

Communicating about racial equity and COVID-19: Connecting data to context

Because we are steeped in the research demonstrating the longstanding health harms from inequities, most of us in public health were not surprised by the **headlines** from Chicago, and now other places, reporting the disproportionate number of **Black, Latinx, and Native** infections and deaths from COVID-19. But for the general public, and even policymakers, the interpretation of those data is likely to be different. Without the background knowledge, when people hear statistics reporting disproportionate impact, they are likely to attribute the cause to individual behavior. When people view the root cause of disparities as individual failings, the only solutions that seem plausible are telling individuals to do better or moving resources away from them since it appears like current resources are not helping. To help people understand the full meaning of data about the distribution of COVID-19, we must connect the context to the statistics every time we mention them. Berkeley Media Studies Group **talks** about this as the difference between depicting a *landscape* versus a *portrait*. Statistics alone will trigger people to think about portraits of individuals. Our job when communicating about COVID-19 is to embed the portrait in a broader landscape.

Depending on local circumstances and data, there may be different ways to embed the data in a larger landscape. Typically, you won't be able to talk about every social determinant of health or public system, so you will have to choose some aspect of the landscape to use as an example. Being **strategic**, you could pick one part of the landscape for which you are actively seeking policy solutions, such as around providing stable housing or food access. In that case, when you describe disparities in data, you could highlight the fact that it is not surprising to see higher rates of illness and death of any kind, including COVID-19, among people who have been deprived of the basic necessities of well-being like food and shelter. Even if you don't have a strategic reason to choose one aspect of the landscape over another, pick something to use as an example to make it easier for your audience to see that the context matters.

In this instance, the data about disproportionate impact comprise the **problem statement**. The part of the landscape that you describe to provide context also points to the **solution**. And, with every communication about COVID-19, be sure to express your **values** so your audience knows why this matters to you personally and to our whole community and region.



If the public's information came only from the media, what would they know?

What wouldn't they know?

Below are some examples of statements that bring the landscape into view.

Bring history into view

We need to show *why* we have different rates of underlying conditions like hypertension and diabetes; otherwise, people will assume that individuals are solely to blame for not taking better care of themselves. Dr. Michael Lu, dean of U.C. Berkeley School of Public Health, explained this well, including the connection to institutional racism, when he said:

“Differential access to health care is only one of many social determinants which determine who gets sick from COVID-19. Living in crowded housing or on the streets increases your risk exposure. Breathing toxic air from nearby brownfields, oil refineries, and freeways increases your risk for asthma and chronic lung disease, two major risk factors for COVID-19. Growing up in a food desert with limited access to healthy food increases your risk for obesity and diabetes, also major risk factors for COVID-19. What does this have to do with racism? Because residential segregation, income inequality, food insecurity, environmental injustice, and many other social ills that disproportionately affect communities of color are often the results of racist policies ... it's racist policies, rather than personal irresponsibility, that are making most people of color sick.”

In just a few sentences, Dr. Lu explained the connection among COVID-19, social determinants of health, and racial disparities. He also took the next step of making it personal while still explaining the science:

“And it's putting up with all the anti-Asian xenophobia that is making me sick. Once or twice we can put up with, but experiencing racism over and over again across the life course takes a toll. It creates wear and tear, or allostatic load, on our body and soul. So even if the virus doesn't kill us, racism will. The only antidote to racism is anti-racism.”

Explain the disproportionate chance for exposure and less access to treatment

We can explain that the data reflect the fact that certain populations, including essential workers who toil for low wages, are at much greater risk for exposure — a group that includes many people of color. In New York City, for example,

75% of frontline workers — nurses, subway staff, sanitation workers, drivers, grocery cashiers — are people of color. While some are able to shelter in place and work remotely, many workers of color have no choice but to be in circumstances that put them at great risk. In an interview on CNN, Dr. Camara Jones emphasized the research findings on historical lack of access Blacks have to health care in general that means they experience greater risk now:

“We know, for example, that there is significant racial bias within the health care system. Blacks, for example, are less likely to receive life-saving procedures compared to whites. And this is a well-known scientific fact. There are many studies that have shown this.”

Connect health outcomes to the policies that structure our systems

In an opinion piece for *The Sacramento Bee*, Dr. Tony Iton, vice president of The California Endowment, explains that decades of policy violence created the disproportionate exposure to COVID-19. He explains that the disproportionate outcomes are the consequence of a “callous and predatory system that limits their access to quality, affordable health care, basic employment benefits, housing and education” rooted in the racism of America’s founding. In the op-ed, Dr. Iton brings history forward by reminding readers that we saw the same sorts of racial disparities with Hurricane Katrina and the foreclosure crisis, which, like this pandemic, result from our policy decisions:

“Our country manufactures social vulnerability through policy violence. Policy violence is the intentional absence of protective policy in the face of abject need. Policy violence leaves large segments of our society experiencing constant daily stress as they try to navigate a healthy life without health insurance, decent housing, affordable child care, paid sick leave, or quality education.”

Bringing history into the picture, using tangible, local examples of disproportionate exposure and less access to treatment, and pointing to policy (as cause or solution), are three ways to bring context to the disparities in data around COVID-19.

Unfortunately, we are going to see many more examples of racial disparities as the pandemic evolves. We will continue to offer tips for communicating about them effectively. The issue is far too complex to be solved — or talked about — with just a few media bites. Still, we will make progress if, with every discussion of data, we make the context surrounding COVID-19’s disproportionate impact



visible with tangible descriptions of the landscape connected to our public health values about keeping everyone in our communities safe and healthy.

No one tip sheet can cover every aspect of effectively communicating about racial equity because the topic is complex, especially as it intersects with the novel coronavirus. And, as always, communication will always be more effective when it is integrated with community organizing and partnerships, data collection efforts, policy strategy, building internal capacity, and all the other components that are part of our health equity work. Since much of the recent news has been on new data showing racial disparities in COVID-19 morbidity and mortality, this tip is focused on communicating about data. Future tips will cover other areas of racial equity communications and other communication strategies.

For more information about BMSG's work with local health departments on communicating about health equity, contact Katherine Schaff, DrPH, schaff@bmsg.org.