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The impact of COVID-19 among Black women: evaluating perspectives and sources of information

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Abstract

Objectives: Coronavirus disease 2019 (COVID-19) has burgeoned into a pandemic that highlights the countless social and health disparities that have existed in Black communities within the United States for centuries. Recent epidemiological data show that Black communities are being disproportionately impacted by COVID-19, resulting in higher morbidity and mortality rates compared to other racial and ethnic groups. For Black women in particular, a long-standing history of systemic racism and marginalization has resulted in increased vulnerability and susceptibility to certain adverse health outcomes. Recent data show that COVID-19 knowledge rates among Black participants are low, and that Black women who become infected with COVID-19 have higher risks of complications and mortality compared to their non-Black counterparts. Given this data, there is a need to explore where and how Black women are obtaining information that pertains to COVID-19, along with the impacts that COVID-19 may be having on their daily lives.

Design: We conducted interviews with 15 Black women who are clients at a community-based family service center to assess their understanding of COVID-19, determine how they were obtaining COVID-19 information, and evaluate the various impacts that COVID-19 was having on their lives. An initial codebook was developed based on the recorded interviews which included deductive and inductive codes. A thematic analysis of the data was then conducted using MaxQDA (Verbi Software), focusing on Black women's experiences related to COVID-19.

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Results: The majority of participants were using a combination of social media platforms and news sources to obtain information about COVID-19. Most participants (79%) expressed confusion, misunderstanding, and mistrust of the information that they were receiving about COVID-19.

Conclusion: In addressing COVID-19-related health disparities within Black communities, it is imperative for trusted entities and organizations within Black communities to provide accurate and tailored information regarding this novel virus.

Keywords

Health disparities; Black women; African American; COVID-19; coronavirus disease; information sources

Introduction

The novel coronavirus disease 2019 (COVID-19) has had a profound impact among Black communities within the United States. As data regarding COVID-19 continue to emerge and evolve on an ongoing basis, one particularly alarming report has noted the large-scale effects of COVID-19 on minority populations – specifically Black communities. The recent Morbidity and Mortality Weekly Report (MMWR) published by the CDC demonstrated that there was a disproportionate burden of COVID-19 infection and mortality rates among Black patients (CDC 2020a; Garg et al. 2020). Within the MMWR report, it was remarked that of 580 patients hospitalized with confirmed COVID-19 diagnoses, 33%, were Black despite the fact that they comprised only 18% of the catchment population; this suggests an overrepresentation of Blacks among hospitalized patients (CDC 2020a; Garg et al. 2020). Currently, out of every 100,000 Americans, approximately 26 Black individuals die from COVID-19 – a mortality rate more than double those of Latino, Asian, and White communities (APM Research Lab 2020). In certain states, such as New York, this rate is exceptionally higher, with Black patients dying at rates five times higher than other racial and ethnic groups (APM Research Lab 2020).

The risks Black women face during pandemics

For Black women in particular, the socioeconomic and health disparities that were present prior to COVID-19 exacerbate their vulnerability to COVID-19 morbidity and mortality. Black women experience extensive health disparities and inequities compared to their White counterparts. For instance, Black women are more likely to suffer from pre-existing health conditions (e.g. diabetes, asthma, obesity) that increase the risk of mortality from this novel virus (CDC 2020b; Thebault, Tran, and Williams 2020). Black women disproportionately confront the reality of not being believed by health care providers, as well as working in professions in which they are simultaneously essential and undervalued (Attanasio and Kozhimannil 2015; Simien 2020). Black women are more likely to live in high-density areas where social distancing is not as feasible, and they comprise a significant percentage of the front-line workforce who are at risk for exposure on a daily basis (Simien 2020). Prior to the pandemic, Black women were more likely to experience economic hardships while balancing multiple responsibilities (e.g. child care, caring for parents or elders, active

community roles, financial responsibilities), resulting in acute and chronic stressors which both directly and indirectly contributed to their health outcomes (Simien 2020). Not only are Black women more likely to experience consequential impacts from COVID-19; they are also less likely to recover from the impacts of this disease (Simien 2020; CDC 2020b).

