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RESEARCH ARTICLE

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Health disparities, race, and the global pandemic of COVID-19: The demise of Black Americans

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Abstract
This article examines the chronic health conditions of African Americans who experience disparities because of poverty, low literacy, and cultural practices that affect decisions about food, nutrition, and health care. It will examine governmental policies, for example, the Affordable Care Act (ACA) (Artiga et al., 2020), and how these policies contribute to health and wellbeing of people from low-income communities. Furthermore, it explores the overrepresented deaths among African Americans and other communities of color resulting from the pandemic—deaths that result from co-existing health conditions and the inability to afford immediate care.

"There is no such thing as a single-issue struggle, because we do not live single-issue lives."

Audre Lorde (2012)

ADVENT OF COVID-19

The advent of COVID-19 has changed life as we know it. Daily news reports cite the numbers of new COVID-19 infections, deaths, and vaccine rates; however, this information obscures the lived experiences of individuals, family members, friends, neighbors, community members, or colleagues. When we delve into personal stories, we learn about the gaping holes left in lives of survivors, families, and communities caused by COVID-19 deaths and those people left with lingering disabilities. We are all connected and the loss of one person can upend the lives of many others. The infectiousness of this disease has altered our social behaviors and curtailed even the rituals of death.

Reporting overall numbers also conceals ways the disease disproportionately affects African Americans.

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> African Americans, who represent about 13.4% of the US population, comprise 18.2% of COVID cases and 20.9% of deaths… . African Americans become more seriously ill and are more likely to die from COVID-19 because African Americans suffer more from underlying illnesses and adverse health conditions. (Snowden & Graaf, 2021, p. 13)

The Center for Disease Control and Prevention (CDC) (2020) indicated that African Americans are 1.4 times more likely to contract COVID-19, 3.7 times more likely to be hospitalized, and 2.8 times more likely to die than are Whites. COVID-19 has exacerbated structural inequalities related to poverty, inadequate housing, poor education, isolation, food insecurity, unemployment or front-line jobs, and inability to work from home. Lack of access to healthcare and frequent exposure means that many people are at high risk of contracting and dying from the disease. Approximately 75% of Black Americans say they are worried they or a family member will contract COVID-19 compared to 64% of White adults (CDC, 2020).

Much of the literature inaccurately refers to African Americans as an undifferentiated group (Amuta-Jimenez et al., 2020). People referred to as Black/African American differ from each other in education, occupation, income, skin color, immigration status, and health status. A recent immigrant from African countries or the Caribbean has a different experience than people whose ancestors were once enslaved in the US African Americans who are lighter skinned may have a different experience than those of darker complexion, although skin color's relationship to health is unclear (Uzogara, 2019). Nevertheless, because much of the literature refers to African Americans, that terminology is used in this article.

Black Lives Matter has evolved since its inception to become a movement that addresses multiple aspects of oppression, social injustice, and human rights violations against Black people (Hillstrom, 2018). Persistent racism and lack of access to equitable healthcare evidence consistent social injustices that have a detrimental on the wellbeing of African Americans. Therefore, in this article we discuss common health conditions, social factors influencing health of African Americans, health policies, social determinants, and racism and its relationship to health outcomes. Finally, we provide solutions to address the aforementioned issues.

COMMON HEALTH CONDITIONS AND PREVALENCE AMONG AFRICAN AMERICANS

African Americans are living longer; the death rate for African Americans decreased 25% from 1999 to 2015 (CDC, 2020). However, the bad news is that African Americans are more likely to die at early ages from all causes, as young African Americans are contracting diseases that are more commonly found at older ages for other races (Cunningham et al., 2017). Compared to their White counterparts, African Americans are generally at higher risk and have higher rates of heart disease, stroke, cancer, asthma, influenza, pneumonia, diabetes, and HIV/AIDS (Carratala & Maxwell, 2020). African Americans tend to be diagnosed with cancer at later stages than their White counterparts, leading to adverse outcomes. DeSantis et al. (2019) indicated that "African Americans bear a disproportionate share of the cancer burden, having the highest death rate and the lowest survival rate of any racial or ethnic group for most cancers" (p. 211). African American women are more likely to experience poor maternal health and Black women's infant deaths occur at almost twice the rate of children of White mothers.

