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Elena Peterson
ekpeterson@usfca.edu

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THE COVID-19 PANDEMIC

The COVID-19 Pandemic: An Analysis of its Inequitable Impacts Towards the Black Population
with Recommendations to Dismantling Institutional Racism

Elena K. Peterson, MPH Candidate

University of San Francisco

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Abstract

Due to the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the 2020 coronavirus disease pandemic uncovered health inequities throughout the United States. This paper explores institutional racism as the reasoning behind these health inequities. A discussion of the United States' failure to implement preventative precautions once notified initially of the coronavirus is featured. Events that took place after the recognition of the coronavirus, such as the economic impacts and passed legislation, are highlighted as well. An overview of the Trump Administration's lack of focus towards vulnerable populations, which includes the Black communities, is included. Also, there are highlights on the work being completed at the policy, community and individual levels to combat the coronavirus impacts on the Black populations.

Public health gaps that are discussed within the paper include: the lack of federal support for reallocating funding to underserved communities that would address the racial health disparities amongst the Black population, the lack of focus on health disparities amongst vulnerable populations within an established federal strategy, and the need for amplifying the Black population's voice throughout the United States after centuries of health inequities. These gaps are focused on within the generated recommendations. These recommendations include the creation of a national coalition, the revision of the Department of Health and Human Services' National Health Security Strategy, and the development of a community-based participatory workforce within graduate schools near densely populated Black communities. These recommendations enhance the need for closing the inequitable gap amongst the Black population at the policy, community and individual levels. These recommendations not only focus on the 2020 coronavirus disease but are also framed to be transferable during future pandemics.

Introduction

On December 31, 2019, the World Health Organization's (WHO) was notified of a pneumonia of unknown causes that was found in the city of Wuhan in Hubei province, China. As a result of these cases, WHO requested for additional laboratory tests to be completed as they were to begin monitoring the situation. WHO identified the unknown public health issue as the coronavirus disease, which can be identified as an infectious disease caused by the spread of the coronavirus. (WHO, 2020) The coronavirus disease is also known as COVID-19, which stems from shortening 'coronavirus disease' and recognizes 2019 as the year the virus was initially recorded.

Researchers state that COVID-19 is spread through droplets of saliva or discharge from the nose from an infected person onto another. This infection can be spread by asymptomatic, presymptomatic and symptomatic carriers. (Wiersinga WJ, Rhodes A, Cheng AC, Peacock SJ, and Prescott HC, 2020) Researchers speculate that the virus originated from an animal, such as a bat, being sold at the Huanan Seafood Market. (CDC, 2020) As of July 2020, there are 120 vaccines under development to combat COVID-19. Also, as of July 2020, the National Institutes of Health initiated Phase 3 of the clinical trial of investigational vaccine for COVID-19. (NIH, 2020) Until a vaccination is established, the guidelines for reducing the spread of COVID-19 are through the use of face masks, social distancing and contact tracing.

Throughout the increase and spread of COVID-19 within the United States, health inequities have been uncovered. The Black population has been shown to be extremely vulnerable to the pandemic's impacts. According to a Center for Disease Control and Prevention (CDC) study, a Non-Hispanic Black person has a rate of contracting COVID-19 that is approximately 5 times greater than of a non-Hispanic White person. The CDC recognizes that

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these populations are vulnerable due to their living conditions, working conditions, and health circumstances. (CDC, 2020)

COVID-19 impacts have been inequitable to the Black population, and this is due to institutional racism. Institutional racism can be defined as “the systematic distribution of resources, power and opportunity in our society to the benefit of people who are white and the exclusion of people of color.” (Solid Ground Organization, 2020) Institutional racism impacts where families live, the quality of education, income, types of food access, clean environment access, and the types of interactions they have with the criminal justice system. Institutional racism has been one of the biggest contributors that has spread COVID-19’s health inequity throughout the United States.

To decrease the inequitable response to the COVID-19 pandemic, it is essential for corrective actions to take place at the federal, state, and local levels of government. Because of the significant difference in which populations contract COVID-19, creating a national coalition is essential to gaining collective pressures on how the federal budget should get allocated. This allocation would allow funding to be transferred to the vulnerable Black communities being impacted by COVID-19. Also, the federal government would need to improve its pandemic strategies to guarantee equitable access. Finally, public outreach that combines graduate health students and the Black community is critical to understanding this population’s needs. Through the implementation of these three recommendations, the Black communities would be more equitably served. Moreover, trust would be built again between government agencies and the communities they serve. Trust is important because when successfully established, the public is more likely to respond to passed public policies. (Organisation for Economic Co-operation and

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Development, n.d.) Building the nation's trust is vital to addressing the United States' past, present, and future health inequities.

Background

Timeline

As shown in Figure 1, The United States' ineffective response to the COVID-19 pandemic is one of the driving factors that unjustly impacts the Black population.

