

Addressing Hampton Roads Community Mistrust in the Wake of the Pandemic

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CommuniVax

A Coalition to Strengthen the Community's Role
in an Equitable COVID-19 Vaccination Campaign



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Executive Summary

CommuniVax established a national research coalition in September 2020 composed of 5 local research teams: Alabama, California, Idaho, Maryland, and Virginia, focused on African American/Black and Hispanic/Latino communities, and coordinated by a central “hub” that is housed at the Johns Hopkins Center for Health Security and guided by a national expert working group. The Virginia team, whose CommuniVax involvement began in late spring 2020, includes Eastern Virginia Medical School, Norfolk State University, Hampton University, and Virginia Commonwealth University. The Virginia team has a Hampton Roads component and an Eastern Shore component.

This report highlights findings from qualitative research on COVID-19 vaccination in low-income Hampton Roads communities conducted from January through September 2021. It relies on 40 individual interviews, 16 focus group discussions, and ongoing interactions with a community advisory board comprised of residents in low-income housing from across the region.

A recurring theme of our report is that while low-income communities have been undeniably affected by COVID-19, vaccination itself seems far more important to public health professionals than to affected communities. For example, the report finds that low-income communities are very concerned about their mental health in the wake of the pandemic; it is seen as a far more pressing issue than the direct effects of COVID-19. Low-income Hampton Roads communities also seem largely unconcerned with vaccine access. While vaccine access has been an issue nationally, no participants in our study suggested that access issues had affected their decision making about vaccination.

Instead, pervasive mistrust in the pandemic response seems to be the most important factor affecting vaccination among low-income Hampton Roads residents. A major source of mistrust is the constantly changing COVID-19 guidance landscape, which has profoundly affected how vaccines are viewed. Unfortunately, while trusted medical providers can work to counteract this mistrust, many low-income residents report difficulties maintaining long-term relationships with providers. The report notes that increasing vaccination in low-income communities will likely require health systems and public health professionals to become more trustworthy by committing to address other community concerns.

The report recommends that we build trust by doing things *with* community partners, rather than maintaining the status quo by doing things *for* or *to* them. Creating ongoing avenues for community engagement is especially important. Intentional engagement of affected community members is a necessary first step; engagement of individuals who are representative of affected communities should be prioritized over solely interacting with stakeholder groups. The report also notes that decision makers should actively seek out contrarian voices, as we likely have the most to learn from those who disagree with us. As an example of how a community-engaged project might look, the report describes a proposal to create a network of community mental health advocates—socially placed laypeople with established community roles (eg, barbers) who have completed evidence-

based mental health first aid training—that was developed in partnership with community members.

The report also recommends investments in infrastructure that keeps people connected. The digital divide must be addressed to ensure that low-income communities are not left behind by the “new normal.” The report’s final recommendation is to facilitate greater sharing and transparency of state and federal agency vaccination data.

Introduction

This report is part of a national CommuniVax initiative focused on improving the prevention response to COVID-19, especially in communities of color that have been hardest hit by the pandemic. It serves as a supplement to the CommuniVax national report, *Carrying Equity in COVID-19 Vaccination Forward: Guidance Informed by Communities of Color*.¹ This report focuses on the Hampton Roads region of Virginia and details findings specific to the local African American/Black population. It is a call to action and offers recommendations and specific actions that can be implemented by public health officials, government officials, healthcare professionals, academic institutions, community-based organizations (CBOs), faith-based organization (FBOs), and those who conduct community health and education.

Community Description

We worked with low-income housing residents from the following 7 cities from the Hampton Roads region in southeastern Virginia: Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, and Virginia Beach.

