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Integrated Methods for Applying Critical Race Theory to Qualitative COVID-19 Equity Research

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Background: Racism persists, underscoring the need to rapidly document the perspectives and experiences of Black, Indigenous and People of Color (BIPOC) groups as well as marginalized populations (eg, formerly incarcerated people) during pandemics.

Objective: This methods paper offers a model for using Public Health Critical Race Praxis (PHCRP) and related critical methodologies (ie, feminist and decolonizing methods) to inform the conceptualization, methods, and dissemination of qualitative research undertaken in response to the evolving COVID-19 pandemic.

Sample: Using purposive snowball sampling, we identified organizations involved with health equity and social justice advocacy among BIPOC and socially marginalized populations. Focus group participants (N=63) included community members, organizers, activists, and health workers.

Design: We conducted topic-specific (eg, reproductive justice) and population-specific (eg, Asian and Pacific Islander) focus groups (N=16 focus groups) in rapid succession using Zoom software.

Methods: A self-reflexive, iterative praxis guided theorization, data collection and analysis. We obtained community input on study design, the semi-structured discussion guide, ethical considerations and dissemination. Applying PHCRP, we assessed our assumptions iteratively. We transcribed each interview verbatim, de-identified the data, then used two distinct qualitative techniques to code and analyze them: thematic analysis to identify unifying concepts that recur across focus groups and narrative analysis to keep each participant's story intact.

INTRODUCTION

Racialized communities are disproportionately impacted by disasters and public health efforts to respond to them. In the first year of the COVID-19 pandemic, the life expectancies of Black and Latinx populations decreased 3 to 4 times the life expectancies of Whites,[1,2] echoing early predictions that cases, deaths, hospitalizations, and other outcomes would be highest in the communities and populations most impacted by historical and contemporary forms of structural racism. Racism has been defined in many ways. Gilmore's definition of it, which is widely used in Critical Race Theory, emphasizes its structural nature: racism is the "state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death."[3]

Structural racism is a complex assemblage of mutually reinforcing

Results: The praxis facilitated relationship-building with partners and supported the iterative assessment of assumptions. Logistical constraints included difficulty ensuring the confidentiality of virtual discussions.

Conclusions: These novel approaches provide an effective model for community-engaged qualitative research during a pandemic. *Ethn Dis.* 2022;32(3):243-256; doi:10.18865/ed.32.3.243

Keywords: Critical Race Theory; Qualitative Research; Health Equity; Racism; Social Injustice

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and interlocking ideas and practices through which systems and institutions create and maintain racial injustice.[4–7] It both increases risk (eg, by mandating essential work in high COVID prevalence settings) and limits access to solutions (eg, equitable access to COVID testing) among communities of color.[8–10] Racism selectively renders some solutions (eg, access to testing) socially and politically possible, while creating the

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We developed the framework (ie, a disaster praxis), which draws on applications of Critical Race Theory to public health.

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impression that others (eg, closing incarcerated settings) are unimaginable.[11] Understanding the effects of racism is important for addressing the implications of the current public health disaster and future ones. It is also extremely relevant in preparing for emergent high levels of death, disability, financial hardships, and grief associated with it and its implications for generations to come.

In March 2020, the Center for the Study of Racism, Social Justice & Health responded to the pandem-

ic by forming the UCLA/Charles R. Drew University COVID-19 Task Force on Racism and Equity ("the Task Force"), which immediately launched the "COVID Storytelling Project (ie, Project)." The Project, an ongoing, two-pronged research study, has been documenting the perspectives and experiences of diverse racialized and marginalized populations and communities (eg, immigrants, people experiencing incarceration, unhoused people, and racial justice protestors) over the course of the pandemic.

The goals of the study are to understand how social injustices, in particular structural racism, have affected the health of racialized and marginalized populations and communities during the COVID-19 pandemic by prioritizing the voices of communities that are missing from or misunderstood within dominant public health discourse.[12] The existence of structural and other forms of racism is well-documented in the health equity evidence base and in other literatures (eg, sociology, law, economics).[13–17] The critical methodologies, specifically, Public Health Critical Race Praxis (PHCRP), on which the study is based, frame racism as impacting all aspects of how society is organized; they recognize that the oppressive, exploitative systems of White supremacy, capitalism, and patriarchy intersect and mutually reinforce one another.[4,18–21]

Working from the understanding that structural racism exists, PHCRP-based projects pursue answers to one overarching question: How is racism operating here?[22–24]

In this Project, we spe-

cifically sought to clarify three points: How does racism: 1) exacerbate the risk of acquiring COVID-19 or dying from it? 2) affect efforts to mitigate and contain the spread of COVID-19? 3) exacerbate hardships among the communities already experiencing racial, economic, and gendered inequities?

In this article, we describe the framework and approaches used in the Project's qualitative arm through which we conducted virtual focus groups in rapid succession among community organizers and frontline professionals. We also discuss lessons learned to date about integrating Critical Race Theory and empirical methods for qualitative COVID equity research.

FRAMEWORK: RACE CONSCIOUS INTEGRATION OF THEORY, RESEARCH METHODS AND COMMUNITY ENGAGEMENT

To characterize structural racism occurring during the pandemic and identify ways it contributes to COVID inequities for Black, Indigenous, and People of Color (BIPOC) populations, we use the PHCRP and related critical methodologies (ie, feminist, anti-colonial methodologies). As with other critical approaches, PHCRP requires researchers to explicate how their philosophical and theoretical orientations shape their methods and practice. It is very difficult to stand in our commitments to justice and equity within the reality of our institutions, which reflect

how neoliberal academia and the Research Industrial Complex (RIC) operate.[25–27] To this end, we developed the framework (ie, a disaster praxis) discussed in more detail below. It draws on applications of Critical Race Theory to public health. This framework informs the Project's conceptual models, research methods, translation of findings, and community engagement activities. (Figure 1)

This frame is a sociogenic analysis. We examine the larger society within which pandemic inequities are occurring and focus on societal, as opposed to individual-level, determinants of COVID-19 inequities. In particular, we examine historical (eg, indigenous genocide, enslavement of Africans) and contemporary state-sanctioned activities (eg, the global mass displacement of communities by White supremacy). PHCRP's theory, method and action are built on the social justice-oriented epistemologies described herein, which examine the ill societal body.[24,28] To adhere to PHCRP tenets, our approach foregrounds the primacy of racism and articulates assumptions embedded within the research methods and process.