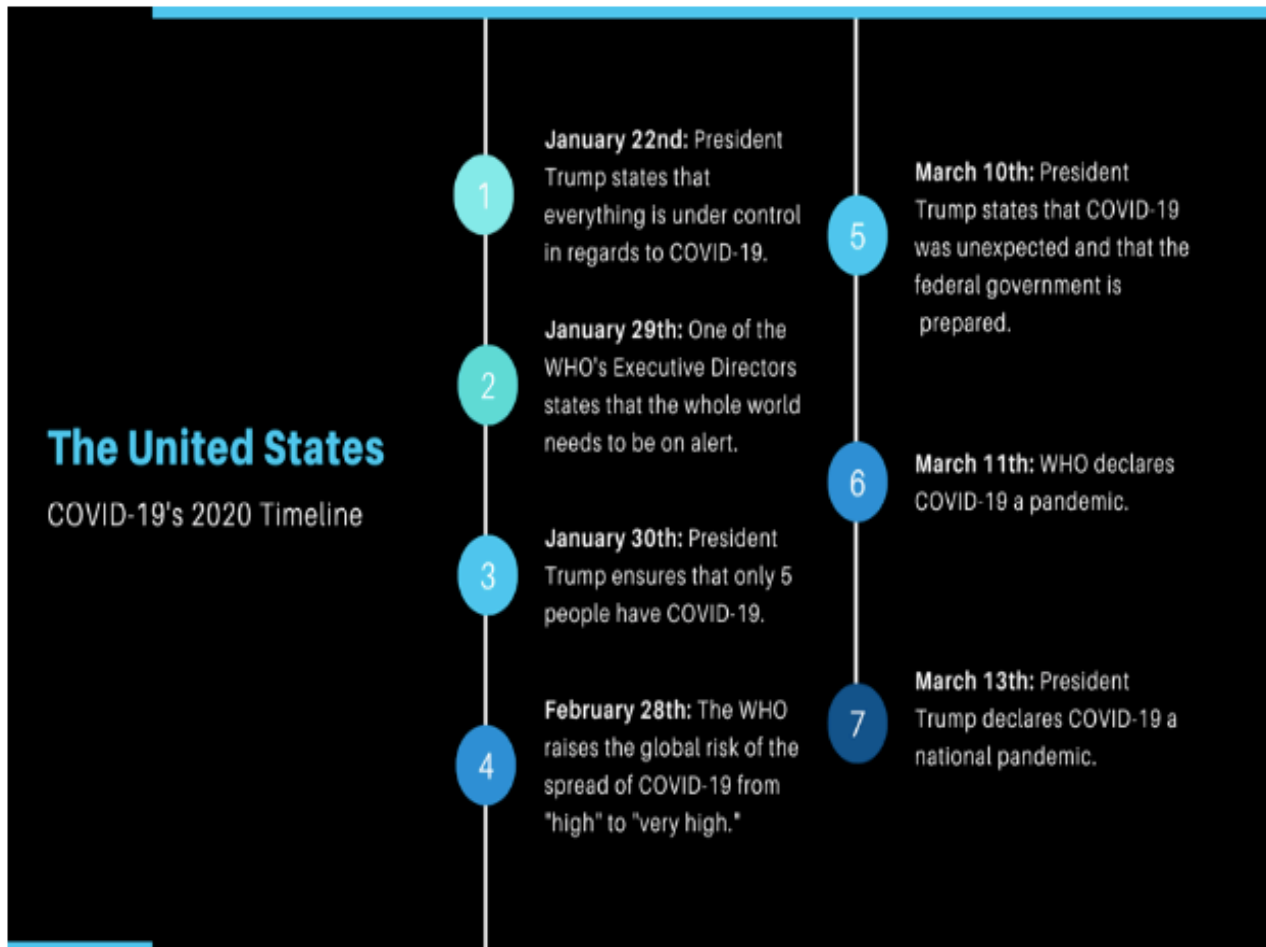


Figure 1: The United States' COVID-19 2020 Timeline

1. **January 22nd:** A CNBC reporter asked President Trump if he had any concerns about the coronavirus coming into the United States. President Trump, "We have it totally under control. It's going to be just fine." (CNBC, 2020)

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2. **January 29th**: The head of the WHO's Health Emergencies Programme, Dr. Mike Ryan, stated, "The whole world needs to be on alert now. The whole world needs to take action and be ready for any cases that come from the epicenter or other epicenter that becomes established." (WHO, 2020)
3. **January 30th**: During a campaign rally, President Trump exclaimed, "We only have five people. Hopefully, everything's going to be great. They have somewhat of a problem, but hopefully, it's all going to be great. But we're working with China, just so you know, and other countries very, very closely. So it doesn't get out of hand." (US News, 2020)
4. **February 28th**: The WHO raised the global risk of the spread of COVID-19 from 'high' to 'very high.'" (Young, L., 2020)
5. **March 10th**: President Trump commented about the spread of COVID-19 by stating, "This was unexpected. ... And it hit the world. And we're prepared, and we're doing a great job with it. And it will go away. Just stay calm. It will go away." (Keith, T., & Gharib, M., 2020)
6. **March 11th**: WHO declared COVID-19 a pandemic. (WHO, 2020)
7. **March 13th**: The COVID-19 outbreak is declared a national emergency within the United States. (The White House, 2020)

Research has shown that the older population and those diagnosed with a chronic disease, such as diabetes, hypertension, respiratory conditions or heart disease, are more susceptible to viral infections. (CDC, 2020) Also, the Black population has an increased rate of dying at an early age due to attaining a health condition, such as high blood pressure and/or diabetes. (CDC,

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2017) Even when COVID-19 was not considered a national emergency within the United States, there were months of time spent where preventative precautions did not take place.

