Deconstructing the “Black Vaccine Hesitant Subject”:
The Broadening of Black Relationalities to Medicine and Power

Tolulope E. Banjo
Adviser: Professor Christine Schuetze

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Abstract

An exploration of the complexities behind vaccination decisions, *Deconstructing the “Black Vaccine Hesitant Subject”: The Broadening of Black Relationalities to Medicine and Power*, examines the public discourse surrounding vaccine hesitancy and vaccination decisions among African Americans. Through a critique of public health messaging, interviews, social media analysis an extensive literature review, this thesis attempts to deconstruct the notion behind the “Black, vaccine-hesitant subject” with a focus on resisting hegemonic narratives that paint Black people as monolithic. This thesis shows that simplifying the complexities behind vaccination decision can obscure nuances and mask the systemic issues that affect vaccination decisions. In contextualizing the perceptions and thoughts of the COVID-19 among Black people, *Deconstructing the “Black Vaccine Hesitant Subject,”* has the potential to provide insight into the complex relationship between Black people and medicine.
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Introduction

Before receiving my license at the age of 16, I asked my mother her opinion on being an organ donor. Completely horrified by my question, her eyes widened in alarm. She shut down the idea, cautioning me about the dangers of being an organ donor while being Black. She explained further saying that if I were to ever find myself in a situation where I was on the verge of life and death from an accident and there was a chance I could be saved, health professionals would not save my life if they knew I was an organ donor. In such a situation, my life wouldn't be worth saving since my body would be considered more valuable to others as parts than as a living whole.

A few days later, my father drove me to the Department of Motor Vehicles to exchange my driver's permit for my license. After some time, my name was called. I gathered my documents and walked up to the representative behind the counter. He asked me a few identification questions and then snapped my picture. Before signing my license, the representative asked me if I would like to become an organ donor. Remembering the conversation I had with my mother a few days prior, I declined the offer and signed my signature on the digital screen in front of me. Although I didn’t know it at the time, this experience was one of the first in which I began to conceptualize Black relationalities to medicine and power and its complexities. In this case, specifically, the relationship that my mother had with medicine was rooted in distrust, and out of her desire to protect me, her caution would impact how our decisions, in relation to medicine, were made.
Black mistrust in the U.S. medical establishment is not unfounded. Since the beginning of the transatlantic slave trade, Black people have been subjected to unimaginable violence. Stripping Black people of their identity and humanity, white slave masters reduced enslaved Black People to what their labor could produce. Black people were not seen as human beings but as property to be bought and sold. This dehumanization was the foundation of medical racism. On plantations, slaves were regularly subjected to harm. For instance, slave narratives and records revealed that slaves were “medically neglected and abused because they were powerless and invisible” (Washington 2006, 36).

Under brutal working conditions, the health of slaves rapidly deteriorated making them susceptible to diseases. Medical care for sick slaves was severely subpar, not only due to fatal misinformation about disease and bacteria but also because of the lack of care for the well-being of Black slaves (Washington 2006). If medical treatment was given at all to slaves, it was for the benefit of the slave owner. Since slaves were seen as property, their health and life insurance were tied to their ability to produce labor. Medical treatment for slaves included exposure to toxic materials such as mercury, chlorine, narcotics, and other dangerous drugs which injured, poisoned, and killed slaves (Washington 2006, 34). The lives of slaves were gambled on. Their bodies were experimented on. The justification of this treatment lies within the ideologies of white supremacy that enabled bigoted views of Black inferiority. Slaves suffered horrible deaths from mistreatment, sickness, and prolonged suffering.

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1I use distrust and mistrust interchangeably.
More recent incidents of medical racism can be found in the inception of birth control. To control ‘unfit populations,’ Margaret Sanger, a follower of eugenics, attempted to control reproduction among Black people. She believed that “the mass of ignorant Negroes still breed carelessly and disastrously, so that the increase among Negroes, even more than the increase in whites, is from the portion of the population least intelligent and fit, and least able to rear their children properly” (Washington 2006, 206). Sanger’s racist ideologies led her to target the reproductive health and rights of Black women. Sanger did not believe that Black people were fit to have children and duplicitously reached out to prominent members of the Black community, making claims to help the health of the community with a project. Believing that she had good intentions, many Black community leaders embraced her “Negro Project,” but little did they know of her ill intentions. Today, Sanger’s promotion of birth control to the Black community, within the context of eugenics, has added to the distrust Black people have towards medicine.

What’s evident throughout the history of the U.S. medical establishment is that medicine has failed Black people and that Black people have every right to be wary of it. The history of medical abuse against Black people is horrific, heartbreaking, and traumatizing. Knowing all this, should Black people be expected to move past this trauma? Should they be expected to trust a system that has historically not protected them? Medical racism is not just a thing of the past. It is still happening today, even when it might not be realized because of the subtleties of how it might play out. Black mistrust in medicine is an important topic that bleeds into other structures and establishments that have also failed Black people (i.e., the government). And while this topic of mistrust is continuing to gain more traction and attention in medical spaces through the
advocacy of Black doctors and health professionals, it is still necessary for the broader society to recognize its salience to other aspects of our structures and establishments.

The COVID-19 pandemic has been a period of global chaos. From overfilled hospitals to over 6 million deaths from COVID, the pandemic has been exhausting and overwhelming. On December 11, 2020, the U.S. Federal Food and Drug Administration (FDA) approved the first COVID-19 vaccine produced by Pfizer-BioNTech for emergency use (Commissioner 2020). For some people, the news of the FDA’s approval of this vaccine offered a glimmer of hope for a foreseeable end to the pandemic, but for others, this news raised alarm and suspicion. Since 2020, I have found myself in several Black spaces that engaged in discourse about COVID-19 vaccines and the pandemic in general. Some of the early discussions I participated in had one thing in common: a sense of hesitancy and mistrust surrounding the novel government-regulated vaccine to combat COVID-19. Several people expressed their concern about taking the new vaccine because they were suspicious of the government and its past with medical experimentation on Black people. Some were particularly suspicious of the intention behind the government’s approval of the vaccine, saying that the “government is out to get us [Black people].”

I was not surprised by these sentiments. Knowing even just a little history of the long brutalization Black people have faced under medical institutions, I could not expect Black people to trust the systems that had justified their violence in the past. Trust is something that is earned.

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2 I discuss COVID-19 pandemic more in-depth in chapter 2. Please refer to this chapter for more information.
It should not be assumed nor taken for granted. Initially, I framed this project around mistrust of the medical establishment and hesitancy toward the COVID-19 vaccines. I wished to understand the relationship between vaccine hesitancy and mistrust among Black people. Furthermore, I wanted to analyze if mistrust was connected to the initial low COVID-19 vaccination rates that were observed among Black people. However, through my research, I quickly came to realize how simplistic my thinking was. The truth of the matter was that the discussion of vaccination decisions was more complicated and nuanced. This is not to say that mistrust is not an important aspect of this discussion, but there is more to the story. Reasons for vaccine hesitancy among Black people are neither uniform nor universal. To deduce hesitancy as a product of mistrust would be incomplete. Also, not every Black person was suspicious or hesitant about the COVID-19 vaccine. Some of the people that I engaged with were excited to hear about the news of the vaccine, and even encouraged others to sign-up to receive it.

With those discussions in mind, my work aims to analyze the thoughts and perceptions of the COVID-19 vaccine more thoroughly among Black people. I aim to construct an inclusive narrative about vaccination decisions while deconstructing the “Black hesitant vaccine subject,” which has been publicized in public health spaces.

This thesis will analyze how the historical and current experiences of Black people in medical encounters have contributed to their mistrust of medicine, as well as structural barriers that reproduce health inequities. Thus, this thesis will resist the monolithic perspectives that assume all Black people feel the same way about the vaccine, the pandemic, etc… Furthermore, in this thesis, I do not generalize the experiences of the Black community or their thoughts surrounding the pandemic and the vaccine. With the desire to represent the diverse perspectives
about vaccines that I have encountered, my research aims to broaden the current discourse on Black mistrust in medicine with a specific focus on Black people’s attitudes and dispositions towards vaccines, including vaccine hesitancy and vaccine acceptance.

I am not only writing this thesis for my current self, but for my future self who aspires to be a doctor who provides holistic care for her patients while acknowledging how existing systems have failed people who look like her. I want to be able to share this work with people who wish to understand how mistrust and hesitancy of the medical establishment can affect the lives of Black people and hope for this work to inspire fruitful discussions around such.

Methodology

To better understand the perceptions and thoughts on the COVID-19 vaccine among Black people, I focused my research on a few different aspects: the historical and current anthropological perspectives on vaccination decisions, the historical experiences of medical racism, the current discourse on COVID-19 vaccination in the US among the Black people and interviewing Black people predominantly from the area of Northern Delaware.

To conduct the interviews, I developed an interview script that guided my semi-informal interview style. The script contained a set of questions that focused on collecting information about the interview participants’ demographic information, such as their hometown, educational background, and job occupation. I also asked questions that pertained to the participants’ experience during the COVID-19 pandemic, such as “how you have been affected by the pandemic” and “what are some of the experiences you and/or the people close to you have
had?”. I followed up with questions that pertain to their thoughts and perceptions about the COVID-19 vaccines, the mediums in which they learned about the vaccine, and what people around them have said about the vaccine. Depending on how the conversation went, I asked some interviewees how they felt about the mask and vaccine mandates that were implemented during the pandemic. Afterward, I asked the interviewees how they felt about the statement: “Black people are hesitant to take vaccine” to gauge their perspective on how they view vaccine hesitancy among Black people, and if they identified with the statement. To finish off the interview, I asked participants about their past medical experiences with questions such as “what have your experiences with healthcare, with doctors, or with other healthcare providers been like when it comes to yourself and those close to you?”, “have these experiences impacted your trust in medicine?” and “do you think race plays a factor in your experience?” I believe this interview-style approach allowed respondents the space and time to process the questions and reply to them as they saw fit. Interviews ranged from 30 to 60 minutes.

For recruitment, I primarily relied on the snowball method. During the summer and fall of 2021, I spoke generally about the nature of my thesis project to friends and family. Through these conversations, I found five potentially interested people in being a part of my project. In the recruitment process, I indicated that I was looking for Black-identifying individuals who were at least 18 years of age and lived in northern Delaware currently or at some point in their lives.

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3 I chose this area because of my family and friends predominantly live there.
For each person who was interested in my project, I emailed them a concise synopsis of the study. I also told them the purpose of the study was an exploration of thoughts and perceptions of COVID-19 vaccines and experiences among Black people and that they would receive a $20 gift card as compensation for their time. If potential interviewees were interested in continuing, I scheduled a time to meet over Zoom⁴ to limit the spread of COVID-19. In total, I interviewed five people. All interviewees were confirmed by January 2022 and all interviews took place during February 2022.

