COMMUNITY-BASED HEALTHCARE INTERVENTIONS: AN ETHICAL APPROACH TO BRINGING HEALTHCARE TO THE MARGINALIZED

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ABSTRACT

Covid-19 shed a light on how disparities, influenced by institutional racism and social determinants of health, led to negative healthcare outcomes. This inspired community organizations such as the Black Doctor's COVID-19 Consortium to take matters into their own hands and play their part in meeting the needs of the community. With evident gaps in healthcare for marginalized communities, I believe that community-based health interventions are an ethical approach to ensure care for marginalized communities. To ensure that a proper intervention is being crafted for these communities, it is important to define what community-based means. This paper explores four models for categorizing community-based: community as setting, target, resource, and agent. While traditional research focuses on the voice of the academic, using Community Based Participatory Research amplifies and recenters the voice of the community, while providing a means to increase their capacity, fostering agency, and promoting solidarity. This paper explores local community-based health interventions in North Philadelphia and emphasizes partnering with the community to determine their needs before creating an intervention. Using community-based interventions to increase access to healthcare for marginalized communities in tandem with existing models of healthcare, follows a utilitarian approach to ensure that the greatest number of individuals can benefit. Community-based health interventions are the most ethical approach to bringing healthcare to marginalized communities.

DEDICATION

This paper is dedicated to marginalized communities across the country.

May your voices be amplified and your stories told.

You are more than deserving.

ACKNOWLEDGMENTS

I would like to acknowledge my Thesis Advisor, Professor Providenza “Enza” Rocco for helping me develop the idea of this thesis, and Catherine Averil for encouraging me when I needed it most. I would also like to acknowledge my dear friend Rhiannon McGrath for helping me get through this. I couldn’t have done this without you.

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CHAPTER 1

INTRODUCTION

When shutdowns were occurring across the globe due to COVID-19, the world began to finally turn their eyes to an ugly truth that was being unearthed—racial disparities existed in healthcare and had negative effects on health outcomes. As headlines begin to highlight the fact that while the Black Community only made up about 13% of the United States, they accounted for an astounding 30% of COVID-19 cases (PBS, 2020). While many in healthcare knew about social determinants of heatlh, information about it started to resound throughout the country. In cities like Philadelphia, where Black and Brown communities were likely to be essential workers, live in densely populated areas, and take public transportation, members of these communities were accounting for even higher percentages of the disease burden in comparison to their white counterparts.

With such glaring disparities occurring, community organizations did their best to focus on those communities that were being affected at higher rates. As I watched community-based organizations like the Black Doctor's COVID-19 Consortium do their best to fill in the healthcare gaps, it was apparent that community-based health interventions had the potential to be an essential model used to decrease health disparities and increase access for marginalized communities similar to North Philadelphia.

CHAPTER 2

COMMUNITY-BASED INTERVENTIONS

Before being able to focus on the intervention, one must first define what it means to be community-based. Defining community plays an important role in helping public health officials to determine who health interventions will be geared towards (McLeroy, 2003). “How a target community is defined determines how resources will be allocated, how an intervention will be delivered, and how a message will be framed (McLeory, 2003).” While “community-based” has a wide variety of meanings, Merzel and D’Afflitti focus on four categories to provide context to the term: community as setting, community as target, community as resource, and community as agent. Although these categories are not an exhaustive list of the many ways to define “community-based”, they help us understand how defining community can influence how problems are addressed, and how the outcomes may differ. While these models are presented as separate approaches, various combinations of these models are often implemented in community-based health promotion. Aside from community as setting, the other three models demonstrate that changes in capacity can be a valuable byproduct of these approaches (McLeroy, 2003).

Community as setting identifies community as where the intervention will take place. The location of the intervention is the focus. The setting of the intervention can be as vast as a citywide initiative, or as focused as a particular neighborhood, local organization, community center, or an institution such as a church (McLeroy, 2003). When interventions are implemented with community as setting in mind, the mission is to change the behavior of individual members of the community, with the sum of those changes leading to a change in the population’s risk for disease (McLeroy, 2003).

Community may also be defined as the target of the initiative. "*The community as target* refers to the goal of creating healthy community environments through broad systemic changes in public policy and community-wide institutions and services. In this model, health status characteristics of the community are the targets of interventions, and community changes, particularly changes thought to be related to health, are the desired outcomes. (McLeroy, 2003)".

The final two categories define community as resource and community as agent. The former model recognizes that communities have resources and assets that can be strategically reallocated to focus on a specific health initiative (McLeroy, 2003). This model is based on the belief that "a high degree of community ownership and participation is essential for sustained success in population-level health outcomes. (McLeroy, 2003)" The latter views communities as "naturally occurring units of solution" who are accustomed to meeting the needs of their communities in one way or another (McLeroy, 2003). Community as agent places importance on "respecting and reinforcing the natural adaptive, supportive, and developmental capacities of communities" (McLeroy, 2003). Although community as agent is rooted in empowerment, it is important to recognize that many marginalized communities lack the capacity to carry out this role due to social, economic, and political structures that have historically hindered them (Garcia, 2017). It's one thing to be an agent of change or a unit of solution when you have been set up with the proper tools and resources to help you thrive. It is another thing to be this agent of change in your community when you have less capacity due to having to jump over systemic and structural hurdles, be it social,

economic, or political, to get to what you need. Maybe that's where Community Based Participatory Research comes in.