South Korea

The CDC reported that South Korea and the United States each had its first COVID-19 case on the same day, which was January 20th. (CDC, 2020) Just a month later, the CDC also reported that South Korea conducted approximately 82% more tests when compared to the United States. (CDC, 2020) South Korea's increased testing is attributed to the formation of a public-private partnership that quickly ramped up testing and issued early social distancing guidelines. These guidelines were generated after reviewing the country's previous strategies and outcome of the 2012 Middle East Respiratory syndrome (MERS) outbreak. Because of these preventative, initial actions, South Korea set up 633 testing sites and screened 20,000 people daily. (Aye, 2020)

European Nations

The European nations developed a collective resource called the Health System Response Monitor (HSRM), which was designed in response to the COVID-19 pandemic to collect and organize updated information on how countries are responding to the crisis. The HSRM focuses on health system responses but also captures wider public health initiatives, which allows for a collaborative effort amongst the various countries that make up the European nations. (COVID-19 Health System, 2020)

United States

Stakeholders. Unlike South Korea and the European nation's established pandemic partnerships, the United States cut off their relationship with China. President Trump blamed China for not containing the coronavirus properly and began calling it the "Chinese virus,"

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during press briefings. (Chiu, 2020) In addition, President Trump accused the WHO of being under China's control throughout the pandemic. As a result, President Trump withdrew the United States from the WHO. As COVID-19 continues to surge, the head of the American Medical Association stated that ending the United States' relationship with WHO puts the health of the its at grave risk. (Cohen, Z., Hansler, J., Atwood, K., Salama, V., & Murray, S., 2020) Additionally, President Trump stripped the CDC from the control of the coronavirus data, which means all of the United States' hospitals have been ordered to send all patient information to the administration's database. Because of this new direction, public health experts are concerned with transparency of that data. (Stolberg, 2020)

Health System Capacity. Researchers assessed the United States' health system capacity in response to COVID-19 when compared to 16 other countries - Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, China, Italy, Singapore, South Korea, Spain, and Taiwan – and found that the its workforce and acute hospital bed capacity is lower than many of the other countries. This finding gives reasoning as to why resources were scarce during the COVID-19 pandemic. The shortage of resources led providers to conducting unsanitary actions while treating patients, such as reusing old personal protective equipment and utilizing unrefrigerated, moving vehicles as morgues. (Shuster, 2020)

Affordability of Health Care Services. Moreover, an effective response to a pandemic requires that patients can afford health care services. COVID-19 costs of hospitalization and treatment varies throughout the nation. Various studies have ranged the cost being \$20,000, while others being \$75,000. (O'Brien, 2020) Approximately 30.4 million people are uninsured within the United States. (CDC, 2020) Additional populations remain underinsured due to high

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deductibles and out-of-pocket costs. NBC news reported a United States survey, which stated that 14% of people would avoid seeking treatment of COVID-19 out of concerns for their potential out-of-pocket costs. The survey also concluded that members of the minority populations, those with less than a college degree, and people making less than \$40,000 a year were more likely to avoid seeking out treatment due to the potential high costs. (Alonso-Zaldivar, 2020) This means millions of people cannot or are not seeking out COVID-19 treatment from providers, which makes them more vulnerable and prolongs the United States from completely eradicating the COVID-19 pandemic.

Trend Comparison. The United States has shown an increase with no sign of a plateau or decrease in the number of confirmed COVID-19 cases. (Roser, M., Ritchie, H., Ortiz-Ospina, E., & Hasell, J., 2020) When compared to the European nation's country, Italy, and South Korea, researchers are able to observe decreases within the number of confirmed COVID-19 cases. These decreases may be attributed to both country's effective, preventative precautions.

Economic Impacts of COVID-19

Throughout the United States, there have been economic challenges due to the spread of COVID-19. The COVID-19 deficit has been compared to the Great Recession of 2007 - 2009 and World War II's Great Depression of 1929 - 1941. In California alone, the deficit is estimated to be \$54.3 billion for fiscal year (FY) 2019-2020. (California Government, 2020) Harvard Medical School researched the economic impacts of COVID-19 and found that primary care practices are projected to lose more than \$65,000 in revenue per full-time physician within the 2020 year. (Jett, 2020) This is due to the decline in office visits and fees for services. Overall, it is estimated that \$15 billion to primary care practices will be not be collected within the United States. (Jett, 2020)

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Legislation. The federal government passed legislation to decrease the level of economic impact COVID-19 is estimated to create. The Families First Coronavirus Response Act was passed on March 14, 2020. This Act instructs the Centers for Medicare and Medicaid Services (CMS) to administer a federal medical assistance percentage (FMAP) of 6.2% during the period of the national emergency. This means that the federal government will start paying for Medicaid beneficiaries impacted by COVID-19 at a higher percentage to assist with each state's budget. (Lowey, 2020) This Act targets the Aging and Disability Services Programs, COVID-19's testing costs, and the paying off of provider's claims. In addition, the "Coronavirus Aid, Relief, and Economic Security" (CARES) Act was passed on March 25, 2020. The CARES Act creates a Provider Relief Fund of \$175 billion to hospitals and healthcare providers on the frontlines of the COVID-19 response. (McConnell, 2020) Both the Families First Coronavirus Response Act and the CARES Act experience budget limitations and budget allocations. As well, neither allocate funding towards racial health inequities. Although the nation faces a large deficit, vulnerable populations are at-risk and strategic budgetary action is vital.

