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Self-Efficacy of Urban African Americans in Response to COVID-19 Health Information

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has been found to be complete and satisfactory in all respects,
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Walden University
2024

Abstract

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MS, Kaplan University, 2014

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Dissertation Submitted in Partial Fulfillment

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Public Health

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Abstract

African Americans have experienced health disparities across many diseases due to barriers found in societal structures such as education, housing, employment, income, and health care access. COVID-19 created a public health crisis that exposed the continued existence of these disparities as different ethnicities experienced varying degrees of morbidity and mortality. One of the elements in health disparity is health information and its role in people’s self-efficacy in preventing or treating a disease. This qualitative study was designed to explore the role of health information and self-efficacy experience of African Americans during the COVID-19 pandemic. The conceptual framework was the social ecological model. Interviews were conducted with 22 participants in the Chicago, Illinois area. Twelve themes were identified from inductive coding analysis: valuing personal autonomy and self-efficacy, trusting medical care outside the community, valuing traditional natural remedies and beliefs, unequal access to quality care, mistrust in medical care generally, the influence of friends and family on self-efficacy, increasing self-efficacy by protecting others, accuracy of information, the influence of personal health and family members on decision making and risk-taking, the value of health literacy, the influence of access to care on health understanding and self-efficacy, and the role of isolation and hopelessness. These results revealed an array of factors that influence self-efficacy for African Americans in a pandemic context. Implications for positive social change include considering these factors when planning effective health information in future pandemics to improve health outcomes.

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Dedication

I dedicate my doctoral dissertation work to my three beautiful children, Keaira, Sativa, and D’Shawn. They each represent the best part of me. It is because of their unconditional love, trust, and faith in my ability that I am here. My children have always been and will continue to be my driving force. To my mother, Johnnie L. Thompkins, for instilling in me strength and perseverance. God bless your resting soul. To my father, Howard K. Thompkins, who demonstrated unshakable faith that I would one day be here. To Candy L. Washington, you have been here from beginning to end. Thank you for the endless hours you gave listening, supporting, and believing in me. God bless you. To Zandra Higley for the countless hours and words of love and affirmation. You are solid as a rock. To Dr. James Yizar, for the continued guidance and influence in my life. Thank you. To Ram Eddings, my dear friend. You did this. To Karen Kamusoko, for the countless hours of late-night calls, check-ins, and unwavering reassurance to follow the process. To my dear friends whom I often refer to as my tribe and to my extended family members who have joined me on this journey. This dissertation is for all of us.

Acknowledgments

I am here because God said it would be so. Thank you for spirit and truth. I would like to thank Walden University from Day 1 to Day end. Each step of this journey has been met with support of my goals. To the library and research staff, thank you for the many times you have helped and guided me. To the academic advisors who made countless calls along my journey and showed genuine interest in my success. To the faculty team members in all my classes. Each piece of knowledge gained from you has led me here. To my committee member, Dr. Anderson, thank you for the guidance and critique to help me become the very best. And most importantly to my chair, Dr. Michael Schwab, your guidance, kindness, and reassurance has meant more than you will ever know. It is because of your expertise and precision that I am here. Thank you. This has been one of the most rewarding accomplishments of my life.

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Chapter 1: Introduction to the Study

SARS-CoV-2, known as COVID-19, is an illness that highlighted the health disparity between populations. COVID-19 morbidity and mortality rates were higher for some ethnic groups than others for example, the crude death rate per 100,000 people for Indigenous Americans was 457, for Pacific Islanders was 349, for African Americans was 346, and for Whites, Latinos, and Asian Americans was 328, 263, and 161, respectively (APM Research Lab, 2022). Health disparities during the beginning stages of the COVID-19 pandemic indicated African Americans experienced some of the highest rates of death across the United States averaging 330 deaths out of every 100,000 people (APM Research Lab, 2022). African Americans had a higher prevalence of COVID-19 across the United States in comparison to non-Hispanic Whites where data on race and ethnicity existed (Fernander & Williams. 2022).

The study was warranted as African Americans had some of the highest rates of morbidity and mortality in comparison to other ethnic groups. Self-efficacy experiences of African Americans in the Chicagoland area was the focus of the study conducted with volunteers through the establishment of partnerships with community leaders, churches, health centers, and clinics. The social implications of the study included a better understanding of African Americans' experiences during COVID-19, which could help to improve health care services, public health communication, and resources needed to tailor care for this population. As COVID-19 continues to impact communities, consideration should be given to how system structures contribute to disease prevalence seen among groups especially those already experiencing health disparities. Examining how social structures and experiences combine to impact self-efficacy response to COVID-19 may be used to address disparities in health care access, health information, systemic racism, mistrust in health officials, and in the structures governing them. This chapter highlights the background of historical disparities, the problem and purpose of the study, research questions, theoretical framework, nature of the study, definitions of key terms, assumptions, delimitations, and limitations.

Background

Infectious disease has been shown to account for high morbidity and mortality among African Americans. Historically, the severity of illness and mortality is higher for this population during times of severe public health emergencies (Fernander & Williams, 2022). When death rates of the population declined at the beginning of the 20th century during the 1918 flu pandemic, African Americans in urban environments continued to have higher infectious disease mortality compared to their White counterparts, which attributed to regional differences in mortality rates across the United States (Feigenbaum et al., 2019). Similar disparities in the HIV epidemic indicated how the focus of health and behavior of a person is not enough to address health disparities experienced as a result of systemic inequities (Hull et al., 2020). Although previous epidemic research showed vulnerabilities in racial minority communities, additional data combined with immediate action are needed to mitigate exposure, vulnerability, and limitations in health care access (Bibbins-Domingo, 2020).

Health recommendations have not addressed how following guidelines may lead to differences in health outcomes due to the inequalities found in the social structure impacting the ability to reduce exposure (Hull et al., 2020). Currently, the research community has limited data of African Americans' understanding of public health information or experience with following the recommended health guidelines (Block et al., 2020). According to Fernander and Williams (2022), racial minorities have a decreased ability to follow pandemic-related guidelines and limited ability to handle the pandemic as a result of health disparities and social structures. The current qualitative inquiry explored African Americans' experiences to understand the impact of factors found within the social ecological model (SEM) on self-efficacy response during the COVID-19 pandemic.

Problem Statement

African Americans experience with health care access, health information, testing, and treatment during the COVID-19 pandemic impacted their ability to exhibit control over health and influenced self-efficacy outcomes. Historical and recent experiences within health care systems have led to fear of racism and discriminatory practices in testing, treatment and a high level of concern in contracting COVID-19 (Sneed et al., 2020). Some African American men have expressed concern with wearing face masks due to the potential for increased racial profiling (Bryson, 2020). To better serve racial minority groups, public health professionals need to understand the health care experiences of these populations and there is limited information of the experiences of African Americans' during the COVID-19 pandemic. The current study explored African Americans' experience of the health care system personally, interpersonally, and institutionally with special reference to COVID-19, focusing on self-efficacy as it relates to health information, testing, and treatment.

Purpose of the Study

The purpose of this study was to understand the lived experience of African Americans in response to COVID-19 health information. This study provided data on this population's experience during COVID-19 while examining social, cultural, and structural factors as contributors impacting self-efficacy response. The gap in the literature was addressed using a qualitative inquiry.

Research Questions

RQ1: What are African Americans' lived experience of self-efficacy in relation to the COVID-19 pandemic?

SQ2: How did African Americans respond to COVID-19 health information and recommendations?

SQ3: How did African Americans describe their experience with receiving treatment or testing for COVID-19?

SQ4: What was the lived experience of African Americans regarding the risk that they or their family members would contract COVID-19?

SQ5: What did African Americans do to prevent or minimize exposure to COVID-19?

Theoretical Framework

This research was framed using the Social Ecological Model originating from Bronfenbrenner's (1979) ecological systems theory. This theory addresses human behavior as interconnected with the environment (Bronfenbrenner, 1979). Systems theory allow for multiple layers of environmental factors to be considered as influential components (Glanz et al., 2015). Microsystems of interactions with close groups of family, mesosystems of outside groups, and ecosystems of external environment of system structures and culture (Glanz et al., 2015) underpinned the examination of self-efficacy and health behavior.

Nature of the Study

I selected a general qualitative design. Qualitative research provides insight not only on the perception of individuals but also on why behavior happens from a systems view of social structures such as family, community groups, religious and political groups, and economic institutions (Patton, 2015). General qualitative research is a reflective account of individuals' experiences, belief systems, and opinions of the external environment (Percy et al., 2015). This account was necessary to understand the complexities of self-efficacy responses toward pandemic efforts in the African American community. Phone interviews and Zoom interviews were conducted to increase knowledge of how the experiences of African Americans were influential in their self-efficacy response. African American participants were recruited in the Chicagoland area by contacting churches, community leaders, health clinics, and online organizations. Interview data were collected and analyzed using thematic analysis until no new information from conducting interviews were discovered.

Definitions

COVID-19: SARS-CoV-2 is the virus known as COVID-19 that causes respiratory illness in the lungs and other systems in the body where symptoms range from mild to severe and in some cases cause long-term effects (Centers for Disease Control and Prevention [CDC], 2021a).

Health disparities: Health and social conditions people suffer from as a result of inequitable access to resources such as health care, education, employment, and income (CDC, n.d.-c).

Health equity: A condition in which all people have the same chance to obtain optimal health. When all people are treated equally, preventable health disparities are eliminated (CDC, 2022).

Health information: Information such as medical or health history, surgical procedures, results, medications, or other clinical data unique to the person (American Health Information Management Association, 2021). The concept of health information referred to information provided during the current COVID-19 pandemic by health officials through in-person interactions, TV, and digital media such as websites or virtual social platforms.

Health literacy: Different aspects of a person's ability to gain access to and understand health information to make informed decisions about health. Health literacy can include personal literacy, which is the ability to access, comprehend, and make health decisions. Organizational literacy considers whether all groups of people have equal access to health information and the ability to understand and make health decisions.

Digital literacy refers to the ability not only to access, understand, and make decisions about accurate electronic health mediums but also to use various forms of e-health communication such as telehealth and mobile services. Numeracy is the ability to understand various types of health information delivered through numbers such as personal or nutritional health (National Library of Medicine, 2021).

Misinformation: “False information shared by people who do not intend to mislead others.” Misinformation happens as people look for ways to build understanding where there is a gap information (CDC, 2021b).

Mistrust: Having doubts about the honesty of a person or something and the inability to trust them (Cambridge University Press, n.d.-a).

Self-efficacy: A person’s belief in their ability to perform a given behavior or to have control of their life and the environment in which they live. Self-efficacy is influenced by experiences and the resulting decisions, motivations, and accomplishments that impact behavioral choice (Carey & Forsyth, 2009).

Social determinants of health: The conditions that affect health such age and places where people reside, where they work, and where they interact socially. The conditions also include socioeconomic factors such as employment, income, education, and health care (CDC, n.d.-e).

Systemic racism: The various social systems that contribute to race-based inequities found in different aspects of a person’s life, such as disparities in health, education, and income. Systemic racism is based in the way institutions governing society create exclusionary practices targeting specific populations (McLeod, 2021).

Trust: Believing in the good of a person and that they are honest will not bring undue harm; believing in someone or something and viewing it as reliable and true (Cambridge University Press, n.d.-b.).

Assumptions

There were several assumption made in the study: (a) participants clearly understood the purpose of the study, how it contributes to the community, and the benefits to the field of public health; (b) participants read and understood all aspects of the informed consent form and felt no obligation to continue answering questions until the end of the study; (c) participants answered questions truthfully, freely, and felt safe throughout the interview process; and (d) the design of the study accurately addressed self-efficacy experiences and enabled a thorough data analysis.

Scope and Delimitations

Studies had examined the influencers of self-efficacy experiences within the African American population. I tried to discover how these experiences impacted self-efficacy during the COVID-19 pandemic. Additionally, I sought to ensure that the findings could be transferred to other settings and the study could be used to encourage future research. Delimitations included African Americans residing in the Chicagoland area and not other parts of the United States. The research was not focused on a certain age group and was limited to one geographic area. The study was focused on factors within the SEM to understand self-efficacy experiences and did not include other behavior theories or self-efficacy models.

Limitations

Limitations posed in this study included gaining access to participants in light of changing social restrictions. Communicating to the community about the research and disseminating my contact information to the targeted group to explain the purpose of the study was a challenge. Some participants may not have had access to a computer or been familiar with how to use the Zoom platform to make calls, and all participants were given the option to conduct a phone interview. I also had to determine the proper steps to protect participants' information if Zoom calls were used. Recording, storing, and protecting Zoom data required an additional approval process. Some people may not have used or had access to a cell phone or a landline for the phone interview, which could have limited their ability to participate. Understanding the impact and influence of COVID-19 knowledge and public health measures meant ensuring that the community had access to different media such as computers, social media, and television. The pandemic created challenges with finding community organizations who had to ability to partner with me in reaching community members for the study.

Significance

The purpose of this study was to fill a gap in existing research by providing unique insight on the self-efficacy of African Americans in relation to the COVID-19 pandemic, which was an under researched area in public health. The National Institutes of Health Revitalization Act of 1993 recognized the need to increase knowledge of the health needs of African Americans and the disparities that exist in this population (Crawley, 2001). The disparity of higher COVID-19 morbidity and mortality rates that mirror previous pandemic health outcomes showed that more research was needed. Community health information needs improvement, and health literacy and the ability to understand the current health climate is imperative (Akintobi et al., 2020). The results of the current study could be useful in improving health information and communication, access to care, and quality of care for African Americans. This is a population that suffers from high rates of infection and death while battling comorbidities and socioecological conditions; improvement would be a positive social change.

Summary

African Americans experience health disparities as a result of inequalities found in every layer of society, signaling the need for continual examination of their determinants of health. Research findings revealed African Americans experience with inequalities in society are found to be institutionally woven into social factors affecting health that lead to worse health outcomes (Fernander & Williams, 2022). Inequalities found within societal structures expose racial minorities to increased risk of morbidity and mortality during times of epidemic and pandemic outbreaks (Holmes et al., 2020). The health outcomes of African Americans during the COVID-19 pandemic illustrated how these disparities impact self-efficacy response related to health information. Chapter 1 provided an introduction to the study including the background of historical disparities in health African Americans experience and the disparities seen during the COVID-19 pandemic.

This chapter identified the problem, gap in research, background, research questions, and purpose of the study. The conceptual framework, definitions of key terms, and assumptions about the study design and participants were identified. The scope and delimitations explained the research focus and how it related to the larger population. Limitations described the potential impact of the research on the target group, their ability to participate, and how limitations could be addressed. The significance of this study described the potential impact for the research community by increasing awareness of African Americans' experiences, giving a voice to the participant community and justifying the need to eliminate disparities through policy changes and the creation of health equity. Chapter 2 provides a review of literature including the historical relevance of factors that impact self-efficacy response for African Americans.

Chapter 2: Literature Review

The purpose of this research was to understand African Americans’ response to COVID-19 information and health recommendations during the COVID-19 pandemic, and their self-efficacy in following those recommendations. The literature provided recent and historical context for the experience of trust, mistrust, health disparities, health literacy, communication, knowledge and risk, and cultural competency as influencers of self-efficacy. The SEM was the framework for examining the individual, community, organizational, and policy perspectives, and social cognitive theory framed the examination of self-efficacy influencers.

Literature Search Strategy

The literature search was conducted using the following databases: ERIC, Medline, APA PsycInfo, SAGE, PubMed, ProQuest, Academic Search Complete, Science Direct, PMC, Business Source Complete, and Cinahl Plus. An exploration of themes revealed throughout the literature review included the following keyword searches: *trust*, *mistrust*, *distrust*, *African American*, *health information*, *infectious disease*, *communicable disease*, *SarsCoV-2, COVID-19*, *self-efficacy, health belief, health behavior*, *health literacy*, *knowledge perception*, *risk perception, cultural competency*, *social ecological model*, and *social cognitive theory*.

Conceptual Framework

The framework for this study was the SEM. This framework was chosen to provide a comprehensive examination of how individual, interpersonal, community, organizational, and policy factors influence self-efficacy experiences with sources of health information and recommendations for African Americans during the COVID-19 pandemic.

The literature showed how factors found within SEM impact African Americans' sense of self-efficacy through their experiences in the external environment. SEM originated from Bronfenbrenner (1979) who stated that the ecological environment is interconnected with the first level closest to the person and including where initial interactions happen. SEM demonstrates how systems are interrelated, how they impact a person, and how the person affects each system (Salihu et al., 2015). Microsystems within SEM are the most inner layer of interactions an individual has; mesosystems extend into various community settings, exosystems affect individuals through external experiences not directly related to them, and macrosystems extend even further by shaping structures within the larger society. Each system found within SEM impacts individuals and groups of people differently.

SEM was applicable to this study because African Americans experienced some of the highest rates of COVID-19 with contributing factors outside of individual control. African Americans' increased morbidity and mortality has been attributed to factors such as increased comorbid diseases, decreased access to quality health care, overall poorer heath, disparities in housing such as multigenerational families living together, overcrowding, neighborhood quality, and occupational hazard from the inability to follow health guidelines (Yancy, 2020). SEM allowed for a systematic approach to the exploration of these factors and provided the foundation for analysis of the research findings. Sources of self-efficacy and trust were examined in the literature and provided an understanding of how factors within SEM impact health decisions and behavioral choice.

Microsystem (Individual Level)

A closer look through the lens of SEM helps explain how people make health decisions and establish self-efficacy beliefs. Beginning with the individual and most inner layer of SEM, Bronfenbrenner (1979) described microsystems as “a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics” (p. 22). Microsystems are the most influential, and connections at this level represent the closest relationships for individuals (Kilanowski, 2017). Establishing trust in reliable health information is important to influence self-efficacy of individuals because they initiate a cascade of information and experiences throughout groups of family, friends, and the larger community. The intrapersonal level found within microsystems describes the knowledge a person has, what they believe, and how they perceive experiences shaped by environmental and social settings (Salihu et al., 2015). This layer of interaction sets the stage for efficacy belief systems and how African American’s communicate experiences within their circle.

As individuals experience and share information about experiences resulting from disparities in health, establishing trust in health information coming from the system structures creating them will prove elusive. Johnson et al. (2020) illustrated the harmful effects of systemic racism, poor health communication, and lack of trust in the health community on a person’s belief in the ability to overcome health adversity. Johnson et al. (2020) additionally mentioned how one mother communicated to her daughter concerns of not being given full and accurate health information; the medical community's assumption of her respective level of health literacy; and the experience of being left in a hospital, feeling abandoned, and being unable to communicate her needs with clinical staff members. Several layers of SEM are apparent because this individual communicated to another person an intrapersonal belief based on a real, interpersonal experience of broken trust with the health community.

Microsystem (Interpersonal Level)

Individuals interact and build knowledge from personal experiences, incorporate experiences of others, and create foundations for beliefs about themselves and the larger society. Salihu et al. (2015) described the interpersonal level found within microsystems of SEM as a foundational part of interactions containing a social network including family members, social groups, and health care professionals. McLeroy et al. (1988) added that these groups are influential in individual health behavioral choice. Low participation and retention in clinical research trials with racial minority populations and found they may not believe participation will prove beneficial and may in fact be detrimental both individually and as a community (Alvidrez & Arean, 2002; Salihu et al., 2015).