Theory

Social, political, and health systems may undermine the capacity of community-based workers to caretake, organize for justice, and demand dignity for oppressed populations.[29] These community workers operate as networked systems. They help to build resilient social environments[30] that serve as safety nets and reduce disparities.[31–34] Community workers who pursue justice and build power

for (and within) their communities have been recognized as essential yet they are under-resourced, over-burdened, and under-utilized.[35,36] Based on the prior evidence,[33,34,37] we conceptualize the COVID-19 pandemic as exacerbating the precariousness of these networks through losses of life, connection, wellness, and resources. Literature on the impact of the COVID-19 pandemic on community-based workers supports this theory.[33,34,37]

Integrated Methods

The praxis we developed for this project uses community-engaged research practices that encourage communities and professional researchers to partner as equals to conduct research.[38,39] As with decolonizing and Black feminist epistemologies, the praxis also critiques conventional modes of knowledge production, which presume the inherent objectivity of science. To support transformative change, we use an iterative, reflexive process that links theory, methods and action at each stage of the research process.[18,40,41]

Our praxis also learns from the indigenous practice of storytelling. Within this practice, the information gained from participants cannot be reduced to mere narrative data and/or qualitative methods. We position the storyteller both as master of their lived experience and as teacher of their stories; those stories explain power dynamics in the world around them.[42] The person receiving the story is the (lifelong) learner (ie, researcher). The decision to root the project in this way was based on our desire to re-relate

to research with intentionality.[41,43] We re-relate to research during the pandemic by addressing power differentials between the investigators, the communities we engage and the purpose of the research, which is to bolster social transformation.[41,43]

The stories participants tell about the contemporary and historical conditions of their communities constitute expert knowledge. The participants are the experts sharing how injustices shape the contexts, struggles, reactions, emotions, solutions, and underlying patterns of inequity, which become the processes and pathways through which COVID-19 disproportionately impacts BIPOC communities. The integration of these approaches for knowledge production is appropriate and necessary to study communities' experiences with structural racism from their perspective.

Centering participants and their stories in these ways helps us to: 1) reconceptualize how we understand reality (ie, epistemology); 2) remain intentional about which worlds or life experiences to prioritize; and 3) stand in solidarity with the oppressed by conscientiously avoiding research approaches that may inadvertently reproduce colonial heteropatriarchal research enterprises.[44,45] We dive deeper to explore how multiple axes of oppression impact people on the margins of the pandemic response from within a socio-ecological framework that contextualizes how injustices are interconnected and embodied. [14,46–49]

Action

The praxis prioritizes the dissemination of evidence that can

Epistemological Position

DECOLONIZATION AND BLACK FEMINIST THEORY

- Subvert heteropatriarchal colonial research enterprises (eg, produce knowledge for and by marginalized communities, process of producing knowledge involves redistributing academic institutional resources to affected communities)
- Reconceptualize how researchers know the world (eg, there are multiple realities shaped by power; not all researchers occupy similar positions of power)
- Be intentional on what we prioritize knowing (eg, which research questions will have beneficial policy implications to achieve health equity?)

Theoretical Perspective

RACISM AS A STRUCTURAL DETERMINANT OF EQUITY

- Racism *structures* the distribution of the social determinants of health
- Racism operates across and within social, political, health, and economic systems

Methodologies

COMMUNITY PARTNERED PARTICIPATORY RESEARCH

TRANSDISCIPLINARY CONTEXTUAL RESILIENCE

INTERSECTIONALITY

- Support informal community health systems
- Center community narratives in storytelling the inequities related to COVID-19

Methods for Data Collection

RAPID ASSESSMENT METHODS (see Figure 3)

Embodied Practice

RESEARCH AS CEREMONY AND SOLIDARITY

- Value communities that are typically invisible in mainstream research approaches and mainstream funders
- Maintain a commitment to build community and human relationship during the isolation and disruption of COVID-19 pandemic
- Rely on storytelling to center voices from the margins and, thus, help subvert dominant narratives of racially and socially oppressed populations
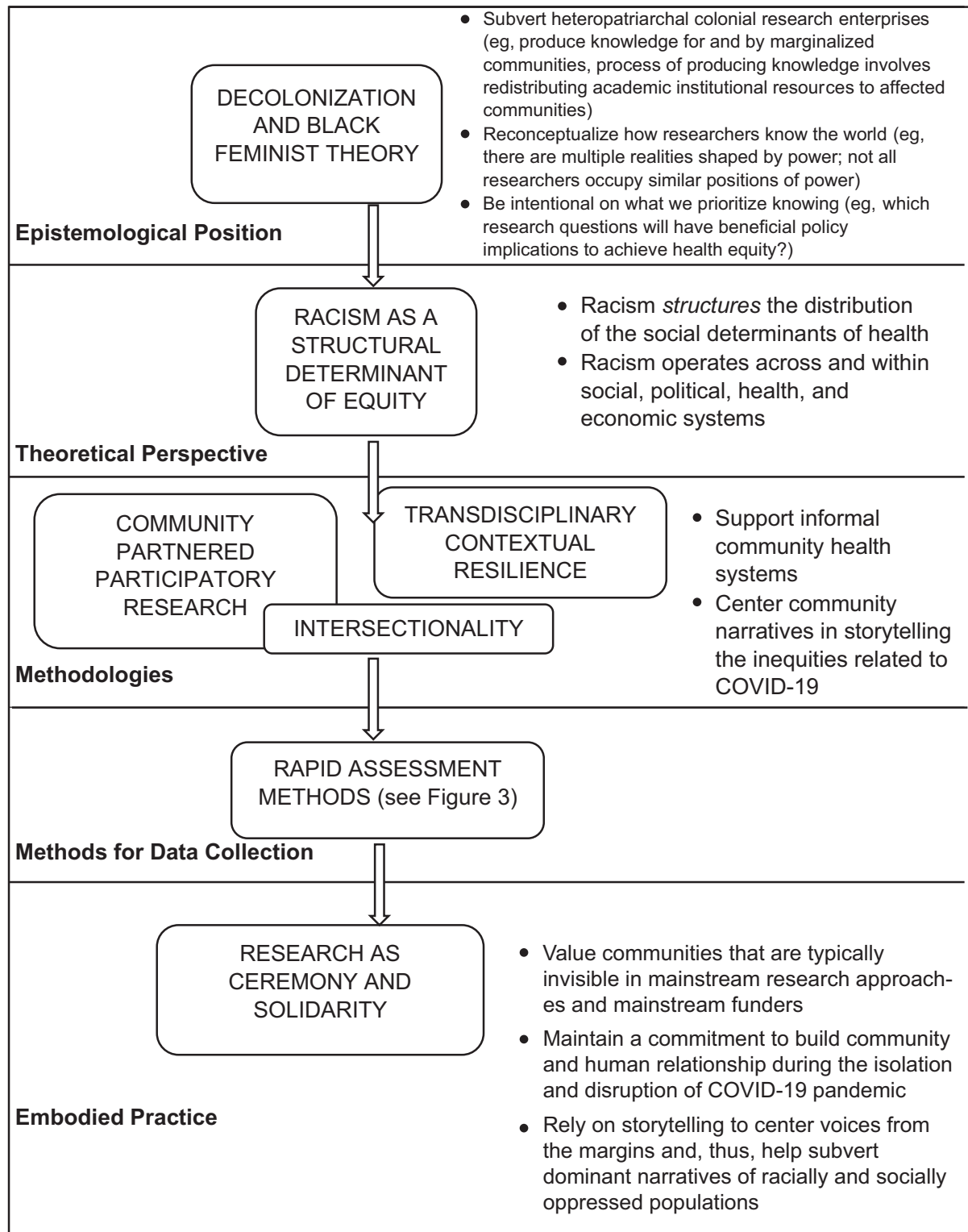
Figure 1. Qualitative storytelling framework: rapid assessment of COVID-19-related experiences, perceptions, barriers and recommendations among racially and socially oppressed populations