Response Methods

After declaring COVID-19 a national emergency within the United States, the CDC provided guidelines to the public, which are of the following: to wash hands often, to avoid close contact with others, to cover mouth and nose with a face cover, to cover coughs and sneezes, to clean and disinfect frequently touched surfaces, and to monitor health carefully. The CDC published the Figure 2 graphic, which gives instructions on how to prevent the spread of COVID-19 to the public. (CDC, 2020)



Figure 2: CDC’s Directions for Preventing the Spread of COVID-19

In response to vulnerable populations, the CDC provides additional guidelines for the families living in close quarters. This is in the effort to focus on underserved communities that need to share households due to financial restraints. Addressing those living in tighter quarters is important as these populations are likely marginalized individuals who live in low-income housing. These additional guidelines include limiting errands, avoiding caring for children or the sick, and separating from the sick. (CDC, 2020)

Although the CDC recognizes that people living in close quarters as the most vulnerable, preventative efforts and funding are lacking. In addition, although variable, researchers found that the average incubation period for COVID-19 is 4-5 days, which means symptoms will not start instantly after being exposed. (Aspril, J., & JH Bloomberg School of Public Health, 2020) The incubation period’s variability stems from external factors such as, validity of the records and the misclassification of the diagnosis. Implications of these variabilities are that maintaining the CDC’s guidelines and creating improved, inclusive strategies are essential to upholding the public’s health in combating COVID-19.

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Impacts

According to a May 2020 study, which captured statistics within Sutter Health in northern California, researchers found that the Black population has 2.7 times the chance of COVID-19-related hospitalization when compared to the non-Hispanic White patients. (Azar, 2020) Supportively, another study stated that the Black population is affected more by COVID-19 than other populations. However, the impact of this virus goes beyond the impacts within a patient's body the socioeconomic factors should be analyzed. Some of the reasons for this inequity include the following: lacking access (money, food, education, health care, job flexibility, etc.), working high-risk essential services, and having comorbid conditions (cardiovascular disease, hypertension, diabetes, asthma, etc.). (Ferdinand, 2020)

The Center for Economic and Policy Research completed a study that looked into a basic demographic profile of workers in frontline industries. This study found that people of color are overrepresented in many occupations within frontline industries. Some of these jobs include the following: trucking, warehouse working, and postal servicing, cleaning services and childcaring (personal care aides, social workers, and nursing assistants). Also, researchers have found that 1 in 1,350 Black Americans have died from COVID-19 or 73.7 deaths per 100,000. This can be compared to White Americans who experience a 1 in 3,100 deaths or 32.4 deaths per 100,000. (APM Research Labs, 2020)

Institutional Racism

Institutional racism has been one of the biggest contributors that has spread COVID-19's health inequity gap throughout the nation. Institutional racism can be defined as "the systematic distribution of resources, power and opportunity in our society to the benefit of people who are white and the exclusion of people of color." (Solid Ground Organization, 2020) For over 400

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years, the Black population has suffered from various discriminatory advances within the public health field. Some examples of institutional racism include the following:

- **1839-1849:** Samuel George Morton, a White craniologist researcher, claimed that Black people had smaller skulls and brains than White people. (Center for History and New Media, n.d.) Dr. Morton contributed to the instilment of institutional racism through his use of academia power and opportunity to belittle the Black population's biological makeup.
- **1945:** Without consent, physicians injected 4.7 micrograms of plutonium into a Black male named Ebb Cade as part of the Human Radiation experiment. Cade was 53 at the time and was estimated to live another 20 years due to good health; however, he only lived another 10 years due to heart failure. (WPI, n.d.) These physicians attributed to institutional racism through their nonconsensual use of experimenting on this Black man, which contributed to the shorting of his life.
- **2005:** The Black population was 10 times more likely than other races to retrieve the Acquired immunodeficiency syndrome (AIDS) (Joyner, T., & Lee, J. S., 2020) Institutional racism was compounded even deeper within the United States' systems when the lack of necessary resources were not allocated properly to the Black population during the AIDS epidemic. The lack of resources attributed to widening of the inequitable gap.

The Spanish Flu. During past pandemics, such as the Spanish Flu, also known as the 1918 Flu, institutional racism showed its impact on the Black population. Researchers found that the Black population was more likely to get sick of the 1918 flu when compared to other races. Institutional racism played a role on this disproportionate amount of deaths as the Black flu

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patients received care at segregated hospitals. (Wade, L., 2020) These segregated facilities were overwhelmed with Black patients, which meant that the care of these patients suffered. When the quality of care suffers and facilities are overpopulated, more people from vulnerable backgrounds are impacted. Similarly, to the Spanish Flu, COVID-19 has impacted the Black population at a higher rate than other populations due to institutional racism.

