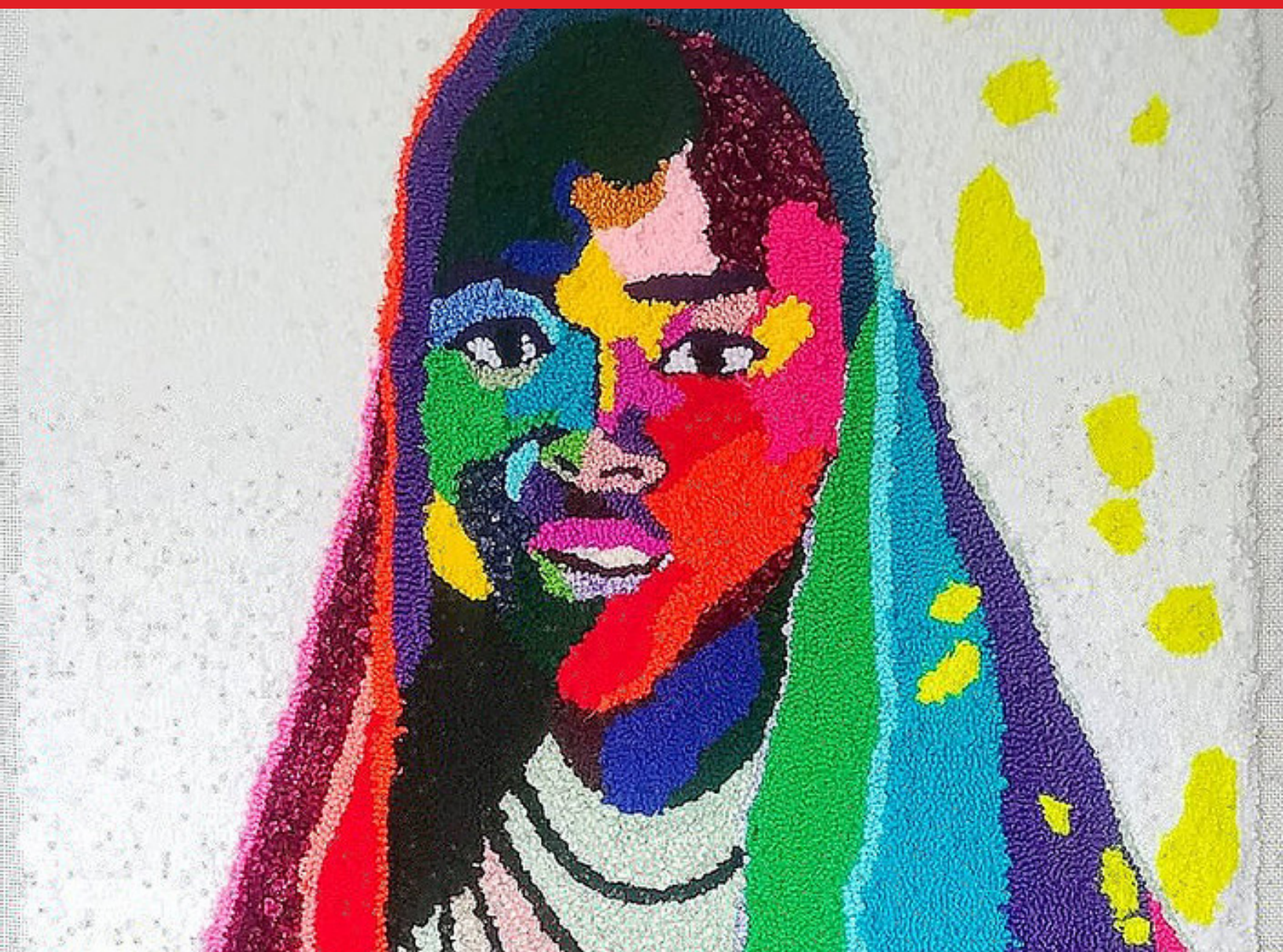


Impacts of COVID-19 in Racialized Communities

May 2021



An RSC Collection of Essays

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Land Acknowledgement

The headquarters of the Royal Society of Canada is located in Ottawa, the traditional and unceded territory of the Algonquin Nation.

The opinions expressed in this report are those of the authors and do not necessarily represent those of the Royal Society of Canada.

Background on the Policy Briefing Report Process

Established by the President of the Royal Society of Canada in April 2020, the RSC Task Force on COVID-19 was mandated to provide evidence-informed perspectives on major societal challenges in response to and recovery from COVID-19.

The Task Force established a series of Working Groups to rapidly develop Policy Briefings, with the objective of supporting policy makers with evidence to inform their decisions.

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Message from the President

In April 2020, the Royal Society of Canada (RSC) struck a COVID-19 Task Force to provide Canadians with independent perspectives on diverse topics relating to the pandemic. The original slate of “topics important to Canadians” was based on the results of a membership survey but has continued to expand as new suggestions are made. At the time of writing nearly 500 Canadians, from coast to coast to coast, have volunteered their time, resulting in 18 Policy Briefings and 130 informed perspectives.

Professor Frances Henry, FRSC, proposed the Task Force addressing the impacts of COVID-19 in racialized communities in Canada. She, together with Professor Carl James, a Fellow who recently chaired the RSC Committee on Equity and Diversity, subsequently served as co-chairs of this initiative.

Their dedication and engagement resulted this exceptional set of essays, produced by scholars and scientists working in various fields of research and clinical practise. The essays, each of which was published by The Globe and Mail, clearly identify how COVID-19 has exacerbated the serious inequities that exist in our country and emphasise the urgency for action to redress systemic racism. These works also illustrate the complexity of the challenges at hand in that different authors working in the same research area have made different recommendations.

On behalf of the membership of the RSC, I would like to thank Frances and Carl for their leadership, and hope that these essays not only provoke reflection, but result in much needed action.

I would like to dedicate this publication to Frances, not only for her overview of the history of racism and racialization in Canada, which serves as an excellent source of background and context to the essays themselves, but also for her many years of dedicated service in both national and international activities of the RSC



Jeremy N. McNeil, FRSC

President

The Background to Racism in Canadian Society

Frances Henry, PhD, Professor Emerita, York University

I. Introduction

Most Canadians do not consider themselves to be racist. In fact, they are often quick to deny their racism and that of the society at large, mainly because racism is generally understood to be overt or physical in nature. Physical acts of violence against racialized people or created incidents such as setting fires to their homes can readily be understood as racist; however, racism is expressed in many covert and often subtle ways. One of the objectives of this working group on racialized communities is to expose the myriad of ways in which racism is formed and expressed in Canadian society.

This paper contains three sections: the first section outlines a brief history of racist history in Canada; the second explains the various structural forms of racism; and the third discusses the two major forms of racism that exist today in our society. Throughout, I discuss the role of White privilege, whiteness studies, and unconscious bias.

The history of racism in Canadian Society started several centuries ago when settlers from Europe, beginning when French explorers, then colonial settlers from the UK, came to what is now known as North America. At the time, the area was settled by Indigenous peoples, the descendants of Asian “migrants” crossing the Bering Straits and moving southwards many thousands of years ago. With the arrival of Europeans, the systematic exploitation of Indigenous people and their communities began and has continued to this day.

Indigenous Peoples

For the last four hundred years, interactions between Indigenous peoples and the dominant White society has been predicated on the assumption that Indigenous peoples were inherently inferior and incapable of governing themselves. Such notions provided the framework for a paternalistic but exploitative relationship. The many treaties between Indigenous groups and the prevailing government were frequently ignored and their legitimacy as nations has never been truly accepted. They were displaced from their lands and, as their spirituality was considered heathen, great attempts were made in earlier times of contact to Christianize them. One of the strongest examples of racism was the legal establishment of the Residential Schools operated by missionary agents under the guidance and support of the federal government. Thousands of children were taken from their homes and placed in these schools and in a process of coercive assimilation forced them to unlearn their traditional cultural behaviour. Today, many Indigenous communities face poverty, inadequate housing, poor schooling, and serious health and substance dependency issues.¹

African (Black) Canadians

The enslavement of Africans and the following racial segregation and discrimination of “free” Black peoples has been an integral part of the history of Canada since the early 1600s. Although Canada is not often recognized as a slave-holding society, slavery continued after the British conquest of New France in 1763. The victims of slavery were totally deprived of their human rights

¹ <https://www.thecanadianencyclopedia.ca/en/timeline/first-nations>

and they were treated as property. Defiant or troublesome enslaved people were often severely punished. Physical and sexual abuse was always a very real threat.

Hostility toward “free” Black persons led to discriminatory employment practices; Black workers often earned one quarter the wages of their White counterparts.² Further, they were restricted in their ownership of property and had difficulty securing education for their children. Widespread distrust and stereotypes encouraged a state-sanctioned society of segregated neighbourhoods and schools.³

The Black people who chose not to move to the United States after Emancipation, largely lived in segregated communities in Nova Scotia, New Brunswick, and Ontario.⁴ It was well into the twentieth century before there was any real integration of Black Canadians into “mainstream” society. Racist attitudes maintaining the racial superiority of White people was the basis of discriminatory practices upheld by Canadians in all sectors, supported by all levels of government.

Chinese Canadians

Chinese people first started settling in British Columbia in the 1850s. They were hired primarily to build railways and roads, and to work in the coal mines and mills. Most notable were the more than 1500 labourers who were contracted to help lay the track for the Canadian Pacific Railway in the 1880s. Due to the dangerous nature of the work and lack of proper medical attention, upwards of six hundred workers died.⁵

When new industries requiring more labourers coincided with a lack of American and European immigrants, the Canadian government reluctantly contracted male Chinese immigrants. They were not permitted to bring their wives or children, or to have relations with White women.⁶ These workers were paid significantly less than were White workers, and due to poor living conditions, hundreds died of disease, malnutrition, and exhaustion. Once there was no longer a shortage of White workers, the Chinese immigrants were considered a threat and an increase of racial bias and discrimination followed. The government of British Columbia passed many anti-Chinese bills to curtail any political or civil rights, including barring people from voting or serving in public office.⁷

Between 1885 and 1923, Chinese immigrants had to pay a “head tax” to enter Canada. The tax was levied under the Chinese Immigration Act and not removed until 1923 when the Chinese exclusion act was enforced. By the twentieth century, Chinese Canadians were forced to move into the service industry where there was less competition with White workers. They did not receive the right to vote until 1947.

Japanese Canadians

When Japanese Canadians first settled in British Columbia in the 1870s, they were subjected to economic exploitation, and segregation in schools and public places.⁸ Right wing organizations,

2 Hill, Daniel G, “The Freedom-Seekers: Blacks In Early Canada”, by Daniel G. Hill, 1981, Pages 2-3

3 J.W.Walker, Racial discrimination in Canada: the Black experience, Canadian Historical Association, 1985.

4 Frances Henry, Forgotten Canadians: The Blacks of Nova Scotia, Longmans, 1974

5 Peter Li The Chinese in Canada, Oxford, 1988

6 Chan, Gold Mountain: the Chinese in the New World - CM Archive, 1983

7 Tarnopolsky,, W. A history of human rights in Canada – History Of Rights.ca 1991

8 “From Racism to Redress: The Japanese Canadian Experience” <https://learning.royalbcmuseum.bc.ca/wp-content/uploads/2015/06/ePubFaShRacRedJap.pdf>

seeking to restrict Asian immigration, carried out race riots in British Columbia in the early twentieth century.

After the bombing of Pearl Harbour in 1941, the Canadian government took the action of removing “any and all persons” of Japanese heritage from any “protected” area in Canada and to detain such persons without trial.⁹ Twenty-three thousand people of Japanese ancestry were sent to relocation and detention camps, or forced labour camps, in isolated areas of British Columbia, Alberta, and Manitoba. Japanese language schools were closed, houses and boats were sold, and savings were impounded.

Despite there being no record of Japanese Canadians being charged for sabotage or disloyalty throughout the war time, the reason given for this decision was wartime security.¹⁰ They were not released until 1949. Racist attitudes prevalent among politicians and the powerful anti-Asian lobby were among the leading factors leading to this unprecedented act of racism.

South Asian Canadians

By the early twentieth century, the Sikhs who lived in British Columbia were viewed with the same racist bias, hostility, and resentment as were other minority groups. The South Asian presence was viewed as a “Hindu Invasion.” In response, legislation was enacted to control the economic and social mobility of South Asians and to prevent more from coming.¹¹ In 1907, an amendment to the British Columbia Election Act added “Hindus” to other “Asian undesirables,” largely to prevent them from participating in provincial elections.

The South Asian community were unable to enter professions such as education, law, and pharmacy and were barred from owning property in some areas of Vancouver. This resulted in many people living in extremely poor conditions. In 1947, they won the right to vote in provincial and federal elections.

Post 9-11, there has been a revival in anti-south Asian sentiment in North America, especially targeting Muslim populations. Persons who are perceived to come from Middle Eastern areas are increasingly held under suspicion.

