

History of

Anti-Blackness in

American Virus Response

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INTRODUCTION

Throughout history, America faced a multitude of pandemics, varying in causation, origin, etc. This paper will be focusing on two specific pandemics, the Spanish flu and COVID-19, due to similarities in symptoms and the policies that were enacted in response to them. I will investigate whether these policies protect or harm vulnerable populations, such as the African American community. Based on the collected data, I argue that these policies were not effective in protecting the African American community. This is not a new problem, rather it fits a pattern of anti-Blackness in the American healthcare system, and particularly in the response to virus outbreaks.

SPANISH FLU CAUSE AND SPREAD

During the years 1918-1920, the United States was struck with the Spanish Flu. There is uncertainty as to where the Spanish Flu originated. Many researchers have theorized that a UK military camp in Étaples, France was the starting point of the virus (“Looking Back at the 1918 Pandemic in Cleveland,” 2020). Meanwhile, other experts believe that the pandemic began in the United States. Nonetheless, the rapid spread of the virus was undoubtedly tied to World War I activity in Europe and North America (“Looking Back at the 1918 Pandemic in Cleveland,” 2020).

The Spanish Flu was caused by influenza type A subtype H1N1 viruses with genes from bird origin (Sam, 2020). Symptoms of the Spanish flu of 1918 were initially marked by severe colds, sneezing, dry coughing, and headaches. After a few days, the symptoms were followed by muscle aches and high fever (Sam, 2020).

The first identified patients in the United States were military personnel in the spring of 1918 (“Looking Back at the 1918 Pandemic in Cleveland,” 2020). Many U.S. soldiers were weakened by malnourishment and chemical attacks, leaving them vulnerable to respiratory illness (“Looking Back at the 1918 Pandemic in Cleveland,” 2020). When they arrived home, U.S. citizens also became infected with the Spanish Flu. However, this initial wave of the virus was so mild that many doctors thought it was merely the “seasonal flu” (“Looking Back at the 1918 Pandemic in Cleveland,” 2020). Complications were extremely rare, and the duration of the illness was short among the majority of patients. By autumn 1918, a second wave of the virus swept across the nation—and this time, the illness proved to be significantly more deadly. Symptoms were so severe that patients were often mistakenly diagnosed with typhoid or dengue fever rather than influenza (“Looking Back at the 1918 Pandemic in Cleveland,” 2020). What caught medical workers so off-guard was that the majority of those affected were young, healthy adults. Roughly 99% of deaths in the United States occurred in patients younger than 65 years old, and close to 50% of deaths occurred in those between the ages of 20 and 40 years old (“Looking Back at the 1918 Pandemic in Cleveland,” 2020). Due to the unusual death spikes in healthy individuals, health professionals came into a realization that it is a flu epidemic.

POLICIES APPLIED FOR THE SPANISH FLU

With no vaccine or treatment of the virus, The Committee of the American Public Health Association (APHA) issued a report outlining appropriate ways to prevent the spread and reduce the severity of the epidemic. They noted first that the disease was extremely communicable and

"spread solely by discharges from the nose and throats of infected persons." Thus they called for legislation to prevent the use of common cups and to regulate coughing and sneezing. They wanted to initiate education programs and publicity on respiratory hygiene about the dangers of coughing, sneezing, and the careless disposal of nasal discharges. They aimed to teach people the value of hand-washing before eating and the advantages of general hygiene ("The Public Health Response," n.d.).

Public Health agencies also strived to reduce the spread of the illness by advocating for ventilation. They held that well-ventilated, airy rooms promoted well-being ("The Public Health Response," n.d.). These ideas were practiced in hospitals as special influenza wards for influenza patients were created and the number of beds per ward was decreased to reduce transmission of the diseases. Those with complications such as pneumonia were separated from the rest to prevent the others from progressing to a more fatal state ("The Public Health Response," n.d.). Sheets were hung between the beds to mimic isolation in limited closed quarters to provide a cubicle for each patient. In the military camps, soldiers were instructed to eat 5 feet apart. Head to foot sleeping was also implemented to reduce the sharing of air space ("The Public Health Response," n.d.).

The gauze mask was another prevention method. In the United States, it was widely accepted for use in hospitals among health care workers. The face masks consisted of a half yard of gauze, folded like a triangular bandage covering the mouth, nose, and chin ("The Public Health Response," n.d.). These gauze masks acted to prevent the infectious droplets from being expelled by the mouth, as well as prevented hands that were contaminated with microbes from

being put to the mouth. The barrier from the hands was thought to be more important than the barrier from the air.