CHAPTER 3

COMMUNITY BASED PARTICIPATORY RESEARCH

Part One of Chapter Three: Amplifying the Voice of the Community

While research is an important part in the development and implementation of an appropriate intervention, the main flaw of traditional research is that it is centered on the wrong voice. Oftentimes the voice of the academic researcher is the focal point of the process, and their knowledge deemed more important and valuable than the members of the community (Garcia, 2017). When research is done in this manner, the goals and desires of the academic, including publication, take precedence over what the community may want or need. Garcia (2017) suggests, "The primary aim is contributing to scientific knowledge, but not necessarily to improve the community's health status or empower communities for social change (Garcia, 2017)." This statement is shared by researchers and others in the public health sector, including medical students like Ashley G. She says:

> "I wish medicine would care more about community impact than it does about publications. What good is a name on a paper if the communities you serve are left unchanged by your presence...For a while I thought I wanted an illustrious academic career, but my heart is truly with communities and I'm realizing what good are the accoladed when the communities I love are still suffering. I feel like we could do so much more if we shifted the priorities in medicine." (@Miss_Ash G, 2022)

While traditional research leaves out critical input from the community and fails to benefit them, Community Based Participatory Research (CBPR) aims to form a mutually beneficial partnership between the researcher and the community. This model provides an opportunity for the community to be a valuable stakeholder in research and ask questions that the community finds of interest. It fosters an environment conducive to

"mutual learning and empower[ing] the community to take a leadership role in its own health and well-being." (Garcia-Rivera, 2017). Communities provide their unique expertise which allows interventions to be tailored to their target and more likely to be effective. According to Suarez Balcazar (2020), "A CBPR approach to addressing health disparities focuses on working from the ground up and giving a voice to communities on what the issues are, what are potential solutions and how to address issues that matter to communities (Suarez-Balcazar, 2020)." Suarez- Balcazar (2020) also insists, "The purpose of CBPR is not simply to find answers to complex social questions but to use those results to provide information that can be used by the community to develop solutions to their problems." In this way, not only is the voice of the community recentered, but they are also in a better position to benefit from the research.

Part Two of Chapter Three: CBPR as an Ethical Approach to Research

Subpart One of Part Two of Chapter Three: CBPR Increases Capacity of Communities

Capacity theory argues that the most ethical action is the one that most increases a patient's (or a community's) capacity for health (Jones, 2020). With this in mind, CBPR should be regarded as the most ethical model for research because of the role it has in increasing a community's capacity. As argued by Suarez-Balcazar (2020), "CBPR emphasizes mutually beneficial partnerships between community, academic, and practice partners, with a focus on bringing together diverse experiences, skills, and knowledge to create capacity to solve critical health problems." Through partnerships with academic institutions, communities can tap into resources that were previously inaccessible. The economic, political, and social resources that academic institutions have can help communities circumvent previous obstacles that prevented communities from

implementing certain solutions. Essentially, through the equitable partnerships formed through CBPR, academics can help increase a community's capacity for health through providing access to its resources.

While providing access to resources is extremely important, we must be mindful not to make academic institutions the savior of the community. While they may have economic resources and both social and political capital, this partnership should not be viewed as an opportunity for them to climb down from their Ivory Tower to come and save the people. We must keep in mind the community as agent model that regarded these individuals as units of solution. Theoretically, these communities may already know which solutions are best or most practical for them, however they just might need the resources, fungible or structural, to bring it to fruition. In all, these partnerships must be genuine and mutually beneficial, and not just an opportunity for clout chasing or a feel-good photo opportunity with no intention for actual sustainable impact in these communities.

Subpart Two of Part Two of Chapter Three: CBPR Fosters Agency

CBPR fosters agency by taking into consideration the context of the individual, including one's experience and intersectionality, when developing an intervention for the community. Suarez-Balcarzar supports this argument by stating, "We have an important role to play in addressing health disparities working together with communities that are disproportionately affected by health disparities. Such an endeavor requires attention to social, economic, and cultural factors that impede health, participation in the community, and the empowerment of individuals and communities (Suarez-Balcazar, 2020)."

Subpart Three of Part Two of Chapter Three: CBPR Promotes Solidarity

As a principle, solidarity binds two or more stakeholders together; because of this, in its essence, CBPR promotes solidarity through partnership. When thinking of solidarity, the words of activist Lilla Watson provide a powerful point. She states, "If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together."(Jones, 2020) In a perfect world, academics would participate in CBPR because liberation of the community is tied to their own liberation. While this may be more feasible in an ideal world, I believe there may be too many complex layers of power to make this the standard. Unfortunately, the liberation of one group is oftentimes tied into the oppression of another.