support communities' ongoing movements for racial, reproductive, environmental, and economic justice. We solicit written and oral research and narratives from community-based workers across diverse settings. We use this information to educate ourselves about their work and we disseminate it to others.

An important part of action is to disseminate the findings to the most impacted communities. In addition to the traditional methods of dissemination that include publishing peer-reviewed articles and presenting at scientific conferences, we also share key findings via social media (eg, Twitter, Instagram, and Medium), websites, newsletters, and events (ie, panels). We present the findings directly to community organizations, health and health care institutions, and policymakers. We leverage our platform to amplify the voice of these communities, we invite partner organizations to discuss any topics of interest to them in brief video interviews called "Task Force Talks." Figure 2 lists topics organizations have discussed to date. The lessons learned from the study results and the feedback from community inform the Task Force's priorities for future community engagement.

The framework outlined in Figure 1 is our model for integrating social justice-based methods for the qualitative application of Critical Race Theory, and PHCRP more specifically, to COVID-19 equity research. As described in the next section, the protocols used to conduct the research integrate standard qualitative methods and our critical, reflexive approaches.

QUALITATIVE METHODOLOGY

The Project, which is ongoing, began in July 2020 as a series of recurring focus groups conducted in rapid succession among advocates for and members of marginalized populations. The overarching aim of the Project is to hear directly from those who have been working across diverse settings on the frontline and essential issues during the COVID-19 pandemic. Applying principles of community-engagement, we began incorporating community input on study design, dissemination, potential barriers, and ethical considerations. (Figure 3) Prior to initiating the study, the Task Force held community sessions to solicit input on the proposed research. Due to the pandemic and COVID-19 stay-at-home mandates, all recruitment, consenting, and data collection were necessarily conducted virtually (eg, using Zoom meeting software) with participants permitted to join either by internet or telephone. The UCLA Institutional Review Board approved all study procedures and materials.

Data Collection

In collaboration with the community partners, the Task Force developed discussion guides to lead semi-structured focus groups. The guide covered multiple domains including barriers and concerns regarding community testing, COVID-19 mitigation strategies, dominant social and economic inequities and challenges pre-COVID-19, COVID-19 information, and health status and access to health care during the CO-

VID-19 pandemic. Facilitators used the guide to ask 10-15 questions in each focus group. Figure 2 lists sample questions and corresponding probes from the semi-structured interview guides. The items are intended to reveal tensions between ideas of individualism, property and ownership with those of mutual aid, communalism, collaboration and cooperation in response to structural racism. After each focus group, all participants received a thank you note via email and a separate email containing compensation of $75 in the form of an Amazon gift card.

PROCESS

Recruitment

We used a purposive snowball sampling strategy focusing on health equity and social justice advocates to identify organizations from which to recruit participants. We also received recommendations from Task Force members with extensive regional or national social justice involvement and individuals referred by others involved in social justice networks. Community partners who work on a wide range of health equity and social justice concerns such as prison abolition, birthing justice, immigrant rights, LGBTQ+ human rights, and international health were eligible to participate. To accommodate busy schedules, participants are provided a choice of dates and times to participate.

Pre-focus Group Meetings

Administrative matters such as securing informed consent and explaining how to use the technol-

Interview Type	Interview Questions and Probes
	Focus Group Interviews
All focus groups	• How easy has it been for those with whom you work to shelter in place safely? • Where is the community with whom you work getting their information on COVID? Such as how to avoid catching or spreading it? • In terms of COVID-19 testing, can you give us a sense of what their experiences have been around testing? Please describe the ways that people are being socially and politically engaged right now. • In what ways is racism operating? Based on your experience with this community or population, what are your recommendations for ensuring the optimal health of this population during and after the COVID-19 pandemic?
Asian & Pacific Islander Groups, also Detention and Incarceration Groups	How are those with whom you work and who serve criminalized populations such as either incarcerated in a detention facility or by ICE? In terms of health status how has the health been of those you work with/people you serve during COVID? Has it changed or stayed the same? In terms of health services, how has the access been of those who work with/people you serve during COVID? Has it changed or stayed the same?
Community Health Worker Groups	• For some communities, legitimate concerns about racism and other injustices in the health care system make it hard for them to trust public health efforts and the health care system. Is this true for the populations you serve? • There has been a lot of talk about pharmaceutical companies developing a vaccine quickly.
Reproductive Health	• What are the challenges in receiving reproductive health care that you've seen, heard about, or experienced? How has the pandemic impacted reproductive health care (eg. prenatal care, postnatal care, birth, doula, education, fertility treatment, abortion, etc.) • How are people finding strength or drawing on strength right around their own reproductive health needs (individual)? • How can we integrate practices that: center pleasure, liberation, bodily autonomy, cultural respect?
	Other Interviews for Community Engagement
Task Force Talks	• What story do you want to share with us? • What was your work on before the pandemic? • How has the pandemic impacted this? • What work is the most pressing for you right now during the pandemic? • If you haven't shared already, what story do you think continues to be invisible? • What needs to happen for this to be different?