Misinformation surrounding COVID-19

As information regarding SARS-CoV-2 continues to emerge, there has been a co-occurring saturation of misleading information about this novel virus through various platforms such as the internet, news, and social media (WHO 2020). Misinformation about the novel coronavirus has proliferated, particularly in regard to the populations the virus affects, how it is transmitted, treatments (including home remedies), and vaccinations (Pennycook et al. 2020; Zarocostas 2020; Hall Jamieson and Albarracín 2020). Per the World Health Organization (WHO), this wide dissemination of misinformation has severely complicated efforts to respond to the pandemic (WHO 2020). For Black communities and Black women in particular, this issue of misinformation is debilitating, hindering attempts to prevent further spread of COVID-19.

Many Black women experience distrust of healthcare systems and medical research due to the history of unethical practices and unjust medical experimentation on Black people (Kennedy, Mathis, and Woods 2007; Suite et al. 2007). This distrust further complicates efforts to provide Black women with accurate information regarding COVID-19 that they will perceive as credible. Distrust among Black women and the Black community in general may also have stemmed from misinformation that was heavily present during the beginning of the COVID-19 pandemic – specifically, a claim that Black people were immune to COVID-19, also known as ‘The Black Immunity Myth’ (Laurencin and McClinton 2020). A recently published study found that those who relied on social media and certain news outlets early during the COVID-19 outbreak were more likely to be misinformed about the virus, in addition to believing conspiracy theories and myths about COVID-19 (Hall Jamieson and Albarracín 2020).

Throughout this pandemic, Black women’s adverse health outcomes and disparities have become a major topic of discussion among public health professionals and health care providers. However, since the onset of the pandemic, there has been limited research on Black women’s experiences and perspectives related to COVID-19. Given the disproportionate burden of disease and the distinctive risks that Black women face, coupled with the problem of misinformation, it is imperative to investigate what challenges Black women are experiencing and how they are obtaining information about this disease. The purpose of our study was to examine the perspectives of Black women regarding COVID-19, along with challenges they may be facing due to the virus. We also aimed to assess their sources of information and whether they trusted the information they received about COVID-19.

Materials and methods

We conducted interviews with Black women who were established patients at the Center for Black Women’s Wellness (CBWW) located in Atlanta, Georgia. The Center for Black

Women's Wellness is a community-based family service center with a mission of improving the health and wellbeing of underserved Black women and their families within Atlanta.

Participant recruitment

Study participants were recruited by Family Support Specialists (FSSs) at the Center for Black Women's Wellness (CBWW), a primary care center based in Atlanta, Georgia that primarily focuses on the needs of Black women. FSSs are trained in providing case management and support services to women, and they also hold strong rapport with the patients at CBWW. All participant recruitment occurred online via flyer distribution by FSSs. Other outreach strategies included the use of the CBWW website and social media platforms. Participants in the study made direct contact with the PI via email to schedule an interview. FSSs who were identified by participants as a referral source were compensated with a $10 e-gift card for every referral who completed an interview. We opted to incentivize FSSs because we were appending recruitment of participants for this study to their already daunting workload, particularly during the time of COVID-19 when healthcare providers were experiencing vast uncertainty about how to continue standard services (Parkinson et al. 2019; Taani et al. 2020).

The women who were recruited for our study can be difficult to reach for a range of reasons, such as unstable housing, unreliable communication sources, and mistrust of research. However, FSSs are typically privy to participant whereabouts, have a number of alternative ways to keep in contact with their cohort of clients, and have trusting relationships that give credibility to the research efforts. All women who agreed to participate were screened to determine whether they met the eligibility criteria for the study. Eligibility criteria for inclusion in the study were: (a) Black/African American, (b) female, (c) 18 years and older, and (d) established patients at CBWW. Informed consent was obtained from all study participants prior to interviews. A total of 15 women were eligible and agreed to participate in the study, and each participant was compensated with a $20 gift card. Interviews lasted approximately 40 minutes and were conducted by either phone or Zoom depending on participant preference.

Procedures

Interviews were conducted using a semi-structured format. Interview questions were obtained from the Pandemic Stress Index (PSI) Questionnaire and the Coronavirus Impact on Health and Wellbeing Survey, and we also included questions to assess technology use and sources of information pertaining to COVID-19 (University of Miami 2020; NIH 2020). The PSI index is a three-item measure of behavior changes and stress that individuals may have experienced during COVID-19. The first item, 'What are you doing/did you do during COVID-19 (coronavirus)?,' assessed behavior changes in response to COVID-19. There were a range of responses to this item, and participants could check all that applied. The second item asked participants to rate the overall degree to which COVID-19 has impacted their daily life on a 5-point Likert scale, responding to the question: 'How much does/did COVID-19 impact your day-to-day life?'. Finally, participants were asked to report the psychosocial impact of COVID-19 – 'Which of the following are you experiencing (or did you experience) during COVID-19 (coronavirus)?' – with a checklist of items pertaining

