What Happens When the Crisis Seemingly Never Ends? Perspectives in Health Communication

Monica L. Ponder, PhD, MS, MSPH[1]

[1] Department of Communication, Culture, and Media Studies, Cathy Hughes School of Communications, Howard University, Washington, DC

Address correspondence to Monica Ponder, PhD, MS, MSPH, Cathy Hughes School of Communications, Howard University, Washington, DC; monica.ponder@Howard.edu

Lessons Learned from the Heart of the Black Belt

In the early onset of SARS-CoV-2, or COVID-19, in the United States, the virus "hit like a bomb" in the southern city of Albany, Georgia after many residents attended the funeral of a retired janitor.[1] Known as "the Good Life City," Albany is home to early American civil rights movement work and symbolic of the community safe havens formerly enslaved African Americans created for themselves.[2] According to the census, 77% of Albany's 70,643 residents identify as Black or African American; only 19.7% identify as non-Hispanic White.[3] In his prolific 1903 publication *The Souls of Black Folk*, sociologist W.E.B. DuBois labels Albany, Georgia, the "heart of the Black Belt" and laments "[h]ow curious a land is this,- how full of untold story, of tragedy and laughter, and the rich legacy of human life; shadowed with a tragic past, and big with future promise! This is the Black Belt of Georgia."[4]

Since its initial designation as an early COVID-19 hotspot, Albany (and the Southern region of Georgia) has experienced at least four surges during the pandemic, occurring in October 2020, January 2021, September 2021, and January 2022. The multiple surges exacerbated an already overwhelmed health system and it wearied Albany residents.[5] Overlaying this local experience are statewide blockages of federally recommended prevention measures, insidious statewide racial power dynamics and ongoing national tensions of racial unrest, intimidation and violence targeting Black people.[6]

In the current US COVID-19 pandemic, Albany, Georgia serves as a case study, illuminating the challenges present in the contemporary practice of health and crisis communication. Though the most immediate concern remains mitigating COVID-19 and related inequities, the efforts are unlikely to succeed over the long-term in eliminating inequities unless they acknowledge and address the underlying social crises with which the community has already been contending. But, how exactly does one develop effective public health messaging that balances the urgent actions necessary to remain safe (eg, mask wearing, vaccination, social distancing) with the cultural sensitivity needed to honor the lived experiences of Black people (eg, grief, long-term implications from COVID-19, anger, fatigue,

distrust in the health care system)?

During crises, public health practitioners often use traditional approaches of the Crisis and Emergency Risk Communication (CERC) Lifecycle framework.[7] According to the CERC model, crises follow the epidemiologic curve, meaning that crises develop in predictable and systemic ways: higher risk period, eruption of accelerated case count, to clean-up and recovery, and on to evaluation. In order to mitigate distress, mortality and morbidity related to a crisis event, this requires that public health communicators "issue specific recom-

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mendations about how to avoid or reduce harm, what symptoms might indicate concern, and where to go for treatment."[7] However altruistic the intent, such prescriptive approaches may not fully account for vital cultural and environmental contexts in message development, including: 1) the roles that historical trauma, everyday racism, interpersonal communication, and health inequity play in individual-level information processing

and behavioral decisioning; as well as 2) the actions urgently required of institutions to keep communities safe.

When developing prevention and risk reduction messaging, the burden of action should not rest solely on individuals or communities alone. It ought not be assumed a crisis follows an epidemiological curve but, rather, for communities of color, the crises may be a steady torrent of uncertainty, precaution, discrimination, and fatigue from navigating systems of oppression. Increases in disease incidence may further aggravate this baseline condition. Any messaging shared with the public should account for these and other complex dynamics. There has been long-standing debate on the ethics of approaches that "override" individual freedom and experiences for the sake of promoting tactical public health.[8] However, ideologies that perpetuate racialized notions (eg, cultural deficiency), ignore the continual state of crisis in which African American, native American and other racial/ethnic populations may be living.[9] Given what we know about racialized trauma, this understanding should inform the default praxis used in all messaging during pandemics or other public health crisis communication.