Combined, these cities have 1.4 million residents, as per US census data. Population by race includes 57.72% White, 30.93% African American/Black, 7.52% Hispanic/Latino, 4.16% Asian, 0.45% American Indian/Alaskan Native, and 0.14% Native Hawaiian/Pacific Islander residents. However, there is stark geographic segregation by race; for example, African American/Black residents represent 41.1% of the population of Norfolk but make up 93% of low-income housing residents in the city, a demographic breakdown similar for all of 52,000 low-income housing residents across the region.²⁻⁹

The relative racial homogeneity within low-income housing presents challenges resulting from racism and persistent trauma that intersects closely with socioeconomic vulnerability. Low-income housing residents are more likely to experience lower rates of educational attainment, be employed in jobs with lower earnings and skill requirements, and exhibit substantially higher rates of disability.¹⁰⁻¹² These factors are further compounded by lower levels of health literacy,¹³ lack of insurance benefits,¹⁴ and access to affordable healthcare.¹⁵ Our target population represents some of the most vulnerable residents in the region. A lack of collective efficacy and broad distrust in the rest of society are serious challenges moving forward.

Burden of COVID-19

Hampton Roads has fared reasonably well compared with the rest of the United States. No city in the region exhibited a higher case burden than the United States as a whole, although all but Norfolk had/still have higher rates per 100,000 than the average for Virginia (Table 1). Two cities, Portsmouth and Suffolk, continue to exhibit higher death rates per 100,000 than the national average of 184: Portsmouth with 216.6 and Suffolk with 211.7 (Table 2). Half of the cities in the region still exhibited higher deaths per 100,000 than the Virginia average of 135, with 137 in Hampton, 135.5 in Newport News, 216.6 in Portsmouth, and 211.7 in Suffolk, respectively.

Table 1. COVID-19 Cases, Hospitalization, and Deaths by City

<i>Indicator</i>	<i>Chesapeake</i>	<i>Hampton</i>	<i>Newport News</i>	<i>Norfolk</i>	<i>Portsmouth</i>	<i>Suffolk</i>	<i>VA Beach</i>	<i>Statewide</i>
Total cases	21,986	11,078	14,812	18,503	9,444	8,240	37,605	697,939
Per 100,000	9,061.4	8,247.9	8,292.2	7,580.8	9,979.9	9,036.6	8,353.2	8,150
Total hospital	1,073	476	555	1,085	714	495	1,781	31,423
Per 100,000	442	354	311	445	755	543	396	367
Total deaths	311	184	242	274	205	193	421	11,534
Per 100,000	128.2	137	135.5	112.3	216.6	211.7	93.5	135

Source: Virginia Department of Health COVID-19 Cases and Testing Dashboard.¹⁶ Accessed August 2, 2021. Abbreviation: VA, Virginia.

Table 2. Current Vaccinations by City

<i>People Vaccinated</i>	<i>Chesapeake</i>	<i>Hampton</i>	<i>Newport News</i>	<i>Norfolk</i>	<i>Portsmouth</i>	<i>Suffolk</i>	<i>VA Beach</i>	<i>Statewide</i>
Total doses	222,677	117,655	153,168	179,486	73,212	82,213	430,497	9.7M
At least 1 dose	122,163	64,339	84,012	99,249	40,557	44,876	235,375	5.3M
Fully vaccinated	107,683	55,908	73,589	85,583	34,348	107,683	209,416	4.7M

Note. Source: Virginia Department of Health COVID-19 Vaccine Dashboard.¹⁷ Accessed August 14, 2021. Abbreviation: VA, Virginia.

The impact of COVID-19 on communities of color in Hampton Roads has been more disproportionate than both the rest of Virginia and the United States as a whole. The ratio of the proportion of African American/Black people in the population to their proportion of cases, hospitalizations, and deaths can be seen in Table 3. For example, African American/Black individuals currently comprise 1.09 times more cases in Norfolk than we would expect based on their proportion of the population. Nationally, African American/Black individuals account for 0.93 times as many cases and 1.1 times as many deaths, based on what we would expect given their proportion of the population. Unfortunately, while disparities in cases have decreased over time in Hampton Roads—approaching parity in several cities—disparities in hospitalizations and deaths have remained stable. For example, over the past several months African American/Black individuals in Norfolk have consistently made up over 1.5 times more deaths and hospitalizations than we would expect. While data specifically for low-income housing residents are unavailable, as a vulnerable subpopulation we should expect the burden of COVID-19 on them to be even higher.