Throughout the states, local governments implemented these regulations in exceedingly different ways. Kansas City banned weddings and funerals if more than 20 people were to be in attendance (U.S. Department of Health and Human Services, 2015). New York mandated staggered shifts at factories to reduce rush-hour commuter traffic (U.S. Department of Health and Human Services, 2015). Seattle's mayor ordered his constituents to wear face masks (U.S. Department of Health and Human Services, 2015). Overall, most states implemented limited social gatherings and mandated good personal hygiene. However, the reason as to why some cities were severely affected was the timing that they implemented these rules. For instance, Philadelphia opted to move forward with hosting its "Liberty Loan" parade in September 1918, during the height of the virus's second wave (U.S. Department of Health and Human Services, 2015). Some 200,000 citizens gathered in the streets of Philadelphia to celebrate and march. The result of that decision? Within 72 hours of the infamous parade, every bed in the city's 31 hospitals was filled. By the end of the 1918 pandemic, more than 15,000 Philadelphians had lost their lives to the Spanish Flu. By comparison, St. Louis decided to close its schools and ban public gatherings early in the pandemic (U.S. Department of Health and Human Services, 2015). In the end, their peak mortality rate was a mere one-eighth of the peak mortality rate of Philadelphia. Ultimately, the 1918 pandemic took the lives of 675,000 Americans (U.S. Department of Health and Human Services, 2015).

INEFFICIENCIES IN THE SPANISH FLU POLICIES

Publications from that time stated African Americans were affected less during the Spanish Flu (Gamble, 2010). In 1918, the United States Public Health Service contended that African Americans had suffered fewer deaths than white Americans during the epidemic. They went on to say that these “facts are so apparent” and had also been noted by Black physicians and undertakers. The Chicago Department of Health in its analysis of the influenza epidemic concluded, “The colored race was more immune than the white ”(Gamble, 2010). Dr. W.H. Frost of the U.S. Public Health Service reported that in seven localities with substantial Black populations, the incidence rates for the Flu were lower than localities white populations even after adjusting for sex and age (Schlabach, 2019). Due to these published data, the belief that influenza took a decreased toll on African Americans was widespread and strongly held.

Does that mean the 1918 policies were effective? No, African Americans still did not receive adequate care. Back then, similar to today, the most effective strategy against the virus was social distancing. However, Black people were forced to live in cramped housing. In Chicago, agreements among homeowners associations, real estate agents, and institutions such as the University of Chicago prevented the rental or sale of homes to Black families (Schlabach, 2019). Restrictive housing covenants kept upwardly mobile middle-class African Americans from moving out of the Black Belt into neighboring suburbs. They were forced to stay in apartments where the housing situation was overcrowded, and landlords neglected repairs and overcharged tenants for rent. This situation put African Americans in harm's way because the pandemic spreads through close contact.

Medical treatment towards African Americans was not better at that time. Nationwide, hospitals either denied African Americans admission or accommodated them, almost universally, in segregated wards, often placed in undesirable locations such as unheated attics and damp basements (Gamble, 2010). The racially exclusionist policies of professional organizations led African Americans to establish their own strategies to improve the health of African Americans. Black medical workers advocated for sanitation laws to clean up tenements and for housing reforms to improve Black neighborhoods that had greatly deteriorated with the influx of African Americans to northern cities during the Great Migration (Gamble, 2010). Black health professionals also created programs to teach personal hygiene and sanitation, especially to poor African Americans and to recent migrants from the South (Gamble, 2010).

Black health professionals were also met with serious racism from white nurses and hospital and health department administrators (Schlabach, 2019). Margaret Hanrahan, director of the nursing service at the Chicago Municipal Tuberculosis Service, indicated that sixteen Black nurses were segregated from their 140 white counterparts and were kept away entirely from white patients (Schlabach, 2019). Olive Walker, a trained nurse of Cleveland, was not able to join the Red Cross Nurses Committee to help with the influenza epidemic at Hiram College. The dean of the college refused to allow her to join when he found out she was Black (Schlabach, 2019). This dean and others in administrative roles expressed resentment and contempt at dealing with Black nurses, moving Walker to conclude that “as far as white nurse educators, administrators, supervisors, and leaders were concerned, Black nurses’ low status in the profession was a result of their allegedly inferior training, lack of executive skills, limited intelligence, weak character, and inability to withstand pressure...only to the extent that she

remained stationed within the Black community, caring only for Black patients, could she earn praise and respect from her white counterparts” (Schlabach, 2019).