Figure 2. Sample focus group and Task Force Talk questions on COVID-19-related experiences, perceptions, barriers and recommendations among racial/ethnic minority and vulnerable populations

ogy to participate in the meeting, are handled in pre-focus group meetings. Each recruit attends one 15-minute pre-focus group session, during which they meet the moderator, assistant moderator and dedicated technology assistant who will be facilitating their focus group. The moderators answer questions recruits may have, obtain informed consent, discuss Zoom logistics, and review the community norms for participating in the group discussion respectfully.

The six community norms, informed by feedback from our commu-

nity partners, are that all participants agree to: 1) allow one person to speak at a time; 2) use the name and gender pronouns each participant provides on their Zoom meeting screens; 3) turn-off cell phones (or take calls off-screen); 4) adjust audio settings to be mindful of background noise while acknowledging that interruptions may happen; 5) engage in respectful discourse regardless of any difference of opinions; and 6) keep confidential the information shared during the sessions. Participants were encouraged to keep their cameras on during each 1-1.5-hour session. Zoom windows include a text box with an individual's name in it. All participants were permitted to use a pseudonym (if they preferred) rather than their actual name, and asked to add their gender pronouns to the text box.

Focus Groups

All focus groups are conducted using Zoom meeting software, including its video and audio recording functions. The dedicated technology assistant stores all recordings in an encrypted cloud-based application that is compliant with IRB protocols requiring blinded for review. Each focus group has between three and six participants; therefore all participants are more likely to be visible to one another at the same time on a single screen. At the beginning of each focus group, the moderator briefly reviews the community norms with the full group of participants and starts the recording.

Populations of Interest

The Project purposively recruited from racially (eg, BIPOC people),

and socially marginalized (eg, people who were formerly incarcerated) populations. Focus group participants include advocates for marginalized populations such as organizers, activists, and health workers, who are members of these populations or work closely with them. Thus far, their work has focused on environmental justice, LGBTQ+ human rights, immigrant rights, undocumented youth, people who use drugs, people experiencing homelessness, anti-gentrification, housing rights, labor rights, anti-racist action groups, reproductive health, mental health, international health, community health workers, youth within the jail system or family members of incarcerated or formerly incarcerated individuals, or people impacted by policing or criminalization. We collected demographic information about participants, the organizations they represent, and the people they serve through a survey.

From July 2020 to March 2021, we conducted focus groups (N=16) with 63 diverse participants. The focus groups were stratified by population (ie, Asian American and Pacific Islanders, LGBTQ+ persons, community health workers) or topic (ie, incarceration and criminalization, immigration and detention, reproductive justice).

Data Analysis

Each interview was transcribed verbatim and two research team members reviewed the transcript for accuracy then de-identified the data so that individual participants cannot be identified from the data. After reviewing and revising each transcript,

they uploaded it into Dedoose software for the analyses.[50] Subsets of focus groups, organized by topic/focus (eg, incarceration/detention, reproductive justice), were analyzed using two distinct qualitative analytical techniques, thematic and narrative analyses. Thematic analysis allows for the identification of recurrent, unifying concepts. The themes draw connections between issues of equity (such as racism and social justice), health and health care (such as testing and access to a provider), and the social determinants of health (such as housing and employment insecurity and loss) that endure across groups. By contrast, narrative analysis keeps the participants' stories intact. It views the participants as expert storytellers recounting the conditions of those for whom they care and with whom they work. Participants' insights about inequities, community health and the pandemic, as well as the stories they share about theirs and others' struggles, values, and identities doing the work help illuminate how structural racism operates in their communities. Thus, treating the data as stories woven together by participants, provides another tool we can use to examine existing community health networks and the ways larger systems operate. Evaluated in tandem, the thematic and narrative analyses allow the concepts to be unpacked within the participants' own lived experiences.

Thematic Analysis

Coding for the thematic analyses are completed through an iterative process.[51–53] First, two to three members of the study team review all

transcripts corresponding to each set of focus groups to generate a preliminary codebook. This development process was guided by the project's theoretical frameworks and Task Force members' prior knowledge of the subject matter allowing for both deductive and inductive code development. The deductive strategy allows the conceptual framework to be applied across all sets of focus groups; the inductive approach allows for the development of unique codes specific to each set of focus group topics. After using a consensus approach to establish the coding scheme, the team members independently code the remaining transcripts for that set of focus groups. Analytical memos are also generated through the coding process to mark identified substantive patterns or conceptual clustering that has been instrumental in thematic development. Dedoose data exports enumerate the frequency with which each code is used and situate them into tables. Tables aid in the reducing and organizing of data across codes; the analysts review them for frequency and depth.

Narrative Analysis

A team member creates the narratives for each participant by reviewing each transcript and compiling each individual participant's contributions. Two study team members then review each narrative to identify how the participants, as both community-based workers and people directly impacted by social injustice, have made meaning of inequity, community-needs, and the pandemic response and experience what they have observed and are

living through. Special emphasis is placed on identifying narrative connections between the current moment and longer historical trajectories. After reviewing the narratives individually, the study team discusses these preliminary findings with one another and comes to consensus on similarities and differences, before confirming the final results.

Continuous Reflection

The aforementioned self-reflective critical praxis requires the naming and ongoing review of assumptions throughout the research process to enhance trustworthiness.[54–56] Trustworthiness in the validity of study findings is established throughout the research process, and in the analysis phase, we confirm the congruence between our findings and the research aims using the following techniques.[56] Prior to data collection, team members completed a questionnaire. Study team members then met on their own to review. Throughout the analysis phase, weekly meetings continue to provide the opportunity for this self-reflection through dialogue on multiple viewpoints and the sharing of salient content specific and methodological literature. Given the diverse expertise comprising the research team, multiple perspectives are represented and inform these discussions. Once the data have undergone a preliminary analysis, preliminary themes are reviewed with representatives from the communities sampled and academic partners in forums and meetings. Finally, to solicit confirmation and confirm the accuracy of complex ideas and quotes, study team mem-

bers reach out to select participants for clarification and confirmation.

