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Commentary

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# The Trust Gap Between the Coronavirus Vaccine and Communities of Color: What Midwives Can Do To Help

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As the coronavirus disease 2019 (COVID-19) pandemic ravages communities, new hope comes with the availability of the novel coronavirus vaccine. One year after the discovery of the severe acute respiratory syndrome coronavirus 2 virus and the emergence of COVID-19, more than 120 million people worldwide have been infected, with over 2.7 million deaths. Within the United States alone, more than 30 million people have been infected and more than half a million people have died.[1] However, the stark racial inequalities exposed by the pandemic are just as horrific as the numbers of people infected and lives lost. The greatest proportion of COVID-19 morbidity and mortality has been among communities of color. According to the Centers for Disease Control and Prevention,[2,3] when compared with white Americans, Black Americans are 1.4 times more likely to be infected, Hispanic Americans are 1.7 times more likely to be infected, and American Indians are 1.8 times more likely to be infected with COVID-19; Asian Americans are less likely to be infected, with 0.6 times the rate among white Americans. Similarly, persons of color are more likely to be hospitalized and die from COVID-19 than white Americans, with the highest rates among Black, Hispanic, and Native Americans.[2] The reasons for such racial and ethnic disparities are not fully understood; however, they may be due in part to a higher prevalence of chronic illness that places people of color at greater risk of severe COVID-19 infection.[4] Additionally, people of color may have an increased risk of COVID-19 exposure and spread through service-related occupations, as well as disparate access to adequate testing and treatment, and less likelihood of receiving quality health care, all of which are related to the physiologic and psychological stress of structural racism within the health care setting that affects overall health.[4,5]

Nevertheless, as communities of color disproportionately bear the burden of the coronavirus pandemic, many persons of color still remain hesitant to receive the new COVID-19 vaccine. In a 2020 study by Bogart et al,[5] half of Black study participants were hesitant to receive the COVID-19 vaccination, and one-third stated they would not receive the vaccination or any treatment altogether. According to a national survey, only 40% of Black and Brown people reported intention to vaccinate against COVID-19, whereas another 32% remained uncertain.[6]

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Although the COVID-19 vaccine has great promise for protecting communities, this potential is nullified when vaccine confidence is lacking and communities of color hesitate or decline to vaccinate.[6,7] Black and Brown people who are pregnant and or breastfeeding have unique fears regarding the COVID-19 vaccine. Because people who are pregnant and or breastfeeding are often excluded from clinical trials, little is known about the effects of a new medication or vaccine on these individuals. As a result, many people, and especially persons of color, may fear potential or unknown harms that the vaccine will pose to their pregnancy and/or infant despite recent recommendations by the American College of Obstetricians and Gynecologists and the Society of Maternal-Fetal Medicine not to withhold COVID-19 vaccination from pregnant and breastfeeding persons.[8,9] Moreover, this fear of potential harms during pregnancy and breastfeeding is coupled with fears that the new vaccine risks harm to communities of color at large. This mistrust of the coronavirus vaccine by communities of color is deeper than uncertainty about the vaccine itself. It points to a deeper issue of overall medical mistrust of government institutions and health and social systems, which is deeply rooted in historical trauma and the current construct of systemic racism.[5,7]

Medical mistrust speaks to people's distrust of the motives and intentions of health care providers and institutions.[10] This mistrust often results in less health service use and preventative health behaviors such as screenings and vaccinations.[11] However, medical mistrust goes much deeper than simply meaning the opposite of trust. Medical mistrust actually implies the suspicion that harm will be done and ill-will is at play.[10] Communities of color have consistently demonstrated higher levels of medical mistrust than their white counterparts. In particular, Black communities have a higher prevalence of medical mistrust in comparison with other races or ethnicities.[5,12]

It is important to understand what influences medical mistrust in communities of color and how communities of color have been the target of systemic inequality. The horrors of slavery produced a legacy of racism and systemic inequality that bred mistrust within Black communities.[13] Enslaved persons were the subjects of clinical experimentation for the purposes of medical training that permitted the expansion of the medical profession and clinical research while ingraining deep biases and misconceptions about the health of Black patients in the minds of health care providers. Following slavery, Black communities were segregated and often denied access to quality health care, employment, housing, and education. Within reproductive health, the legacy of Black midwives, such as the grand midwives, was delegitimized in favor

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of the growing white medical and nursing professions, and subsequently, many Black communities lost an integral and trusted source of care. Communities of color continue to have difficulty finding racially diverse providers with whom they can self-identify and establish trust. Black communities especially are less likely to find a racially concordant care provider compared with white or Asian Americans.[18]

Within Black communities, fears of the infamous Tuskegee Syphilis Experiment also remain alive. This study was conducted in 1932 by the US Public Health Service in an effort to learn the effects of syphilis when, at the time, there was no cure. Black men with syphilis, who were promised free medical care, were convinced that they were being treated but were, in fact, only given placebos. When penicillin was approved as the recommended treatment agent, it was withheld from study participants to monitor disease progression. Since that time, legacy of the Tuskegee Syphilis Experiment has monumentally reshaped ethical research practices, but it nonetheless has caused grave damage to the trust between Black and Brown communities and health institutions and providers.[12] Even though the literature shows a higher trust in midwives than other perinatal care providers,[13] midwives still belong to a greater health care system that communities of color often do not trust.