We also cannot blindly accept reports that the Spanish Flu did not disproportionately affect African Americans, because it was difficult to obtain health records and it’s likely that instances of Black illness were underreported. A recent study reviewed the mortality rates during the Spanish Flu. Researchers found that the white population had higher morbidity, but the Black population had higher mortality and case fatality (Økland & Mamelund, 2019). Even though the Black population had a lower influenza incidence, they were more susceptible to other bacterial diseases, such as Pneumonia (Økland & Mamelund, 2019). Therefore, they tended to have higher case fatality rates than white people. The fact that there is a lack of accurate data collection and uncertainty for African American influenza cases because of inadequate access to medical care speaks volumes on how ineffective America’s virus response is towards Black lives. So, no. The policies back in 1918 were not effective.

COVID-19 CAUSE AND SPREAD

Fast forward to 2020, when we are witnessing the COVID-19 pandemic. COVID-19 is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Maragakis, 2020). Coronaviruses are a common family of viruses in certain species of animals, such as cattle and camels. Although the transmission of coronaviruses from animals to humans is rare, this new strain likely came from bats. However, it remains unclear exactly how the virus first spread to humans.

Similar to the 1918 flu, COVID-19 spreads from person to person through tiny droplets that infected patients expel when they breathe out or cough (Kandola, 2020). These droplets can enter the mouth or nose of someone without the virus, causing an infection to occur. Alternatively, these droplets also land on nearby surfaces or objects, and other people can contract the virus by touching their nose, eyes, or mouth after coming into contact with these surfaces (Kandola, 2020). Common symptoms of COVID-19 include fever, breathlessness, cough, sore throat, headache, muscle pain, chills, and loss of taste or smell (Kandola, 2020). These symptoms are likely to occur 2–14 days after exposure to the virus (Kandola, 2020).

POLICIES APPLIED FOR COVID-19

The COVID-19 virus outbreak began in Wuhan in November, a city in the Hubei province of China (Schuchat, 2020). Reports of the first COVID-19 cases in America started in December 2019. To effectively monitor the virus, the CDC enlisted public health practices to prevent the spread of the virus. In early February, the CDC mandated travel restrictions for non-U.S. citizens or permanent residents arriving from China and later expanded to include other countries with widespread sustained transmission (Schuchat, 2020). Travel health notices were also issued for countries with known outbreaks as the pandemic evolved, and ultimately warnings were issued to avoid nonessential international travel (Schuchat, 2020). On March 14, 2020, the CDC Director issued a No Sail Order for cruise ships, suspending operations in U.S. waters (Schuchat, 2020). Furthermore, screening and public health risk assessment of travelers in selected U.S. airports, initiated on January 17, were also expanded (Schuchat, 2020).

Outside of border control, the CDC regulated actions aimed at reducing COVID-19 spread in high-risk settings. These settings include school, theaters, churches, or other places where people congregate closely. To monitor the virus, all states issued stay-at-home orders, closed schools, and mandated the use of cloth face coverings. At essential businesses, they enforced infection control measures, including identifying and isolating ill persons, cleaning and disinfection, restricting visitors, physical distancing through shift work, and appropriate use of personal protective equipment (Schuchat, 2020).

INEFFICIENCIES IN THE COVID-19 POLICIES

With all the regulations the CDC put into place, were these policies effective? Well, let's take a look at how minority communities were affected. In Chicago, Black people account for half of all coronavirus cases in the city and more than 70% of deaths, despite making up only 30% of the population (BBC, 2020). In Michigan, African Americans make up 14% of the population but account for 33% of the coronavirus cases and 41% of deaths (BBC, 2020). In Louisiana, more than 70% of the people who have died of COVID-19 were African American, despite making up 32% of the Gulf state's population (BBC, 2020). Considering all the implementations are in place, African Americans were still disproportionately affected.