Table 3. Ratio of the Impact of COVID-19 on the African American/Black Population to Its Proportion of the Overall Population: Cases, Hospitalizations, and Deaths

<i>Indicator</i>	<i>Chesapeake</i>	<i>Hampton</i>	<i>Norfolk</i>	<i>Portsmouth</i>	<i>VA Beach</i>	<i>Statewide</i>
Cases						
June 1	1.20	1.14	1.24	1.19	1.21	1.13
August 15	1.03	1.00	1.09	1.00	1.05	0.98
Hospitalizations						
June 1	1.67	1.40	1.63	1.26	1.53	1.49
August 15	1.60	1.40	1.63	1.27	1.47	1.44
Deaths						
June 1	1.33	1.30	1.51	1.17	1.31	1.28
August 15	1.33	1.32	1.51	1.17	1.32	1.29

Note. Newport News and Suffolk excluded due to suppressed data for those cities. Values represent ratio of the percentage of African American/Black people in each city to their proportion for each outcome. Source: Virginia Department of Health COVID-19 Cases and Testing Dashboard.¹⁶ Abbreviation: VA, Virginia.

COVID-19 Vaccination

Regional COVID-19 Vaccination Efforts

As of August 14, 2021, 69.6% of the eligible population in the United States (ages 12 years and over) has received at least 1 dose of vaccine and 59.2% are fully vaccinated. Virginia as a whole slightly lags behind the US average for those with at least 1 dose and exceeds the national average for fully vaccinated individuals. However, due to reporting limitations of local data by the Virginia Department of Health, it is impossible to compare vaccination rates for the region using either the Virginia or US averages. This is due to: (1) lack of reporting of federal doses of vaccine administered at the local level without providing a correct denominator for calculating the rate, and (2) recategorizing of vaccinations by race and locality over time. Due to the large number of federal employees and military personnel in the region, these factors seem to systematically bias both overall vaccination rates in the region and rates by demographic group, which the Virginia Department of Health reports on its website. This had led 1 regional health department to claim that 85% of its adults were at least partially vaccinated after having seen unreleased federal and military data in June.¹⁸ The Virginia Department of Health reports a much more modest rate (59.1% as of August 14, 2021). However, the US Centers for Disease Control and Prevention reports that the same city has achieved a vaccination rate of 16.6% of adults, with no explanation for the discrepancy.

Unfortunately, this underreporting has impacted resource allocation efforts in the region. Local reporting has stressed these low rates relative to the rest of the state and the need for special outreach to the African American/Black population;¹⁹⁻²¹ however, this apparent disparity was almost certainly artificially inflated. There was a substantial increase in African American/Black first doses of vaccine reported by the Virginia Department of Health on July 7, 2021, followed by a reported decrease on July 15, 2021. Upon examining the data, however, this resulted from already-reported cases that were originally coded as “Not Reported” race, as there is a concomitant decrease in the number of vaccinations in that category on July 7, 2021. It is impossible to tell, based solely on the publicly available Virginia Department of Health data, when these

vaccinations actually occurred and why they were not correctly categorized from the beginning. Taken together, these issues raise serious concerns about data quality and cast doubt about the usefulness of the data for making any comparisons across regions or over time.

Approach

Approval for all activities was obtained from the Eastern Virginia Medical School Institutional Review Board. Relevant Institutional Review Board study IDs include: 20-04-NH-0099 (for community engagement), 21-03-EX-0069 (to facilitate providing technology to participants and creating infrastructure for virtual focus groups), and 21-03-FB-0046 (for remaining study activities).

The Virginia team completed 40 semistructured interviews with low-income Hampton Roads residents from April 28, 2021 through June 1, 2021, which were administered by a team of 2 full-time research staff. Interviews were conducted telephonically or virtually, using Zoom video teleconferencing software.

The team has been conducting focus groups since June 11, 2021 and has completed 23 as of September 15, 2021; 21 with low-income residents from the region (n = 96 participants), 1 with representatives of area community organizations (n = 4 participants), and 1 with area vaccination campaign planners (n = 4 participants). Focus groups were conducted via Zoom video teleconferencing software. Participants used tablet computers and data connectivity provided by the team for all of the low-income resident focus groups.