Community Advocacy

In July 2013, the Black Lives Matter (BLM) global, grassroots network was created in response to the acquittal of George Zimmerman, the police officer who was claimed to have killed Trayvon Martin out of self-defense. Martin was a 17-year-old, Black male who was unarmed during the altercation with Zimmerman. (Black Lives Matter, 2020) Fast forwarding to May 2020, the BLM strengthened its voices again after the unlawful death of a Black, 46-year-old man by the name of George Floyd. Floyd was a man who was arrested by Minneapolis Police Department for attempting to use \$20 of counterfeit money. During the time of the arrest, an officer by the name of Derek Chauvin knelt directly onto Floyd's neck. Due to the police officer's full weight being left onto his neck for 8 minutes and 46 seconds, Floyd passed away during the arrest. (BBC, 2020) Three accompanying police officers, by the names of J. Alexander Kueng, Thomas Lane and Tou Thao stood by and were compliant to how Chauvin was conducting Floyd's arrest. (Campbell, J., Sidner, S., & Levenson, E., 2020)

Due to Floyd's death, increased community members are researching and exposing more governmental systems that are inequitably impacting the Black population. Just as BLM has stated that the criminal justice system is unjustly impacting the Black population, its activism has also been able to shed light on how the COVID-19 pandemic is inequitably affecting Black communities.

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Policy Advocacy

BLM has proposed the defunding of the police department to reallocate funding to community health centers, which would aid the Black population during the COVID-19 pandemic. (Black Lives Matter, 2020) Due to their involvement with Floyd's death, the Minneapolis Police Department has responded to the BLM movement and are reforming the department. (Chaloux, 2020) In California, San Francisco, San Jose, and Los Angeles are working to reform their police departments in honor of the BLM's proposal to Floyd's passing. (ABC, 2020) Cities are completing these reallocations by transferring funding from its Police Departments for public health and safety initiatives, mental health services and social justice programs.

Interpersonal Advocacy

Since Floyd's death, the BLM movement published the hashtag, #DefundthePolice, through social media platforms such as Facebook, Instagram, Twitter, etc. This hashtag was established as a social media tactic to unite those who believe the Police Department should be defunded so that community health centers that provide care to the Black population can be properly resourced. Public support and awareness are gained through the usage of this hashtag. BLM supporter's frustration has given fuel to a necessary, interpersonal conversation on how the nation's federal budget should be allocated. As well, it has allowed individuals to conduct conversations regarding the topic of race within their communities. Common conversational practices have occurred online, due to social distancing guidelines, through the use of creating social media posts, reposting infographics related to the BLM movement, and starting Instagram live videos with their community members.

Gaps

It is vital for system adjustments to be made so that the Black population is identified and treated equitably during the COVID-19 pandemic. Some of the United States' failures to address the health inequity gap include insufficient media coverage (television advertisements, social media, etc.), contact tracing information, testing centers, culturally appropriate pamphlets, etc. These gaps can be addressed through creating a national support unit to reallocate funding for underserved populations, improving the federal government's strategies during a pandemic, and increasing partnerships with the Black population during research attempts to better understand the needs of these communities.

Recommendations

Creation of a National Coalition

Creating a national coalition is recommended to connect organizations that wish to reallocate the federal budget to better address racial health disparities. Because institutional racism has been within the United States for over 400 years, this coalition is not expected to be short-term. This coalition is estimated to include the following justice-focused groups: BLM, Color of Change, NAACP Legal Defense and Educational Fund, Inc., UndocuBlack Network and various national agencies. Representatives from the National Institutes of Health's (NIH) Office of Equity, Diversity and Inclusion will be present as well. Group meetings will occur to prioritize the necessary percentage or minimum budget needed to address racial health disparities during a pandemic. These meetings will address the factors that create the inequitable response to the COVID-19 pandemic, which are highlighted within Figure 3. Funded by the NIH, this coalition will provide social media (Facebook, Twitter, Instagram, etc.) advertisements. These

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advertisements would inform the public of their cause to add necessary pressures to reallocating funding to vulnerable populations.