The ages of the interviewees ranged from 22 to 54. On average, all participants have lived in northern Delaware for at least 10 years. Three out of five of the respondents self-identified as Black/African American. One of the respondents identified as Black and Hispanic and another alluded to being a mixture of Black, Native American, and Honduran. The job occupations of my respondents varied from college students seeking to obtain degrees in Bachelor of Fine Arts to a paralegal and a software developer. The highest degree obtained among respondents was a Bachelor of Science. Two of my respondents disclosed that they did not finish college. These same respondents also considered themselves to be parents and were unvaccinated. All identifying information was hidden and protected to ensure confidentiality.

Given the sensitive nature of the project, I changed all the names of the interviewees. At no point did I ask respondents directly about their vaccination status. This information was only disclosed if they were comfortable with it.

⁴Zoom is an online video conferencing software.
There are a few potential limitations of this methodology. In addition to my small sample size, I used snowball sampling to recruit which cannot guarantee that my sample is representative of the Black population in the U.S. Due to this fact, I do not want to generalize the experiences that have been conveyed in this project. Though my sample size was small, there was a sense of familiarity and comfort that was shared between the interviewees and me which allowed our discussions to progress comfortably.

Researcher's Positionality

As a Black student researching this topic, I need to recognize my positionality in relation to the people I interviewed. Though I have come to learn how race bleeds into every aspect of society, it is also important to consider ways in which ideologies of racial capitalism have conceptualized Black people as a single, monolithic/homogeneous category or group. I must not reproduce these notions in my analysis. Black people should not be generalized in their thoughts and perceptions, especially regarding the COVID-19 vaccine. My goal is to contextualize their experiences in conjunction with the history of race and medicine, structural issues, and the diversity of opinions.

Chapter Overview

Chapter 1 of this thesis begins with a review of literature relevant to understanding vaccine hesitancy/refusal, COVID-19 vaccine hesitancy, and the intersection of race and medicine in the U.S. This chapter serves as a theoretical and analytical foundation for discussions of vaccination decisions and hesitancy within the Black community. Chapter 2 provides background information on the COVID-19 pandemic, current vaccines that are approved in the U.S., and the intersection between access to the vaccine and systemic racism.
Chapter 3 focuses on deconstructing hesitancy among Black people in public spheres. In this section, I focus on how public health messaging has been misleading and the ways vaccines are discussed in Black social media spaces. Chapter 4 follows a narrative of the current perceptions of the vaccine among Black people. Here, I will incorporate my interviews with Black people about their experiences and thoughts regarding vaccines, the pandemic, and medicine in general. Lastly, I conclude this thesis with broader perspective and a discussion of what was learned.
Chapter 1: Literature Review and Framework

On September 13, 2021, famous rapper Nicki Minaj tweeted that she would not be getting vaccinated just because the Met Gala required it for all its attendees. She further stated that she would receive the COVID-19 vaccine after she had “done enough research” on it. Approximately twenty minutes later, she amplified her stance on the vaccines by tweeting “My cousin in Trinidad won’t get the vaccine cuz his friend got it & and became impotent. His testicles became swollen. His friend was weeks away from getting married, now the girl called off the wedding. So just pray on it & make sure you’re comfortable with your decision, not bullied.” Nicki indirectly claimed that there is a link between the COVID-19 vaccine and

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5 An annual fundraising event that is held at the Metropolitan Museum of Art’s Costume Institute in NYC.
impotency\textsuperscript{6} which was quite dangerous. As a prominent figure in the pop-culture world, Nicki’s
tweets propagated through social media at alarming rates

![Nicki Minaj Tweet](image)

*Figure 2. A follow-up tweet from Nicki Minaj on September 13, 2021.*

Nicki Minaj’s vaccine skepticism and hesitancy ignited a social media controversy that prompted
responses from global health experts. Health experts such as Dr. Anthony Fauci\textsuperscript{7}, vocalized that
medical researchers have not found a link between the COVID-19 vaccine and infertility and
implored that tweets such as Nicki’s are evidence of misinformation about the vaccine that
circulate on social media platforms (Jones 2021; Timsit and Lati 2021).

However, Nicki Minaj is not the only one who has stated her stance on the vaccine. Her
skepticism about the vaccine is widely shared among people who are distrustful of medicine, the
government, and the motives of pharmaceutical companies. Vaccine hesitancy is not a recent

\textsuperscript{6} Erectile dysfunction

\textsuperscript{7} A renowned public health expert who has served as the director of the National Institute of
Allergy and Infectious Diseases (NIAID) since 1984. He is prime figure in the COVID-19 pandemic.
phenomenon, and it has existed since the beginning of vaccines themselves. A critical exploration of the thoughts and reasonings behind vaccine skepticism, hesitancy, and even refusal is needed to further understand the responses to the COVID-19 vaccine, particularly within the Black community, and how it connects to the history of race and medicine in the U.S.

Vaccination Decisions

What does it mean for someone to refuse vaccination? Or better yet, what does it mean for someone to refuse. A general definition for understanding refusal is as a synonym to resistance, especially public one. Erica Weiss, however, argues that there is more to this definition suggesting the radical possibility of viewing refusal as a quiet abstention (Weiss 2016). This quiet abstention implies a sense of avoidance to participate in certain acts governed by the state. Anthropologists, such as McGranahan, add to this narrative by defining refusal through an ethnographic lens (2016). Embedded within refusal is the inclusion of the “lived expectations, complexities, contradictions, and possibilities of any given cultural group” (McGranahan 2016, 335). This integrative definition takes a holistic approach to understanding refusal within a cultural context, but how does this relate to vaccine refusal?

In theorizing vaccine refusal, Soho argues that vaccine refusal begins long before the “said utterance or act” (Soho 2016, 341) implying that there is more to refusal than simple proclamations. Refusal can be defined as avoidance rather than a direct equivalence to the opposition. Like Weiss, Soho engages with the idea of refusal having overlapping meanings with resistance but cautions that combining refusal with the general ideology of resistance masks the socio-cultural and identity factors that influence vaccination refusal (2016). The overlap amongst
the works of Sobo, Weiss, and McGranahan brings together the idea that refusals are complex, both in terms of defining the act and the meanings of the act itself. Though the literature on vaccine resistance does not exclusively define the phenomenon on its own, the literature on refusal has provided some insight into understanding the phenomenon in more depth.

Why do people refuse vaccines? Vaccine refusers in the U.S. do not share a common or single unifying ideology that influences their decision (Larson and Mnookin 2016). For some time, it was thought that scientific illiteracy was the reason behind vaccine rejectionism (Sobo 2015). Since “public understanding of science was imperfect at best” (Sobo 2015), it was possible that people didn’t get vaccines because they didn’t understand how they worked. Even so, high scientific literacy can also intensify vaccine rejectionism (Kahan 2013; Sobo 2015). This seemed counterintuitive to what would be expected in vaccine refusers. Overall, it is important not to generalize the reasonings behind vaccine refusal.

Furthermore, to understand the counterintuitive findings behind vaccine refusal it is beneficial to look at vaccine decision-making in general. According to Poltorak and colleagues’ work which was focused on vaccination decisions, such decisions “depend not on a singular deliberative calculus and the information and education that informs it, but on contingent and unfolding personal and social circumstances in an evolving engagement” (Poltorak et al. 2005, 718). Their research revealed that the decisions of mothers to vaccinate their children were affected by “personal histories, by birth experiences and related feelings of control, by family health histories, by their readings of their child’s health and particular strengths and vulnerabilities, by particular engagements with health services, by processes building or undermining confidence and by friendships and conversations with others, which are shaped by
wider social differences and transformations (2005, 709). Along the same lines, Sobo characterizes vaccine decisions as a social process shaped by several social factors (2015).

According to a social network analysis done by Brunson, a parent’s “people network” notably affects their vaccination decisions (2013). “People network” refers to one’s spouse, health care provider, friends and so much more. Sobo further explained the results of Brunson’s study stating that “the proportion of people in subjects’ networks who promoted vaccine refusal and delay, or nonconformity was the most significant predictor of subject’s; own vaccine nonconformity...” (2015, 383). Essentially, this finding reveals that the more people in someone’s network that were vaccine refusers, the more likely that person would be a vaccine refuser themselves. This is all a part of the social process that shapes vaccination decisions. Being a vaccine refuser becomes an identity that reflects a particular social positioning. Additionally, Brunson’s study also suggested that media has some influence on parents’ vaccination decision-making, but it is not as strong as people networks (2013).

Still, there are other reasons people refuse vaccination. For instance, Sobo describes how parents in the Waldorf school community, many of whom are cautious about allopathic medicine, found western or “mainstream” medicine to be narrow-minded, simply treating symptoms without discovering the underlying issues behind the illness (Sobo 2015). One parent warned: “You don’t take something to necessarily get rid of a headache; you look at what is

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8 Waldorf schools are traditionally private schools made up of mostly white upper middle-class families.
underlying the fact that someone is getting headaches” (Sobo 2015, 389). A few parents endorsed the idea of homeopathy, suggesting that medicine should amplify the body’s natural responses to illness. Some parents cast doubt on the schooling and abilities of doctors trained in the U.S. To them, four years of education was not sufficient (even though medical training in the US is much longer than that) enough to be credible. They believed that they needed to take self-responsibility to educate themselves and not rely on the information they received from doctors (Sobo 2015). This self-responsibility was a symbol of “one’s capacity for independent thinking” (Sobo 2015, 385), a vital aspect of the community and the philosophies of Waldorf schools.

Other reasons for vaccine refusal are rooted in skepticism and cynicism about the intentions behind vaccine production (Reich 2010; Sobo 2015). For example, in regards to the Human papillomavirus vaccine (HPV), several parents objected to it because “they believed its approval and marketing resulted from political corruption, powerful lobbying efforts, and profit motives of large pharmaceutical companies” (Reich 2010, 172). People who have these concerns are coming across examples of pharmaceutical companies benefiting from vaccines. Examples such as Merck, a pharmaceutical company which witnessed an increase in their stock price from their vaccines such as Gardasil and RotaTeq, reinforce suspicions in the profit motives behind vaccine production (Reich 2010). Suspicions of a profit motive behind vaccine production have elevated the distrust of vaccines and their perceived efficacy. Which has led to increased concerns about the safety of vaccines and their necessity (Reich 2010; Sobo 2015).

Vaccine safety is another reason why people may refuse vaccines. In addition to suspicions about the motives behind vaccine production, concerns about vaccine safety have a few origins. For some, the speed at which vaccines are produced causes them discomfort. In a
study by Jennifer Reich on parents' health care and vaccine decisions, a participant expressed that her disapproval of the HPV vaccine was due to her doubts about the testing process (2010). She felt as though the vaccines were being rushed out onto the market for money reasons. Another participant in this study reported that her discomfort with the HPV vaccine was because it was untested on a wide range of the population and the potential side effects that may arise from a lack of “long term testing” (Reich 2010, 173).

