and 4) the auto-generated electronic transcript. In order to evaluate the information quickly, the interviewer and observer read the scribe’s notes and augmented them with any relevant information from their notes. At this point, the amended scribe’s notes became the formal record of the data collected. The audio recording and the electronic transcript were saved to be utilized in a second instance of data analysis at a later date.

Qualitative analysis approach

The formal process of qualitative analysis examines the information garnered during the conversations to extract the core concepts underlying the statements made by the study participants. Such a synthesis process is subjective in that the analysts interpret the information from their unique frame of reference. In the present study, the interviewer, scribe, and observer also constituted the analysis team. At each analysis step, they discussed the basis for their interpretation of the information thoroughly, with final agreement by consensus.

The synthesis process can be inductive (that is, allowing for the information to emerge without any pre-conceived parameters) or deductive (in which the evaluation of the data is via a set of pre-determined queries).¹⁰ We opted for a deductive process to expeditiously garner critical pieces of information regarding the experiences and challenges of the community.

Based on the three objectives of the study, we designated nine focus areas considered key to fulfilling the study’s goals. Table 1 details the correspondence of study objectives and focus areas. To extract the information necessary to illuminate the nine focus areas, we created a list of 26 “basic analysis questions” to be answered with the information provided by the study participants (see Appendix 2).

Table 1. Project Objectives and Focus Areas of Interest

Objectives	Focus Areas
1. Understand the population of focus’ lived experiences with the COVID-19 pandemic	1. Description of experiences 2. Viability of mitigation strategies 3. Identify the most vulnerable
2. Explore ways to address the challenges specific to COVID-19	4. Description of challenges 5. Strategies exercised to address challenges 6. Support needed
3. Outline strategies to effectively communicate relevant information	7. Current status of information 8. How to craft & deliver messages 9. Seeds of Bi-directional Communication

Analysis steps

1. Identifying the information needed to answer the basic analysis questions: Immediately after each data collection event, the three analysts answered the basic analysis questions from their recollection of the conversation and their notes, entering their individual answers in an electronic database. Shortly thereafter, the three analysts met virtually via Zoom and examined their entries. In many instances, there was a concordance on the answers. In cases in which responses differed, analysts discussed them. If needed, review of the scribe’s formal notes provided clarification. In the end, the three analysts agreed on one single set of data that answered each of the primary analysis questions for the data collection event. The cycle repeated for each of the eight data collection events. At the end of this step, the study’s electronic database included eight answers (one *per* data collection event) for each of the 26 basic analysis questions. Figure 1 details the process of building the database for the study.

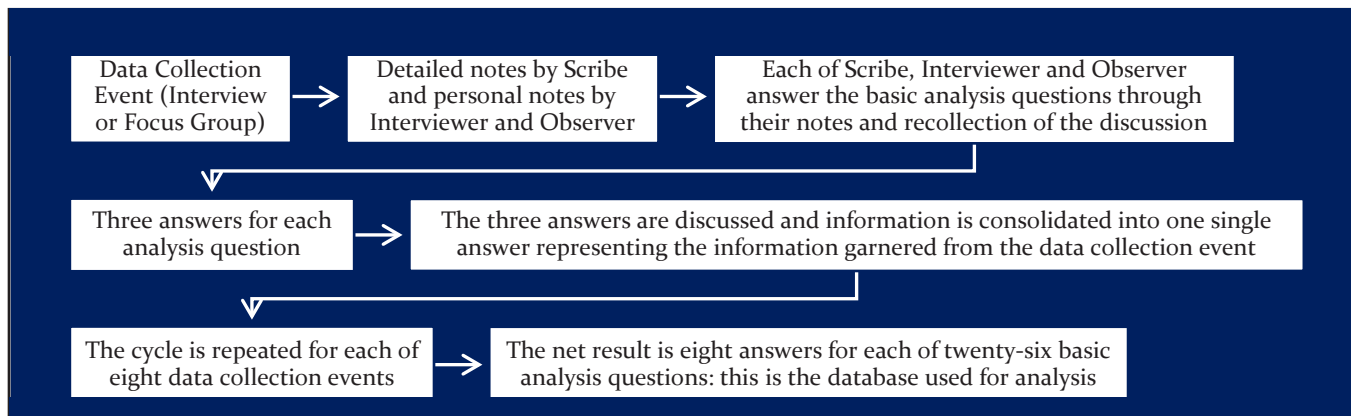


Fig. 1: Process to build database

2. Identifying the essential concepts embedded in the answers to basic analysis questions: Operating from the set of eight answers to each of the basic analysis questions, the analysts discussed the concepts underlying the information and partitioned paragraphs into “statements” that, by their consensus, represented a distinct concept. They then identified a code that would name the concept. In this manner, the information deconstructed into component pieces with assigned primary codes and secondary codes describing its essence.
3. Assigning primary and secondary codes to each statement: According to their level of complexity, the answers to six basic analysis questions were discussed and jointly coded by three analysts. Eight questions were discussed and jointly coded by two analysts. Seven questions were coded individually by one analyst with review by a second analyst. The remaining 11 questions, considered mostly descriptive, were coded by a single analyst. The list of 49 primary codes and 107 secondary codes used is included in Appendix 3.
4. Identification of an additional focus area: During the coding process, it became abundantly clear that issues of disparity, inequality, and racial bias were prominent in the information provided by study participants. Therefore, we added a 10th focus area to incorporate those concepts, termed “experiences of inequality and bias.”
5. Assignment of coded statements to focus areas: Two analysts discussed the primary codes and decided by consensus the likelihood that a coded statement would inform each of the ten focus areas. Each code mapped to one or more focus areas (see Appendix 4). Each analyst took the responsibility of reading about half of the coded statements and assigning each statement to the relevant focus area. For the most part, the assignment followed the mapping of codes to focus areas established *a priori*. On a few occasions (based on its content), a coded statement would be assigned to a different focus area than determined by the map. Assignments made individually by an analyst were reviewed by the other analyst. Instances where the reviewer disagreed with the initial assignment were discussed and defined by consensus.
6. Grouping codes into sub-units of analysis: To aggregate coded statements into cohesive interpretative units, the same two analysts discussed how the primary codes defined pieces of information that naturally coalesced to illuminate specific topics within the focus areas. They agreed that the primary codes uniquely informed ten “subunits of analysis” across the focus areas (see Appendix 4). Accordingly, they assigned each coded statement to a unique subunit of analysis within the focus areas.
7. Content synthesis: To draw the lessons contained in the data, the team generated printouts of the coded statements by focus area and subunit of analysis. Each of the three analysts reviewed an assigned set of focus areas. Within each focus area and subunit, analysts organized the data by primary code to identify topics across the smaller coded units. They then wrote synthesis paragraphs fleshing out the skeleton of ideas created from the coding and categorization of the data. In this fashion, there were ten narrative synthesis pieces produced, one for each focus area.

8. Assembling the results narrative: With the content synthesis complete, the team leader collated the ten narrative pieces into a document portraying analysis by focus area and subunit of analysis. This initial document was formatted to consolidate the information into cohesive sections and eliminate redundancy. Related information described across focus areas merged, and some sub-units of analysis became independent sections. The final narrative results included twelve distinct sections.
9. Review of results narrative: Since each analyst had synthesized only a fraction of the overall data, they all read the results narrative in its entirety to gauge congruence with the information heard at the data collection events. Six substantive items required discussion, of which four resulted in relevant changes in the narrative results.
10. Review by study participants: All study participants were invited to review specific sections of the report to check whether the narrative results corresponded to the information they had provided and the reality in their community. At this time they were also offered the opportunity to comment or expand on any item described, as well as to identify any important issue not discussed or portrayed in the report.

RESULTS

Of the nineteen individuals invited to participate, fifteen consented to be a part of the study, for a 78.9% response rate. Demographic information of participants is presented in Table 2.

Table 2. Demographic characteristics of study participants

Characteristic	No.	%
Gender		
Female	12	80.0
Male	3	20.0
Age (years)		
19 - 35	3	20.0
36 -65	9	60.0
66 and over	3	20.0
Zip code of residence		
Study area	10	66.7
Out of area*	5	33.3

*Participants have close ties to the community of focus

We identified each coded statement with a numeric ID. In writing the study results as a narrative derived from the information gathered, we use footnotes to reference the statement ID(s) underlying the synthesized content. A statement used exactly as recorded in the database is included in italics and within quotation marks, followed by its unique ID. However, such references throughout the report should not be construed as *verbatim* quotes, since our primary source of data were notes and not a transcript of the conversations. When necessary, we have included text in brackets within a quoted statement to clarify its content.

We invited all fifteen study participants to read assigned sections of the report and provide feedback. Seven responded (46.7%). Respondents unanimously agreed that the report provided an accurate and fair portrayal of the community's experience. In addition, they provided four comments that represented additional information, four comments that expanded on statements, and three recommendations. All comments and recommendations have been incorporated within the corresponding sections of the report.

In addition, one participant stressed the futility of repeatedly documenting disparities if no action was to be taken to address them: *“Although the report is ‘fair,’ it hurts to know that it also recaps the constant existence of systemic racism that only gets ‘attention’ during a syndemic. Pandemics such as COVID-19, and other health-related pandemics, seem to merely add to the already social and health-stricken stresses in these communities.”*¹

Study results are presented in three main sections corresponding to each of the study objectives.

¹ Comment by participant after review of the report

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Objective 1:

UNDERSTAND THE POPULATION OF FOCUS' LIVED EXPERIENCE OF THE COVID-19 PANDEMIC

This section details results related to:

- Experiences of people with the requirements of the pandemic
- Impact of the pandemic response
- Education of children
- Technology
- Health care
- Testing
- Experiences of inequality

Experiences of people with the requirements of the pandemic

Home Dynamics

Participants expressed that stress and anxiety were commonplace in households, rooted in the sudden and profound disruption of usual routines and the uncertainty of the situation. Because of the pandemic, families living in poverty are now dealing with added challenges in paying rent or utility bills and buying food.²

*Childcare*³

- Major stressor for families, particularly those of essential workers.
- Grandparents are still the major source of childcare support within families.
- When arranging for shared care to be made with friends or relatives, there is concern about unknown exposures for children at someone else's home.
- Families who lack support from grandparents, other relatives, or friends have the added financial stress of paying for childcare.