DISCUSSION

Thus far, we have described the integrated, CRT-informed praxis that guides all aspects of the project, disclosed assumptions embedded within it, and described the research methods. Below, we outline lessons learned from our broader theoretical approach as well as logistical and ethical lessons related to the project methodology.

During moments of acute crisis in the pandemic (eg surges in hospitalizations), there is a pressing need to generate actionable evidence and share it with impacted communities quickly. Therefore, we have sometimes opted to share any relevant findings with community immediately even if doing so makes it difficult to subsequently publish the findings in traditional "academic" venues (ie, scientific journals). Our team, which comprises researchers, students, and faculty of color, is subject to many of the same social injustices and health inequities that are of interest to this research. As a result, many members of the research team have had to contend with challenges within and across both professional and personal realms. For us, the project is a "labor of love"; therefore, we continue conducting the work while contending with these challenges and we prioritize giving (back to) the BIPOC and other marginalized communities from which we come.

Decolonized storytelling operates outside of conventional academic public health research[40–42,45] in ways

that are often oppositional to it. Our methods strive to practice decolonizing methods, being useful to the broader community while responding to the dictates of academia).[45] These tensions often leave us dissatisfied and feeling we are not doing either well.[57,58] Tuck and Yang cautioned against this when describing the disconnect between work that claims to be decolonizing but that is not in service of actual decolonization.[59]

While Task Force members are involved with providing mutual aid and building grassroots community power, the formal work of storytelling is limited in how far it can extend and break from existing institutional norms. For example, the copyright standards of many academic journals are unwilling to publish work that has been published previously in reports or op-eds, blogs or other venues that the general public can readily access. This limits the ability to disseminate findings to the public and the scientific community simultaneously. To generate empirical evidence is often labor intensive and, therefore, access to the evidence is biased toward those with more resources, including time. In short, while we seek a progressive challenge to existing systems of inequity, we have found that institutional and structural pressures often confine the work to reformist paradigms.

Below we outline lessons learned related to project design that consider both logistical and ethical considerations.

Recruitment

One central challenge the project has faced has been recruiting, scheduling, and holding focus groups ex-

clusively online. Invitations may be rerouted to junk/spam folders or quarantined by email servers and thus ignored or found after the recruitment period. Strategies such as marking emails as important and copying the person who recommended the potential participant have been useful. Limited availability due to a multitude of reasons (ie, child/elder care), many related to the ways COVID-19 has impacted lives,

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During moments of acute crisis in the pandemic (eg surges in hospitalizations), there is a pressing need to generate actionable evidence and share it with impacted communities quickly.

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have also been a barrier. Additionally, documenting perspectives and experiences on local, national and international levels has been challenging because of scheduling across time-zones. Finally, many of those invited to participate declined because of lack of capacity. The work in their communities is of primary concern and does not allow them to participate, even in the online groups.

Remuneration

Institutional restrictions limited the types of remuneration that could be provided to focus group participants to Amazon e-gift cards; however, spending money with this corporation contradicted the social justice principles of many participants. Several of the community-based organizations working with immigrant and detained communities expressed disappointment about the choice of using Amazon considering the company's ties to immigration and border surveillance enforcement efforts.[60,61] Representatives of an organization focused on detention refused to participate due to the amount of the incentive and expressed that their participation would lead to re-traumatization. Thus, they asked for at least double the amount of incentive and required that the study provide self-care (eg, acupuncture) after their participation. We were unable to accommodate the request; therefore, they declined participation. Practically, Amazon gift cards purchased in the United States could only be used within the United States and Canada, making it difficult to recruit international participants. Furthermore, and likely largely due to the pandemic, the study experienced significant delays in delivering incentives.

An additional challenge was the difficulty remunerating partners, many of whom are from under-resourced organizations, for their involvement in the work. Historically, NIH and other funders have provided less support for racially conscious, community-engaged work than for more traditional academic research (eg, clinical or pharmaceutical re-
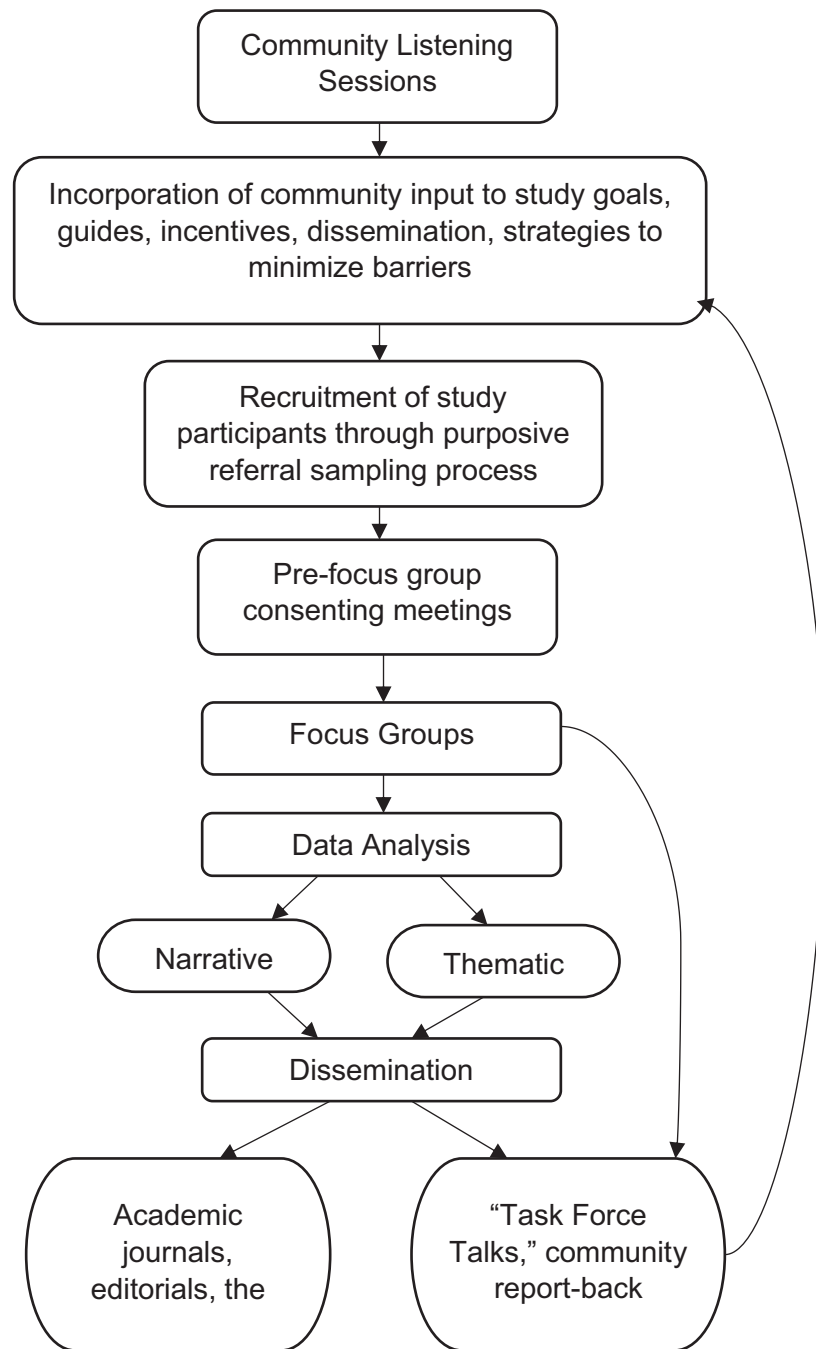
Figure 3. Qualitative storytelling methods for data collection rapid assessment of COVID-19-related experiences, perceptions, barriers and recommendations among racially and socially oppressed populations