This sort of thinking is not unfounded. Clinical trials in the US have been critiqued several times for lacking diversity because it leaves a big portion of the population out of the story (McGrail 2021). Furthermore, there are a few instances of vaccines that were discontinued due to vaccine safety (“FAQs about Vaccine Recalls | Vaccine Safety | CDC” 2020; Miranda Hitti n.d.). Additionally, the framing and marketing of vaccines have caused some to question their safety. The promotion of vaccines, though maybe in good faith, may cause more suspicion of vaccines. For instance, a parent in Reich’s study expressed that the promotion and marketing of vaccines can ignore how problematic vaccines can be themselves. She recalled a parenting magazine she had recently read that expressed excitement about a new vaccine that would provide six vaccines in one shot. This promotion was quite concerning for the participant because she felt as though there wasn’t much consideration of how unsettling the idea sounded (Reich 2010). Overall, the reasons for refusing vaccines are endless.

Like vaccine refusers, vaccine hesitant people have similar thoughts about vaccines but are slightly more nuanced. Vaccine hesitancy, according to the SAGE Working Group on Vaccine Hesitancy (WG), “refers to the delay in acceptance or refusal of vaccination despite the availability of vaccination services” (MacDonald 2015, 4161). Though vaccine hesitancy has
been described as a continuum between those who accept vaccines without doubt and those who refuse vaccines entirely, WG considers this continuum to be quite limiting in describing the group of people who consider themselves to be ‘vaccine hesitant’ (Dubé et al. 2013; MacDonald 2015). Vaccine hesitancy is complex. It depends on several components such as the cultural, political, social, and personal factors that influence vaccination decisions (MacDonald 2015; Konstantinou et al. 2021; Dubé et al. 2013). To be more specific, some of these factors include historical influences, geographic barriers, experiences within healthcare, relationship and communication with media, influential leaders and celebrities that are pro-vaccination and anti-vaccination, religion, culture, identity and so much more. Additionally, these factors can also interact with each other to influence vaccination decisions which can add another layer of complexity to the situation. Therefore, there is no simple answer to understanding vaccination decisions or why people are vaccine hesitant.

WG attempts to address this conundrum by framing vaccine hesitancy as a “behavioral phenomenon which is vaccine and context-specific measured against an expectation of reaching a specific vaccination coverage goal, given immunization available” (MacDonald 2015, 4162). In other words, vaccine hesitancy is a behavior that we understand within the context of data and the availability of vaccines. For example, vaccine hesitancy may appear in contexts where vaccination uptake is low due to system failures such as the limitation of immunization services (MacDonald 2015). However, it is important to note that low vaccination uptake is not solely due to vaccine hesitancy. It may be a factor, but it is not the only determinant. WG’s definition of vaccine hesitancy is a good starting place to begin understanding the phenomenon.
In summary, when discussing vaccine hesitancy, vaccine refusal, or other vaccine decisions, it is important to contextualize the determinants and the reasons behind these choices. Although we cannot generalize a singular reason behind these phenomena, we can, however, use current knowledge to understand how the COVID-19 vaccines are perceived in the United States and the choices people make about them. To take it a step further, I am particularly interested in how the COVID-19 vaccines have been framed and marketed especially in Black communities. Additionally, I want to understand the remarks members of the Black community have made about the vaccine. To do this, we need more racial depth in the discussion of vaccination decisions – something existing scholarships have attempted to address recently but still have ways to go.

The Legacy of Race and Medicine

To begin understanding the importance of race and medicine within the context of vaccination decisions within the Black community, one must address the structural factors, ideologies, and racial histories that have eroded the trust of Black people in the medical establishment (Miller and Miller 2021). The transgenerational trauma inflicted on Black people in the United States has impacted the relationship Black people have with medicine. The distrust in medicine produced from this trauma is the ramification of racism, particularly medical racism.9

9 Or Scientific racism.
The concept of race is embedded within every sector of the United States. In fact, it is integral to the foundation this country was built upon. According to Omi and Winant, “notions of race do not only inform our conscious understanding of the social world, but they also permeate our unconscious mind” (Omi and Winant 2015, 107). Therefore, notions of race within the field of medicine have shaped the treatment of Black people in the establishment. In her phenomenal book *Medical Apartheid*, Harriet A. Washington traces the long history of medical experimentation and abuse on Black people and its impact today (2006). Washington describes egregious examples of physicians who abused their roles as doctors to conduct experiments on slaves, and as horrifying as they were, none came close to the infamous experiments of James Marion Sims, revered as the “father of gynecology.” His approach to this work can be described as sadistic as best. He had little regard for Black people, particularly Black children, and women. He went as far as puncturing the skulls of Black infants, whom he believed to have bones, unlike white children, to open their skulls (Washington 2006). Yet, he didn’t stop there. He operated on young Black mothers with little to no experience in obstetrics and left several of them in miserable conditions. He would not treat his white patients the way he treated Black slaves. These are examples of the racist ideas permeating the space of medicine: Sims’ racist ideologies of the Black body justified his barbaric acts of violence. Yet, Sims is regarded as one of the many doctors who advanced “the campaign of scientific racism in medical education” (Miller and Miller 2021, 481).

Furthermore, Washington offers an outline of the events that followed the Tuskegee Syphilis Study. According to Washington, the “Tuskegee Syphilis Study is the longest and most infamous…experimental abuse of African Americans (Washington 2006, 192). The origin of the
Tuskegee Syphilis study had good intentions: to help Black sharecroppers of Macon County in Alabama in 1929. Syphilis, a sexually transmitted disease, can first appear as sores on genitals but if left untreated will develop into “an assortment of skin growths, running sores, gumma, bone decay, and heart damage… profound neurological damage—blindness, insanity (paresis), paralysis, and death” (Washington 2006, 169 -170). One of the sponsors of the Tuskegee Institute searched for syphilis-treatment programs up until he lost his funding from the stock market crash of 1929.

Since the study could no longer support itself, the U.S. Public Health Service (PHS) stepped in to take over. Unfortunately, PHS’s physicians did not care for the Black patients infected with syphilis as they should have. One physician expressed doubt about the possibility of eradicating syphilis among Black people. Other physicians “portrayed Black Alabamans as resistant to health measures, intellectually inferior, impetuous, degenerate, and, above all, at the mercy of frighteningly powerful sexual drives” (Washington 2006, 170). These harmful thoughts about Black people, in my opinion, unconsciously shaped how doctors treated them. Syphilitic Black male patients were monitored for almost 40 years (1932 to 1972) without ever receiving treatment for the disease, even though treatment for the disease became available in 1943. Why? Because this experiment was allowed to happen to Black people—a group of people that has been exploited and abused by the medical establishment. Many patients were simply left to die.

The result of such an incident “…left behind a damaging emotional legacy rather than an organized response to the tremendous toll of premature death and preventable disease that has afflicted African Americans over many generations” (Hoberman 2012, 18). But this incident is not the sole reason for the distrust of the medical establishment. Medicine has perpetually
Banjo committed atrocities against African Americans for centuries that have gone unchecked for a long time. I will not provide an exhaustive list of violence inflicted upon Black people under the banner of medicine. The purpose of sharing even these few examples is to shed light on the complex relationship Black Americans have with the medical establishment. We cannot forget this violence. We must consider the impact that it has had on Black people and their relationship to medicine.

In *Black and Blue*, Hoberman claims that some physicians are disturbed by the idea that racial differences may play a role in medical diagnosis and treatment options, yet published medical research in the last two decades shows that physicians make racially motivated decisions to “deny appropriate care to Black patients or to inflict on them extreme measures (such as amputations) that many white patients would be spared” (2012, 1). In other words, modern-day physicians are uncomfortable with accepting that racial bias still plays a significant role in medical practice, but evidence shows that race still plays a role in medical care. Hoberman continues to explain that most doctors do not think that information about medical racism matters in their professional careers (2012). Meaning that they did not see how medical racism impacted their lives, their practice, and the patients they saw. This attitude is quite dangerous as it ignores the history of the field that has mistreated Black people. To disengage from the history of medical racism is an act of violence. It ignores “the long history and persisting reality of racially motivated medical behaviors that can alienate, injure, and sometimes kill Black patients” (Hoberman 2012, 7).

We cannot separate the brutal history of the American medical system in the lives of African Americans and then wonder why we see distrust of the establishment within this
community. We also cannot ignore the impact race still plays in medicine today: racial health disparities exist. It is important to understand the legacy of medical racism because it is connected to the distrust of the medical establishment. Vaccines are an extension of the medical establishment.

COVID-19 Vaccine Decisions Among Black People

With an understanding of how race and medicine intersect in addition to previous scholarship on vaccination decisions, we can better understand forces shaping perceptions of attitudes towards the COVID-19 vaccines among Black people in the US.

The COVID-19 pandemic has had disastrous consequences. Amassing over 800,000 deaths since December 2021 in the US alone, the pandemic disproportionately affected African Americans (Laurencin 2021; Kricorian and Turner 2021; Balasuriya et al. 2021). Black people are more likely to work essential jobs and less likely to have jobs that allow them to physically distance themselves or stay home, leaving them vulnerable to contracting the disease (Laurencin 2021). In comparison to white people, Black people had significantly higher rates of COVID-19 cases, hospitalization, and death (CDC 2020). Pre-pandemic, racial health disparities existed as by-products of racism, slavery, structural violence, and poverty (Finerman, Williams, and Bennett 2010). Structural violence, a concept created by Johan Galtung in the 1960s, describes the social structures that perpetuate inequality and harm certain groups of people (Galtung 1969). Paul Farmer elaborates on this term defining it to be structures that are “embedded in the political and economic organizations of our social world; they are violent because they cause injury to people” (Farmer et al. 2006, 1686) and that it must be studied with an understanding of
Within the context of health disparities, structural violence points to the ways in which “social, economic, and political systems expose particular populations to risks and vulnerabilities that lead to increased morbidity and mortality” (Cher Chicago n.d.). The ramifications of these systems (i.e., racism, poverty, lack of access to quality care) have exacerbated the impact COVID-19 has had on the lives of Black people.

Since the rollout of the COVID-19 vaccine in late 2020, the discourse surrounding COVID-19 vaccines among African Americans is one that includes vaccine hesitancy, distrust, limited access, historical experiences of medical exploitation, and racism. In September 2021, the Kaiser Family Foundation (KFF) published data that showed that Black people received a lower share of COVID-19 vaccination in comparison to the total population. White people received the COVID-19 vaccination at a rate 1.2 times higher than Black people (Lopes et al. 2021). Laurencin in “Addressing Justified Vaccine Hesitancy in the Black Community” notes that several studies have shown that vaccine hesitancy within the Black community can be attributed to distrust in government and the medical field, and the U.S.’s track record of racism in medical research and care and that these could be possible explanations for low vaccinations among Black people (2021). However, Laurencin also claims that there are “systemic and structural challenges to inadequate vaccine production and distribution” (2021, 545). In other words, there were structural barriers that posed a threat to equitable vaccine distribution among Black people.