SOCIAL DETERMINANTS OF HEALTH

Fewer African Americans are accessing testing and vaccines for COVID-19 than Whites (Recht & Weber, 2021). According to Nydegger and Hill (2020), "the unprecedented COVID-19 pandemic has exacerbated the marginalization, stigma, health disparities, and structural racism that was already crippling African American communities" (p. 655). Likewise, "a growing body of scientific literature suggests that racism is a fundamental cause of premature morbidity and mortality among racial and ethnic minority populations" (Butler et al., 2018, p. 279). Persistent racial disparities in health status are linked with economic and social conditions, individual health behaviors, and systematic inequality in access to adequate health insurance.

Social determinants of health (SDOH) is a term used to recognize multiple complex and interrelated factors that influence health, including reduced access to adequate employment and housing; public transportation; education; and grocery stores selling healthy foods. African Americans may suffer increased exposure to environmental problems; targeted marketing of unhealthy substances and foods; impaired access to health care services; physical injury or psychological trauma, and chronic exposure to discrimination (Hill, 2016).

Contributors to poor health include education level and health literacy (HL). People with low literacy are less able to benefit from health education, less willing to engage in disease prevention, and may not manage chronic disease as well as literate adults (Lopes & McKay, 2020). HL is commonly defined as the ability to read, understand, and act appropriately on health communications. "Mastering health literacy tasks requires [individuals] to often make simultaneous use of more than one literacy skill—document retrieval, decoding prose, and numeracy" (Schecter & Lynch, 2011, p. 212). However, this conception of HL is limited in that it focuses on "reading comprehension, holds individuals responsible for health outcomes, ignores societal conditions that limit access to healthcare, defines HL as a risk instead of an asset, and aims to create compliant patients" (Prins & Mooney, 2014, p. 26). Common understandings of HL are being replaced with a view that emphasizes health communications as mutual responsibility in which health providers are expected to communicate in clear terms and verify patient understanding (Hill & Ziegahn, 2010).

Mistrust of the healthcare system may also contribute to lack of patient adherence with health recommendations. Based in current and historical experiences, some African Americans are predisposed to mistrust health messages and they may avoid interacting with the healthcare system altogether (Bogart et al., 2021; Wells & Gowda, 2020). African Americans consistently report being the recipient of discrimination within the healthcare system. Healthcare practitioners have implicit biases that result in under- and mis-diagnosis, undermedicated pain, and stereotypes that interfere with care of African Americans (Rowland & Isaac-Savage, 2014). This coupled with the history of the Syphilis study in Tuskegee, Alabama, the HIV/AIDS crisis, and the history of slavery has resulted in mistrust of physicians and the entire medical system (Snowden & Graaf, 2021). African Americans often prefer doctors with similar racial and cultural backgrounds (Street et al., 2008), but there are not enough to meet the need. Additionally, few physicians are attuned to the influence of low literacy, poverty, and differing health beliefs and cultural practices on their patients' health and are unaware that some individuals experiencing poverty, unemployment, poor housing, violence, and lack of transportation have little free choice about health behaviors (Hill, 2011). Due to the mistrust of health care institutions in the African American community, these institutions must train trusted medical personnel of color (Nydegger & Hill, 2020).

Structural racism is directly related to social determinants of health (Egede & Walker, 2021). Systemic racism can be defined as "exploitative and discriminatory practices, unjustly gained resources and power, and maintenance of major resource inequalities by ideological and institutional mechanisms that are controlled by White people" (Maness et al., 2021, p. 19). Structural racism exposes the methods societies use to sustain discriminatory practices. Due to mutually reinforcing inequitable systems, it has received insufficient attention as a determinant of population health. Discriminatory practices in one sector of society act to reinforce parallel practices in other sectors, and vice versa, and these become encoded in law, policies, and regulations.

> As a structured system, racism interacts with other social institutions, such as the political, legal, and economic institutions, shaping the values, policies and practices within these institutions and being re-shaped by them. By creating unequal access to resources and opportunity, racism is a fundamental cause of racial inequities in health. (Williams & Cooper, 2019, para. 4)

Mutually reinforced discriminatory practices based in false beliefs and stereotypes can be observed in education, health care, employment, credit markets, and the justice systems (Egede & Walker, 2021).

