# COVID-19 Among African Americans: From Preliminary Epidemiological Surveillance Data to Public Health Action

See also Morabia, p. 1111, and the *AJPH* COVID-19 section, pp. 1123–1172.

In April 2020, preliminary and incomplete data released by several states and large cities indicated that African Americans were at increased risk of dying from COVID-19,[1–3] highlighting deep inequalities in socioeconomic resources, health, and access to care. Some, but not all, reports indicated that infection rates were also relatively high among African Americans. In early April, *Mother Jones* began requesting racial and ethnic breakdowns of COVID-19 infections and deaths from health departments in all 50 states and the District of Columbia.[2] Of those, 21 states released no racial or ethnic breakdowns of those infected by mid-April. Twenty-six states did not release breakdowns of fatalities by race. Despite the inadequacy of public health surveillance data, there was reason to be deeply concerned about the disproportionate impact COVID-19 was having on African Americans. The initial reports of pronounced ethnic disparities in COVID-19 mortality rates quickly led to concerted calls from community activists, policymakers, and lawmakers for improved public health surveillance data that provide monitoring of racial disparities in rates of infection, hospitalizations, and deaths.

Epidemiological data indicate that marked racial disparities exist in confirmed COVID-19 cases and deaths, with higher rates among African Americans. Racial disparities are evident in all regions of the country (Table 1).[1–7] Current data are preliminary and limited. Comprehensive surveillance data are urgently needed that include racial/ethnic characteristics and gender, underscoring that some US populations are disproportionately affected by COVID-19. At a later stage, differentials based on zip codes, as was done years ago for HIV in several locations, could further map population disparities in COVID-19 in greater detail.

A number of direct socioeconomic factors likely contribute to disparities in COVID-19 mortality among African Americans, including poverty, lack of health insurance, and decreased access to health care. Other factors, such as historic mistreatment and marginalization that has left many African Americans distrustful of the government and the health care system, may also have played a significant role.[3]

With respect to factors that affect risk of contracting the virus through lack of social distancing, a disproportionally higher percentage of African Americans hold jobs that require them to continually interact with the public in fields such as food services (grocers, fast food workers), the hotel industry, public works, public transportation, and health care. Compared with the general population, African Americans are less able to work from home, which increases their risk of contracting the virus in transit or at work.[1] African Americans are also more likely to live in overcrowded neighborhoods or in multigenerational households.

African Americans are more likely than Whites to have chronic diseases that increase the risk of COVID-19 mortality, including hypertension, obesity, diabetes, asthma, and cardiovascular disease. Structural problems such as nonavailability of nutritious foods ("food deserts"), lack of safe or affordable places to exercise, and substandard housing contribute to the burden of chronic diseases among African Americans.

Initial reports of disparities in COVID-19 mortality rates were from densely populated, historically segregated urban cities in the Northeast and Midwest such as Chicago, Illinois; Detroit, Michigan; and Milwaukee, Wisconsin. In such localities, a disproportionate number of African Americans live in highly segregated neighborhoods and face structural inequalities such as unstable housing, overcrowded public housing, decreased access to health care, and lack of employment opportunities. African Americans are overrepresented in low-wage jobs and often lack benefits such as paid sick leave and health insurance. Other reports of racial disparities in COVID-19 mortality have been from southern regions of the United States, such as New Orleans, Louisiana and parts of Mississippi, North Carolina, South Carolina, and Georgia. A colorblind approach to public health surveillance and response cannot bring about

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TABLE 1—Preliminary Epidemiological Surveillance Data on COVID-19 Cases and Deaths in the United States, April 2020

| Authors | Location | Findings |
|---|---|---|
| Eligon et al.[1] | Chicago, IL | African American residents have made up more than half of coronavirus cases and 72% of deaths, despite being less than one third of the city's population. African Americans residents in Illinois account for less than 15% of the population, but 28% of COVID-19 cases and 43% of deaths. |
| Rios and Rangarajan[2] | Wisconsin | In Wisconsin, nearly twice as many African American residents of Milwaukee County have tested positive for the virus as White residents, and about 80% of patients who have died in the county were African American. African Americans make up just 6% of the state's population but 25% of its COVID-19 cases and 39% of its deaths. |
| Katersky and Torres[4] | New York City | African Americans are twice as likely as Whites to die from COVID-19 and more than twice as likely as Whites to have a nonfatal hospitalization. |
| Rios and Rangarajan[2] | Connecticut | African Americans are overrepresented among those infected with COVID-19 in Connecticut. |
| Perry et al.[5] | Washington, DC | About 46% of the population is African American, but the rate of COVID-19 deaths in the city is 62.5%. |
| Georgia Department of Public Health, 2020 (https://dph.georgia.gov) | Georgia | As of April 23, 2020, the Georgia Department of Health reported that African Americans accounted for 31% of all confirmed COVID-19 cases (6445 of 21 102), and were 52% of all confirmed COVID-19 deaths (442 of 846). |
| Loiaconi[3] | Louisiana | About 70% of people who have died from the virus were African American, but only about one third of the state is African American. |
| Rios and Rangarajan[2] | Mississippi | African Americans make up 38% of the state's population and 66% of COVID-19 fatalities. |
| South Carolina Department of Health and Environmental Control, 2020 (https://bit.ly/2zlySHB) | South Carolina | Data from the South Carolina Department of Health and Environmental Control indicate that African Americans account for 36% of COVID-19 positive cases, and 57% of deaths from COVID-19 in the state. According to the US Census Bureau, 27.1% of the South Carolina population is African American. |
| Poston et al.[6] | Los Angeles County, CA | African Americans represent 17% of COVID-19 deaths, but make up only 9% of the population. Data collected by the California Department of Public Health indicate that African Americans account for 11% of COVID-19 deaths, although they make up only 6% of the state's population. |
| Garg et al.[7] | United States | A report from the Centers for Disease Control and Prevention (CDC) indicated that about 1 in 3 people who became sick enough to require hospitalization from COVID-19 were African American, even though African Americans constitute 13% of the US population. The data analyzed by the CDC were from 14 states. The COVID-19-associated hospitalization rate among nearly 1500 patients identified through COVID-NET for the 4-week period ending March 28, 2020, was 4.6 per 100 000 population. Among patients with race/ethnicity data (n = 580), 261 (45.0%) were non-Hispanic White, 192 (33.1%) were non-Hispanic Black, 47 (8.1%) were Hispanic, 32 were Asian, 2 (0.3%) were American Indian/Alaska Native, and 46 (7.9%) were of other or unknown race. |

equity when both the health care system and the structural conditions that inform it are so unequal.

To mitigate racial disparities in COVID-19 infection and mortality, safer working conditions and living environments are needed that include provisions for personal protective equipment, social distancing, and hand and surface hygiene. Public health professionals can reach out to at-risk neighborhoods and faith-based community leaders to encourage preventive practices.

Culturally appropriate health messaging concerning COVID-19 prevention, identification, and infection is important. In Clark County, Nevada, for example, a new public service announcement is targeting the African American community. In addition, there is an urgent need to ensure that African Americans have access to COVID-19 testing and basic health care resources. African American churches can serve as testing and triage centers, health action zones to bridge government resources with community resources, and platforms to overcome trust issues related to health care. AJPH

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## CONFLICTS OF INTEREST

The authors report no conflicts of interest.

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