Therefore, low vaccination rates within the Black community cannot be attributed solely to attitudes toward the vaccines but also as a result of systemic failures that prevent access to the
vaccine as well. Bajaj argues that the racial gap in vaccination rates cannot be primarily attributed to historical traumas but to “everyday racism” that Black people experience (Bajaj and Stanford 2021). Bajaj claims that fixation on specific historical abuses such as the Tuskegee Syphilis Study takes attention away from the abuse Black people suffer in the clinical encounters today, and it would be better to frame the conversation of mistrust in the COVID-19 vaccines in terms of everyday racism. This author raises an important point that there are some Black people who do not even know of the historical medical abuses that Black people have faced. It would be inaccurate to attribute their distrust of medicine, vaccines, etc... on these atrocities. Personal experiences in medicine now would be a better marker for understanding distrust. This experience of ‘everyday racism’ is important in contextualizing the experiences of Black people in medicine.

Other reasons for hesitancy and distrust within the Black community can be due to social media and misinformation. Social media can be an avenue through which information can spread like wildfire. False information about the vaccine can influence vaccination decisions and contribute to vaccine hesitancy (Laurencin 2021). When false information is transmitted through social media it can be manipulated and targeted to underserved communities (Conger 2021).

This chapter builds a conceptual framework surrounding vaccination decisions, the legacy of race and medicine and current literature on vaccination decisions among Black people. Building upon this foundation, I explore complexities behind vaccination decisions and deconstructing hesitancy in the later chapters.
Chapter 2: Pandemic, Vaccination and Black Communities

“It’s going to disappear. One day, it’s like a miracle, it will disappear”

– President Trump, February 27, 2020, on the coronavirus

Beginnings of the Pandemic

In mid-December 2019, multiple clusters of patients in Wuhan, China began to experience fever-like symptoms and shortness of breath (Senser 2020). On December 30, 2019, the Chinese doctor Li Wenliang, a whistleblower, sent out a message to other doctors in the Wuhan area warning them of the novel disease. Immediately after this, he was accused by the local police of spreading false information, which would result in an investigation (Gewirtz 2020). About a week later, Chinese authorities revealed that a new coronavirus disease was the cause of the outbreak. On January 11, 2020, the Wuhan Municipal Health Commission announced that a 61-year-old man had died from respiratory failure caused by the novel coronavirus known as SARS-CoV-2 named by the World Health Organization (WHO) (CNN Editorial Research n.d.).

Around this time in the United States, the Center of Disease Control and Prevention (CDC) implemented health screenings for all passengers on flights from Wuhan, China that would arrive at major airports such as Los Angeles, New York, etc… Despite warnings from

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10 Someone who informs others on the dangers of an activity that could be a danger to other people.

11 SARS-CoV-2 was also officially named COVID-19 by the WHO.
U.S. intelligence about the possibility of an outbreak, President Trump did not take the virus seriously (Goodman and Schultin 2020). On January 20, 2020, the CDC announced the first case of SARS-CoV-2 in the U.S was found in Washington state (Senser 2020). Two days after this announcement, President Trump told the American people that “We have it totally under control. It’s one person coming in from China. It’s going to be just fine” (Dogget 2021). However, this was only the beginning of the impending disaster of what we now know as the COVID-19 pandemic.

On January 31, 2020, the WHO declared the coronavirus a public outbreak of “international concern” (Senser 2020). Countries all around the world began reacting to the news of coronavirus cases by implementing travel restrictions from Wuhan (Goodman and Schultin 2020). About a week later, the Chinese doctor, Li Wenliang, died of coronavirus sparking outrage on the Chinese social media platform, Weibo (CNN Editorial Research n.d.). Despite the increasing number of cases growing globally and in the United States, President Trump continued to minimize the severity of the pandemic making claims such as “I think the virus is going to be – it’s going to be fine” and “looks like by April, you know in theory when it gets a little warmer, it miraculously goes away.” (Dogget 2021). Then he lied to Americans that the coronavirus cases will decrease (Goodman and Schultin 2020). The virus was not fine, and the coronavirus cases did not decrease. By the end of February, the number of COVID-19 cases had increased from 6 (at the end of January) to 62 confirmed cases (WHO 2020).
On March 11, 2020, COVID-19 was declared as a pandemic\textsuperscript{12} by the WHO. Two days later, President Trump announced a nationwide emergency, and following this was the closure of U.S. states to stop the spread of the virus (Senser 2020). From the cancellation of sporting events to college students being abruptly sent home, to nationwide shortages of personal protective equipment (PPE), the rippling effects of the pandemic spilled into everyday life (Katella 2021). The world was brought to a screeching halt and life as we knew it would be changed forever. On March 16, 2020, the White House announced social distancing measures, banning gatherings of more than 10 people (NPR 2020). People were encouraged to stay home, and if they were to go out, to keep six feet apart from other people. Though they were created to minimize the transmission of COVID-19, social distancing measures would separate people, families, and friends for a period. The uncertainty of the future was high. People began panic-buying in grocery stores, clearing out

\textsuperscript{12} A pandemic is defined as an epidemic (disease) that spreads all over the world.
shelves of toiletry products, cleaning supplies, and other everyday necessities (Lufkin 2020). Shortages were inevitable and stores scrambled to restock their items.

Coronavirus cases skyrocketed. By March 23, 2020, there were more than 40,000 confirmed COVID-19 cases and 473 deaths (Robert Heimer, Jiang, and Peterson 2020). U.S. hospitals were not adequately equipped to face the multitude of challenges that would come with the increasing number of cases. Not only did hospitals not have enough PPE for the staff, but they also had difficulty maintaining staff and healthcare workers. The current healthcare workers were overburdened and overworked which took a toll on their mental health (Grimm 2020). With healthcare staff members spread thin and a lack of critical materials, such as cleaning supplies, medical gas, and ventilators, both patients and staff members were put at risk to contract the virus. Some hospitals, at this point, were forced to adopt a triage policy in regard to patient care and ventilator allocation (Ruderman 2020). “Who lives and who dies” was the question to answer. With limited resources, hospitals were left with the bioethical dilemma of choosing who would receive care and who wouldn’t. By April 6, 2020, the U.S. surpassed 10,000 coronavirus deaths (Calfas, Ping, and Kotsov 2020).

And still, in the middle of all the chaos, racial health disparities were exacerbated. In April 2020, civil rights leaders and doctors advocated for the CDC to release COVID-19 data on African Americans citing that African Americans were affected by the pandemic disproportionately in comparison to other races (V. Williams 2020; Senser 2020). In a letter written to Alex Azar, secretary of the U.S. Department of Health and Human Services, by the Lawyers’ Committee for Civil Rights Under Law, doctors and civil rights activists wrote that the “...lack of transparency and data [COVID-19 data on African Americans] is preventing public
health officials from understanding the full impact of this pandemic on Black communities...” Furthermore, they also stated that they were concerned that African Americans had lower access to COVID-19 testing which may delay treatment and increase the mortality rates among Black people (Press 2020).

Early COVID-19 data recorded that African Americans were contracting and dying from COVID-19 at higher rates than other groups (Ray 2020; J. Williams 2020). For example, in places such as Chicago and Louisiana, Black people made up about 70% of COVID-19 deaths during this time (Senser 2020; J. P. Williams 2020). This was alarming considering that Black people are a minority in these areas and yet made up a huge percentage of COVID-19 deaths. Black communities were hit hard by the pandemic due to pre-existing racial health disparities, poverty, and structural racism. COVID-19 exposed our failing healthcare infrastructure and exacerbated its pre-pandemic problems. In this section of my thesis, I discuss COVID-19 and its impact on Black communities and workers. I have also specified which Black communities were most affected because they were not affected equally. In addition to this, I have discussed COVID-19 vaccines, inequalities of vaccine distribution, and vaccination efforts within Black communities.

**What is SARS-CoV-2?**
There is a distinction\textsuperscript{13} between a virus and a disease. A virus is an infectious agent that requires a host, such as a person, animal, or plant, to survive and multiply (Mayo Clinic 2020). A disease, according to Doctor Marshall Marinker, is defined as a “pathological process most often physical as in throat infection, or cancer of the bronchus, sometimes undetermined in origin, as in schizophrenia. The quality which identifies disease is some deviation from a biological norm” (Marinker 1975, 81). Diseases can be thought of as deviations from the norm\textsuperscript{14} that affects a part of the body. Severe acute respiratory syndrome 2 (SARS-Cov-2) is the virus attributed to the development of coronavirus disease also known as COVID-19 (Mayo Clinic n.d.). Origins of the virus are currently unknown as investigations to determine it have been inconclusive thus far (WebMD 2021). Due to the nature of viruses, SARS-Cov-2 has had a few variants due to mutations in its genetic code (CDC 2020). The virus is also very transmissible and spreads very easily “through droplets and virus particles released into the air when an infected person breathes, talks, laughs, sings, coughs or sneezes” (Hopkins Med n.d.). COVID-19 has several symptoms including cough, muscle aches, fatigue, and so much more. Some people contract ‘mild COVID-19’ meaning that they have little to no symptoms, but those who develop severe symptoms may experience respiratory failure, organ damage or death (Hopkins Med n.d.). The virus also has the potential to exacerbate pre-existing medical conditions\textsuperscript{15}. People who have pre-existing conditions are more likely to develop a severe case of COVID-19 outcome. The current

\textsuperscript{13}This is for clarification purposes because sometimes people can confuse the two words.
\textsuperscript{14}Defining what is ‘normal’ can be difficult. The term is socially constructed based on cultural and social norms.
\textsuperscript{15}Underlying medical conditions and pre-existing medical conditions are used interchangeably.
mortality rate for COVID-19 in the United States is 1.2%, but this statistic may look different when you break it down by things such as race and socioeconomic status. For example, in comparison to White people, Black people are 1.7x more likely to die from COVID-19 and 2.4x likely to be hospitalized for COVID-19 (Table 1). When the COVID-19 death cases are broken down by age, it is evident that people over the age of 50 are more likely to die from the disease (Figure 5).

![COVID-19 Cumulative Crude Death Rates in the U.S.](image)

*Figure 4. Elisabeth Gawthrop, The Color of Coronavirus (AMP Research Lab, 2022)*

<table>
<thead>
<tr>
<th>Rate ratios compared to White, Non-Hispanic persons</th>
<th>American Indian or Alaska Native, Non-Hispanic persons</th>
<th>Asian, Non-Hispanic persons</th>
<th>Black or African American, Non-Hispanic persons</th>
<th>Hispanic or Latino persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases(^1)</td>
<td>1.6x</td>
<td>0.7x</td>
<td>1.1x</td>
<td>1.5x</td>
</tr>
<tr>
<td>Hospitalization(^2)</td>
<td>3.1x</td>
<td>0.8x</td>
<td>2.4x</td>
<td>2.3x</td>
</tr>
<tr>
<td>Death(^3)</td>
<td>2.1x</td>
<td>0.8x</td>
<td>1.7x</td>
<td>1.8x</td>
</tr>
</tbody>
</table>

*Table 1. Center for Disease Control and Prevention, Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity (2022)*
Who Gets to Social Distance: The Story of Black Essential Workers

When the pandemic first hit, life stopped for many people. With social distancing guidelines in place, many jobs abruptly closed their offices and workspaces and created policies for remote work. Teachers educated students through Zoom classes, jobs were completed from the comfort of home offices, and people were able to meet virtually to reduce the spread of COVID-19. But which jobs could take advantage of this new workplace dynamic? According to data collected by Pew Research Center, adults who have achieved higher levels of education and income are more likely to say that their work can be done remotely. On the contrary, those
who have lower income are more likely to say that their work cannot be done from home (Parker, Horowitz, and Mikin 2020). This means higher-paying jobs are more likely to be able to be done remotely than low-paying jobs. Although remote work existed before COVID-19, it is not excused from the systemic and structural inequalities that exist in our society. Putting in place “Social distancing guidelines”, public health officials recommended that people shelter in place at home and stay six feet apart from others if they were to go out, but this was not feasible for jobs that were deemed “essential” by federal and state executive guidelines (McNicholas and Poydock 2020). According to the CDC, essential workers are “those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the United States (U.S.)” (CDC 2021).