II. The Forms of Racism

Racism is a complex aspect of human behaviour. It can be broken down into three major components: individual, systemic or structural and cultural/ideological. With respect to individual behavior, a distinction must be made between attitudinal and behavioural. For example, an individual might have a set of beliefs or attitudes towards Black people, that they are lazy, or slow, or have criminal tendencies. These attitudes may not always lead to discriminatory behaviour perhaps because the opportunity to discriminate overtly does not arise. However, negative or even hostile attitudes may translate into what is called “everyday racism” or “microaggressions,” such as refusing to shake hands, or not sitting next to a racialized person on a bus or train. Institutional or systemic racism refers to the policies and practices within groups or organizations which are intentionally or often unintentionally discriminatory. A state sanctioned example of institutional racism is the

9 Sunahra, Ann Gomer: The Politics of Racism: The Uprooting of the Japanese, James Lorimer, Pub. 1981

10 Ujimotov, Naidoo, J. Asian Americans: Research on Current Issues, Proceedings, Asian Canadian Symposium, McMaster University and University of Windsor 1988

11 Buchignani, N. and Indra, D., The Continuous Journey of South Asians to Canada 1985 McClellan and Stewart

former height and weight requirements for police officers that in effect discriminated not only against women but also certain ethno/racial groups who are on average smaller in physical size.

Throughout the twentieth century, racialized peoples in Canada were subjected to overt physical forms of racism.¹² The primary forms of discrimination against racialized people were in the areas of employment and housing discrimination. A field experiment was conducted in 1975 in which four groups of job seekers: one young group of White and Black applicants and one older group of White and Black seekers were sent to follow and respond to help-wanted advertisements in the newspaper in Toronto. They carried identical but false resumes and introduced themselves as job seekers. They were actually actors who had undergone several periods of training in how to act as a job applicant. The number of jobs offers differed markedly by a ratio of 3 offers to Whites versus 1 offer to Blacks. A follow up study used phone calls to track jobs; one group used common Anglo Saxon names while the other used "ethnic" sounding names.¹³ The Anglo Saxon applicants received many more call backs for interviews than did the ethnic named group. Similarly, researchers phoned in response to apartment vacancy ads listed in the newspaper and when they were told the apartment was available, Black men and women were sent to the address, where they were quickly told the apartment "has just been rented." These and many other incidents of racism directed against individuals have been noted in our history.

III. Racism and Society

Race and Class

A very long-standing discussion and debate in issues of race and racism is the question of race versus class. Is racism the primary problem today, especially in countries like the United States, or the outgrowth of a system that oppresses all poor people? Scholars and theorists have long debated this point. C.L.R. James, a renowned Marxist, examined the labour force and the system of capitalism. He came to the conclusion the class system exploited labouring people and its divisions created social classes who served the interests of the White elites. James also thought that a few Black people would be allowed to rise through the ranks of power, thus dividing the Black population. Cedric Robinson writing later developed the concept of "racial capitalism" which he saw as coming from colonization, which was or had been dependent on slavery, violence, imperialism, and genocide. He noted capitalism's intent to differentiate groups of people, which led to racial hierarchies.¹⁴

For these and other theorists, class and race were intertwined, but social and economic class were more determinative. Bourdieu, a prominent social theorist, articulated the concept of "habitus" or cultural capital, expanding the Marxian notion of capital and economic class into the realm of culture.¹⁵ Cultural capital refers mainly to the symbolic realms of culture such as one's skills, tastes, clothing, mannerisms, credentials, which one acquires by being a member of a particular social class. Sharing similar tastes and values creates a particular kind of cultural identity and leads to the popular notion of "people like us" or "us and them," concepts that lead to or reinforce social inequality between people and groups in society. Cultural capital is particularly

12 Frances Henry and Carol Tator, *The Colout of Democracy: Racism in Canadian Society*, Nelson, 2010

13 Frances Henry and Effie Ginsberg, *Who Get the Work: A Test of Racial Discrimination in Employment*. Toronto, Social Planning Council of Toronto, 1985

14 *Black Marxism: The Making of the Black Radical Tradition*, published in 1983

15 <https://uk.sagepub.com/en-gb/eur/understanding-bourdieu/book224806>

relevant in the employment arena when Blacks and other people of colour apply for positions in corporate companies, legal firms, and even university positions. Despite having the necessary academic qualifications and previous employment experience, such applicants are often turned away because they don't fit the norms and cultural value systems of the workplace (playing golf, enjoying fine dining, and other accoutrements of middle and upper class life).

More recently the concept of intersectionality posits that several social categorizations such as race, class and gender and others may apply to a given individual or group. These are overlapping and interdependent systems of discrimination or disadvantage" and this theory has gained in popularity. Intersectionality generally refers to the ways in which race, gender, religion, class and other variables interact to bar certain people from employment or other desired amenities of life in modern society.

The term "structural" racism refers to all the major social forces, ideologies and processes that interact with each other to create and maintain inequities between social, racial and ethnic groups. Structural racism operates at a societal social level. It goes beyond the inequities that take place at the individual level and it involves but does not depend on the actions of individuals to maintain itself. Examples of structural racism includes social and geographic segregation.

Social Segregation

When groups are separated by race/ethnicity, residential or geographic segregation takes place. Such practices are common in modern societies when skills, education, ethnicity/race, and immigration determine residential living patterns. In part, such segregation is determined by the will and values of the people involved who want to live together and also by their economic status. (In earlier times, of course, residential segregation was, as in the U.S., determined by legal action). Segregation also takes place in educational institutions where groups of students are placed together. The practice of academic streaming is one such example of where students are frequently segregated by academic achievement; but it is well known that for structural reasons students from racialized backgrounds do less well in schools and their achievement levels are subsequently lower. Some workplaces, especially those whose employees do not need high levels of skill, are also areas of segregation, bringing people with common ethnicities together. Such workplaces are also often places where recently arrived immigrants can find employment, and some are devoted exclusively to short term migrant labour and have poor working conditions.

In addition to poor working conditions and low wages, these areas of segregation also strongly influence health. Residential segregation, in particular, influence the health of inhabitants by concentrating poverty, environmental pollutants, infectious agents. The crowding together of multigenerational families increases the ability illness and disease to spread. The strong relationship between illness and geographical segregation has recently been demonstrated in Toronto where in the Northwestern areas of the city, home to many ethnic migrants, has far higher proportions of the COVID-19 virus infections other areas of the city.

Systemic Racism

This term, sometimes also called institutional racism, refers to the policies, practices, and norms that govern the institutions of society, such as our justice system, our educational systems, employment organizations, etc. These policies set the standards, behaviours, and values of these systems, most of which have been in place for many years and generations and were established

by the primarily White populations that settled this country. Thus, they are already embedded in a value system which precludes non-White or racialized peoples. Systemic racism involves larger, structural, and institutional operations rather than individual biases and behaviours. “Our education systems, our healthcare systems, our judicial systems, our criminal justice system, our policing systems ... The very institutions that make up the way we live, how we’ve structured society, how we come to make decisions, how we decide what’s fair or just... These systems are built with an already ingrained bias, a racist lens and embedded with a discriminatory lens that doesn’t provide or allow for equal or fair opportunities for racialized peoples to succeed within.”¹⁶

Indigenous and Black people as well as other peoples of colour are stigmatized and disadvantaged at every turn by systemic racism. It is responsible for wealth inequality. According to StatsCan, 23.9% of Black Canadians are considered low income, compared to 12.2% of White Canadians. Gaps in higher education exist and Statistics Canada found that though 94% of Black youth aged 15 to 25 would like to obtain a bachelor’s degree, only 60% thought they could. They also have higher rates of incarceration. Indigenous people represent about 26% of those in a correctional facility, though they only account for about 3% of the national population.

First-generation Black Canadians make an average income of nearly \$37,000, compared to an average income of \$50,000 for new immigrants who are not members of a visible minority. Black Canadians are far more likely than are non-racialized Canadians and other visible minorities to be unemployed. But the income gap between Black Canadians and non-visible minorities doesn’t go away for the children or grandchildren of Black immigrants. One main reason is that teachers often treat Black children differently and, in general, Black children do not do as well as other students in the educational system largely because the curriculum is generally not geared to them. Black Canadians are nearly twice as likely as are non-racialized Canadians to be considered low-income. And Black Canadians are 20% lower in income than other visible minorities and 12.2% lower than Whites or non-visible minorities. Black Canadians are more likely to be victims of hate crimes in Canada than any other community according to data reported by police in 2018.

“The reality is that racism is expressed not just as conscious acts of hate or violence, but it’s far more complex than that. It evolves out of a set of deeply rooted systems in our country. So deeply rooted that it might be easy to miss.”¹⁷

Systemic racist systems in a settler colonial state such as Canada were put in place at the creation of the country to benefit the White colonists—while disadvantaging the Indigenous populations who had lived here for thousands of years prior to colonialism. “Taking land away from Indigenous people across all of the Americas and then bringing in free labour from Africa and enslaving Black people created wealth and opportunities for White people,” notes T. Ford, a former Toronto District School Board trustee, entrepreneur, and activist. Much of our society today continues to reinforce this power dynamic.¹⁸

For example, Canada’s federal policing system, the Royal Canadian Mounted Police, was created in order to control the Indigenous population in post-Confederation Canada. The RCMP have continued to be perpetrators of violence against Black and Indigenous people over 150 years later. It isn’t just about a few bad cops having “unconscious biases,” as RCMP Commissioner Lucki

16 Brittany Andrew-Amofah, Broadbent Institute; <https://www.chatelaine.com/living/systemic-racism-explained-faq/>

17 Andrea Davis <https://www.ctvnews.ca/canada/five-charts-that-show-what-systemic-racism-looks-like-in-canada-1.4970352>

18 <https://officialfamemagazine.com/2020/07/03/what-is-systemic-racism>

suggested before releasing a statement that acknowledged systemic racism within the police force. The very system through which the state criminalizes individuals has been racist from its inception.

In the period between the late eighties and the mid-nineties, racism in Canada received increased attention. Racial unrest in Vancouver, Toronto, Montreal, and Halifax, and the demands of racialized community members for greater participation in Canadian society were difficult to ignore. As a result, during this brief moment in time there were encouraging signs of change. Various levels of government and public-sector organizations, such as boards of education and human services and cultural organizations, developed policies and programs and modified some of their traditional practices to respond to demands for equity. Money was allocated, racialized-minority communities were consulted, and racialized people in small numbers were being hired and appointed to serve in previously all-White organizations and institutions.

A significant shift in ideology and practice occurred from about 1995 onward, however. Municipal, provincial, and federal levels of governments began to alter their anti-racism and equity policies, programs, and funding commitments. Perhaps the first and most dramatic change occurred in Ontario with the election of a neoconservative government led by Mike Harris and his common-sense revolution. Almost overnight, the provincial government brought to an abrupt end all anti-racism initiatives. Other provincial and municipal governments followed a similar strategy.

Fundamental racial inequality continues to affect the lives of racialized and Indigenous peoples in Canada. Stereotyped assumptions and practices are manifested in the workplace and the classroom. The common stereotypes of Blacks, Muslims, and other minoritized communities in the print and electronic media reinforce images of “otherness,” and contribute to the notion that the cultures of certain ethno-racial communities are more deviant and dangerous to the Canadian identity. Patterns of policing and the attitudes and behaviour of police officers and immigration officers toward minoritized communities across this country are still marked by racialized beliefs and practices, resulting in the differential treatment of particular groups, such as Black and Indigenous peoples. The schools and universities are sites of struggle and inequity for racialized students and faculty. In some areas, the justice system still fails to give fair and equal treatment to racialized and Indigenous communities. Eurocentric barriers impair the delivery of accessible and appropriate services by social and health-care agencies. The state, through its legislation and public policies, further reinforces neoliberal ideologies and practices that disadvantage racialized people.

The current COVID-19 pandemic is another example of systemic racism at work. In the United States, Black and Latinex people are dying from COVID-19 three times more often than White Americans. And while there isn't a lot of race-based data in Canada, the rates of racialized infection and deaths among racialized people are likely the same. “The pandemic exacerbates existing racial inequalities because of the systems in place, despite the fact that the virus itself doesn't discriminate by race. It's only able to discriminate because of the conditions that individuals are subjected to on a day to day basis”.¹⁹

While the attention paid to racism and inequity by various forms of government in Canada has waxed and waned over the years, there were nevertheless important legislative actions taken. These include for example, the Canadian Charter of Rights and Freedoms, the Canadian Human Rights Act, 1977, the Employment Equity act 1986. A major complaint mechanism was the establishment

¹⁹ <https://officialfamemagazine.com/2020/07/03/what-is-systemic-racism>

of the Human Rights Commissions at both the Federal and provincial level. The Canadian courts of Justice have also included racism as a defense especially in charges laid by police.

Unconscious or Aversive Racism

In addition to these factors that deal with racism in society, several newer paradigms of what racism means and how it operates have come into play. As racism has become more understood not only by people but also by the scientific disciplines that study it, overt racism has become relatively rare but covert or hidden forms of racism, often referred to as “aversive racism,” are especially prominent. Two forms require special attention. In the first instance is “unconscious bias.” Experiences of discrimination and other forms of racism can now be understood through our unconscious biases, which result from our experiences in growing up, learning, living life, meeting and interacting with people, where we unconsciously absorb biases that become part of our thinking but not necessarily our actions. Even when people think they are open-minded and fair because they do not accept or even believe in overt racist actions, they may nevertheless be influenced by their unconscious thoughts and biases. Nowhere is this more evident than in the employment arena and particularly the hiring process. In the workplace, unconscious bias may look like: a hiring process that favours applicants from developed countries with similar educational backgrounds, social activities that favor those who are able to stay late and may not have children or elders to care for, or conferences and panels without any diversity in their speaker line-up. Workplace bias may take many forms to include intolerant comments, exclusionary acts, and disparaging jokes.