² IDs 181,201,208,393

³ IDs 191, 205, 211-214

Remote education⁴

- Parents (or grandparents who are taking care of children) have had to assume several roles in support of remote education, and this has increased household stress.
- Demands of the new role as facilitators of remote education included:
 - Creating a structured environment to assist learning
 - Having to procure technology resources for the children (both devices and internet connectivity)
 - Having the technical abilities to assist children in the online learning environment
- Although the county school system provided devices and internet hotspots, many families struggled to access needed technology.
- In many instances, adults had to provide support to remote education while at the same time managing work responsibilities.
- There was concern that families with special needs children may not have the skills and knowledge required to create a well-structured learning environment.
 - Online education did not provide the necessary resources and support services that a special needs child may need to meet necessary learning accommodations.⁵
- Although remote education posed difficulties, it was a valuable resource for students and parents alike. In some communities learning stopped altogether due to lack of an online learning platform.⁶

Work situation⁷

- Essential workers and their families face potential exposure to the novel coronavirus at work.
 - It is unclear whether employers provide adequate personal protective equipment.
 - Workers realize that, if infected, they could become sources of infection for their household members.
 - For workers living in crowded quarters, there would be constraints to self-isolation at home if a worker is infected.
- For workers in industries not conducive to remote work, the lack of income and the unknowns of the pandemic create more stress and anger.
- In contrast, those with the ability to work from home and adequate resources to support remote education have the opportunity to spend more time with their children.

Families with custody arrangements⁸

- In some cases, there was an interruption of visiting schedules if a non-custodial parent was at high risk for severe disease, given the possibility of exposure from potentially infected children.
 - Possible emotional toll for children from abrupt disruption of the relationship with the non-custodial parent.

⁴ IDs 184,196, 199, 215,216

⁵ Participant comments (2) after review of report

⁶ Participant comment after review of report

⁷ IDs 182,183, 188, 193,195,202

⁸ IDs 192,194, 204, 209

- In other cases, there is unease about potential exposures to children while visiting a non-custodial parent.
- There is concern that financial difficulties brought about by the pandemic would constitute an excuse not to pay child support.

Mitigation Behaviors⁹

- Adoption of mitigation behaviors depends on whether or not people believe that the threat of the virus is real.
 - Seniors, those over age 65, seem to be taking the situation seriously and staying home to avoid exposure to the virus.
 - Even when stay-at-home orders were current, some individuals continued to meet in their usual gathering places, and young people held large parties.
- People on fixed or limited incomes had to go out often looking for necessities, since they cannot buy several weeks' worth of supplies.
- Some persons, based on their personalities, are accustomed to being out among people and participating in various social activities meaning that the stay-at-home orders have been emotionally difficult for them.
- Southern culture tends to favor interaction and embracing of one another, making it difficult for people to remember and comply with social distancing even when they understand that it is for the best.
 - Families like to congregate, thinking they are safe because specific individuals have not received a diagnosis.
 - People have had to find creative ways of continuing celebrations common in a family or community such as baby showers or birthday parties.
 - At times, people have good intentions of respecting the social distancing requirements but end up with an unintentional gathering.
- For many, social distancing is a luxury. Individuals living in small homes or apartments with several other people do not have the resources to follow the requirement.
- Persons experiencing homelessness do not have the facilities for proper sanitation, nor can they easily social distance.

Motivation to adopt mitigation behaviors¹⁰

- The gap between older people preparing and younger people ignoring the situation narrowed as testing ramped up in the county: people heard more about the number of cases, and the impact of the pandemic became more visible.
- As the situation has continued to evolve, the shift to accepting social distancing has taken place for many individuals.
- However, since there are mixed messages and misconceptions about the pandemic circulating in the community, the majority need a personal connection to help them understand the need for mitigation strategies.

⁹ IDs 546-549,551-553,556,558,562,564,565,567,568,571,574,578,580,582,584-587,590-593,604,606

¹⁰ IDs 557,596,827,831-842,844

- The strongest motivator to adopt mitigation behaviors was the death of a household member or severe consequences for someone close to the household.
- The motivation was also present when households had members that would be especially at risk, such as a child with asthma.
- Yet, there is a feeling that mitigation practices must be mandated for people to comply.

Other Challenges

Transportation¹¹

- The lack of or limits to public transportation created a major challenge, particularly at the beginning of the pandemic, when provisions were scarce. It was necessary to go outside of the community to have access to needed supplies.
- The many who rely on rides from friends or relatives saw usual arrangements disrupted due to the need to keep social distance and the emphasis on staying at home.

Mental health¹²

- The added stress brought about by the radical changes families have to accommodate is taking a toll on emotional wellness and mental health.
- The economic stress experienced is tied to mental health stress.
- There is uncertainty about how long the disruption being endured will last and how feasible it is to withstand the hardships of the mitigation measures.
- The need for mental health support will heighten as a consequence of the added stress experienced.

Impact of the Pandemic Response

Economic Impact

The economic fallout from the restrictions to economic activity is hard for the community. Small businesses have had to close because they were unable to adjust to the mitigation strategies. Such closing has severe repercussions, from the loss of jobs to the loss of access to goods and services. The situation means that the community needs assistance in terms of replacing lost income.¹³

Job disruption¹⁴

- The impact on work options is not even:
 - Many are out of work due to the pandemic.

¹¹ IDs 394-399

¹² IDs 36,39,46,48,53,400-402

¹³ IDs 1,29,81,82

¹⁴ IDs 3,5,12-14,21,25,26,30,50,51,58,59,64,83,84

- Some did not lose their jobs but sustained a reduction in hours and, therefore, in income.
- There are individuals in industries that can transition to remote work, while others face the possibility of exposure to the virus in their "essential jobs" (e.g., store clerks, medical personnel).
- The economic impact has been hardest on those who have limited or fixed incomes, those living paycheck to paycheck in minimum wage jobs, or those who depend on informal income, "hustling" for odd jobs such as helping neighbors clear their yards, move items, build fences, paint, etc.¹⁵
- Many laid-off are unable to find other jobs because they lack qualifications or proper credentials to apply.
- Some people may not realize that they can qualify for unemployment.

“Livelihoods [have been] very much impacted. In the past, people could go out and hustle, get a decent amount of money every day. Not anymore. They could do day labor. Not anymore. And this is affecting mental health. It is a very bad feeling not to be able to provide for family, for people not to know how they are going to pay for food, rent, utilities.” (ID46)

Businesses¹⁶

- Hardest hit were the high touch industries in the hospitality field (e.g., restaurants, hotels) or personal care (e.g., barbers).
- Businesses have adjusted in one of three ways: 1) implementing social distancing, 2) moving to remote work, or 3) issuing layoffs.
- Small business owners are looking for alternative income streams to weather the storm of the pandemic.
- For some small businesses, applying for the Payroll Protection Program loans, the process has been difficult, and they have not received funding.
- Local farmers and gardeners have also been affected as they struggle to maintain food production.¹⁷

Sources of economic relief

Stimulus check¹⁸

- The receipt has been uneven.
- The distribution to community members has been patchy, especially when considering individuals who file taxes through a third party agency.
 - The assistance was welcomed in the community but considered insufficient to meet the needs of people who have lost their sources of income.

¹⁵ Participant comment after review of the report

¹⁶ IDs 6,11,18,23,28,29,31,37,42,44,52,55,57,60-62,65,72,80,85

¹⁷ Participant comment after review of the report

¹⁸ IDs 4,8,10,15,24,27,40,41,49,54,68,69,65

- A participant wondered about the parameters that were used to establish the amount of monetary relief provided to individuals and families.¹⁹

Unemployment benefit²⁰

- Community members have had mixed experiences with the application process and receipt of the benefits.
- The expanded unemployment benefit had been very valuable for people who received it and had helped stabilize many families.
- Some are now making more than they did when fully employed, which has resulted in the loss of other benefits (e.g., the Supplemental Nutrition Assistance Program).
- The benefit has also operated as a disincentive for people to want to return to work, particularly when businesses reopen in situations that could expose employees to the virus.
- Once the benefit lapses, it will prove difficult to cover payments with the lower-income generated through jobs.
- Persons who are not eligible for unemployment support are severely impacted. *“Those who do not qualify [for unemployment,] they are having the most financial difficulties, no longer able to pay bills/rent or provide for families”* (ID63).

Other sources of support²¹

- Churches and social services agencies constitute major sources of support, particularly regarding food assistance.
- Despite being impacted by the pandemic, social services agencies have adapted their operations, providing for appointments by telephone and online mechanisms for working with clients.
- For the most part, agencies’ efforts to continue providing services have been successful, with two main exceptions:
 - Agencies focused on persons who are homeless have substantial problems to operate.
 - Even as mental health needs were increasing, people were still unable to access services.

Impact on Social Networks²²

- The rich social networks within the community have been a source of strength and support, for example:
 - Those working on essential jobs are shopping and acquiring necessities for others so that they do not need to go out.
 - Families are working together to provide childcare, particularly when parents are essential workers.