Communication of low trust in institutional structures can pentrate historically marginalized communities, inhibiting any real momentum in health promotion behaviors. Tang et al. (2021) noted variations in trust, and that racial minorities lean inward toward their respective communities, religious institutions, or other interactions at this level as a determinant for health information. African Americans' social network extends beyond the immediate family and into the community where information from previous systemic racism becomes an extended cultural experience (Johnson et al., 2020). African Americans’ expressed concern over receiving equitable care and health information in light of contracting COVID-19 and whether race is a cofactor in receiving life-sustaining measures (Johnson et al., 2020). The public health community should begin to establish trust through the elimination of disparities and facilitating improvements in economic investment, environmental health, education, housing, health care access, treatment, and mistreatment in these communities as social sectors.

Mesosystem (Community Level)

Community settings for African Americans have historically been a place for support and a shield from outside factors that negatively affect them individually and as a group. An ecological look at communities is useful in understanding group characteristics such as age, race, residence, social interactions, where and how people come together, and the influential forces affecting them (Minkler & Wallerstein, 2012). Mesosystems include deeper interactions and how they relate to one another (Bronfenbrenner, 1979), including those in the workplace, community, educational system, or other places where social interaction takes place (Kilanowski, 2017). Privor-Dumm and King (2020) looked to the community in examining spiritual leaders as a layer of protection as African Americans’ faced disparities in disease transmission from the COVID-19 pandemic. African Americans continue to experience this health inequity, and public health officials need to understand how influential the community is in helping to ensure trust in the overall health care system, providers, and sources of health information. Community leaders offer a way to build vital and sustainable partnerships, and public health officials need to ensure communities have at the front end of a crisis the resources needed to make positive and informed health decisions.

Public health officials need to address with community leaders’ disparities in health, equitable access to resources and ensure the overall experience of people in the community is one that is built on trust. Increasing results in vaccinations will need to include a deeper look into meeting the needs of the community and the contextual value of African Americans’ experiences as opposed to a focus solely on the organization (Privor-Dumm & King, 2020). African Americans place value on religious organizations within the community, and leaders are a vital component expressing concerns, facilitating dialogue, and improving the relationship between institutions and people (Privor-Dumm & King, 2020). This population has been shown not to trust various institutions such as education, health, or government institutions and may not use these structures as a resource for health information (Privor-Dumm & King, 2020). Researchers have called for additional investigation to ensure the community has a voice to improve social structures, build trust in community leaders, and to create sustainable processes with successful outcomes (Privor-Dumm & King, 2020). African Americans’ experience when seeking health information and treatment has a direct influence on personal and community health decision making, and strengthening this relationship should be examined at the community and institutional level.

Exosystem (Organizational Level)

This organizational layer found within SEM refers to the interconnectedness of institutions, system structures, individuals, and communities. Exosystems are explained through events not directly experienced by the individual but still have an impact, and how different systems affect the individual and community as impressions are formed with different sources of contextual information (Bronfenbrenner, 1979; Kilanowski, 2017). For instance, African Americans live in areas where there is overcrowding, limited natural resources, and inadequate space for outdoor activities such as parks or places to play, and their reliance on resources such as public transportation creates a higher risk for them contracting COVID-19 (Holmes et al., 2020). Differences seen in African Americans' overall health status put them at higher risk for disease and demonstrated the inequities of resources found within social, political, and environmental determinants of health (Holmes et al., 2020). For instance, Privor-Dumm and King (2020) mentioned the historical experimental treatment and devaluation of African Americans and institutional inequities as factors in their low adherence to vaccine recommendations. The African American community may view the governing institutions as the leaders setting the stage for policy, the overall experience of disparities in health, distrust in health information and health outcomes, and the lack of community resources.

Macrosystem (Public Policy Level)

This layer of social system represents the culmination of experience for individuals as the development and direction of societal structures. Macrosystems include all three systems and represent how cultural values, belief systems, and other external structures serve as influential components for individuals and communities. Chronosystems are environmental influencers occurring across a period of time (Bronfenbrenner, 1979; Kilanowski, 2017). Holmes et al. (2020) explained the outer layer of SEM or exosystems is where health and institutional policy impact a person's health and how the disparities African Americans experience are a result of an entire system of economic, social, and environmental inequities. Public health at this layer should work toward shaping policy that will no longer leave communities at risk.

Policy change should be expeditious in the elimination of disparities to avoid future health crises with the potential to devastate vulnerable communities. Holmes et al. (2020) indicated the need for a further look into social determinants of health in times of epidemics and pandemics to create more equitable health outcomes and to demonstrate the difference in status, health, and resources for populations with a lower socioeconomic status in comparison to those with a higher socioeconomic status. Research conducted in Chicago during the 1918 flu demonstrated how increased infection and death were directly related to determinants of health seen in residential population, age, income levels, and education (Holmes et al., 2020). Evidence showed the relationship of health, social determinants of heath, and socioeconomic status for African Americans as disparities are passed down and lack of trust is passed on through the communication pathways of SEM.

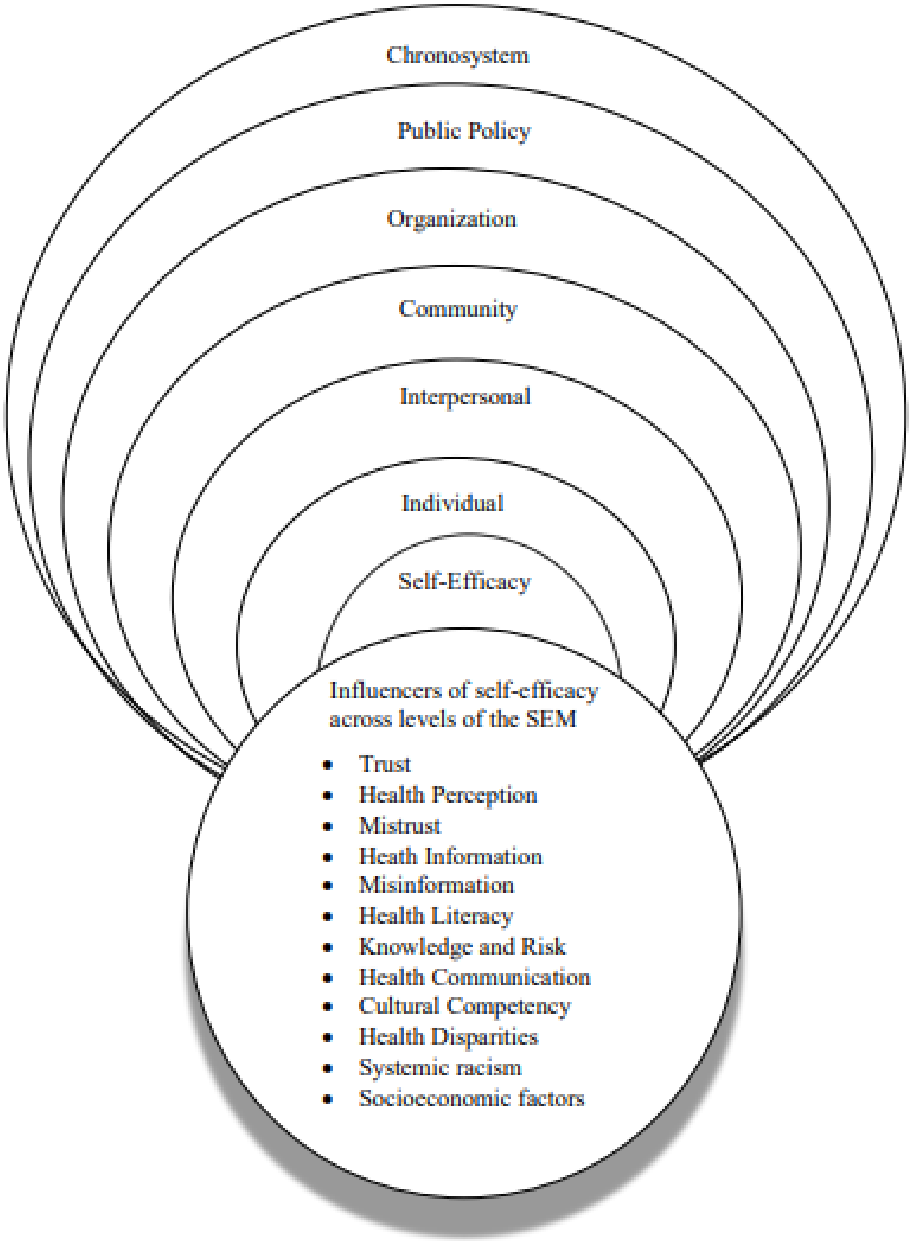
Chronosystem (Community Level Over Time)

Historical insight on the experiences of African Americans provided a foundation for understanding the impact of present-day health disparities, outcomes, behavior, and belief systems. Chronosystems, the last layer in SEM, represents events in a person's life that have changed or remained the same across a period of time (Bronfenbrenner, 1994). Chronosystems reflect not only individual attributes but also the environment a person experiences across their life and can include different aspects of socioeconomic status including income, home location, work location, life stressors, and family structure (Bronfenbrenner, 1994). The layers of SEM provide a framework to examine individual influencers and a collective view of chronosystems that shape behaviors and beliefs about self and the environment.

All the components within the SEM from the innermost layer of personal interactions through the outer layers of policy development combine to shape the health outcomes of an individual (Kilanowski, 2017). McLeroy et al. (1988) noted that health initiatives targeting changes in individuals without considering structural factors extending beyond the person will meet challenges in reaching targeted populations, and how larger systems influencing the establishment of cultural norms also have an effect on microsystems influencing behavior. A deeper look into health behavior decisions should consider the ways in which the SEM influences self-efficacy in individuals and groups (see Figure 1).

Figure 1

SEM and Self Efficacy Influencers



Literature on Key Variables

Self-Efficacy

A person’s efficacy beliefs, thoughts, and behaviors are shaped based on personal experience, shared information from others, and experiences happening in different social structures within society. Social cognitive theory (SCT), explained behavior, cognition, and other external factors as influential components; and the combination of them interacting together, influencing behavioral patterns (Glanz et al., 2015; Resnick, 2014, Chapter 9). Cognition, behavioral patterns and internalized thoughts about self, stem from the experience of performing a given behavior, vicarious experience, external input from others, and the building of knowledge from prior experiences (Resnick, 2014, Chapter 9). Participants in a study examining attitudes about testing and vaccination indicated barriers in the current system impacts efficacy response and shapes their belief about receiving treatment after a positive test result (DeRoo, 2021). When considering African Americans’ trust in sources of COVID-19 health information, it is important to note how self-efficacy, a component found within SCT works; by contributing to both internal belief systems and beliefs about the external environment. If a person has a higher belief in the ability to accomplish goals, there will be a stronger motivating push toward completion, perseverance, and the ability to come back from challenges (Bandura, 1997a). Conversely, lower self-efficacy will result in higher levels of stress, the inability to manage the stressor or find adequate ways to adjust.

Psychological State and Self-Efficacy

Examining how efficacy influences views about self and the external environment offers a window to understand how inequities across SDH contribute to belief in those views, and ultimately shapes behavioral choice. Psychological state refers to, a person making determinations on the ability to succeed from physiological factors creating efficacy judgements about health, during times needed to exert strength and endurance (Bandura, 1997c). Personal efficacy beliefs determine how someone perceives themselves, their response to a given situation, motivational cues and adaptive behaviors (Bandura, 1977b). People make determinations as they respond to their health status, successes, or adversities; and higher stress levels internally indicate, lack of control (Bandura, 1977c). A person's psychological state influences beliefs and for some is built as part of a collective experience. For instance, African Americans may have efficacy judgments of about self and health as they internalize the experiences of their extended family groups and the overall state of their ethnic community.

Mastery Experience and Self-Efficacy

Efficacy experiences influence individuals' thoughts and behavioral patterns about events happening currently, and those faced in the future. Mastery of experiences is not achieved by adaptive measures a person already has but is interwoven in a combination of factors needed to overcome obstacles including, cognitively processing, responding to, and controlling a plan of action (Bandura 1997b; Bandura 1997c). Preventative COVID-19 health information suggested people master behaviors such as social distancing, mask wearing, and washing and sanitizing hands often, which may be an obstacle in underserved African Americans communities. Mastery is the strongest indicator in determining if a person will be able to succeed, which ultimately results in a stronger sense of efficacy (Bandura, 1997c). Lack of resources in the African American community to increase self- efficacy while providing COVID-19 health information may impact a mastery experience; setting the stage for lack of trust in the institution and a foundation for individual and community beliefs about how to cope.

Social Persuasion and Self-Efficacy

Social persuasion affects self-efficacy as individual's express belief in others ability to succeed (Bandura, 1977c). As people are told they have the ability to succeed at a particular task, they will decrease any disbeliefs or negative focus on areas where there's challenges and increase persistent effort (Bandura, 1977b; Bandura, 1997c). Persuasion evokes behavioral change, helping people put forth efforts toward their own success, increasing skill and building of personal efficacy beliefs systems (Bandura, 1997c). Social persuasion is impactful in self-efficacy as African Americans share stories of personal experience and the experience of others from different interactions within an environment.

Vicarious Experience and Self-Efficacy

Another component of self-efficacy is vicarious experience where a person builds efficacy beliefs based off the accomplishments of others. Vicarious experiences for African Americans may lean into the experiences of extended family, social peers, and communities to make inferences about COVID-19 health information and health recommendations. This process is referred to as modeling and serves as a way for individuals to socially compare themselves with people of similar life circumstances (Bandura 1997c). Modeling builds personal efficacy and impactful in influencing beliefs about whether a person can succeed or fail in a given situation (Bandura, 1997b). The disparity in health outcomes, disease prevalence, and inequity of resources for African Americans during the COVID-19 pandemic, influences a collective, cultural experience.

Disease Prevalence and Self-Efficacy

COVID-19 disease prevalence shows minorities have higher morbidity and mortality in comparison to non-minorities which may have an impact on efficacy beliefs about the ability to control one's health. Age adjusted death rates reveal for COVID-19 across the U.S. per 100,000 people, Indigenous deaths at 561, Latinos 478, Pacific Islanders 469 and African Americans 448 (APM Research Lab, 2022). Although African Americans' fell behind Indigenous American and Pacific Islanders when examining age adjusted death rates, a study conducted by the Commonwealth Fund representing 681 or 1/3 of all U.S. counties where African Americans held a higher population, had 53% of all COVID-19 morbidity and 63% of mortality (APM Research Lab, 2022; Fernander, & Williams, 2022; Zephyrin et al, 2020). Disparities for African Americans exist in both in urban and rural locations showing an increased morbidity, mortality, and case fatality rate across the U.S. and are more likely than their White counterpart to die from COVID-19 by 15% in Michigan, 51% in Wisconsin, and 7.9% in Louisiana (Holmes et al., 2020). In Illinois, the crude death rates per 100,000 people for African Americans are highest at 343 compared to Whites at 293, Latinos at 215, Asians at 144, Indigenous populations at 133 (APM Research Lab, 2022). Age adjusted deaths in Illinois show a similar pattern and higher for African Americans than all ethnic groups other than Latinos, and 2.3 times higher than Asians and 67% higher than White Americans (APM Research Lab, 2022). African Americans were also 2 times more likely to die in Chicago and 13% more likely to die in Illinois overall (Holmes et al., 2020). Testing, treatment, and low vaccination rates have also shown a similar disparity across the U.S., which may be another indicator of barriers this population experience. African Americans have shared their concern about mistreatment factors both historical and current and the presence of higher deaths rates from other diseases as a contributor to the decision on becoming vaccinated (Balasuriya et al., 2021). Recent data indicates only 10% African Americans have received one dose of the vaccination compared to 55% of Whites, and 21% of Hispanics and only 8% of African Americans have received a booster in comparison to 60% of Whites and 15% of Hispanics (Ndugga et al., 2022).

Disparities in health reveal coexisting patterns with socioeconomic factors including all of the aforementioned and may be influencers of efficacy response and health outcomes. There is a connection between health and the socioeconomic environment that impacts how people live and their behavioral choices (Marmot, & Allen, 2014). According to Jones et al. (2018), in a comparison of the state of African Americans today compared to where they were in 1968 relative to Whites, revealed although there were improvements, African Americans still fell short compared to their White counterpart in education, income and health and in some cases are worse off today. Institutionally, racism was highlighted as a one of the factors in COVID-19 disparities and in other areas where we see increased morbidity and mortality (Corbie-Smith, 2021).

Changes that address COVID-19 disparities should look toward health care institutions and systemic racism experienced at different levels within our society (Hull et al., 2020).

Lower income levels for instance, are associated with a higher likelihood of COVID-19 infection and potentially increases severity of disease due to the relationship of poverty, comorbidities, health care access, and the inability to social distance from others (Chin et al., 2020). Racial minorities may experience challenges with social distancing due to extended generations of families affecting how often people come in contact with the virus and how it is transmitted (Bibbins-Domingo, 2020; Chin et al., 2020). It is important to note, while all African Americans populations may not experience the same types of social disparities, they will to some degree be affected by the same type of systemic racism leading to a higher chance of increased COVID-19 infection (Peek et al., 2021). Researchers in the field of health communication mentioned how shifting the focus of change away from individuals, brings more focus on the longstanding systemic inequities within society; and how disparities in health are influenced and controlled by current system structures and not within control of the group experiencing them (Hull et al., 2020). Examining the root causes happening within our society expands understanding of why disparities in health for African Americans continue.

Trust

Individuals have both direct and indirect experiences influencing their ability to trust in people and institutions. When examining this concept for minorities it is important to not view trust as a needed change for this population, but with a focus more on the actual cause of mistrust (Crawley, 2001). Two types of trust, interpersonal and institutional trust examine how people experience the health care system; and people who report having lower levels of trust have additionally reported a negative experience within health care (Schwei et al., 2014) The establishment of institutional trust is critical for health behavior and the reduction of health disparities; and qualitative research is needed to understand what identifiers constitute a negative health experience, if it happens at the individual level with the health care provider, or on a larger health system level (Schwei et al., 2014). Interpersonal trust is the level of trust a person has in their physician where institutional trust happens on a system level and includes the overall medical profession, health care system, insurance companies and other related organizations (Schwei et al., 2014). Both types of trust are interwoven as a person's level of trust in the institution will impact the ability to establish interpersonal trust with a provider (Schwei et al., 2014). Conversely, when a breech in interpersonal trust ensues, institutions will work toward eliminating of the experience of prejudicial treatment, however, a gap in patients' expectations of a fair and equitable health system overall supersedes any corrective measures an institution tries to implement (Sullivan, 2020). Trust experiences happening both at the interpersonal level and institutionally, impact efficacy and influence how information is shared with family, friends, and the larger community.

Belief and trust in health institutions is built from information people receive and what they experience firsthand. Trust is the combination of knowledge from previous experience and from others setting the stage for establishing belief systems, future expectations, determining degrees of trust and an overall ability to trust (Goold, 2002). Socially, trust is built from anticipated interactions with expectations of another to act in their best interest (Goold, 2002). Although trust is discussed in interpersonal relationships, it is part of a larger system of interactions between people who are not necessarily familiar with each other (Gilson, 2006). Establishing trust in health care poses a unique challenge, and as interactions happen at multiple stages, the overall experience influences beliefs about the system as a whole. Trust in health care is dynamic and critically important requiring cohesiveness at different levels of the organization (Gilson, 2006) When considering the relationship between patients and their physician, willingness to trust creates a layer of vulnerability as patients rely on the physician to act as the expert in providing care (Sullivan, 2020). If a patient believes the physician to be trustworthy, levels of self-efficacy increase along with the expectation of health from the recommended behavior (Lee & Lin, 2009). The establishment of trustworthiness supersedes efficacy response and influences beliefs about interpersonal relationships, treatment expectations, and the overall institution.