search). This model makes it difficult to compensate individuals and community-based organizations fairly for their contributions to the work.

Zoom Technology

Though the availability of Zoom technology allowed us to enroll participants who might otherwise be difficult to recruit in person due to, for instance, distance to the study site, the reliance on Zoom technology for all stages of the project (recruitment, consent and data collection) also presents several challenges. First, computer literacy among our participants varied widely. To address this, it was important to provide technical support and instructions in one-on-one or small group meetings scheduled with participants who requested it before the formal focus group and dedicated technical support for the duration of each focus group. Technical glitches related to internet access/connection occurred throughout data collection for both participants and moderators. Participants who used Zoom's phone-based platform also had difficulty maintaining a reliable connection using their cell phone service providers at times.

Anonymity/Confidentiality

Even though participants were offered an opportunity to use a pseudonym to preserve their anonymity, many participants worked in similar fields (social work, community outreach, etc.), knew each other, and preferred that their contributions to the discussion be associated with (vs disassociated from) their identities. We also had concerns with our inability to know or control for who else might be in a participant's physical space and the implications of that both for that participant's comfort and in terms of other study-related considerations (eg, other participants' confidentiality). This was a challenge that we addressed by continuously underscoring the importance of participants protecting each participant's confidentiality.

Conducting Community-Engaged, Qualitative Research During the Pandemic

The distinct realities of conducting community-engaged research that emphasized storytelling as the primary methodology are noteworthy. The infeasibility of face-to face interactions during the pandemic—especially the initial months—was not ideal for conducting focus groups. Comfort with technology and unfamiliarity with the Zoom platform posed challenges. [62,63] There were differing levels of familiarity with the technology and access to devices to support that technology. It was necessary for a dedicated co-moderator to provide technical support, assist with name changes, and manage the waiting room.[62] Lastly, Lobe et al emphasizes a quiet space with limited interruptions as a requirement for successful online gatherings. In this project, we found that this was not feasible for all participants.[63] Given the realities of caretaking for elders, children, and/or sharing living space with others, we included the expectation of interruptions in our community norms.

Considering the aforementioned challenges, doing this type of research during the pandemic did create opportunities. For example, the shift to using online the Zoom platform created flexibility and increased participation.[62,63] Participants were able to participate in the focus groups from many locations, including work, free time, or even while they ran errands. Similar to others,[64] we have found that online focus groups extend the reach of recruitment efforts beyond a specific geographic area. Finally, drawing on group dialogues may help to heal the ongoing effects of trauma and harm.[46] Focus groups continue to be opportunities for participants to witness the depth of commitment to support communities during COVID-19 and to challenge the existing social contracts that allow inequities to persist.

CONCLUSION

In this article, we offer a model for integrating critical theory into the conceptualization, methods, and dissemination of qualitative research conducted via Zoom in rapid response to the evolving pandemic. Strengths of this project include our adaptations of the methods to accommodate the realities of the populations of interest. The strategies address the assumptions embedded within the project and they inform the process of relationship-building among colleagues and partners who are doing vital social justice work for community health. From a CRT perspective, a strength of this article is the transparency with which we disclose the assumptions guiding each aspect of the work, how we see the world, and

AUTHOR CONTRIBUTIONS

Research concept and design: Amani, Huỳnh, Skrine Jeffers, de la Rocha, Bradford, Ford; Acquisition of data: Amani, Cabral, Huỳnh, de la Rocha Ford; Data analysis and interpretation: Amani, Cabral, Sharif, de la Rocha, Ford; Manuscript draft: Amani, Cabral, Sharif, Huỳnh, Skrine Jeffers, McAndrew, Baptista, Bradford, de la Rocha; Statistical expertise: Amani, Bradford; Acquisition of funding: Amani, Ford; Administrative: Amani, Cabral, Sharif, Huỳnh, Baptista, McAndrew, de la Rocha, Ford; Supervision: Amani, Ford

REFERENCES

1. Andrasfay T, Goldman N. Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. *Proc Natl Acad Sci USA*. 2021;118(5):e2014746118. https://doi.org/10.1073/pnas.2014746118 PMID:33446511

2. Arias E, Betzaida T-V, Ahmad F, Kochanek KD. Vital statistics rapid release provisional life expectancy estimates for 2020. *National Center for Health Statistics*. 2021;15. https://doi.org/10.15620/cdc:107201

3. Gilmore RW. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*. Berkeley, CA: University of California Press; 2007.

