Institutional Distrust among African Americans and Building Trustworthiness in the COVID-19 Response: Implications for Ethical Public Health Practice

Alicia L. Best, PhD, MPH  
Faith E. Fletcher, PhD, MA  
Mika Kadono, PhD, MA  
Rueben C. Warren, DDS, MPH, DrPH, MDiv

Alicia L. Best is an Assistant Professor at the University of South Florida, College of Public Health. Faith E. Fletcher is an Assistant Professor at the University of Alabama at Birmingham, School of Public Health, Department of Health Behavior. Mika Kadono is a Research Specialist at the Moffitt Cancer Center, Participant Research, Interventions, and Measurement Core (PRISM). Rueben C. Warren is a Professor and Director at the National Center for Bioethics in Research and Health Care, Tuskegee University. Please address all correspondence to: Alicia L. Best, 13201 Bruce B. Downs Blvd, MDC 56, Tampa, FL 33612; Phone: (813) 974-5290; Email: abest@usf.edu.
Abstract: African Americans are disproportionately affected by COVID-19-related disease and mortality due to long-standing social, political, economic, and environmental injustice; COVID-19 inequities are exacerbated by institutional distrust. In the absence of trust, public health authorities have not adequately fulfilled their professional and ethical obligations to protect African American communities from the negative effects of COVID-19. As institutional distrust is shaped by individual and collective experiences of untrustworthiness, we propose a paradigm shift from increasing trust among African Americans to increasing trustworthiness among medical and public health institutions/systems throughout the United States. This narrative review extends the literature describing how social determinants contribute to COVID-19 inequities by demonstrating how institutional distrust develops over time and is reinforced through systems of injustice. Additionally, we illustrate consequences of institutional distrust for COVID-19 inequities and provide recommendations for building trustworthiness through ethical public health practice.

Key words: Institutional distrust, trustworthiness, COVID-19 pandemic, health inequities, public health, ethics.
In late 2019, an outbreak of severe acute respiratory syndrome—coronavirus-2 (SARS-CoV-2)—was identified, rapidly spread, and escalated to the coronavirus disease 2019 (COVID-19) pandemic.\textsuperscript{1, 2} In the United States (U.S.), COVID-19 disproportionately affects racial/ethnic minority and socioeconomically disadvantaged populations.\textsuperscript{1-6} African Americans are up to three times more likely to contract COVID-19, and up to six times more likely to die from a COVID-19 infection compared with non-Hispanic Whites in the U.S.\textsuperscript{2} Disparities in disease morbidity and mortality, such as those illustrated by COVID-19, are not new, and merely highlight long-standing social, political, economic, and environmental injustices.\textsuperscript{1} In fact, the U.S. Department of Health and Human Services documented racial/ethnic health disparities almost 35 years ago.\textsuperscript{7} Although not surprising, racial/ethnic disparities in COVID-19 incidence and mortality rates are, notably, unnecessary, avoidable, and unjust.\textsuperscript{8}

Public health is concerned with promoting health, preventing disease, and enhancing quality of life at the population level; key public health models/frameworks underscore the fact that social conditions are powerful determinants of health within a given population.\textsuperscript{9} In the absence of an effective treatment or vaccine, the best means of protecting the public’s health against COVID-19 includes social distancing, wearing a face covering, and practicing personal hygiene (e.g., hand washing).\textsuperscript{10} However, the ability to engage in recommended protective behaviors differs among various segments of the population. For example, practicing social distancing and adhering to stay-at-home orders present estimable challenges for many African Americans,\textsuperscript{3} who are more likely than non-Hispanic Whites to reside in densely populated areas, live in multigenerational households, use public transportation, and/or work in service sector
jobs that do not afford the privilege of working from home. Further, African Americans constitute a significant proportion of the “essential workforce” providing critical services during the COVID-19 pandemic (e.g., nurse aides/assistants, food service workers, grocery clerks, building custodians, bus drivers). In short, an individual’s capacity to fully engage in public health preventive behaviors exists within a larger social, economic, and environmental context; therefore, racial/ethnic and socioeconomic inequities exposed by COVID-19 signify a larger ethical failing when a country fails to protect its most vulnerable.