Trust and Self-Efficacy

Self-efficacy beliefs and trust both stem from experiences with people, communities, organizations, the external environment, and information shared from these experiences impact behavior response. Bandura (1997c) mentions self-efficacy, a component of social cognitive theory (SCT), as acting with social and environmental factors “to govern human thought, motivation and action” (p. 34). Self-efficacy serves as an indicator of how a person will respond in a given situation, in terms of what they think, believe, and the amount of motivation and dedication toward a specific behavior (Bijl, & Shortridge-Baggett, 2011). Higher self-efficacy results in better self-regulation, readjustment, and less stress (Bandura, 1997a). Efficacy belief systems are impacted by factors such as where a person lives, race, ethnicity, and experiences both individually and within community groups. Individuals with less access to resources are left without a sense of power, and experience higher levels of emotional distress (Ross, 2011). COVID-19 illuminated various disparities without continued focus, and how less resources have left communities to deal with both economic hardships and in emotional distress (Jean-Baptiste, & Green, 2020). Both experiences and interactions found within layers of SEM indicate contributors to self-efficacy and the COVID-19 disparities in African Americans communities equally indicate factors outside of the individual.

Trust additionally influences efficacy, shaping response and establishing beliefs about self and larger social structures. Theories on trust remain vast, but foundationally trust is necessary in society and based on individual and institutional experiences and interactions (Sullivan, 2020). While socially, trust offers an opportunity to establish healthy relationships, it requires belief in people, entities, taking risk, and relinquishing control (Ross, 2011; Sullivan, 2020). People make active judgments to trust based on past experiences of proven trustworthiness and those with lower income levels and more marginalized groups report higher levels of broken trust as part of their lived experience (Gilson, 2006; Sullivan, 2020). Further examination of trust, efficacy, and the lived experiences of African Americans during the COVID-19 pandemic will help the public health community better tailoring health communication, provide community resources and provide health care professionals with an understanding of their unique and relevant health needs.

Trust and Health Perception

Increased morbidity and mortality during the COVID-19 pandemic demonstrated proven disparities in health for African Americans and the need for increased understanding of how factors like efficacy and trust contribute to health outcomes. Benkert et al. (2006) conducted a study examining the perception of racism's influence on cultural mistrust, trust in providers, and its combined effect on satisfaction with care. By not taking into consideration the unique health conditions of African Americans and bias in care, trust remains an issue in patient-provider relationships for primary care services and with adherence to provider recommendations (Benkert et al., 2006). Additionally, perceptions of racism, trust, and provider relationships remains limited despite acknowledgment from the African Americans community of discriminatory treatment within the health care spectrum (Benkert et al., 2006). Mistrust experiences and perceptions of care, racism, and mistreatment all affect the health behavior and outcomes of African Americans. Vaccine efficacy was reexamined by researchers to change the language of hesitancy to one of distrust, shifting the focus outward toward systemic level issues rather than on individuals. For instance, vaccine disparities in Chicago showed an inequitable distribution in access when a predominately White community in the 60611area had 77% of its members receive the first dose compared to a predominately African Americans in the community in 60621 area with only 34.2% receiving the dose and that disparity still exists sitting at 106% and 57.9% respectively (Madorsky et al., 2021; Chicago Data Portal, n.d.). Researcher additionally noted these types of inequities in racial minority communities lead to distrust in the systems designed to provide care for them (Madorsky et al., 2021). It is critical to understand how public health information, recommendations, and treatment such as vaccine distribution impacts this community in order for health officials to work toward the elimination of disparities in the distribution of care and services.

Self-efficacy is impacted by a person’s health perception as community resources such as vaccines and access to care is made available to different populations. Sachs et al. (2017) examined African Americans perceptions of health, community, barriers to health, mistrust, and how those experiences influence health behavior. The lack of investment in communities fostered a sense of devalue, and members expressed having a lack of hope and feeling discouraged in the pursuit of health (Sachs et al., 2017). Structurally, living in communities with food desserts or where healthy food creates an economic burden and limited places to exercise, additionally influenced health behavior (Sachs et al., 2017). Health education was expressed as a component lacking in communities despite residents expressing the need to teach families about healthier choices (Sachs et al., 2017). Health care and most notably primary care were not an option for residents where most expressed concerns with the ability to trust in providers and experiences with substandard care (Sachs et al., 2017). From an institutional perspective there was an overarching expression of mistrust and community members mentioned the preference of using home remedies instead of using health care, missing opportunities for primary and preventative care services (Sachs et al., 2017). Researchers illustrated the importance of understanding perceptions a community has about their health, factors influencing health behavior, and care they receive in health care settings (Sachs et al., 2017). Community members described experiences with providers and the lack of community investment left them with a feeling of inferiority, isolation and uncared for (Sachs et al., 2017). Recognizing the needs of a community is essential to give them power and help establish the creation of programs centered on their unique needs, ultimately improving health, and helping in the creation of effective, longstanding programs (Sachs et al., 2017). Researchers concluded further studies on distrust and perceived racism in minority communities should be considered to improve minority health and work towards the reduction of health disparities (Sachs et al., 2017). African Americans health is not based solely on behavioral choices but includes a network of system structures that in combination influence efficacy responses and create environments where they see no investments in their health conditions overall.

Other groups within the African American community reveal a similar experience and set of beliefs with placing trust in the health system. Hansen et al. (2016) noted how experiences of older African Americans shape trust with their health care providers. Older generations report experiences of mistrust as a result of prejudicial treatment due to their age, exercise of autonomy and health belief system (Hansen et al., 2016), African Americans males in the LGBT community report discriminatory treatment due to their sexual preference and how the influence of discrimination resulted in less health care utilization (Qiunn et al., 2019). African Americans women report perceptions of discriminatory acts as happening upon entry to medical establishments, having to assert their voices, being looked at as drug users; and did not feel their doctors would be an advocate for their health, while noting a lack of trust. (Cuevas et al., 2016). The similarities of a collective mistrust experience within subgroups of African Americans demonstrate the need to further understand how mistrust influences efficacy both individually and within communities.

Mistrust

Inequitable treatment creates an opportunity for mistrust as people share information about their experiences and influence others. Research illustrates mistrust in the health system results from discriminatory experiences both of a personal nature and those within community group dynamics (Sullivan, 2020). Mistrust is based not only from personal experience but also past and learned experience coming from a specific racial or ethnic group (Katz et al., 2009). Trust and mistrust coexist as a dual concept where mistrust is not only the lack of trust but is additionally indicative of a conscious belief in intentional malice (Jaiswal, 2019a). Varying levels of trust are considered contributors to the disparities in health seen in racial and ethnic minorities across the U.S. and mistrust in the African Americans community is evident in various system structures where Whites have held power (Schwei et al., 2014; Benkert et al., 2006).

Research has shown racial and ethnic minorities overall have significantly lower levels of trust when compared to Whites (Kennedy et al., 2007; Braunstein et al., 2008). Despite improvements that focus on increased access, it is well documented, African Americans still experience disparities in access and overall quality of care when compared to their White counterpart (Kennedy et al., 2007). Reports of discrimination reduce trust in providers and in health care institutions, creating communication barriers, reduced health seeking, and medical adherence behaviors (Williams et al., 2019). Improving the experience of racial and ethnic minorities in health care systems will positively impact institutional trust and decrease disparities in health (Schwei et al., 2014). Efficacy responses are influenced by the experiences of African Americans when seeking care, and the persistent effort to create trustworthy institutions is needed for this community.

Health Information, Communication, and Self-Efficacy

Access to accurate health information is crucial in influencing self-efficacy in both individuals and groups. Information flows quickly, with limited ability from the research community or others responsible for the accurate dissemination of health data, to check, dispute, and remove misinformation (Viswanath et al., 2020). Today, COVID-19 health information on disease transmission, morbidity and mortality is available in almost real time, leaving an opportunity for the global spread of both accurate and inaccurate information (Viswanath et al., 2020). Racial minorities my be particularly susceptible to exposure from inaccurate sources of health information retrieved from non-credible sources outside the scientific and public health community. Researchers mention the importance of having access to health information to establish levels of health risk and make health decisions; and how social determinants of heath (SDH) are important during a health crisis as they influence the ability to obtain and understand health information, and to positively implement health behaviors (Tang et al., 2021; Viswanath et al., 2020).

African Americans may face disparities with limited access, health literacy, and levels of trust in accurate health information, creating for them an undue burden of health inequality. Researchers have questioned how the vast amount of COVID-19 information affects various groups from different socioeconomic backgrounds, and if information is spread equally across all communities (Viswanath et al., 2020). Sources of health information is obtained as people actively research for it or through more passive processes, such as when information appears in media outlets while engaged in other activities (Tang et al., 2021). Researchers sought to understand the health behaviors of middle-aged African Americans in obtaining and evaluating health information during COVID-19 and found more participants received health information during scanning activities such as social media or television use (Tang et al., 2021). This leaves an opportunity for public health officials to build trust and use these sources to communicate directly with this community. Middle-aged participants relied on television as the main source for receiving health information over social media and faced difficulty deciphering inaccurate information from various forms of media based on decision making from learned experiences (Tang et al., 2021). This demonstrates how individuals' decision to trust sources of health information and recommendations is influenced by both direct and indirect experiences happening within their environment.

Misinformation

The type and quality of health communication and misinformation has mirroring effects on minority health as they seek out trusted sources of providers and health information to care for themselves and their communities. Chandler et al. (2021)

conducted a study with Black women to examine their sources of COVID-19 health information and the impact in their lives. They sought to understand the obstacles Black women faced during the pandemic, to reveal their sources of COVID-19 health information, and their trust in these sources (Chandler et al., 2021). Researchers noted Black women were suffering from COVID-19 infections at a higher rate higher than seen in their White counterpart and the existing disparities in health they experience additionally increases the likelihood of higher morbidity and mortality (Chandler et al., 2021). In Black communities and particularly for Black women, misinformation about COVID-19 has been counterproductive in stopping the spread of the virus (Chandler et al., 2021). In addition to misinformation, both previous and current mistrust experience in health care and with other system structures are pivotal in the mistrust of COVID-19 health information (Chandler et al., 2021). Current pandemic research has revealed limited data on Black women's experience, limited insight on their views of COVID-19 health information and noted the importance of gaining this perspective in light of their increased health risk (Chandler et al., 2021). The need for mitigation efforts of COVID-19 is vast and should include a focus on factors within social structures including economic, housing, access to food, employment, and tailored health services to eliminate gaps in health care access (Chandler et al., 2021). Misinformation and mistrust experiences for African Americans impact self–efficacy beliefs, behaviors and health.

Health Literacy

Health literacy, knowledge, and the perception of risk are all contributors of self-efficacy. Health literacy, "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions," has been revised by the U.S. Department of Health and Human Services to include a stronger emphasis on the person, and break down health literacy into personal and organizational definitions (National Institutes of Health, n.d.). Personal health literacy looks deeper by examining if the person understands health information and is empowered to use the information to make the best health decision (National Institutes of Health, n.d.). It is the degree to which individuals have the ability to find, understand and use information services to inform health-related decisions and actions for themselves and others (National Institutes of Health, n.d.). The organizational definition puts ownership of health literacy on the organization to ensure health information is delivered in a way that allows for all people to have equal access and opportunity to understand meaning and resource allocation. It is "the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others" (National Institutes of Health, n.d.). SDH such as poverty and lower education levels place individuals at increased risk for low health literacy and poorer health outcomes.

Lowered literacy and educational attainment for African Americans is a result of systemic inequalities, racism, and aids in the continuation of policy leading to disparities in health (Adebayo, 2020). Health literacy is dynamic and low literacy is not unique to low SES as it affects all people's ability to access information, and the skills needed to navigate through varying degrees of health information (National Institutes of Health, n.d.). Lower health literacy, however, impacts the person and is influenced by societal structures that directly contribute to inequities in the ability to understand and access health information.

Knowledge and Risk Perception

Efficacy and risk connect itself as a person with high efficacy or the belief in the ability to perform a given behavior and equally high-risk perception, will enlist stronger preventative behavioral measures; while conversely, a person who has lower levels of efficacy and higher risk perception will likely not act in ways that reduce or prevent exposure to risk (Nazione et al., 2021). Researchers examining two types of COVID-19 communication, both mediated and interpersonal, asked participants to explain their perceptions with risk, efficacy, and preventative behavior (Nazione et al., 2021). They explored the perception of risk in African Americans and noted 50% believe in fate or destiny as the factor of health outcomes or expressed health as a primary concern (Nazione et al., 2021). Risk communication from government websites such as the CDC or WHO was shown to not be a source of health information in comparison to other forms of communication such as social groups, news and social media, and researchers noted the importance of ensuring these outlets understand the effectiveness of efficacy communication (Nazione et al., 2021). Researchers additionally mentioned the importance of understanding risk and efficacy perceptions to better inform health communication from public health officials (Nazione et al., 2021). Efficacy proved a strong indicator of behavior showing a higher association with preventative behavior than the combination of severity and susceptibility perceptions (Nazione et al., 2021). Although severity and susceptibility perceptions are indicative of some variance in prevention, efficacy stood as the strongest indicator, and as underutilized in health communication (Nazione et al., 2021). Efficacy influences behavior, and even with the perception of risk, tailoring heath communication using a source people trust may positively impact behavioral choice.

Health Communication

Effective health communication is critical in understanding the needs and behaviors of minority groups who experience health disparities and whose health behavior is contradictory to mainstream medicine. In alignment with mastery of experience, a patient's self-efficacy is influenced in environments where trust exists and success in experiences happen through supportive communication, offering motivation to act in adherence to medical protocol and overcoming obstacles to adherence (Lee & Lin, 2009). Higher levels of self-efficacy allow patients to better adapt to being sick, overcome challenges, improve communication of health and patients trust in their physician leads them to better expectations of health when adhering to recommended treatments plans and behavioral advice (Lee & Lin, 2009). Researchers concluded, patients who trust in physicians exhibit a stronger level of self-efficacy, have better outcomes in health status, and higher efficacy leads to better reporting of health conditions (Lee & Lin, 2009). The type of health communication a person experiences when utilizing the health care system is noted as a primary component in the continuation of disparities and future utilization of the health care system (Adebayo et al., 2020). Health communication is most effective when it incorporates both the patient and provider, focused on patient needs, providers are actively engaged in those needs, and incorporates the patient’s perspective in the care plan (Hashim, 2017 as cited in Adebayo et al., 2020). Health communication from providers is likely to become a relied upon source of information if the relationship between the provider and patient is built upon trust. African Americans experience of racism in health care, negative experiences with accessing services, and worse health outcomes create for ethnic minorities the precursor for disparities contributing to chronic illness and increased disease morbidity and mortality (Hashim, 2017 as cited in Adebayo, 2020; Mays et al., 2007). This experience could make it harder for ethnic minorities to discern when to place trust in providers and their health communication.

As health officials provide information and services to ethnic minorities, it is imperative to not only understand external factors affecting behavioral choice, but also build a relationship of trust, that demonstrates value and respect. Interpersonal relationships where patients are understood and valued individually and culturally are more likely to reveal health conditions to their provider and adhere to medical protocol with health implications expanding beyond the patient and into the extended community group (Adebayo et al., 2021). Cultural competency and sensitivity are key points in mistrust and found to be lacking in providers and clinical workers alike, and these differences result in significant gaps in understanding how to provide care (Kennedy et al., 2007). Behavioral practices may in fact be based more on historical disparities such as low income and structural racism such as decreased health care access, coverage, and lowered quality of care (Singer, 2012). The current health care system is framed around Europeans and centered on their value systems which may be misaligned with other groups who additionally represent the larger societal structure (Singer, 2012). Mistrust and its historical context should be incorporated in cultural understanding when providing care in order to avoid reoffending (Adebayo et al., 2021). Research indicates better health outcomes for African Americans call for increased cultural competency and more specifically its effects on relationships with providers and their patients (Benkert et al., 2006). Improved cultural awareness and communication may help health officials and care providers build understanding of the many factors impacting behavioral choice and response.

Health Disparities and Self-Efficacy

The purpose of the historical review is to understand the relevancy and health effects of longstanding mistrust experiences within the African American community. Past health conditions of African Americans dating back to slavery were of marginal concern to slave owners and in turn, African Americans endured an enormous amount of mental, physical, social neglect and discrimination (Noonan et al., 2016). The combined historical effects of slavery and health disparities are still visible today, as 150 years post slavery African Americans still bear the burden of inequality, and discrimination; and consistently suffer worse health outcomes from systemic inequities such as clean water, environmental sanitation, and access to health care services (Noonan et al., 2016; Hagen, 2005). Both the psychological and physiological effects of slavery have been passed on throughout generations and thought to be responsible for maladaptive health responses evident in the overall lowered health outcomes seen in African Americans (Grossi, 2020). Health trends indicate African Americans had higher death rates than Whites across all cases of mortality with the leading cause of death in the early 1900's resulting from pneumonia, influenza, heart disease, TB, and stroke respectively (Hahn, 2020). Black populations have displayed a significant amount of resilience throughout history and during the 20th century, relied on more traditional forms of medical practice and spiritual connections forming a protective layer within their respective communities (Hahn, 2020).

Although the passage of constitutional amendments guarantees rights for African Americans, institutions within the U.S. are still unable to ensure this population share the benefits of equal access seen across the larger society (Hahn, 2020). Additionally, the Civil Rights Act, stands as a pivotal marker to indicate the illegitimacy of discrimination in every sector of society including residential housing, securing health care and employment (Hahn, 2020). Despite the protections in place to guarantee equitable access, disparities within this community both historically and present day indicate larger systemic contributors extending beyond an individual's behavioral choice, beliefs, or value system.

Systemic Racism

The historical effects of systemic racism still evident in social structures today helped African Americans shape efficacy beliefs and trust in the overall system governing them. For instance, the Tuskegee study brought to the forefront discriminatory roots embedded within the history of the United States as the Public Health Service and the Tuskegee Institute partnered to study untreated syphilis in Negro male (Hagen, 2005). It is noted as the primary reason for both historical and current context in the lack of trust in government bodies and the mistrust we see in health care (Kennedy et al., 2007).

Hagen (2005) mentioned three decades post Tuskegee, the level of disbelief and bitterness still resides. This study exposed multiple layers of discrimination of African Americans in public health, research, and health care impacting trust, and demonstrating complete disregard of the person at the institutional level.

Both historical and current systemic racism has contributed to the continual mistrust in health officials and health information impacting the ability of African Americans to have control over their health. Researchers today question what the legacy of Tuskegee has taught them when addressing the dynamics of infectious disease research in African Americans such as with AIDS and the effects on their role in the practice as educators (Hagen, 2005). Public health officials are called to understand how Tuskegee has led to the belief in AIDS as a way to purposefully bring harm to this community (Thomas & Quinn, 1991). The Tuskegee study left behind a legacy of broken trust that brought apprehension in trusting HIV education in the early 21st century enabling the disease to spread faster in this community (Hagen, 2005). Today estimated rates of HIV prevalence is still eight times higher than in White counterpart populations (Mattocks et al., 2017). The latest studies indicate African Americans make up an estimated 42% of the newly diagnosed cases in the US (CDC, n.d.-a). While mistrust is directly related to poor health outcomes for both ethnic and non-ethnic minorities alike with HIV, African Americans however experience higher morbidity and mortality, less opportunity to access medication, and less compliance with medical recommendations (Mattocks et al., 2017). Mistrust is also a component in the reduction of health seeking behavior such as HIV preventive health and treatment (CDC, n.d-b.) and HIV infected members of this population also report low trust in the health system and less compliance with prescription medication (Mattocks et al., 2017). Additional factors including poor health and social inequality are directly attributed to the disparity in HIV and AIDS in African Americans communities (Thomas & Quinn, 1991). As African Americans continue to experience an overall lower socioeconomic status, they have a harder time with accessing care, HIV health related information, increased risk and decreased chances of a positive health outcomes (CDC, n.d.-b). Equitable access to care and trust in health information remains a critical factor in health outcomes, adherence, and prevention.

