Journal of Racial and Ethnic Health Disparities
https://doi.org/10.1007/s40615-020-00756-0

RESEARCH ARTICLE

The COVID-19 Pandemic: a Call to Action to Identify and Address Racial and Ethnic Disparities

Cato T. Laurencin [1,2] · Aneesah McClinton [1]

Received: 2 April 2020 / Revised: 2 April 2020 / Accepted: 3 April 2020

Abstract
The Coronavirus disease 2019 (COVID-19) pandemic has significantly impacted and devastated the world. As the infection spreads, the projected mortality and economic devastation are unprecedented. In particular, racial and ethnic minorities may be at a particular disadvantage as many already assume the status of a marginalized group. Black Americans have a long-standing history of disadvantage and are in a vulnerable position to experience the impact of this crisis and the myth of Black immunity to COVID-19 is detrimental to promoting and maintaining preventative measures. We are the first to present the earliest available data in the peer-reviewed literature on the racial and ethnic distribution of COVID-19-confirmed cases and fatalities in the state of Connecticut. We also seek to explode the myth of Black immunity to the virus. Finally, we call for a National Commission on COVID-19 Racial and Ethnic Health Disparities to further explore and respond to the unique challenges that the crisis presents for Black and Brown communities.

Keywords Coronavirus · COVID-19 · Pandemic · Race · Ethnicity · Disparity

The Black Immunity Myth

Black American history is rooted in racial injustice and there are countless efforts made to counteract a legacy of oppression. Blacks are disproportionately affected by poverty [1], mass incarceration [2], infant mortality [3], limited health care access [4], and health-related conditions including heart disease [5], diabetes [6], stroke [7], kidney disease [8], respiratory illness [9, 10], and human immunodeficiency virus (HIV) [11]. Many are well versed in this marginalized status and possess first-hand accounts of the devastating impact of social injustice that permeates through communities. The continent of Africa has also known the impact of inequity and maintains 25% of global disease burden [12]. Perhaps these unique social conditions led numerous individuals in Black communities in America and the world over to accept the myth of Black immunity to Coronavirus disease 2019 (COVID-19); the potential for immunity against a global crisis presented one less struggle amongst the many formidable challenges.

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus was first identified in late 2019 in Wuhan, China, after health officials identified a perplexing trend of pneumonia of unknown etiology amongst citizens that eventually lead to researchers identifying the new virus. During the outbreak, a young Cameroonian student who resided in China was infected and became the first African to contract the virus. He received treatment for the illness in China, and within a few weeks, he recovered from the condition [13]. Subsequently, various unsubstantiated reports emerged declaring that the genetic constitution of Blacks or even the presence of melanin rendered Blacks immune to the virus. The news spread via social media and in social settings even as prominent Black figures reported that they contracted the virus [14].

The unproven claim is not inconsequential as many may disregard vigilant action to protect against the disease which may result in unpredictable social and health consequences, the most alarming of which is the uncanny similarities to the HIV epidemic in which some Blacks did not consider that they could be affected by a disease that initially emerged amongst gay White men in America. Today, HIV has ravaged Black

✉ Cato T. Laurencin
laurencin@uchc.edu

[1] Connecticut Convergence Institute for Translation in Regenerative Engineering, UConn Health, Farmington, CT 06030, USA

[2] The Africana Studies Institute, University of Connecticut, Storrs, CT 06269, USA

Published online: 18 April 2020

communities by disproportionately affecting Blacks who maintain the highest rates of infection amongst all racial groups [15]. Furthermore, while there are countless reports on the ages of those affected and the greater tendency for men to succumb to the disease, there is an unmistakable lack of reported and accessible data on the racial and ethnic composition of those infected with COVID-19. The scarcity of this information generates a more substantial concern in which insufficiently identifying the affected may ultimately result in historically marginalized groups shouldering the greatest burden of disease and disproportionately bearing the social impact.