¹⁹ Participant comment after review of the report

²⁰ IDs 16,17,20,22,32-35,43,66,67,71,432

²¹ IDs 87, 76-79,86,87,653-655,911,912

²² IDs 610-615,617,618,622-624,627,630,632,634,638,639,640,651,656

- Some community advocates have undertaken support activities such as making masks, sharing supplies, and ensuring communication about information about resources.
- With younger generations using social media, they have found different ways to connect and conduct tasks.
- However, a major problem has been making decisions on whether to visit with family or to stay away.
 - The many families that include elderly persons have had to weigh the risk-benefit of providing the usual level of support to relatives and the risk of infection.
 - As a result, older people were not getting the same support and resources that they had before the pandemic.
 - Conversely, elderly relatives could not be called upon to provide the commonplace support with extended families.
 - There is some concern that people can turn for the worse without others knowing and being able to help.
- The need to stay at home and social distance stresses the community fabric:
 - Participants grieved the loss of weekly extended family gatherings, as well as traditionally held family reunions.
 - Common interactions of individuals in the streets have been curtailed.
 - Usual activities that brought people together for interaction and "fellowship" have been lost, including church services and even funerals.
 - Virtually keeping in touch is difficult for those who do not have devices or know how to use available platforms. Consequently, many community and family members are not able to support each other.

There is a sense of loss in the face of the implicit end to usual social gatherings, which promoted emotional wellbeing: *“Conditions that were already difficult [are] aggravated [and yet] we can’t gravitate to one another.”* (ID640)

Other impacts of the pandemic

*Negative Behaviors*²³

- The mitigation strategies have created a lot of stress in the community.
 - There is appreciable concern that stress and anxiety will lead to violent behavior, such as child abuse and intimate partner violence. Several participants referred to the danger of women and children “trapped” at home with their abusers.
 - A lack of mental and emotional health services can add to the possibility of this happening.
- There was concern about the potential increase in using drugs and alcohol as mechanisms for dealing with stress.

²³ IDs 427,428,431,433,900-904,907,908

Unforeseen Consequences²⁴

- Fear of stigma, in which individuals and families are unwilling to share being diagnosed with the virus.
- Loneliness and isolation experienced by many older adults because of social distancing and other mitigation strategies. Elderly people whose families live out of state are particularly vulnerable and need support.
- Misperception of the virus origin and mechanism of spread (e.g.; a participant witnessing one instance of verbal violence against an individual of Asian descent).
- On the other hand, families with the resources to easily adapt to the situation find the stay-at-home orders to be a release from hectic schedules that allows them to recharge.

Trauma²⁵

- The pandemic is unprecedented with stories of the stress and strain of the situation, affecting the community at all levels.
- Much has been lost in terms of social interactions, economic well-being, and community connectedness.
- People are missing the normalcy of routine activities and exchanges.
- There is concern about future waves of COVID-19, causing extreme stress and anxiety.
- In many cases, families are losing loved ones, the matriarchs or leaders in their families, and sometimes multiple family members.
 - In many cases, people cannot spend the last days with their dying relative in the hospital setting.
 - Families cannot hold a traditional funeral or memorial service where they could grieve together and support each other.
- For those who have ignored the social distancing guidelines and possibly shared the virus with the relative who dies there is a level of personal guilt.

Vulnerable populations²⁶

Three population subgroups stand to be significantly affected in the face of the pandemic:

1. Individuals and families (including children) who are homeless. They are limited in the availability of running water for washing their hands and other basic hygiene needs. A strategy to support them is needed, in view of a predicted second wave in the winter.
2. Children with special needs. Given the shift to remote instruction, they face difficulties with learning by losing the structure and support they had at school.
3. Persons struggling with mental health issues. They face serious difficulties in accessing the help they need to adjust to the new levels of change and stress.

²⁴ IDs 283,288,426,430,434,435,639

²⁵ IDs 282, 285,298,300,415-421,424

²⁶ IDs 304-307,309,310-314

Long-term impact²⁷

Participants identified some likely long-term consequences of the pandemic response, as follows:

1. Increase in the number of homeless individuals and homeless families, since the temporary relief from foreclosures and evictions will have an end date. Once the ban lifts, families will have to either pay what is owed or face eviction. It is urgent to create mechanisms to support people and families who will become homeless.
2. Permanent deficits in children’s learning and overall capacity, due to the challenges in providing supportive structures, needed accommodations and resources for them at home.
3. Increased health disparities, given the over-encompassing effect of the pandemic response on social, educational, and economic factors. There will be a likely increase in negative social determinants of health and an adverse net effect on the community’s health status.
4. The almost universal turn to remote work, requiring that people “*change their idea of what a work situation should be,*”(ID919) and potentially resulting in limits to hiring based on ability to work remotely. This could lead to rising unemployment.

Education of children²⁸

- There was consensus among participants that internet access and availability of digital devices were critical to the success of online education, and that both were in short supply in the community.
- For some, the lack of technology was overcome by the provision of devices from the school system or assistance from individuals in their social networks (e.g., church).
- Families with several school-age children faced the additional barrier of needing several devices to accommodate schoolwork, and parents had to schedule device time for each child.
- Many encountered hurdles to using the online educational platform used in the county school system, due to limitations in access to internet-ready devices and lack of technical skills for accessing the program.
- Remote education necessitates support from adults in the household. The students’ new learning reality requires that parents or grandparents provide both a structured

One participant related her personal experience (living outside the focus area) where her children were able to successfully transition to online work due to having the proper resources. Meanwhile her cousins (residing in the inner city) faced a very different situation with not having enough computers or other devices for their children and lacking access to the internet. This anecdote was illustrative of the disparity in resources for remote education. (ID217)

²⁷ IDs 918,919,921, 923-925

²⁸ IDs 217-219,223-242

environment and subject matter assistance to ensure work completion and learning takes place, however:

- Not every parent can stay home to support the kids' learning
- Many parents lack the knowledge of school subjects necessary to support their kid's work
- Parents of children with special needs face difficulties in educating children with learning disabilities, as the remote modality does not include the resources and support services needed to meet the child's learning accommodations.²⁹
- Participants related that the remote education format was very stressful for parents, and that actual learning was difficult for children.
- Teachers, too, had to struggle and "go the extra mile" to facilitate learning.
- The net balance will be a deficit in children's educational achievement.
- Nevertheless, some children and families are adjusting well to the situation and even benefitting. One foundation for this has been the ability to connect with teachers and build a strong relationship to provide support and encouragement to students.
- The collaboration between Mobile County Public School System and local television networks for the purpose of providing remote education via television was also a good development despite some of the challenges it presented.³⁰

Technology³¹

- Technology was mentioned as the most valuable tool to address many of the challenges posed by the pandemic:
 - It has been fundamental to maintaining critical activities, such as education of children and working from home.
 - It has offered viability to enterprises that formerly required a personal presence on location, such as fitness studios.
- A valuable contribution unique to technology is the capacity to keep people connected: "[It is] a lifeline." (ID676)
 - Zoom, Facetime, and social media are now tools to bridge the social distancing divide.
 - Individuals and families rely on video conferencing to check in and support each other, even across the country.

Pandemic mitigation strategies are forcing many services and activities to online platforms requiring an internet enabled device. However, both the possession of technology and the skill to use it are scarce, secondary to lack of financial resources to purchase devices or internet access, as well as lack of training in the use of technology. For most people smart phones are the only technology option available. (ID 683)

²⁹ Comment by participant after review of the report

³⁰ Comment by participant after review of the report

³¹ IDs 554,555,559,659-661,664-666,668,669,675,677,679-682,684-687,691-697,699-702,705-707

- Churches have embraced technology to “*be creative in doing ministry,*” (ID706) moving to television, virtual services, live streaming, Zoom meetings, and telephone calls.
- Congregations proactively provide support to church members who were not technology savvy.
- Technology has been critical to the implementation of telemedicine.

Access to Technology³²

- Access to technology is uneven and limited in the community.
- The closing of public libraries, which usually provided access to computers and the Internet, has effectively curtailed technology access for many (e.g., homeless).
- Areas where support is needed in order to increase access to technology include:
 1. Enhanced infrastructure to boost connectivity.
 2. Access to digital devices for families to support online education for children.
 3. Promotion of digital literacy at the community level.
 4. Sustained and safe access to community-based computer portals, such as those usually provided by public libraries, for individuals that have no other forms of access.

Healthcare³³

- Barriers to care encountered prior to the pandemic remain or have exacerbated.
 - Transportation proved a challenge, especially for the elderly, who were struggling to get to appointments.
 - Due to the pandemic, persons may lose employer-provided insurance. If laid-off, they face financial difficulty in making insurance payments.
 - The uninsured continue relying on advice from friends or relatives along with home remedies as the first line of care, and a visit to the emergency room or urgent care if symptoms persist.
- Individuals who had a usual source of care prior to the pandemic continued to have access to doctors and medical care (i.e., Veterans Administration, urgent care, local medical practices, etc.)
- However, there were disruptions in healthcare on various levels:
 - People who usually need frequent healthcare encounters have seen changes in their scheduled visits.
 - For some, a healthcare encounter may include blood work but not a face-to-face visit with the care provider.
 - Postponing of procedures not deemed critical.
 - Some patients treated at hospitals were discharged sooner than originally planned due to the enhanced risk of COVID-19, having to come home where it is difficult to give them the care they need.

³² IDs 142,146,151,169-172,176,177,662,668,673,688,689,698,703

³³ IDs 90,93,94,97,98,99,101,102,103,105,107,108,113-117,122-124,128,129,131-135,137

- There was distress when family members were not able to accompany relatives hospitalized due to diseases other than COVID-19, given the ban on the visitation of patients.
- Receiving care for COVID-19 proved to be difficult for some members of the community, particularly in the initial days of the pandemic.
 - At times when people sought care for symptoms related to the virus, they were given medication without receiving care.
 - There was one anecdote of a community member visiting three hospitals before getting proper care.
- Still, there were reports of resources where people could call, report their symptoms, and get recommendations on care and testing.
- Fear of exposure to COVID-19 has led some people to delay seeking medical care for serious conditions out of fear of being exposed to COVID-19

Experiences of a primary care clinic ³⁴

- Community clinics encountered many difficulties in acquiring resources such as personal protective equipment to treat their patients safely.
- Strategies used to provide face-to-face care when needed included rotating days to see patients and staggering appointment visits.
- During the strict stay at home period, there were patients newly diagnosed with diabetes and hypertension. Through grit and dedication, primary care providers found ways to perform the necessary monitoring and help people get their conditions under control.
- It was suggested that primary care clinics could play a big role in the care of persons who did not experience severe COVID-19 symptoms, allowing hospitals to focus their resources on those needing inpatient care.