Transportation, health care, emergency services, and food services are examples of sectors that the CDC considers to be essential (McNicholas and Poydock 2020). These sectors typically require workers to be in-person, exposing them to COVID-19 more than those who have the option to work virtually. Some essential workers reported not being provided proper PPE by their workplaces to protect themselves from contact with other people and others reported having poor working conditions (Stewart 2020; Rosenthal 2020). Additionally, most essential jobs are low wages. As essential workers put themselves at risk to go to work, many of them earned wages that barely allowed them to make ends meet (Kinder and Stateler 2021).

Black people make up about 15% of the workforce in essential jobs and 19% of the workforce in low-wage frontline essential jobs, yet they make up 13% of the population in the U.S (Thorbecke 2020; McNicholas and Poydock 2020; Kinder and Ford 2020). In comparison to White people, Black people are more likely to have jobs that were deemed essential – cleaning
services, transportation, food services, etc.... According to Rogers and colleagues, Black people disproportionately “hold the top nine jobs that placed them at high risk for contracting” the virus and passing it on to their families (Rogers et al. 2020, 319). With little support from businesses and industries, Black essential workers were expected to show up daily and perform their duties. However, there is a contradiction: essential workers are important to the survival of society, yet their lives are considered expendable. It’s one thing for jobs to require being around a lot of people. It’s another thing for a job to require you to be around people during a pandemic without proper PPE. Black essential workers were valued for their labor, but their lives were simultaneously disregarded (Williams et al. 2020). Black laborers are overrepresented among the millions of essential workers who earn less than $15 an hour (Kinder and Stateler 2021). Not only were they more exposed to their virus, but they were also poorly compensated for this sacrifice which wasn’t even one they signed up for. Black labor is the backbone of our economy, but it has been this way since chattel slavery. After the brief closure due to the pandemic, state governments began setting plans in place to begin the reopening process of their states from April 2020 to July 2020 (Times 2020). The reopening of states exacerbated the impact of COVID-19 on Black communities. Black essential workers were placed in a position to come into more contact with people which would result in a higher likelihood of contracting the virus. It was a careless decision for states to begin opening back up as COVID cases surged. This decision revealed where the priorities of states and businesses lie and it was not with the health and safety of essential workers, especially Black laborers. Unfortunately, maintaining the economy mattered more to those in power than the lives of those who kept it going.
COVID-19 highlighted the structural inequalities that exist within society. Structural inequalities are maintained through disenfranchising certain groups of people. For Black people, centuries of structural racism have affected their lives for generations. These structural inequalities have permeated every aspect of their lives (e.g. housing, employment, education, etc….) which has contributed to their overrepresentation among essential workers, racialized segregated residential spaces, educational inequality, and health disparities (Thorbecke 2020; Yancey-Bragg 2020; Catalyst 2020). Housing disparities suggest that Black people are more likely to live in highly dense populated areas which also leaves them more vulnerable to contracting COVID-19 (Garfield, Artiga, and Orgera 2020). These areas tend to be poor with dilapidated housing, fewer access to goods and services, and food deserts (Noppert 2020; Garfield, Artiga, and Orgera 2020). Data also shows that Black people are also more likely to live in multi-generational housing which can exacerbate the transmission of the virus (Eugene Scott 2020). All these factors can result in racial health disparities which provide an explanation as to why the Black working class was hit the hardest amongst Black communities. It is important to specify this because the Black working class not only is overrepresented amongst essential workers, but they are also more likely to be earning low wages and living in poorer densely packed areas.

Development of COVID-19 Vaccines

To fight the virus, research scientists worked tirelessly to produce a vaccine effective to decrease the chances of experiencing COVID-19 symptoms. Vaccines are biological substances
that stimulate the immune system to fight against pathogens that cause disease (Policy (OIDP) 2021). Once vaccinated, the body can produce immune responses to the disease without causing the symptoms (WHO 2021). Vaccines are not cures, however. They are used proactively to prevent diseases and cures are used to treat diseases after a person has been infected by them (Forward 2020).

Vaccine development is a long and arduous process. It can often last up to 10 to 15 years involving multiple steps that include public and private participation (History of Vaccines n.d.). However, COVID-19 presented a dire situation, and its vaccines were rapidly developed in response to it. In December 2020, the FDA granted an emergency use authorization of the Pfizer-BioNTech, Moderna, and Johnson & Johnson’s Janssen COVID-19 vaccines before full approval (Ledford 2020; Maragakis and Kelen 2022). The speed at which these vaccines were approved for emergency use reflected the “urgent need to protect people from the coronavirus pandemic...a public health emergency”

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16 Viruses, bacteria, or microorganisms that cause disease
17 Administering the vaccine into the body via injection, inhalation, or orally.
18 Also called Pfizer vaccine.
19 Also called the Spikevax vaccine
(Maragakis and Kelen 2022). The Pfizer and Moderna COVID-19 vaccines use messenger RNA (mRNA) that produces a protein similar to the surface protein on coronaviruses.

This information is used by the body to create antibodies\(^{20}\) that will be used to attack coronavirus if it were to enter the body (Mayo Clinic n.d.). The Pfizer and Moderna vaccines require two doses to be considered fully vaccinated (Mayo Clinic n.d.). In 2021, the FDA approved a booster shot\(^{21}\) for the Pfizer and Moderna vaccines after at least five months following the required doses (Maragakis and Kelen 2022). Recently, the FDA approved a second booster shot of the Pfizer and Moderna COVID-19 vaccine for Americans ages 50 and older (Lovelace 2022). The Pfizer vaccine is reported to have a 91% efficacy in preventing severe symptoms from COVID-19 while the Moderna is reported to have a 94% efficacy (Mayo Clinic n.d.).

The Johnson & Johnson’s Janssen COVID-19 vaccine is a vector vaccine. This kind of vaccine is made from the genetic material of the COVID-19 virus and then placed into a live virus that will be administered to the body. Like the mRNA vaccine, the genetic material of the virus produces a surface protein that stimulates the immune response (Mayo Clinic n.d.). The Johnson & Johnson’s Janssen vaccine only requires 1 dose to be fully vaccinated. However, the booster shot approved for this vaccine is either the Pfizer or the Moderna COVID-19 vaccine two months after full vaccination (CDC 2022). Currently, the Johnson & Johnson’s Janssen vaccine has an 85% efficacy in preventing severe COVID-19 illness 28 days after vaccination.

\(^{20}\) Proteins that bind to the surface of foreign pathogens.
\(^{21}\) An additional half dose of a vaccine to help maintain protection from disease.
Despite this, there is a chance one may develop blood-clots (Mayo Clinic n.d.). The production of the COVID-19 vaccine presented a turning point in the pandemic. At this point, the vaccine was an avenue of hope of returning to life pre-pandemic. Though the vaccine is meant to mitigate the effects of COVID-19, the novelty of the vaccine created suspicion around its intention, effectiveness, and safety.

![Sandra Lindsay, a New York Nurse, is the first to receive the COVID-19 vaccine in the US](Governor Cuomo’s Office)

**Figure 7. Sandra Lindsay, a New York Nurse, is the first to receive the COVID-19 vaccine in the US**

**Not Everything is About Vaccine Hesitancy**

In the previous chapter, I mentioned that decisions about vaccinations are quite complex and involve several different factors. In early to mid-2021, many people cited ‘vaccine hesitancy’ as a primary reason for low COVID-19 vaccination rates among Black Americans (PBS 2021). However, the oversaturated narrative of vaccine hesitancy is dangerous and incomplete. It blames individuals and masks the systemic barriers that contributed to the low COVID-19 vaccination rates among Black people. Vaccination is a personal choice. However, when groups of people have or experience limited access to the COVID-19 vaccines and do not have the opportunity to make their own vaccination decisions, then it becomes a collective issue.
According to data provided by the Kaiser Family Foundation (KFF), it revealed that barriers to vaccination such as a lack of health insurance can impact access to healthcare (Artiga and Kates 2020). In 2019, 11.4% of Black Americans, who are non-elderly, remain uninsured.

Another barrier to COVID-19 vaccination was the online registration for a vaccine appointment which often required pages of documentation. In a survey conducted by Pew Research Center in 2015, they found that Black and Latinx households are less likely to have high-speed internet access and a computer in comparison to White and Asian households (NW, Washington, and Inquiries n.d.; Atske and Perrin n.d.; Perrin and Duggan 2015). Additionally, people of color are more likely to work jobs that do not give them time to look for vaccination appointments (much less attend a vaccine appointment) (Lewis 2021). This was unsurprising since we know that Black people disproportionately hold essential jobs that not only compensate poorly but are also inflexible in their work hours.

A discussion of inequities in vaccine distribution is vital. In February 2021, a scandal erupted in Philadelphia over vaccination efforts. The organization “Philly Fight COVID” (PFC) was a non-profit start-up that initially focused on coronavirus testing and mass vaccination (Feldman, Marin, and Yu 2021). The group itself was founded by 23-year-old Andrei Doroshin, a Drexel grad student. He assembled together people from different backgrounds in marketing, engineering, and medicine, yet he himself had no background in healthcare (Emily Scott 2021; Feldman, Marin, and Yu 2021). The startup, though it had wholesome origins, began going downhill after Doroshin unveiled his plans for PFC to make money from mass vaccination by charging insurance companies money for each administered dose of a COVID-19 vaccine.
In January 2021, PFC held its first mass vaccination. This event was an informal partnership with the Philadelphia Department of Public Health and Mayor Jim Kenney, who believed this event would help racially diversify COVID-19 vaccine recipients in Philadelphia. 2500 doses were administered that day. This almost seemed like good news until the City Council President Darrell Clark asked for a demographic breakdown of all the recipients of a COVID-19 vaccine that day. PFC failed to provide racial and ethnic data of the recipients. This was suspicious. Why were they not able to provide this data? I suppose it was because the data would show an inequitable distribution of the vaccines which would be alarming considering that a huge portion of Philadelphia’s residents are Black.