Unconscious bias occurs when quick judgments and assessments are made about others and opinions are formed without conscious realization. These opinions are created during our formative years, where we learn social norms from family and friends as well as in institutions such as school and church. Diversity is multi-dimensional and is comprised of complex similarities and differences that each person possesses. These variables include, but are not limited to, race, religion, gender identity and expression, socioeconomic status, age, ability, etc.

At the institutional or systemic level is a subtler form of bias, the inherent tendency of structures and/or processes to support particular outcomes.²⁰ More specifically, this occurs when unconscious bias remains unquestioned and adopted into policy and practice, producing discriminatory practices in the operation of an organization. If unchecked, such biases contribute to inequality for many different groups, both within and outside of organizations, for example, by gender, Indigeneity, age, language, sexual orientation, geographic location, and disability. Unconscious bias can undermine the goals of equity, inclusiveness, and respect for diversity in many different organizational and institutional contexts.

White Privilege, White Supremacy, and the Power of “Whiteness”

The phrase “white privilege” was coined by Black historian W.E.B. Dubois in 1935 and later adopted by Peggy McIntosh in 1989 in an article called “White Privilege: Unpacking the Invisible Knapsack.”²¹ “White privilege refers to privilege, which puts me at an advantage,” she noted. McIntosh asked herself an important question that inspired her famous essay, “On a daily basis,

20 Auster and Prasad, Impact of gender diversity on performance appraisal. 2016 <https://www.researchgate.net/>

21 First appeared in Peace and Freedom Magazine, July/August, 1989

what do I have that I didn't earn? Our work should include asking the two looming follow-up questions: Who built that system? Who keeps it going?" She explains:

I think whites are carefully taught not to recognize white privilege, as males are taught not to recognize male privilege. So I have begun in an untutored way to ask what it is like to have white privilege. I have come to see white privilege as an invisible package of unearned assets that I can count on cashing in each day, but about which I was "meant" to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks.

She cites many examples of White privilege that we are often not even aware of: For example:

1. I can if I wish arrange to be in the company of people of my race most of the time.
2. I can avoid spending time with people whom I was trained to mistrust and who have learned to mistrust my kind or me.
3. If I should need to move, I can be pretty sure of renting or purchasing housing in an area which I can afford and in which I would want to live.
4. I can be pretty sure that my neighbours in such a location will be neutral or pleasant to me.
5. I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.
6. I can turn on the television or open to the front page of the paper and see people of my race widely represented.

"In effect White privilege means having greater access to power and resources than people of colour do in same situation."²²

One of the most examples of White privilege is the ability to accumulate wealth—a privilege created by overt, systemic racism in both the public and private sectors of society. It must also be noted that many White people do not enjoy the privileges that come with relative affluence, such as food security. Many do not experience the privileges that come with access, such as nearby hospitals. It does not assume that everything a White person does is unearned or unmerited, but rather that there is a built in advantage and what they do is assumed to be "normal." If White privilege is "having greater access to power and resources than people of color [in the same situation] do," then what is more exemplary than the access to wealth, the access to neighbourhoods, and the access to the power to segregate cities, deny loans, and perpetuate these systems?

White privilege is demonstrated in many ways aside from wealth. Whites are less likely to be interrogated by police and are seldom subject to police harassment. In general the criminal justice system treats Blacks more harshly than it does Whites. Why mention these issues in an article defining White privilege? Because the past and present context of wealth inequality serves as a perfect example of White privilege. Privilege also refers to laws that impact individuals, and many countries including our own have a history of laws that explicitly targeted racial minorities to keep them out of the country or out of neighbourhoods and deny them access to wealth and the services to which White people are entitled. White privilege defines access to wealth and the ability to perpetuate systems of discrimination.

²² Francis E. Kendall, author of *Diversity in the Classroom* and *Understanding White Privilege: Creating Pathways to Authentic Relationships Across Race*

White people become more likely to move through the world with an expectation that their needs can readily be met. People of colour move through the world knowing their needs are on the margins. White privilege was and is still being created and maintained through the power of systemic racism. Simply put, White privilege is that hidden undescribed and often unconscious sense of being able to live and experience life without harassment or discrimination because of race, colour of skin, gender, etc. Although White women experience White privilege, they have nevertheless experienced “male privilege,” which includes gender inequality.

In recent times, the term “White privilege” has gradually been turned into “White supremacy,” increasingly used in the media and the public agenda. It seems to appeal to people because it presents a more accurate way of describing today’s realities. The term was prominently used by Delgado and Bell in their pathbreaking work promoting “critical race theory” when they noted that White supremacy and racism are long standing features of American life.²³ They also described systemic and individual racism as almost secondary to the supremacy embedded in American culture. A popular Black author, Ta Nehisi Coates, wrote essays and later several books in which the notion of White supremacy was used to describe all the forms of racism experienced by Blacks in the U.S. and elsewhere. Where White supremacy was used to describe the KKK and other “hotheads” it is today recognized as a fundamental force in American society.

Poverty and Race

The relationship between poverty and race is undeniable. More racialized and Indigenous people live in conditions of poverty than do Whites and that seems to be true all over the world. Some people believe that poverty creates racism but in fact it is the other way around. The conditions of life that limit access to goods, resources, education, and power in a general sense are denied to people who are not White and as a result they are forced to live in substandard conditions. It is the racism that existed in settler societies, the racism that led to the subjugation of peoples through colonialism and the expansion of Europeans into far off places in the world, which created the conditions that still exist today. Social and often political conditions that limit access to power and resources such as education, employment, adequate housing, etc. that has created the link between poverty and racism

IV. Conclusion

The question has often been asked, how does racism play such an important role in modern democratic societies, especially those which have enshrined anti-racist legislation such as a Human Rights Codes and others. Canada is a case in point as it has such legislation and, as well, even courts of justice have recognized racism and discrimination as illegal acts. Multiculturalism, as a public policy enshrined in legislation, provides a framework for legitimizing cultural and racial diversity and for ensuring the rights of all Canadians. Yet, despite the Multiculturalism Act’s affirmation of the pluralistic nature of Canadian society, Canadians appear deeply ambivalent about the public recognition of what are deemed “other” cultures, the freedom of non-White racial and non-European cultural groups to maintain their unique identities, and the right of minorities to function in a society free of racism.

23 Derrick Bell and Richard Delgado. Critical Race Theory, 1970’ -present. https://owl.purdue.edu/owl/subject_specific_writing/writing_in_literature/literary_theory_and_schools_of_criticism/critical_race_theory.html

Canada prides itself as a fair, just, and democratic society, yet it harbours racists and racism. One reason of course is that Canada, like some other countries, has for a very long time overlooked or minimized its own history as a settler society and even as a slave holding society. Discrimination against the Indigenous populations of the country has taken and still takes many forms that government departments have, until recently, rarely acknowledged. As it became a country of growth and required more labour than its original population could supply, Canada turned to immigration but even then it preferred immigrants from European (White) countries. It was not until the points system of immigration was developed in 1967 that immigrants from other areas of the world were entitled to come to Canada. Up to that time, the racist nature of Canadian immigration was widely recognized. The points system has resulted in a greater degree of diversity and today racialized population groups make up 20% of the population; however, racism as a commanding force in this country is constantly challenged and denied by applying the arguments of democratic liberalism. In a society that espouses equality, tolerance, social harmony, and respect for individual rights, the existence of racial prejudice, discrimination, and disadvantage is difficult to acknowledge and therefore remedy. Canadians have a deep attachment to the assumptions that in a democratic society, individuals are rewarded solely on the basis of their individual merit and that no one group is singled out for discrimination. Consistent with these liberal, democratic values is the assumption that physical differences such as skin colour are irrelevant in determining one's status. Therefore, those who experience racial bias or differential treatment are considered somehow responsible for their own state, resulting in a "blame it on the victim" syndrome.

In an ironic turnaround, liberal principles such as individualism, universalism, equal opportunity, and tolerance become the language and conceptual framework through which inferiorization and exclusion are defined and defended.²⁴

Thus there is a degree of dissonance in Canadian society because of a conflict between its democratic liberalism enshrined in law, values and norms and the social consequences of racism. There is a constant and fundamental moral tension between the everyday experiences of racialized and Indigenous peoples and the perceptions of those who have the power to redefine that reality—politicians, bureaucrats, educators, judges, journalists, and the corporate elite. While lip service is paid to the need to ensure equality in a pluralistic society, most Canadian individuals, organizations, and institutions appear to be far more committed to maintaining or increasing their own power. The dissonance between its laws and norms and the lived experience of racialized and especially Black people creates a form of tension which has been termed "democratic racism,"²⁵ which defines the co-existence between democracy and racism, allowing both to flourish.

At the time of this writing, racism has come back onto the public agenda. Largely as a result of the Black Lives Matter protests, around the world, mainly attended by White people, a new consciousness has developed. The demand for anti-racist specialists and their knowledge is very great. Many corporations and institutions have added anti-racist personnel, policies, and actions to their agenda. Several universities are at the forefront of not only studying racism but attempting to put important structural changes in place. Many universities now have persons of colour in high administrative positions such as vice- presidents and provosts. Governments at all levels are funding anti-racist activities. Important changes are being studied by policing organizations that

24 E. Mackay, *Managing and Imaging Diversity*, PhD thesis, University of Sussex 1996; D. Goldberg, *The Anatomy of Racism*. University of Minnesota Press

25 Henry and Tator, *ibid* 2010

go beyond merely hiring more diverse personnel. One must wonder, however, to what extent structural change is going to be implemented, especially if it costs a great deal of money. How long will the new climate last?

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COVID-19 Among Racialized Communities: Unravelling the Factors Predictive of Infection and Adverse Outcomes

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Abstract

The COVID-19 pandemic has highlighted the potential impact of factors that enhanced disparities in health outcomes across different population groups in Canada. The opportunity exists to work closely with these communities in a timely manner to determine the factors that are most associated with COVID-19 and severe illness. Careful messaging and information sharing are important to avoid misconceptions and reduce the chances of stigmatization. This work should be accompanied by an appropriate knowledge translation strategy to ensure that the information generated is of value to the community and is shared in an appropriate manner. Introduction: The current COVID-19 pandemic is arguably the most devastating infectious illness

Introduction

The current COVID-19 pandemic is arguably the most devastating infectious illness that has affected humans since the great influenza pandemic of 1918-1919. The pandemic is caused by infection with severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2), a novel human coronavirus. Its novelty means that the human immune system would not have previously encountered it and as such, humans have no pre-existing immune defense against the virus. The SARS-CoV-2 is one of seven coronaviruses that affects humans. While some coronaviruses are responsible for common respiratory infection each year, these infections are typically mild. Prior to the advent of SARS-CoV-2, the human coronaviruses (HCoVs) that were most associated with severe illnesses were SARS-CoV-1 and the Middle East Respiratory Syndrome coronavirus (MERS-CoV).

The pandemic caused by SARS-CoV-2 has had profound consequences for all population groups around the world. While all age groups are affected by this latest coronavirus disease, known as COVID-19, in Canada approximately 90 per cent of cases occur among individuals older than 19 years of age [1]. As of October 25, 2020, Canada has had more than 215,000 cases and close to 10,000 deaths (about 5 per cent). The vast majority of cases are not associated with travel links (92 per cent), suggesting acquisition within Canada. The majority of cases (79 per cent) and deaths (93 per cent) have been reported from the provinces of Quebec and Ontario [1].

Risk factors for severe outcomes include older age, immunocompromising conditions and medical comorbidities, among other factors [2-4]. Data from the United States have shown that individuals from African-American and Hispanic populations are overrepresented in groups with poor outcomes, including hospitalizations and mortality [5]. Similarly, in the United Kingdom (UK), individuals of African ancestry have been shown to be more than twice as likely to die from COVID-19 compared with their white counterparts, even when one adjusts for some socioeconomic factors as well as comorbidities [6]. In this regard, an analysis of 3370 people admitted to intensive care units in the UK with confirmed COVID-19 found that 402 (11.9 per cent) were black, 486 (14.4 per cent) were Asian, and 2236 (66.4 per cent) were white, compared with the respective national population figures of 3.3 per cent, 7.5 per cent, and 86.0 per cent [7]. In addition, in the UK, there have been cases among children of a multisystem inflammatory disease syndrome that resembles an illness referred to as Kawasaki disease. Among this group of individuals, African-Caribbean children were overrepresented, making up six of eight children with this rare syndrome [8].

In the above context, it is clear that there are signals that would suggest that the African-American and African-UK populations may be at increased risk of adverse outcomes from COVID-19. Data have emerged in Canada to suggest that African-Canadians are disproportionately affected. In this regard, data generated by the City of Toronto show that Black people are disproportionately represented among COVID-19 cases [9]. Individuals who are most affected live in neighbourhoods with low median family incomes compared with those least affected. Families with household incomes of greater than \$150,000 per year account for 21 per cent of the city's population but only 6 per cent of COVID-19 cases. In contrast, those earning less than \$30,000 per year account for 14 per cent of the population and 27 per cent of cases. Viewed from another perspective, those earning greater than \$50,000 per year account for 70 per cent of the population and 47 per cent of COVID-19 cases while those earning less than \$50,000 yearly account for 30 per cent of the population and 53 per cent of cases.

