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Coronavirus Rates in Alabama Hit Blacks the Hardest — and Experts Are Not Surprised



Source: Upsplash, CDC.

In Alabama, COVID-19 is taking a significantly greater toll on black residents than on whites and the population in general, with a higher rate of disease incidence and a higher rate of fatalities as a result.

And what's happening here reflects what's happening all over the country, as acknowledged by a growing chorus of medical experts who are pointing out that COVID-19 is having a pronounced impact on the black community compared to the population in general.

A few headlines demonstrate the alarm:

- *USA Today*: Black medical leaders: Coronavirus magnifies racial inequities, with deadly consequences
- *The Guardian*: A perfect storm': poverty and race add to Covid-19 toll in US deep south
- *Washington Post*: 4 reasons coronavirus is hitting black communities so hard
- *Statnews.com*: 'We're flying blind': African Americans may be bearing the brunt of Covid-19, but access to data is limited

For many people this revelation comes as a shock. Not so for Dr. Mona Fouad, director of the UAB Minority Health and Health Disparities Research Center, who has developed years of research telling her to expect this pandemic to hit black communities harder.

“Probably you’ve been hearing ... not just here in Alabama but other places in the country, that African Americans are impacted at a higher rate than other groups,” Fouad said. “And a lot of people have been talking about ‘What’s happening?’ And ‘Why is that?’



Dr. Mona Fouad, MD, Professor/Sr. Associate Dean, Preventive Medicine. Source: UAB

“I feel like saying, ‘Aha.’ We should expect that, because we know that with the African American communities there are a lot of challenges that we’ve been talking about for years with our health disparities [efforts] and we’re sure that when a disaster or a crisis comes, these disparities will even become more apparent or more of a crisis. You can see that for many reasons. And every disaster we have has its own reasons for why we have the group that — they have more burden of disease.”

Since 2002, Fouad and her colleagues have been investigating health disparities in Birmingham, Bessemer and more rural areas of the state. They have found that in this state and others in the region, people who are poor and who have less education and a number of other recognizable factors are more prone to have bad health — higher death rates from diabetes, heart disease, obesity and stroke, among other diseases.

Especially given that COVID-19 is deadliest among those with underlying health issues, and given that such diseases and “[social determinants](#)” like [unemployment](#), [unsafe neighborhoods](#), and [lack of affordable transportation](#) — tend to occur in higher rates in the black population, it’s no surprise to Fouad that COVID-19 would have a disproportionate impact on that community of people, she said. The fact is that disastrous situations — whether a pandemic or a natural disaster — usually affect the most vulnerable populations the most.

“When we had Hurricane Katrina, who was the population affected most and left behind? Not the people who have their SUVs and were able to pack and go, but the people that couldn’t get out,” Fouad said. “So it’s similar now.

“The comorbidities really increase the risk of the severity for the person when they develop COVID; and we know that because of the health disparities that we have, we have more African Americans that suffer from hypertension, heart disease and diabetes and obesity. So if we’ve been talking from the beginning that people with underlying disease should be more careful, so that’s the population. But nobody said that, you know?”

Officials not making explicit the likelihood that coronavirus would hit black Americans harder created a missed opportunity, she noted.

“Nobody said, let’s reach out and maybe intervene more aggressively for some of our interventions to make sure that the populations at high risk are really understanding the risk and make sure that they are able to follow these guidelines,” she said.

“Like, when we say social distancing and you have to wash your hands and you have to do this, — how are you going to do this with high density areas like, if people are poor and living in public housing, or live in small apartments with many people in it? How are they going to do that?”

Despite those factors, some have questioned whether infection and death rates are higher among black Americans for COVID-19. What does the research show?