After this incident, the start-up was investigated more closely. PFC continued to hold mass vaccination as well as plan for community mass testing events. PFC unexpectedly shut down its plans for mass testing, leaving the organizations (e.g. Black churches) that it had closely planned testing events in a limbo jeopardizing the plans for testing in communities of color (Feldman, Marin, and Yu 2021) Soon after this, PFC decided to scratch COVID-19 testing altogether because its founder did not consider it to be important anymore. PFC even decided to stop using “best practices” during vaccination appointments (Feldman, Marin, and Yu 2021). At this point, it was evident that the group was deviating from its original goals and their demise was inevitable. They were no longer focused on helping people get vaccinated but on how to profit from the situation. Eventually, issues with PFC’s vaccine appointment scheduling developed which caused booking issues. This forced people to be turned away from their vaccine appointment even though there were enough vaccines available. Let me reiterate: People who
signed up to receive the COVID-19 vaccine were turned away even though there were enough vaccines available.

Figure 8. People waiting in line at a COVID-19 vaccination site in February 2021 (AP Photo and Matt Rourke)

How was this equitable? With an excess of COVID-19 doses left over volunteers at PFC’s mass vaccination events let their families and friends know about the leftover vaccines.

Doroshin also grabbed handful of these extra vaccines for his friends and family members (Feldman, Marin, and Yu 2021). This situation was chaotic for everyone involved, but there is something to be learned from this example. In a Black populated city like Philadelphia, vaccine inequities were present. Not only did PFC fail to disclose the demographics of its patients, but they also failed at supporting the organizations that do the groundwork in supporting Black communities in their battles with COVID-19. I cannot help but wonder how many people had to turn away due to their inadequacies. Do Black communities benefit from incompetent vaccine distributions? They do not.

Black Doctors COVID-19 Consortium (BDCC)
Though PFC failed the Black community of Philadelphia, the Black Doctors COVID-19 Consortium came together to address issues about the disproportionate impact of COVID-19 on Black and brown communities (Schlosberg, Davis, and Ghebremedhin 2020). Founded in 2020 by a visionary and community leader, Dr. Ala Stanford assembled a collective of medical professionals within 48 hours that would be known as BDCC. Her organization created “a testing and vaccination alternative targeted to communities of color in Pennsylvania” (Penn Live, 2021). Currently, the BDCC provides free testing and vaccination clinics for the worst-hit areas of Philadelphia. Additionally, they also provide home vaccinations for accessibility purposes (Chinchilla 2021b). The BDCC has provided COVID-19 testing to more than 25,000 native Philadelphians and administered over 50,000 vaccine doses (1000 of which include homebound vaccinations) (Penn Live, 2021).
In 2021, the organization was awarded Philadelphia’s top award for service: Magis Award (Chinchilla 2021b). Serving primarily Black Philadelphians, BDCC has been touted as a trustworthy organization that prioritizes conveying the safety and effectiveness of the vaccine to communities of color (Chinchilla 2021a).

Since its inception, the group has promoted equitable vaccination distribution among people of color. Discussions on low vaccination rates among Black people should include vaccine accessibility and structural barriers which contribute to the issue. Not everything is about vaccine hesitancy. Though it can be a factor in decisions about vaccinations, it would be an over-generalized statement that absolves institutions of their role in perpetuating structural barriers that limit access to the COVID-19 vaccines among Black people.
Chapter 3: Deconstructing Black Vaccine Hesitancy in Public Spheres

In the past chapter, I spent time illustrating that low-vaccination rates among Black people cannot be chalked up to just vaccine hesitancy and/or mistrust. Sometimes data does not tell the full story which includes the nuances and contributions of structural barriers and accessibility issues that prevented Black people from receiving the COVID-19 vaccine. This is not to say that hesitancy and mistrust are not a factor in this discussion because it is. However, it is dangerous to only focus on just this part. It absolves institutions from being accountable for structural barriers and heterogenous variables that affect vaccination decisions.

This section of the thesis focuses on deconstructing Black vaccine hesitancy of COVID-19 vaccine in public spheres (public health messaging and social media). I discuss the ways in which public health messaging has been misleading in its analysis of Black vaccine hesitancy through homogenization of Black people and assumptions of the role racial history has played in shaping vaccination decisions. Additionally, I include a social media analysis of how the COVID-19 vaccine is discussed in predominantly Black social media spaces. The purpose of this is to present a diverse perspective of the different views of Black people in social media spaces in resistance to monolithic narratives that assume Black people feel the same way about COVID-19 vaccines.

Fixation on Racial Atrocities

“All generalizations are dangerous, even this one”

- Alexandre Dumas (July 24, 1802)
When it pertains to epidemiology, this field seeks to identify the causes of disease to improve the mechanism that applies to maintaining public health (Lesko et al. 2017). Paul Farmer describes standard epidemiology as "narrowly focused on individual risk and short on critical theory" (P. Farmer 1996, 265). When epidemiology is broadened to public health, there is a tension that exists between internal and external validity (Balzer 2017). From an epidemiological standpoint, internal validity is the extent to which the result of a study is can determine a cause-and-effect relationship between diseases and the individuals that were studied. External validity is the extent to which the internally validated study can be generalized to a target population (Patino and Ferreira 2018; Lesko et al. 2017). However, there are limitations to this aspect. Invoking generalizability can be problematic (Linton 2020). For results to be generalizable, it implies there is a shared characteristic among the individuals studied and the broader population. This idea of a shared characteristic(s) can permit the homogenization of certain populations. Since epidemiology is a fundamental component of public health, we cannot neglect how this ideology is reproduced in the public sphere.

Public health messaging is important. It can influence the ways in which people perceive and understand certain issues. It's crucial for public health messaging to be careful and thoughtful in how it frames issues. In regard to the attitudes and perceptions of the COVID-19 vaccine, there was an unsettling hyperfocus on Black Americans. Even before the vaccine roll out in December 2020, several studies and articles remarked on the attitudes of Black people, citing things such as: “Survey finds that Black people are more hesitant about the vaccine.” Black people became a pinnacle point of the issue on vaccine hesitancy.
Black Americans are the most hesitant to get a COVID-19 vaccine

Karen Weintraub
USA TODAY
Published 6:33 a.m. ET Oct. 29, 2020 | Updated 11:46 a.m. ET Oct. 29, 2020

Coronavirus vaccines face trust gap in Black and Latino communities, study finds

By William Wan
November 23, 2020

Black People Are More Hesitant About A Vaccine. A Leading Nurse Wants To Change That

November 24, 2020 - 5:34 PM ET
Many of these articles would cite that the reason for hesitancy included mistrust due to racist medical history i.e., Tuskegee Syphilis Experiment \(^{22}\)(Wan 2020; Weintraub 2020). It was almost as if there was an expectation for Black people to be hesitant. This set a precedent for understanding vaccination decisions among Black people. Black people were assumed to be hesitant.

As mentioned in Chapter 2, low vaccination rates were observed among Black people initially. Due to the precedent of vaccine hesitancy among Black people, many people attributed low vaccination rates to this. Furthermore, to explain the phenomenon, journalists, public health officials and politicians began invoking the Tuskegee Syphilis experiment as a way to explain hesitancy and low vaccination among Black people (Dembosky 2021a; “Conversations With America: Unpacking the COVID-19 Vaccine - YouTube” 2021; “(276) Governor Cuomo Delivers Virtual Remarks at Abyssinian Baptist Church - YouTube” 2021). The lingering effects of The Tuskegee Syphilis \(^ {23}\) experiment became the prime reason for hesitancy among Black people in public spheres. Karen Lincoln, an associate professor at the University of Southern California, says that Tuskegee is mentioned every time in discussions about why Black people seemed to be more hesitant about the vaccine or had lower COVID-19 vaccination rates in (Dembosky 2021b). Lincoln explained that Tuskegee had become a “scapegoat,” for “why many African Americans

\(^{22}\) See chapter 1 for more information.
\(^{23}\) Tuskegee Syphilis experiment is also referenced as just ‘Tuskegee.’
are hesitant, it almost absolves you of having to learn more, do more, involve other people — admit that racism is actually a thing today.” (Dembosky 2021a).

This excellent quote by Karen Lincoln wrapped everything up perfectly: using racial atrocities, such as Tuskegee, to explain is low vaccination and/or hesitancy is flawed. It is a dangerous generalization that overshadows the historical and structural barriers that prevented Black people from being able to receive the vaccine. Essentially, blaming vaccine hesitancy on Tuskegee was an overestimation. In “Beyond Tuskegee – Vaccine Distrust and Everyday Racism,” Bajaj and Stanford comment that “These historical traumas certainly provide critical context for interpreting present-day occurrences. But attributing distrust primarily to these instances ignores the everyday racism that Black communities face” (Bajaj and Stanford 2021).

How much does Tuskegee’s legacy affect vaccination decisions? According to Maxine Toler, a 72-year-old Black woman who is the president of her senior advocacy club and spends times asking her Black neighbors in LA on their thoughts about the vaccine, explained that people who did not want the vaccine had “modern reasons,” which included religion, safety, and “distrust of the former President Trump’s relationship with science” (Dembosky 2021a). She also included

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24 Discussed more in-depth in Chapter 1.
that only a few people mentioned Tuskegee and if they did, they did not have the best memory of the events. Placing emphasis on Tuskegee obscures the reasons for vaccine hesitancy among Black people. Additionally, it homogenizes the opinions and perspectives of Black people on the vaccine. There are a myriad of variables that influence vaccination decisions and perceptions.

Vaccine Perceptions in Black Social Media Spaces

Social media has played a huge role during the pandemic. From Twitter to Reddit, social media is a space for people to come together and share information and knowledge. It is defined as platforms where people find others who share their same identity, views, and interests. In other words, it’s an internet-based community space. Positively, finding spaces and communities that interest you can strengthen your relationships and connections. However negatively, finding spaces that you can identify with the potential to polarize groups and how they feel towards certain things such as the COVID-19 vaccine. From the works of Poltorak and Sobo 25 (Sobo

25 I discuss these two works more in-depth in the literature review in chapter 1.
2015; Poltorak et al. 2005), we understand vaccination decisions as a social process shaped by social factors and engagements with other people. Though these works were not focused on analyzing social media, they can still be applied to it: the conversations that take place through social media can also be a part of the social factors that shape vaccination decisions. Brunson has suggested that the media can have some influence on vaccination decisions and perceptions (Brunson 2013).

This section explores the current perceptions and discussions about the COVID19 vaccine in online Black spaces (i.e., ‘Black twitter’\(^{26}\)). Black social media, and the comment sections of Instagram posts. Analyzing how the vaccines are being discussed in these spaces may provide insight into the various ideas and perceptions about the COVID-19 vaccines within the Black community in resistance to public messaging of homogeneity and to highlight the heterogeneous perceptions of the pandemic and the vaccines. This provided insight into the vaccination decisions among Black people and the complex relationship between Black people and the American medical establishment.

From June 2021 to December 2021, I spent time bookmarking posts that I came across on social media from either Black people or Black pages that mentioned anything about COVID-19 vaccines and/or the pandemic. I attempted to get a variety of posts and comments of different views on these issues. A limitation of this method is that these social media posts, individually, may not be representative of the Black community — but this is intentional. In resisting the

\(^{26}\) “Black Twitter” collectively describes an online digital community on Twitter where majority of its members are Black.
homogenization of Black people, I do not want to claim that these posts can be generalizable or representative of a population. Rather, these posts serve as an example of the diversity of opinion that exists among Black people.