4. Gee GC, Ford CL. Structural racism and health inequities: old issues, new directions. *Du Bois Rev*. 2011;8(1):115-132. https://doi.org/10.1017/S1742058X11000130 PMID:25632292

5. Laster Pirtle WN. Racial Capitalism: A fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States. *Health Educ Behav*. 2020;47(4):504-508. https://doi.org/10.1177/1090198120922942 PMID:32338071

6. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389(10077):1453-1463. https://doi.org/10.1016/S0140-6736(17)30569-X PMID:28402827

7. Bonilla-Silva E. Rethinking racism: toward a structural interpretation. *Am Sociol Rev*. 1997;62(3):465-480. https://doi.org/10.2307/2657316

8. Laster Pirtle WN, Wright T. Structural gendered racism revealed in pandemic times: intersectional approaches to understanding race and gender health inequities in COVID-19. *Gend Soc*. 2021;35(2):168-179. https://doi.org/10.1177/08912432211001302

9. McClure ES, Vasudevan P, Bailey Z, Patel S, Robinson WR. Racial capitalism within public health-how occupational settings drive COVID-19 disparities. *Am J Epidemiol*. 2020;189(11):1244-1253. https://doi.org/10.1093/aje/kwaa126 PMID:32619007

10. Bailey ZD, Moon JR. Racism and the political economy of COVID-19: will we continue to resurrect the past? *J Health Polit Policy Law*. 2020;45(6):937-950. https://doi.org/10.1215/03616878-8641481 PMID:32464657

11. Davis AY. *Are Prisons Obsolete?* New York City, NY: Seven Stories Press; 2011.

12. Fortuna LR, Tolou-Shams M, Robles-Ramamurthy B, Porche MV. Inequity and the disproportionate impact of COVID-19 on communities of color in the United States: the need for a trauma-informed social justice response. *Psychol Trauma*. 2020;12(5):443-445. https://doi.org/10.1037/tra0000889 PMID:32478545

13. Ford CL, Griffith DM, Bruce MA, Gilbert KL, eds. *Racism: Science & Tools for the Public Health Professional*. Washington, DC: APHA Press; 2019. https://doi.org/10.2105/9780875533049

14. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev*. 1991;43(6):1241-1299. Last accessed April 17, 2022 from https://doi.org/10.2307/1229039

15. Massey DS, Denton NA. *American Apartheid Segregation and the Making of the Underclass*. Cambridge, MA: Harvard University Press; 1998.

16. Zuberi T, Bonilla-Silva E. *White Logic, White Methods: Racism and Methodology*. Lanham, MD: Rowan & Littlefield; 2008.

17. Omi M, Winant H. *Racial Formation in the United States*. 3rd ed. New York: Routledge; 2014. https://doi.org/10.4324/9780203076804

18. Combahee River Collective. A Black Feminist Statement. In: Moraga C, Anzaldúa G, eds. *This Bridge Called My Back: Writings by Radical Women of Color*. Kitchen Table: Women of Color Press; 1986:286.

19. Hill Collins P. *Intersectionality as Critical Social Theory*. Durham, NC: Duke University Press; 2019.

20. Robinson CJ. *Black Marxism : The Making of the Black Radical Tradition*. University of Chapel Hill, NC: North Carolina Press; 2020.

21. COVID-19 Task Force on Racism & Equity. *Statement on Policing and the Pandemic. 2020*. Last accessed May 16, 2022. https://www.racialhealthequity.org/blog/policingandpandemic

22. Jones CP. Action and allegories. In: Ford C, Griffith D, Bruce M, Gilbert K, eds. *Racism: Science and Tools for the Public Health Professional*. Washington, DC: APHA Press; 2019:223-241. https://doi.org/10.2105/9780875533049ch11

23. Jones CP. Toward the science and practice of anti-racism: launching a national campaign against racism. *Ethn Dis*. 2018;28(suppl 1):231-234. https://doi.org/10.18865/ed.28.S1.231 PMID:30116091

24. Ford CL, Airhihenbuwa CO. Commentary: just what is critical race theory and what's

it doing in a progressive field like public health? *Ethn Dis*. 2018;28(suppl 1):223-230. https://doi.org/10.18865/ed.28.S1.223 PMID:30116090

25. Morales Vazquez E, S. Levin J. *The Tyranny of Neoliberalism in the American Academic Profession*. American Association of University Professors [website]. Last accessed May 16, 2022 from https://www.aaup.org/article/tyranny-neoliberalism-american-academic-profession#.YoKcfcPMJhE.

26. Newfield C. *Ivy and Industry: Business and the Making of the American University, 1880-1980*. Durham, NC: Duke University Press; 2003.

27. Ferguson RA. *The Reorder of Things : The University and Its Pedagogies of Minority Difference*. Minneapolis, MN: University of Minnesota Press; 2012. https://doi.org/10.5749/minnesota/9780816672783.001.0001

28. Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. *Soc Sci Med*. 2010;71(8):1390-1398. https://doi.org/10.1016/j.socscimed.2010.07.030 PMID:20822840

29. National Academies of Sciences Engineering and Medicine C on CBS to PHE in the US, ed. *Communities in Action: Pathways to Health Equity*. Washington, DC: National Academies Press; 2017. https://doi.org/10.17226/24624

30. Cacari Stone L, Avila M, Duran B. El Nacimiento del Pueblo Mestizo: critical discourse on historical trauma, community resilience and healing. *Health Educ Behav*. 2021;48(3):265-275. https://doi.org/10.1177/10901981211010099 PMID:34080474

31. Peretz PJ, Islam N, Matiz LA. Community health workers and COVID-19 - addressing social determinants of health in times of crisis and beyond. *N Engl J Med*. 2020;383(19):e108. https://doi.org/10.1056/NEJMp2022641 PMID:32966715

32. Boyce MR, Katz R. Community health workers and pandemic preparedness: current and prospective roles. *Front Public Health*. 2019;7(MAR):62. https://doi.org/10.3389/fpubh.2019.00062 PMID:30972316

33. Pinto RM, Park S. COVID-19 pandemic disrupts HIV continuum of care and prevention: implications for research and practice concerning community-based organizations and frontline providers. *AIDS Behav*. 2020;24(9):2486-2489. https://doi.org/10.1007/s10461-020-02893-3 PMID:32347403

34. Wilson MG, Lavis JN, Guta A. Community-based organizations in the health sector: a scoping review. *Health Res Policy Syst*. 2012;10(1):36. https://doi.org/10.1186/1478-4505-10-36 PMID:23171160

35. Minkler M, Rebanal RD, Pearce R, Acosta M. Growing Equity and Health Equity in Perilous Times: Lessons From Community Organizers. *Health Educ Behav*. 2019;46(1_suppl)(suppl):9S-18S. https://doi.org/10.1177/1090198119852995 PMID:31549555

36. Pastor M, Terriquez V, Lin M. how community organizing promotes health equity, and how health equity affects organizing. *Health Affairs*.2018;37(3):358-363. https://doi.org/10.1377/HLTHAFF.2017.1285

37. Rahman R, Ross A, Pinto R. The critical importance of community health workers as first responders to COVID-19 in USA. *Health Promot Int*. 2021;36(5):1498-1507. https://doi.org/10.1093/heapro/daab008 PMID:33569593

38. Minkler M, Wallerstein N. *Improving Health Through Community. Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, CA: Jossey-Bass; 2002.