Almost all of the participants who did not represent a community organization or who were vaccine planners were residents of area low-income housing; 62.5% considered their home to be in an urban setting, 32.5% said that they lived in a suburban setting, and 0.05% reported living in a rural area. All but 7 low-income resident participants reported someone in their household to be at increased risk for COVID-19 due to health status or employment as an essential worker. All low-income resident participants identified as African American or Black aside from 2 White and 1 Native American/Alaskan Native participants. Participants were twice as likely to be women and skewed older, with an average age of 45 years.

Recruitment was conducted using flyers, re-contact based on participation in previous studies, and referral from our community advisory board (CAB) and other participants. Interviews and focus group discussions were redundantly audio-recorded (ie, with 2 audio recorders for phone interviews or 1 audio recorder and 1 video recording if Zoom was used). Recordings were professionally transcribed. HyperRESEARCH version 4.5.2 (Researchware, Inc., Randolph, MA) was used for coding.

Community Engagement Infrastructure

Our network of professional and community stakeholder partners includes regional public housing authorities and low-income housing community advisory boards.

Regional Public Housing Authorities

The Virginia team has fostered longstanding relationships with 8 public housing authorities (PHAs) that provide low-income housing in the Hampton Roads region of Virginia. One of these, the Virginia Beach Department of Housing and Neighborhood Preservation, is a city office that administers housing choice vouchers (ie, tenant-based assistance) to low-income residents who qualify. The remaining 7 are PHAs: (1) Norfolk Redevelopment and Housing Authority (the largest housing authority in Virginia), (2) Newport News Redevelopment and Housing Authority, (3) Portsmouth Redevelopment and Housing Authority, (4) Hampton Redevelopment and Housing Authority, (5) Suffolk Redevelopment and Housing Authority, and (6) Chesapeake Redevelopment and Housing Authority. These PHAs both administer vouchers (eg, housing choice vouchers) and own/manage property-based assistance, typically public housing or project-based Section 8. Combined, these agencies provide housing benefits to 75,275 residents. Residents across PHAs are demographically similar, while the non-PHA agency has a higher proportion of non-Hispanic White residents (ranging from 2% to 6% for the PHAs vs 16%). The agencies vary by size and population density of their cities and represent both urban and rural areas. We have met separately with each agency once per month since November 2020 and convene a combined regional meeting each quarter (11 monthly and 3 quarterly meetings).

Low-Income Housing Resident Community Advisory Board

We have been meeting with a Norfolk low-income housing CAB for almost a decade. This CAB has been involved in a range of grant-funded research activities ranging from childhood asthma, smoke-free public housing, and compliance with COVID-19 guidance. The CAB is an active partner; 2 of its members have been coauthors on recent manuscripts. We maintained contact with the CAB during the pandemic, shifting it to a virtual format with weekly meetings. Additionally, we were able to expand the CAB to the entire region using virtual community engagement methods developed over the past year. Each CAB member, some of whom had never used a computer before, were provided with a tablet with high-definition webcam, free unlimited internet access in the form of a data plan tied to the tablet, and basic digital literacy training and technology support. There are currently 24 CAB members, all of whom receive a housing benefit from one of the housing agencies listed above. Average attendance for the weekly meetings during the pandemic exceeds 90%. We have held 176 meetings with some form of the CAB (ie, either the original or expanded CAB) using technology that we have provided since the beginning of the pandemic. During this time, the CAB has been heavily involved in data analysis, helping interpret results and better identify emergent themes from participant feedback.

Local Observations

The following observations are based on participant interviews and focus group discussions with feedback from our partner CAB providing context.