Most of the posts I have analyzed came from Twitter and Instagram – the two platforms I spent the most time on collecting information. Below each post, I analyzed the content, considered the background information, and made interpretations based on the message it conveyed.
Social Media Post #1

In Figure 13, the author of this tweet writes “mind ya business but if you really wanna know...” and includes a TikTok video as a vague way of revealing their vaccination status and thoughts about the COVID-19 vaccine. The TikTok video included a person explaining that they identified as a “transvaxxite” in response to people asking them about their vaccination status. A “transvaxxite,” in this context, is a person who claims vaccinated even though they are not. The person in the video followed up by saying “vaccination is a spectrum. Don’t be a bigot.” I cannot tell if this person in the TikTok video was being satirical or humorous, but the original

27 After speaking with a friend who identifies as transgender, we concluded that the word “transvaxxite” is transphobic due to the context in which it was used: mocking and derogatory.
video on TikTok was deleted. It could be because this person received backlash for the term “transvaxxite” or for placing the identity of vaccination on a spectrum. Since it was posted, I can only assume that they relate to what was said in the video hence why they wrote “mind ya business.” There seems to be a social incentive in identifying as vaccinated to the public even when the individual is not. Perhaps, to avoid backlash, the author of the tweet obscurely implied that they were not vaccinated. It is more socially acceptable to be vaccinated than it is not to be vaccinated. One interpretation of this act could be refusal – a quiet abstention against the social norm of being vaccinated. Another interpretation of this could be an application of Brunson’s work: the perceived social hegemony of vaccination can influence how people decide to disclose their vaccination status.
Social Media Post #2

In Figure 14, the author of the tweet includes several loudly crying face emojis and then writes “dawg just get vaccinated lmao0000” as a response to a repost of Kyrie Irving’s Instagram post. The several crying emoji is typically used to convey intense emotions like grief, laughter, or joy (Emojipedia n.d.). In this case, the emojis were most likely used to convey a sense of laughter or mockery of the post by Irving. Irving’s post emerged during a period of time when he was under scrutiny from the public for refusing to get the COVID-19 vaccine which was recommended by the National Basketball Association’s (NBA) COVID-19 protocol for all players in September 2021 (Greer 2021). Kyrie was very vocal about his opposition to the vaccine stating that the Instagram post portrays a Black man attempting to unlock the padlock chain around his head. It is unclear who the man in the picture is supposed to represent. It could
be Kyrie attempting to be a “free-thinker” which is why the person in the photo is removing the chair around his head, but the meaning of the image is unclear. It could also refer to the idea of him feeling ‘chained’ by public scrutiny for not getting the COVID-19 vaccination. The author of the tweet was essentially telling Kyrie that he needs to stop making claims about the vaccine and to just get vaccinated alluding to fact that they were not taking Kyries’ reasons for not wanting to get the vaccine as legitimate. This post demonstrates stark differences in the views among Black people on the COVID-19 vaccine.
Social Media Post #3

In Figure 15, the author of this tweet, implies that people who are pro-vax\textsuperscript{28} will defend booster shots for COVID-19 as science; however, multiple booster shots indicates that the vaccine is not as effective as it is claimed to be if it requires multiple does. The author of post also claims that they are not anti-vax but that they hate pro-vaxxers. This tweet was posted after the FDA approved booster doses for the COVID-19 vaccines. The tweet reveals that not everyone necessarily saw the FDA approval of booster shots as good news. This could be because conversations about booster shots were not present in the initial proposition of the two-dosage COVID-19 vaccine.

What does it mean for some to claim that they are neither pro-vax nor anti-vax? If vaccination decisions are perceived as a continuum where people can exist in between refusing vaccines and accepting vaccines\textsuperscript{29}, then it is possible for someone to understand the implications of vaccines but not necessarily be supportive of them.

\textsuperscript{28} Someone who is pro-vaccine or in support of vaccines

\textsuperscript{29} Discussed more in-depth in Chapter 1.
Social Media Post #4

@CeromeRussell

I got folks in my family that ain't anti-vaxx but they scared of it because of the misinformation. I'm trying my best to convince them to get it

9:58 AM · 9/7/21 · Twitter for Android

Figure 16. A tweet by @CeromeRussel

In Figure 16, the author of this tweet expresses that they have folks in their family who are not anti-vax, but they are scared to get the vaccine due to misinformation that has circled around. However, they reveal that they are trying to convince their family to get the vaccine.

Based on the information by the tweet author, one could assume that those family members who are hesitant to take the vaccine are hesitant due to misinformation. Vaccination decisions and perceptions can be impacted by false information that propagates through social media and communities. This post serves as a reminder that not everyone who refuses the vaccine is anti-vax. Labels such as anti-vax are socially constructed. They exist for the benefit of assuming the behaviors and tendencies of others which can obscure reality. Refusing the vaccine can be due to a myriad of reasons which should be acknowledged, but labels such as ‘anti-vax’ carry negative connotation that assumes ignorance on behalf of the person who was labeled. This post highlights the stark differences of opinion that exist among Black people.
Social Media Post #5

#TSRHealth: Pfizer COVID-19 Vaccine Becomes The First To Be Fully Approved By The FDA

Today, FDA approved the first COVID-19 vaccine for the prevention of COVID-19 disease in individuals 16 years of age and older.

Visit the COVID-19 Information Center for vaccine resources.

Figure 17. An Instagram post by The Shade Room which includes some of the comments under the post

Figure 17 includes an Instagram post by The Shade Room (TSR), an American media company founded in 2014 with a focus on Black celebrity gossip and news (Ha 2020). Since
2014, it has amassed over 26 million Instagram followers with a target audience of African Americans. In the post above, TSR shares news from the CDC about the Pfizer COVID-19 vaccine becoming fully approved by the FDA on August 23, 2021. Before this, the Pfizer vaccine was approved for emergency use \(^{30}\) by the FDA.\(^{31}\) There were various reactions to this news. In the comment section of this post, some comments expressed disbelief of the vaccine’s full approval: “Wait so they been injecting mfs w something that wasn’t even approved????????” Other comments expressed they would not be taking the vaccine regardless: “Still not getting it, neither is my daughter.” Reactions to this Instagram post highlight some of thoughts and perceptions of the COVID-19 vaccine among Black people. While these reactions focus on vaccine hesitancy or distrust, it is important to recognize they are perceptions that people in the community hold.

\(^{30}\) It is possible that most people do not know that the Pfizer COVID-19 vaccine was only approved for emergency use in December 2020. \\
\(^{31}\) See Chapter 2 on vaccine development for more information.
Chapter 4: Vaccine Narratives

“What we experience is our own concept of things. That is why no two people see quite the same world, and why, in many cases, different people see such different worlds. To put it another way, we make our own world by the way in which we think; for we really do live in a world of our own thoughts.”

— Emmet Fox

The thoughts and perceptions of the COVID-19 vaccines among Black people vary, as well as their experiences during the pandemic. No two experiences are the same. In deconstructing the Black vaccine hesitant subject, I have shown the different ways in which the discourse surrounding Black people and the COVID-19 pandemic is complex. In doing so, I have supplemented this claim through interviews with Black people about their background, life experiences, and thoughts surrounding the vaccines.

This section is a collection of the diverse perspectives and experiences of Black Americans on COVID-19 vaccines, the pandemic, and their relationalities to medicine. This section presents reflections that showcase the differences in how Black people are shaped by their social networks, personal experiences, knowledge of medical racism, structural barriers etc…in their vaccination decisions.

My goal is to show the challenges in understanding the various perspectives of the vaccines within the Black community. Even within my small sample size of interviews, I was able to obtain valuable information about the networks of my participants, the sources they used to learn about the vaccine, reasons for their vaccination decisions, past experiences within medical institutions, and so much more. These next sections will integrate the experiences and thoughts of my participants into vaccine narratives.
COVID-19 Vaccine Decisions and Perceptions

Macdonald, Poltorak and colleagues argue that there are several factors and circumstances that can influence a person’s vaccination decisions (MacDonald 2015; Poltorak et al. 2005). Some of these factors include historical influences, personal clinical encounters, religion, beliefs and attitudes, and risk/benefit. Among the five people I interviewed, Yara and Luke, are hesitant to get the COVID-19 vaccine. The other three participants are vaccinated. However, out of these three, Maddie was hesitant at first to take the vaccine. Maddie is 22 years old and self-identifies as African American or Black. She’s currently a college student in another state but her immediate family resides in Newark, DE. She is a Christian who takes a faith very seriously. Maddie reveals that she was initially hesitant to take the vaccine but eventually took it after considering the possibilities of missing out on life:

I did have concerns about the vaccines for a couple of different reasons. One is because, as a Christian, I thought about what the Bible says about the Mark of the Beast\(^\text{32}\) because it sounds a little familiar. Especially with the way that people were saying you need your vaccine card to enter restaurants [and how it could potentially lead to not entering] essential [places], like grocery stores and stuff. I always thought that ... was really alarming. And it made me feel even more distrustful. And in terms of the vaccine: personally, I was torn because I was like, ‘what is in that vaccine?’ But then I’m also like, ‘I’ve taken a lot of vaccines already in my life.’ Like, if they said, ‘I can’t travel and stuff unless I take this vaccine,’ okay, I’ll suck it up. And to be honest, I’m not necessarily willing to sacrifice a lot of the things I want to do socially, so that I could [bypass] the vaccine.\(^\text{33}\)

\(^{32}\)A biblical apocalyptic concept that refers to a number or mark that someone receives to buy and sell items required by Anti-Christ (a satanic-like figure in the Bible). Some Christians believe that the COVID-19 is this mark because of the vaccine mandates.

\(^{33}\)Maddie 22, Black woman, Senior College student. Interviewed by Tolu on February 12, 2022
In the case of Maddie, she was hesitant at first to take the vaccine because of her religious beliefs, citing that she was a Christian, and skepticism about the contents of the vaccine. For Maddie, she alludes that her Christian beliefs initially made her hesitant about taking the COVID-19 vaccine. Literature remarks that religious beliefs can contribute to vaccine decisions, such as refusal or uptake, based upon how the theology is applied (Hudson and Montelpare 2021). However, her religious beliefs were not the only reason for her hesitancy, she was also skeptical about the contents of the vaccine hinting at a concern about vaccine safety. Research shows that concerns about vaccine safety can contribute to reasons why one may not want to take vaccines (Reich 2010). Ultimately, Maddie realized that she had taken other vaccines in her life without questioning its contents. Instead, she shifted her attention to the social aspects of life that she would miss out on without taking COVID-19 vaccine. These social incentives, such as traveling, were reasonable enough for her to reconsider her position on the vaccine. Additionally, as a college student who lives on campus, foregoing her senior year of college in the dormitory due to COVID to her college’s COVID-19 vaccine requirements was not ideal. The pandemic affected a big portion of her college career, so it is understandable that the social aspects that were available pre-pandemic were things Maddie looked forward to getting back and the vaccine provided this opportunity. This is not to say Maddie completely relinquished all skepticism and hesitancy about the vaccine, but the social sacrifices she perceived that she would have to make were not worth it in the long run.