to mental health challenges, substance use, sexual behavior, financial stress, and support (University of Miami 2020). The Coronavirus Impact on Health and Wellbeing Survey examines the impact of shelter-in-place orders on individuals' mental health and wellbeing (NIH 2020). One example of a question from the questionnaire is: 'Over the past two weeks, have you been bothered by any of the following problems: Little interest or pleasure in doing things; feeling down, depressed, or hopeless; trouble falling asleep, staying asleep, or sleeping too much; feeling tired or having little energy' (NIH 2020).

Only the first author and interviewee were present during the interviews to increase participants' comfort voicing their perceptions regarding COVID-19 and to ensure consistency in data collection. Interviews were recorded with Otter.ai, a platform that records and transcribes meetings in real-time. Transcriptions were reviewed and edited for accuracy against the original audio recordings. Prior to content analysis, we created tables on Excel for each section of the interview to organize participants' narrative responses. Each author was assigned a subset of interview responses to review. Once reviewed, the responses were then coded, with each author developing a list of individual codes and coding data line-by-line (Saldana 2009). A codebook was developed from individual lists, which included both deductive codes (extracted from the questions themselves) and inductive codes (drawn from a review of the transcripts). After an initial codebook was developed, the team discussed the codes, and the codebook was refined for clarity and completeness. Team members discussed discrepancies in coding until we achieved a consensus (Chernick et al. 2015). Once the codebook was finalized, the data was analyzed through reducing the data into themes. Afterwards, we considered the relevance of identified themes to the research question in order to keep the developing analysis integrated, using MaxQDA (Verbi Software) qualitative data management software (Given 2012; Nowell et al. 2017). The analysis of the interview data revealed four main themes (Hsieh and Shannon 2005; Field 2009): (a) the impact of COVID-19 on the lives of participants, including changes to behavior; (b) financial implications of COVID-19; (c) health effects of COVID-19; and (d) information sources and understanding of COVID-19 information. This study was approved by the Institutional Review Board at Emory University.

Results

Demographics

Demographic data was obtained to gather insight on current living circumstances, along with the socioeconomic status of the women which could potentially result in additional stressors and challenges during the pandemic. participants identified as Black or African American. Participants' ages ranged from 18–31 years (M = 25.4). Thirty-six percent of participants (n = 5) lived with a partner, 57% (n = 8) were single, and one participant was in a relationship but not living with their partner. In regard to employment, 57% (n = 8) of participants were unemployed, and 43% (n = 6) of participants were employed either full-time or part-time. Fifty-seven percent (n = 8) of participants had some form of post-secondary education (e.g. college, graduate school, trade school) as their highest education level. Yearly household income varied among participants: 43% (n = 6) reported a yearly household income of below $20,000; 21% ($n$ = 3) reported an income of between $20,000 and 30,000; 27% ($n$ =

3) reported an income of between $40,000 and 50,000; and one participant stated they were unsure of their yearly household income. The majority of participants had health insurance (79%; $n = 11$). Of those who were insured, 63% ($n = 7$) had a regular health care provider, while 36% ($n = 4$) did not have a regular health care provider and went to the emergency room or urgent care as needed.

Changes to life and financial implications

Participants were asked about life changes related to COVID-19 (e.g. How has COVID-19 impacted your life or your family's life thus far?) along with financial implications of COVID-19 (e.g. Are you experiencing any personal financial loss because of COVID-19?). The majority of participants (93%) stated that the pandemic resulted in changes to their daily lives through having to practice social distancing and isolation, along with difficulties in child care. When participants were asked how much of an effect COVID-19 was having on their day-to-day lives, responses ranged from 1 (no effect at all) to 5 (an extreme effect), and the majority of participants (71%) responded 5. A majority of participants (83%) cited financial losses and concerns as a result of COVID-19. These financial implications of COVID-19 included difficulty finding work, job loss, reduced work hours, and having to change certain spending habits due to a limited budget.

27-year-old woman divorced and living with a partner who voiced how she enjoys the various resources offered to the women living within her community – specifically the CBWW:

> … had to stop my job due to risk and switch to a grocery delivery job where the pay is very low.

24-year-old woman who is currently living with her partner and has had to adjust her finances due to COVID-19:

> My job is actually closed indefinitely … so I'm pretty much relying on my partner and unemployment and family to try to help pay bills and stuff.