Disparities in health for African Americans predates Tuskegee and research indicates earlier accounts of systemic racism influential in establishing efficacy beliefs and mistrust. During the 1700’s yellow fever pandemic, African Americans were told to believe they were immune to infection, called to the front lines to provide care for Whites, and died at the same rate as their counterparts (Evans, 2020). The 1918 influenza pandemic revealed higher mortality than Whites with similar preexisting conditions, and inequities such as racism, segregation, access to health care; and African Americans nurses pushed to provide care at White institutions are all believed to be a contributor in rates of infection and mortality (Evans, 2020). Additionally, in the early 1900’s until 1920’s infectious disease deaths in urban areas were higher for African Americans in comparison to their White counterpart during the 1918 flu pandemic (Feigenbaum et al., 2019). A historical review revealed higher infectious disease originating in the south later declined due to a shift of African Americans who largely population this area; and after the migration of this community into more urban environments, disproportionate rates of infectious disease deaths were so significant it created entire regional shifts in mortality rates for all of the United States (Feigenbaum et al., 2019). The health system as part of a larger social structure has revealed a legacy of disparities for African Americans that parallels disproportionate rates of both infectious and non-infectious disease and increased morbidity and mortality overall.

Current studies show a similar account of how systemic racism has led to disparities in health and less trust in the health system. The CDC (n.d.-d) indicate African Americans have the highest rates of influenza compared to other ethnicities and have a higher likelihood of being in the hospital from flu related complications. Ethnic minority communities experience a higher rate of infectious disease in comparison to other groups resulting from medical mistrust and decreased heath care access (Evans, 2020).Poverty and other social determinates such as inadequate housing place poorer people such as Black and Hispanic populations at increased risk for worse flu symptoms and increased hospitalizations (CDC, n.d.-d). Further qualitative research is needed on medical mistrust to examine from an intersectional perspective the mistrust experienced by underserved communities (Jaiswal, 2019b). African Americans are called to the sciences in order to advocate for their communities to build a better understanding of research and to help repair the climate of mistrust (Kennedy et al., 2007). Discrimination, mistrust, and improvements in communication have remained stagnant over the last decade and researchers emphasized how the experiences today are equally applicable (Cuevas et al., 2016). Historical evidence on the overall impact and mistrust in social systems is clear however, the steps to build foundational trust and establish health equality remain slow as

African Americans continue to experience discrimination, decreased access and worse health outcomes.

Systemic racism is not limited to the disparities found within social structures such as health systems, but additionally includes the interactions people have while accessing health services and during patient-provider interactions. Perceptions of discrimination provide contextual insight into the mistrust of physician care and the health care system overall (Armstrong et al., 2013; Malebranche et al., 2004). As a result, African Americans today are noted to use a different approach to health care including the use of alternative or other forms of treatment; and indicate they feel a sense of devalue with provider relationships, less sense of severity with illness diagnosis, treatment, and lower quality of care services (Hansen et al., 2016; LaVeist et al., 2000). Foundational mistrust is multilayered, and reports of racial bias and stereotypical belief systems from providers has led to differences seen in health care (Kennedy et al., 2007). Researchers examined how African Americans perceived discrimination, mistrust, and lower quality of care in the health system compared to Whites, noting how these perceptions are shaped by previous experiences; and offered suggestions on the improvement of patient provider relationships, including the avoidance of behaviors perceived as discriminatory, remaining mindful of communication and the impact on health (Cuevas et al., 2016). Systemic racism remains a key factor in efficacy, adherence and overall choices people make about their health, and whether organizations can be entrusted with the care.

Socioeconomic Factors

The examination of socioeconomic factors offers indicators on how disparities impact health, efficacy, and the ability to trust social structures reenforcing them. According to the first recorded Census, Black populations earned less than 45% of White populations resulting in a significantly lowered ability to access resources, accounting worse health outcomes for this population (Hahn, 2020). Disparities in income, education, and health in the early 1900's show only 22% of Blacks owned property in comparison to 49% of Whites; 37.8% of black boys, and 41.9% of black girls attended school in comparison to 72.2% and 71.9% of white boys and girls respectively (Hahn, 2020). In a comparison of African Americans high school graduation rates from 1968 to current time, African Americans completed school 54.4 % compared to Whites at 75%. And while the gap has closed to 92.3% and 95.6% respectively; African Americans graduate college at lower rate by half compared to Whites despite being two times more likely than in 1968 to have a degree (Jones et al., 2018). Literacy levels were equally disparaging as only 4.6% of the White population was considered illiterate in comparison to 44.5% of the Black population (Hahn, 2020).

African Americans exposure to educational advancement in comparison to Whites show a mirroring disparity with less completion of high school education at 72.5% versus 87.2% respectively and 18.6% of Blacks having a bachelor's degree compared to 32.5% of their White counterparts (Institute of Education, 2016, as cited in Noonan et al., 2016). This disparity continues in unemployment where African Americans rates double that of Whites at 6.5% and 3.5% respectively (U.S. Bureau of Labor Statistics, 2019). A review of estimates from 2017 indicated African Americans experienced higher unemployment and 8% higher than in 1968 where unemployment rates declined by .6% for Whites during the same timeframe (Jones et al., 2018). Comparable household incomes for African Americans are the lowest for half a century in comparison to all other races at $35,398 for Blacks, $53,657 for Whites and $74,297 for Asian populations (Renwick, 2015, as cited in Noonan et al., 2016).

Disparities in education, income, and health are highest for African Americans and reinforces how larger social issues are direct factors in the efficacy of this population. Further research continues to reveal how higher layers found within SEM impact efficacy and health. Noonan et al. (2016) conducted a review of literature on the health status of African Americans, framing their study around SEM and applying a focus on disparities, determinants of health, risk, morbidity and mortality. The use of SEM centered on SDH and described the differences seen in race, poverty levels, and gender as influential components of health (Noonan et al., 2016). Researchers explicitly noted the difference in focus of health disparities and health inequalities by making a distinction in disparity of health; as being uneven in particular groups, verses an inequality or social conditions such as economic level, racial category, or gender, who experience differential treatment that otherwise would not warrant exposure (Noonan et al., 2016).

Racial discrimination is evident and part of a social structure that crafted an intentional process alienating African Americans from societal benefits in health, not seen or accounted for through health measures but nonetheless, evident with manifestations in other areas of African Americans lives (Noonan et al., 2016). This population remains the poorest of all ethnicities with the lowest income levels for the past 50 years and its direct association decreased overall health and higher chance of illness and death (Noonan et al., 2016). Researchers here mentioned the Heckler Report created by Margaret Heckler in 1984, illustrated the magnitude in which African Americans today still suffer from undeniable health and social inequalities in the US, highlighting under-reporting of African Americans health and providing a map for corrective measures to help eliminate disparities in racial minorities (Noonan et al., 2016). Additionally, the report revealed the lack of influence African Americans have on social change as they lack positions of power in policy making (Noonan et al., 2016). Racism is seen in every sector of society including the educational system, equal housing opportunity, quality of neighborhoods, employment opportunities, health care access, health outcomes, environmental exposures, nutritional deficiencies, increased violence in neighborhoods and in drug abuse (Noonan et al., 2016). Institutions have historically failed African Americans from a socioeconomic perspective and with every social determinant of health; therefore, it should not be an anomaly that trust in system structures remain elusive.

It is important to consider how discrimination and socioeconomic status (SES) intersect when specifically addressing disparities in health and mistrust of health institutions. SES stands as a predictor of health, and described as being inclusive of education, income, employment level, and as an indicator of health and racial disparity (Williams et al., 2019). Researchers sought to examine the relationship of discrimination on health, the use of health care services, and its impacts from a social perspective. They mentioned studies indicate reports of discriminatory acts have an inverse effect on access to care, and that minorities consistently show disparities in health across multiple health conditions and levels of disease severity (Williams et al., 2019). Discrimination is considered an overall risk in health outcomes and in the use of heath care services and complex in that system structures are influenced by it; and the reinforcement of it is seen across various segments of our society that shape how our political, legal, and financial structures operate (Williams et al., 2019). From an institutional perspective, racism manifest in housing through racial segregation, which is a key indicator in SES by reducing access to education for both elementary and higher education and impacting employment opportunities (Williams et al., 2019). Increased SES reduces discrimination in White communities but opposite effects for Black and Brown communities where comparable increases in SES shown additional increasing reports of discriminatory exposure (Williams et al., 2019). The application of SEM in examination of efficacy continues to illustrate larger societal factors outside of the individual.

SEM and efficacy beliefs connect itself as African Americans experience social, educational, and economic differences over other ethnic groups. Researchers examined the relationship of a person’s sense of self-efficacy and SES as it relates to their residential neighborhood and notes SES is viewed as an attribute of a person versus the environment in which they exist (Boardman & Robert, 2000). Residential SES determines the number of resources an area has and what a person can access across a span of time which reinforces personal efficacy beliefs and stands as a determining factor in societal placement (Boardman & Robert, 2000). Employers have been shown to discriminate in areas with some of the lowest SES, reinforcing a decreased influx of economic and other resources and further causing an inability to secure employment (Boardman & Robert, 2000). Self-efficacy builds as a person develops belief systems about self, the approval of others and how they measure in society (Boardman & Robert, 2000). Neighborhoods with a lower SES and decreased opportunity to be around higher efficacious people, may experience lower personal efficacy beliefs, while higher SES indicates increased self-efficacy, better employment, and personal and professional development opportunities (Boardman & Robert, 2000). As shown in Figure 1, contributors in efficacy beliefs are directly tied to the experiences happening within the layers of SEM and demonstrate through existing literature how impactful they are in African Americans behavioral choice, health outcomes and institutional trust.

Summary and Conclusion

The literature review provided an examination of how system structures within society are influential in the self-efficacy experiences of African Americans. Individuals, community, organizations, and public policy work in unison to create an environment in which individuals build experiences, knowledge, beliefs, and value systems. African Americans exists within this system and for them, or other low income, historically oppressed people, this involves a higher level of discrimination and health disparities for both infectious and chronic diseases, as well as an overall disparity in social determinants of health.

Self-efficacy for African Americans as it relates to sources of COVID-19 health information, is built upon the interconnectedness of these systems and the individual and collective experiences happening within them. Lower levels of knowledge about COVID-19 and the disproportionate number of infections in African American women indicate additional exploration is needed of African Americans women’s experience with access to COVID-19 health information and the impacts in everyday life (Chandler et al., 2021). Awareness of how the combined effects of current and historical disparities shape trust and self-efficacy could help to improve cultural competency and tailoring health information for this community. Positive impacts on self-efficacy and trust within this community could require broader policy changes that increases equity in education, income, housing, and health care.

Chapter 3 presents the research questions and qualitative methodology that examined self-efficacy experiences of African Americans with COVID-19 health information and recommendation using SEM as the framework for the study. This chapter covers the research design and the process for analysis of the research findings. Additionally, this chapter addresses how the research participants were found and the interview process using semistructured interview questions. The research findings are open for participants, community leaders, stakeholders, and the research community to better understand ways to improve self-efficacy and trust experiences for African Americans during a pandemic crisis. Benefits and risk to the participants are addressed in the chapter.

Chapter 3: Research Method

The examination of self-efficacy is complex and stems from different experiences within society. In the African American community, self-efficacy has been shown to be influenced throughout history by disparities in health, income, education, and other determinants, which have led to low trust in the systems and structures governing them. The current study provided context for those influencers through the exploration of experiences at each layer of SEM. I used a general qualitative approach to conduct semistructured telephone and Zoom interviews to explore participants' experiences of self-efficacy with sources of COVID-19 health information and recommendations.

Research Design and Rationale

I chose qualitative methodology for this study because it provided an in-depth approach to understanding the experiences of African Americans during the COVID-19 pandemic. People create meaning from their individual and collective experiences within their environment, and qualitative methodology provides a reflective and systematic approach to gain understanding (Ravitch & Carl, 2016). Qualitative research improves knowledge of how individuals, groups, and systems function by turning inward and gathering detailed information on the experiences and perceptions of the group affected (Patton, 2015). The current study participants were selected using a purposeful random sampling selection process. Purposeful sampling allows the researcher to reach a participant group that possesses the information the researcher is seeking (Patton, 2015). This sampling process also allows for the selection of particapnts who can provide meaningful information related to the research questions (Patton, 2015).

Research Questions

RQ1: What are African Americans' lived experience of self-efficacy in relation to the COVID-19 pandemic?

SQ2: How did African Americans respond to COVID-19 health information and recommendations?

SQ3: How do African Americans describe their experience with receiving treatment or testing for COVID-19?

SQ4: What was the lived experience of African Americans regarding the risk that they or their family members would contract COVID-19?

SQ5: What did African Americans do to prevent or minimize exposure to COVID-19?

Role of the Researcher

As the researcher, my role was to uncover the experiences of African Americans during the COVID-19 pandemic. My purpose after receiving approval from Walden University's Institutional Review Board (IRB Number 12-21-22-0694321) was to explore the factors that influence self-efficacy within the African American community. My role included reaching out to local churches and leaders within the community to inform them of the research. I was the person designing the research method, conducting interviews, and collecting data for analysis. I had the responsibility of ensuring all participants' data were protected and stored securely. I remained aware of my position as the primary researcher and the potential to affect participants' responses to interview questions. Positionality refers to how the researcher is connected to the research, such as location, community membership, how and where the research takes place, and shared culture or identity (Ravitch & Carl, 2016). I approached the interview in an unbiased manner and informed the participants of their right to withdraw from the study at any time.

Sampling

The sampling method was purposeful random sampling. A random sample was drawn from African Americans residing in the Chicagoland area, which included the counties of Cook, DuPage, Will, Kendall, Kane, McHenry, and Lake County. The study sample was selected from community volunteers based on the eligibility criteria. Purposeful random method is used in qualitative research to select participants who have specific insight or connection to the research constructs through lived experience, place of residence, employment, or other attributes (Ravitch & Carl, 2016). Purposeful random sampling allows the researcher to ensure participants remain within the research criteria from question development through data collection (Patton, 2015). Purposeful sampling was selected due to the vast number of African Americans in this geographic area and the inability to capture a large sample size. Purposeful sampling helps to decrease bias in research and increases credibility because the participants are randomly selected from a large group of individuals (Patton, 2015).

Participants were recruited from the Chicagoland area from places of worship, community centers, and health clinics. Each organization was contacted by phone and informed of the study. A follow-up email was sent to the contact person or organization to reintroduce the study, provide them with the research flyer, and invite them and community members to conduct a prescreening interview. Anyone who emailed or called for the initial participant interview was emailed the prescreening questionnaire. The inclusion criteria were as follows: African Americans over the age of 18; resides in Chicago or the greater Chicagoland area; and has received COVID-19 health information, health recommendations, testing, and treatment from a physician, nurse, clinic, community center, or public health professional. The participants came from a variety of education levels, socioeconomic levels, and neighborhood residences to allow for a broader range of experiences. Eligible participants were scheduled for a 60-minute phone or Zoom interview. Data collection continued until data saturation was reached. Saturation is reached through the process of collecting, analyzing, and searching for new patterns in the data until no new information emerges (Ravich & Carl, 2016).

Data saturation differs depending on the models of sampling and analysis method used. Data saturation in general refers to repeated information in the data without a direct connection to theory (Saunders et al., 2017). Theoretical saturation in contrast, focuses on the formulation of themes and categories rooted in theory (Saunders et al., 2017). Inductive methods of saturation are used to look for new codes and themes emerging from data, whereas a priori saturation moves away from inductive methods toward ones that already exist (Saunders et al., 2017).

Instrumentation

I, as the researcher, served as the primary instrument or tool used to determine the research process including interview questions, research methods, and data collection process (see Ravitch & Carl, 2016). The interview questions (see Appendix D) were created by me as the primary researcher. The interview questions focused on the experiences of African Americans with sources of COVID-19 health information and recommendations, testing, and treatment. Additionally, questions were designed to elicit data that would help me understand participants' self-efficacy related to their experiences. Participants were asked open-ended questions developed and aligned to answer the research questions. Open-ended questions allow participants to fully answer questions according to their experiences and perceptions (Patton, 2015).

After IRB approval, each phone interview was audio recorded using a handheld audio recording device. Each Zoom interview was also recorded using a handheld audio recording device. The devices were checked each day prior to the interview to ensure they were working properly. I kept a backup recording device in the event the primary device stopped working during the interview.

Data Collection

Once I gained approval to conduct the study from Walden's IRB, I began the participant recruitment process. The participants were African Americans recruited from the Chicagoland area. I contacted church leaders, health centers, and community organizations. My goal was to develop a relationship with community leaders and inform them of the research, and my role as the primary researcher was to gain approval from trusted sources within the community.

Participant recruitment began with the research flyer (see Appendix A) and a recruitment email (see Appendix B), which was emailed to church and community leaders in the Chicagoland area. Prior to emailing the flyer, I contacted each church leader and community organization by phone to inform them of the research and my role as the primary researcher. Preliminary research participants were emailed the interview prescreening tool (see Appendix C) to ensure they met the inclusion criteria; if they did, they were emailed an informed consent document and instructed to email the document back. Participants were then scheduled for a 1-hour phone or Zoom interview. Prior to the start of the interview, I reviewed the informed consent document with the participant and reaffirmed the participant's right to end the interview at any time.

Data collection was planned for October through December 2022. I conducted interviews with participants using telephone or Zoom. No video recording took place during the Zoom interview. Each interview was scheduled for 1 hour, and the audio was recorded using a handheld device. If follow-up interviews were needed, the participants were informed that they would be contacted for additional interview times. Participants were called if an additional interview were needed, and they followed the same interview process as the initial interview. During the initial interview, I asked each participant the same questions from the interview guide in addition to any follow-up or probing questions to gain additional information.

Data Analysis

The data analysis process included several steps beginning with determining how to store the data in a secure way to protect the participants. Each participant was assigned a general numerical identifier to secure their identity and locate data if clarification was needed during analysis. Participant interviews were audio recorded, and additional handwritten notes were taken during the interview. Participant interviews were transcribed, and transcripts and notes were uploaded to NVivo, a qualitative data management system. Although inductive and deductive approaches can be used in qualitative analysis (Ravitch & Carl, 2016), an inductive approach was used to develop data into a series of codes and categories to identify similar patterns or themes from participant interviews. The Chicagoland County data identified in the prescreening questions were linked to participant responses through a numerical identifier and used to analyze variation in experiences. The interview questions were designed to link to information from the literature review; interactions and experiences happening within the systems of SEM; and the components of self-efficacy including psychological state, mastery experience, social persuasion, and vicarious experience.