Changing positions on the vaccine is not easy. For people with a skeptical approach to biomedicine, the novelty of the COVID-19 vaccine certainly did not help their case. In my interview with Luke, a 53-year-old Black father of two kids, he disclosed his unvaccinated
COVID-19 status and his disposition towards western medicine which in his opinion can often rely on drugs:

I am not vaccinated...The COVID vaccine, in my estimation, is just too new to really identify with all the potential adverse effects that this vaccine might sort of accompany...I’m going to be skeptical. I have a mindset that God put everything that we needed on earth. Someone will say, well, medicines come from me. Yeah, I get it, but there are natural remedies to a lot of what ails people. We just choose not to go that route because it might be a little more inconveniencing. Like you got to make a cup of tea as opposed to popping a cold medicine pill, you know what I mean? I just take that holistic route of not necessarily looking for medicine to cure me, right? I take precautions, I don’t want to catch a cold, right? So, I will bundle up in the wintertime, I will dress appropriately for the weather. I wash my hands frequently. If someone’s coughing, I make sure that I’m distant from them, you know, or sneezing? I take my precautions because I don’t want to get sick. I do not want to pop drugs...I’ve always looked at trying to find natural ways to sort of combat the aches and pains of life.34

For Luke, the novelty of the vaccine was a concern. As someone who is skeptical of medicine and drugs, the COVID-19 vaccines were too new for him and the possibility that all its side effects had not been discovered was not a risk he seemed comfortable taking. Furthermore, Luke mentions taking a holistic approach to medicine. Since he is skeptical of drugs, particularly manufactured ones, the concept of holistic medicine was an attractive alternative. His perspective about healing and illness was similar to the medical practices of homeopathy and naturopathy35.

34 Luke is a 53-year-old Black man who did not finish college. Interviewed by Tolu on February 12, 2022.
35 Homeopathy refers to a type of medicine which emphasizes a “natural system of healing that works with your body to relieve symptoms, restore itself, and improve your overall health” (Interstitial Cystitis Association 2015). Homeopathic medicines include creating remedies from natural resources, such as plants or extracts, to treat illness. Naturopathy focuses on prevention and self-healing through natural therapies (Bastyr University n.d.). Naturopathic medicines involve using natural methods to cure illness such as detoxification, lifestyle changes, hydrotherapies, and more (Lee and Kemper 2000).
Both types of medicine have overlaps but they generally fall under holistic medicine. When Luke discusses the use of using teas or making lifestyle adjustments to prevent illness, he reveals that alternative medicine suited his personality more. He would rather take preventative cautionary measures to decrease the chances of contracting COVID-19 than take a vaccine that still requires years of analysis to truly understand its long-term effects. However, later in the interview, Luke admits that he would possibly take a COVID-19 vaccine in the future. He discloses that he is still doing his research on the matter and seeing if its efficacy stands against new variants of the virus.

Vaccine hesitancy is a temporal position. To be vaccine hesitant does not equate to refusal or acceptance of the vaccine, but it is a delay in a course of action due to certain factors. Though Maddie and Luke’s stories are different in how they grapple with their vaccine hesitancy, it is evident that it is a temporary state. For Maddie, the thought of missing out on the social aspect of life was a motivating factor to shift her perspective on the vaccine. Luke acknowledges that he may receive the COVID-19 vaccine once more is known about the vaccine’s long-term effects. His hesitancy toward vaccines stems from his skepticism of man-made drugs and if they are necessary.

On the other hand, not everyone is vaccine hesitant. Speaking with Dana, a 22-year-old senior in college whom self identifies as Black and Hispanic, offered a contrasting perspective. She is from a five-member household and will be the first to graduate college in her family. While most of my interviewees identified as vaccine hesitant, Dana relayed her excitement about the COVID-19 vaccines in our interview:

I was excited for [the vaccine]. Honestly, I’ve never had bad reactions to vaccines in general. So, I was like we can finally get our lives back. I’ve never been scared of
vaccines, and I've never had any reactions to them. I was always on board and like, just waiting for my turn [to receive the COVID vaccine] ... I wasn’t hesitant at all about it. No one’s really had to try to convince me.36

Dana’s excitement about the vaccine pertained to her wish to return to life pre-pandemic. Her comments about being excited about the vaccine contrasted the perspective of people who were vaccine hesitant. Dana’s attitude towards the vaccine is a reminder that we cannot generalize Black people and their positioning on the vaccine. While it is important to highlight the complexities surrounding COVID-19 vaccination decisions in the Black community, it would be insufficient to ignore the instances where taking the vaccine was not a heavy-weighing decision for some people. For example, Edward, a 27-year-old who self identifies as Nigerian and Black American and works as a software engineer, discussed how easily he opted to take the COVID-19 vaccine, no questions asked:

When the [COVID-19] vaccine first came out, I simply opted to take it. I didn’t do enough research on it. I kind of just went [with] what was being said [about the vaccine] through the news outlets, the CDC, and information on websites and went to get it. The vaccine’s effectiveness has shown itself. I didn’t, I just didn’t do enough research [about it] and I care about what the risks were as much because I had seen what COVID had done to the people around [me]. I think when the vaccine came out, it seemed like a good thing.37

During my interview with Edward, he struck me as someone who was very lax about his vaccination decisions. Without doing much research on his own, he trusted what was said about the vaccine and received the COVID-19 vaccine because of it. I would not describe Edward’s

36 Dana, 22, Black and Hispanic, senior in college. Interviewed by Tolu on February 5, 2022.
37 Edward, 27, Black American, moved to Virginia for work two years ago but his immediate family resides in northern Delaware. Interviewed by Tolu on February 6, 2022.
attitude toward the vaccine as excitement, but there was a sense of trust in his tone that contradicted distrust and hesitancy. I can appreciate comments like Edward’s that are different from public health messaging that relied on a simplistic narrative about vaccine distrust among Black people.

**Thoughts on Hesitancy of COVID-19 Vaccine Among Black People**

In my interviews, I asked participants how they felt about the phrase “Black people are hesitant to take the vaccine.” I was interested in their perspectives and if they identified with the statement. Most of my interviewees responded empathetically to the statement. For example, while speaking with Yara, a 43-year-old mother of three who remains unvaccinated, she revealed that she understood why Black people would be hesitant about the vaccine and mentioned the Tuskegee Syphilis experiment:

> I don’t blame African Americans for being hesitant...If we look at the history, the American history, then yeah, we have to respect their hesitancy. You have this Tuskegee project and I found out about other experiments that were done on poor southern people that were primarily African Americans... So, yeah, I understand their hesitancy. I understand it. I mean, yeah, for me once, shame on me, fool me twice, shame on you. Or is it the other way? But yeah, I understand it...it’s just really sad. 38

Yara was the only one to mention the Tuskegee Syphilis experiment. It is possible that the knowledge of historical medical mistreatment shaped her decision to remain unvaccinated; however, as I have mentioned before, that would be too simplistic. When I spoke with Maddie

38 Yara, a 43-year-old woman who identifies as Black, Native American, and Honduran. She did not finish college and works as a paralegal and a real estate firm. Interviewed by Tolu on February 6, 2022.
about this topic, she was very passionate in her response explaining that the hesitancy of vaccines among Black people is an extension of the failures and mistreatment of Black people in Western Medical systems:

[Black people] have been deeply mistreated. There’s so much history of us being used as lab rats, not just historically, but currently. Like our pain being underestimated. Our medical health issues are overlooked and misdiagnosed because people can’t understand what stuff looks like on melanin [skin]. Like there’s just such a buildup that I understand, the initial hesitation to [the vaccine] as well as hesitation towards engaging with the Western medical system. 39

I took note of Maddie’s passion while discussing the issue of hesitancy in the interview. It was clear that the knowledge of past and current mistreatment of Black people was bothersome. She acknowledges that there is a connection between hesitancy and the traumatic experiences of Black people in medicine. What struck me about her comments was her remark of “initial hesitancy.” This implied that she understood why Black people could be hesitant to take the vaccine, however, there is an expectation that they move past their hesitancy. In her experience, that was the case. She was initially hesitant to take the vaccine but later decided to. Her decision to vaccinate was made independently of her knowledge of the racial histories of medical mistreatment.

Even among my small sample size, the differences in opinions, experiences, and thoughts about the COVID-19 vaccine are apparent. Vaccination decisions have proven to be a complex process shaped by several factors. This collection of experiences emphasized the importance of pushing back against assumptions that homogenized the perspectives of Black people. As I

39 Maddie
mentioned at the beginning of this thesis, understanding vaccination decisions among Black people is not simple in the slightest. However, in embracing the complexity of this issue, we were able to open the door to future conversations that will take a more inclusive approach in analyzing vaccination decisions among Black people.
Conclusion: Why it Matters.

“The end ...is just the beginning.”

Bethany Hamilton

In this thesis, I have deconstructed the notion of the “Black hesitant subject” that has been framed in public spheres. Through a critique of public health messaging, interviews, social media analysis, and a literature review, I conclude that vaccination decisions among Black people surrounding the COVID-19 vaccines extend beyond mistrust and hesitancy. It is shaped by several factors that include systemic barriers and accessibility issues. Black hesitancy is a phenomenon that should be observed within contexts that critically analyze how it is perceived and how it is applied to groups of people. In constructing an inclusive narrative, I wanted to resist homogenizing the perceptions and experiences of Black people. In doing so, this thesis reveals some of the heterogenous differences of opinion that exist within this group of people. Under racial capitalism, Black people are often assumed to be monolithic and treated as such. This was evident in public health’s characterization of Black hesitancy toward the COVID-19 vaccines. The danger of this homogenization is that it obscures 1) the role of structural barrier and 2) dilutes the heterogenous experiences of this group and 3) prevents us from understanding the variables involved in vaccination decisions. I emphasize this importance because this issue goes beyond vaccines—it is also a present-day issue in medicine where Black people are often homogenized or stereotyped.

So, are Black people more hesitant to take the vaccine? I think we should proceed with caution in answering this question. Based on data and what I have discussed in this thesis, there is not a straightforward way to answer this question without assuming or generalizing the reasons
for hesitancy. There are Black people who are hesitant to take the COVID-19 vaccines, but that’s no different from the fact that there are White people who are hesitant to take the COVID-19 vaccines as well. Perhaps, it would be better to address why hesitancy was more stereotyped among Black people, the reasons for hesitancy, and how we can address these issues.

Vaccination decisions are complex, but that should not stand in the way looking for solutions to ensure that everyone has access to the vaccines, is well informed on them, and can make a choice for themselves on whether they want the vaccine or not. This is not an easy task to do, but one that is necessary.

As an extension of the medical establishment, perceptions of the vaccine among Black people can provide insight into the relationalities Black people have with medicine. I hope this work opens the door to future conversations about the issue. Though there is a lot to cover and understand, my wish is that we do not shy away from the difficulties of this discourse but that we embrace them and find a way forward.
Bibliography


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