21-year-old woman who has recently moved to her community and is living alone:

> It's so hard for me to find a job because no jobs [are] hiring because of this [COVID-19] going on …

31-year-old woman who is currently employed and working full-time from home:

> They have cut our hours back … but see in the peak of the COVID I was giving birth so I was also off of work.

Effects on health

Questions about the effects of COVID-19 on health assessed whether participants experienced difficulty accessing health care services for either themselves or their family members due to COVID-19, concerns surrounding exposure to COVID-19, and mental health implications of COVID-19. Participants (46%) cited that the current pandemic was having an impact on health care for either themselves or their children due to various reasons, such as appointments being cancelled and rescheduled, difficulty finding someone

to watch their children during appointments, and difficulty filling prescriptions. Of the participants who stated that the pandemic was having an impact on their health care, 67% also reported experiencing mental health concerns as a result of COVID-19. Participants cited mental health challenges such as increased anxiety, depression, feeling more lonely or isolated, and altered sleep patterns.

21-year-old who is single and who recently moved to her community:

> I can't fill my prescriptions for my inhaler because my doctor office is closed so I can't go to the doctor, and they can't give me a new prescription because of this [COVID-19] that's going on.

27-year-old woman who is divorced and living with a partner, and was receiving mental health support services prior to COVID-19:

> I do live with anxiety … I think it's the anxiety in not knowing.

29-year-old woman who recently had her first caesarean section and voiced having difficulty healing:

> I did [have difficulty receiving health care services]. A lot of my appointments was canceled so they were trying to limit the amount of people.

31-year-old woman who is single and voiced concerns about becoming sick with COVID-19:

> Oh anxiety yes … [I have been getting] less sleep. I don't know why it's been harder lately to go to sleep.

29-year-old woman who is single and pregnant and states that she does not like the community that she currently lives in:

> Increased anxiety and depression having to deal with a lot at one time. Preeclampsia is already a lot … and then having to deal with all this [COVID-19] properly … it's just extra stress.

Sources and understanding of COVID-19 information

Study participants reported using various sources and content platforms to find information about COVID-19. Examples of questions included 'How have you been getting information about COVID-19?' and 'What platforms are you using to get information about COVID-19?' Over half of the women (67%) stated that they were using a combination of different sources to obtain their information (e.g. social media, television, internet, friends, and family members). Fifty-eight percent of participants used media platforms such as Instagram and Facebook to obtain COVID-19 information; 58% also obtained their information from news sources. Some participants (33%) also listed additional sources such as email updates, texts or group messaging, subscriptions to health sites, and information from family and friends.

Women were also asked about their confidence and comfort level with the COVID-19 information they had obtained (e.g. Do you feel comfortable with the information that you are receiving? Have you been confused about the information you have received about

COVID-19?). The majority of participants (79%) cited confusion with the information they had received. Some participants directly expressed that they did not know what to believe in regard to the information they had encountered about COVID-19. Two participants stated that they avoided the news entirely, because they did not feel comfortable with the information that was being provided by news channels, and that they trusted social media over the news.

22-year-old woman living with her partner who states that prior to COVID-19 she was obtaining the majority of her health information through social media:

> Sometimes I feel unsure about the information that I'm receiving because it's a lot of different things about it. Everybody's not saying the same thing. So, I'm kind of unsure about what to believe.

31-year-old woman who has been practicing social distancing and obtains most of her information through social media:

> I feel like the news doesn't report everything … they always spin it.

21-year-old woman who is living alone and states that Instagram is the most popular app that she uses on her phone:

> Yes [the information about COVID-19] it's confusing because I have so many different stories about it [COVID-19] I don't know what to really believe.

29-year-old woman who states she primarily uses Facebook to obtain information about COVID-19:

> I'm confused [about the COVID-19 information] but I'm just going to follow their directions.

19-year-old woman who states that she typically obtains her health information from various sources such as apps and social media, along with family and friends:

> There's a lot of deaths. So, I'm not sure what to believe is it actually the virus killing them or the injection they get? I'm not really sure about that part.

31-year-old woman divorced and living with a partner who expressed fears related to loss of wages because of COVID-19:

> Like to be honest, it's so much going on … there's so much information. It's overwhelming. You see it every time you turn around, you just see something about it. Yeah.

29-year-old woman who lives alone and fears being diagnosed with COVID-19, and worries about her friends and family being diagnosed as well.