Trustworthiness

Trustworthiness is built on a systematic approach to research demonstrating consistency in the research process and investment of time in the collection and analysis of data. The term "trustworthiness" was used interchangeably with "validity" by Ravitch and Carl (2016) with distinctions for qualitative analysis found in how a researcher remains true to the experiences shared by the participants. Trustworthiness is established by spending adequate and equal time covering each interview question and the establishment of relationships within the community to become a trusted source. Spending time at the place where research is conducted and developing relationships with research participants adds to trustworthiness (Patton, 2015). Interviews with the participants were conducted through Zoom and over the phone. I established trustworthiness by meeting with community and church leaders over the phone and through Zoom.

Credibility

Credibility in qualitative research is established from research methods that demonstrate a design complex enough to capture information relevant to the research questions. Credibility or internal validity refers to the process of triangulation to the research method including a thick description of data, time investment where the research is conducted, and a thorough description of research findings (Ravitch & Carl, 2016). Additionally, credibility involves using a research method that looks for uncommon themes and applies a thorough analysis process (Patton, 2015). I established credibility by spending enough time with each participant gathering data, until I was able to reach the point of data saturation and no new information was emerging. The selection of participants was based on the research criteria, and a purposeful sampling strategy was used to gather data relevant to the research questions. During each interview, I remained aware of my biases and personal experiences being a part of the African American community.

Transferability

This research was not aimed at applying the findings across the entire African American community. Qualitative research should result in data that are unique to the participant sample but may yield information that is applicable in a wider contextual setting (Ravitch & Carl, 2016). The small number of participants cannot represent the entirety but may provide insight into new approaches to reach this population in a larger context. Transferability requires providing sufficient data such that recognizable information from the study is considered in broader applications (Patton, 2015). Descriptive data were used to provide the location of the research, the participants, my position in the research, and the findings from data analysis.

Dependability

I established dependability in the research by remaining consistent throughout the interviews and outlining the research process thoroughly to support the study. Dependability ensures the correct research method is used to answer the research questions and a systematic process is used to collect data relevant to answering the research questions (Ravitch & Carl, 2016). Each interview was allowed the same amount of time, and each participant were asked the same questions. I followed the same method of transcription and data analysis for each interview.

Confirmability

Confirmability in the research was established as I remained aware of my role as the primary research instrument. In qualitative research, confirmability is acknowledging the potential for bias in data collection and analysis and the systematic process used to reduce its potential (Ravitch & Carl, 2016). During the interviews and data analysis, I watched for any injection of my views, perceptions, and interpretations of what the data meant. I recognized how close I was to the research being part of the African American community. Both the research and analysis should have outcomes consistent with my findings if the study is repeated by someone else. I ran checks on the entire research process by communicating with colleagues and scholars in the public health community to ensure my thoughts about the data, analysis, and findings were critically evaluated. Also, the transcripts were made available to the participants, helping to ensure the data were a credible source.

Ethical Procedures

This research was conducted with ethical consideration during the entire process. The study is subject to researcher bias by identifying with participants through ethnicity and as a part of collective, cultural experiences. The first step was obtaining IRB approval from Walden University. The researcher had a peer review of the interview questions to make sure they did not lead to a predetermined outcome and data interpretation is without bias. Confidentiality was maintained to protect any identifying information of the research participants. Informed consent was obtained from each participant. Researchers should ensure informed consent reflects as much information about the research, the intention, length of time and allows participants to have discussion about any concerns (Ravitch & Carl, 2016). The informed consent document outlined the purpose of the study, the research criteria, the duration of the research, any risk to the participants and the benefits of the research. All participants were informed of their right to withdraw from the research at any time. The informed consent additionally acknowledged the sensitive nature of the topic. The research participants were assigned a numerical code to conceal identity. All interview transcripts were stored securely and recording devices with interview notes were kept in a secured, locked area. All of the research data will be stored for five years after the conclusion of the study, and then destroyed. It was important to ensure all participants were well informed on the process and how their identity was protected. This helped participants feel confident in sharing information and contributed to trust and established integrity in the research process.

Summary

This chapter focused on the research method and approach used for participant selection. It outlined the data gathering process to answer the research questions and the process for collecting and analyzing data to show trustworthiness in the research findings. The chapter also focused on the ethical procedure for the entire research including, protection of the participants, data collection, storage, informed consent, and rights to withdraw. Chapter 4 will outline where the research took place, and analysis of the research findings.

Chapter 4: Results

The purpose of this study was to understand the lived experiences of African Americans in response to COVID-19 health information. Qualitative data were collected through semistructured interviews with 22 participants between the ages of 24 and 61. All participants resided in Illinois either in Cook or surrounding counties. A range of experiences were captured regarding their personal experience. All interviews were recorded using a digital recorder and transcribed for analysis using NVivo software. Data saturation was reached as no new information was discovered based on the interview responses and thematic analysis. I reviewed the data several times for coding and theme development to ensure a thorough analysis process was completed.

This chapter discusses the participant demographics, data collection, analysis, trustworthiness, and results of the study. Data analysis was conducted to answer the following research question and subquestions:

RQ1: What are African Americans' lived experience of self-efficacy in relation to the COVID-19 pandemic?

SQ2: How did African Americans respond to COVID-19 health information and recommendations?

SQ3: How do African Americans describe their experience with receiving treatment or testing for COVID-19?

SQ4: What was the lived experience of African Americans regarding the risk that they or their family members would contract COVID-19?

SQ5: What did African Americans do to prevent or minimize exposure to COVID-19?

Demographics

The purpose of the demographic breakdown was to illustrate the varied background and experiences of participants. A total of seven women and 15 men participated in phone or Zoom interviews. The education levels ranged from two participants with a high school diploma, three with an associate’s degree, 12 with a bachelor’s degree, three with a master’s degree, and two with undisclosed education level. Participant income ranges were 15 participants in the $0–25,000 range, three in the $25,000–50,000 range, one in the $50,000–75,000 range, two in the $75,000–100,000 range, and one in an undisclosed range. Additionally, 19 participants resided in Cook County, two resided outside of the Chicagoland area, and one was undisclosed.

Data Collection

I conducted phone and Zoom interviews with 22 participants. Each participant was assigned a numeric identifier to protect their identity. Data were collected over 4 months. Each interview was allotted 60–90 minutes to give participants time to reflect on and answer each question. Each interview was recorded using a digital recorder. Participants were recruited through the establishment of community partnerships and fliers posted at their organizations. Each participant received a $25 e-gift card at the end of the interview session. Variations in data collection during the interviews arose from participant Wi-Fi connection issues on the phone and on the computer when signals were lost and reestablished. Also, distractions during the interviews resulted from the participants’ family or friends. Participants were sent a copy of the transcripts to verify accuracy of the data and provide any revisions. No revisions from the transcripts were made.

Data Analysis

The data were collected from interviews with 22 participants using open-ended questions. Participants provided information on their lived experiences during the COVID-19 pandemic. Before the analysis process began, the data were checked for accuracy from the audio recordings and then analyzed line by line. All participant transcripts were reviewed separately and then together to look for similarities and differences in responses.

After the data were reviewed, the responses for each participant were coded using both NVivo and manual coding. The purpose of manual coding was to look for any additional, relevant codes not listed by NVivo. The manual process was helpful because it allowed me to become closer with the data and remember key pieces of information that were not discovered by relying on the codes provided by NVivo. The review of data was an iterative process that occurred several times throughout the analysis beginning with initial coding, development of standardized codes, and identification of categories and themes. I found that NVivo provided some codes that were helpful, but the process of looking at the data line by line manually helped me with identifying the themes. I became immersed in the data, connecting to the interviews and thinking about ways to develop the data further through additional research. I also found NVivo was most helpful when I started organizing the supporting data for the final themes. Using the text search query also helped me to visualize how themes emerged from the coding process, how to find key pieces of data, and where to include them when reporting the results.

I began by grouping similar excerpts of data. From there, I assigned codes to get a better understanding of the sentiment of the data. The codes were initially long and varied conceptually. I moved through the process of reviewing excerpts and assigning codes several times. Once I felt I had coded all the data, I began to look for similarities and regrouped them. After this was completed, I developed a set of standardized, concise codes that allowed me to organize my thoughts about how to continue to analyze the data further. After the standardized codes were organized into sections of similarity, I developed categories. I was mindful of the many codes and wanted to ensure the category titles I grouped them into left room for me to explore participants' varied experiences even if they were similar. From there, I developed the themes and during this process referred to the data to ensure the assignment of codes, categories, and themes flowed in a systematic format. Both the categories and themes were revised several times during the analysis process to ensure clarity of thought and structure until final themes emerged. The purpose of this analysis was to find the connection between the research questions and the data. Table 1 presents the codes and categories, and Table 2 shows the categories and themes.

Table 1

Resulting Codes and Categories

Code	Category
Autonomous decision making Nonadherence to health information Adherence to guidelines Religious protections Natural healing Negative health experience Positive health experience Low community resources Low quality of life Higher quality of life Safety in White communities	Self-efficacy attitudes toward receiving medical care
Family leadership Health behavior Increased health literacy Increased risk-taking Personal health Family health concerns Influence of family/friends Social media resource Confusion of information Low trust in government Trust in family/friends Trust in health systems Trusted health information Racial mistrust Historical mistreatment	Factors contributing to self-efficacy beliefs, behaviors, and health understanding
Sense of hopelessness Isolation Trusted medical interventions	Health information and recommendation impact on personal efficacy and mental health

Table 2

Categories and Themes

Category	Theme
Self-efficacy attitudes toward receiving medical care	Valuing personal autonomy and self-efficacy
	Trusting medical care outside the community
	Valuing traditional natural remedies and beliefs
	Unequal access to quality care
Factors contributing to self-efficacy beliefs, behaviors, and health understanding	Mistrust in medical care generally
	The influence of friends and family on self-efficacy
	Increasing self-efficacy by protecting others
	Accuracy of information
	The influence of personal health and family members on decision making and risk-taking
	The value of health literacy
	The influence of access to care on health understanding and self-efficacy.
Health information and recommendation impact on personal efficacy and mental health	The role of isolation and hopelessness

Evidence of Trustworthiness

Credibility

I allotted the same amount of interview time to each participant to give them time to answer the questions. Some interviews were shorter than others. The variation in interview time resulted from some participants not providing in-depth responses despite my probing for additional information, and some participants shared more information about their experiences. During the interviews, I remained aware of my potential for bias being a member of the African American community and the possibility of shared experiences. When asking interview questions, I probed for clarification when I needed to understand the response or redirect the participant toward the interview question. All participants were selected based on the same sampling process. Data saturation was reached after 22 interviews were conducted and no new data were collected. All interviews were transcribed and coded in the same manner, and themes were developed from the codes.

Dependability

I used the same process for each interview allowing the same amount of time. I asked the same questions in the same format and the same order. I used the same method for recording the interviews. After each interview, I transcribed the data and sent each participant a copy to ensure the information accurately reflected the information they shared and offered them the chance to add any additional information during a follow-up conversation. No participants made any changes to the transcripts. Each interview was coded using the same data analysis process.

Confirmability

I remained aware of my role as the primary researcher during the data collection and analysis process. I remained mindful of the possibility of personal injections during the interview process because I was close to the experiences being part of the African American community. I also remained aware of my position when coding the data or interpreting the data during the coding process. The research process should have consistent outcomes if repeated in the research community. The research and data analysis process were reviewed systemically to ensure confirmability. The interviews were made available to each participant to ensure the credibility of the data.

Transferability

The findings in this study are not generalizable to the larger African American community and are unique to this study population. Participants shared their individual experiences regarding health information and recommendations during the COVID-19 pandemic. The findings may be transferable to another population with similar geographic circumstances and the same research process.

Results

The participants were asked about their experience during COVID-19 and provided responses that were similar and contrasting. Participants had a variety of experiences that contributed to their sense of self-efficacy, including their ability to decide what was in their best interest regardless of the health information and recommendations related to COVID-19. Overall, participants had a strong sense of personal choice in health decision making and believed that individuals should do what is best for them. A sense of leadership within the family unit was impactful in following the health information and increasing understanding through teaching others. There were varying experiences within the health system when seeking out health information, following guidelines, and receiving care, all of which impacted trust and health decision making. Some participants did not feel trust in the health system was a concern. Some participants were able to access health information and care, but others felt there was a lack of resources available in their community. Some participants felt traveling outside of their immediate community offered a sense of safety and trust in accessing resources and following recommendations and guidelines. The experiences shared by the participants are captured in the following sections addressing the themes that were used to answer the research questions.

Self-Efficacy Attitudes Toward Medical Care

Personal experience, previous and present treatment both individually and as an African American, spiritual beliefs, natural healing, and trust in the government presented as overall themes when considering individuals' attitudes toward receiving medical care. Participants' responses demonstrated how these experiences acted as influencers of self-efficacy beliefs and behavioral response.

Theme 1: Valuing Personal Autonomy and Self-Efficacy

Some participants reported that regardless of the type of health information and recommendations being offered, the decision whether to adhere to them depended on personal choice. Some expressed that each person should be able to decide what works for them based on their beliefs. Personal autonomy and the ability to make health decisions independent of influence from family, friends, or the community presented in establishing behavioral choice. P2 described autonomous decision making by stating:

> I believe what I believe, and I don't follow suit into the what the community believes or what the next man believes. Um, I make up my own mind, I make up, you know, as far as what I'm going to believe, I do what I feel is best for me. I don't follow the masses.

This focus on individual autonomy was echoed by P13 who commented:

> I think everybody is entitled to their own belief about vaccination so if you believe that the vaccine is bad for your body, for yourself, and I believe it's good for me, I'll do what is good for me and you do what is good for you. So, I don't infer, I don't, try to change your belief, because I believe that everybody's entitled to believe in whatever they want to do.

Self-efficacy beliefs and the ability to successfully execute health behavior was demonstrated as participants received health information about COVID-19, the behaviors of others and when making health decisions. P2 described autonomous decision making in spite of others health behaviors, stating:

> I am a person that believes in my own, I believe, my own thing. So, I'm not saying whatever people believe in doesn't affect me and I know what I want, and I know what I believe in, so I don't allow the masses or the environment or my clique to influence me in any way. I do my things myself.

Theme 2: Trusting Medical Care Outside of the Community

Participants mentioned how recognition of the lack of resources within their communities led them to feel it was safer to seek care outside of their communities. Some participants felt as if they were not cared for by the government, which reinforced a lack of trust in the medical care provided in their own community. Some participants mentioned the government would provide White or more affluent areas safer vaccines and resources to better deal with the pandemic overall. Limited testing resources, long testing lines and existing deserts within the community were factors in people seeking care. The experience led to some participants traveling to more affluent areas and mentioned the active decision to seek care outside of their community. P10 stated:

> When it first came out, I wanted to make sure it was safe, so I did say I'm going in the White neighborhood. I did have those feelings and I did do that cause I figured if it was anything. I mean I know from experience when they have old food, they put it in the black and brown neighborhoods. If it was something wrong with that testing why not dump that in the black and brown neighborhoods.

This sentiment was echoed by P1 who mentioned communicating with others where safe health care can be found and said, "one of the other jokes was, if you're really worried about that, then go to a neighborhood that's predominantly White and then you know that one is going to be safe." Seeking safer health care for family members by also taking them outside of the community was mentioned by P10 who stated:

> When my mom was eligible for the first shot, we went in a White neighborhood for her to get the vaccine. So yeah, my past experience. I’m a 61-year-old black woman that grew up in the United States…I mean come on.

P1 acknowledged how historical treatment of racial minorities was still relevant in causing hesitation, but also how those atrocities remained in the past with current protections in place to keep them from being repeated saying:

> When you look at how a lot of medical experiments in the early days and medical advancements are used to treat black and brown people as subjects. I think that gave me some pause just because the history is so bad and being representative of that community is just kind of hard to ignore those things. Also, at the same time, I’m also able to recognize that a lot of those things (a) happened quite a bit ago and (b) like the public policy is there for people to look at where you can see that those things were outlawed, but it doesn’t take away that feeling completely.

Theme 3: Valuing Traditional Natural Remedies and Beliefs

Some participants held to the belief in God as a source of protection from COVID-19. This belief system for some, also felt the virus was cursed and that prayer or spiritual beliefs could help prevent contracting COVID-19 or even replace the protection a vaccine could offer. P21 mentioned how myths directly impacted behavioral choice stating:

> There were so many myths at that time. So, this limited us from taking this medicine, which also increased the spread of the virus, and also prevented us from

> taking precautions, but were being told, this was a curse, and we should pray so I prefer to pray than to take the vaccine.

Spiritual practices played a role in self-efficacy and health decision making as P12 mentioned the impact of spiritual beliefs on vaccinations and said:

> At first, I didn't trust the health care because it wasn't like Christian, so I also follow the information that they say this vaccine is kind of demonic and taking the mark of the beast. So, I can't have trust in the medical system. Because I didn't want to have the mark of the beast. So, I can't take the vaccine at first.

P20 felt the use of immune boosting foods would be enough to fight the virus and caused doubt on the efficacy of the vaccine stating "sometimes you may look for lemons, sometimes ginger or aloe vera. Each helps our immune system, and also, in fighting any type of flu including COVID-19."

Theme 4: Unequal Access to Quality Care

Participant responses varied based on the experience navigating within various socioeconomic levels and ranged on the lower economic end being associated with reduced resources and more affluent areas having the resources needed to follow the recommendation and guidelines. Some participants mentioned while not directly experiencing the effects of poorer communities not having the resources needed, they were able to directly witness the difference by level of affluence. P1 mentioned a distinct difference in communities stating:

> For me, I never really felt like I had an issue with access to testing. However, I do live in a pretty affluent neighborhood. I'm not sure if you're familiar with the

> West suburbs, but I live in an area that has a pretty high socioeconomic status as like the kind of deadline for people, the median income, if you will. So, all the local stores, all of them, were all doing testing regularly.

The sentiment of socioeconomic level and resource allocation was further described by P1's experience with less affluent communities and access to testing resources by stating:

> I do attend Church in an area, which is one of the poorest zip codes in the country and when I was talking to people at the church or trying to help my parents get people, get our church members tested, even though we obviously weren't going to church, but we were looking for testing, that was a lot more difficult. We actually had to create an agreement with a hospital that they would come to the church twice a week to do testing so that people in those neighborhoods could get tested because they don't have as many drugstores or grocery stores that may have pharmacies. So testing was really kind of few and far between for them. And so of course, we know in Chicago that neighborhoods with low socioeconomic statuses are disproportionately minorities.

P9 described their direct experience with the lack of resources in the community by commenting "there was no one doing any lectures, no one doing any talking. Nobody knocking on any doors." This experience continued to be echoed as P1 acknowledged the need in lower socioeconomic communities and the perpetual cycle of illness and lack of health care stating:

> It was really frustrating because it seems to be this kind of self-fulfilling prophecy, right? That like people who do not make as much money get sick more

> often because they have less access to health care. But then when they do get sick, they don’t get better because they have less access to health care.

P2 associated lower community resources with race and apathy from political leaders by describing the experience in the Black community by stating:

> I’m not in the immediate city, so I do know that in the city that it was a lot rougher, and I do contribute that to being in an African American community. Our health community and hospital didn’t have adequate funding. So, everything was hard. It makes me feel that the president-government doesn’t really care about black folks. Yeah, because like I said the hospital didn’t have adequate funding and they didn’t provide enough resources during the pandemic like enough hand sanitizer and enough face masks. It was like the system was exclusive from Black folks.