An Emerging Trend

Initially, numerous individuals racialized COVID-19, controversially declaring it the "Chinese virus," viewing it as an infectious agent that would only spread in a distant foreign country and could be properly mitigated with travel restrictions. By the end of January 2020, the first US case was reported in Washington state and was identified in a man who had returned from Wuhan; by the end of March, the US became the epicenter of the pandemic accounting for the most reported cases worldwide. While New York harbored the greatest number of cases, concerning trends began to arise just weeks into the enforcement of social distancing guidelines with news reports outlining the rapid spread of the disease in cities that could potentially become the next hot spots including Boston, Chicago, Detroit, New Orleans, and Philadelphia. A larger proportion of Black Americans reside in these cities compared with the overall US population of 13.4%. According to the US Census, Black people consist of 78.6% of the population in Detroit, 59.7% in New Orleans, 47.4% in Philadelphia, 30.1% in Chicago, and 25.3% in Boston. The concern is that Blacks tend to live in close communities and an infectious agent has the ability to spread amongst this group due to proximity. The culmination of Blacks maintaining greater disease burden, higher poverty rates, limited health care access, higher rates of jobs in service industries where they are less able to work from home [16] with a subsequent increased exposure risk, and the unfolding spread of the virus in cities with larger Black populations is a forewarning that if disregarded may constitute imprudent action.

The State of Connecticut Experience

In many ways, Connecticut is a microcosm of America. According to the US Census, the state is comprised of 66.5% White, 12% Black, 4.9% Asian, 0.6% American Indian/Alaska Native, and 16.5% Hispanic/Latinx. A significant proportion of the Black population (at least one-third) resides within only a few cities and towns in Connecticut (a state that has over 150 cities and towns) [17]. The state of Connecticut currently has over 3000 confirmed COVID-19 cases with a total of 96 deaths to date (as of April 1, 2020). The top 3 counties with the most cases include Fairfield, New Haven, and Hartford counties. The racial and ethnic breakdown of those diagnosed with COVID-19 in the state was obtained upon request from the Connecticut State Department of Public Health. As of now, this is the earliest data available (as of April 1, 2020) on the race and ethnicity distribution of COVID-19 diagnosis and death in the state of Connecticut.

The data includes a total of 3141 cases with over 50% of the data missing on race and ethnicity on the COVID-19 laboratory case reports received by the Department. The Department conveyed that there is not a geographic pattern to the missing data and reported that data is missing for approximately more than half of cases in all counties. Missing data on race and ethnicity may be related to the testing site, such as tests obtained in the outpatient setting. Furthermore, data obtained on other reportable diseases follows a similar trend in which there are missing race and ethnicity data on laboratory reports.

The distribution of men and women diagnosed is 1528 (48.9%) men and 1599 (51.1%) women with a total of 14 (0.4%) cases missing gender information. Race and ethnicity information was missing for a total of 55% of the cases. The total confirmed cases are 60.8% White, 17.2% Black, 2.9% Asian, 15.9% Hispanic/Latinx, 0.2% American Indian/Alaska Native, and 2.9% other (Table 1).

As for those who succumbed to the illness, we obtained the following data upon request from the Connecticut Office of the Chief Medical Examiner. There are 96 reported deaths with six cases missing race and ethnicity information. The total deaths are 69 (76.7%) White, 13 (14.4%) Black, 6 (6.7%) Hispanic/Latinx, and 2 (2.2%) Asian (Table 2). The average age of the deceased is 81 years for Whites, 72 years for Blacks, 62 years for Hispanic/Latinx, and 76 years for Asians. As of now, the national data on race and ethnicity is not readily accessible.

Table 1 The total confirmed cases by race and ethnicity

Race	Case (%)	Population in CT (%)
White	60.8	66.5
Black	17.2	12.0
Asian	2.9	4.9
Hispanic/Latinx	15.9	16.5
American Indian/Alaska Native	0.2	0.6
Other	2.9	–

Confirmed COVID-19 cases based on race and ethnicity

Data as of April 1, 2020

Source: Connecticut Public Health Department

Table 2 The total deaths by race and ethnicity

Race	No. of deaths	Deaths (%)	Population in CT (%)
White	69	76.7	66.5
Black	13	14.4	12.0
Asian	2	2.2	4.9
Hispanic/Latinx	6	6.7	16.5
Total	90		