St. Johns, a predominantly Black Louisiana parish, has similar COVID-19 cases (43,000+) to St. Bernards, a predominantly white Louisiana parish. However for St. Johns, the death rate of COVID-19 is 78.7% while the mortality rate in St. Bernard, Louisiana is 21.4% (US Census Bureau, 2020). Once again, the number of cases between the two cities is similar,

but St. Johns has a death rate that is around four times higher. So how come these CDC regulations are not as effective in Black populations?

The most effective strategy known to reduce COVID-19 infection is social distancing, but this cannot be achieved when you have to work in crowded conditions. There's a large concentration of Hispanic workers in construction and a large concentration of Black workers in service sector jobs. And since both of these industries are qualified as essential businesses, employees continued to work during the pandemic. A study from Scott M. Stringer, the NYC comptroller, found that 75% of front-line workers in the New York City — grocery clerks, bus and train operators, janitors, and child care staff — are minorities (Afridi & Block, 2020). More than 60% of people who work as cleaners are Latinx, and more than 40% of transit employees are Black (Afridi & Block, 2020).

Another study amplifies that people of color are overrepresented in many occupations within frontline industries. These occupations were also considered “essential businesses,” meaning that people of color are overrepresented as “essential workers.” This makes them more susceptible to the spread of the virus. For example, among frontline workers just over four-in-ten (41.2%) are Black, Hispanic, Asian-American/Pacific Islander,(Rho et al., 2020). Hispanics are especially overrepresented in Building Cleaning Services (40.2%). Blacks are overrepresented in Child Care and Social Services being 19.3% of workers (Rho et al., 2020). Workers of color are particularly overrepresented in the following occupations: bus drivers, transit and intercity (56.75%); most of the top 10 occupations in Trucking, Warehouse, and Postal Service; most of the top 10 occupations in Building Cleaning Services; all of the top 10 occupations in Health Care, and more (Rho et al., 2020).

Crowded conditions are not limited to workplaces. At home as well, people from marginalized backgrounds are more likely to live in crowded conditions. COVID-19 spreads faster in locations with a higher density such as cities. Black Americans are more likely to live in urban counties than suburban or rural ones, according to a Pew analysis (Parker et al., 2020). We also cannot forget the extremely crowded living conditions at homeless shelters, where most of the inhabitants are people of color and 52% are African Americans (Kaur, 2020). Additionally, we cannot ignore prisons and jails -- similarly crowded places with disproportionate Black populations. All of these locations are easy targets for the virus to spread quickly, demonstrating that social isolation is ineffective for individuals, mostly African Americans, who cannot escape crowded areas. Being able to maintain social distance while working from home, telecommuting, and accepting a furlough from work are issues of *privilege*; which many people of color, such as African Americans do not possess.

PATTERNS OF POOR TREATMENT

What happens when African Americans do contract the virus? Do we receive care? According to the Urban Institute analysis of March 2011, African Americans experience less access to medical care than their white counterparts (Buettgens, 2011). Compared to white Americans, Blacks have lower levels of health insurance coverage and are less likely to have insurance coverage through an employer (Duckett & Artiga, 2014). How does the absence of health insurance hinder access to healthcare? A 2015 report from the Kaiser Commission on Medicaid and the Uninsured explained when you're uninsured, you are far less likely than those with insurance to report health concerns (Majerol, Newkirk & Garfield, 2015). Thirty percent of

adults without coverage said that they went without care in the past year because of its cost compared to 4% of adults with private coverage (Orgera, Garfield & Damico, 2020). Uninsured people are also less likely than those with coverage to receive timely preventive care. This means that silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. In 2013, only 1 in 3 uninsured adults (33%) reported a preventive visit with a physician in the last year, compared to 74% of adults with employer coverage and 67% of adults with Medicaid (Majerol, Newkirk & Garfield, 2015). Uninsured patients are also less likely to receive necessary follow-up screenings after abnormal cancer tests (Tejeda et al., 2013). Consequently, uninsured patients have an increased risk of being diagnosed in later stages of diseases, including cancer, and have higher mortality rates than those with insurance (Wilper et al., 2009) Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2010, nearly a quarter of uninsured adults said they did not take a prescribed drug in the past year because they could not afford it (Cohen & Villarroel, 2015). When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance (Abdullah et al., 2010).