Factors Contributing to Self-Efficacy Beliefs, Behaviors, and Health Understanding

Participants shared multiple experiences as impactful in their understanding of health information, establishing belief systems, behaviors, and risk. Some felt it was necessary to consider race and historical mistreatment. Additionally, one participant felt current experiences while being treated for COVID-19 was discriminatory and created a sense of mistrust.

Theme 5: Mistrust in Medical Care Generally

Some participants mentioned the impact of past atrocities within the African American community created a sense of mistrust of the medical community and in health information. Some women felt dismissed during past experiences navigating the health system and how it was a direct influence in COVID-19 behavioral response. P10 mentioned an experience where pain and discomfort were not addressed by the medical community and stated:

> Well, I know by me being a woman of color just from my experience I have not been taken seriously several times in health care. I know they just came out with a study that spoke to the systemic racism and sexism in the medical field which you know it's in every system in this country it's what this country was built on racism, so it's in the medical field also. I've had doctors who for whatever reason thought I was a prostitute because I came in the hospital, I was looking for a meal and a bed. I had another doctor tell me you're not in any pain. How are you gonna tell me I'm not in pain. You can't tell me what I'm feeling.

P1 shared the same sentiment by providing a more general statement about the treatment of Black and brown people by the medical community:

> I think the biggest instance of mistrust is when you look at how a lot of, I don't want to say a lot, but how some government policies and things historically have disproportionately targeted black and brown people. When you look at how a lot of medical experiments in the early days and medical advancements used black and brown people as subjects, I think that gave me some pause just because the history is so bad and being representative of that community is just kind of hard to ignore those things.

Theme 6: The Influence of Friends and Family on Self-Efficacy

While some participants maintained a sense of autonomy overall, making their own health decisions based on experience and personal belief systems. Misinformation from friends and family in some cases, was noted to cause some confusion in health beliefs. When health behavior was influenced by friends and family the behavior was centered around concern for others health and maintaining safety. Some participants were not affected by others belief systems and maintained their ability to seek out information from reputable sources as a prevention method. P7's fear of the vaccine was based on others experience, stating:

> When people were like, oh, when you get the vaccine, you're gonna get really sick so I guess that was kind of like a scary moment. Like the day I got the first vaccine, I was kind of scared, like, oh my gosh am I gonna get sick? What's gonna happen to me but literally I got the first vaccine, and I was fine, like no issues, so I was just kind of like, well listening to other people and everything that happens to other people don't always happen to you.

Concern for the health of a family member directly impacted behavior response as P19 said:

> With COVID 19. I lived at my parents' house. My mother being an asthmatic, I had to be extra careful since I didn't want to contract it. So, the interaction with her since she is asthmatic, if I contract it, I didn't contract to her. She will be sicker than I would be. The fact that I had to follow some of the guidelines as long

> as I have contact with my mother so that is me following the guideline and other people following the guidelines who are around me.

P9 mentioned behavior and belief systems was influenced by socioeconomic level and stated:

> Depending on what level you’re at, because here we have a lower class or middle class or upper class, and in between all three of those, we get the lower-lower, lower middle, and lower upper. Those people. The individuals are very mindful. You got one group that’s very ignorant. They don’t have no beliefs in anything. They think that the government may or they just trying a conspiracy to try to kill us. And so, they pass on misleading information with that one group. And you have another group of individuals that are very mindful of your behavior, and they wanna do the right thing, and I’m just trying to help you stay alive and stay safe. Um, and then we have the ones that does, you know, they’re gonna help you too. So, I’m aware of what it’s like in the community. Everywhere I go, I can see it and how people behave. But the impact was me making my decision on what I was gonna do to stay safe, period.

In contrast, to the previous comments P1 mentioned friends and family were not influential in health decision making and described the importance of following the guidelines for personal health and safety and said:

> It didn’t play that big of a role only because I’ve had experience with being exposed to certain things, so I just know that you have to be careful. Um, if they tell you, if you’re told, and maybe you don’t know everything, but if you’re told,

> this is at least part of the prevention which can help give you some shield, you need to do what you can. This is something new, we haven't had a pandemic, and no one was around in the last one that's here now, so we have to do what we can so that belief of you just try everything that you can.

Theme 7: Increasing Self-Efficacy by Protecting Others

Participants who assumed the role of family leader mentioned how interaction was impactful in health behavior for other family members, increased their own understanding of COVID-19 and helped to influence their own health behavioral choices. They purposefully sought out health information from trusted sources and enforced the guidelines with extended family members and friends who wanted to interact within the family unit. As detailed below, the decision about how much participants adhered to recommendations depended on multiple factors, including their own personal health status, trust in the health system, personal experience, past or present experience as an African American, the health of their family members, work obligations or out of concern to the general public. Modeling was evident from older generations teaching children and grandchildren and with adult children protecting older family members. Two examples of modeling behaviors are demonstrated as P2 stated:

> I was very influential to them, and I did lay down the law as far as if you're going to be around me, because even though that's my son, OK, we're going to get a little lax. You know, he comes over and at least wash your hands and you know, let's not be all hugged up and all of that.

P5 described being an adult child but leading the family through modeling and mentioned:

> I had to lead by example because I was the head of the family. I'm the eldest child in the family so I had to do what is required of all of us so the other people could follow, and the family could stick together on a guideline.

P14 mentioned their health behavior directly influenced family members behavior and said "my health behavior affected them in a positive way because they followed the procedures that were in place so we wouldn't contract the virus." P11 also mentioned how they felt a sense of obligation to understand the health information and follow the recommendations in order to keep their family members safe and described their experience saying:

> But I feel like I made the right decision for me and my family. If I talk about influence, I do think that the information that I was getting from the university perspective and you know from news and social media and so forth, keeping my family up to date probably influenced their decision.

P13 described the family's response overall with the recommendations and said:

> My family really took the information, getting from the world health organization seriously. Now we took it seriously. We observe almost all the measures that was required the social distance the face mask and with washing hands.

In one case, the sense of leadership extended beyond COVID-19 and led them to model health behaviors in other areas as P8 mentioned also going to the doctor for regular check-ups resulted the family mirroring the behavior saying "My health behavior outside of COVID-19 encouraged my family members to also do that. They would go for regular check-ups. They would go with me."

Theme 8: Accuracy of Information

Participants shared varied experiences with health information and its impacts on their health behavior. Some mentioned the ability to decipher misinformation on social media with minimal negative impact on behavior. Others mentioned actively seeking information from reputable and trusted government sources only, while others mentioned how social media, friends and family sharing misinformation had a negative impact on their health decisions, beliefs and created a sense of confusion. It is important to note the difference in meaning for misinformation and disinformation but in this context, they are used interchangeably. P5 stated how the effects of social media and other influential sources created a sense of confusion stating:

> There is some misinformation about COVID 19. They really scared me. Sometimes I could not know what to do or what to believe anymore. I was just, I just go to friends and ask them, what do you think about this and that? That misinformation came from social media, some spam messages.

P12 described the experience of misinformation with vaccine safety and mentioned "I was always worried about social media where this information was spread because I was hearing like someone trying to put something in the vaccine, I was scared at first. Like trying to put microchips in the population." P19 described different sources of health information they received and how it influenced what they believed. "I got information from my tv, social media, and friends would call me and tell me about how it spreads and from mainstream media. At some point it like felt some of the information was exaggerated." Some participants demonstrated the ability to seek out accurate sources of information and minimize the effects of misinformation. P1shared how researching the information helped them with determining what was accurate stating:

> Typically, anything I see on social media as news, unless it's coming from the news channels or like CNN that happens to have a page, I'm cross checking it anyway, so I don't think that misinformation caused me to really struggle with trust or anything.

P20 shared the experience with misinformation and the influence on health decision making stating:

> There's a misconception about the vaccines you think that they make men sterile. It is not very healthy that some people become zombies. Now that misconception was very high, but I was able to overcome it and took the vaccines.

P20 also described the ability to independently research and make heath decisions based upon the personally seeking heath information:

> When I did my research most of the time, I didn't believe in conspiracy theories. I'm a political person, I believe in statistics and science. Now, due to my research, I saw that everything to do is to take the vaccine rather than listening to the misconception.

Self-efficacy was demonstrated as participants had belief in the ability to seek out health information and make informed decisions about their health behavior. P20 described their experience stating:

> I’ve received information from online to social media about the vaccine and how to prevent yourself from getting the virus and how to wear mask. How to prevent it from spreading to others if you have it. The information is helpful and had a positive impact to keep society from getting that virus.

Theme 9: Influence of Personal Health and Family Members on Decision Making and Risk-Taking

Participants’ health behavior and beliefs about COVID-19 was influenced by personal health and the health of their immediate family which dictated the level of risk they were willing to take. Some participants felt their immune system was stronger than other races and shared with others in their circle being African American meant they were stronger. If participants felt their immune systems were strong, they would be able to overcome the disease if they contracted it. P19 associated being young with not being affected as severely as others and stated:

> My people believe they have a better immune system. So, they believe they have a lower chance of contracting COVID-19. My people believe their immune system is a bit stronger. I thought my health was a bit good. I believe even if I contracted it, I would recover. That my immune system was good, and I would recover in a matter of days.

P13 associated health decision making with having good health and the choice to follow health recommendations saying:

> So, I really take what the health person now says because my health is my number one priority because if I’m not feeling healthy, I’m not feeling well, I won’t feel

> happy and not feeling good, and I won’t be able to go to work or go to church or go anywhere.

In contrast P2 mentioned concern about their current health status and how it was influential in health decision making including how other diseases affect their health and said:

> I tried to be as cautious as I could. I didn’t want to contract it because of my health conditions, I have high blood pressure and I’m a diabetic so with my health, I, you know, I wanted to make sure that I was as isolated as I could be because I didn’t know. It was understood that if I caught a cold, it could. It could. It could wipe me out. I mean, it could really affect my wellbeing and my living.

Theme 10: The value of Health Literacy

The type of health information and where it originated had an important influence on behavioral choice. Participants mentioned the importance of listening to accurate sources of health information in order to practice the correct health behaviors and increase understanding of COVID-19, the impact on personal health, as well as the health of family members and the larger community. P6 was able to seek information out directly from a personal doctor and the medical community and described the experience and said:

> I trusted the information and I followed the information carefully and applied it to my daily life so that I can keep myself healthy. I had my principles and I just told myself that this COVID is real, and I should not follow the misinformation. I just kept on and stuck to the information from my doctors and the health sector.

One participant mentioned how listening to family members and friends caused them to practice behaviors that were inaccurate and created irrational fears. P17 described the process of listening to friends before deciding to seek out health information from other sources saying:

> My friends used to share their status it’s like, you should go for this or that. Okay, you know what? First, it used to be maybe my friends and then I could see like, it wasn’t good enough, because, you know, they don’t give accurate information, because then that’s why I started seeking the information. Maybe I could go and watch news that kind of stuff.

P21 described the impact of listening to friends had on beliefs and behavioral choice and said:

> It impacted me and influenced me negatively and positively. It influenced me negatively in terms of, for example, some of the memes. There was so funny that I even enjoyed listening to them. But how did this affect me negatively in terms of some of the things that I think even some of them ended up believing them. But ended up back practicing them for example, do not kneel before a dog. Do not talk to a dog. I ended up believing that if I talk to a dog, I will have COVID-19.

The same sentiment was shared as P7 described moving from friends as a source of health information to a more trusted source:

> I definitely feel like social media could play a huge role, but I feel like it’s more just kind of like, you just need to trust science more so, versus trusting your friend’s sister who shared something from a person who says, oh, don’t get the

> vaccine because you’re gonna be tracked by the government, but it’s like, we all have cell phones to track us anyways so I feel like more, so I think social media played a huge role.

Theme 11: The Influence of Access to Care on Health Understanding and Self-Efficacy

Misinformation was influential in behavioral response. In some cases, the information created mistrust in health information. Participants feared receiving the vaccination and when making decisions on what was the best course of action for their health. Tracking devices was mentioned as one the reasons for vaccine hesitation. Some participants felt the process was not clearly communicated and that no health official in their community provided information to increase understanding of the virus. P12 specifically mentioned not having any information explained:

> They didn’t even bother to explain to me just like I do what is good for me. I wanted to try because I was scared to die. I think during that time they didn’t have any vaccines, so people had to look for a way and just be careful.

P13 mentioned how misinformation either caused confusion in behavioral response or affected the ability to interact with people who may not have follow the correct sources for health information:

> That was one of the false information I got. I think the hand sanitizer if you use it to much it causes cancer of the skin. I heard something about that the vaccine changed my DNA. The MRNA in the vaccine, the liver inside the person, people say the DNA is affected. That being a being around vaccinated people is

> dangerous. So that there was a lot of misinformation. Because I was like okay if what these people are saying is true that means this vaccine is not good for my body so why should I pick it? Why should I take it? Why should I follow this?

In contrast, P1 described the frustration misinformation caused when having conversations as others had a lack of understanding from using more inaccurate sources of information and said:

> Mostly just created really, really frustrating conversations with other people who maybe don't do the same due diligence where a quick Google search will tell you that is not true. So, I don't think it affected me personally and my actions as much as it did my interactions with other people.

Health Information and Recommendation Impact on Personal Efficacy and Mental Health

Some participants mentioned how the recommendations and guidelines decreased their ability to interact with family and friends. This experience had an impact on self-efficacy and the ability to model successful preventative behaviors for some who were more isolated than others.

While overall participants felt the health information and guidelines in place were for their protection, the isolation both at home and in the hospital, setting created for some of them mental and emotional distress. Several participants below mentioned the recommendations and guidelines created a sense of isolation and negatively impacted their mental health. P7 stated, "I know COVID affected a lot of people's mental health and that stuff. So, I thought that probably was the biggest play for me was like, the mental health aspect of it, being stuck inside.” P14 used spiritual beliefs to help cope with the mental impact and mentioned “I’m just grateful to the God Almighty to helping us to fight this deadly virus because certainly doing the pandemic I was depressed.”

P21 described the experience of being in the hospital during the isolation period and how the lack of social support impacted them emotionally saying:

> There was limited resources at that time and the isolation was not good. I felt my self-esteem was lowered. The isolation really affected me. Because at that time, lack of support, I needed someone to talk to but that was not the case. Instead, I was wrapped up in a room so that I could not access my family members. It really affected me, I felt that was the lowest point of my life.

P9 maintained how the mental and physical effects of guidelines, contracting COVID-19, recovery, and the lack of closure has its own impacts:

> Now I went through a lot, of physical problems, mental problems, on trying recovery and what has happened. So, my belief in whether or not it worked it did. The shot helped a lot, but the symptoms are still there. Some of the aftereffects of what has happened, um, after you contract something, you decide to get better, it makes you very angry, um, in a sense where I’m so upset, how did the virus get out? I can’t say who is actually blame, but to let something so powerful get out of a laboratory, which I know is not that correct information, um, and spread across the world, causing millions of people to die and no one wants to take responsibility, and no one’s held accountable is a really disturbing thing.

The participants responses showed how isolation and depression had a direct effect on self-efficacy and belief in the ability to adhere to guidelines and quarantine recommendations during contagious infection periods or even practice preventative measures. The mental impacts may have created additional burdens for those communities experiencing decreased access to resources. Overall participants shared a range of experiences that impact the sense of self-efficacy including those happening individually, with family and friends, within their respective communities and with navigating the health system overall.

Summary

This study sought to answer the research question, what are African Americans lived experience of self-efficacy in relation to the COVID-19 pandemic? Four additional subquestions extended the study further by asking, (a) How did African Americans respond to COVID-19 health information and recommendations (b) How do African Americans describe their experience with receiving treatment or testing for COVID-19, (c) What was lived experience of African Americans regarding the risk that they or family members would contract COVID-19, and (d) What did African Americans do to prevent or minimize exposure to COVID-19? I conducted 22 phone and Zoom call interviews of African Americans living in the greater Chicagoland area. The participants all came from different backgrounds and shared varying experiences during the pandemic. The data was transcribed and coded using NVivo and manual coding. Twelve themes resulted from the data analysis process. The overarching sentiment found throughout participant responses, centered around how their interactions and experiences either with family, friends, within communities and with navigating the health system, combined to create a foundation for health beliefs and behavior during the pandemic. Themes resulting from participant responses overlap answering more than one research question and across the framework of this study.

A brief overview of the themes revealed: (1) Participants value personal autonomy and expressed a higher sense of personal efficacy to make behavioral choices independent of external or influential factors; (2) past and present mistreatment created mistrust in health care provided in the community causing them to look for care in more affluent neighborhoods; (3) spiritual beliefs and traditional natural remedies were valued when establishing beliefs about contracting, recovering, and treating COVID-19; (4) social disparities were believed to be influential in creating efficacy beliefs with testing and treatment; (5) experiences in the health system either positive, negative, or racially motivated impacted heath behavior and both current and historical mistreatment was impactful in trusting health information and receiving treatment; (6) friends and family influenced personal efficacy through information sharing, misinformation, and health literacy; (7) leading the family helped individuals develop a higher sense of personal efficacy through modeling and increased health literacy; (8) misinformation on social media, and inaccurate health information from family and friends impacted health behavior; (9) personal health and concern for family members' health created a sense of obligation to increase personal efficacy and a factor in risk perception; (10) personal efficacy influenced by trust in the source of accurate heath information (11) misinformation and lack of access to health information lowered personal efficacy belief in the ability to care for oneself; and (12) health recommendations created a sense of depression, lowered mental health, self-esteem, and isolation.

Chapter 4 explained the results of the data analysis from this study. The results were based on the experience described by participants during the COVID-19 pandemic. Chapter 5 provides an interpretation of the study findings, limitations, recommendations, implications for social change and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand the lived experience of African Americans in response to COVID-19 health information. The study explored self-efficacy experiences in relation to the pandemic. This chapter provided an interpretation of the study findings, limitations, recommendations, implications for social change, and a conclusion. This chapter also reviewed how the findings relate to the literature in Chapter 2 and in the context of the conceptual framework.

The participants shared their in-depth experiences during COVID-19 regarding what was happening individually, with family and friends, in communities, and in health organizations. The experiences served as a basis for knowledge and beliefs about themselves, their cultural ethnicity, and the external environment. In other studies, African Americans expressed concern about equitable health care treatment during COVID-19 and whether race impacts quality of care (Johnson et al., 2020). Systemic racism, health communication, and mistrust experiences can negatively impact a person's self-efficacy and their belief in their ability to care for themself during times of health challenges (Johnson et al., 2020). Areas of a lower socioeconomic level where some African Americans reside face additional factors such as higher population, decreased access, comorbidities, and other determinates that increase COVID–19 risk (Yancy, 2020). The discussion of the findings included an examination of how these and other factors impacted participants' self-efficacy in the context of the literature.

Interpretation of the Findings

The purpose of this study was to understand the lived experience of African Americans in response to COVID-19 health information and recommendations. A qualitative approach was used to develop themes from participants' experiences. The research questions reflected my desire to understand how participants' experiences within varying social structures impacted their sense of self efficacy, health behavior, and response. The study explored self-efficacy experiences occurring within the levels of SEM at the individual, interpersonal, community, organizational, and public policy level, as well as across a period. According to Salihu et al. (2015) SEM provides a pathway to understand how the levels relate to and affect the individual and how the individual impacts each SEM level.