Confirmed COVID-19 death based on race and ethnicity

Data as of April 1, 2020

No American Indian/Alaska Native and other race deaths reported

Source: Connecticut Office of the Chief Medical Examiner

A Request for Data

It is often claimed that the pandemic has exposed the deficiencies of the American health care system, and perhaps this crisis has already begun to reveal an engrained racial bias that may further disempower racial and ethnic minorities including Black, Native American, Hispanic/Latinx, and Asian Americans. At the end of March, news quickly spread that Democrats are requesting data from the federal government that outlines the racial disparities in the country's response to the crisis [18]. They emphasize that the existing and pervasive disparities will likely ensure that a national response will not impact American communities equally. The importance of the racial and ethnic breakdown of those affected cannot be overemphasized and may also impact philanthropic initiatives reaching communities [19]. The concern is that while there is an existing threat of an infectious disease that has the potential to infect and devastate many, the particularly vulnerable will experience a greater proportion of disease burden and social upheaval that includes increased mortality, limited health care access, economic collapse with loss of wages and housing, and an overall lack of resources and equity to sustain in a dynamic crisis.

A Call to Action

When COVID-19 arrived in the US and progressed to infect hundreds of thousands of Americans, it was evident that all institutions and industries were not prepared for the crisis. Although the medical community has experienced surprise and adverse events in the past [20], the unprecedented nature of this crisis is a complete shock to the system. In particular, the health care system quickly realized that the rapid influx of ailing citizens would outpace the available supplies from personal protective equipment to ventilators, and even personnel. The economic collapse is unimaginable and continues to unfold. A great concern is that by not systematically identifying the affected, we may repeat similar acts of unpreparedness when addressing the racial and ethnic disparities of the disease. Therefore, all measures taken must entail concerted and deliberate efforts that incorporate the expertise of leaders in the field to address high-priority issues, and any haphazard attempts will not suffice and may even exacerbate the feeble conditions of the most vulnerable. First and foremost, data and trends on numbers from racial and ethnic groups affected by COVID-19 must be provided by the state and national health departments. Second, we must prospectively understand and respond to the specific challenges taking place with people of color and the SARS-CoV-2 virus. We call for a National Commission on COVID-19 Racial and Ethnic Health Disparities, a dedicated body to envisage essential recourse and mobilize to action the necessary safeguards. Deploying a National Commission exhibits prudent action that protects the many racial and ethnic minorities who at baseline do not have a safety net; they are the unprotected who are branded with an imposed status as the first to endure impact.