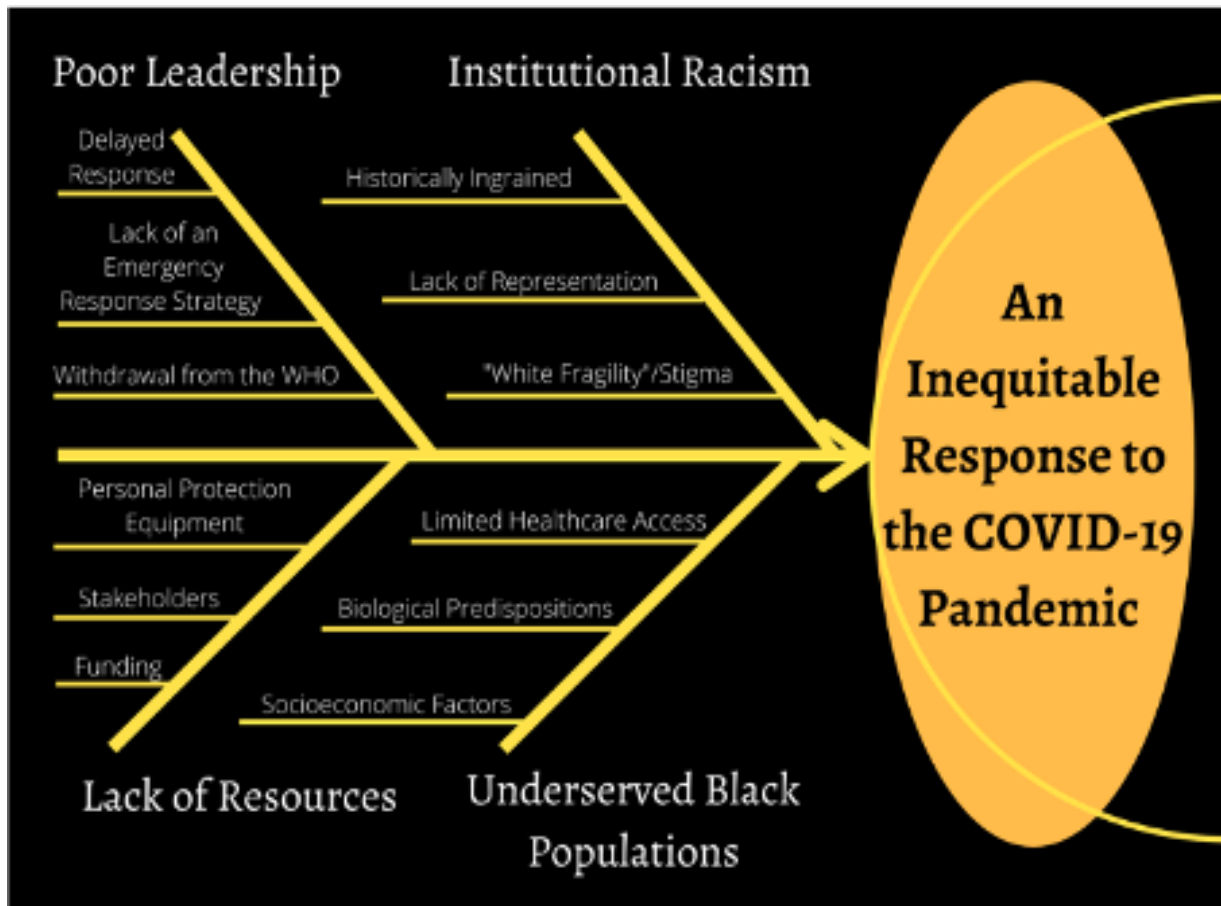


Figure 3: Fishbone Diagram of an Inequitable Response to the COVID-19 Pandemic

Reallocated Funding vs. the Coalition. Through this reallocation, the Black community would be served more equitably. The 2021 Budget requests \$94.5 billion for HHS, which is a 10% decrease from the 2020 enacted level. This can be compared to the 2021 Budget requesting \$705.4 billion for the Department of Defense, which is a \$0.8 increase above the 2020 enacted level. (HHS, 2020) The coalition's goal will propose reallocating money from the Department of Defense. This is being done as a proactive strategy to fund healthcare treatments and provide preventative care to those most vulnerable. In addition, research has noted that the Police Department's appropriations tend to account for the largest share of a city's budget.

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Investing money into the health of the nation will benefit the United States overall. (Narain J. P., 2019) Because of this, this coalition will push to reallocate funds from the Department of Defense and the Police Departments with the motive to gain funding for community health centers that densely serve the Black population during the COVID-19 pandemic and beyond.

Revision of the National Health Security Strategy

The U.S. Department of Health and Human Services' (HHS) 2011 literature states that the agency is striving for a nation that is free of disparities in health and healthcare. (HHS, n.d.) Although making a goal to rid the nation of racial and ethnic health disparities is important legislation is necessary to address the institutional racism that has been ingrained throughout the governmental systems for centuries.

In December 2006, within HHS, the Pandemic and All-Hazards Preparedness Act (PAHPA) established a new Assistant Secretary for Preparedness and Response (ASPR). Every four years, the ASPR creates the National Health Security Strategy (NHSS) to establish a strategic approach to enhance the security of the United States' health during the times of crisis. According to the ASPR within HHS, the 2019-2022 NHSS provides a vision to strengthen the United States' ability "to prevent, detect, assess, prepare for, mitigate, respond to, and recover from disasters and emergencies, including strategies to improve readiness and adapt operational capabilities to address new and evolving threats." (HHS, 2020) Contrastingly from the HHS' action plan to reduce racial and ethnic health disparities, within the July 2020's version of the 2019-2022 NHSS, there is no mention of addressing health inequities or any health disparities throughout the document. It is essential for the HHS's goals to overlap throughout all of its

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agencies. Policies do not exist that ensure an equitable pandemic response, which leaves racial health disparities still present and unaddressed.

Revision to the drafted version of the 2019-2022 NHSS is vital to ensuring vulnerable populations are identified before and during an outbreak. The HHS' action plan to reduce racial and ethnic health disparities was the recognition of the public health crisis but including this issue within the NHSS would solidify the HHS's initial goals and ensure resources are allocated to Black communities during a pandemic.

The most recently published Census data would guide the federal government on which cities and states have the most densely populated Black communities. These locations would be included within the published NHSS to promote accountability amongst the public and to ensure that if a future pandemic was declared, the federal government would already have it documented on which locations get resources initially.

Community-Based Participatory Workforce Development

Community-Based Participatory Research (CBPR) has been shown to reduce disparities and recommends transforming the culture of academics to strengthen collaborative research relationships amongst the communities that are researched. (Wallerstein, N. B., & Duran, B., 2006) Through the CBPR practice, people from diverse backgrounds are equitably involved as partners for research. Due to being part of the population, community member's strengths and internal knowledge is recognized amongst the partnering academia. One attribute that makes CBPR effective is the established trust between the research population and academia.