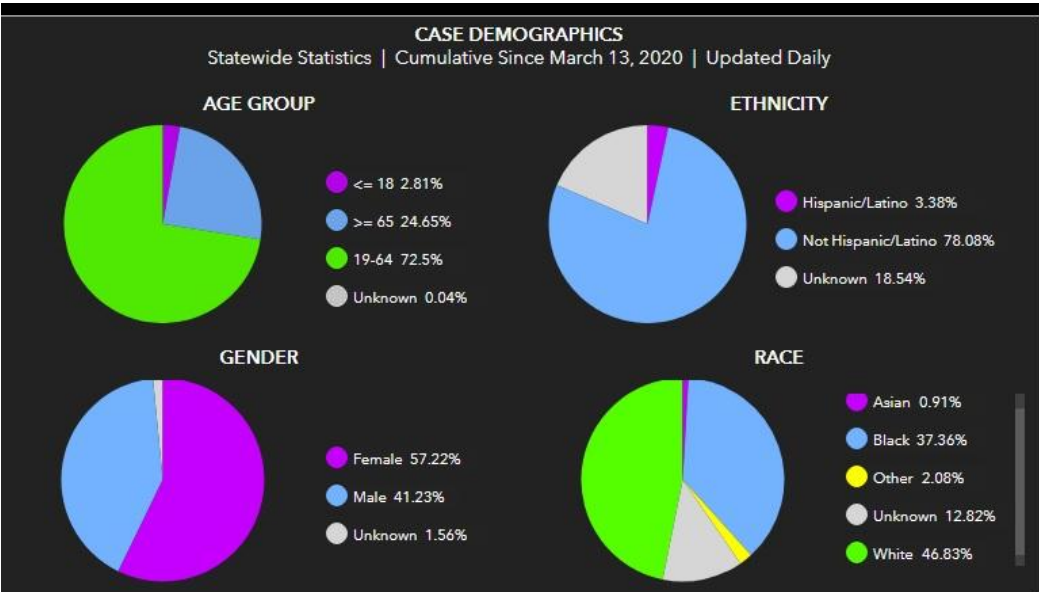
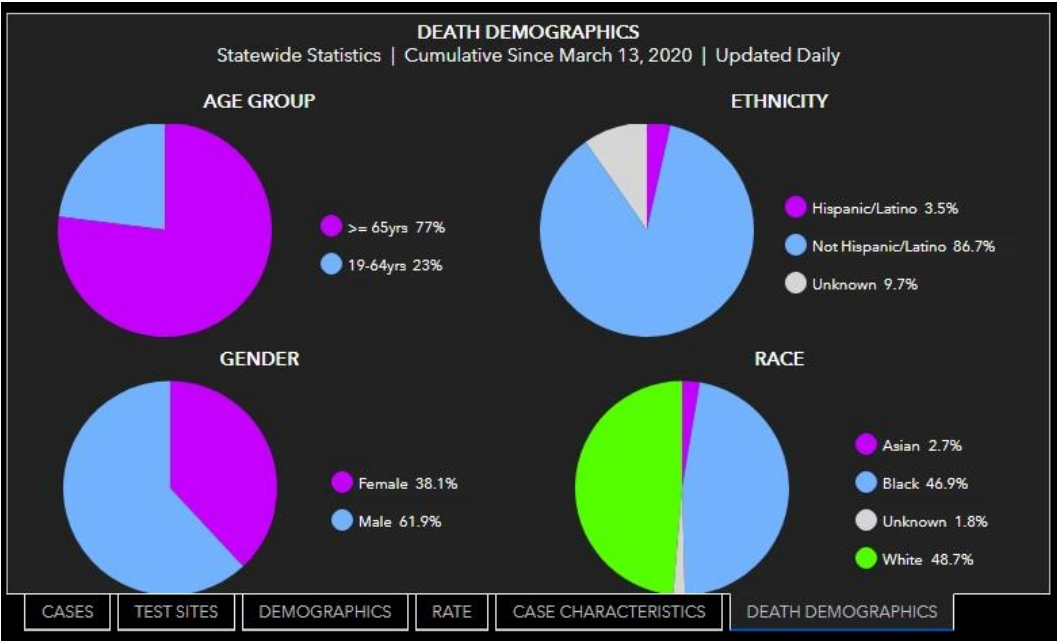
State facts

According to the database provided by the Alabama Department of Public Health Division of Infectious Diseases & Outbreaks, as of April 18, Alabama’s COVID-19 cases can be divided this way: 47.03 percent white, 37.32 percent black, 1 percent Asian, with unknowns at 12.61 percent, and persons who identify as “other” at 2.05 percent.

