Health, Identity and History: Vaccine Hesitancy Among Minority Groups in the COVID-19 Pandemic

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With the development and distribution of the COVID-19 vaccine and the arrival of the summer season, people are feeling happier and beginning to come out of their homes. It's clear that there is a growing sense of hope that the pandemic may be approaching its conclusion. However, standing in the way of our pursuit of normalcy is the refusal among some to partake in the vaccine, despite its proven efficacy and safety by experts. In an almost Shakespearean fashion, there is a fierce standoff between two teams: those who are in favor of the COVID vaccine and those that are against it. Between socio-political conspiracies and social media standoffs, many people seem to have ardently made up their mind and refuse to get vaccinated.
However, I think that in the medical community, we mustn't dismiss the vaccine hesitancy movement as entirely composed of "ignorant" or "uninformed" individuals. Specifically, I believe we should be paying more attention to the validity of vaccine hesitancy among minority populations.

When we take a minute to evaluate the historical exploitation and mistreatment of minority groups by science, suddenly their hesitation feels distinct from the anti-vaccine sentiments expressed primarily by white communities. But can it really be that simple? To paint a more accurate picture, we must consider how race-politics inform vaccine development and distribution and recognize that communities of color have experienced a lack of access to vaccines resulting from numerous unique barriers. This represents a far more multifaceted and accurate portrayal of the relationship between medicine and minority populations and, as providers, exploring such perspectives would help rebuild trust with patients of color in a post-COVID world.

The examples of minority exploitation in medicine are innumerable: surgical experimentation on black slave women in the 19th century American South, the famous Tuskegee Study, the case of Henrietta Lacks, the forced sterilization of Native American women among countless others instances which may have not received as much national attention. Time after time, science has labeled black and brown bodies as dispensable in the name of scientific progress, the impact of which lingers in the minds of communities of color. Now facing a pandemic against a virus that only one year ago we knew very little about, it's understandable that an average person of *any* race would have some healthy skepticism about how this vaccine was developed so quickly, especially when most people lack an advanced knowledge of virology and immunology.

Adding to this skepticism is the fact that we've faced other diseases for decades without a successful vaccine trial, yet in just one year we've produced a COVID vaccine that is 95% effective. We haven't seen a breakthrough like this since the development of the polio vaccine in 1955, and it seems almost miraculous that another high-quality vaccine was created in one year when other illnesses like HIV/AIDS, malaria and dengue fever have taken the lives of so many people without any successful vaccines. This divergent outcome lends itself partially to a political explanation in that these illnesses typically affect queer populations and populations of color unlike polio and COVID

which had a greater burden on the white, wealthy communities that hold the decision-making power in this country.

In 2018, the CDC reported that 79% of new HIV infections were among black, queer men and a 2021 study in *The Lancet* acknowledged that the HIV/AIDS epidemic was "built on historical social [in]justice" that could be tied to various health inequities including race and identity. Of course, the true explanation for the lack of progress against certain pathogens is multifactorial and is informed by politics, science, and the specific characteristics of each virus I've mentioned. However, I maintain that if HIV were affecting the globe as COVID has, we would be much closer to an efficacious vaccine. Thus, while the scientific and viral obstacles are certainly contributory, the sociopolitical ones are *especially* contributory, and represent a man-made and solvable problem that slows down scientific progress. Indeed, the reason we have *not* maximized time and resources is because these other viral illnesses do not primarily affect the populations that benefit most from established social systems.

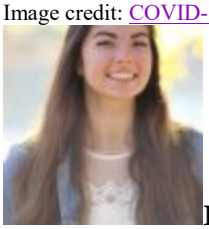
Unfortunately, the ongoing systemic injustices that perpetuate such health disparities justify vaccine hesitancy among minority populations. The skepticism demonstrated by our black and brown patients is fueled by mistreatment by both governing bodies *and* by medicine and has only been exacerbated by inadequate efforts to distribute vaccines and education to their communities. Research shows that of the 339 million vaccines that have been administered in the United States at the time of this publication, nearly two thirds of recipients were White, 9% were Black, 16% were Hispanic, 6% were Asian, 1% were American Indian or Alaska Native, and <1% were Native Hawaiian or Other Pacific Islander. This unequal distribution suggests that we aren't adequately educating minority patients about the vaccine's merit, that we aren't providing them access or that they are simply refusing to partake. Odds are that it's due to an interplay among all three, and this pattern is only worsened by the shortage of minority representation in medicine. This lack of representation means that the average minority patient is less likely to encounter a physician who looks like them or relates to them culturally, thus perpetuating a mistrust already fueled by a lack of culturally-informed care and biases.

Further burdening communities of color is the fact that the disease has disproportionately affected individuals from demographics which already face social barriers to health. While the coronavirus itself does not discriminate, factors such as unemployment, poverty, access to health care and race/ethnicity have unfortunately been key predictors of disproportionate devastation among communities of color. Furthermore, even at baseline, minority groups also have increased rates of comorbid conditions that put them at greater risk for COVID complications due to these same social determinants. Yet, with the vaccine now available for mass consumption, they are expected to display faith in scientific institutions and governing bodies that have historically failed them and if they display hesitancy, they are lumped in with other anti-vaccine movements which didn't suffer the same historical injustices. Indeed, the white communities less stricken by COVID who forgo vaccination can afford this luxury of ignorance and privilege, which is distinct from the vaccine skepticism among communities of color jaded by historical exploitation and mistreatment.

I believe that efforts to understand the *reason* for this hesitation will both improve cultural competency and help repair the broken trust between minority groups and medicine. A health care worker's journey with this lofty goal can start small: volunteering with vaccine administration within communities of color, uplifting underrepresented in medicine (URM) health care trainees, and learning about trauma-informed care are all easy ways to make a difference. By familiarizing oneself

with the historical truths that inform the minority experience with medicine, a provider may become more likely to administer unbiased and culturally competent care and can mitigate preventable disease in these populations.

Health and healthiness is not a universal experience, but rather a privilege not guaranteed for all. By acknowledging the interplay between identity and medicine, we build a more solid foundation of trust with patients and combat preventable adverse outcomes tied to class, culture and race. In medicine, we tend to have tunnel vision: what does this patient look like? What can I see in this image? What can I read in a patient's chart? It's therefore important to remember that medicine is broader than we acknowledge; it interacts intimately with history, identity, socio-politics and so on. To ignore this fact does a disservice to our minority patients who are at risk of being left behind by a system built on a foundation of exploitation and mistrust. Moving forward, it is more important than ever to sharpen cultural competency, to acknowledge the unseemly disparities that plague U.S. health care and to continue to advocate for populations of color whose voices are systematically shut out.



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Haleigh is a third year medical student at Oregon Health & Science University in Portland, Oregon class of 2023. In 2017, she graduated from Vassar College with a Bachelor of Arts in biochemistry and in 2019 she graduated from the Johns Hopkins: Bloomberg school of public health with a Masters of Health Science in biochemistry and molecular biology. She enjoys baking, painting, jigsaw puzzling and playing with her kitten in her free time. After graduating medical school, Haleigh would like to pursue a career in pediatric cardiology or pediatric surgery.