Low-Income Communities Are Concerned About Their Mental Health

While participants recognized that COVID-19 has devastated their communities, both directly (eg, almost a third of our sample reported losing immediate family members or close friends to COVID-19) and indirectly (eg, social and economic effects of the lockdown), mental health emerged as their most pressing concern. When asked to rank their perceived community health needs, our partner CAB considered COVID-19-related mental health issues to be far more important than the direct impact COVID-19 itself. They also recognized that the impact of the pandemic on mental health has been complex. They explained that while isolation and stress has led to new cases, they were also concerned about how the pandemic would affect members of their communities with existing serious psychiatric disease.

One of our participants provides a tangible example: a 68-year-old African American/Black man who suffers from schizophrenia and had been hospitalized with COVID-19 8 months before his interview relayed that the disease was devastating both due to its physical impact and for its disruption to his psychiatric care. He originally felt that COVID-19 was a hoax before becoming sick himself. He said, “I wasn’t concerned at all, I didn’t believe it. I just thought it was a hoax, just somebody talking to be talking, but I found out it was real.” COVID-19 has been both a short- and longer-term disruption to his psychiatric care. He said, “I’m diagnosed with paranoid schizophrenia and they wouldn’t let me get my medicine because I had COVID and that was a very hard time.” He reported that following his release from the hospital, he was barred from entering the building where he saw his psychiatrist, although he was told he did not have to quarantine. In his words, it took “2 or 3 months to get my shot” (ie, a long-acting injectable psychiatric medication) after his hospitalization. And although he has since navigated that barrier, he reported that “I still have to go through a lot of red tape to get it because I was sick.” For example, public transportation makes him anxious because he fears contracting COVID-19 again, which has led him to use it less. Unfortunately, this is the only way he can get to the location where he receives his psychiatric care, which has resulted in an ongoing access barrier. He reported that he felt betrayed by his providers, since he had received uninterrupted psychiatric care for 30 years before the pandemic. This disruption has only increased his anxiety: “I have an attempted murder charge on a police officer and I have to be on these meds so that I don’t go off or something.”

Additionally, multiple participants reported that the pandemic had either exacerbated or caused less-severe mental health conditions, including clinical depression, anxiety, and posttraumatic stress disorder.

Low-Income Communities Seem Largely Unconcerned About Vaccine Access

No participants reported an inability to access a vaccine if they wanted it. However, 2 participants brought up long lines at mass vaccination sites and another discussed having to wait to schedule an appointment, although these issues had been resolved by the time interviews were conducted. The CAB has also not discussed any major barriers to access.

Mistrust Is Pervasive and Continues to Perpetuate Health Inequities

Marginalized community mistrust in COVID-19 vaccines should be viewed in the context of their experiences before the pandemic. In particular, mistrust of government is ubiquitous, even among those willing to become vaccinated. Notably, the “government” label is broadly applied. In a conversation with a 38-year-old African American/Black female participant, she explained it like this:

Participant: Um, the way that African American [people] have been treated for years, things that we went through. The first thing, we have no separation with the government, the police department, any of that. In my community's eyes, it's all one.

Interviewer: Mm-hmm.

Participant: So, whatever, however they've been tainted, it is then through arrest in the community, if it's been from eviction from public housing, however their life has been tainted from a public agency, it just continued on.

Interviewer: Do you think that extends to public health workers?

Participant: Yes. Yes, ma'am. Like, I can say when my primary care physician left this area, it took me almost 2 years to find a doctor...

Interviewer: Mm-hmm.

Participant: ...that I could trust. They feel as if they work hand in hand together. Like I said, our public health officials, our police department, social service, they feel as if it's all one family.

While the idea that mistrust of an institution or authority affects how marginalized communities perceive other important institutions is troubling, it has been a consistent theme throughout our research. Not only does mistrust persist over time, but it also seems to spread to other areas in response to new situations. In the particular case of COVID-19 guidance, we have also seen a tendency to mistrust messaging made available by untrusted sources; for example, public health guidance developed by a third party has been seen as less trustworthy when it is disseminated by a housing authority.

Notably, the 38-year-old African American/Black female participant cited above described a powerful force for overcoming mistrust—trusted medical providers. We have consistently found that the recommendation of a trusted physician or other provider is enough to motivate even untrusting individuals to get a COVID-19 vaccine.