Past Research. Through the use of CBPR principles, past research in graduate school settings has been shown to be impactful. In 2002, federal funding and support was provided by the Indian Health Service to the University of New Mexico's Master's in Public Health (MPH)

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program to set up a satellite program to serve professional health development needs of the Navajo Nation. This satellite program took place in the four corner areas of the states of New Mexico, Arizona, Utah and Colorado. There were 20 students enrolled within the program, 13 of them being Native Americans. CBPR principles were used through the creation of a multi-year curriculum that these students followed to eventually produce an MPH degree that was specific to their completed work and the population's needs. This cohort was able to benefit through intensive academic and other support strategies that recognize student's multiple work, family and traditional cultural responsibilities.

Funding. This recommendation would be implemented by first receiving support and funding from the federal government to graduate schools that are near densely populated Black communities. The Office of Minority Health (OMH) would be the main stakeholder providing support. This recommendation would be implemented by first receiving funding from the federal government's OMH through the National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities (NIMIC) Initiative. (HHS, 2020) As well, the OMH would provide insight and guidance through the construction of the program. Goals and objections of the graduate program in addressing the unequitable pandemic response of COVID-19 aid would be established using collaborative efforts between the community and the graduate students.

Graduate Programs. These graduate programs would include health-related degrees, such as in public health, nursing, sociology, public policy, etc. Considering the results of the 2010 Census, the cities with the highest reported number of Black people are featured within Table 1. (US Census Bureau, 2016) Moving forward, the Census data would be used when determining which schools should develop their own community-based participatory workforce

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as part of their graduate degrees.

Places with the Largest Number of Blacks or African Americans: 2010 Census			
Locations	Total Population	Graduate Schools	Graduate Degrees
New York, NY	8,175,133	Columbia University & University of Buffalo	MPH, MS
Los Angeles, CA	3,792,621	University of California - Los Angeles & University of Southern California	MPH
Chicago, IL	2,695,598	Loyola University Chicago	MA/MD
Houston, TX	2,099,451	University of Texas Health Science Center	MSN/MPH
Philadelphia, PA	1,526,006	University of Pennsylvania and West Chester University	MPH and MPA
Phoenix, AZ	1,445,632	University of Arizona and Grand Canyon University	MPA

Table 1: Places with the Largest Number of Blacks or African Americans According to the 2010 Census

Throughout the graduate program, the students would work using the principles inspired by CBPR within these populations. Community members and the graduate students will formulate goals and objectives within the workforce. At the end of each semester, the graduate students and community members would review their goals and objectives and evaluate the initiatives that were completed to serve the population’s needs. Written evaluations would be completed by the student when submitting their final papers. Recommendations ways of improving collaborative strategies and community health work would be suggested and could be implemented within the following semester if deemed appropriate.

Implications

Creation of a National Coalition

Through the reallocation of the Department of Defense's funding to vulnerable populations, the Black population would be served more equitably. This coalition would add pressure to the redistribution of funding to community health centers, specifically in areas most vulnerable during a pandemic. There would be improved health outcomes for people of color with this shift. Supportively, by including various social justice groups from throughout the nation, the coalition will adhere to the needs of the Black population. As a checks and balance tactic, the coalition will consider the needs of each of the agencies. Collaboratively, the coalition will focus their efforts on serving the Black populations throughout the nation.

Additionally, researchers have found that reducing health disparities has significant, cost-effective economic impacts on the United States' economy. For example, research suggests that by eradicating racial and ethnic health disparities, the United States would reduce medical care costs by \$230 billion in addition to indirect costs of excess morbidity and mortality by more than \$1 trillion for over three years. (Thornton RL, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR., 2016) This data stems from sufficient evidence which supports policies that target education at an early childhood, urban planning and community development, housing, income enhancements and supplements, and employment. By eradicating racial and ethnic health disparities, cost-effective evaluations have shown that these interventions lead to long-term savings. Therefore, this coalition will increase and pressure local, state, and national officials by continually publicizing the cost-effective impact the nation would receive when addressing health disparities. Due to COVID-19's estimated \$54.3 billion deficit for FY 2019-2020, it is critical for the federal government to look towards cost-saving initiatives.

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The coalition will consider the policy, community, organization, and interpersonal levels throughout the coalition's implementation efforts. (CDC, 2020) From the public policy level, the coalition will pressure local, state, and national governments to reallocate funding. Because of this, the impacts of this policy implementation will improve as it will capture more people. (Eyler, 2016) In addition, they would be working with public advocacy groups, such as the BLM network, to add more individuals to the grassroots movement. Through the adding of various social justice organizations, the coalition will gain more people from community and organization levels. Additionally, the coalition will use social media to increase support, which will reach individuals from the interpersonal levels.

The creation of a coalition to reallocate funding has some limitations. The political obstacles of reallocating funds from the Department of Defense is the first. The coalition will be part of changing the narrative and the social norms surrounding policing. They will work with communities and provide education on their goals and objectives to reallocate funding for community health centers. Although the thought that taking funding from the Department of Defense and the Police Department may be initially considered radical, just as the BLM movement was once consider so too, the coalition will work to instill trust and credibility throughout the nation. Through this social change, the coalition will work to gain more community support to transfer funding from the Department of Defense and Police Departments for community health programs that target Black populations. As well, another limitation may be the initial challenges of identifying which individual(s) of the coalition are the main coordinators. This will be addressed by creating a team of leaders from various organizations, which will guarantee all parties are represented.