> I'm not going to say that I believe everything [about COVID-19].

Discussion

This study assessed the perspectives of COVID-19 among Black women living in Atlanta, along with the platforms they were utilizing to obtain health information about COVID-19.

The women in our study expressed various concerns related to COVID-19, such as disruptions to their daily lives and routines, financial implications, and uncertainties, along with health concerns (most notably mental health). These findings are consistent with recent literature and reports which have noted that the consequences of the pandemic are likely to be worse for Black women (Simien 2020; Ryan and El Ayadi 2020). As the pandemic progresses, researchers have predicted that it will continue to have both direct and indirect impacts on mental health, financial wellness, and maternal health for women globally (Ryan and El Ayadi 2020). However, for Black women, these impacts are especially noteworthy given that they were already experiencing a magnitude of adverse outcomes in these domains pre-pandemic (Ryan and El Ayadi 2020; Ellington et al. 2020; SAMHSA 2019; Lopez, Rainie, and Budiman 2019).

Black women experience multiple structural inequalities due to their race (e.g. racism, social isolation), gender (e.g. gender pay gap, fewer educational opportunities), and class (e.g. unemployment and underemployment rates) (Gee and Ford 2011; Singh et al. 2017; Paradies et al. 2015; Watson et al. 2002; Owens and Fett 2019; Prather et al. 2018; Perry, Harp, and Oser 2013). These determinants put Black women at higher risk for a range of life-threatening medical conditions, including COVID-19. Strategies to address these inequities may constitute innovative and holistic multi-level prevention efforts that address not only COVID-19, but also the determinants that exacerbate the issue. For example, policies and structural factors such as economic pressures to return to work or disproportionate workplace exposures to COVID-19 should be considered. With deepening food insecurity, increasing housing instability, slow job recovery, and the replacement of many in-person health services with telehealth services, the need for solutions to bridge communities and systems of care has become greater than ever.

The participants in our study reported obtaining information pertaining to COVID-19 through a variety of sources, with the most common sources being social media and the news. Confusion about information surrounding COVID-19, along with disbelief and mistrust of the information they received, were prevalent findings among the majority of study participants. Recent reports have found that compared to White Americans, Black Americans are more likely to use their phones in search of health-related information (Pew Research Center 2015). Research has also demonstrated that Black Americans are more frequent users of certain social media platforms (e.g. Instagram) compared to White Americans (Pew Research Center 2019).

As social media platforms increase in popularity and become a mainstream source for acquiring information, they can offer unlimited access to health content while transcending factors such as age, education, race, or ethnicity (Dalmer 2017). However, there has recently been much controversy surrounding the accuracy and reliability of health information about COVID-19 on social media. Pennycook et al. (2020) found that many study participants had difficulty discerning what was true and what was false among online content pertaining to COVID-19. Furthermore, in the same study conducted by Pennycook et al. (2020), many users stated that when accessing social media platforms, they did not consider the accuracy of the information they were sharing. This resulted in considerable potential for the

unintentional dissemination of highly inaccurate and misleading content (Pennycook et al. 2020).

Several public health leaders have raised concerns regarding the large-scale dissemination of false information about COVID-19. The director of the WHO recently stated in response to COVID-19, 'We're not just fighting an epidemic; we're fighting an infodemic' (Zarocostas 2020). Easy access to online health content is beneficial for providing patients with health information. However, it is only beneficial when such health information is accurate. It is possible that the confusion our study experienced in regard to COVID-19 was attributable to conflicting information and misinformation, which are prevalent among social media and online platforms, coupled with information that they obtained from additional sources.

Although there has been a considerable amount of misinformation surrounding this novel virus, the historical and contextual factors that may also contribute to mistrust in COVID-19 information cannot be ignored. The treatment of Black patients in health care settings, coupled with systemic racism that Black communities have experienced and continue to experience, may also be contributing to mistrust surrounding this information. One outcome of misinformation about COVID-19 has been the 'Black Immunity Myth' – a phrase coined by Laurencin and McClinton (2020) – which resulted in many Black communities believing that they were not at risk of COVID-19 at the height of the epidemic (Laurencin and McClinton 2020). According to Laurencin and McClinton (2020), the potential for immunity was hypothesized to have been a coping mechanism against a global crisis that would have presented one less struggle amongst many of the current challenges that Black communities face. Laurencin and McClinton (2020) compared 'Black Immunity Myths' to similar myths that arose during the height of the HIV epidemic, in which Black communities believed that they could not be affected by the virus (Jaiswal, LoSchiavo, and Perlman 2020). Both online misinformation and the aforementioned historical contexts are relevant when discussing health outcomes amongst Black women, because both of these may play a combined role in participants' confusion regarding COVID-19.