As a CAB member recently described, “I don’t really trust these boosters at all, but I’ll get it if my doctor says I should.” As noted previously, however, it can be difficult for low-income community members to develop relationships with providers.

Changes to COVID-19 Guidance Affect How Vaccines are Viewed

In general, while study participants and partner CAB members have taken COVID-19 seriously, they exhibit strong preferences for nonpharmacological mitigation measures, such as wearing masks, social distancing, and cleaning potentially infected surfaces. Among those who have been vaccinated, this expresses itself as a tendency to overestimate the efficacy of these measures while undervaluing the effectiveness of vaccines. Among the unvaccinated, who hold a range of views that can be characterized as “vaccine-hesitant” to strongly “anti-vaccine,” this is expressed either as an outright dismissal of vaccines’ efficacy or a belief that they will do more harm than good. Further, since vaccination is not their preferred strategy, even minor changes to COVID-19 guidance seem to broadly affect attitudes about vaccination.

While the Johnson & Johnson pause involved only a single vaccine, it emerged as an important disincentive to vaccination broadly (ie, even with other vaccines). In total, 5 participants noted that the Johnson & Johnson pause caused them to cancel appointments to get other vaccines. The team was able to get much more specific feedback from the CAB about the Johnson & Johnson pause due to meeting with them weekly. Before the pause, the CAB was roughly split into thirds based on their attitudes toward vaccination: anti-vaccine, vaccine-hesitant, and pro-vaccine. There was a marked shift after the pause was announced on April 13, 2021, with roughly half of the CAB identifying as anti-vaccine after that point. While the pause was lifted on April 23, 2021, the impact of the pause on CAB member perceptions of vaccines persisted. For those who had shifted from hesitant to more negative views, there was a strong sense that they had been asked to trust in the COVID-19 effort, that their trust had been violated, and that they had no intention of trusting in the effort again. As stated by a CAB member: “We trusted in it despite everything that’s happened in the past and now we feel betrayed.”

Changes in masking guidance have also affected attitudes about vaccines on multiple occasions. While the US Centers for Disease Control and Prevention recommendation to lift masking requirements for vaccinated individuals from May 2021 was initially viewed with skepticism, news and messaging that the vaccines were working as intended seemed to improve attitudes about vaccine efficacy over time. However, the reversal of that messaging in late July 2021 seems to have had a disproportionately stronger negative effect on vaccine attitudes, as the team again received multiple reports of unvaccinated, but not necessarily strongly anti-vaccine, study participants or CAB members interrupting vaccination plans after the announcement.

More recently, the announcement of plans for vaccine boosters has again undermined trust in the efficacy of vaccines, even for those who have previously been vaccinated. All of our CAB members expressed misgivings about the need for booster shots (eg, “I’m just not ready.”), with only 2 stating that they would get a booster if it were offered today. While it seems likely that many CAB members will eventually decide to get a

booster shot, it is unclear whether any of them can truly be considered pro-vaccine at this point. Unfortunately, those who have been more moderate or hesitant in the past seem to have been strongly dissuaded by news of the boosters. Those who have always held strongly anti-vaccine views, roughly a third of the CAB, do not seem persuadable at this point. Some might choose to comply with an employer mandate due to the strong disincentive of losing a job, but it seems likely that a majority would choose to seek an exception or quit if none were available.

The Pandemic Further Isolates Marginalized Community Voices

Many of the services that residents of low-income communities rely on are still disrupted by COVID-19. Unfortunately, our societal responses to the pandemic, especially embracing virtual alternatives such as telehealth, have left under-resourced and marginalized communities behind. While seniors faced particular challenges due to unfamiliarity with technology, the digital divide poses notable barriers to low-income communities generally. For example, we have noted that data connectivity is often poor in low-income communities, even when residents are paying for high-speed access. Further, while there are programs that provide federal and state subsidies for broadband internet, local providers will disqualify individuals with outstanding balances from prior service agreements, meaning that the ability to pay an up-front cost is often a condition to receiving the benefit. It is also often unclear whether there will be additional costs to residents or how long the subsidy will last and what ongoing costs there will be after it is no longer offered.