Telehealth ³⁵

- Telehealth has been a valuable alternative for the provision and receipt of care.
- The swift approval of telehealth as a reimbursable modality helped providers offer continuity of care amidst the uncertainty of the pandemic's initial days.
- For some in the community, the change to virtual visits is unwelcomed in that they prefer the face-to-face interactions with their healthcare providers and the resulting confidence in receiving good care.

There were challenges related to the necessary learning curve with telehealth, particularly for the elderly: “[participant] had not spoken to anyone who had lost access to providers, [but] described how interactions have become limited with virtual visits. This is more difficult for older patients who may not understand or be as comfortable with the virtual visit. It raised the question of whether or not they are getting good care.” (ID124)

³⁴ IDs 95,100,104,105,121

³⁵ IDs 88,92,96,106,109,110,112,120,121,124,125,126,127,130,138,140,704,705

- Some patients with chronic conditions and routine visits have chosen not to or are unable to attend appointments online or via telephone.
- For others, the implementation of telehealth services is a positive development in health care.
- Telehealth holds potential post-pandemic to help overcome barriers to care, such as meeting the needs of homebound patients, of those in rural areas lacking transportation, or during times of disaster.
- A participant related the potential for telehealth to be one lasting change from the COVID-19 experience, becoming a major force for healthcare from this point forward.
- However, lack of access to computers or the internet limits access to telehealth.

Testing

Access to testing³⁶

- Seniors (who usually have regular health care) can go through their doctors to get access to testing.
- Persons without a regular source of care face barriers to testing.
 - The idea of a doctor’s referral for COVID-19 testing presupposes that a person has a medical provider, but that is not the reality of many persons in the community.
 - Questions about insurance and requirements for payment also constitute a barrier, as many lack resources to cover the cost.
- Even the screening questions are a deterrent, particularly if querying for symptoms, as explained by a participant, *“this created a barrier because people can be positive without symptoms.”* (ID161)

A participant stated that financial barriers to testing have resulted in persons *“staying at home and dying or going to get help when it’s too late.”* (ID178) Overall, *“Testing has improved. People are able to get tested, if needed. However, some are still unable to get tested because they do not have a primary care physician who can recommend them for testing, and they lack insurance to get a primary care physician.”* (ID167)

Access to testing sites³⁷

- The location of testing sites evolved throughout the pandemic.
 - In the beginning, it was difficult to find testing (Mobile Infirmary was identified as the first location to offer testing).

Addressing disparities in testing will require working with community based organizations, especially community clinics, to provide testing sites and cover the costs.(IDs 804-806)

³⁶ IDs 150,152-154,158,161,164-168,178

³⁷ IDs 148,49,151,155,156,158,159,162,166,167

- Progressively, testing became easier to access, especially with the opening of the testing site at Ladd-Peebles Stadium
- Very early in the pandemic, when testing was severely limited, it was necessary to be extremely proactive and “*have connections*” (ID158) in order to be considered for testing.
- Currently, the supply side has improved, but the barriers discussed in the preceding section are still very much at play.
- Issues that compound access to testing include:
 - Lack of information on the availability of testing sites.
 - Lack of transportation to get to sites.
 - Community-placed sites are not accessible for people who are severely ill and cannot walk to get tested.
 - Small community-based clinics have not been able to offer testing.

Recommendations regarding testing³⁸

Participants warned that the whole process to get tested is still perplexing and varies from site to site: “*Testing is difficult as people need to have an appointment to get tested, there is a screening and there are barriers. [There is] confusion about whether or not people need to pay for testing.*” (ID151)

- Widespread community testing was deemed fundamental
- For testing to be effective, it was necessary to provide a clear path for community members to access testing, a path void of convoluted procedures.
- Building blocks for such path were outlined, to include:
 1. Clear and uniform criteria of who should be tested.
 2. Very simple decision aids to help persons evaluate if they should get a test.
 3. Removal of payment barriers.
 4. Making it easy for persons to avail themselves of testing by establishing testing sites in the community:
 - At churches
 - At healthcare sites that are sources of usual care for residents
 - Deploying mobile testing units as necessary (e.g., rural areas, such as Theodore or Bayou La Batre)
 5. Reconsideration of screening questions to communicate correctly in the community, avoiding the use of medically oriented terms.
 6. Clear post-test protocols to support quarantine/care at home or referral to the hospital if needed.
 7. Teams available to provide follow-up for persons who have to quarantine at home, to ensure that “*they are doing okay and not [feel] isolated.*” (IDs 171,172)

³⁸ IDs 142,146,151,166,169-172,174,176,177

Experience of disparity and bias

While COVID-19 impacts all population groups, long-standing disparities and injustices in low resource minority communities are becoming starkly apparent. Such communities are hit harder by the virus itself while also being hit harder by the pandemic response strategies. (ID275)

Disparity³⁹

- The pandemic highlights disparities in terms of who is affected and who can adjust quickly and even benefit from the situation.
- Low-income communities have well-documented needs such as a deficits with transportation, reduced access to healthful foods, and insufficient access to healthcare.
- Factors amplifying the effects of the pandemic include:
 - Lack of access to good information services such as the news.
 - Reduced ability to meet personal needs as persons often depend on public services, friends, or family members to assist them.
 - In terms of income, those who depend on informal strategies such as day laborer activities or other odd jobs have seen their ability to make money eliminated with the mitigation strategies.
 - Essential workers in these communities experience enhanced risk of exposure due to their occupation.
- Disparities in testing were obvious in that wealthier areas had access to testing sites before the low-income communities.
- Even at community-based sites, the need for referral from a health provider and the requisite payment will prevent many from the community from receiving testing.
- Disparities will make the impact of pandemic worse in low resource communities, requiring attention not just in terms of physical health but also in terms of mental and emotional health so that the situation does not spiral out of control.

[There is frustration] in the community and, for those who serve the community, [there is] hurt. Why is it that more persons of African American descent are dying? [There is nothing inherently different in being African American but] there is the economic [disparity]. (ID952)

Distrust in Health Care⁴⁰

- African Americans have a long history of unequal and even harmful treatment from the healthcare system.
- The history of discrimination and harm means that many in the community are not surprised by the

“I do not think that people are shocked [by the news of higher death rate from COVID-19 among African Americans]. I wouldn’t expect it to be any different knowing the history and things.” (ID272)

³⁹ IDs 787,791-793,795-797,798,800- 802, 809,811,816-819

⁴⁰ IDs 861-866, 868-874

statistics of African Americans dying at a higher rate than whites.

- However, many in the community, especially advocates, are “curious” about such reality and quizzical of why disparities persist in terms of the comorbidities that make the virus’ impact worse.
- Distrust and frustration lead to questions about what is happening.
 - It extends to the shared information and the manner it was shared, especially early on when the state only reported numbers and not disaggregated data by race/ethnicity.
- Distrust in health care may keep persons from going to the hospital (even if experiencing COVID-19 symptoms) for fear of receiving subpar treatment simply because they are Black.

Distrust in the messages⁴¹

- The inconsistent message between government officials and public health officials triggers the distrust. People filter messages through the history and past experiences of their communities to ask "who do I trust?"
- Long-held wariness has made it difficult to decide who or what to believe, including suspicion or fear of the test.
- As a result, community members did not have a clear understanding of the virus itself, its modes of spread, or their level of susceptibility.
- Accordingly, conspiracy theories surrounding the pandemic have swayed the community.

Experience of Bias⁴²

- The experiences of bias run deep in the African American communities’ understanding of the COVID-19 pandemic, such as entertaining ideas that the schools closed because white parents were afraid that Black kids would give their children the virus.
- Another view growing out of the history of mistreatment is the creation of the virus to keep African Americans down or to "*kill them.*" (ID943)
 - The resulting distrust has people resorting to home remedies instead of the hospital for fear of how they will be cared for.
- The bias also is seen in how noncompliance in the African American community is portrayed as opposed to similar activities in the white community.
 - Large social gatherings in the African American community are demonized, while those in the white community are ignored.

⁴¹ IDs 962,963

⁴² IDs 940,941,943-945

Injustice of disparity ⁴³

- Experiences of disparity are a norm in the community, with one participant describing the situation as “*another storm to be weathered.*” (ID259).
- Persons are accustomed to the high unemployment in their community and are experienced in developing strategies for trying to develop side hustles to cover income shortfalls and get needed services such as transportation.
- Experienced injustices include low pay for what is termed “essential jobs” that also lack benefits such as sick leave.
- Constantly living with injustice and distrust can create a sense of hopelessness that undermines compliance with virus mitigation strategies.
- It can also lead to far more detrimental results, such as violence, given people's deepened stress levels.
- The situation is seen as the difference between the “haves” and “have nots.”
- The ongoing disparities raise questions for justice, especially for those community advocates who have been working to address health disparities for many years.

When asked about the issue of the African American community experiencing higher mortality from the disease, a participant responded that was just another example of the community being hit harder. They are accustomed to it hence such news doesn't make much of an impact: “*So what else is new?*” (ID258)

⁴³ IDs 253-261,263-266,267,269,271,275,276

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Objective 2:

HOW TO ADDRESS THE CHALLENGES SPECIFIC TO COVID-19

This section details results related to:

- Strategies exercised to address challenges
- Formulation of mid-and long- term response strategies

Strategies exercised to address the challenges

Facing the onslaught of disruption brought about by the pandemic itself and the mitigation response, community institutions, networks, and individuals developed strategies to address the rapidly shifting situation, as described in the following sections.