During data analysis, I uncovered several themes that aligned with the literature presented in Chapter 2. Although there were similarities, there were also some different themes as impactful as those found in the literature. Table 3 shows the research questions, categories, and themes. The goal was to demonstrate how the categories and themes aligned with the research questions and how the experiences shared by participants were influenced and interconnected throughout SEM layers. Figure 2 provided a conceptual view of how each theme and SEM interconnect from microsystem through chronosystem level experiences.

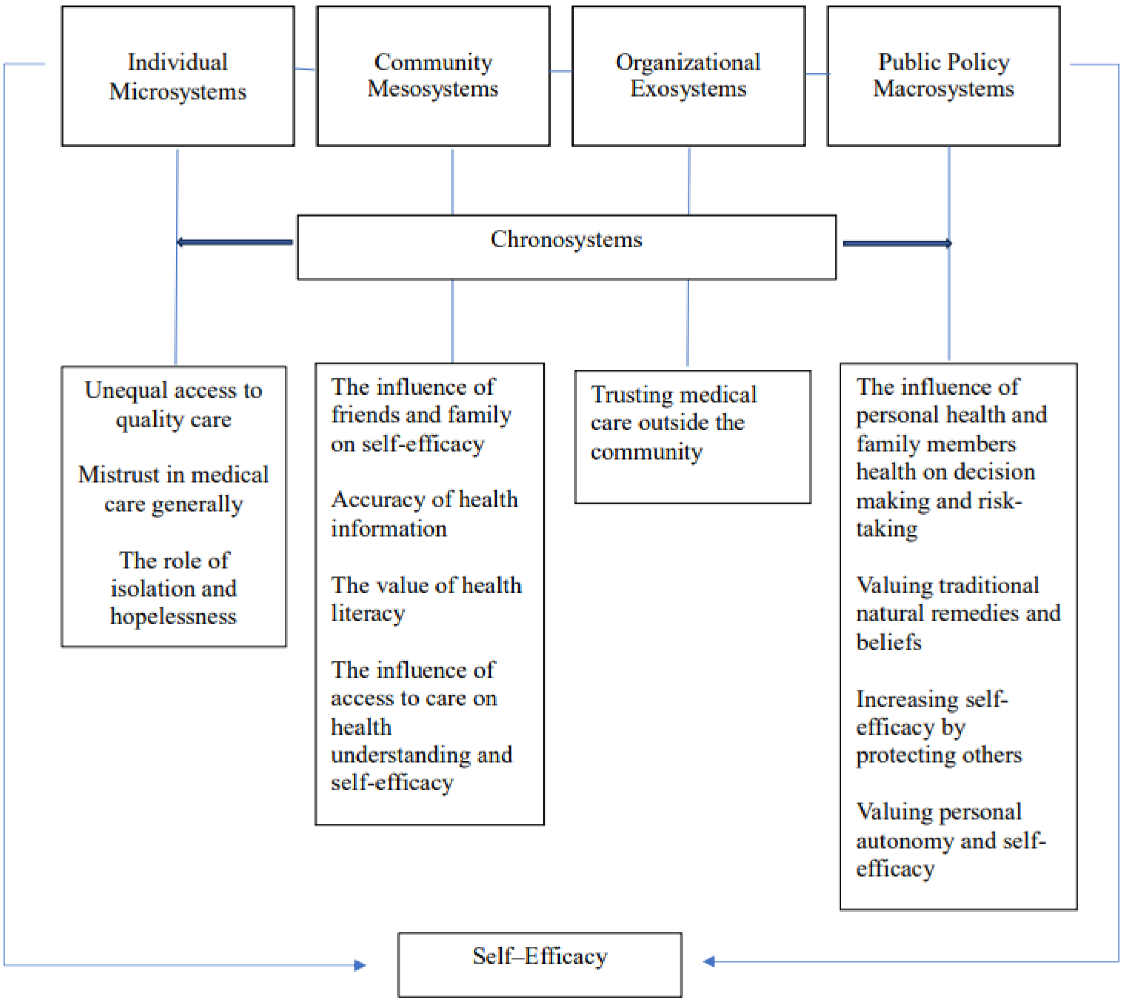
Table 3

Research Question, Category, and Theme Alignment

Research question	Category and theme
RQ1: What are African Americans lived experience of self-efficacy in relation to the COVID-19 pandemic?	Category: Self-efficiency attitudes toward medical care. Theme 4: Unequal access to quality care. Category: Factors contributing to self-efficacy beliefs, behaviors, and health understanding Theme 5: Mistrust in medical care generally. Category: Health information and recommendations impact on personal efficacy and mental health. Theme 12: The role of isolation and hopelessness.
RQ2: How did African Americans respond to COVID-19 health information and recommendations?	Category: Factors contributing to self-efficacy beliefs, behaviors, and health understanding. Theme 6: The influence of friends and family on self-efficacy. Theme 8: Accuracy of information. Theme: 10: The value of health literacy. Theme 11: The influence of access to care on health understanding and self-efficacy.
RQ3: How do African Americans describe their experience with receiving treatment or testing for COVID-19?	Category: Self-efficacy Attitudes toward medical care. Theme 2: Trusting medical care outside the community.
RQ4: What was lived experience of African Americans regarding the risk that they or family members would contract COVID-19?	Category: Factors contributing to self-efficacy beliefs, behaviors, and health understandings. Theme 9: The influence of personal health and family members health on decision making and risk-taking. Theme 3: Valuing traditional natural remedies and beliefs. Category: Self-efficacy attitudes toward medical care Theme 1: Valuing personal autonomy and self-efficacy.
RQ 5: What did African Americans do to prevent or minimize exposure to COVID-19?	Category: Factors contributing to self-efficacy beliefs, behaviors, and health understanding. Theme 7: Increasing self-efficacy by protecting others.

Figure 2

Factors Influencing Self-Efficacy Response to COVID-19 Health Information



The first research question addressed the overall experiences shaping beliefs about COVID-19 health information and recommendations.

Research Question 1

What are African Americans lived experience of self-efficacy in relation to the COVID-19 pandemic? The themes provided insight into the impact of different types of microsystem interactions. SEM's innermost layer of microsystem includes interpersonal interactions, subjective and objective information, and perceptions about experiences within the environment (Bronfenbrenner, 1979). The literature indicated that interactions at this level set the stage for influencing beliefs about the environment and how interpersonal experiences with family, socially, and within the health care system can influence behavioral choice (Kilanowski, 2017; McLeroy et al., 1998). The effect of socioeconomic status emerged as participants shared personal experiences with low pandemic resources, describing how this circumstance shaped their beliefs about the health system, government, and their ability to follow health information and recommendations.

Unequal Access to Quality Care (Theme 4)

Some experiences were direct and based solely on an experience with lack of resources while others were indirect, contrasting the difference in resources available in lower socioeconomic neighborhoods compared to those in more affluent communities. Research showed how socioeconomic disparities have been a part of the African American experience throughout history as they lag in comparison to their White counterparts in income, education, property ownership, and health (Hahn, 2020; Jones et al., 2018). The literature confirmed how systemic racism seen throughout social structures was created to deny African Americans equal access to health and remains prevalent today as those same socioeconomic disparities prevail (Noonan et al., 2016).

Some participants in my study mentioned how their experience with witnessing the contrasting difference in the two communities shaped their beliefs and behavior about either not trusting the care provided in less affluent neighborhoods or actively seeking care in more affluent communities. Participants described how their experience with limited or no resources in the community left them feeling like they could not properly care for themselves and is consistent with a lower sense of self efficacy. In contrast, some participants who described having no issue with accessing resources either through employment or within their community displayed a higher sense of self-efficacy, which positively influenced their beliefs about having the tools necessary to understand health information and model recommendations to stay healthy and teach others. The literature revealed the interconnection of socioeconomic level and self-efficacy impacts on health, personal belief systems, behavioral choice, trust, goal completion, motivation, and the ability to persevere through challenges (Bandura, 1997a; Bijl & Shortridge-Baggett, 2011; Marmot & Allen, 2014).

Mistrust in Medical Care Generally (Theme 5)

Katz et al. (2009) showed how mistrust arises from experiences happening personally and from learned experiences as part of a collective ethnic group. In my study, different types of interactions, both personal and those experienced by others, were critical in helping participants formulate beliefs and behavioral responses. One participant described her previous mistrust experiences of being a Black woman seeking care from the medical community, and how this experience influenced her level of trust in present day COVID-19 health information and sense of safety overall. Another participant in my study reported a previous experience of being treated like a drug abuser and how she was expected to tolerate pain in lieu of receiving medication. The findings in my study confirm what previous studies reported that African American women have historically been mistaken for a drug abuser and expected to endure pain over receiving pain medication, and similar reports from other African American communities based on age or as part of the LGBTQ community regarding mistreatment leading to low trust in health care (Cuevas et al., 2016; Hansen et al., 2016; Quinn et al., 2019).

Participants additionally described experiences of either being turned away for COVID-19 medical treatment during times of illness or watching other non-African Americans receive better treatment. This kind of mistrust experience is confirmed in the literature as African Americans reported how both current and historical mistreatment, racial discrimination, and higher rates of mortality from other diseases impact behavioral choice and inhibit people’s willingness to seek care during the pandemic (Balasuriya et al., 2021; Okoro et al., 2022). These experiences of low trust create frustration and hesitancy, which influenced personal efficacy. The literature is clear about this: Positive and supportive health communication is a critical component for mastery experiences, and building trust sets the foundation for seeking care, adopting motivational cues, and stimulating appropriate adaptive behavioral responses that reduce disparities and improve health outcomes (Adebayo et al., 2020; Lee & Lin, 2009). Researchers also agreed that reducing discriminatory experiences by removing barriers through improved heath communication and improving cultural competency by including patient perspectives establishes trust, increases personal efficacy and adherence to recommendations, and improves health (Adebayo et al., 2020; Schwei et al., 2014; Williams et al., 2019). The next theme focuses even more closely on the impact of adherence to health recommendations on personal efficacy.

Role of Isolation and Hopelessness (Theme 12)

This theme was based on participants' experiences of how following health recommendations was related to their mental health and sense of personal efficacy to overcome health challenges. Participants described feelings of depression, hopelessness, and how the isolation caused them to lean toward spiritual guidance. In some cases when low access to community resources was a barrier, following health recommendations was negatively impacted. Although this kind of experience was probably not unique to African Americans because following recommendations and guidelines is consistent across populations, the social disparities that affect African American communities may contribute to making this experience especially powerful in lowering personal efficacy.

Some participants described experiences of being isolated in the hospital and not having the support of family, which created depression and negatively impacted personal efficacy. Two components of self-efficacy, psychological state and vicarious experience or modeling, influence the ability to overcome health adversities. Looking to family, communities, and spiritual practices has historically been a way for African Americans to protect themselves from social disparities and negative experiences in health care and when making decisions about trusting health information (Bandura, 1997c; Johnson et al., 2020; Privor-Dumm & King, 2020; Tang et al., 2021). African Americans suffer from limited access to mental health services, and limited access is especially impactful when African Americans are faced with limited social support in other areas (Okoro et al., 2022). Not having support systems during a health challenge can lead to low personal efficacy and worse health outcomes, particularly for groups who experience preexisting social and health disparities. In my study, the experience of social distancing in neighborhoods where there were already low resources for food created an undue burden of emotional distress.

Participants mentioned worrying about whether food resources would last and whether they would have a way to sustain themselves. Communities that experience social disparities, such as lack of investment creating food desserts and other social conditions limiting opportunities for mental and physical health, tend to have a poor sense of self and need continued efforts to improve resources and health outcomes (Privor-Dumm & King, 2020; Sachs et al., 2017). Isolation was not presented in the literature as a cofactor in self-efficacy; however, my findings align with the literature by confirming the need to expand resources for mental health support and represent an opportunity to understand the impact on beliefs and behavioral response.

Research Question 2

How did African Americans respond to COVID-19 health information and recommendations? This research question addressed the micro and mesosystems of SEM and how extended interactions in response to health information influenced personal efficacy. Participants described how information from others played a role in their sense of personal efficacy. As mesosystem and microsystem interactions expand, they begin to include other people in the community, in a social setting, or in other places where people engage and share beliefs about the environment in which they exist (Bronfenbrenner, 1979). The following themes demonstrate how friends, family, and communities came together as influencers in establishing beliefs about health, literacy, and behavior.

Influence of Friends and Family on Self-Efficacy (Theme 6)

As people shared information during the pandemic, some participants described socioeconomic level as one of the determining factors for a person's level of health literacy and for them to establish health beliefs. One participant believed a higher socioeconomic status meant the person shared accurate health information and practiced correct health behavior, and a lower socioeconomic status was attributed to passing on misleading health information, which lowered health literacy. Inferences about health were also made as family members provided direct information about themselves and their experiences in the external environment. Social persuasion, which is a component of self-efficacy, can impact a person's belief in their own ability to succeed in performing a given task and in behavioral response (Bandura, 1977c). In a study on the role of family with understanding and risk for cardiovascular disease, families played an instrumental role in sharing health information, beliefs about health behavior, and beliefs during times of illness and health risk (Ellis et al., 2019). The health history of cardiovascular disease within families was important to participants in behavioral choice, belief systems, and awareness (Ellis et al., 2019). Additionally, information sharing, and behavioral patterns established early in childhood were hard to break (Ellis et al., 2019). Families were found to be instrumental in motivational cues, establishing support systems and physical environments to improve health behavior or support with increasing activity levels (Ellis et al., 2019). The influence of friends and family on health beliefs and behavior is consistent with the findings of my study and the combined impact of information sharing, modeling, and motivation.

Accuracy of Information (Theme 8)

Misinformation, social media, and myths spread among family, friends, and the community played a role in beliefs about health information. Some participants in my study mentioned how misinformation on social media caused confusion in what to believe. Although some were able to seek out sources of what they believed to be reputable health information, others received their information from social media, which in some cases led to practicing health behaviors that were contrary to public health recommendations. Some participants in my study felt myths around vaccine information were tied to religious beliefs such as the mark of the beast or people being injected with a microchip for the purpose of human tracking, which impacted their behavioral response.

The literature confirms minorities are shown to have an increased potential for exposure to inaccurate sources of health information and how equitable access is a key factor in the reduction of risk and health decision making (Tang et al., 2021; Viswanath et al., 2020). In a study conducted on vaccine hesitancy, participants felt a lack in access to accurate health information fueled the spread of and exposure to misinformation (Shearn, & Krockow, 2023). Researchers have also questioned if health information is shared equally across communities as SDH during health emergencies determines access, literacy, and behavioral response (Tang et al., 2021; Viswanath et al., 2020). In my study, a participant mentioned having no access to accurate online or in-person health information and for them, no access led to a decreased belief in their ability to properly provide self-care. The participant described having a lowered sense of personal efficacy and being unable to implement adaptive health behvior due to lack the lack of resources in the community.

Value of Health Literacy (Theme 10)

Accurate and trusting health communication were important for participants as they actively searched for health information. Accurate health communication is important in building efficacy because the rate at which information flows inhibits the ability to consistently verify and remove inaccurate sources of health information (Viswanath et al., 2020). Health literacy is not considered a person's responsibility as it requires health institutions to ensure people have access to and understand the information being communicated (National Institute of Health n.d.).

Participants in my study were aware of the direct impact of inaccurate health information and mentioned how it decreased trust, created fear, and influnced response. Some particants also mentioned how trust in providers impacted their belief in health information and sense of personal efficacy. The literaure have shown how trust ensues from both first hand experience and shared information about the experiences of others creating a foundation for beleifs, decsion making, increases in self-efficacy and with adhereance to health recommendationsn (Goold, 2002; Lee & Lin, 2009). Participant responses in my study aligned with the literature as they shared how trust in providers and accurate sources of health information impacted personal efficacy and health decision making.

Influence of Access to Care on Health Understanding and Self-Efficacy (Theme 11)

Health recommendations such as social distancing and wearing masks were suggested to master to reduce exposure, however, equitable access to full health information is needed for individuals to practice behaviors that facilitate learning, build personal efficacy and with the assessment of risk for themselves and family members. Mastery experience, a component of self-efficacy is shown to build trust in seeking care, behavioral response, and increases the ability to work cognitively through information, response and in controlling action (Adebayo et al., 2020; Bandura, 1997b; Bandura, 1997c; Lee & Lin, 2009). As one participant in my study described the impact of not having online access to sources of health information and attempted to seek out information in person at community health clinics without any success as there were no available medical staff to speak with to answer questions. They described only having access to health information through a brochure. They communicated this was a low socioeconomic neighborhood, and health information in this case did not flow through their community. There was no one going door to door to help people understand any health information or recommendations and the only source was family and friends. They mentioned the negative experience of no access impacted their belief in the ability to take care of their own health. Disparities in access to health information and communication create for individuals and communities, low trust, economic hardship, loss of power, belief in the ability to have control over health, and increases in mental distress (Jean-Baptiste, & Green, 2020; Johnson et al., 2020; Ross, 2011).

African Americans experiences result from social structures within society dictated by policy impacting health, and further examination of differences within them during a health crisis will help to ensure better health outcomes (Holmes et al., 2020). In contrast to the previous experience some participants in my study mentioned no issues with access to health information and received it through employers, in their community and from trusted online sources. They felt a higher sense of personal efficacy, mastery and positive in the ability to make informed, independent health decisions about what to do for themselves and in some cases in the ability to teach others. Previous research has questioned how equitable dissemination of health information and SDH serve as a predictor in the ability to access, understand and practice behavior (Tang et al., 2021; Viswanth et al., 2020). The findings in my study align with the literature as both experiences indicate the negative impact of limited access to health information on beliefs and behavioral response.

The next research question examines self-efficacy response by looking into exosystem level interactions and their influencers. Exosystems are organizational level experiences and while they may not directly happen to an individual, they may still have an impact on efficacy beliefs. When examining the effects of exosystems, a person will internally process what happens in the environment and relate it back to a situation happening on a more interpersonal, microsystem level (Bronfenbrenner, 1979). Additionally, the opposite may be true where a person will directly relate interpersonal, microsystem experiences with those happening in exosystem environments (Bronfrenbrenner, 1979). Past and present experiences demonstrate the significance of exosystem environments and how they are internalized by individuals.

Research Question 3

How do African Americans describe their experience with receiving treatment or testing for COVID-19? The theme of medical care outside of the community was presented in contrast to the literature as participants described how their beliefs about the pandemic and distribution of resources throughout communities influenced beliefs and behavioral response.

Some participants felt access to resources such as testing, treatment centers, and quality of care at hospitals, clinics, and other locations varied depending on the socioeconomic status of that community and shaped their beliefs about where to seek equitable care. As one participant mentioned, African Americans have historically held the burden of deserts and access to various types of stores remains a relevant issue in present day communities. One participant partnered with a local hospital to help establish testing centers and described how these same testing centers were already available in more affluent communities. The literature shows improvements in health care access and quality of care, but also how the lack of investment in communities creates barriers, influences perception about health, self and mistrust in system structures overall. (Benkert et al., 2006; Kennedy et al., 2007; Sachs et al., 2017; Schwei et al., 2014). Another participant in my study mentioned a previous, personal, experience of non-COVID-19 related discrimination while seeking health care and attributed the event with both historical and present day systemic, gender, and race-based mistreatment of African Americans in general. Some expressed belief that bad vaccines were being distributed in Black neighborhoods much like bad food was distributed in grocery stores within those same neighborhoods. One participant also mentioned the lack of resources in the community felt like the government did not care about Black people.