Gains in Vaccinations May Require Addressing Other Concerns

Our primary “vaccination win” with our community partners occurred when we stopped focusing primarily on vaccination and reaffirmed our commitment to equity. In early April 2021, several CAB members with strong anti-vaccine views expressed discomfort over the resources being devoted to vaccination while so many other, inequities remained. We listened to these concerns and stressed that while we do want to promote vaccination, we were not going to try to change individual CAB members’ minds on the issue (this had been our approach for some time). We then asked a question: Knowing our goal of promoting vaccination and our commitment to doing that respectfully, would they still partner with us on projects designed to address other community-identified needs? They responded that they would. We believe that this represented an important turning point in our relationship with them, as several members were beginning to lose interest in the CAB due to our focus on promoting vaccination.

We then moved to address mental health; the community need our partners had identified. By the end of May 2021, we submitted a major grant application targeting mental health with the CAB, regional PHAs, and several academic institutions from the area as partners. Feedback from our partners strongly suggests that this renewed their commitment to working with us.

Recommendations

Build and Maintain Ongoing Relationships with Underresourced Communities

The primary goals of community relationship-building are to: (1) become more trustworthy partners to vulnerable communities, and (2) create authentic bidirectional information sharing. We are convinced that the only way to improve trust is to embrace participatory solutions that are perceived to meet community-identified needs. Most importantly, marginalized communities want to do things with partners, instead of continuing to have things done to them. Because of a history of oppression, distrust is a formidable barrier to even starting those partnerships.

In the short term, local jurisdictions might need to work with institutions that have already successfully partnered with vulnerable communities. The model that we have created with our partner low-income housing resident CAB is a useful example. Our weekly CAB meetings have provided an extremely important barometer of community attitudes toward changing COVID-19 public health guidance that would have been impossible to capture without a substantial commitment of time and resources. Thus, we recommend creating additional CABs while recognizing that many organizations will not have the capacity to maintain them. Collaborating with academic partners with expertise in community engagement is a short-term solution and offers local jurisdictions a way to ensure that staff are exposed to and trained to conduct authentic community engagement in support of longer-term efforts.

Embrace Targeted Engagement of Affected Community Members as a Necessary First Step

Stakeholders from community organizations or service providers are often not useful proxies for marginalized community voices. Engagement also requires specificity—what we learn from a specific group of people is only guaranteed to be completely relevant to that group. For example, engagement in African American/Black communities often defaults to interacting with churches. Church leaders are typically familiar with the voices of their congregants, but less so for those who do not attend church. Similarly, churchgoers' health needs often overlap with their neighbors but will not be completely the same. Differences can quickly become relevant.

How does this look in practice? Our work at Eastern Virginia Medical School could provide a useful example. While we engage a range of communities, we keep lay community member engagement separate from engagement of representatives of stakeholder organizations. In the particular case of low-income housing residents, we engage the residents themselves if we want to know about their experiences. While staff from PHAs are often aware of resident needs, they do interpret that information through a specific lens. For that reason, when we engage PHA staff we typically focus on their organizational role in the context of interacting with residents, rather than on staff perceptions of resident experiences. Similarly, engaging with church leaders will likely be most informative when we want to know more about their experiences as clergy in

the context of their churches. This implies that engaging nonclergy might be the best strategy if we wanted to capture the experiences of church congregants. Specific recommendations about who to engage depend on context and goals, as suggested by the examples above. However, as a starting point, engagement of individuals who are representative of affected communities should be prioritized over solely interacting with stakeholder groups.

Seek Out Contrarian Voices

We understand anti-vaccine views because we created a space in which community members felt that they trust us to discuss those views without feeling judged. This was a conscious choice and should be seen as a necessary first step for work with marginalized communities. In practice, the work of promoting equity can only occur when community members are comfortable sharing their views without consequences. This does not reflect the status quo and requires a great deal of community member trust in those doing the engagement. The most important work will likely be contentious and community members will simply opt to telling outsiders what they think others want to hear if they are not comfortable with the dynamics of the situation.