Does dire conditions in the hospital change when African Americans do have health insurance? Let's read a Black woman's story. In early 2017, Whitney, a Ph.D. candidate at an elite university, was newly pregnant with her first child. Massachusetts, where she lived, had one of the lowest maternal mortality rates in the U.S. In her last trimester, however, Whitney grew worried when she experienced severe acid reflux and an elevated heart rate. The staff at her medical practice group waved her concerns away and told her to focus on managing her high

blood pressure, but when she eventually went into labor, her heart rate shot up still higher and didn't return to normal even after she gave birth. Whitney also had trouble breathing. The medical staff, believing she might have a blood clot, ordered two CT scans. Both came back negative, so though she remained short of breath, Whitney was discharged. As days went on, she went to several health professionals asking if she had peripartum cardiomyopathy (PPCM), a form of heart failure associated with pregnancy (being of African American descent is a known risk factor for PPCM). All the doctors she went to misdiagnosed her, dismissing her concerns as just anxiety. Finally, she discovered a PPCM Facebook group, through which she contacted a trusted doctor. Roughly 12 weeks after her initial inquiry, tests confirmed that indeed, she had PPCM. After receiving the correct treatment, she began seeing a therapist to help her process the experience. "The way the doctors and nurses brushed off my concerns made me feel so degraded," she said. "I really don't feel like healthcare institutions are set up to protect women of color" (Stallings, 2019).

Whitney's story is a testament to the racial bias Black patients face in the hospital and the effect of the racial bias towards Black patients. In a 2012 study, scientists found a correlation between pediatricians' implicit (unconscious) racial biases and how they treated pain in a simulated African-American or white teenager following surgery (Sabin & Greenwald, 2012). As the strength of provider implicit bias favoring whites increased, the likelihood of prescribing appropriate pain medication decreased only for the Black patient (Sabin & Greenwald, 2012). A meta-analysis of 20 years of studies covering many sources of pain in numerous settings found that Black/African American patients were 22% less likely than white patients to receive any pain medication (Meghani Byun & Gallagher, 2012).

African American patients are also more likely to have underlying health conditions. In the United States, Black people are more likely to have underlying health issues like diabetes, heart disease, and lung disease. In 2017, African Americans were 20 percent more likely to die from heart disease than non-Hispanic whites (“Heart Disease and African Americans,” 2020). African American women are 60 percent more likely to have high blood pressure, as compared to non-Hispanic white women (“Heart Disease and African Americans,” 2020). African American adults are 60 percent more likely than non-Hispanic white adults to have been diagnosed with diabetes by a physician. In 2017, African Americans were twice as likely as non-Hispanic whites to die from diabetes (“Heart Disease and African Americans,” 2020). Coupled with underlying health conditions and poor treatment in the hospital, there’s no coincidence as to why Black people are dying more. Due to this pattern of inadequate health care, COVID-19 mortality rates are higher for Black folks.

HISTORY REPEATS

When you don’t learn from the past, history is bound to repeat itself. We’ve seen how policies and medical racism repeats itself in this country. There is also a pattern of mass racial ignited attacks happening during a pandemic.

During the summer of 1919, communities across America were reeling from white mobs inciting brutality against Black people and cities were still wrestling with a third wave of the Spanish flu pandemic (Ortiz, 2020). From April to November in 1919, about 30 riots broke out across the eastern U.S., with hundreds of accounts of beatings, lynchings, and the burning of churches and buildings. As a result of the violence, the Ku Klux Klan also saw a resurgence

(Ortiz, 2020). As bloody as that summer was, it failed to result in any protections for African Americans, and if anything, exculpatory work of the white press, police, grand juries, and others ensured that perpetrators were protected rather than punished. This storyline parallels with today: violence against Black communities at the hands of police or former law enforcement, converging with a months-long pandemic. Recently, we witnessed their harsh treatment towards Black bodies and their ability to get away with murder. As a response to the many Black lives lost, there have been mass demonstrations and protests across the 50 states to fight for racial justice. Nonetheless, protestors encountered major pushback from police and racist white individuals, often resulting in riots and arrests. 101 years later, law enforcement still has not offered protection for Black folks.

CONCLUSION

The root cause of the ineffective policies in American virus response is anti-Blackness. The notion of social distance is anti-Black because Black bodies are on the line, not able to work from home or their living conditions keep them cramped, making it impossible to follow the “6ft rule.” When they do seek treatment, doctors provide inadequate care which makes the patients worse off than before. Furthermore, African Americans have to deal with police brutality and racist attacks from others, while trying to maintain our health. Racial violence from the healthcare system and the police have left Black people exhausted and with no protection.

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