Compliance with social distancing ⁴⁴

- Participants acknowledged that the practice is uneven in the community, with some people observing and others not.
- It is necessary to provide examples of social distancing:
 - Grocery stores and businesses marking the six feet space helps promote the practice.
 - Observing social distancing happening through zoom interviews on TV is beneficial.
- However, *“resources are an important aspect of this; education on how [to social distance] but also tools for doing so such as technology to allow them to do so”* (ID600).
- Examples of creative ways to address everyday routines and keeping social distance were provided.

A participant talked about going to the laundromat and seeing different things. One location was business as usual with people sitting around. A second location had taken the benches out so that people could only go in, start the clothes washing, and return to their cars to wait. (ID579)

⁴⁴ IDs 554,555,559,563,570,575,579,581,588,600,602, 624,625,633,637

- To celebrate their pastor for his years of service, church members worked with law enforcement to do a parade and promenade within their cars in front of the pastor's residence.
- Most churches have adopted social distancing strategies by providing "drive-in services" staged outside, where people can attend in their cars. This has worked well.
- There are family-friendly activities, such as riding bikes, which can occur with allowance for social distancing.
- New ways to connect in person while socially distancing have been created, for example, drive-by baby showers and Pastor yard-to-porch visits.
- Necessary shared rides are provided with the passenger sitting in the back seat.
- A difficult aspect of social distancing is the limitations imposed on in-person gatherings, a very important component of the community fabric.
 - A participant who organizes a local festival is struggling with how to plan for it. *"Because that festival is not a social-distancing event. Same thing as the Fourth of July. These are gathering times. Hard to plan for. One family reunion had to be cancelled. Another is still going on and I am leery of going. Case by case is how people will take it"* (ID322).

Social networks in action⁴⁵

- Macro- and micro-social network elements have been exercised to address the economic challenges created by the pandemic response.
- At the macro level, government assistance in the form of unemployment benefits and stimulus checks has been important to help individuals and families weather the financial storm.
- Discounts in utility bills and leniency for payments, such as bank loans, have provided relief.
- Locally, social services agencies continue working via phone. People are making use of food banks and communal pantries.
- Some small businesses continue being supported by their customers even though not able to provide direct services; others have applied for business loans.
- At the micro-level, family, and neighborhood networks, including "church families," are critical to the communities' capacity to meet the pandemic response's demands.
 - Families are pooling resources and sharing necessary items in low supply.
 - If transportation is a problem, the family member who has access to a vehicle will pick up groceries or other articles and deliver them.
 - Community advocates play an important role in the dissemination of information about community-based resources and opportunities.
- There is heightened communal concern for elderly people and persons at high risk for severe COVID-19.
 - Relatives or neighbors are stepping in to do grocery store runs and generally *"check in on them."*
 - A good strategy to protect the elderly has been allocating specific times for senior citizen shopping at grocery stores.

⁴⁵ IDs 616,619, 620,626,628,631,636,644-650,652,656-658

Adaptation to the pandemic⁴⁶

Lack of a frame of reference for the pandemic situation has hindered the process of adaptation and the adoption of mitigation strategies. Participants frequently referred to the experiences of going through a hurricane as the only framework known in the community. They emphasized the difficulty of reconciling what people were used to experience when a hurricane hits to the experience of the pandemic: *“Unlike a hurricane which we have time to prepare for and it's over soon, we could not prepare for this and it still exists after months.”* Also: *“There is no resource [that we can access to deal with the situation]. We can't google and find out.”* (IDs 325,327)

- Participants related that the pandemic had distressed everyone in the community.
 - There was a longing for things to go back to normal and a slow realization that things may never return to what used to be.
 - There is uncertainty surrounding mitigation strategies, as well as the duration of the pandemic.
 - People do not know what to do and for how long, making the process of adaptation one of fits and starts.
 - Uncertainty about what to expect complicates matters and seeds fear.
- Participants stated that a component of adaptation to the pandemic comes from people considering other mechanisms to face the challenges, requiring trial and error to overcome the barriers.
- An important component of adaptation is to accept that the situation is lengthy.
- Adaptation entails the realization that changes will occur in the way people conduct daily activities and usual business.
- For people to adapt, it is necessary to provide them with clear information to create a realistic frame of reference for the situation, which includes the fact that “return to normal” may not happen.

“... Once this clears, things are going to be different. It needs to be said what may be impacted and what is going to change, [information] which will benefit the community... People will probably still take precautions and practice certain mitigation steps like wearing masks, even a year from now. ... Families may still not want to come together for big events like family reunions or return to normal family visits, and may continue to have virtual communication.” (ID337)

⁴⁶ ID315,316,324,328-331

Formulation of mid- and long-term response strategies

Suggestions for a pandemic response plan⁴⁷

- In discussing the impact of the response deployed in the early stage of the pandemic, participants provided an outline of “lessons learned” that can delineate key elements of a pandemic response plan responsive to community needs, as follows:
 1. Economic relief and food assistance were considered pillars of a pandemic response, to be delivered through mechanisms that ensure quick access (e.g., EBT cards used in the aftermath of hurricanes).
 2. Economic relief must accommodate the reality of people working in the informal economy, unreached through usual fiscal channels.
 3. Aid (both economic and material goods) should be provided in a systematic way to match the duration of the crisis.
 - Local bank relief (i.e., payment of house notes) and utility bill reductions make a difference.
 - Food assistance from churches or community-based agencies is critical.
 4. To promote online learning success for children, schools should train parents to access the virtual platforms used for remote education.
 5. Foster the capacity to quickly pass innovations applied in industry to the front lines of the pandemic, for example, evaluating the use of the high-performance filters utilized in aviation as solutions for improving indoor air quality at community clinics.
 6. Provision of information that is meaningful to persons at the community level.
 7. Cultivating a sense of shared responsibility “...addressing the impact as a community and not just a call to action for heroes. Everyone has a place in combating the virus” (ID761).

- Successful tactics mentioned by participants included:
 - Allocation of protected shopping periods at grocery stores, exclusive for seniors and other high-risk individuals
 - Workplaces are offering flexibility with schedules and letting workers choose shifts.
- An important objective is ensuring that children are fed, either through direct provision of food or through economic support to parents.
- It is critical to address how to deal with depression and counteract it.

“We receive a letter from the Mayor every night about what is happening in [the City of] Mobile. [I want to know] what is the plan for Toulminville? what is the plan for Chickasaw?”(ID758) The implication was that people want to hear about plans that refer to their immediate reality.

⁴⁷ IDs 749-762,764,766,953,955

Pandemic preparedness⁴⁸

- Participants acknowledged the evolving nature of the pandemic and the difficulty of developing plans with limited knowledge and under uncertain circumstances.
- The first step to pandemic preparedness had to be the recognition that the pandemic would continue through the fall and next year.
- Once that prospect was accepted, community assets could be tapped to evaluate the situation and the availability of resources, formulate strategy and support implementation of a preparedness plan.
 - Existing community coalitions could be mobilized to address COVID-19 preparedness.
 - Plans should be sensitive to the needs of underserved communities.
 - It is important that Social Services agencies formulate their own pandemic preparedness plans.
- It is necessary to incorporate small community clinics into the overall medical preparedness strategy, so they have access to needed supplies (i.e., equipment, PPE⁴⁹, testing capability, etc.).
 - Access to supplies would enable such clinics to participate in the care of COVID-19 patients actively and reduce stress to the major healthcare systems.

In preparing to withstand the prolonged effects of the pandemic -particularly in anticipation of a second wave- people need to have clear information about what can be expected by way of relief from the government, along with well-defined instructions regarding how to access the assistance. A “roadmap” to respond to the threat of COVID-19 would be useful. (IDs 333,336)

Key components of pandemic preparedness⁵⁰

1. Need to provide for childcare for essential workers.
2. Clear and transparent messages from leadership at all levels
3. It will be necessary to provide both economic resources and resources to support mitigation behaviors (i.e., masks).
4. Ensure adequate supply of necessities, such as disinfectants and other basic supplies.
5. Create a system to inform the public of outlets that have such supplies in stock.

Outreach⁵¹

- Participants recommended three basic outreach functions: education, information, and provision of resources.
- These functions could be performed simultaneously.

⁴⁸ IDs 767-769,771,772,775,777-780,782

⁴⁹ Personal Protective Equipment

⁵⁰ IDs 770,773,774,776,778

⁵¹ ID784-786

- The community needs “*information on alternatives available, such as alternatives for transportation services. Provide lists of other resources that are generally unknown to the public and connect the public to them*” (ID785).
- Information offered to the community should be “*reliable information that can be understood and used for the community's benefit, whether it's yard signs or flyers*” (ID784).
- Participants stressed the need to provide resources in a systematic way and through the duration of the pandemic.
- A new basic need in the community is access to phones. Finding ways to provide phones for community members was recommended.

“Set up a team to go out in the community with education, providing resources such as masks. Perhaps something similar to a mobile health fair that would allow for social distancing.” Also: “Send people into the community. [Provide] information, testing, masks, gloves. Get equipment out to the public. Give them resources.” (ID786)

Reopening of churches⁵²

- Social distancing limitations to persons' ability to congregate in the church have resulted in spiritual stress for church members and financial hardship for some churches.
- There is concern that African American churches would be limited in their ability to reopen, given the logistic and financial requirements of deep disinfection and cleaning.
 - There would be serious barriers to holding two services during the day due to the constraints of sanitizing between services.
 - The elderly population wanted to go back to church, but there were safety concerns in doing that.
- Churches faced a big challenge in accommodating COVID-19 mitigation needs. They would likely have to face the disjunctive of complete closing vs. the holding of full services
- Participants stressed that some African American churches would require special support to endure the effects of the pandemic.

Needed financing for pandemic response and long-term preparedness⁵³

- A budget and funding thereof should be considered to begin solving the various problems associated with the pandemic.
 - It is necessary to define the cost of response measures to be taken.
- Underserved communities require dedicated funding to implement outreach, response, and long-term preparedness strategies.