A preliminary analysis of this data shows that racialized communities are more likely to be overrepresented among COVID-19 cases relative to their share of the population. In the Greater Toronto Area, whites account for 48 per cent of the population and 17 per cent of COVID-19 cases [9]. This is in contrast to the situation with Black people who account for 9 per cent of the population and 21 per cent of cases. Indeed, in the City of Toronto, white and East Asians are the only groups where their share of the population exceeds their share of COVID-19 cases; persons who identify as Arab, Middle Eastern, South Asian, South-East Asians and Latin Americans, are also overrepresented among COVID-19 cases.

Given the data from the U.S. and the UK, additional data relating to the Black population are warranted, particularly as this relates to the determination of risk factors for infection and adverse outcomes. In this context, while Black Canadians often reside in neighbourhoods that are most severely affected by COVID-19, the extent of penetration of the infection into the Black population is unknown. Furthermore, granular details are missing to enable the identification of those at greatest risk within the community. Consequently, data are needed to determine the extent to which Black Canadians are infected with COVID-19 and the extent to which infection is likely to be associated with potential risk factors, including medical comorbidities, socioeconomic and demographic profiles.

What is the knowledge gap and what can we do to address this?

Risk factors for illness and severe outcomes among racialized communities are yet to be determined. It is appropriate to conduct a seroprevalence study to provide insights into the infection burden and provide an opportunity for an examination of the relationship between serologic evidence of infection and various clinical and socio-demographic data. This information would also provide some evidence of the potential herd immunity within the population. Herd immunity refers to the minimum proportion of immune individuals in a population that is needed to provide protection to interrupt the spread of viral infection. Estimates of the desired herd immunity for COVID-19 vary by country with 67 per cent in the U.S. and 56 per cent in Iceland [10].

A team led by Dr. Upton Allen plans to examine the prevalence of antibodies to SARS-CoV-2 among a population of Black Canadians within specific geographic postal code zones. Reference will be made to this work at specific points in this document. The team will collect clinical as well as socio-economic and demographic data that will allow us to examine the various factors that are most likely to be associated with infection within the study cohort. In large seroprevalence studies,

it is possible to obtain data on several presumably at-risk groups, including Black Canadians. With 4.7 per cent of the population of Ontario identifying as Black Canadians [11], a study of 1000 subjects could potentially include only 47 Black Canadians. Such a number would not be adequate to provide meaningful results that allow for the examination of disease-related factors within the population. Thus, unless a concerted effort is made to enroll sufficient numbers of these individuals, the generalizability of study findings is compromised. We propose reaching out to these communities and engaging them in a manner that enhances participation. To this end, this study that targets Black Canadians is a first step toward engaging various ethnic groups. They were chosen as the first group to target due to signals that suggest increased risks of poor outcomes, coupled with great enthusiasm from community leaders to have this work done, thereby enhancing the chance of success.

How does one determine seroprevalence?

Seroprevalence relates to how common a particular infection is within a community as determined by measuring antibodies in the blood. This testing is referred to as serologic testing. There are different forms of serologic testing for SARS-CoV-2. One category of tests detect the presence of antibodies that indicate whether someone was infected with the virus. The second category of tests detect whether the antibodies that are present are able to “neutralize” the virus. They provide information on whether a person is likely to have immune protection from the virus. While there are several unanswered questions relating to how protective individuals with COVID-19 antibodies are from future episodes of COVID-19, it is likely that previous infection with the virus provides some protection from future episodes of COVID-19. Given that it is possible that these various antibodies could potentially wane over time, it is important to measure the evolution of changes over time to determine how long someone is likely to maintain protection from further episodes of COVID-19.

Serologic testing for SARS-CoV-2 continues to evolve. Early challenges included the potential for cross-reaction with antibodies to other coronavirus, including the seasonal coronaviruses mentioned above [12-17]. Because of this potential for cross reaction between SARS-CoV-2 and other human coronaviruses, extreme care needs to be taken when selecting an assay.

An alternative approach would be to use an assay that does not require a blood test (e.g., saliva). The use of saliva samples and other bodily fluids as a less invasive alternative may provide, as they have for other viral infections including HIV and measles, an alternative form of testing of SARS-CoV-2 infections [18-19]. However, in general they tend to be less sensitive. While such assays are being developed, it is unclear if they will be able to reliably detect SARS-CoV-2 antibodies at an appropriate level of sensitivity months after someone has recovered from COVID-19. Saliva antibody testing is different from saliva testing (as an alternative to nasal/nasopharyngeal swabs) for detecting active infection.

Community engagement

In order to conduct seroprevalence studies in the Black population, it is necessary to engage the community at an early stage. This is necessary for several reasons, including creating a trusting atmosphere that facilitates participation. Racialized community, including the Black population of North America, are very much aware of research studies that have been conducted in the past that took advantage of these populations resulting in ethical concerns. The communities

are sensitized as a result of these studies and as such it is necessary to be very transparent with what is proposed, how the research will be conducted, what oversight mechanisms exist to monitor the project and how the results might benefit the community. With this in mind, we have established strategies to achieve these goals. First, the research will be led by members of the Black community who have credibility in academia and the community. Second, the research must undergo scrupulous ethics review at different levels. Third, a community advisory group should be established with representation from across the socioeconomic and demographic spectrum. Fourth, the establishment of a knowledge translation strategy as outlined below.

Risk factors for infection that potentially cross racial/ethnic lines

In the process of teasing out the risk factors of COVID-19 among Black Canadians, it is important to define the factors that cross race and ethno-cultural lines. It is possible that several groups share risk factors that are associated with health disparities. These include, but are not limited to poverty and its associated factors, living conditions and types of occupation. Some individuals live in crowded environments, sometimes in multi-generational settings where there is a high risk of secondary spread of infection to vulnerable persons within the home. In some communities, there is a high proportion of individuals in particular types of jobs that put them on the front line as this relates to potential exposure to COVID-19. An example are Personal Support Workers (PSWs). During the course of our work to date, we have found that there are some PSWs who work in multiple locations in order to earn enough to support their families. In addition, it is not unusual for individuals to have multiple different types of jobs.

In the above regard, it is appropriate to not only study Black Canadians, but to define specific postal codes zones where both Black as well as other Canadians can be evaluated. This will allow for the groups to be compared in order to appreciate differences, while being able to identify risk factors that are common across the groups.

Risk factors of severe illness

A first step toward the determination of the risk factors that are associated with severe outcomes is the establishment of who is getting infected and why, as mentioned above. For example, how prevalent are potential markers of disease severity present among the population (asthma and other lung disorders, heart disorders, obesity, Sickle Cell Disease, among others)? While the full spectrum of clinical conditions that are associated with severe outcomes is yet to be determined, early on in the pandemic, the factors associated with severe influenza illness among adults and children served as a guide. Additional data would be required to tease out who among those with COVID-19 end up with worse outcomes. Thus, in addition to seroprevalence data, it would be appropriate to examine hospitalization and other data sources to get an appreciation of the markers of illness severity. For example, traditional markers of severity of respiratory infections include the need for hospitalization, length of hospital stay, admission to intensive care units (ICU), need for oxygen support and ventilation, duration of ICU stay and mortality.

Knowledge translation

If one identifies who is most at risk of COVID-19 illness and severe outcomes, what happens next? How does one ensure that the data generated are beneficial to the community studied and to society in general? Thus, knowledge translation (KT) is an important component of research.

Simply put, the findings of research should not be locked away in an academic vault that is not accessible to the participants and the public. The old adage of “from the bench to the bedside and to the community” applies. It is important for the research findings to be translated in a manner that can be shared with the community, taking into account heterogeneity within the community as this relates to sex, gender, language, age and other variables. In order to assist with this task, it is now expected that research teams collaborate with groups that have special expertise in KT. Furthermore, it is essential that the process of preparing for adequate KT starts early. To this end, in our own research we have engaged a KT group to assist us with a KT strategy at an early stage.

Data monitoring review with community input

In our own research, we have identified that a data monitoring and review framework with community input is an important component of the research. It is not uncommon for communities participating in research to ask if they can see the data at selected periods before they are released to others external to the communities. The process of data review could be coordinated with knowledge translation; however, from a practical perspective, the review group would be a smaller number of individuals representing the community. The latter brings into focus how best to determine the person(s) to best represent a particular racialized community.

Coping with misconceptions

During the course of our work so far, we have identified the need to address several misconceptions. These misconceptions are not confined to any one racial, ethnic or socioeconomic group and often relate to the origins of the virus that causes COVID-19, the relative susceptibility of different ethnic groups, the modes of acquisition and transmission of COVID-19, the role of home remedies and the most appropriate treatment and prevention strategies. While further work is needed to determine the basis and origins of misconceptions, it is important for COVID-19-related public health information to take into account misconceptions, and be messaged and delivered in a manner that is appropriately targeted to the population. An important misconception relates to the role of potential vaccines against COVID-19.

The timely arrival of deployable vaccines is essential, given the global impact of COVID-19. Achieving an appropriate level of herd immunity is of paramount importance. Current estimates suggest that the level of herd immunity that is needed to interrupt the sustained transmission of SARS-CoV-2 is at least 65 per cent. Data from the U.S. indicate that during the first wave of COVID-19 less than 10 per cent of the population developed antibodies against SARS-CoV-2 [20]. In Canada, a blood donor survey suggested that less than 1 per cent of individuals developed antibodies against SARS-CoV-2 [21]. This would suggest that there is a long road to travel on the way to herd immunity from natural infection. However, it must be appreciated that the blood donor pool of individuals might not be representative of all population groups in Canada, including those residing in areas most affected by COVID-19. It is not likely that an appropriate level of herd immunity would be achieved without a vaccine that can be deployed in a timely manner. This would suggest that vaccines will likely play an important part in controlling infection in this pandemic. With this in mind, it is important to have in place a plan that allows for the fair allocation of vaccines to those choosing to be vaccinated.

Fairness in vaccine allocation and program implementation will be important principles that will guide the deployment of COVID-19 vaccines. It would seem reasonable that individuals from

populations at the highest risk of severe outcomes should be given priority for vaccination. There are also compelling reasons to prioritize the vaccinations of others who are in essential services or who reside in homes with highly vulnerable individuals, for example. Misconceptions have resulted in confusion regarding why some groups have been mentioned as among those who may be given priority for vaccination. This has to be communicated in an appropriate and transparent manner so as not to create the impression that certain groups are being targeted as “testers” of the vaccines to see if they work before others are vaccinated. This underscores the importance of ensuring that the candidate vaccines are adequately studied in a careful and systematic manner and do not appear to be rushed. In this manner, when the vaccines are ready, an appropriate system of fair allocation can be developed to minimize misconceptions.

Due to these misconceptions as well as inconsistencies in scientific messaging, coupled with arguably some lack of transparency, it cannot be assumed that some groups would accept COVID-19 vaccines if they were available today and they were given priority for vaccination. For example, a PEW Research Center survey in the U.S. showed that among Americans, 44 per cent of Black people and 25 per cent of whites would not accept the vaccine if it were available [22]. Acceptance rates were also lower among some religious groups studied. Conspiracy theories abound as circulated through various forms of social media. Research to determine the reasons for these relatively high rates of vaccine non-acceptance needs to be given priority. Transparency in communicating the vaccine development process will go a long way in enhancing public confidence and vaccine acceptance. Non-traditional means of communicating the outcomes of safety and efficacy trials are important so that the public can be fully engaged in knowledge acquisition. Simply put, uniformly high rates of acceptance of a COVID-19 vaccine cannot be assumed across population groups, including those at high risk of severe outcomes from COVID-19.

Summary

In summary, data are warranted to determine the extent to which the Black community has been infected with SARS-CoV-2 and the granular list of risk factors associated with infection and poor outcomes. In the pursuit of these data, active community engagement is important, coupled with an appropriate knowledge translation process.

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COVID-19, Systemic Racism, Racialization and the Lives of Black People

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Abstract

As the Canadian government gears up for a second wave of the COVID-19, without a vaccine, this could mean more fatalities and poor health outcomes for many. Though there is not much to be said about the origin and treatment of this disease, there are glaring noticeable disparities among marginalized groups. People of African descent are yet again on the frontline of the disease's impact. This disease sends a national and global shockwave that triggers a plethora of financial, economical and health crises. COVID-19's glaring impact continues to unmask heightened risk factors for members of the African, Black, Indigenous and racialized communities. Historically, members of the African and Black communities are disproportionately affected. There are multiple underlying predispositions, such as overcrowding correctional facilities, underlying health conditions, inadequate access to healthcare, food, housing, employment, and employment safety. These disproportional illustrations are yet another marker of those who remain underserved and ignored. This paper presents not only a glimpse of the devastation, but the urge to act now. We provide some recommendations to address the myriad of threats and devastations to our communities caused by COVID-19.