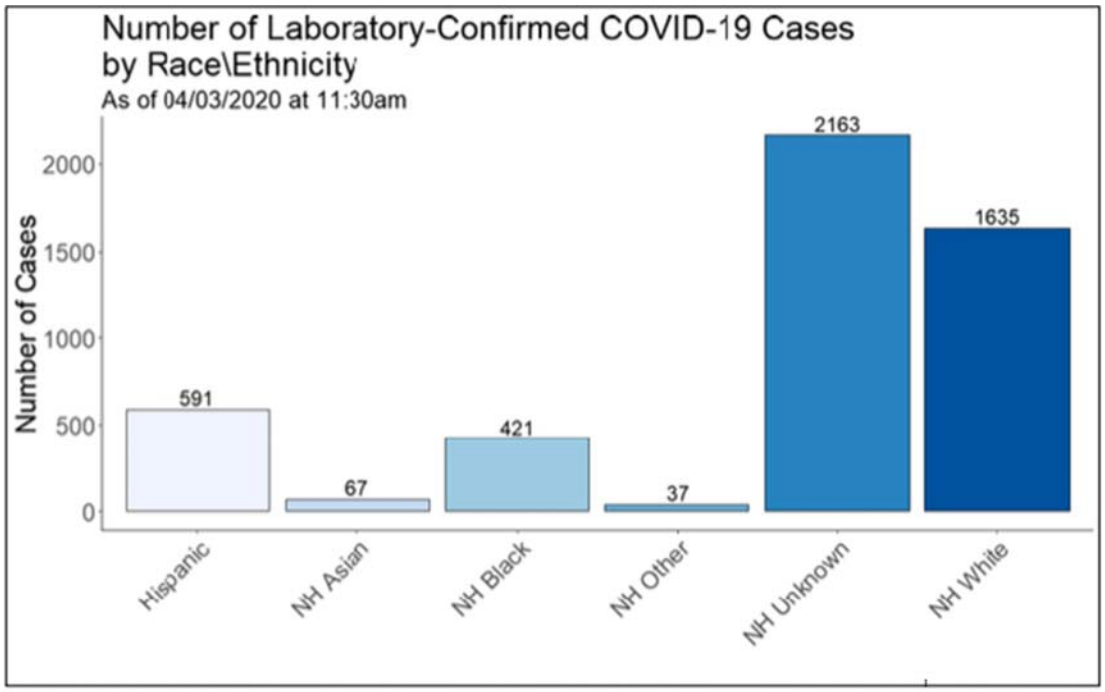
Conclusion

Our review of the preliminary data explodes the myth of Black immunity to COVID-19 and demonstrates that Blacks have a higher rate of infection and death in comparison to their population percentage in the state of Connecticut. To our knowledge, this is the first paper to present data on race and ethnicity in the peer-reviewed literature for those in America affected by COVID-19. Our conclusions are limited by the missing race and ethnicity data and the fact that this is the earliest data available. We recognize that this crisis is ongoing, and we will continue to follow the trend of infections and mortality with the intent to publish a follow-up perspective as the information becomes available.

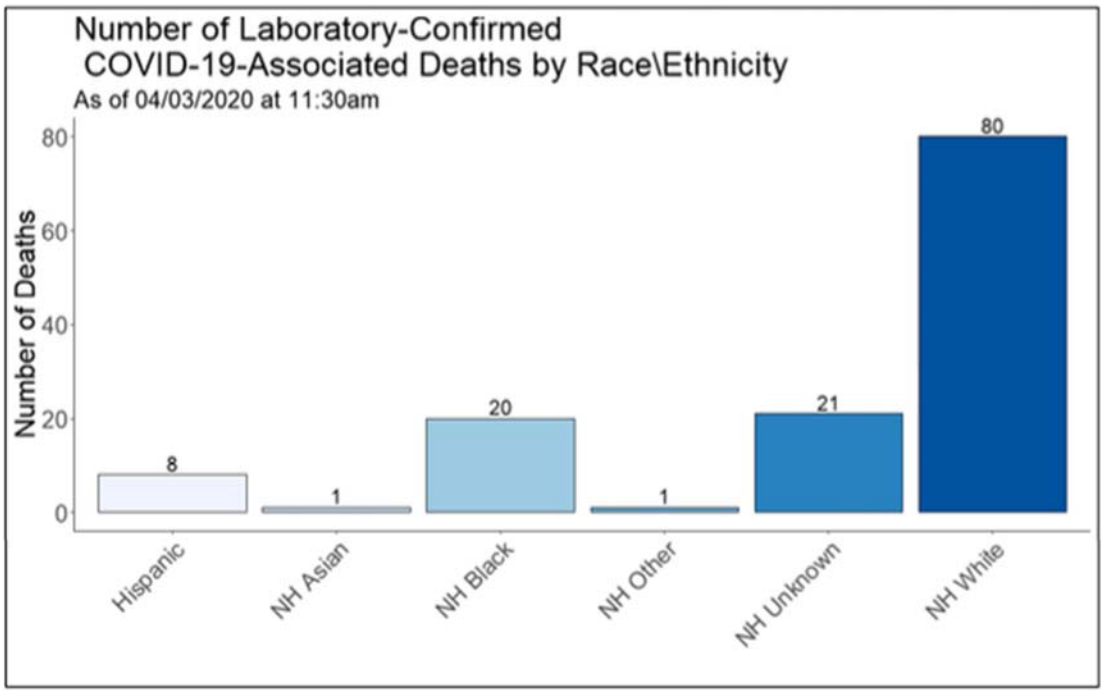
COVID-19 as a disease may potentially have devastating effects on communities of color. While the virus does not discriminate, America's history of discrimination creates potential longer-term scenarios akin to our experience with HIV, influenza, and other infectious diseases in Black and Brown people. We call for action to identify and address racial and ethnic health disparities in the COVID-19 crisis.

Added in Proof

We requested data from the Department of Public Health on March 31, 2020. After frequent inquiries for the race and ethnicity data for the COVID-19 cases and deaths in the state of Connecticut, we are pleased to report that the Department has now tabulated and presented their data on their website as of April 3, 2020, and is presented in Fig. 1 [21].



*NH=Non-Hispanic



*NH=Non-Hispanic

Fig. 1 Connecticut State Department of Public Health first report on COVID-19 cases and deaths based on race and ethnicity as of April 3, 2020

Funding Information Support from the NIH BUILD Award 1U54MD009476 and The Connecticut Legislative Black & Puerto Rican Caucus is gratefully acknowledged.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed Consent Not applicable.