Revision of the National Health Security Strategy

Revision to the July 2020 version of the 2019-2022 NHSS is vital to ensuring vulnerable populations are identified before and during an outbreak. By revising this version of the 2019-2022 NHSS, the HSS will be more uniform within its agencies and will force the Department to continuously focus on racial health disparities. Policies do not exist that ensure an equitable pandemic response, which leaves racial health disparities still present and unaddressed. Through the improved NHSS, a more effective, quicker response to addressing vulnerable populations within a pandemic would occur. With a revision to the NHSS, the United States would be more successful, better prepared, and can act more effectively during a pandemic, while still assuring that the nation is free of disparities in health and healthcare. (HHS, n.d.)

However, this recommendation has the limitation of the HHS' possible lack of participation. How this limitation would be addressed would be that the public wants to see the HHS' live up to the goals that were presented within its action plan to reduce race and ethnic health disparities.

Community-Based Participatory Workforce Development

Black community leaders and university graduate students will develop a CBPR workforce that will connect health-related graduate program students to Black community members. Through the use of CBPR principles, the Black community's health is estimated to improve.

This recommendation's major limitation is the political pushback that institutional racism has instilled within the various governmental systems. Because institutional racism has been instilled into the systems for centuries, a huge amount of work to dismantling institutional racism is predicted.

Conclusion

Within this paper, the gaps that were featured included the lack of national support for reallocating funding to underserved communities to address the racial health disparities amongst the Black population during the COVID-19. Through the establishment of a national coalition, funding would be more equitably allocated. Another gap was the lack of focus on health disparities amongst vulnerable populations within the HHS's National Health Security Strategy. This gap was addressed within the second recommendation by its proposition to include health disparities within an updated pandemic strategy. The final gap that was discussed was the need for promoting the Black population's voices through increased community work. By developing and initiating programs inspired by community-based participatory research, advanced insights to community health would be discovered, unheard voices would be amplified and trust between discriminated communities and the academia would be solidified. With all of these recommendations implemented, the Black population would be more effectively served throughout the COVID-19 pandemic and beyond, which would help in the closing of the inequity gap and, ultimately, push to the eradication of institutional racism for good.

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Appendix

MPH Foundational Competencies

Foundational Competency	Description of how used for Capstone
Evidence-based Approaches to Public Health	
1. Apply epidemiological methods to the breadth of settings and situations in public health practice	
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	
3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software as appropriate	
4. Interpret results of data analysis for public health research, policy and practice	
Public Health & Health Care Systems	
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings	
6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels	
Planning & Management to Promote Health	
7. Assess population needs, assets and capacities that affect communities' health	
8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs	
9. Design a population-based policy, program, project or intervention	
10. Explain basic principles and tools of budget and resource management	
11. Select methods to evaluate public health programs	
Policy in Public Health	
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence	
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes	Generated recommendations that identify community-based, governmental, public, and private organizations that would form a coalition to allocate funding from police department and the Department of Defense to health community centers in predominantly Black communities.

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14. Advocate for political, social and economic policies and programs that will improve health in diverse populations	
15. Evaluate policies for their impact on public health and health equity	Evaluated the existing drafted National Health Security Strategy (NHSS) document to determine the gaps impacting the health of the Black population. Modifications were provided that better aligned the NHSS' and the Department of Health and Human Services' priorities of eliminating health disparities.
Leadership	
16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making	
17. Apply negotiation and mediation skills to address organizational or community challenges	
Communication	
18. Select communication strategies for different audiences and sectors	
19. Communicate audience-appropriate public health content, both in writing and through oral presentation	Outlined, drafted and finalized Capstone paper including a literature review, recommendations and implications on a current public health problem. Created a slide deck based on the Capstone paper and delivered an oral presentation at Health Professions Day in front of an interprofessional audience.
20. Describe the importance of cultural competence in communicating public health content	
Interprofessional Practice*	
21. Perform effectively on interprofessional teams	
Systems Thinking	
22. Apply systems thinking tools to a public health issue	Created a fishbone diagram to visually depict the factors that contribute to the United States' inequitable response to the COVID-19 pandemic.

Health Policy Leadership Concentration Competencies

Competency	Description of how Capstone used
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1. Apply economic concepts to understand the effect of changes in policies at the government, health systems, and public health sectors	
2. Synthesize economic concepts to assess equity and efficiency in making health policy recommendations in underserved communities	
3. Formulate efficient health policy change recommendations through the analysis of proposed health policy initiatives that could affect health outcomes of vulnerable populations	Evaluated existing National Health Security Strategy (NHSS) to determine the gaps impacting the health of the Black population during a crisis. Modifications to the document were recommended that ensured that the NHSS’ and the Department of Health and Human Services’ priorities of eliminating health disparities were in alignment with one another.
4. Develop recommendations to improve organizational strategies and capacity to implement health policy	
5. Analyze policy options to address environmental health needs at the local, state, and federal levels	