COVID-19, Systemic Racism, Racialization and the Lives of Black People

COVID-19 has shown us that it knows more about ourselves as a society than we admit. The disproportionate effects of COVID-19 on Black, Indigenous and racialized populations is revealing in many ways. The great urgency for change lies bare at the tentacles of anti-Black racism. John Hopkins University, Coronavirus Resource Center highlights that as of October 18, 2020, there have been more than 1.1 million deaths worldwide; the U.S has the highest mortality rate at nearly 220,000 deaths and Brazil second at more than 153,000 deaths.

One in 1,125 Black Americans has died (or 88.4 deaths per 100,000), 1 in 1,375 Indigenous Americans has died (or 73.2 deaths per 100,000), and 1 in 2,450 White Americans has died (or 40.4 deaths per 100,000), according to APM Research Lab. Meanwhile, in Canada, the federal government does not collect race-based data, and only recently have some provinces, such as Ontario, started to do so. Black community groups, such as Alliance for Healthier Communities, have been rallying for race-based data collection in order to disaggregate the data not only for accountability but for the health and safety of marginalized people. It is only by clusters of COVID-19 in highly concentrated marginalized communities that we can deduce its impact. Hence, the range of data that we examine is from the U.S. Canada's failure to collect race-based data is symptomatic of an ongoing denial and complacency of anti-Black racism.

For far too long, people of African descent have been feeling the heat of systemic oppression. Undeniably, COVID-19 has taken Black lives at an alarmingly higher rate. For some, it is difficult to remain hopeful in a sea of despair. However, we have had great teachers who have cemented a greater spirit of life, a genetic marker of truth. In this, we breathe hope. A critical examination of COVID-19's impact on Black communities is an act of resistance and subversion despite anger and pain. We write as reclamation of and reparation to self. Hope and healing emanate from the truth of our experiences. We echo the public's outcry of dismay and distrust. We stand in solidarity

with the voices that ricochet from the past, scattered far and wide, whispering sweet sounds of freedom and justice. We stand in solidarity with the voices that continue to demand such. We stand with voices muzzled by dissent and popularity.

We are in perennial mourning. In Black and African communities, death has always been an event where community and family come together for support. Though resistance and resilience form a collective spirit of solidarity that binds people of African ancestry in the African Diasporas and on the continent, there are different processes of racialization. Blackness is not monolithic, and neither is oppression. Therefore, it has been absolutely heartwrenching to see the inhumane ways in which people are dying and how they are not allowed to have their families by their side to physically say their goodbyes. Thus, it is difficult for our community to not only see these deaths as something out of Darwin's "survival of the fittest" theory, but also as an expected outcome if we want economic survival. Yet, when asked, "How many lives must be sacrificed for the growth of the economy?" deflection is the answer, and, we hear, "But we cannot shut down the economy for long." Hence, there is a very vocal minority that has deeply resented being "sheltered in place." They want us to get back to normal. However, normal itself, has been the problem. We cannot go back to normal because of the deep divisions and inequalities that COVID-19 has revealed in our communities and nations.

COVID-19 shines a light on ongoing major health disparities. In the U.S, for example, the pattern that is seen for COVID-19, according to Dr. David Williams in an interview with CNN's *Global Public Square* host, Fareed Zakaria (GPS, 2020), remains the same for every major cause of death of Blacks in the U.S. for more than 100 years. This means that African Americans disproportionately die from diseases, such as heart disease, cancer, diabetes, infant mortality, and hypertension, irrespective of COVID-19. Fundamentally, there are economical, social, and epidemiological factors in health surveillance, such as the under-reporting of health conditions and inadequate access to health services that form a structural and systemic breach in identifying and disseminating information for prevention and care. These social determinants are, evidently, among a wide range of pre-existing conditions and predispositions that increase the risk of COVID-19's morbidity and mortality. However, there are variations of health predisposition and impact based on geographical regions. According to Public Health Ontario, "In Canada, Black populations have higher rates of obesity, hypertension and diabetes, as well as difficulty accessing health care, such as access to a regular doctor." Another risk factor is chronic exposure to racism (Public Health Ontario, 2020). How then can we deny the saliency of Blackness in COVID-19 when social determinants, such as race, gender, education and health services weigh heavily on an individual's health? These mask a predisposed vulnerability of Black and Indigenous people. Dei (2020), referencing the work of Johal (2005) sees Blackness as at times serving as a "pigmentary passport of punishment."

Moreover, we cannot overlook the double victimization of Black people in spaces such as prisons and work. "[Black] [women] are less likely to stop working in high-risk jobs, like caretaking in assisted living facilities, in custodial and clerical work at hospitals, or as cashiers/clerks in grocery stores" (Lindsey, 2020). The criminalization of Black males, as Gilbert et. al., 2016 illustrated, has rendered them invisible, particularly in the areas of health. The blame for poor health outcome has been shifted to Black males rather than historical, social, political, educational and institutional forces that undergird their health outcomes, such as de facto segregation and the prison industrial complex.

In the U.S., nearly one in three (32 per cent) Black males 20-29 years old is under some form of criminal justice supervision on any given day — either in prison or jail, or on probation or parole. As of 1995, one in 14 (7 per cent) adult Black males were incarcerated in prison or jail on any given day, representing a doubling of this rate from the year 1985. The 1995 figure for white males was 1 per cent. A Black male born in 1991 has a 29 per cent chance of spending time in prison at some point in his life. The figure for white males is 4 per cent, and for Hispanics, 16 per cent. Forty-nine per cent of prison inmates nationally are African American, compared to their 13 per cent share of the overall population (The Sentencing Project, a non-profit organization).

By design, social distancing in correctional facilities is a challenge. Inmates are an arm's-length away, separated by bars. In some facilities, prison guards are not allowed to wear masks. Also, some prisons do not have enough supplies. Lawrence Bartley, director of *News Inside*, calls attention to a rapidly changing rate of infection. To date, 9,436 inmates across the U.S. have tested positive. Handwashing is next to impossible. According to Bartley, inmates in a Mississippi facility share a sink with 60 people in the facility. Also, at Riker's Island, the average rate of infection is 10 times that of the regular population. In addition, the disproportionate devastation is seen in the mainstream.

In the United Kingdom, the Office for National Statistics published a study in an article in *The Guardian*. The study covered deaths in hospitals and in the community between March 2 and May 15 and found Black men had the highest mortality rate from COVID-19. Among Black men of all ages, the death rate was 256 per 100,000 people, compared with 87 deaths per 100,000 for white men. Compounding COVID-19's impact on the Black community is the police killing of unarmed Blacks. George Floyd's death captivated the world stage, prioritizing truth over fear among protestors, angered by Floyd's murder, and rightfully so. This surge of global protests marks a "new rhythm, specific to a new generation...with new language and new humanity" (Fanon, 1963). Also, Africans were targeted for deportation, eviction and reports of severe beatings in the streets of Guangzhou, China. Furthermore, "Black Brazilians live, on average, 73 years — three years less than white Brazilians — according to the 2017 National Household Survey. The U.S. has a nearly identical life expectancy gap between races" (Caldwell and de Araújo, 2020), and in Brazil, "people of colour are 62 per cent more likely to die from the virus than whites" (Genot, 2020).

Frantz Fanon admonishes us to examine the compartments of the ordering in these two specific parts, the "native world" and the "colonial world," consequently gaining insights into their key features in Black suffering (1963). Natives, by default, are always on the wrong side of the system's vulnerability. It is important to understand the potency of this vulnerability. It is a false assumption of chances and coincidences. Nothing in the "colonial world" is by chance. Its effects are orchestrated and calculated with an intended target: the marginalized natives. Case in point, elementary teachers in Ontario's Durham District School Board were mandated to provide a letter grade for students' 2019/2020 final report card that reflects assignments completed only between January 2020 and March 2020, disregarding work done prior and during remote learning. Compounding the impacts of this policy is the previous Work-to-Rule stemming from the teachers' strike in Ontario. During this period, only a semblance of a progress report was issued. Consequently, parents had no real sense of how their children had performed in school. It is even more disheartening for those children who, despite the anxiety of being locked indoors staring at a computer screen for hours, were trying to comprehend and synthesize instructions with limited face-to-face human interactions. Despite these extreme variables, they still managed

to complete and submit assignments. They now have to deal with the trauma of being told that none of that mattered. What's officially recorded is the period between January 2020 and March 2020, and nothing else. This is a great example of "spirit murdering," as Bettina Love (2019) conceptualizes it. Yes, of course, any student, regardless of race, can fall prey to this seeming technicality. However, this experience is particularly problematic for Black and Indigenous students who are disproportionately pushed out of the public school system. This process could mark the beginning of their pathologization and medicalization (Dei, 2010). It's the building of a case file that suggests they don't belong. The subliminal effects are that these racialized students are perceived to perform below grade level; therefore, the assumption is there must be an underlying issue, which usually translates to problems at home, single-parent household, learning disability, behavioural, etc. What follows is heightened surveillance. Students are monitored for lunch, yet not offered one. They are monitored for aggression but given no critical engagement through culturally relevant instructions. They are closely monitored not for improvement but defects. What's been described is not hypothetical but based on students' actual experiences. Denying students' social reality simply means upholding racism in favour of power and privilege.

COVID-19 impacts the global community, revealing deep schisms (Afful-Broni et. al., 2020). The fault lines in state and institutional responses, beginning with school systems, national/state governments, policing and law, media, etc. are clear reminders of the urgent need for a new global futurity. There are deep divisions in contemporary society that COVID-19 has exposed. Our institutions are deeply flawed in matters of social justice, equity and fairness. It should not be a daunting task to address these cleavages if we are fully committed to ideals of fairness. We cannot hide from it as these inequities cannot be simply wished away. We must acknowledge that we are in serious trouble. We are not always the "global community" we claim to be. While much is still unknown about the epidemiology of the virus, some facts are becoming clear about society as a whole. COVID-19 discriminates and feeds on the weak, disadvantaged, poor, and elderly. In Europe and North America, we see clearly that Black, African, Indigenous and racialized lives are in peril. We are disproportionately on the frontlines as health and social service workers, in the lines of sanitation, food delivery, health care and home-care. The high death rate among Black and racialized communities is clear as is what we need to do about it. Historically, the lack of health care and the racialization and feminization of poverty has put Black and African communities in the most vulnerable situations. We are among the lot in the most at-risk occupational jobs at this time of COVID-19, and among the least able to afford lockdown and social distancing. Yet we are called upon to make the ultimate sacrifices for wider society. Social/physical distancing taught some lessons. Just watch how the Black body can be avoided on the street as we walk along the same path. We live that experience, and we know what we are talking about. These are hard truths, and no intellectualizing the truth will make it palatable to the ears.

Recommendations

- Racism is a bigger issue than the COVID-19 pandemic. We recommend a multipronged approach to fighting anti-Black racism in Canada that focuses attention on every sector of society: health, education, law and justice, employment, transportation, housing, etc.
- The pursuit of a national health equity response to the pandemic is significant. This requires doubling educational efforts around anti-Black racism initiatives within all state institutions.

- The government mandates the collection of race-based data on health and disease throughout all major health networks in Canada.
- The state commits substantial funding to assist Black and Indigenous communities/ populations disproportionately affected by COVID-19.
- Set up a health advisory group on Black and Indigenous health funding for research on diabetes, hypertension and heart disease, which disproportionately affect Black and Indigenous peoples.
- Research needs to be supported and directed to learn how Black and Indigenous communities understand COVID-19's impact, and how these communities are teaching their children about health and racism.
- Steps must be put in place as to how a future vaccine for COVID-19 will be administered to ensure that Black and Indigenous populations are not further marginalized in the distribution of COVID-19 vaccines.
- State direct resources must be implemented. For example, economic subsidies, mental health and healing, etc. must be implemented to alleviate the economic, social and emotional impacts of COVID-19 on Black and Indigenous communities.
- Ensure the Black and Indigenous communities are well represented at the table of high-level decision-making planning and policy-making affecting Black and Indigenous community health.
- COVID-19 has also revealed differential access to technology and other educational resources that have been put in place to mitigate the impact of shelter, etc., for learning. Plans should be devised to ensure that such lessons are learned and to address the different impact of access to technology and communication on Black and Indigenous communities, e.g., school laptops.
- Develop strategies to combat the anonymity of intensifying online hate that affects Black and Indigenous communities.

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Black Immigrants: Oscillating Between COVID-19 and Dead Silence

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Abstract

Black immigrants in Canada, I am arguing, are one of the most effected groups with COVID-19. Yet, one has to create magic to reach this conclusion. The lack of aggregated data is a shame of the Nation. The lack of interest is a strong message, I am concluding, that these groups do not matter. This is true in Québec as in the rest of Canada. In the end, I offer some policy indications attempting to address this lack of aggregated data and looking into the future.

The presence of Blackness in Canada seems to haunt the nation. It makes visible how the nation imagines itself as an umbrella of whiteness and as such, Blackness as a unidimensional, unnuanced and uncomplicated category that belongs somewhere else, outside the socius of the nation. This is true whether you are in English-speaking or French-speaking Canada and whether you are a Canadian-born Black or a Black immigrant.