The deep medical mistrust in communities of color has added to the problem of vaccine hesitancy. Black communities are significantly less likely to be immunized than white communities, and this same trend is likely to continue with the COVID-19 vaccine.[7] Black communities may understand the value of vaccination, yet they do not always trust the government, pharmaceutical companies, or health institutions that sanction and create them.[7,16] Despite rigorous scientific research that continuously affirms the safety and efficacy of vaccination, vaccine hesitancy and refusal undermines immunization campaigns such as the COVID-19 vaccine.[7,14] As a result, racial disparities continue as Black and Brown communities lag in vaccination rates and continue to suffer from preventable infectious diseases. For example, vaccine hesitancy has caused racial and ethnic gaps in yearly influenza vaccination rates as Black communities have higher mistrust and are less likely to be vaccinated than white communititess.[7] In addition, a 2018 study showed that Black women demonstrate the highest levels of mistrust and lowest rates of vaccination with regard to the human papilloma virus vaccine compared with other racial or ethnic groups. Within this same study, Asian and Hispanic women also demonstrate higher levels of mistrust and lower vaccination rates than white women.[14]

Midwives have the potential to positively influence COVID-19 vaccination rates and build trust among the persons of color they serve. Recent literature emphasizes a shift away from vaccine refusal as a knowledge deficit issue and instead characterizes it as an issue of mistrust with the broader health system.[7] An essential first step to building trust is to listen to persons of color and acknowledge their reasons for vaccine hesitancy and medical mistrust. It is only through acknowledgement that reconciliation can begin and trust can be earned, and it is important for midwives to avoid denying the perspectives and experiences of persons of color. Ignoring these perspectives neglects the experiences and inequities that shape a person.[18]

Midwives must approach communities of color by first acknowledging their lens of mistrust. Listening and acknowledging systemic racism and historical mistreatments empowers communities that have historically been marginalized, mistreated, and ignored. One study suggests using motivational interviewing to acknowledge the roots of mistrust and vaccine hesitancy and address this topic in a nonconfrontational and nonjudgmental manner.[15] One may also consider employing relationship-centered care by probing perspectives concerning the vaccine through open-ended questions, using shared decision making, listening with respect, and showing empathy and support.[15] Employing these techniques to actively listen to persons of color and acknowledge mistrust and vaccine hesitancy can be challenging and will often require time; however, all midwives should fully engage in this hard work with intentionality and patience. It may be helpful to discuss vaccine hesitancy over the course of multiple visits if time constraints are present. For example, one visit may explore an individual's perspectives and acknowledge their position; an invitation to discuss further at a subsequent visit can then be offered. At the follow-up visit, the individual's readiness to vaccinate can be assessed and further steps taken.

Midwives also have a professional duty to educate their patients of color concerning COVID-19 and the vaccine's safety and efficacy. Bogart et al (2020) show that 97% of their Black study participants embrace at least one vaccine misconception or COVID-19 conspiracy theory, resulting in high levels of COVID-19 vaccine mistrust.[5] For example, this study reports that more Black participants than white participants believe COVID-19 was created in a laboratory. It is imperative to equip patients with accurate information about COVID-19, the vaccine, and preventative behaviors. Multiple studies show that health care providers are more trusted sources of information regarding the pandemic than government sources and pharmaceutical companies.[5,7] Patients rely on midwives to provide trustworthy, evidence-based information concerning the COVID-19 vaccine.

Midwives of color are critical to reducing COVID-19 vaccination hesitancy in communities of color. By providing racially concordant care, they are able to build a greater sense of trust in vaccine hesitant populations. Patients of color are more likely to trust COVID-19 vaccine information and may be more apt to vaccinate if this information is received from a midwife of color. The literature continuously supports that racially concordant care improves interpersonal relationships, increases patient satisfaction, and improves overall health outcomes.[15,16] Although midwives of color are the crux of racially concordant care, it is vitally important to recognize that the burden of education and trust development does not solely rest on them. All midwives should fully commit to listening, acknowledging vaccine hesitancy, educating, and fostering trust with communities of color.

There is also tremendous power in storytelling to help relieve vaccine hesitancy in communities of color. As more midwives receive the COVID-19 vaccination, they are able to share their experience with patients of color. Shared experiences help midwives connect with patients and relate to them in unique, and often less obvious, ways. Communities of color can be empowered by hearing a midwife's personal story of COVID-19 vaccination hesitancy and how they overcame this

fear and decided to vaccinate. It may also be helpful if midwives share any vaccine side effects, or the lack thereof, with their patients.

When discussing COVID-19 vaccination with persons of color, midwives must respect the person's autonomy and decision making. It bears reminding that no one should be forced or coerced into making a health care decision including the decision to vaccinate. Every person, regardless of race or ethnicity, has the right to make a self-determined decision. Even when a person decides against recommendations to vaccinate, midwives must trust that patients are making the choice they believe is in their best interest. It is essential to allow time for vaccine-hesitant patients of color to explore the research, listen to experiences, and make autonomous decisions with which they are comfortable. In time, many may grow to trust the COVID-19 vaccine's benefits and willingly choose to vaccinate.

There is great potential for midwives to help reduce COVID-19 vaccine hesitancy among communities of color and to begin fostering trust between these communities and the health community at large. Although the pandemic has created unique constraints to providing midwifery care, there is still room for action that can create positive change. Meaningful steps include actively listening to communities of color and acknowledging reasons for vaccine hesitancy, educating individuals with evidence-based information regarding COVID-19 and the vaccine, sharing personal experiences of COVID-19 vaccination, respecting individual autonomy, and advocating for racially concordant care when possible. Such measures will allow midwives to help increase vaccination rates in communities of color and offer protection against COVID-19 within these communities that need it the most.

## CONFLICT OF INTEREST

The author has no conflicts of interest to disclose.

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