Among those who have died in Alabama, the database confirms a dramatic, undeniable difference. More than half — 53.9 percent — of those who have died in Alabama were black, 40.8 percent were white, 3.9 percent were Asian, and 1.3 percent were of “unknown” racial classification.

To put that in perspective, Alabama’s estimated population of 4.9 million people is 68.1 percent white, 26.58 percent black, 1.3 percent Asian, fewer than 2 percent classified as other, less than 2 percent classified as “two or more races”, just over half a percent Native American, and .04 percent Native Hawaiian or Pacific Islander.

It does not take major math skills to see that there is an indisputable disparity between Alabama’s black residents — making up 27 percent of the state population but 54 percent of those who have died from COVID-19 — and the state’s white population, which makes up 68 percent of the population, but 41 percent of the deaths.



These graphics were taken today from the Alabama Department of Public Health. The percentage numbers have shifted slightly since the story was written.

Although some states are at present providing only limited demographic data if any — making it difficult to compare one location to another — experts believe that what’s past in dealing with other diseases is prologue for coronavirus.

“My guess is that it will be, percentage-wise, the same as the extent of health disparities already. In other words, a large number of African Americans are overweight, have diabetes, hypertension, and essentially COVID-19 is laying those people low,” said Dr. Frank Franklin of the UAB School of Public Health.



Frank Franklin, Professor emeritus, UAB School of Public Health. Source: UAB

Franklin, who is retired but still works with the university, compared the coronavirus situation to how low-lying areas tend to flood during severe storms, with the people in those areas always affected more than those who live elsewhere. With higher incidences of underlying conditions, as well as negative environmental factors, African Americans are in the flood zone, far more likely to be more heavily impacted by COVID-19, which will affect the larger population — particularly the white population — at lower rates, he said.

Known factors

The federal government and researchers across the country have long been aware of race-related health disparities. The U.S. Health and Human Services Department, for instance, has an Office of Minority Health which acknowledges that disparities exist: “The death rate for African Americans is generally higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide,” according to <https://www.minorityhealth.hhs.gov/omh>.

But why do blacks suffer from the underlying health conditions that make coronavirus more likely to kill at higher rates than the general population? The Robert Wood Johnson Foundation lays much of the blame on poverty, in an extensive report released in 2018:

Poverty has long been recognized as a contributor to death and disease, but several recent trends have generated an increased focus on the link between [income and health](#). First, income inequality in the

United States has increased dramatically in recent decades, while health indicators have plateaued, and life expectancy differences by income have grown. Second, there is growing scholarly and public recognition that many nonclinical factors—education, employment, race, ethnicity, and geography— influence health outcomes. ...

*Compared to higher-income Americans, low-income people face greater barriers to accessing medical care. They are **less likely** to have health insurance, receive new drugs and technologies, and have ready access to primary and specialty care. Low-income workers are more likely to be employed by organizations that do not offer health benefits...*

*Low-income Americans also have higher rates of behavioral risk factors — smoking, obesity, substance use, and low levels of physical activity — which are powerfully influenced by the more challenging home and community environments in which they live. ... Low-income communities also contend with other structural challenges that contribute to higher rates of obesity and chronic disease, including **less access** to fresh foods; a **higher density** of fast-food restaurants; and a built environment that is **not conducive to physical activity**, with less open space and fewer parks and sidewalks...*

*More broadly, low-income Americans encounter numerous daily environmental exposures that create greater allostatic load — the wear and tear on the body that accumulates with **repeated or chronic stressors**. The communities in which low-income people live have higher levels of violence, discrimination, and material deprivation—including the lack of housing, heat, water, and electricity. These communities have more environmental pollutants, under resourced schools, and higher rates of unemployment and incarceration. For residents with a home, the threat of eviction is commonplace, as more than one in five renting families in the United States **spends half of its income on housing**....The negative cardiometabolic effects of poverty seem to **start early** and continue throughout the life course. Race strongly influences other socioeconomic factors, including income: Black Americans continue to have both lower incomes and shorter life expectancies than white Americans do. There are many reasons for racial health disparities, but the **literature** suggests that a central role is played by chronic financial hardship caused by centuries of exploitation and segregation, as well as the direct toxic effects of discrimination on mental and physical health. Even today, access to education, credit, economic opportunity, and healthy environments varies across races. The relationship between race, income, and health persists both within and across races. Low-income black Americans live shorter lives than high-income black Americans, and affluent blacks die earlier than affluent whites.*