When a nation decides that, in a midst of a pandemic, it does not want to verify who is (most) affected by COVID-19, it is sending a strong signal that the said group does not matter. Here, a major lesson we have learned from the field of sociology is that intentions in moments like these matter less; their final effects matter more. *Toronto Star* reporter Alex Boyd (2020)¹ writes, "Despite a growing awareness in the United States that some minority groups might be at higher risk for the coronavirus, provincial health officials in two of Canada's hardest hit provinces [Ontario and Alberta] say race-based data isn't needed here [in Canada] yet." Dr. David Williams, Ontario's chief medical officer of health, contended that race-based statistics "are not collected in Canada unless certain groups are found to have risk factors." But how do we determine that risk factor if we do not have data and what is that risk factor to begin with? "Right now we consider our main risk groups (to be) the elderly, those with other co-morbidities, regardless of what race they are," Williams said. "Regardless of race, ethnic or other backgrounds, they're all equally important to us." (Boyd, 2020, n.p.).

In the absence of data, as specialists and academics who want to suggest informed policies, we have to aggregate our own data, deduct from an existing data and/or second-guess. This was the case with researchers Choi, Zajacova, Haan and Denice (2020)² from Ontario's Western University. Even though their study does not focus on Black immigrants, it is significant for my argument. The researchers began their study with two premises: the first was anecdotal and the second built on the first, writing, "Anecdotal stories about the COVID-19 pandemic suggest that Black, racialized and immigrant people in Canada have been disproportionately affected by COVID-19." This is because immigrants — Blacks or otherwise — "are pushed to the front lines of the economy, working in settings with greater exposure to the COVID-19 virus." In situations like these one has no choice but to draw on other nations (UK and U.S.)³ that collect race-based data.

In the U.S., Black communities (Black immigrants included) have been disproportionately affected by COVID-19 so Choi *et al.*⁴ asked: is the situation different in Canada? To answer their question, to their surprise, the researchers came to realize that racial minorities and immigrants (including Black immigrants) have been excluded from the list of populations vulnerable to COVID-19. By combining COVID-19 and census data, the researchers made "creative use of health and census data" only to conclude "that Black and immigrant communities in Canada are disproportionately

affected by COVID-19. ... Our findings showed COVID-19 infection rates are significantly higher in health regions with a higher percentage of Black residents," Choi et al. write. "A one percentage point increase in the share of Black residents in a health region is associated with the doubling of coronavirus infection rates. We also found that a one percentage point increase in the share of foreign-born residents is associated with a three-per-cent rise in COVID-19 infection rates" (n.p.).

This is especially true in cities like Montreal, Vancouver, Hamilton and Toronto where the researchers observed two things. First, the notable presence of Black residents and second, the majority of these Black residents are recent immigrants. Choi et al. (2020) offered two examples from two different parts of Canada. The first example is from the oilsands of Alberta where the petroleum industry hire large numbers of Black immigrants (among others) with close proximity between employees, a major factor in the spread of the coronavirus (see Bouka & Bouka, 2020⁵, for the situation of Black immigrants in meat plants in Alberta). The second example is from western Québec where the mining industry does the same with Black immigrants (among others). Again because of close proximity, the workers in these mines in Québec were disproportionately affected by COVID-19.

The Story of Marcelin François: Does it have to end this way?

Besides the mines, Québec has another COVID-19 hotspot where Black immigrants are disproportionately affected. Mostly in the Greater Montreal area and mostly in long-term care facilities, health-care workers are mostly Black immigrants. Indeed, these Black immigrants put themselves at risk by caring for others at the height of the coronavirus so much so that the government of Canada granted them permanent residency (CBC, 2020).⁶ In conducting a meta-analysis of the coronavirus situation in Québec, Bouka and Bouka (2020) concluded, "In Quebec, disparities in COVID-19 infection rates are shaped by the intersection of race, gender, immigration, labour, and public health. Health care workers account for 20 percent of infections, and in the hard-hit Greater Montreal area, up to 80 percent of the aides in long-term care facilities are racialized women, mostly Black and Maghrebi. Industries of care are feminized and undervalued despite being critical to preserving the health and safety of the population" (n.p.).⁷

Though most long-term health care workers are women, I want to tell the story of Marcelin François for two reasons — it epitomizes the Black immigrant struggle during COVID-19 in Canada with its brutally dehumanizing nature and for its policy implications.

Fleeing the aggressive anti-immigration policies by the Trump administration, within two or three months, 18,000 asylum seekers mostly from Haiti crossed the border from the U.S. into Québec (NPR, 2018).⁸ One of these asylum seekers was Marcelin François. *La Presse* reports that he was 40 years old — a husband and a father of three young children — working in a textile factory during the week and in long-term care facilities on the weekend (Boisvert, 2020).⁹ Because François was working under the table in the long-term care facilities, there was no employment record of him working at any of them. François was status-less. He applied for asylum and was denied. His final chance was based on a humanitarian appeal, and he was waiting for that appeal.

His wife, Oséna Charles, tells *La Presse* "Il n'était pas malade. Il ne faisait pas de fièvre. Il toussait" [He was not sick. He didn't have fever. He coughed]. One morning, Charles explains, François simply laid on the couch. He cried and said, "Je vais mourir... je vais laisser les enfants" [I am going to die... I am going to leave the kids]. Charles did not think he looked sick so she returned to bed. She woke to him crying for their 11-year-old son to call 911. Before the ambulance arrived,

François passed away in Charles's arms. The family was quarantined. Two days later, Charles received a phone call indicating that François's case was "80% not coronavirus." The following day, another call confirmed that the cause of his death was, in fact, coronavirus. François died on April 14, yet Charles still does not know his burial location. And, she remains at-risk because she too works in Chez Cargill, a meat-processing plant with close proximity between workers and high cases of COVID-19 (Boisvert, 2020).

Oséna Charles does not need prayer to avoid infection with the coronavirus, she needs to have legal status in Canada (if only on a humanitarian basis), and she needs an informed policy on how to deal with COVID-19. To have such an informed policy, a number of changes are needed:

1. Canada needs disaggregate data on COVID-19 and race. This will allow for an honest look at who is most affected by COVID-19. It is disingenuous and flawed to depend on another nation's numbers (e.g., U.S.¹⁰ and U.K.) and try to guess whether we are similar to them or not. Canada is not the U.S., it has its own particularity and all policies have to be informed by this particularity.
2. We know that not all racial groups are affected equally, which should inform how we analyze and draw conclusions from race-based data.
3. Race does not stand alone so it should be intersected with gender, social class, language competency, settlement and health (among others).
4. We need longitudinal studies — ones where we locate ourselves in time (living in this moment where neutrality is not an option and white fragility should be put aside in favour of a hard, honest conversation) and space/location (being in Canada, which region, etc.).
5. Legal status matters, especially when it comes to Black immigrants. In the U.S., as an example, Black immigrants are disproportionately not only affected by COVID-19, but overrepresented in deportation (NPR, 2020)¹¹.
6. English Canada is no different than French Canada when it comes to the disproportionate rate of COVID-19 in Black communities. Bouka and Bouka (2020)¹² found exactly the same situation of the meat-processing plants and their conditions in Québec as well as in Alberta. In May 2020, employees at the JBS meat-packaging plant in Brooks, Alberta, which employs many South Asian and South African immigrants, constituted 26 per cent of Alberta's active COVID-19 cases. Carpooling, crowded living conditions, lack of oversight and prioritizing profit over safety are identified as primary reasons for the outbreak in one of the highest rates of coronavirus-affected areas in Canada. Temporary workers, mostly Black Caribbeans, are as affected by the virus as Black immigrants. These issues call for government policy and oversight; they should not be left to the private sector. Also, the points raised herein remind us of the need for disaggregate data broken down by many factors, one of which is race and immigration.
7. Bouka and Bouka (2020) ask, "Why do Canadians tolerate these types of working conditions that can become public health issues during a crisis like COVID-19? Is it because of who is overrepresented in these fields: female, racialized, and immigrant workers who struggle to get substantive political representation?" (n.p.). These questions remind us of the need to define who, how and why someone is considered an "essential worker." We need a clear policy on the obligation of the state toward these essential workers, among whom Blacks/ Black immigrants are overrepresented and disproportionately affected by COVID-19.

8. The last two policy points also relate to disaggregate data and are suggested by Bouka and Bouka, whose work is one of the most comprehensive when it comes to the intersection of Black immigrants and COVID-19. They write: "Provincial healthcare professionals need to pay as much attention to collecting data on race and immigration profiles as they do in collecting data on gender, education, and income. This data needs to feed into national environmental population surveys that will allow public health officers to tie specific demographic markers to health status over time. It will paint a clearer picture of social, economic, and health disparities between various communities and point to needed improvements and progress. This will also enable provincial health officials to identify variations and gaps between federal and provincial jurisdictions. For example, while refugees are resettled and supported by the federal government, their access to health services is the responsibility of the provinces" (n.p.).
9. Bouka and Bouka continue: "this data should then be the starting point for engagement between public health officers, immigration and labour policy-makers, and relevant stakeholders from relevant industries. Together, they can help develop more robust social and labour protection for racial minorities, newcomers and migrants. We need to be invested in the health and work conditions of racialized and immigrant populations in Canada, not only because, as COVID-19 has demonstrated, safety for them means safety for all, but most importantly because this is what this country says it stands for" (n.p.)¹³.

Though I focused on the broad category of Black immigrants, we need not lose sight that within that group, gender, age, sexuality, (dis)ability, social class and education (among other social demographics) all play a factor in is the Black immigrant experience. As we move forward, the intersection of women, youth,¹⁴ LGBTQ and working class should never leave our analysis as we make sense of how Black immigrants are affected and/or experience COVID-19. Only then can we think about Blackness as a multidimensional¹⁵, multicultural¹⁶, multilingual, complicated and with multiple entry points category. Yet, our starting point in this analysis has to acknowledge the challenge of Black immigrants and their vulnerability to COVID-19¹⁷; and that the story of Marcelin François should never have been allowed to happen, especially not in a capable place like Canada.

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Racial Inequity, COVID-19 And The Education Of Black And Other Marginalized Students

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Abstract

COVID-19 is functioning to exacerbate inequities not only on the health (especially mental health) of racialized students but also on their educational, social, and recreational lives. I argue that it is important to give attention to how the coronavirus and racism align in order to address the disparities in schooling and education for these students – noting their access to food, academic supports, physical contact with educators, and computers, online and reliable internet. I conclude by suggesting that the current context presents an opportunity to reimagine schooling and education that is accessible and responsive to all students and parents especially those for whom existing policies, programs, curricula and practices have silenced their voices, stifled their potential, and limited their successes.

Black community members, parents and students have long protested the inequities that have contributed to the social and educational conditions in which they find themselves. Today, the Novel Coronavirus, COVID-19, has added yet another layer of complexity to their problems in society. In fact, the pandemic has not only added to the social and educational inequities among young people, it has exacerbated the racial injustice with which racialized and Indigenous youth must contend. In a *Globe and Mail* article (September 6, 2020) on “How race, income and ‘opportunity hoarding’ will shape Canada’s back-to-school season,” education reporters Dakshana Bascaramurty and Caroline Alfonso write, “Before the pandemic forced a crisis in the education system, many school boards had committed to addressing systemic racism and inequity by re-evaluating programs, such as French immersion (which attracts a higher proportion of affluent, white students) and streaming (which routinely put Black children on a path to applied courses, which limit their options after graduation), that have disadvantaged students from low-income and racialized communities. Now with educators focused on the basics of opening schools, reimagining the system seems impractical, if not impossible.”

So, it is understandable that racialized parents would ask the question that was put to *Toronto Star* columnist Amira Elghawaby (September 8, 2020), “how do we best help our children, who are now going through two different types of stress and anxiety?”

Our concern here is with the sources of stress and anxiety of racialized students, which has exacerbated the institutional inequities they encounter as they journey through schooling at a time of crisis in health and well-being. In addressing this situation, we must scrutinize how institutional policies, programs and practices serve to sustain the educational, health and social systems of Black, Indigenous and other racialized youth.

Setting the Context: The lives of Black and other racialized youth in Canada

The 2016 census of Canada indicated that children under 15 years old represented 26.6 per cent of the Black population while only 16.9 per cent of the Canadian population were in that age group (*Statistics Canada*, February 2019; see also Houle, 2020). That slightly more than one-

quarter of the Black population is being schooled at this time means that COVID-19 is not merely having a major long-term effect on the schooling and education of Black students, but also on the social, economic and political welfare of Black communities, and by extension, Canadian society as a whole (James, 2019/2020). The situation of Black students at the Toronto District School Board (TDSB), Canada's largest school board (and the only board that provides relevant data), serves as a useful reference. According to that board's data, Black students make up about 12 per cent of high school students; however, they were more likely to be overrepresented in the lowest level of educational programs (including special education) and less likely to pursue postsecondary studies. Those who did, more often chose to attend college. Much of this has to do with teachers' low expectations, the streaming of students into non-academic programs, more punitive disciplinary practices toward Black students, and the absence of Black, Indigenous and other racialized people in class materials and curriculum. Black students were also suspended and expelled from school, and dropped out at higher rates than other students (James & Turner 2017; Szekely & Pessian, 2015).