References

1. Firebaugh G, Acciai F. For blacks in America, the gap in neighborhood poverty has declined faster than segregation. Proc Natl Acad Sci U S A. 2016;113(47):13372–7.
2. Western B, Wildeman C. The black family and mass incarceration. Ann Am Acad Pol Soc Sci. 2009;621(1):221–42.
3. Collins JW, David RJ. Racial disparity in low birth weight and infant mortality. Clin Perinatol. 2009;36(1):63–73.
4. Copeland VC. African Americans: disparities in health care access and utilization. Heal Soc Work. 2005;30(3):265–70.
5. Carnethon MR, Pu J, Howard G, Albert MA, Anderson CAM, Bertoni AG, et al. Cardiovascular Health in African Americans: a scientific statement from the American Heart Association. Circulation. 2017;136(21):e393–423.
6. Marshall MC. Diabetes in African Americans. Postgrad Med J. 2005;81(962):734–40.
7. Kissela B, Schneider A, Kleindorfer D, Khoury J, Miller R, Alwell K, et al. Stroke in a biracial population: the excess burden of stroke among blacks. Stroke. 2004;35:426–31.
8. Laster M, Shen JI, Norris KC. Kidney disease among African Americans: a population perspective. Am J Kidney Dis. 2018;72(5):S3–7.
9. Barnes KC, Grant AV, Hansel NN, Gao P, Dunston GM. African Americans with asthma: genetic insights. Proc Am Thorac Soc. 2007;4(1):58–68.
10. Ejike CO, Dransfield MT, Hansel NN, Putcha N, Raju S, Martinez CH, et al. Chronic obstructive pulmonary disease in America's black population. Am J Respir Crit Care Med. 2019;200(4):423–30.
11. Laurencin CT, Christensen DM, Taylor ED. HIV/AIDS and the African-American community: a state of emergency. J Natl Med Assoc. 2008;100(1):35–43.
12. Crisp LN. Global health capacity and workforce development: turning the world upside down. Infect Dis Clin N Am. 2011;25(2):359–67.
13. Vincent D. Coronavirus: a Cameroon student on how he recovered [Internet]. BBC. 2020 [cited 2020 Mar 31]. Available from: https://www.bbc.com/news/world-africa-51502711
14. Glanton D. Column: let's stop the spread — of the myth black people are immune to the coronavirus [Internet]. Chicago Tribune. 2020 [cited 2020 Mar 31]. Available from: https://www.chicagotribune.com/columns/dahleen-glanton/ct-dahleen-glanton-coronavirus-black-immunity-myth-idris-elba-20200319-5auoqjzrmbcsphitbhpocth3qa-story.html
15. Laurencin CT, Murdock CJ, Laurencin L, Christensen DM. HIV/AIDS and the African-American community 2018: a decade call to action. J Racial Ethn Heal Disparities. 2018;5:449–58.
16. Gould E, Shierholz H. Not everybody can work from home: Black and Hispanic workers are much less likely to be able to telework [Internet]. Economic Policy Institute. 2020 [cited 2020 Mar 30]. Available from: https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/
17. Percent African-American or Black population by town [Internet]. The Connecticut General Assembly. 2010 [cited 2020 Apr 1]. Available from: https://www.cga.ct.gov/red2011/documents/popmap/Pop_Percent_AA_2010(2).pdf
18. Silverstein J. Democrats demand data on racial disparities in America's coronavirus response [Internet]. CBS News. 2020 [cited 2020 Mar 31]. Available from: https://www.cbsnews.com/news/democrats-demand-data-on-racial-disparities-in-americas-coronavirus-response/
19. Villarosa L. COVID-19: using a racial justice lens now to transform our future [Internet]. NonProfit Quarterly. 2020 [cited 2020 Mar 30]. Available from: https://nonprofitquarterly.org/covid-19-using-a-racial-justice-lens-now-to-transform-our-future/
20. Laurencin CT, McClinton A. Medical surprise anticipation and recognition capability: a new concept for better health care. J Racial Ethn Heal Disparities. 2019;6:869–73.
21. Coronavirus disease 2019 (COVID-19) [Internet]. Connecticut's Official State Website. [cited 2020 Apr 3]. Available from: https://portal.ct.gov/Coronavirus