Unfortunately in February 2021, the *Journal of the American Medical Association* (JAMA), used by many physicians for continuing medical education, released a podcast in February 2021 questioning the veracity of structural racism in medicine, prompting a backlash and boycott (McFarling, 2021). Researchers who submitted manuscripts addressing racism in medicine to JAMA reported being asked to replace discussion of racism with "bias" or "social factors" instead or they were directed to submit the manuscript as a commentary or editorial instead of a peer review article. While a plethora of recent medical articles were available to inform the writing of this article, many of them were indeed editorials and commentaries. This ill-informed and outrageous controversy demonstrates the persistence of structural racism from medicine.

SOCIAL FACTORS INFLUENCING HEALTH OF AFRICAN AMERICANS

The current pandemic has led to high rates of job loss, high rates of exposure to COVID-19 in low-wage workers (Handwerker et al., 2020), and fear of screening because testing positive could disrupt employment. People working in public service occupations are paid low wages, have close contact with others, and often continue working when ill. "The greater impact of COVID-19 on African Americans demonstrates the consequences of pervasive social and economic inequality and marks this as a critical juncture" to address health disparities based in race, class, and gender (Snowden & Graaf, 2021, p. 12).

Limited data exist about African Americans' understanding of and compliance with public health recommendations pertaining to COVID-19. A recent survey (Block et al., 2020) indicated that in a nationally representative sample restricted to African Americans, participants revealed low adherence to recommendations to wash hands frequently, maintain social distancing, and wear masks in public. A lack of knowledge or mistrust of information sources that African Americans do not perceive as credible may result in higher susceptibility to COVID-19. Therefore, culturally appropriate public health communications are imperative (Block et al., 2020).

Social factors affect African Americans at younger ages than their White counterparts: unemployment, living in poverty, inability to see a health provider, smoking, inactive lifestyle, or obesity (Cunningham et al., 2017).

> Blacks have significantly lower educational attainment and home ownership and almost twice the proportion of households below the poverty level compared with whites across the life span. This might help explain disparities in mortality via chronic disease related-behaviors, health-related quality of life, and health care utilization. (Cunningham et al., 2017, p. 445)

Race is associated with both chronic health conditions and body mass index (BMI) (Davis et al., 2013). Eighty percent of African American women and 70% of African American men are considered overweight or obese (Carratala & Maxwell, 2020). Excess body weight contributes to arthritis, diabetes, gout, hypertension, gallbladder disease, and some cancers. Obesity can alter cardiac, pulmonary, and endocrine functions. Obesity is strongly linked with metabolic syndrome, a condition occurring when an individual has two or more of the following: increased blood pressure, high blood sugar, excess body fat around the waist, abnormal cholesterol or triglyceride levels, and insulin resistance. Metabolic syndrome is a precursor for Type 2 diabetes and heart disease (Okosun et al., 2013).

Recommendations for treatment of metabolic syndrome include 30 minutes of daily physical activity, a diet composed of fresh vegetables and fruits, lean protein, and whole grains, limited saturated fat and salt, maintaining a healthy weight, and avoiding smoking. Adhering to such recommendations is difficult for those living in poverty or in isolated communities. African Americans often experience increased poverty and food insecurity. They may reside in food desserts, meaning areas where access to grocery stores selling affordable healthy food is limited. When convenience stores are the only accessible option, healthy food including fruits and vegetables, is difficult to obtain. The USDA defines low food security, formerly known as food insecurity without hunger, as “reduced quality, variety, or desirability of diet” without reduced food intake. Very low food security, previously known as food insecurity with hunger, relates to “disrupted eating patterns and reduced food intake” (USDA Economic Research Service, 2020, para. 1). Indications of food insecurity include worrying that food will run out, skipping meals, eating smaller food portions than optimal, inability to afford a balanced meal, and losing weight. Low and very low food insecurity contribute to poor nutritional status and adverse health outcomes.

Another complication is cultural food preferences. Lucan et al. (2010) found that for African Americans, taste and familiarity were important considerations when selecting and preparing food. Cost, convenience of preparation, accessibility, cultural preferences, and lack of nutritional knowledge served as barriers to healthy eating (Winham et al., 2020). For many African Americans, food preferences, intake, and preparation are rooted in culture and traditions that involved consumption of high fat foods. Further, Capodilupo (2015) found that rather than striving for a thin ideal, skin tone/color, hair length and texture, and facial features may be more salient to positive body image for some African Americans.

