

# COVID-19 & AFRICA WEBINAR SERIES:

## SHARED EXPERIENCES WITH COVID-19 IN AFRICAN AND AFRICAN AMERICAN COMMUNITIES

May 18, 2020, by Emmanuel Akyeampong & Alex Taylor, Harvard Center for African Studies

This document summarizes the conversations from the May 13, 2020, webinar on Shared Experiences with COVID-19 in African and African American Communities.

The full recording for this webinar is available here: <https://vimeo.com/418187232>

### SPEAKERS



Emmanuel Akyeampong  
Harvard University



John Nkengasong  
Africa CDC



Evelynn Hammonds  
Harvard University



David Williams  
Harvard University

COVID-19, detected in Wuhan, China in late 2019, has become a global pandemic. After ravaging Italy, Spain, and Iran in early 2020, the eye of the storm has moved to the U.S. and Africa. As of May 8, 1.38 million confirmed cases were reported in the U.S. with 220,000 recovered and 81,799 deaths, the highest number of cases worldwide. As of May 11, Africa has reported a total of 67,957 confirmed cases with 23,184 recoveries and 2,340 deaths. Clearly, the level of testing in Africa does not match that in the U.S., so the scale of infection in Africa is yet to be ascertained.

#### **COVID-19 and Disparities in African and African American communities**

COVID-19 has revealed deep disparities in African and African American communities socially, economically, and in terms of health outcomes. These disparities have a long history, made visible during this pandemic, that intersect with long-held perceptions about African bodies, which over time have been seen as either immune to or particularly susceptible to disease. In the U.S., African Americans, Hispanic, Latino, and Native American communities have been disproportionately affected.

---

African Americans represent one-third of U.S. deaths from COVID-19 and 30% of COVID cases despite constituting only 13% of the population. Genetics do not make blacks more susceptible. In the U.S., medical and public health experts speak of "biological weathering," where the body ages prematurely as a result of the cumulative toll of poor jobs, poor housing, inadequate diet, lack of health insurance or underinsurance, and racial stress, resulting in early death.

Professor Evelyn Hammonds noted that "The obsession with the black body is deeply cemented in medical theory and practice. As early as the eighteenth century, if whites observed that they seemed to be dying more or less of a particular disease, a comparison was always made of white, black, and brown bodies, always with a focus on difference." Further reflecting on the dangers of this default position, she stated "It limits action towards prevention, care, and treatment. It often meant white elites in medicine or politics took the position, 'we don't need to direct resources towards black people because they are going to die from this anyway, because their bodies are different from our bodies.' So, once it is discovered that black bodies are just as susceptible, you will find that black people have suffered more. This pattern traces to the outbreak of smallpox during the Civil War to the 1918 flu pandemic."

"Mortality rates and outcomes are attributed to class differences and racism, but not to race. It is not the color of my skin that determines my risk; it is how society reacts and implements policies based on the color of my skin." Asked why the belief that blacks are more or less susceptible to disease persists, Professor Hammonds responded,

"It has persisted over time because it reflects a particular kind of anxiety about difference in a racially stratified society. It's an easy answer that allows regular people to think that the problem lies in the behaviors and bodies of the consistently disenfranchised and marginalized. It's an easy out that stops thinking and limits action. We need to quickly, effectively, persistently, and loudly say it is not the case. Stop allowing that answer to dominate public discussion, because it keeps us from focusing on the social determinants."

One of the important social influences that predicts health outcomes globally is socioeconomic status. Professor David Williams illustrated the disparities for blacks in Africa and the Diaspora. In the U.S., blacks earn 59 cents for every dollar earned by whites; in the U.K., black Africans earn 60 pence to every 77 pence for those of Afro-Caribbean descent for every one pound earned by whites; in South Africa, blacks earn .20 rand to every .40 rand for coloreds to every one rand earned by whites. The commonality across these contexts is populations of African descent have fewer economic resources, and massive economic inequality leads to health vulnerability. Data from England and Wales, for example, shows death rates four times higher for blacks than whites.