The common sentiment amongst their experience was (a) a direct tie to systemic racism and the historical mistreatment of African Americans as seen present day by the current disparities in health (b) continued mistreatment of African Americans seen in present day inequalities from a SDH perspective leading to systemic inequities and (c) lack of trust in the care provided within African American communities as a direct result of both. The culmination created beliefs that the only way to receive equitable, safe, health care was to seek it out in predominately White or more affluent communities. The experience influenced behavioral response and for some, created delays in the decision whether to follow health recommendations. The findings here present a new opportunity to understand where African Americans feel safe seeking care as a shift from staying close to the community was communicated from several participants.

In contrast, some participants dually recognized the impact of previous and current systemic racism, but their experience during testing and treatment did not include low access to community resources, or any direct, discriminatory treatment. They recognized disparities in health access still exist, but also felt current policy was in place to ensure all health information was the same across communities and recommendations such as ensuring vaccinations were safe. They held a high sense of personal efficiency, trust in providers, and in their ability to either follow the health recommendations or make their own informed health decisions.

Although all communities should experience the same health care access and resources, differences exist within them. As a result, cultures, and subcultures in communities' experience both similar and different patterns of interactions throughout life cycles, and within relationships which contribute to the establishment of cultural belief systems (Bronfrenbrenner, 1979). Macrosystems, the next layer of SEM, is comprised of microsystems, mesosystem and exosystems and illustrate the cultural experience of African Americans. The next two research questions explore how macrosystems help to establish both cultural beliefs and behavioral response.

Research Question 4

What was lived experience of African Americans regarding the risk that they or family members would contract COVID-19? Risk is both historically and present day related to SDH and for African Americans interconnect within all layers of SEM acting as a mediating factor of self-efficacy beliefs. Although SDH is not exclusive in determining outcomes, they are linked to influencers such as, health perception, health beliefs, behavioral response, health literacy, and knowledge and risk perception. Themes below demonstrate how participants responses varied in the assessment of risk based on different factors related to their health, the health of family members or from experiences in external environment. While examining participants evaluation of risk, it is important to note how social determinates on a macrosystem level will inevitably play a significant role in health outcomes.

Influence of Personal Health and Family Members on Decision Making and Risk-Taking (Theme 9)

Psychological state, a component of self-efficacy considers how a person makes predictions about their health and ability to overcome challenges (Bandura, 1997c). Some participants in this study mentioned how good health was a factor in risk assessment and if they were young and contracted COVID-19 having a high immune system aided in their recovery. One participant described the risk associated with being Black meant a person’s immune system was inherently stronger and they needed to focus more on natural healing remedies by incorporating foods to increase immune function despite health recommendations. Other participants described how being younger as a factor in risk assessment resulted in them either becoming very ill from COVID-19 or being hospitalized. And others described how personal health, or the health of a family member was a factor in risk assessment and behavioral choice as some of them experienced comorbid conditions such as diabetes, asthma, or high blood pressure. In these cases, individuals who believed in their ability to have control over their health despite challenges presented by the pandemic and equally had a perception of risk may have executed preventative health behaviors. Conversely participants who believed in the ability to have control over their health, but a lowered risk reception, may not have exhibited those same behaviors.

The literature revealed how emphasizing efficacy in health communication had a higher behavioral response over risk communication and even though high personal efficacy and high-risk perception will result in higher preventive behavior, efficacy remains under used as a health communication resource. (Nazione et al., 2021). In my study, where participants had a lowered sense of efficacy even with high-risk perception, they may not believe they had the ability control their health and may not be motivated to implement preventative health behaviors. The findings in my study showed participants associated risk with personal health status, age, and the health status of family members. While those are factors, a new opportunity to understand risk perception presented as the study did not reveal all participants directly associated risk with external factors in the community related to SDOH.

Valuing Traditional Natural Remedies and Beliefs (Theme 3)

Some participants described how spiritual beliefs played a role and how prayer, and belief in God is a factor in the assessment of risk and in health decision making. In some cases, this was coupled with the use of natural healing remedies such as herbs and immune building foods to help fight the effects of the virus. In other cases, spiritual beliefs were a factor during times of illness when participants were isolated in the hospital and cut off from family or in their home alone. Participants who were cut off from food and other resources used prayer and faith as a coping mechanism. In alignment with literature traditional form of health care treatment, spiritual beliefs and places of worship were found to remain a staple in African American community's indicative of views about their relationships with providers and experience within the health care system (Hansen et al., 2016; La Veist et al., 2000). In a study on the mental impacts and social wellbeing of African Americans during COVID-19, researchers found places of worship a foundation for establishing trust, providing support socially, assisting with community needs and health resources (Okoro et al., 2022). Spiritual leaders continue to be an influential source for health information, and it remains a vital source for the health community to partner, ensuring the equitable distribution of resources, social support, and trust (Privor-Dumm & King, 2020). In addition to the literature, the findings in my study also confirm that some African Americans may seek places of worship for mental support, to receive health information and make inferences about trust and behavioral response.

Valuing Personal Autonomy and Self-Efficacy (Theme 1)

The theme presented in contrast to the literature as some participants described a contrasting difference from the findings, by expressing a sense of personal autonomy over friends, family, and the community including places of worship. Some participants held a high sense of personal efficacy, believing whatever decision they made was right, and they had the ability to follow through with their personal choice. They described not being influenced by information shared by friends and family and maintained the ability to seek out COVID-19 heath information independently. For some, personal life experience was attributed to personal efficacy, placing trust in the medical community and following health information to protect one’s health. In other cases, there was not a concern for helping others follow what they believed or practiced personally and emphasized each person should do only what works for them despite health information and recommendations. This finding leaves a new window of opportunity to understand further a potential shift away from the collective to a more individualized approach specifically with health communication while continuing to ensure personal efficacy remains high in addition to ensuring the equitable dissemination of health information and distribution of health resources.

Personal efficacy, the ability to assess risk and behavioral choices that may or may not align with health information and recommendations are not the only factors impacting risk. SDH found in income, residence, and employment increase risk and exposure from decreased access to open areas, food sources, and increased environmental hazards, all disproportionately affecting African Americans health (Laster-Pirtle, 2020; Bateman et al., 2021; Holmes et al., 2020;). In addition, social structures, political decision making, and health policy combine as influential components. The final research question continued to look at macrosystem level interactions and the impact on exposure and behavioral response.

Research Question 5

What did African Americans do to prevent or minimize exposure to COVID-19? The theme of increasing self-efficacy by protecting others focused on increases in personal efficacy and literacy, but also modeling behaviors. Vicarious experience, or modeling is a component of self-efficacy and helps a person build beliefs in their own ability by watching others in their family, peer group or within communities. In the context of health behavior, modeling, risk and exposure is demonstrated by participant responses and then examined from a larger social context.

Personal health was used in the assessment of risk and in the cases where older age and comorbid disease coexisted, participants followed health recommendations and guidelines to reduce risk and help minimize exposure. For other participants, behavior choices were made despite age or health status and more out of concern for other family members' health. Some participants felt a need to protect whom they saw as vulnerable members of the family such as children or older parents. In this case, participants practiced modeling behaviors in alignment with health recommendations to reduce risk of exposure for themselves and ultimately for the family. Other members would eventually begin to model their behavior. Family leadership was important to some participants in the assessment of risk as they described how access to accurate types and sources of health information was critical in behavioral choice to protect themselves and their family. In some cases, taking on the family leader role increased personal efficacy and the need to ensure they received accurate health information and could make informed decisions. Although health information and communication are designed to be homogeneous across society, it was accessible for some and not as easily for others.

Some participants described setting up washing stations either inside the home or directly outside of the home where family members washed their hands upon entering. Others mentioned requiring masks be worn in the house while in close proximity to each other and maintaining a safe distance in the home whenever possible. One participant also described the experience of taking public transportation with others who were coughing and not wearing masks which negatively influenced their sense of personal efficacy and increased the potential for exposure. Following health recommendations such as social distancing, purchasing sanitizer or other protective equipment, may be more difficult for those with a lowered SES and participants' risk for exposure varied. Research indicates that all African Americans to some degree, experience the same systemic inequities that leads to social disparities and increased risk of contracting COVID-19 (Bateman et al., 2021; Peek et al., 2021). The overall health of African Americans in general and adherence to health information and recommendations still results in disparities created by social structures decreasing the chance to reduce risk and exposure such as overcrowding in the home, limited outdoor space and the use of public transportation (Bibbins-Domingo, 2020, Holmes et al., 2020; Peek et al., 2021).

The final SEM layer, chronosystems, brought the research questions and literature together by demonstrating the interconnectedness and the combined impact on self-efficacy during the COVID-19 pandemic. The most inner layer of a person's experience through larger, institutional policy shape culture, belief systems and ultimately health outcomes (Kilanowski, 2017). Previous literature has shown how chronosystems look at social structures across time in a person's life, and how they affect behaviors and beliefs about themselves and the external environment. Systemic inequalities resulting in disparities have been demonstrated throughout the history of African Americans including environmentally, in residential neighborhoods, in education, income and higher morbidity and mortality in infectious and non-infectious disease (Boardman & Robert, 2000; Evans, 2020; Feigenbaum et al., 2019; Grossi, 2020; Hagen, 2005; Jones et al., 2018; Noonan et al., 2016; Williams et al., 2019).

Chronosystems culminate the experiences within SEM and interconnect them with all the influencers of self-efficacy presented in this study. Overall, the findings confirm what is already found in the literature to impact the self-efficacy of African Americans. New knowledge was discovered where participants found value in personal autonomy, family leadership, mental health, and where participants felt safety and trust in seeking care. All the new findings provide a window to explore belief systems and if the health behavior of African Americans has changed over time.

Limitations of the Findings

The study had several limitations including sample size, demographic population, geographic location, researcher bias, and study design. This was a qualitative, thematic analysis using semistructured, open ended interview questions. The sample size was small with 22 participants and does not allow for generalizations to the larger African American population in the Chicagoland area or as an ethnic group. Saturation was reached after 22 interviews and no new information was discovered as I reviewed the data. The responses shared by the participants may not adequately reflect the experience of different age groups as the study included anyone between the ages of 18 or older. The study could have been more specific within age demographics to capture that segment of the population. The study was limited to African Americans in the greater Chicagoland area and the experiences may be different for those living in other urban and rural areas within or outside of Illinois.

As the researcher and part of the African American community, I remained aware of the potential for bias throughout the study. During the interviews I remained neutral, not adding or taking away from participant responses. I asked for clarity in responses where needed and allowed participants to express their experience. I was also careful not to inject my opinions or beliefs while analyzing the data. Even with this awareness, I recognize my mental confirmation of experiences I relate to as a member of this community. I reviewed the data several times to ensure my tendency to lean in on those experiences I recognize did not cause me to overlook other sections of responses that may not be as familiar. I used only the transcribed excerpts of participants in the study for data analysis.

The study design could have led to researcher bias by targeting the Chicagoland area with a large African American population that may have shared experiences. A broader study could have reached further outside of urban areas to determine if those experiences were unique to one geographic location. Additionally, the study had a variety of educational, and socioeconomic levels. A study designed to target a specific demographic within those groups could provide a more detailed account of the experiences for that population.

Recommendations

This study has shown how the experiences of African Americans happening within different layers of our social structure shape their sense of self efficacy. The study revealed the complex nature of self-efficacy, and the many influencers impacting health beliefs and behavior during a pandemic response situation. The results reveal an opportunity to expand knowledge on the beliefs system and behavior of African Americans during the COVID-19 pandemic. Opportunities to expand research presented as participants stated how making a personal decision on what to believe and how to respond to health information was important. In addition to what was found in the literature, a high sense of personal autonomy despite what the masses believed was mentioned throughout the research and expanded across all demographics. Taking on the role of family leader during the pandemic whether by an older or younger person was another indicator to understand through research behavioral response. A qualitative study can reveal a deeper understanding of whether the leadership role for African Americans has changed over time and what health communication should look like to target that individual. The family leader in this case has set the health behavior of multiple generations of people.

This study did not attempt to measure self-efficacy. A quantitative design can be beneficial to understand on a larger scale the self-efficacy of this population and create a more generalizable study of African Americans current health behavior. Quantitatively the study can compare differences in self-efficacy influencers during the pandemic across varying demographics including socioeconomic levels. Additionally, the experience of trust in the health system, as the study indicates, may not be in the community as participants felt seeking care amongst the White population would render safe health care and resources. Future studies can examine differences in where African Americans feel safe receiving care and why.

Implications

The implications for social change from this research are grounded in its conceptual framework. SEM looks at the layers of interactions at the individual, community, organization, and public policy level. The research goal was to identify how experiences within those layers impacted self-efficacy response to COVID-19 health information. Results found within the study confirm how various factors acted as influencers of self-efficacy during the COVID-19 pandemic such as trust, mistrust perceptions of health and risk, health literacy, misinformation systemic racism, health disparities and others. Those factors are all found and connected within the layers of SEM, contributing to past and present-day preventable health disparities as demonstrated in the literature. This study contributes to positive social change by providing insight into experiences impacting self-efficacy response during COVID-19 which can then be used to extend research and evaluate pandemic response in underserved communities. On an individual and family level, social change works towards the elimination of inequitable microsystem experiences happening in the health care system. Also creating targeted efforts to increase trust in every demographic within the family unit. Recognizing the family leadership dynamic and tailoring communication to health leaders within the family. At the organizational level by working toward increasing health resources in the community and by ensuring those resources are equitable and available to the most vulnerable during a health care crisis. On a policy level by creating legislature that addresses the end of health inequities found within the study such as, discrepant experiences happening in the African American community, lack of community resources such as places for health care treatment and health communication for vulnerable groups unable to access the internet or access to sources of accurate health information. The positive social implications at various levels are clear and exist within all socioeconomic components of the underserved.

Conclusion

This study sought to understand the lived experiences of African Americans in response to COVID-19 health information. Participants provided valuable insight into the factors contributing to their health decision making in response to health information during the current pandemic Findings indicate self-efficacy was influenced by experiences and interactions happening throughout SEM. While it is imperative to ensure health information is tailored effectively to reach target populations that experience higher disease burdens; equally important, is ensuring that all communities, especially those with a lower socioeconomic level, have equal access to health resources and treatment to build trust at every level in the personal health decision making process. This study can be used in future research to examine barriers further and to help improve health information and planning for future pandemic response. Despite heath information being made available to all people, and some participants having access to all the resources needed, some still expressed concerns with barriers from minimal to no health information in their communities, discriminatory health care experiences and inequitable health resources in their most vulnerable geographic areas. Themes within the study were: (1) valuing personal autonomy and self-efficacy; (2) trusting medical care outside the community; (3) valuing traditional natural remedies and beliefs; (4) unequal access to quality care; (5) mistrust in medical care generally; (6) the influence of friends and family on self-efficacy; (7) increasing self-efficacy by protecting others; (8) accuracy of information; (9) the influence of personal health and family members on decision making and risk-taking; (10) the value of health literacy (11) the influence of access to care on health understanding; (12) the role of isolation and hopelessness.

The findings provide new opportunities to understand the value of personal autonomy above and beyond public health information and recommendations or apart from the influence of friends, family, or the community. The role of family leader was another new opportunity to understand how the role impacted beliefs about increasing personal literacy, modeling, motivation and influencing the behavior of extended family members. The family leader role was seen both in older and younger generations. Isolation and hopelessness directly associated with pandemic response are new findings that may influence future behavioral response. This leaves room to explore ways to reduce mental health impacts particularly with underserved groups already experiencing disparities within the communities.

This study concludes with the sentiment that self-efficacy is in fact influenced from experiences happening within different social structures in our society and illustrated the specific factors impacting both individuals and communities in health beliefs, trust in health information and response during the COVID-19 pandemic. The study demonstrates the need for a continued focus on social justice that eliminates all social and health disparities, creating equitable experiences for our most vulnerable communities.

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Appendix A: Electronic Recruitment Flyer

Research Study

Recruiting members of the Black community

Let your voice be heard and share your story with me!!
I'm a Doctoral research student interested in your experience with COVID-19

Who can participate in the phone interview??

African Americans over the age of 18 who reside in Chicago or the greater Chicagoland area!

Your contribution to the study:

- Increases understanding of community needs.
- Increasing understanding of pandemic experiences.
- Help to improve health communication in your community.

Contact Information:

Katrina Volbrecht, Primary Researcher 331-425-9410
Katrina.Volbrecht@waldenu.edu

$25 E-Gift Card For Participating!!

Appendix B: Recruitment Email

Dear Potential Participant,

My name is Katrina Volbrecht, and I am a doctoral student at Walden University, enrolled in the Public Health program with an emphasis in Community Health. I am conducting a study to understand the experiences of African Americans in response to COVID-19. The data gathered in this study will help public health leaders inform on the needs of this community based their experience during COVID-19; identify ways to tailor pandemic related health information; and improve future pandemic response based on the experiences of this community.

If you’re interested in participating, you will conduct a phone or Zoom interview for 1 hour with me to answer questions directly related to the study. For participating you will receive a $25 electronic Visa gift card. You will be contacted by me to schedule a date and time to conduct the phone or Zoom call interview. I will send you a reminder of the interview 24-48 hours before the schedule date to reconfirm your participation. If for any reason, you are unable to attend the interview, please let me know to allow time for other participants. I look forward to speaking with you and learning from your experience.

Appendix C: Interview Prescreening Tool

Name:

Race or Ethnicity:

Are you above 18 years of age: Yes or No

Age:

Education Level:

Income Level:

☐ 0-15,000

☐ 15,000-25,000

☐ 25,000-50,000

☐ 50,000-75,000

☐ 75,000 or above

Phone Number:

Email Address:

Do you reside in the Chicagoland area: Yes or No

County in Illinois of Residence: ___________________

Have you received COVID-19 health information, recommendations, testing or treatment from a physician, nurse, clinic, community center or public health professional: Yes or No

Appendix D: Interview Questions

1. What was your experience with testing or treatment for COVID-19? Please explain how this experience made you feel.
2. Describe your experience with access to testing and treatment. Please tell me what happened and how you felt about it.
3. What kinds of the health information and recommendations did you receive for COVID-19?
4. What was your response to the health information and recommendations? What did you think and how did you feel?
5. How did the heath information and recommendations affect your understanding of COVID-19?
6. How does trust in the public health information and recommendations influence your response?
7. What were any barriers you experienced with following the health information and recommendations? Again, I'd like to hear what happened and what you thought and felt about it.
8. Describe your experience with accessing the following resources in your community: access to hand sanitizer, places to wash and keep your hands clean, access to face masks or other protective equipment and your ability to social distance. How did this experience make you feel about following health recommendations?
9. Describe your experience with misinformation about COVID-19 i.e. meaning any false or misleading information. How does misinformation affect your ability to trust in health information and recommendations.

10. Describe any experiences of mistrust in the public health community that influences your beliefs about COVID-19? How did those experiences make you feel?
11. Describe your beliefs about contracting COVID-19?
12. How does the health beliefs of other African Americans influence your beliefs about contracting COVID-19?
13. How did the health information and recommendations influence your beliefs about preventing contracting COVID-19?
14. How did your health behavior during COVID-19 influence the health behavior of family and friends in your community?
15. How does your health influence your own beliefs about contracting or recovering from COVID-19?
16. How did other African Americans experience during COVID-19 influence your health behavior?
17. Describe your experience influencing family and friends to follow health recommendations guidelines?
18. How did helping family and friends during COVID-19 influence your ability to follow health recommendation guidelines?