A recent investigation of the situation of Black students in the Peel District School Board (PDSB), Canada's second largest school board, produced similar findings. In their report *"Final Report: Review of the Peel District School Board"*, the Ontario government commissioners expressed what they considered to be a "consistent failure" of the school board to address "the poor outcomes of too many of our Black children" (Chadha, Herbert, & Richard, 2020, p. 7). In Nova Scotia, home to most of the oldest Black communities in Canada, studies have reported on the long years of students grappling with the "adversity of racism" (Mackey, 2018). In speaking to the detrimental impact of racism on Black students' learning and their overall life trajectories in Edmonton, Alberta, Henry Codjoe (2001) surmised that race is not merely a contributor, but in many cases, a major, if not sole, determinant of their inadequate educational outcomes as well as their emotional well-being and mental health (see also Patel 2015).

How COVID-19 exacerbates educational inequities among racialized students

Added to the educational issues with which Black youth have to contend, is the impact of COVID-19 on their health, social and educational lives. Reporting on the how the disease disproportionately affects marginalized communities, reporters Bascaramurty and Alfonso (2020) referenced one located northwest of downtown Toronto "which has become the epicentre for COVID-19 infections." They report that it is a community where "many students live in cramped housing, have parents who are essential workers and rely on public transit to get around, all things that contribute to the high infection rate – which is 10 times that of the least-infected parts of the city. The average annual income for residents in the area is \$27,984 – half of what it is for Toronto as a whole." The high school in this community is said to have "the largest Black student population in the country."

In Toronto, Public Health data shows that while Black people make up 9 per cent of the population, they account for 21 per cent of COVID-19 cases (FR24News, July 31, 2020; also see the essays by Allen; Henry; and McKenzie in this volume). Contributing to the high incidence of the disease are inequities related to, among other factors, socioeconomic status and place of residence. Relatedly, the risk of virus transmission has to do with individuals' living situation (apartment housing, residing with elderly relatives), type of employment (of parents and youth if working), the schooling context (number of students in classes), state of health (pre-existing illness, e.g.,

asthma), and education delivery method (in person or online) — all of which have implications for the students' education (see Khunti, Singh, Pareek, & Hanif, 2020; Egede & Walker, 2020). The point is, COVID-19 serves to exacerbate the inseparable systems of embedded inequities — of which education is a major foundational pillar — thereby adding to the problems of those most vulnerable to its effects in educational, social, economic and other areas. In any event, ignoring racial inequities and not attending to how the coronavirus and racism align, noting their specific effects on particular racial groups, will not produce the outcomes needed. As Gaynor and Wilson (2020) proffer, racism is itself a rampant epidemic which restricts individuals' airflow, stifles their ability to breathe and move freely, and constricts their health and productive life.

Issues of inequity: Nutrition, academic supports, mental health, and online learning

It is understandable that school closures have the greatest impact on students living in poverty, particularly in terms of access to food, academic supports, mental health and schooling arrangements..

Access to nutrition: For some students, attending school means not only engaging in learning, but getting at least one meal. Hence, school closures for these students contribute to lack of access to nutritious meals and hunger (Miller, 2020). The absence of meal programs on which some low-income students depend will contribute to their lowered attention to and motivation for learning or a lowered capacity to engage in a productive education process (Gaynor & Wilson, 2020). Indeed, a nutritious diet is integral to one's ability to learn, therefore a lack of much-needed nutrients will likely further disadvantage poor racialized students, who are already academically behind their peers. Bascaramurty and Alfonso (2020) reference a Toronto educational advocate in the Latinx community saying "she worries about the way children from low-income neighbourhoods will fall behind this year if they are educated at home: They'll be less engaged, it will be more difficult for them to finish their homework and, crucially, many will miss out on all the non-academic parts of school that keep low-income communities afloat, such as breakfast and lunch programs."

Inadequate academic support: Studies have long shown that breaks from school are notorious for widening achievement gaps. For instance, gaps in mathematical and literacy skills between children from lower and higher socioeconomic backgrounds often widens during vacation periods from school (Parolin and Lancker, 2020). These gaps tend to be a result of low-income families inability to afford supplementary academic or extracurricular programs that could contribute to their children's intellectual development while away from school. So being out of school and accessing fewer hours of learning, and/or engaging in learning through a methodology, curriculum and pedagogy (online and/or in person) that disaffirms their needs, interests and ambitions could further these students' lowered school participation, academic performance and educational outcome.

The fact that a significant proportion of Black and other racialized people tend to be precariously employed as essential and frontline workers means that having to work is a must, for otherwise they would have no income (Gaynor, & Wilson, 2020). Some Toronto low-income parents see this situation as forcing them "to choose between their health and their kid's education" (Yang & Kennedy, 2020). For some parents, such choice "comes at a steep price" since to properly support their children's learning at home means being able to help with curricula materials as well as the needed equipment for remote learning — something that "working from home" and/or affluent parents are able to do in addition to providing their children with "learning pods" (see

Bascaramurty & Alfonso, 2020). The fact is, accessibility to extra academic and extracurricular support (especially for grade nine students who were transferred, and not promoted, into high school) is important to helping students continue with or maintain their learning so they meet the expected educational level; and in doing so, realize good mental health and emotional well-being.

Mental health and social distancing: Further to the point of mental health concerns of students, is the awareness that being out of school and isolated from friends have heightened the deleterious effects of COVID-19 and coping efforts (Parolin & Lancker, 2020). In a national survey of “what Canadians are reporting about their mental health and substance use during the pandemic,” the Centre for Addiction and Mental Health (CAMH) found that from May to July 2020, about one-quarter of people between 18 and 39, reported experiencing anxiety, and feeling lonely and depressed during that period; and about 30 to 32 per cent were engaging in binge drinking, a practice that went down 5 per cent in June. And adults with children in the home, tended to have higher levels of anxiety and depression, typically in the range of 25 to 30 per cent which lessened in June and increased in July. Adults without children in the home had lower levels of anxiety and depression. While the data does not show racial differences, we can surmise that given systemic inequity, Black Canadians, for example, likely experience higher levels of anxiety and depression insofar as they have to cope with anti-Black racism as an additional mental health stressor.

After months of physical distancing, social separating, and in some cases, self-isolation, many parents (like their children) are becoming increasingly concerned with their children’s education and mental health. In their article about the experiences of low-income parents who reside in an area of Toronto that is “hardest hit” by COVID-19, Yang and Kennedy (September 12, 2020) write that for one Black single mother of two children, “remote learning in the spring was manageable for her 17-year old son, but a nightmare . . . for her eight-year old daughter who she tried to keep on track while also working.” The reporters indicated that poor internet connections and “late nights prepping for next day lesson plans” caused this parent to discontinue her daughter’s schooling saying, “it was causing high amounts of stress in the household.” Concerned that her children might academically and socially fall behind their peers, she added: “I am worried for my mental health (and) my kids’ mental health” (p. A20). The reality is that a student’s psychological condition plays an incalculable role in their learning process and has long-lasting effects on their social well-being, particularly for those more vulnerable. Moreover, in the absence of the socialization and sensory feature of in-person schooling, students are likely to experience critical loss in peer-to-peer learning opportunities, teacher to student instructions, having little to no physical activities, and not being able to socialize with friends at lunch and/or on sport teams — all of which are important to their emotional and social development (Bhamani, Makhdoom, Bharuchi, Ali, Kaleem, & Ahmed, 2020).

Remote learning, online schooling, and in-person teaching: As September 2020 approached for students to return to school, parents and their children had to decide between online and in-class teaching-learning arrangements --t formats was vastly different from what teachers were used to, hence especially problematic since teachers were never prepared to teach as required in today’s schooling context (Bhamani, Makhdoom, Bharuchi, Ali, Kaleem & Ahmed, 2020). American studies have shown that teachers consistently reported that they were unprepared to teach online; were working less hours (7 versus 9) per day; and taught less new “standard-aligned material” to their students; and students were increasingly disengaged from learning (a significant percentage of

them did not even log in, or make contact with the teacher). These issues were especially evident in high-poverty, urban schools (Herold & Yettick, 2020). According to Middleton (2020):

Classroom assessment, teaching and learning, and measurement and interpretation of student growth are among the numerous areas that have been affected by the sudden switch of schools to online instruction that will require much thought in order to examine the impact of the significant deviation from the classroom norms There are many unknowns that remain as schools plan to move forward with instruction (p. 41).

He also makes the point that deviation from usual classroom instruction practices have created “additional variance in test scores so the ability to compare the same student’s test performance relative to others across last year and this year will be problematic” (Middleton, 2020, p. 42).

Explaining the cost, such as tiredness, anxiety or worry, resulting from communicating or learning through Zoom, Brenda Wiederhold (2020) writes that technology is disrupting “our normal intricate human communication methods that have been finely tuned over centuries to help humans survive.” And having relied on “vocalizations, gestures, and movements” (and not just a person’s face as on zoom) to communicate means that individuals are now lacking access to many of the nonverbal cues of the whole body, hence they have to work harder to try and overcome whatever differences exist between themselves and the communicator, and in doing so, understand what is being communicated in their interactions. “So, there is an element of mental exertion and performance involved with online communication that can be taxing.” Wiederhold refers to this as “zoom fatigue” (p. 437; see also Noonoo, 2020).

Clearly, students without the language, and the social and cultural capital of the school (as represented through the teacher) -- for instance, lower income and racialized students (and those with disabilities like autism) — will have to work harder to pick up on the subtitles, nuances and slight delays (or nonsynchronous) expressions of teachers (and their peers if they show their faces on screen). It is understandable why such students would be less engaged and counted among those most likely to be truant. Yang and Kennedy (2020) mention that some of the Toronto teachers they interviewed for their newspaper article “watched helplessly as certain students simply disappeared” and in the case of one elementary teacher, “she lost touch with nearly half of her students.” One high school teacher is quoted as saying, “there were some students, no matter how hard we tried, we were unable to reach them.” A grade three teacher who “lost touch” with one of her students emailed the parent, stating: “All I knew is the last email I sent was to let them know I was thinking about their child, and I wish them well” (p. A20). Therefore, in the current context with lack of access to learning materials, quiet spaces, computers or tablets, and reliable internet, students in low-income families, particularly Black and other racialized students, will struggle to keep up with their learning.

Many might think that online learning allows for equal opportunities and reduces inequities; but it is not the case. Rather, it operates as an extension of an inherently disadvantageous system that further exacerbates the conditions in which social and cultural hierarchies are entrenched, and racial diversity as a value obfuscated or minimized. Based on her research on the “promise of e-learning in the Toronto District School Board,” Farhadi concludes that the approach to e-learning is premised on a “meritocratic political philosophy” in which students’ differences are obviated; course content is delivered “as one-size-fits-all across a diverse range of learners;” and contradictory assessment practices conflate “mastery and feedback with quantifiable outcomes—

or grades” (p. 187). Whereas before COVID-19, teachers might have accessed students’ Ontario Student Record (OSR) and/or their Individual Education Plan (IEP) to familiarize themselves with the students’ needs, concerns, interests and expectations, the onset of remote and online learning makes that no longer possible. And rightly so since in this new schooling context, new protocols to protect the privacy and security of students must be developed.

Where do we go from here? An opportunity to imagine education differently

Given the schooling and education issues we are forced to confront today, we should concede that while schooling might have worked for some, for others—particularly Black, Indigenous and other racialized students and parents—schooling has not been working. As such, the current context presents an opportunity to reimagine schooling and education that is accessible and responsive to all students and parents especially those for whom existing policies, programs, curricula and practices have silenced their voices, stifled their potential, and limited their successes. It is imperative that, as we contemplate a program of education that will best serve the needs and interests of *all* students and parents, it is important to give special attention to racialized low-income people whom the systems of education have consistently failed (Cote-Meek, 2014; Farhadi, 2019; James & Turner, 2017, Shah & Shaker, 2020).

Whatever happens to racialized students is never solely of their own or their parents’ making, but involves individuals charged with providing an education that will make them productive citizens of the society as well as institutions (political, economic, social, cultural, media, child welfare, judicial) that wittingly and/or unwittingly, sustain a system that pathologizes, instead of better preparing them for productive lives as adults. We must build a schooling and education system that values, and hence serves, Black, Indigenous, other racialized and low-income students and families on the basis of their lived experiences, just as it does for white and affluent students. Doing so will benefit all of society since we will not see such failed citizens in remedial classes, employment insurance offices, hospital emergencies, healthcare facilities, police cruisers, courts of justice, and correctional institutions.

Recommendations

1. Education policies, programs and practices, at school, board and provincial levels, must be assessed to ascertain the ways in which they help to maintain schooling structures that keep racism in place and operate as barriers, such as streaming, transfer instead of student promotion, disciplinary protocols suspensions and expulsion, to the educational participation, performance and outcomes of racialized students.
2. Schools should create accessible partnership programs with universities, community and other neighbourhood agencies. These wrap-around programs should be stable and supportive as well as culturally relevant and responsive to students’ needs and interests, especially those of racialized students.
3. In the period of COVID-19, provide information to students and their families in order to enable easy access to health-care services. Rather than merely mitigating social risk, special accessible social and recreational programs should be established to support structural interventions that will help students and families cope with the current uncertainty in education.