Invest in Infrastructure that Keeps People Connected

Three things are needed to address the digital divide and ensure that low-income communities are not left behind by the “new normal”: (1) internet-cable devices with high-definition cameras (eg, tablets, computers, phones), (2) unlimited data plans from reliable broadband providers, and (3) basic digital literacy training and technology support. Providing any of these while neglecting another will limit success. It is important to recognize that this is not just a simple matter of providing funds for devices and data plans. Although seniors are often justifiably singled out as the most in need, in our experience it is a mistake to assume that anyone will be able to navigate new technology on their own, regardless of age. This support requires a special skill set and a great deal of patience. Resources should be devoted to providing these.

Create or Strengthen Community Capacity to Address Community-Identified Needs

In the longer term, it is important for local governments to engage in truly participatory solutions with marginalized communities. This should be thought of as paradigm shifting—inequities exist on the scale that they do today because our systems are fundamentally flawed. Note that this is not meant as an indictment of individual people involved in local government, who almost always want what is best for their communities. By way of practical example of how this might look, we outline an approach that we developed in partnership with our CAB.

We propose integrating mental health first aid training into a coordinated engagement strategy designed to create a network of community mental health advocates who can respond to signs of mental illness and substance use during the course of their normal day-to-day interactions with other community members. Barbers, who serve as trusted confidants within African American/Black communities, have been targeted in past efforts,²² but the training will not be limited to them. Standard mental health first aid

will be augmented with community-focused lessons to emphasize being responsive to community needs, addressing stigma in context of the specific community, and familiarity with local referral sources, with priority given to partner primary care sites. There will be virtual meetings of the community mental health advocate program and participating primary care sites each month. The goal will be for the community mental health advocates to interact with providers, counselors, social workers, and nonmedical office staff from the clinics on an ongoing basis. Content for these sessions will be drawn from evidence-based best practices and needs of the clinicians and community mental health advocates, with relationships between all parties being bidirectional. We anticipate encountering both novel questions and promising practices in the community. Tablet computers with high-definition webcam and unlimited data connection will be provided to participating community mental health advocates at no cost to them to facilitate these meetings.

While this project could be funded at several thresholds, we anticipate substantial impact from a modest investment in resources, primarily nonmedical staff time to manage the mental health first aid training and ongoing meetings. Overall, this program could create revenue for participating primary care sites by increasing referrals.

Facilitate Greater Transparency of State and Federal Agency Data

Basic questions about the distribution of vaccinations in the region seem currently unanswerable with publicly available data. This could likely, at the very least, be addressed by providing local demographics data with modified denominators to reflect that individuals in the pool of possible vaccinations are correctly counted. A better solution would be complete demographic data on federal doses paired with their county of residence, as with the nonfederal data.

Conclusion

While it is difficult to assess exact group-level vaccination rates for specific populations, our work suggests that a substantial proportion of African American/Black low-income housing residents in Hampton Roads remain unvaccinated. Unfortunately, mistrust in vaccines seems to be increasing in this population, even among individuals who have already been fully vaccinated. This raises several questions, including whether currently vaccinated individuals will choose to get a booster when they qualify and the likelihood of vaccine-hesitant and anti-vaccine holdouts becoming vaccinated at all. While we expect that some current concerns will become less important over time for individuals with more moderate views, those with strong anti-vaccine views seem unlikely to change their minds in the mid to long term. While this group currently represents about a third of our partner CAB, it is difficult to say whether this proportion is representative to their communities more broadly. However, feedback from PHA partners suggests that the proportion of unvaccinated low-income housing residents is likely much higher generally than is represented by our CAB, meaning that the true state of vaccination in Hampton Roads low-income communities could be much worse.

Our recommendations center around trust-building through engagement and collaboration on projects to address community-identified needs. While there could be a substantial proportion of low-income housing residents who never choose to become vaccinated, recent events such as the emergence of the Delta variant remind us that the pandemic is not yet over. As the need for additional interventions, such as booster shots, come to light, it is important that we do not lose the trust of those who have already placed their faith in the pandemic response.

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