Lack of information can further exacerbate the current disparities in COVID-19 morbidity and mortality rates for Black women. Several participants in our study stated that the pandemic had an impact on their health care, resulting in limited access to or cancellation of certain health services, difficulty obtaining medications, and mental health implications. For Black women – especially Black women who are pregnant, postpartum, or with pre-existing health conditions – the barriers that they experience in health care settings may be further heightened during this pandemic. COVID-19 itself does not discriminate; however, health care systems in the United States have a long-standing history of discrimination, which has contributed to a myriad of health inequities for Black women and the Black community overall (Laurencin and McClinton 2020). To address the disparities heightened and revealed by COVID-19, these inequities – along with implicit bias among health care systems and health care providers – must be acknowledged.

The role of community organizations and policy

Given the confusion among participants about COVID-19, it would be highly beneficial to connect Black women to sources of information that they consider trustworthy and

that provide accurate, contextually relevant information. Community-based organizations can address this issue by engaging in discussions with target communities to identify concerns related to the pandemic and developing solutions to disseminate accurate and trusted information. Trusted community organizations can present factual data and have the ability to tailor resources in a way that can meet local community needs. In doing so, they can address myths, provide necessary tools to navigate the healthcare system, and clarify conflicting advice. Additionally, community members can be taught how to discern between factual and invalid sources of information, especially as they navigate social media.

The COVID-19 pandemic has interrupted many people's access to healthcare through the loss of their job and/or health benefits. People with chronic conditions and mental health concerns are in need of continued care, especially during a time of stress and uncertainty. Lack of access to these services could have detrimental effects on those directly and indirectly impacted by the pandemic. Participants reported increased symptoms of anxiety and depression, which may have to be addressed by a healthcare provider. However, if the loss of employment leads to a lack of insurance, those services may no longer be available. States that have not done so should consider expanding Medicaid coverage, so that a larger number of people can become eligible should they find themselves uninsured. Continued coverage could allow those experiencing chronic physical or mental health conditions to resume managing their health. Doing so helps improve overall health for those who are most affected and at higher risk for death and hospitalization because of COVID-19.

As the pandemic progresses, its impact on Black women's health should be at the fore-front of public health interventions given that COVID-19 is expected to have significant downstream effects through disrupting health services, increasing economic instability, weakening social support systems, and the further widening of gender and racial disparities (Gausman and Langer 2020).

Limitations

Our study is not without limitations. Given the limited sample size and the fact that we recruited our sample from a small clinic in Atlanta, our results cannot be generalizable to all Black women living in urban areas. Our results also may not represent the views and experiences of patients in other settings. Additionally, interviews may have been subjected to social desirability bias. Although some of the interview questions that we asked were obtained from existing instruments (Pandemic Stress Index Questionnaire and the Coronavirus Impacts on Health and Wellness Questionnaire), given the novelty of this virus, there is a dearth of questionnaires available to measure the impacts of COVID-19 on communities of color. Future studies should evaluate COVID-19 knowledge levels among Black women coupled with the sources that they are using to obtain COVID-19 information. Given that a large percentage of women in our study voiced mental health complaints as a result of COVID-19, future studies should also assess the mental health implications of COVID-19 among this population.

Conclusion

Our study demonstrated that within our sample of Black women, there is mistrust concerning COVID-19-related information, along with a misunderstanding of the information being obtained. In addressing the COVID-19-related health disparities and adverse outcomes that Black communities are facing, it is imperative for individuals of color to be provided with highly accurate and tailored information regarding this novel virus from trusted entities and organizations within their communities. Now is a critical time for public health professionals to take an active role in partnering with such entities in addressing the inadequacies and disparities that Black women are experiencing during this pandemic. This pandemic can result in unprecedented consequences for Black communities, including the deepening of certain disparities that existed among Black women prior to the emergence of COVID-19. Action must be taken to ensure that Black women are obtaining accurate information on COVID-19. Thus it is crucial to establish trusted sources of information for this target group when working to alleviate disparities.

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Availability of data and material

The data that support the findings of this study are available within the article. Further inquiries regarding data can be made to the corresponding author.

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