HEALTH POLICY AFFECTING ACCESS TO HEALTHCARE

The Patient Protection and Affordable Care Act of 2010 (ACA) created healthcare coverage choices for low- and moderate-income individuals, and promoted employer-based health coverage, extended coverage for dependents, and eliminated higher premiums or denial of coverage for preexisting conditions. It also required all people to have health insurance coverage or be subject to a tax penalty. Many people who did not purchase insurance did so because of concerns they would not be able to afford essentials, such as food,

clothing, and shelter for their families. Expansion of the ACA occurred in 2014 for adults with incomes at or below 138% of poverty in states that adopted Medicaid expansion and made tax credits available for people with incomes up to 400% of poverty who purchase coverage through a health insurance marketplace. For example, the federal poverty income threshold was $25,465 for a family of four with two children, and $17,308 for a single parent of one child. If a family's total income is less than the corresponding threshold, then that family is considered in poverty (Garfield et al., 2021). The ACA of 2014 increased access to healthcare for many Americans and narrowed longstanding racial and ethnic disparities in health coverage (Artiga et al., 2020).

Coverage rates increased for all racial/ethnic groups between 2010 and 2016, with the largest increases occurring after implementation of the ACA Medicaid and marketplace coverage expansions in 2014 (Garfield et al., 2021). African Americans had larger percentage point decreases in their uninsured rates compared to Whites over that period. Unfortunately, the ACA Marketplace coverage was difficult to understand for users and initially, the poorly designed computer platform crashed, causing frustration among those attempting to enroll. The 2016–2020 US government administration revised policies that affected the availability and affordability of healthcare coverage and prescription medications. This included allotting decreased funds for outreach and enrollment assistance, elimination of the tax penalty for not having healthcare coverage, and lowering the cost of prescription medications, including insulin. In 2017–2018, healthcare coverage gains stalled and began reversing for some groups (Lopes et al., 2020).

RACISM AND ITS RELATIONSHIP TO HEALTH OUTCOMES

African Americans are subject to historical trauma resulting in psychological wounding that manifests in surviving generations as psychological wounds that undermine physical, emotional, and social wellbeing (Chioneso et al., 2020). Medical research has revealed that the accumulation of chronic, everyday negative experiences challenges the human body's ability to resist disease. The concept of *allostatic load* reflects evidence that chronic hypervigilance places high demands on the body's ability to cope with challenges. In the lives of African Americans, allostatic load comes in the form of microagressions, discrimination, segregation, violent neighborhoods, and bereavement triggering a cluster of biological events that results in dysregulation of interrelated physiological systems, including the sympathetic nervous system, immune system, and cardiovascular and metabolic systems (Massey, 2017). Such dysregulation is linked with cardiovascular disease, declines in cognitive and physical functioning, and all-cause mortality (Massey, 2017; Ong et al., 2017). This is compounded with the experience of watching others die in your community, including close family members. Consistent exposure to racism contributes to poor mental health as does "stigma, prejudice, restricted income, the built environment, and food insecurity" (Allen et al., 2018, p. 512).

The intersectionality framework considers multiple, compounding social, economic, political, and structural factors that further affect already marginalized groups rather than focusing on single, social identities (Elnaiem, 2021). Intersectional stigma explains co-occurring, mutually enhancing social identities and related inequities from multiple influences and sources. Stigma and existing power structures enhance structural racism and discrimination. Racializing a disease by attributing it to specific cultures or racial/ethnic minority populations as with COVID-19 and other diseases/infections has occurred throughout history (Bailey et al., 2020).

SOLUTIONS

Healthy People, 2020 identified educational and community-based programs as a method to prevent disease and injury, improve health, and enhancing quality of life. Community settings, worksites, and schools are considered suitable sites for that education. In pandemic conditions, "education and specifically health literacy are necessary to enable citizens to use knowledge to act appropriately and in a way that is necessary for one's personal defense and the defense of those for whom one is responsible" (Lopes & McKay, 2020, p. 575). "A person's health literacy may fluctuate depending on the complexity of medical conditions and the relationships between patients, healthcare providers and healthcare systems" (Hill, 2011, p. 69).