CHAPTER 4

COMMUNITY-BASED INTERVENTIONS IN PHILADELPHIA

In this chapter, I would like to highlight two community-based interventions in Philadelphia: The Black Doctor's COVID-19 Consortium and Begin the Turn. Each intervention identified a specific need and sought ways to bridge the gap through being intentional, meeting the community where they were at, and forming relationships with the community.

Part One of Chapter Four: The Black Doctor's COVID-19 Consortium

Born out of frustration that Philadelphia's African American population was dying at a disproportionate rate to their white counterparts. With African Americans being 6x less likely to have access to testing, then white individuals in affluent populations, Dr. Ala Stanford decided turn her frustrations into fuel and take matters into her own hands. In April of 2020, Dr. Stanford rented a van, gathered PPE from her office, and whatever testing kits she could gather, and took to the road (Meyer, 2020). Her mission was to bring testing to the Black and Brown communities of North Philadelphia, who did not have access to testing. As testing increased from 12 individuals on the first day to 500 individuals by day 3, Dr. Stanford new that her team was meeting an important need of the community. This was the beginning of the Black Doctor's Covid-19 Consortium (BDCC). While it is undeniable that the BDCC set out to do great things, Dr. Stanford mentioned that trust was something that she had to earn from the community. One way to establish trust from the community was to partner with institutions that the community trusted. The BDCC partnered with local churches, mosques, and community centers that were well known and well trusted throughout the

community. By showing up consistently for the community, the BDCC began to gain the trust of the community, which came in handy for their next intervention-vaccinations.

In January of 2021, the BDCC began to vaccinate the North Philadelphia community. While there were many assumptions floating around that Black folks did not desire to get vaccinated, Dr. Stanford uncovered that it was a myth. The issue wasn't lack of desire, but rather access. Black and Brown individuals would consistently show up despite the weather to get their vaccination. During the 24-hour Vax-a-thon hosted at the Liacouras Center, a participant told the media, "Black people DO want to get vaccinated, all we need is the opportunity. (Toner, 2021)" This supported what Dr. Stanford's observation as well.

What I admire about the BDCC is how intentional they were in their approach. They focused on communities with the highest positivity rates from the beginning. As they began to vaccinate the masses, they always sought out ways to make their services accessible to those who needed it. In the beginning of the vaccine rollout, individuals had to go online, fill out a form, and reserve their appointment. Dr. Stanford made sure to have paper forms at their vaccination cite for those who did not have access to the internet. Two months into vaccinating the community, Dr. Stanford announced that the BDCC changed to a first come first serve site to somewhat level the playing field for those without access.

I had the privilege of volunteering with the BDCC. After working with the organization, I was inspired to become a community doctor. I wanted to do my part in showing up for marginalized communities. I desired to meet the community where they

were at. As an incoming Family Medicine Resident, I hope to do my best to decrease barriers and increase access for these individuals.

Part Two of Chapter Four: Begin The Turn

Begin the Turn is a community-based intervention which focuses on aiding in the recovery of individuals with substance use disorder. This program takes a unique approach by taking a mobile unit into Kensington, a neighborhood in North Philadelphia "identified through mapping concentrated areas of fatal and nonfatal overdoses" (O'Gurek, 2020), to provide buprenorphine services to the community. They enlisted the help of a community advisory board to decide what services to provide. Along with buprenorphine, individuals in the program have access to counseling, a case manager, and a physician that can address other small medical issues including wound care. During the first 14 months of the program, the BTT team saw and assisted about 340 individuals (Miller, 2020). For those seeking to implement a similar initiative, or struggling to decide what initiative would be best for their own community, Dr. O'Gurek, a physician who works with BTT, emphasizes the importance of understanding what the community needs. He advises, "Spend time and energy to truly understand the critical needs of the community first. Ask the community what kind of program they want as opposed to assuming our model or one like it will simply work translated to another community. (Miller, 2020)"

CHAPTER 5

COMMUNITY-BASED INTERVENTIONS FROM A UTILITARIAN VIEW POINT

I believe implementing community-based interventions to meet the need of marginalized communities is rooted in utilitarianism. Utilitarianism focuses on achieving the greatest amount of good for the greatest amount of people. Through using community-based health interventions to increase access to healthcare for the marginalized, in conjunction with standard healthcare that is accessible by the majority, you cast a wider net, allowing for a greater amount of people to access healthcare. If one is truly trying to do the greatest good for the greatest amount of people, the main focus should be how to make things accessible to the masses. This requires thinking about barriers that prevent individuals from accessing the care that they deserve. Intentionality and inclusivity are imperative to implementing interventions that truly decrease barriers and increase access for marginalized communities.

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