Alabama Possible, an organization fighting poverty in the state, pointed out in its 2019 Poverty Data Sheet, that African American households in the state are considerably poorer than their white counterparts.



Kristina Scott, executive director of Alabama Possible. Source: Alabama Possible.

“In Alabama, only 13 percent of white families live in poverty, but 29 percent of African Americans do,” Alabama Possible Executive Director Kristina Scott wrote in an email response to BirminghamWatch. “White families’ median household income is \$53,012, while African Americans’ median household income is \$31,183....

“As a result, African American households are more likely to be working in ‘essential’ jobs that put them in touch with the public – grocery workers, delivery personnel, maintenance workers. That puts them at a higher risk of contracting the virus,” Scott said. “In addition, Alabama has not expanded Medicaid, and for workers – predominately workers in the service industry – who have lost their health care and/or the ability to pay for health insurance – going to the doctor may not seem financially feasible.”

And therein lies a significant problem in testing for the coronavirus. Fouad said it is likely that we still don’t know the real number and spread of COVID-19 cases in Alabama because access to testing is limited for the population most likely to be exposed to the virus.

“Testing now is a drive-through testing,” Fouad said. “You have to have a car. You have to have a cell phone. You have to have a doctor. And you have to be able to communicate your symptoms to a phone line to make an appointment. You tell me — what else could you do to be really putting a challenge here? And you have to drive your own car. Who’s going to drive someone with symptoms to take them?”

Fouad said testing limits could mean that sick people are coming to the hospital later than they should, perhaps in later stages of the disease after their symptoms have escalated. And those with underlying health conditions, therefore, have a greater risk of dying.

“Discovering the COVID late with symptoms may also impact the outcome,” she said. “So for sure, if we can detect early, and also if you have access to testing and you know that people are positive, this would also help so that you don’t spread the disease. So testing is very important.”

It’s important that high-risk groups get access to testing, and also that they know their test results quickly enough to limit the spread of the disease, she said.

Considering the risk factors, Fouad said, officials should have expected the pandemic to hit harder in the black community. “Think about all these risks, and put them together,” she said. “If you think about the comorbidity, the social determinants, the lack of access, the lack of information, the challenges of access to testing — all the barriers they have to work through – put all together and that group will be at higher risk.”

Fouad said that to truly address health disparities, even after the coronavirus pandemic, particular focus has to be trained on fighting disease outbreaks where they have the most impact.

“We don’t know the impact of COVID on long-term health outcomes. So we really need to make sure that African Americans are included in that [research] and that we are addressing this,” she said. “Because we already have health disparities, and we don’t want it to even increase that gap by not giving special attention. ... This may exacerbate the health disparities if we really are not intentionally reaching out to the African American communities and making sure that we control the infection there.”

Franklin believes that erasing the health disparities requires providing health insurance and healthcare access to everyone. Then, policymakers have to look “upstream” as he put it, to provide better neighborhoods, education and employment that provides an equitable standard of living for everyone regardless of race or background.

But solving the problem of health inequities has not been easy.

“We haven’t addressed it as a state or community... or society, and maybe this will be a bit of a wake-up call. But I’m just not hopeful that it is,” he said. “Because the general public health rule is *panic-neglect-panic*. And we seem to do that cycle. People knew this pandemic was coming... they just didn’t know when. And yet, we were ill-prepared. Very ill-prepared.”

[The Rumor: Black Americans Are Not Affected as Much by the Coronavirus Pandemic](https://birminghamwatch.org/?url=https%3A%2F%2Fbirminghamwatch.org%2Fcoronavirus-rates-alabama-hit-blacks-hardest-experts-not-surpris...)