⁵² IDs 910,913,956,958

⁵³ Comments by two participants after reviewing the report

Objective 3:

HOW TO EFFECTIVELY COMMUNICATE RELEVANT INFORMATION

This section details results related to:

- Current Status of Information
- How to Craft & Deliver Messages
- Seeds of bi-directional communication

Current status of information

How the Pandemic is Understood

*Perceptions*⁵⁴

- For the majority of residents, the pandemic is beyond their realm of experience, and they have struggled to adjust.
- Fear of the unknown is a primary driver in the community, leading to:
 1. People being afraid of becoming infected with the virus and being unable to get tested or get care.
 2. People having an excuse to ignore recommended mitigation strategies, as the situation doesn't make sense.
 3. Receptivity to conspiracy theories about the virus and the recommendations
 4. Increased apathy resulting in the lack of consistent thought process regarding pandemic information.

Early on, community members were not prepared for the pandemic. Many, especially the older generation, have been able to make the transition to taking the virus seriously and acting to limit exposure. (IDs 380)

*Incoherent Messages*⁵⁵

- Participants cited the inconsistency of the information provided to the community and the lack of a unified message regarding both the pandemic and the mitigation strategies in particular, as the reasons for the ample variation in the extent of the adoption of mitigation behaviors by community members.

⁵⁴ IDs 381,382,385, 386, 389,390

⁵⁵ IDs 360,364,370-372, 375, 891

- Mixed messages resulted in people being unclear on how the virus spreads or who is susceptible.
- There is confusion surrounding the use of masks, whether or not to use them, and how to properly wear them.
- The lack of a clear, unified message makes it easier to entertain conspiracy theories, given the backdrop of distrust of the medical community, particularly the white medical community.
- Clear educational messages are necessary to end the confusion and deficit of understanding.

Leadership, such as mayors and governors, are delivering mixed information that lacks consistency. There is ongoing change in state orders called to action, resulting in further confusion and inconsistency. There is uncertainty about what activities can be undertaken on a daily basis such as what businesses are open. (IDs 361, 368, 369,377,946,947)

Lack of leadership and division⁵⁶

- The observed lack of consensus among leaders on how to handle the pandemic has generated apathy and denial among community members.
- Some people will not adopt mitigation behaviors because they do not feel those are necessary, given the leaders' and officials' lack of unanimous messaging.
- A person may think, "*the leaders are not together with this [the stay at home and social distancing orders], so why should I?... I am going to do what I want to do.*" (ID363)
- With the lack of leadership and mixed messaging, people do not receive transparent information to understand the full aspects of the virus.
- One participant remarked that the lack of unified messaging for a health-related topic is an unusual situation.

Knowledge of COVID-19 in the Community⁵⁷

- People lack education on the full extent of the virus, including symptoms and complications.
- Due to scientists not yet fully understanding the course of the virus, many outstanding questions exist regarding knowledge of the disease.
 - Uncertainty of whether people fully recover from the virus after being exposed and whether there was a risk of being diagnosed with it again.
 - There is uncertainty of how a vaccine or

One participant referred to the initial disagreement between city governance and the health department regarding the closing of businesses as one example of the division between leaders, stressing that "*the great divide that we have affects how people listen to the messages and [distracts] from the big important message we should be listening.*" (ID363)

⁵⁶ IDs 362,365,373,375,379

⁵⁷ IDs 436,438,443,449-451,926,928

cure could be developed as the full understanding of the virus is pending. *“How are we going to create a vaccine if we are not necessarily sure what is going on? ... How do we protect ourselves or make an informed decision on receiving a vaccine?”* (ID930).

- The question of the length of the pandemic remained unknown, but participants referenced scientists informing the virus will return in winter.
- People understand that being in close contact with a person infected by the virus creates a possible risk of exposure, whether at home or in a workplace.
- Many are beginning to wear gloves and masks in public to lessen their exposure and that of others.
 - Yet, people are uninformed on how to properly dispose of protective equipment, at risk of exposing other people who may come in contact with the discarded equipment.
- A key informant explained the community is unaware of the presence of asymptomatic carriers of the virus, but one may obtain this knowledge if acquainted with healthcare-affiliated individuals.
- Additional beliefs of disease transmission were shared, such as saliva, and air.

Misconceptions⁵⁸

- Some people do not believe that the pandemic is real and think the virus is fake.
- Among those who believe the pandemic poses a threat, not all think they will contract the virus, resulting in ignoring mitigation instructions.
 - This is a common misconception among individuals under the age of forty, who deem themselves as *“indestructible”* or *“invincible”*(IDs 852,854).
 - It may have to take witnessing a person of a young age dying from the virus for this misconception to be proven false.
- Before the progression of the pandemic, there was the misconception that the virus did not impact the African American community, but this idea may no longer be accepted as more cases appear within this race, which includes many high-risk individuals.

Progressively more people are following the government orders. Initially the feeling was that they could stay at home but still “party” by having friends and family at their house.(ID859) Beyond that, the shift from the stay-at-home to safer-at-home confused people about the ongoing threat from COVID-19. (ID858)

Messages received by the community⁵⁹

- As the community continues to receive information from multiple sources, there is concern that mixed messaging results in unclear understanding.
- There can be overwhelming amounts of information provided, causing difficulty comprehending what is received, and resulting in people accepting and reacting to different messages.

⁵⁸ IDs 847,849,851,853,855,856,860

⁵⁹ IDs 888,889,891,893-895,896,898,899

- Messages that have penetrated the community include:
 - Protection from the virus requires safety precautions, such as practicing mitigation steps, wearing masks, and standing six feet apart.
 - To decrease the possible risk of being exposed, it is necessary to stay home or take shelter and practice safe hygiene routines.
 - The elderly and individuals diagnosed with diabetes, asthma, or cancer are at high risk and should avoid exposure.

Ways in which the community receives information⁶⁰

- Information continues to circulate as the pandemic unfolds, and people are relying on various sources of information depending on what is accessible.
- One may receive information by word of mouth or television, while another may receive information from the internet or websites if access to the internet and computers is available.
- Vulnerable populations receive information from various sources, including medical doctors, news media, word-of-mouth, and regular updates from the Mobile County Health Department.
- However, most people receive information from family members, friends, or neighbors, by “word of mouth.”
- Another informational source is televised-news, local and national, but this source may not be available to those without proper access or electricity.
- Radio is a prominent way for information to reach the community.
- Public health organizations, such as CDC⁶¹, provide information through postal-service mail, focusing on certain groups, e.g., elders.
- Mailers are also used by a local church health network to disseminate information.
- Social media is another outlet to retrieve information regarding the virus, and it is considered “*the best source*” by some. (IDs 737,739)
 - Persons able to access the internet and social media applications may be relying on this type of communication for information.
 - However, social media may be the

Word of mouth scenarios included elders passing information received from physicians to other family members, or elders getting information from their family members, or persons sharing information with neighbors. The information becomes second hand as one person hears it then passes it on to another. The initial source may have been from the CDC website or even an email from the government. Yet, word of mouth is unreliable. “*Words are left out or things get added.*” Concerns were raised regarding word of mouth even though this method was the only source of information for some citizens, such as persons who are homeless. (IDs 711,715- 717,723,726,734,736)

⁶⁰ IDs709,711- 714,718,719,725,727-729, 736,738, 741,743,744,747,748,835

⁶¹ Centers for Disease Control

source of various messages resulting in mixed information, misinformation, or possibly non-credible information. *“The information is not 100% accurate, and the false information makes more impact than legitimate information”* (ID710).

Acceptability of Vaccines

- When discussing the development of a vaccine, participants expressed that some people would be willing to receive the vaccine, while others would not.
- People who are receptive to the Flu vaccine would possibly be supportive of a potential vaccine to prevent COVID-19. *“Those who normally get a flu vaccine, they would, but if they do not receive the flu vaccine, then they would not.”*(ID961)
- For people to accept vaccination, the vaccine must exist for some time and intensely tested to rule out side effects and recall. One must receive further education before receiving the vaccination. A key informant expressed, *“Even if available, at first, I wouldn’t take the vaccine. I would wait a little bit.”*(ID959)

How to craft and deliver messages

The lack of clear, consistent messages has created a lot of confusion in the community limiting the level of knowledge among community members. To reach the community and address the perceptions and misconceptions, it is important to understand what we mean by community and who we are trying to reach with specific messages.(ID378,935) Realities differ from neighborhood to neighborhood: levels of educations and social placement can also impact understanding and acceptance of COVID-19.⁶²

Education of Community⁶³

- Education is a critical mechanism for empowerment and support for the community.
- To be most effective in communication relating to COVID-19, the education messages and activities must be culturally relevant and understandable.

*Messages to be conveyed*⁶⁴

- Terms such as pandemic need to be defined.
- Adding a frame of reference helps people come to grips with the situation and incorporate the needed mitigation strategies into their lives.

It is important to gather the best information developed by scientists and portray how it is relevant to the community. (IDs 525,526,531,544)

⁶² Comment by participant after review of the report

⁶³ IDs 248,251

⁶⁴ IDs 244,245,318-320,459-462,464,466,468-471,479,480,484-486,488

- Help people understand the symptoms of COVID-19 and what a person should do if experiencing them, along with practical information on where to get tested, the cost, and payment requirements.
- Include information on asymptomatic carriers and the risk of asymptomatic transmission.
- The idea of a vulnerable population needs to be clearly defined. *“Media talks about the vulnerable population being more at risk, but people do not identify themselves as vulnerable or know the meaning.”* (ID₃₁₇)
 - Stress what others, especially the young, can do to keep vulnerable people safe.
- Clear explanations of the mitigation strategies are and why they are important to help people be more aware and open to adopting them.
 - Clear, accessible messages on recommended practices such as social distancing, avoiding large crowds, and how to use masks.
 - The mitigation factor around handwashing should also be highlighted.⁶⁵
- Promoting virtual channels of connection, such as Zoom and Facetime, to motivate people to stay at home and practice social distancing.
- It is important to do a media or educational campaign encouraging people to keep up their routine doctors' visits, since there is fear of exposure to the novel coronavirus if going to the hospital or doctor's office.
- Messages should acknowledge the changing situation and provide comfort while also sharing positive stories of recovery.