February and March had few reported cases in Africa, with emerging theories to explain this low incidence. Some referenced the black body's immunity. Scientists wondered if the strain of coronavirus in Africa was milder. Africa's youthful population was credited for the low incidence in a continent where only 2% are over 65 years old. Africa's heat and humidity even received some of the credit. Then in mid-April, the number of reported cases in Africa rose by more than 40% in one week. Clearly, the lack of tests in Africa have obscured the real proportions of this pandemic on the continent.

---

Now international concerns have focused on the huge numbers of poor in Africa, which has 7 of the 10 poorest countries in the world; that the majority of Africans are daily workers in the informal economy; and live in settlements where social distancing, quarantine, the frequent washing of hands, and other recommendations of the World Health Organization cannot be practiced.

Dr. John Nkengasong of the Africa CDC framed COVID-19 not only as a health concern, but as a human rights issue, a security issue, and an economic issue: "Even before the first case of COVID-19 on the African continent was detected on February 14 in Egypt, Africa was already hit hard by economic shocks because of its dependence on external trade. Trade within the continent constitutes only 11% of the total volume, while 89% of trade is with the outside world; when the outside world is hit, African economies come to a standstill." Further illustrating this global dependence, Dr. Nkengasong reflected that "If we were hit by this virus in January, we would have been swept away because no laboratory on the continent had access to diagnostics. A pandemic affects the whole world. Countries have approached this by looking inward but are making the mistake that if you defeat this in the U.S. or Europe you defeat it worldwide. If it grows out of hand on the African continent, it will continue to be a serious threat across the whole world."

### **Underlying health conditions that have made Africans and African Americans vulnerable to COVID-19**

Africa from the 1980s has witnessed an HIV-AIDS epidemic; in 2018, 20.6 million people were living with HIV in eastern and southern Africa, 54% of the total worldwide. Over 25% of tuberculosis deaths occur in Africa.

In 2018, 93% of the 228 million malaria cases worldwide were in Africa, which also represented 94% of the estimated 405,000 estimated deaths. In the U.S., medical and public health experts point to underlying conditions like hypertension, cardiovascular disease, obesity, diabetes, and asthma that leave African Americans particularly vulnerable to coronavirus. The Harvard T. H. Chan School of Public Health has directly linked air pollution to the probability of more severe COVID-19 cases. To give a very local example: the Bronx is the most-unhealthy county in New York with 21 more times asthma hospitalizations than any other county. This is connected to the industrial sites, warehouses and highways in the borough. 44% of the population of the Bronx is black. By April 9, black and Latino people accounted for 62% of New York City's confirmed deaths from COVID-19 but just 51% of its population, and Bronx residents showed particularly high death rates.

Professor Hammonds stated, "These gaps in coverage for African Americans are well known and established; if there is some good to come out of this, it will be that renewed attention is brought to these disparities." But she wondered given the longstanding prevalence of high HIV rates in African American and Latino communities, "What will it take for our public health system to come to terms with that when we've become inured to these health disparities? When something like COVID-19 strikes, it is no surprise that these communities will suffer a great deal." Professor Williams again illustrated this point through data from a study of 12 hospitals in New York City involving of 6,000 patients, where only 6% of those hospitalized for COVID-19 did not have more than one comorbidity. 88% had two or more, such as hypertension, obesity, diabetes, or heart disease, all of which impact African American populations at higher rates thus putting them at greater vulnerability.

---

Professor Williams stated, "The bigger question we need to ask is why do African Americans have these non-communicable diseases at higher rates and get them at younger ages? The research suggests higher levels of exposure to psychosocial stressors, economic stressors, and the stress of racial discrimination leads to these physiological compromises. We cannot blame the community or population but rather the policies that we have put in place that create these greater vulnerabilities."