39. Del Pino HE, Jones L, Forge N, et al. Integrating community expertise into the academy: south Los AFngeles' community-academic model for partnered research. *Prog Community Health Partnersh*. 2016;10(2):329-338. https://doi.org/10.1353/cpr.2016.0028 PMID:27346780

40. McCall B, Shallcross L, Wilson M, Fuller C, Hayward A. Storytelling as a research tool and intervention around public health perceptions and behaviour: a protocol for a systematic narrative review. *BMJ Open*. 2019;9(12):e030597. https://doi.org/10.1136/bmjopen-2019-030597 PMID:31796479

41. Patel L. *Decolonizing Educational Research: From Ownership to Answerability*. New York: Routledge; 2015. https://doi.org/10.4324/9781315658551

42. Kovach M. *Indigenous Methodologies: Characteristics, Conversations and Contexts*. Toronto, Canada: University of Toronto Press; 2009.

43. Gaudry AJP. Insurgent Research. *Wicazo Sa Rev*. 2011;26(1):113-136. https://doi.org/10.1353/wic.2011.0006

44. Smith LT. *Decolonizing Methodologies: Research and Indigenous Peoples*. 2nd ed. London, UK: Zed Books Ltd; 2012.

45. Lê Espiritu BY, Echeverria A, Jung Y, Man S. *Teaching "Race and Oral History in San Diego" During COVID-19: Rethinking Community, Storytelling, and Labor*. The Abusable Past [website]. September 30, 2020. Last accessed May 16, 2022 from https://www.radicalhistoryreview.org/abusablepast/teaching-race-and-oral-history-in-san-diego-during-covid-19-rethinking-community-storytelling-and-labor/

46. Duran E, Firehammer J. *Story Sciencing and Analyzing the Silent Narrative Between Words: Counseling Research from an Indigenous Perspective*. New York, NY: Springer; 2015:85-97, https://doi.org/10.1007/978-1-4939-1283-4_7

47. Golden SD, McLeroy KR, Green LW, Earp JAL, Lieberman LD. Upending the social ecological model to guide health promotion efforts toward policy and environmental change. *Health Educ Behav*. 2015;42(1)(suppl):8S-14S. https://doi.org/10.1177/1090198115575098 PMID:25829123

48. Krieger N. Theories for social epidemiology in the 21st century: an ecosocial perspective. *Int J Epidemiol*. 2001;30(4):668-677. https://doi.org/10.1093/ije/30.4.668 PMID:11511581

49. Sumbul T, Spellen S, McLemore MR. A transdisciplinary conceptual framework of contextualized resilience for reducing adverse birth outcomes. *Qual Health Res*. 2020;30(1):105-118. https://doi.org/10.1177/1049732319885369

50. Dedoose Version 8.0.35. Published online 2018. https://www.dedoose.com/

51. Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Serv Res*. 2007;42(4):1758-1772. https://doi.org/10.1111/j.1475-6773.2006.00684.x PMID:17286625

52. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101. https://doi.org/10.1191/1478088706qp063oa

53. Bernard HR. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Lanham, MD: Alta Mira Press; 2002.

54. Bryman A. *Social Research Methods*. 3rd ed. Oxford, UK: Oxford University Press; 2008.

55. Elo S, Kääriäinen M, Kanste O, Pölkki T, Utriainen K, Kyngäs H. Qualitative content analysis: a focus on trustworthiness. *Sage Open*. 2014;4(1). https://doi.org/10.1177/2158244014522633

56. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24(2):105-112. https://doi.org/10.1016/j.nedt.2003.10.001 PMID:14769454

57. Perez Huber L. Beautifully powerful: A latcrit reflection on coming to an epistemological consciousness and the power of testimonio. *Am Univ J Gend Soc Policy Law*. 2010;18(3):839-851. Last accessed May 15, 2022 from https://digitalcommons.wcl.american.edu/jgspl/vol18/iss3/22/

58. Bowleg L. "The master's tools will never dismantle the master's house": ten critical lessons for black and other health equity researchers of color. *Health Educ Behav*. 2021;48(3):237-249. https://doi.org/10.1177/10901981211007402 PMID:34080476

59. Tuck E, Yang KW. Decolonization is not a metaphor. *Decolonization*. 2012; 1(1). Last accessed May 15, 2022 from https://jps.library.utoronto.ca/index.php/des/article/view/18630

60. Woodman S. Palantir and Trump's Deporta-

tion Machine. *The Intercept.* March 2, 2017. Last accessed May 16, 2022 from https://theintercept.com/2017/03/02/palantir-provides-the-engine-for-donald-trumps-deportation-machine/

61. Hao K. Amazon is the invisible backbone of ICE's immigration crackdown. *MIT Technology Review*. October 22, 2018. Last accessed May 16, 2022 from https://www.technologyreview.com/2018/10/22/139639/amazon-is-the-invisible-backbone-behind-ices-immigration-crackdown/

62. Dos Santos Marques IC, Theiss LM, Johnson CY, et al. Implementation of virtual focus groups for qualitative data collection in a global pandemic. *Am J Surg.* 2021;221(5):918-922. https://doi.org/10.1016/j.amjsurg.2020.10.009 PMID:33070983

63. Lobe B, Morgan D, Hoffman KA. Qualitative data collection in an era of social distancing. *Int J Qual Methods*. 2020. https://doi.org/10.1177/1609406920937875

64. Reisner SL, Randazzo RK, White Hughto JM, et al. Sensitive health topics with underserved patient populations: methodological considerations for online focus group discussions. *Qual Health Res*. 2018;28(10):1658-1673. https://doi.org/10.1177/1049732317705355 PMID:29298574

65. Essie Justice Group [website]. Black mama's bail outs: The community care blueprint in action. Last accessed May 16, 2022 form https://essiejusticegroup.org/

66. Stop LAPD Spying Coalition [website]. Last accessed May 16, 2022 from https://stoplapd-spying.org/

67. Youth Justice Coalition [website]. Last accessed May 16, 2022 from https://youthjusticela.org/