**Institutional distrust and ethical public health practice**

As outlined in the *Public Health Code of Ethics*, the “effectiveness of public health policies, practices, and actions depends upon public trust gained through decisions based on the highest ethical, scientific, and professional standards” Some scholars have argued that “the most important asset that public health can have is the public’s trust.” As a consequence of persistent racism and socioeconomic injustice, institutional distrust warrants considerable attention in relation to COVID-19 inequities. Institutional distrust refers to an individual or group’s lack of confidence in systems, whether they be medical, public health, and/or governmental. *Trustworthiness* is a requisite condition to foster trust that is frequently overlooked; in the absence of trustworthiness, distrust is only rational. Thus, public health practitioners and institutions have an ethical responsibilities to meaningfully engage, educate, and inform diverse communities about health issues, particularly during a public health crisis. In failing to establish trust in the context of historical and ongoing injustice, public health authorities sowed the seeds of the terrorizing effects of COVID-19 on African Americans, rather than protecting all Americans equitably.
Within the context of health and health care, perceptions of risk and trust are intertwined. Individuals rely on expert and institutional knowledge to inform perceptions of risks. Individual risk perceptions, however, are influenced by a variety of other factors including individual experiences, collective memories, and evaluations of the trustworthiness of experts, themselves. Evaluations of trustworthiness are based on historic knowledge and references to how institutions and regulatory bodies approached risk mitigation in the past. For these reasons, individual risk perceptions often diverge from those of experts. Environments of institutional distrust drive individualized perceptions of risk and decreased adherence to public health recommendations and interventions. Institutional distrust is more prevalent among racial/ethnic minority and low-socioeconomic status populations, especially African Americans; distrust is shaped by individual and collective experiences of injustice; ultimately, it is injustice that exacerbates health inequities.

The legacy of medical, research, and public health injustice experienced by African Americans fosters institutional distrust, thereby violating public health ethics theory, practice, and core values. One of the most frequently cited violations influencing institutional distrust in African Americans is the U.S. Public Health Service (USPHS) Study of Untreated Syphilis in the Negro Male in Macon County, Alabama (USPHS Syphilis Study). Over a 40-year period (1932-1972), the USPHS deliberately misled over 600 African American men and their families about the nature and goals of their study (i.e., document the natural progression of untreated syphilis in African American men). The U.S. government implemented national surveillance of these men, and intentionally withheld effective treatment once available. This alarming ethics violation demonstrates untrustworthiness in U.S. research, medical, and public health systems, simultaneously.
While the USPHS Syphilis Study remains relevant to institutional distrust among African Americans, intersecting and overlapping violations of justice occurring long before and after the USPHS Syphilis Study, shape and reinforce institutional distrust among African Americans. The negative association between institutional distrust and health care utilization among racial/ethnic minority populations is well-documented. Evidence of and justification for African Americans’ distrust of health care systems have continued to build during the COVID-19 pandemic. For example, several reports from COVID-19 patients and their families, health professionals, and community leaders suggest that racial/ethnic minority populations are experiencing barriers to COVID-19 testing and treatment, as well as mistreatment from health care professionals. Preliminary data and personal narratives indicate that African Americans are more likely than non-Hispanic Whites to be sent home without testing despite displaying symptoms of COVID-19 infection. Moreover, many predominately African American neighborhoods do not have the protective gear and equipment (including tests) necessary to perform COVID-19 testing. Given the scarcity of COVID-19 tests, and the overwhelmingly high rates of COVID-19-related disease and mortality among African Americans, the inequitable distribution of COVID-19 testing equipment is yet another clear violation of public health ethics and another display of untrustworthiness.