A participant suggested there was a need to work harder to help young people understand how the elderly are affected by their actions. To hit home, messages should focus on the idea that “you are saving lives” if you follow the recommendations. (ID₄₆₃)

Education strategies

Unified message, multiple voices⁶⁶

- The most important aspect of an education campaign is the need for a standard, unified message that is clear and understandable.
- In developing messaging and partnerships, it is important to have elected leaders and public health leaders on the same page, communicating the same messages. If they deliver different messages, then people in the community will not know who to listen to.
- There need to be clear guidelines with concrete examples and tools to implement mitigation strategies.

Addressing the pandemic is a joint effort of many levels in the community. The voices of medical personnel, scientists, and community leaders (e.g.; pastors) must be unified to make an impact and address fears. Also, elected officials (especially those from the African American community) are important messengers in sharing the information. (IDs 457,494,496, 497,508,503,504,507-510,513,516, 522,523)

⁶⁵ Comment by participant after review of the report

⁶⁶ IDs 246,252,455,458,472-474,477,478,481,482,487,492,495,499,500,505,506,512,519,540

- The messages should use visuals and statistics to easily communicate with members of the community.
- Statistics must be clear, explaining what is counted and what the numbers mean.
- A toolkit with education materials can be distributed to community leaders, churches, and media outlets to equip them with valid, coherent information.
 - Use these materials to educate pastors, barbers, and other local business owners to help the message penetrate the community and touch those harder to reach.

Avenues for dissemination of the information⁶⁷

- Various routes of information exchange exist in the community, including churches, medical practices, news media, word-of-mouth, and social media.
- Mechanisms for reaching community members include postcards, news media, social media, email, websites, newspapers, and radio.
 - Radio is the best channel for reaching the community since a majority of people have access to it.
- Short videos or TV spots could be helpful if featuring people that the locals can easily identify with. These spots should include stories of individuals who have lost loved ones, medical personnel who have been treating the virus, and other community members.
- Information can be collected on a website to be accessed by community members and shared on social media

A key informant suggested to “*focus on hip-hop [radio] channels for the younger generations, or anything the younger generation can hear [or] use. The older generation will listen to the younger generation.*” The idea of focusing on the younger generation to pass the information to the older generation was deemed an effective way to communicate pandemic information in the African-American community.(ID 722)

Dissemination strategy⁶⁸

- The intention should be to saturate the community with messages regarding actions to take and why they are important.
- Since the community is not a monolithic unit, any education campaign must be multifaceted, working with tools ranging from social media to yard signs to mailers.
- Include flyers and posters placed in key locations (e.g., convenience stores, restaurants) where a large number of community members will see them.
- A participant suggested approaching dissemination efforts as community projects, based at churches functioning as community resource sites.
 - Onsite testing provided in a cheerful environment, with snacks, fellowship, and an overall sense of hope.

⁶⁷ IDs 456, 476,491,493,501,503,515,520,521, 529,533,534,536,539,708,714, 717,719-722,724,725,727-730,733,737-740,742-744,746

⁶⁸ IDs 458,483,502,511,517,527,528,530,537,538,745

- This participant envisioned churches as sites for education, dissemination of information, and pick-up location for medication and food assistance.
- As community leaders, pastors are valuable partners to serve as messengers to share important information about COVID-19 and the mitigation strategies.

Seeds of Bi-directional Communication

Throughout the qualitative data collection process, we were confronted on a few occasions with participants conveying their sense of déjà vu. They had had conversations about the reality of their communities many times before, some with us, and some with others. Where we had made the COVID-19 pandemic the focus of the conversation, the issues of socioeconomic disadvantage, inequality, distrust, and structural racism would have surfaced whatever the topic might be.

A participant stated: *“It's not the virus that needs to be fixed. I think this [pandemic] is an opportunity to highlight all of our weaknesses. Don't want us to be caught up on what we can do for COVID, we could put anything here (meaning a blank line) and still be having the same issues ...the same questions could have been asked a year ago, the same thing that was happening in households a year ago, is happening in households now, just intensified.”* Such statement reveals the extremely slow progress of equity in underserved neighborhoods. It highlights the need to address the fundamental drivers of inequity to foster resilience to any stressor, not just COVID-19. (ID: Notes focus group 3, page 14, lines 3-8)

Nevertheless, throughout the discussions, participants outlined a path forward with regards to an engaged approach to addressing COVID-19 related challenges in their community, as follows:

1. Intention: Approach the community with the intention of community benefit:
“Convey that you are not [just] scholars, that you care” (ID 348).
2. Define the goal:
“Less death, less sickness, lesser [number of lives] being taken and affected. That should bring us together” (ID349).
3. Ground rules:
 - Acknowledge that research *per se* is not a value for the community:
“The survey you did last year should have told you that [we do not have health insurance]” (ID277).
 - Subscribe to continued communication:
“Open a window with the pastors so that it can be an ongoing conversation”(ID518).

- Accept there are no easy answers:
“But, participants stated that they weren't sure what would work” (ID475).

4. Minimal requirements:

- Deepen your understanding of the community to be efficacious:
“Continue to get to know and understand the community, so that we can provide for them” (ID514).
- Ensure output relevant to the underserved communities:
“What is the plan for Toulminville? What is the plan for Chickasaw?” (ID758).
- Understand the issues faced by the community:
“Understand the needs ...Understand the community, do the research ...If we don't know the community we can't help” (ID348).
- Understand the issues faced by Social Services Agencies:
“[Agencies want to help] but the big issue is who owns it” (ID339).

5. Approach:

- Involve all stakeholders:
“Utilize and engage a partnership of community leaders and local government/individuals, such as district officials and commissioners, so they can be a part of this” (ID524).
 Other stakeholders to be involved: health care providers, health leaders, business owners, business leaders, and law enforcement. (IDs 342,350,353-356,358)
- Coordinate efforts:
“...organizations have an individual that is assigned to specific issues like this. All should sit down or Zoom and talk it through or engage and allow communication... to know how to better put resources together” (ID351, 357).
- Create products in collaboration with the community:
“The messaging is necessary. That has to be done. So the [education] ...that is a collaborative effort. We can do those educational pieces. ... May be we need to partner with some leadership [to craft/deliver messages]” (ID525).

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Appendixes

Appendix 1: Interview Guide

Appendix 2: Basic Analysis Questions

Appendix 3: Designated Primary and Secondary Codes

Appendix 4: Content Synthesis Matrix

Appendix 1. Interview / Discussion Guide

Objective 1: Understand the population of focus' lived experience of the COVID-19 pandemic

- What are the perceptions of community members regarding COVID-19?
 - Do perceptions vary by gender? By age-group?
- Let's talk about how COVID-19 has affected usual routines for families in the communities around University Hospital (former USA Medical Center)
 - How have home dynamics changed?
[PROMPTS: have families...
 - Stayed at home except for essentials?
 - Increased activity with a child's schoolwork?
 - Experienced issues with child support?
 - Experienced issues with children's custody arrangements?
 - Allowed family members or others to move into household?
 - Felt closer together? or had more arguments?]
 - How have families' sources of income been impacted?
[PROMPTS: have main breadwinners...
 - Employment status been impacted?
 - What sectors of employment have been affected?
 - Lost employment? Considered essential employee?
 - Worked from home?
 - Applied for unemployment?
 - Continue to receive retirement / Social Security / SNAP benefits?
 - Received or are slated to receive Federal Emergency Aid?]
 - How have health care needs been impacted?
[PROMPTS: have families ...
 - Health insurance status been affected?
 - Lost health insurance? Type of health insurance?
 - Been able to access usual source of health care?
 - Have to suspend elective healthcare? (chronic diseases, mental health, dental, eye care?)
 - Needed care for COVID-19?
 - Received care for COVID-19?]
 - What role is technology playing in this new normal?
[PROMPTS:
 - How have technology needs changed for people in the community?
 - How has the use of home computers increased or decreased?
 - How has the use of cell phones increased or decreased?
 - What resources do families have to access technology?]

- How have social networks in the community been impacted?
[PROMPTS:
 - How is “social distancing” being (or not being) implemented?
 - Are people checking up on elderly neighbors or family members?
 - What is the impact on limitations to religious gathering?
 - What alternatives do congregations have to stay in touch?
 - How are people managing for transportation to get groceries and other necessities?
 - How has access to social services agencies (Catholic Social Services, etc.) been impacted?]

- Let’s talk about how the community experiences the COVID-19 pandemic...
 - What are sources of information about COVID-19?
[PROMPTS:
 - What messages were effective?
 - Where did effective messages come from?]

 - What information is circulating in the community about COVID-19?
[PROMPTS: What does the community think about ...
 - How COVID-19 spreads?
 - Who is vulnerable to COVID-19?
 - The news that there are more deaths from COVID-19 in communities of color than in majority communities?
 - Testing for COVID-19?
 - How the disease is treated?
 - What should people do if they think they are sick with COVID-19?
 - How the COVID-19 situation will impact the interaction with law enforcement]
 - The monetary help that the government has promised?]

- Mitigation of the spread of the pandemic at this point relies on social distancing and people staying at home. How easy or difficult is for the community to implement these strategies?

- Are there people in the community who are going to be especially hurt by the pandemic? Who would they be?

Objective 2: How to address the challenges specific to COVID-19.

We have talked about the experiences of families in the communities surrounding the University Hospital. Let’s now summarize what are challenges for the community as a whole and what may be ways to address those challenges...

- What are the major challenges the community faces with regards to COVID-19?

- How has the community addressed those challenges?
[Prompts will be:

- Work related changes
 - Care of Children
 - Usual income sources
 - Transportation
 - Shopping for necessities
 - Access to support agencies
 - Usual Health care
 - Mental Health
 - Testing for COVID-19
 - Care for COVID-19
 - “Social distancing”
 - Elderly care / respite care for those caring for elderly relatives, friends, etc.
 - Access to religious community]
- How can the community be better prepared for a lengthy COVID-19 threat (into the Summer, Fall, etc.?)
 - What can the Center for Healthy Communities do to help?