As the fumbled roll-out of the US COVID response suggests, an alternative to the dominant ideologies of health communications research and practice are necessary to respond effectively to the pandemic. "Critical theory disrupts the universalist assumptions of altruism that are built into the rhetoric of much health communication work and brings the theorist/practitioner face-to-face

with the assumptions that serve as the foundations for carrying out health communication interventions locally, nationally, and globally."[10] The Critical Health Communications Praxis (CHCP) allows crisis communicators to unpack the complex intersectional mechanisms linking power context, and agency in ways that affect morbidity, mortality and disparities in the distributions of death and disease during public health crises, and the development of effective interventions—in particular, health communications solutions—to them.[10–12] CHCP can be used to deconstruct the dominant frameworks of risk framing in health communications practice that may be ineffective at best and re-traumatizing at worst for racial and ethnic minoritized groups.[13] Culturally sensitive, decolonized, and non-paternalistic frameworks for public health crisis communication are necessary to address the co-occurring crises of COVID-19, racism, and the unspoken challenges that communities of color face every day.

TOWARD A HEALTHY EQUITY MODEL FOR HEALTH AND CRISIS COMMUNICATION

The messaging used by various researchers, clinicians and public health professionals over the course of the pandemic has been inadequate and may have confused members of the public and the public health community about how best to optimize health. The implications may be particularly serious for the racial/ethnic minority populations who have

been disproportionately impacted by COVID-19 since the beginning of the pandemic. Public health communication needs to evolve over the course of crises such as the COVID-19 pandemic. Practitioners require culturally responsive crisis communications models in order for the equity-focused crisis mitigation efforts they undertake to succeed.

The recommendations below support the development and use of culturally responsive models of public health communication, and they identify considerations for integration into new models.

Self-Care

Growing evidence supports the practice of self-care as a strategy to cope with the detrimental psychological effects of racial oppression and discrimination.[14,15] Practitioners should reframe rest, community connectedness, and healthy coping modalities as intervention. This framework is also touted within the disability rights advocacy community, as multiple comorbidities continue to be the leading indicator of poor outcomes from infection with COVID-19.[16] Health communication is a necessary public health discipline in that it can influence perceptions, beliefs and attitudes that can change social norms. When developing health messaging, practitioners can learn from feminist, intersectional and disability advocacy and discourse to implore communities to seek respite with as much intention as they do mask wearing and vaccinations. This is a message that communities need to hear, repeatedly. There is widespread consensus in the public health literature that social connect-

edness causally protects and promotes mental health.[17] It is important to acknowledge and celebrate the positive aspects of community, in part because so much attention focuses on racial/ethnic problems, potentially reinforcing stigmata or contributing to fatalism. Communities are more than mere hot spots of disease.

Health Messaging

In health messaging, practitioners must consider the cumulative effects of trauma on the body when assessing and reporting on risk. The term "weathering" refers to the long-term mechanism by which chronic exposure to racism produces health inequities.[18] The messaging used to address public health crises cannot suggest current disease incidence and behavioral recommendations are unrelated to the social, environmental, historical and political contexts that people live. If not careful, there can be an (unintended) valuation of personhood in how epidemiological outcomes are reported, which may exacerbate mitigation efforts and contribute to population harm. Therefore, it is critical to determine whether any higher risk for illness and disease that communities experiences is due to the poor choices (eg, behavioral resistance) of community members or to the oppressive systems that place them at higher risk by force (eg, front line workers, inequitable health care access).

Messaging that Recognizes Historical Harm

Health communication practitioners can lead the way in reframing the current rhetoric depicting cultural mistrust/distrust of the health

care system. In a pandemic that has disproportionately burdened Black Americans, there is much rhetoric on historical atrocities contributing to Black communities' distrust of the health care system (eg, Henrietta Lacks, the Tuskegee Syphilis Study, Marion Sims).[19] While valid as an explanation, it is also reductive. It blames the poorer outcomes of Black populations on behaviors they take in response to mistrust, but obscures the responsibility that institutions have to address the root causes of mistrust. To address this requires answering a different question: What have public

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health and health care institutions done to earn the trust of communities of color? Developing messages that demonstrate empathy and recognize the historical harm that remains in the psyche of Black and Brown communities is humane and necessary.

Engagement of Health Consumers

There is much to be learned from the public relations literature on sustaining engaging relationships with stakeholders and, within this context,

health consumers. Rather than pursuing messaging that is framed paternalistically, practitioners can apply two-way communication models that consistently receive and consider the needs of the public. This requires that crisis communication responses remain a dynamic art of responsiveness in order to retain trust and validate the lived experiences of communities. Two-way dialogue, as opposed to one-way communication, is a core component of stakeholder relations in the public relations discipline.[20] As a result, practitioners recognize that crisis events require a relational response because they can affect how stakeholders interact with the organization.[21]

CONCLUSION

Public health communication practitioners play an important role in supporting communities during crises. As described in the case of Albany, Georgia, bolstering "the Good Life City" requires the application of an equitable and culturally responsive framework for crisis communication to help residents feel safe, connected and truly heard.

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