The ongoing Flint water crisis is an example of environmental injustice that is exacerbated by the COVID-19 pandemic. In 2014, officials in Flint, Michigan switched the local water supply to save money, which contaminated the city’s water and poisoned its majority African American population. The Flint water crisis has resulted in death, acute and chronic disease, behavioral health issues, and ongoing anxiety among residents. The Governor of Michigan during the water crisis testified before the U.S. Congress, “This was a failure of government at all levels. Local, state and federal officials—we all failed the families of Flint.”
Despite this acknowledgment, the Flint water crisis is ongoing,\footnote{26} which exemplifies truth without reconciliation, and it intensifies institutional distrust among African Americans in Flint and throughout the U.S.\footnote{25} In the midst of the COVID-19 pandemic, Michigan (like most states) instituted a stay-at-home order; but without safe drinking water at home, Flint residents experience a crisis within a crisis.\footnote{26}

\textbf{Accumulating injustice.} Life course perspectives such as cumulative inequality theory posit that inequity is generated at the systems level, and that the negative effects of inequity accumulate over time.\footnote{27} Accordingly, individual-level factors such as institutional distrust develop as a result of structural realities and experiences of injustice,\footnote{19-23} and when left unreconciled, the effects of these injustices amass over time.\footnote{27} Further, emerging research in transgenerational epigenetic inheritance, along with theoretical frameworks such as biosocial inheritance, suggest that physiological and cultural characteristics may be influenced by posttraumatic trauma and adverse early life experiences that can be passed down from one generation to the next.\footnote{28-29}

\textbf{Consequences of Institutional Distrust on COVID-19 Response}

\textbf{Lack of perceived susceptibility and/or severity to COVID 19.} Federal reaction to COVID-19 was delayed, leaving Americans little time to prepare for an unprecedented period in modern society.\footnote{30} A recent study by Wolf and colleagues found that compared with non-Hispanic White and Hispanic adults, African Americans were more likely to report feeling only “a little prepared” or “not prepared at all” for the COVID-19 pandemic.\footnote{4} Findings from that research also suggest a lack of perceived susceptibility to and/or severity of COVID-19 among African Americans.\footnote{4} Perceived susceptibility and severity are key constructs that help to predict and explain behavior, particularly in the context of health-related activities.\footnote{31} In the
aforementioned study, African Americans reported being less worried about COVID-19 (perceived severity) and less likely to believe they would contract the virus (perceived susceptibility) than non-Hispanic Whites. Existing institutional distrust, combined with unclear and inconsistent government recommendations, may have increased skepticism among African Americans relative to non-Hispanic Whites, leaving them less equipped to cope with the COVID-19 pandemic.

**Skepticism towards public health intervention and research.** Research indicates a strong association between institutional distrust and nonadherence to health-related recommendations. For example, Quinn and colleagues found that institutional distrust was associated with lower influenza vaccination among African Americans. As the scientific community races to develop a COVID-19 vaccine, the notion of vaccine hesitancy (i.e., delay or refusal of vaccination) is of paramount importance. Working to rectify institutional distrust now is fundamental to optimizing COVID-19 vaccine uptake in the future. Additionally, ethical inclusion of racial/ethnic populations in COVID-19-related research (and in biomedical research generally) is key to reducing health inequities. Preliminary dialogue through social and news media outlets surrounding COVID-19 vaccinations indicates that some African Americans are concerned about research exploitation, namely being used as a means to an end, in vaccine development.

**Recommendations for Ethical Public Health Practice to Develop Trustworthiness**

**Truth and Reconciliation.** Institutional distrust can accumulate over time and be transferred intergenerationally as a result of unreconciled historical and continuing injustice. Medical, research, and public health institutions/systems must facilitate critical reflection, courageous dialogue, and accurate/truthful documentation regarding institutional untrustworthiness.
Although critically important, admitting untrustworthy actions (both committed and omitted) toward African Americans, and acknowledging that institutional distrust is justifiable, only starts a process towards reconciliation. Institutions and systems must also take measurable steps toward rectifying injustice through tangible reparations. As argued above, the ongoing Flint water crisis is one of countless examples in which institutional untrustworthiness was acknowledged without appropriate follow-through and recompense.\textsuperscript{24-26} In alignment with public health core values, public health and medical institutions should prioritize structural competency and transparency among its institutions, as well as increase awareness of structural barriers and systemic racism in the general population.\textsuperscript{34} The following sections describe recommendations that can be acted upon to help build institutional trustworthiness.