Williams and Cooper (2019) recommend three strategies to overcome health inequities and reduce racial inequities among racial minorities, with the goal of ultimately eliminating them; (a) dismantling the social and health structures that support systemic racism, (b) emphasizing prevention of health conditions by addressing social risk factors to ensure high quality care for all, and (c) raising awareness of inequities, build political support, and increase empathy for addressing social inequities in health. The latter strategy requires investment in convincing the public and especially policymakers that change is needed to address widespread racial inequities in health and to build political will to effectively address them. Space constraints prevent discussion of public health efforts to address health care disparities.

Solutions originating from adult education

A "key determinant of health within the SDOH [social determinants of health] framework is education" (English, 2012, p. 15). Adult health learning can take place in multiple ways including individual learning, learning from health professionals and systems, or in community settings (Hill & Ziegahn, 2010). Adults seek opportunities to learn about living a healthier lifestyle, especially when experiencing a health scare or receiving an unfortunate diagnosis (Hill, 2011; Mancuso, 2008) and they may use informal, nonformal, and self-directed learning strategies (Baumgartner, 2014). However, much remains to be learned about how to support learning that allows people to act in ways that promote health (Coady, 2013) especially in regards to relatively unexplored, diverse, and complex health issues in racial, ethnic, and sexual minority communities (Collins & Rocco, 2014).

Incorporating health topics in adult basic education classes has potential to build health literacy skills, eliminate health disparities, and improve health outcomes (Diehl, 2011). Using health information as a topic for learning can improve literacy and health knowledge. Specific literacy competencies can be supported in the adult literacy classroom, for example, selecting healthy food based on nutrition labels or completing medical forms. Adult literacy instructors tend to build a trusting relationship with learners so approaching education about health issues is facilitated.

Much adult health learning takes place in Black churches. In addition to providing spiritual guidance and direction, the African American church works to provide their members with culturally relevant health education that meets social and community needs (Gaillard, 2007). Rowland and Isaac-Savage (2014) noted that the Black church has engaged in healthcare and health promotion activities that address the health needs of their parishioners. Adult educators can partner with churches to support the African American community by lending their expertise in program design and implementation that address disease prevention and healthy lifestyles. They can assist patients to connect with the healthcare system and address health literacy. Rowland and Chappel-Aiken

(2012) commented that "from the needs assessment phase to program implementation and evaluation, adult educators can ensure that programs are firmly rooted in adult learning principles and strategies that promote lifelong learning and healthy lifestyles of congregations and the surrounding community" (p. 23).

Low participation of African Americans in traditional health promotion activities offered in health centers and schools serve to perpetuate health disparities (Linnan & Ferguson, 2007) so unconventional settings must be considered, for example, Black barbershops and hair salons. They are accessible in all communities; play an important role in the community; people visit on a regular basis; and nutrition, physical activity, and health concerns are frequent topics of conversation (Linnan et al., 2014). Due to the intimacy and trust within the relationship, barbers and hair stylists can be trained as peer educators and provide educational service to their clients. They can

> provide accurate health information in a format suited to the social, cultural, ethnic, communication values, norms, and beliefs of the Black community … [they] may function as peer helpers who share related experiences, values, and lifestyles and serve as role models and sources of credible information. (Hill et al., 2016, p. 3)

Community health workers are community members trained to be of help to others, provide relevant health education, and serve as trusted intermediaries with the healthcare system. They may be paid or volunteers working in association with the local health care system. Because community health workers are most often of the same race, ethnicity, socioeconomic status, and life experiences as the community members they serve, they are able to facilitate access to health care services, increase use of health screenings, and improve communication with health providers. Mayfield-Johnson (2011) comments that "community education is a type of learning rooted in the processes of empowerment, social justice, and collective consciousness" (p. 65).

CONCLUSION

Adult educators are present in many settings including education, community, and health care institutions. According to English (2012), "adult education has a long history of negotiating positionality and using it to understand systems and relationships, and to facilitate dialogue on these issues" (p. 19). SDOH theories stress the multiple, interactive factors that influence health; however, they lack emphasis on adult learning or ways that changes could be accomplished. Critical Adult Health Learning includes a role for adult educators to enact change by engaging citizens and health professionals in thinking differently about health and its antecedents (English, 2012).

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