Reflecting on the African experience, Dr. Nkengasong noted the complications of facing a global pandemic on a continent that already had over 1.1m deaths last year from TB, HIV, and malaria. COVID-19 compounds the existing health, economic, and social welfare burdens. Africa CDC's response strategy hinges on three pillars: limit transmission, limit deaths, and limit harm (as it relates to economic harm, social justice, human rights, and the compromise of COVID-19 on existing immunization programs). Africa's youthful population may be an advantage in overcoming COVID-19, and the lack of transportation infrastructure, which is typically an obstacle to development, may also serve an advantage in limiting the ability of rapid movement of people. Dr. Nkengasong cautioned that these minor advantages are not enough to overcome the endemic disease burden on COVID-19.

**Unequal access to testing, diagnostics, healthcare, and the capacity to follow WHO, US CDC and Africa CDC safety guidelines**

There is a worldwide competition to acquire personal protective equipment (PPE – masks, gloves, gowns), test kits, and ventilators. Lacking financial resources, many African governments have struggled to find necessary resources. 41 countries have only a total number of 2,000 ventilators. Somalia's health ministry had none.

South Sudan has 4 ventilators, and Liberia has 5. In contrast, the U.S. has more than 120,000 ventilators. African medical professionals have resorted to training sessions by their colleagues in the West via Zoom and WhatsApp. Dozens of African countries have limited capacity to test for and treat coronavirus.

The response of African governments from late March to seal or tighten their borders, ban public gatherings, and close schools among other preventive measures was prudent; but, across a continent where the majority earn their livelihoods daily through participation in the informal economy, where the nature of work is such that few can work from home, and where the housing conditions of the poor in Kibera in Nairobi or Makoko in Lagos do not allow quarantine and social distancing, it has not been easy to follow the guidelines of WHO and the Africa CDC. How do you wash your hands frequently in Harare (Zimbabwe) when taps have been dry for nearly 10 years? If your source of water is a community tap or borehole, or if you share a toilet with several others, how do you self-quarantine? In the northeast and mid-west U.S., racial inequities in labor and housing density threaten African American lives. In the US south, poverty and inadequate health care explain the underlying health conditions. It is not until after the deaths of African Americans in COVID-19 in Chicago became public that the city sought to provide residents of predominantly black communities with masks in April.

Professor Hammonds reflected that "It is obvious that to effectively impose a lockdown will disproportionately affect people who have living conditions or work that make it impossible to do that. Those in lockdown who can do their work are people who have some kind of privilege.

---

Lockdown adds an additional burden even as it provides some protection for exposure, but those who must go out and work or lose their jobs will be most exposed and have a higher risk of getting the disease." Professor Williams noted that in New York City, 60% of essential workers were persons of color.

For the Africa CDC, Dr. Nkengasong stated that lockdown and curfew measures must strike a balance between saving lives and saving livelihoods, and that lockdowns are more effective than curfews. In South Africa, for example, cases were increasing by 31% daily before lockdown. 21 days after lockdown measures were implemented, the daily increase was only 5%. Similar results are seen across the continent.

Dr. Nkengasong noted "There is no doubt that lockdowns are a public health tool, but they are also a challenge for those living on less than \$2 a day, which is true of half the African population. It is a struggle to balance economic weakness and vulnerability while maintaining a strategy of public health value." Community champions, community engagement, and community education efforts have been key to Africa CDC's response. Their engagement strategy spreads awareness and encourages community ownership of the response.

Speaker Titles:

- **Dr. John Nkengasong**, Director, Africa Centers for Disease Control and Prevention
- **Professor Evelyn Hammonds**, Chair of the Department of the History of Science & Barbara Gutmann Rosenkrantz Professor of the History of Science at Harvard University
- **Professor David Williams**, Florence & Laura Norman Professor of Public Health & Chair, Department of Social & Behavioral Sciences at Harvard University
- **Professor Emmanuel Akyeampong**, Oppenheimer Faculty Director of the Harvard Center for African Studies & Ellen Gurney Professor of History and of African and African American Studies

Special thanks to our partners of this webinar:



You can learn more about the Harvard Center for African Studies at [africa.harvard.edu](https://africa.harvard.edu).