**Community-centered public health practice.** Engaging communities that are most burdened by COVID-19 is a critical component to ethical public health practice.\textsuperscript{13} Community engagement not only demonstrates respect and sensitivity, but it also helps capture relevant social, cultural, and environmental realities necessary to contextualize public health information.\textsuperscript{35} Accordingly, formative research (including message pre-testing) is a critical step in developing effective public health interventions and messages.\textsuperscript{35} Since health crises such as COVID-19 disproportionately affect disadvantaged and vulnerable communities,\textsuperscript{1-6} it is particularly important to engage those affected in message development and risk communication.\textsuperscript{35} Regarding COVID-19 messaging, the phrase and practice of “social distancing” is counter to the communal culture and values of African Americans; it fundamentally disrupts the mutigenerational family and community support networks necessary to cope with systemic racism and structural barriers.\textsuperscript{36} To lessen COVID-19 transmission risks, the term *physical distancing* has emerged to emphasize the importance of social interaction and
connectivity to foster emotional, mental and physical well-being, even in times when physical proximity may be unsafe.

**Elevate trusted sources.** In addition to efforts aimed at slowing the spread of COVID-19, the World Health Organization has established a new platform to curtail “an overabundance of information—some accurate and some not.”

Characterized as an infodemic, the influx of information makes it difficult for consumers to identify trustworthy sources and reliable guidance. The accumulation of unreconciled injustices, combined with “misinformation, missteps, conspiracies, and cover-ups” during the COVID-19 pandemic has intensified African Americans’ distrust in public health, medical, and government systems. In light of this, increasing the visibility of trusted and respected individual and organizational stakeholders to deliver public health information and messages is critically important. Dr. Georges C. Benjamin, one of the nation’s most influential physician leaders and Executive Director of the American Public Health Association said the following: “We [African Americans] get a lot of misinformation circulating through our communities. We fundamentally don’t trust some of the [non-black] institutions because they do not serve us well. We need to make sure our trusted institutions, clinicians of color, churches, community organizations, are better educated.”

Some other important organizational/institutional sources of information which can be leveraged within various African American communities include the National Medical Association, the National Black Nurses Association, the National Pan-Hellenic Council (i.e. Black Greek-lettered fraternities and sororities), and others.

**Leverage intergenerational communication.** In addition to promoting trusted professional sources to deliver information, public health institutions should consider the importance of familism (i.e., solidarity among multigenerational family and community networks) and the oral tradition within African American communities.
college students, African Americans are more likely to be first-generation college students compared with non-Hispanic Whites, which often positions them to act as conduits of health and other information between their older family members and U.S. institutions. Thus, health information can be delivered from the younger generation to their older family members (i.e., upstream intergenerational communication). In fact, many African American adults already act as intermediaries between their older family members and the health care system; older family members rely on them to translate health information. Given that the risk of severe illness and death due to COVID-19 increases with age, effective delivery of prevention and testing information to older adults is critical. One approach to leveraging intergenerational communication in the COVID-19 pandemic is to engage adult children, grandchildren, and other caretakers of older African American adults in message development processes and explicitly target these groups in communication strategies aimed at protecting older African American adults from COVID-19, as they may be consuming or delivering this information to their older family members.

**Conclusions**

Centering the most marginalized groups in a crisis is a social justice imperative that requires acknowledgment of institutional untrustworthiness, neglect, and failure to address the structurally imposed vulnerabilities that give rise to inequitable outcomes during the COVID-19 pandemic. Situating distrust (and historic untrustworthiness) of institutions in the context of historical and continuing injustice is vital to effectively addressing distrust, and thereby increasing adherence to COVID-19 and other public health recommendations (e.g., vaccine uptake), optimizing health care utilization, and enhancing equitable participation in research among African American and other racial/ethnic minority communities. In view of this, future
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research and practice efforts must include implementation and evaluation strategies focused on building trustworthiness of U.S. medical and public health institutions/systems.
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