Objective 3: How to effectively communicate relevant information.

- How does the community get information about COVID-19?
- What messages should be provided?
 - How do community members refer to COVID-19?
 - What may be a better term: “physical distancing” or “social distancing”?
 - What messages would help motivate people to stay at home and reduce social interaction?
 - Should the heightened risk of persons with common conditions such as heart disease, diabetes, asthma, hypertension, etc. be mentioned? How so?
- Who should be providing the messages?
- What channels should be used to convey messages?
 - Should channels be different for Educational messages (how the virus spreads, symptoms of the disease, who are most at risk, etc.) *versus* specific information about testing and/or healthcare options for COVID-19?
 - Would apps that calculate individual risk of severe disease be effective?

[Prompts for potential message channels:

- Text
- Social media
- Letter by health care provider
- Postcard with specific messages

- Yard signs
- Radio
- TV
- Church Bulletins]

- Are there environmental exposures that are affecting the community during the COVID-19 pandemic?
- Who else should we approach to get relevant information and suggestions for action?
- Are their topics that we have not discussed that you would like to talk about?

Demographic information: (Interviewer asks of each participant)

- What age category do you fall into?
 - A. 19-35 _____
 - B. 36-65 _____
 - C. 66 or older _____
- How do you identify yourself?
 - A. Female _____
 - B. Male _____
 - C. Other _____
- Are you a resident of any of the following zip codes?
 - A. 36602 _____
 - B. 36603 _____
 - C. 36604 _____
 - D. 36605 _____
 - E. 36606 _____
 - F. 36607 _____
 - G. 36610 _____
 - H. 36617 _____
 - I. Not a resident of the focus area _____

Appendix 2. List of basic analysis questions for rapid qualitative review

Document experiences of people

1. What is the community's perception of COVID-19?
2. What are stressors/challenges are experienced by individuals and families regarding home dynamics?
3. What stressors/challenges are experienced by individuals and families regarding sources of income?
4. How has the education of children been affected due to staying at home?
5. How has access to health care been affected by the COVID-19 pandemic?
6. How has technology played a role in the community during the pandemic?
7. How has interaction with social networks been changed due to new restrictions and social distancing?
8. How is information/communication being received regarding COVID-19?
9. What specific information is continuously focused in the community regarding COVID-19?

Are general strategies to mitigate spread going to work?

10. How realistic is that social distancing will be adhered to?
11. To what extent can community members implement the needed mitigation steps, particularly "stay at home"?
12. What unforeseen consequences are affecting the community because of the mitigation steps?

Identify the most vulnerable and reasons for vulnerability

13. Who are the people in the community who are going to be the most hurt by the pandemic?

How to address challenges specific to COVID-19.

14. What are the major challenges the community faces due to COVID-19?
15. What strategies are community members using to meet the COVID-19 challenges?
 - a. How are families addressing work related challenges?
 - b. How are families addressing income challenges?
 - c. How are families addressing shopping for necessities?
 - d. How are families addressing healthcare for COVID-19?
 - e. How are families accessing testing for COVID-19?
 - f. Other strategies being used in the community
 - g. What role are social service agencies playing?
16. What needs should be addressed to help the community deal with a lengthy COVID-19 threat or extended stay-at-home order?
17. How can the Center for Healthy Communities serve the community during this pandemic?

How to effectively communicate relevant information

18. How does the community get information about COVID-19?

19. What messages would be most effective in the community?
20. Who would be the best messengers for good information to resonate in the community?
21. What are the best channels/media for getting information to the community?
22. Other thoughts about COVID-19 and the low resource community?

How to engage in bi-directional communication

23. Who else should we approach to get relevant information and suggestions for action?
24. Are there any additional environmental health concerns?
25. Are there any important issues we have not addressed with our questions?

Analysts input

26. Other comments/observations/ thoughts arising from the interview/focus group

Appendix 3: Analysis sub-units and primary codes included

Subunit of Analysis	Assigned Primary Code	Subunit of Analysis	Assigned Primary Code
1. Experiences of People	1. Challenges 2. Environmental Concern 3. Home Dynamic 4. Motivation to Adopt Mitigation Strategies / Behaviors	2. Requirements of Pandemic	5. Adaptation to Pandemic 6. Mitigation Behavior 7. Reopening 8. Technology
3. Impact Pandemic Response	9. Economic Impact 10. Long-term Effect 11. Most Impacted 12. Most Vulnerable 13. Negative Behaviors 14. New Normal 15. Role of Churches 16. Social Network 17. Trauma 18. Unforeseen Consequences 19. Vulnerable Populations	4. Education of Children	20. Education* 21. Education strategies*
5. Health Care	22. Health Care	6. Testing	23. Access to Testing
7. Experience of Inequality	24. Define Community 25. Disparity 26. Distrust in Health Care 27. Distrust in the System 28. Experience of Bias 29. Higher Death Rate 30. Injustice of Disparity	8. Strategy for Response (Mid- and Long-Term)	31. Engagement 32. Outreach 33. Pandemic Preparedness 34. Pandemic Response 35. Recommendations for Survival 36. Vaccine
9. How Pandemic is Understood	37. Changing Situation 38. Incoherent Messages 39. Knowledge of Disease Course 40. Knowledge of Disease Spread 41. Messages in the Community 42. Misconceptions 43. Perception 44. Scientific Knowledge Base 45. Understanding of Disease Course 46. Understanding of Disease Spread	10. Education of Community 11. Messaging	47. App/Language Education* Education Strategies* 48. Channels of Communication / Information 49. Vote

* This code could have been used for sub-unit 4: Education of Children or sub-unit 10: Education of Community

Appendix 4: Content Synthesis Matrix		Obj. 1: Community members' experiences						Obj. 2: How to address challenges			Obj. 3: How to effectively communicate					
		Description of experiences; Viability of mitigation strategies; Identify the most vulnerable; Challenges Description of	Impact of Pandemic response	Education of Children	Healthcare	Testing	Experiences of inequality and bias	Strategies to address Challenges	Strategy for Response (Mid- and Long-term)	Support needed	Current Status of Information	How to craft and deliver messages	Seeds of bidirectional communication			
1. EXPERIENCES OF PEOPLE		Experiences of people with the requirements of the pandemic														
2. REQUIREMENTS OF PANDEMIC		Experiences of people with the requirements of the pandemic														
HOME DYNAMIC		xx						x								
MITIGATION BEHAVIOR		x						x								
MOTIVATION TO ADOPT MITIGATION STRATEGIES / BEHAVIOURS		x													x	
TECHNOLOGY		x														
CHALLENGES		xx														
ENVIRONMENTAL CONCERN		xxx														
ADAPTATION TO PANDEMIC																
REOPENING																
3. IMPACT PANDEMIC RESPONSE		Experiences of people with the requirements of the pandemic														
ECONOMIC IMPACT			xx													
SOCIAL NETWORK			xxx													
NEGATIVE BEHAVIORS			xx													
UNFORESEEN CONSEQUENCES			x													
TRAUMA			x													
MOST IMPACTED			x													
MOST VULNERABLE																
VULNERABLE POPULATIONS			x													
LONG-TERM EFFECT			x													
NEW NORMAL																
ROLE OF CHURCHES			x													
4. EDUCATION OF CHILDREN		Experiences of people with the requirements of the pandemic														
EDUCATION																
EDUCATION STRATEGIES							xxx									
5. HEALTH CARE		Experiences of people with the requirements of the pandemic														
HEALTH CARE																
6. TESTING		Experiences of people with the requirements of the pandemic														
ACCESS TO TESTING																x

Note: Red color shows where codes that had been originally assigned to several focus areas were consolidated

Appendix 4:

Content Synthesis Matrix (page 2)

Appendix 4: Content Synthesis Matrix (page 2)	Obj. 1: Community members' experiences							Obj. 2: How to address challenges			Obj. 3: How to effectively communicate		
	Description of experiences; mitigation strategies; identify the most vulnerable; Description of Challenges	Impact of Pandemic response	Education of Children	Healthcare	Testing	Experiences of inequality and bias	Strategies to address Challenges	Strategy for Response	Support needed	Current Status of Information	How to craft and deliver messages	Seeds of bidirectional communication	
7. EXPERIENCES OF INEQUALITY													
DEFINE COMMUNITY						x					x		
DISPARITY						xx							
DISTRUST IN HEALTH CARE						xx							
DISTRUST IN THE SYSTEM						x							
EXPERIENCE OF BIAS						x							
HIGHER DEATH RATE													
INJUSTICE OF DISPARITY						x						x	
8. STRATEGY FOR RESPONSE (MID- AND LONG-TERM)													
PANDEMIC RESPONSE								x				x	
PANDEMIC PREPAREDNESS								x					
OUTREACH								x					
ENGAGEMENT								x				x	
RECOMMENDATIONS FOR SURVIVAL													
VACCINE										x			
9. HOW PANDEMIC IS UNDERSTOOD													
CHANGING SITUATION										x			
PERCEPTION										xx			
INCOHERENT MESSAGES										x			
SCIENTIFIC KNOWLEDGE BASE										x			
KNOWLEDGE OF DISEASE COURSE										x			
KNOWLEDGE OF DISEASE SPREAD										x			
UNDERSTANDING OF DISEASE COURSE										x			
UNDERSTANDING OF DISEASE SPREAD										xx			
MISCONCEPTIONS										xx			
MESSAGES IN COMMUNITY										x			
10. EDUCATION OF COMMUNITY													
EDUCATION											xxx		
EDUCATION STRATEGIES											x	x	
APPLANGUAGE											x		
11. MESSAGING													
CHANNELS OF COMMUNICATION / INFORMATION											xx		
VOTE												x	

Note: Red color shows where codes that had been originally assigned to several focus areas were consolidated

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