4. School curricula should incorporate relevant curated online courses in which the academic goals also take into account the psychosocial aspects of students' lives.
5. Parents must be seen as partners in the educational process of students and should be informed of their children's educational programs, and how they might support their children not expecting them to be their children's teachers. Further, during the time of COVID-19, educators must ensure that parents are fully informed about the best schooling program for their children (online or in-school) so they are able to make informed choices and decisions to maximize their children's learning.
6. Teachers must be more invested in making their lessons, in terms of curricula content and pedagogy, accessible to all of their students especially those whom have been identified as in greatest need of social and educational supports.
7. School boards should periodically collect data pertaining to the online attendance, educational participation, academic performance, and learning assessments of students. Working with, and interpretation of, such data should include researchers with relevant lived experiences.
8. Teachers must be provided with the appropriate education, training and support on various online software equipment, programs, and resources; and they must ensure that the online platforms which they use are both materially and academically accessible and available to all learners.
9. Education workers teachers, principals, teaching assistants, support workers, and guidance counsellors with the support of social workers — must become informed about the specificity of the mental health and social well-being concerns of racialized students, and be able to help address students' questions, worries, and anxieties.

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COVID-19 Effect on Black Communities in Quebec

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Abstract

This article examines the effects of COVID-19 on Black communities in the context of Quebec, where colour-evasiveness prevails. Since the social status of race and the history of Black populations are consistently marginalized in this province, anti-Black racism is not understood, recognized, or addressed adequately. COVID-19 has exacerbated existing inequalities concerning diverse Black communities in Quebec and has affected them disproportionately. Yet, the absence of race-based data and the pervasiveness of color-evasiveness, hinder a comprehensive study of its effects. We argue that social class and migration status allow for an insufficient understanding of Black peoples' experiences and that race must be acknowledged as a singular form of stratification. We advocate for the collection of race-based data to detect and address discrepancies and persistent barriers. Like the United Nations Human Rights Council (2017), we underscore the necessity of taking action to uphold the human rights of people of African descent, including addressing the virus of racism

COVID-19 Effect on Black Communities in Quebec

It is both timely and telling that the advent of COVID-19 falls at the midpoint of the International Decade for People of African Descent (2015-2024) proclaimed by the United Nations. As the organization is "deeply concerned by the structural racism that lies at the core of many Canadian institutions and the systemic anti-Black racism that continues to have a negative impact on the human rights situation of African Canadians"¹, we consider COVID-19 as an important opportunity to deepen our understanding of how race and racism, impact the way an epidemic affects Black communities. In contrast to the rest of Canada, Quebec provides a unique vantage point to examine this issue given its position as a French-speaking majority at a provincial level, yet a linguistic minority on a national level. As such, it is relevant to discuss race, not as a biologically defined concept, but as a socio-historically constructed social category², in order to ascertain how diverse Black communities in Quebec have been deeply affected by COVID-19.

While Quebec is part of a larger global dynamic, its socio-political and historical relationships with and within the rest of North America help us understand the process and dynamics that involve Black communities in contemporary society. As co-colonizers of what is modern-day Quebec, the descendants of French settlers have largely defined themselves as a dominated and exploited minority, under the threat of losing their language and culture, since the British conquest of the late 18th century. After decades of English dominance, the 1960's marked the beginning of French nationalism – while Indigenous communities remained marginalized at both provincial and federal levels, Quebecois settlers took their place as the demographic, linguistic and sociological majority, and established their political power and influence over their own development and governance. This period can be largely associated with the expansion of influential labour movements that sought to raise class consciousness, among which various union groups and activists defended the rights of the working class. As highlighted by Weber³, in addition to social class, social status is also a form of social stratification that shapes the distribution of power in society.. Hence, grassroots and community organizations have brought attention to inequality based on Indigeneity, gender,

sexuality, language, disability, age, migration status, religion, etc. For instance, Quebec feminist movements have pushed forward gender equality, and Francophone advocates have mobilized in the interest of the survival of the French language. We contend that it is relevant to engage in an analysis of the social status of race to further the study of social stratification in Quebec. Grasping that race and racism are non-essentialist relational constructs that vary according to social-historical and political contexts, and understanding that they are not secondary or complementary to gender or class based inequality⁴ is paramount to situating Black people's experiences of COVID-19.

Since race was an integral part of Nazi ideology and is still part of Klux Klux Klan's justification of racist violence, for some observers, race and racism are automatically equated to doing similar harm as these extremist political groups. This equation hinders an understanding of how race structures inequality as it exclusively focuses on intentional, overt and violent actions from individuals belonging to fanatical groups with a specific ideology. Because science has invalidated biological explanations of race by demonstrating that racial distinctions are not genetically discrete, reliably measurable, nor meaningful⁵, the concept has been categorically expelled from the domains of French sociology as an object of analysis. Its study mobilizes a range of euphemisms to avoid the use of the word race, such as ethnic group, culture, national origin, or visible minority⁶. In this light, many people in Quebec have been taught that it is better to ignore racial difference. This colour evasive approach⁷ is based on the claim that it is better to recognize everyone's humanity. Yet, race as a socio-historically constructed category continues to spew real negative consequences in society. Colour-evasiveness inadvertently reinforces a linear causality logic inference between acknowledging racial differences and potential discrimination, conflict, and assumptions of inherent hierarchies. This particular form of racism is actually the best way to ignore and subtly perpetuate injustice on the basis of race by referring to non-racial dynamics to explain racial inequality⁸. The existence of racism cannot be negated or minimized because of an intense wish of dissociation from publicly condemned extremist groups and historical events. If we do not name and analyze race and racism from multiple theoretical lenses, we are unable to address the ways they have and continue to structure inequality in various contexts in everyday life⁹, including the health sector. In several contexts, recognizing difference operates as a positive means of highlighting the specificity, the contribution, and the equal status of a group. For instance, the recognition of Francophones by the Canadian nation is not in and of itself Francophobe.

It can be difficult for a social group that perceives itself as a minority to recognize another minority in its midst. As a linguistic minority in North America, Quebec widely perceives persistent linguistic and cultural threats to its existence despite its position as a majority within its jurisdiction¹⁰. As such, given the significant investment towards the survival of the French language led by the majority of Quebecers over the years, there appears to be some reluctance to recognize that aside from language, race and racism are issues that need to be contended with, as they are not solely the purview of Canadian English speakers or Americans. Paradoxically, Quebec francophones have compared their struggles for liberation and social justice to those concerning anti-colonial and independence movements in Africa, and those of African Americans. The expression "nègres blancs d'Amérique" or in English "White Negroes [in some translations Niggers] of America" was even deployed in popular discourse in the 1960s¹¹ to reinforce this perceived social positioning. Yet, while Quebec francophones experienced subordination due to Anglo-conformity¹², their history does not consist of the racialized processes of coerced migration from their continent of origin to the Americas, followed by enslavement, segregation, ongoing dehumanization, and the denial of equal social status. In other words, despite the juxtaposition of African and

African-American resistance movements to Quebec nationalist and separatist struggles in some intellectual circles, French Quebecois settlers are not Black and do not navigate society as such. Furthermore, while the “nègres blancs” analogy was being deployed, anti-racist struggles of the actual Black population residing in the province and in the rest of the country were being ignored; conveniently erasing the critique of structural racism and racial capitalism advanced by Black intellectuals¹³. Despite discrimination based on language, Quebec has not and does not evolve in isolation from the rest of the Americas. Although the historical narrative emphasizes collaborative relationships with Indigenous nations and the conquest and rule of a British elite, Indigenous people were colonized in Quebec, Black people were enslaved and experienced anti-Black racism in this province like in other North American jurisdictions¹⁴.

Although Black people’s experiences in Quebec have primarily been studied through the prism of acculturation or immigration-related challenges¹⁵, their socio-historical experiences in this province cannot be reduced to migration and the idea of the “newcomer”¹⁶. The history of Marie-Josèphe Angélique, an enslaved Black woman executed by hanging in Montreal, New France, in 1734¹⁷ is one of many examples that well exceeds those boundaries. In fact, several events throughout Quebec’s history speak to anti-Black racism such as the degrading experiences of Black porters in Montreal on the Canadian railways from the end of the 19th century until the mid-eighties, including their initial exclusion from union membership¹⁸; the forgotten 1969 Sir George Williams (Concordia University today) protests denouncing anti-Black racism in the education system¹⁹; the unapologetic use of blackface by student protestors to depict their perceived position of subjugation and servility with regard to rising tuition costs in 2012²⁰; and more recently, the appropriation of sensitive parts of Black culture through highly mediatized stage production entitled SLAV, which tells the story, many would argue inappropriately, of enslaved Africans, played by an almost all-White cast. In response to the show’s cancelation following protests by the Black community and its supporters, certain intellectuals argued that censorship was at play, and the production was eventually re-instated. There was clearly limited comprehension of the gravity of the longstanding colonial and racist exploitation of Black peoples’ cultural work, little attention paid to the contemporary underemployment and representation of Black Quebecois artists, and their quasi-exclusion from the show²¹. Several commentators centered the show’s authors’ disappointment and good intentions in their desire to respect the suffering of Black people who were enslaved and few asked: When an historically marginalized group remains underrepresented and faces unequal status in the artistic world and society at large, is it not legitimate for members of this group to express their concerns regarding cultural appropriation? Whose voice is legitimate in the public space? This demonstrates how anti-Black racism has permeated multiple spheres of Quebec society and the need for a better understanding of colonization, anti-Black racism, and historically rooted unequal status. The medical and health sectors are not exempt, as can be illustrated through the experiences of the Haitian community during the eighties due to the improper associations made between them and HIV by the Red Cross²², and their disproportionate exposure to, and life-threatening circumstances in the face of the COVID-19 pandemic as it unfolds.

Colour-evasiveness and COVID-19

Quebec has been deemed the COVID-19 epicenter of Canada, as it has steadily accounted for nearly half of all cases reported and the highest fatality rate nationally according to Canadian Government authorities. Multiple analyses are ongoing in an attempt to shed light on this predication and numerous factors have been considered; from Montreal’s highly concentrated

population as a major city to insufficient measures mobilized to contain the virus. These endeavours have also led to the identification of populations at greater vulnerability to COVID-19, namely, the elderly, the chronically ill, the homeless, the incarcerated, the “culturally diverse”, and the poor. Consistent with Quebec’s dominant political stance, what has been blatantly marginalized from the discussion, is race. While various Quebecois media outlets have disseminated information on how COVID-19 has disproportionately affected Black American communities in terms of number of cases and deaths, the question of race is missing, most notably in French-language media.

Without naming race, it has been determined that existing inequalities have only been exacerbated by the current epidemic. To this point, Black communities in Quebec have one of the most concerning socio-economic portraits in the province. Compared to the general population, their unemployment rate is twice as high and their salaries are nearly 30% inferior, which fall not only among the lowest in the province, but also in the country²³. They are overrepresented in low-status employment positions and underrepresented in decision-making bodies and higher-paying employment²⁴. They tend to experience more challenges related to property ownership and are subjected to substandard dwellings, unaffordable rents, and racial discrimination in the rental market²⁵. In the media, stereotypical information representing them as threatening or deviant is most often selected and propagated²⁶. This stigmatization is reflected in their relationships with law enforcement and other social agencies. Black communities are subjected to over-surveillance, racial profiling, police brutality, incarceration in ways that are disproportionate and distinct from any other group²⁷. Similarly, Black children are overrepresented in youth protection agencies, detention centers, and prisons²⁸. Added to this, is their educational profile marked by over-policing, racial profiling, excessive punitive measures, special education overrepresentation, and high school perseverance challenges²⁹.

Regardless of gender, language, age, or whether they are newcomers, Quebec-born immigrants, or from long-standing generations, Black Quebecers have been contending with social inequalities for many decades. Hidden behind the widespread terms of ethno-culturally diverse, immigrant, or visible minority communities, we can partially ascertain the effects of COVID-19 on Black communities. Their increased vulnerability to contracting the virus is made evident in their significant presence in the health field, where they are likely to occupy positions such as client-care attendants, aids, and cleaners. In fact, one third of Black women in the country work in healthcare³⁰. The circulation of COVID-19 in predominantly Black populated neighbourhoods such as Côte-des-Neiges–Notre-Dame-de-Grâce and Montreal-Nord are also cause for concern. In addition to the disproportionately high instances of the virus, the privilege of practicing protective measures against it such as social-distancing, is not a *fait acquis* where the typical household in these boroughs may produce overcrowding and consist of dilapidated structures involving poor ventilation. While COVID-19 has shifted the typical media coverage of Montreal-Nord from high crime and gang-related violence, it has not reduced the likelihood of its residents’ engagement with the police. A report issued by the Canadian Civil Liberties Association³¹ shows that Quebec is also leading the country in terms of fining people who are not respecting physical distance protocol and Black people are among the groups most targeted. The enforcement of measures to contain the virus also affect Black children who are disproportionately placed in youth-protection, as parental-visitation was suspended as a precautionary measure. Schooling inequalities are also aggravated through complicated facilitation of distance-learning due to difficult access to the internet and other resources.

Amidst the unprecedented COVID-19 canvas, researchers in Quebec are engaged in work on a plethora of topics including its effect on mental health, financial well-being, tourism, etc. The crisis in long-term health care facilities has prompted expeditious action intended to improve this problematic situation that has resulted in inhumane conditions for their residents and high death tolls³². However, despite similar situations experienced by Black people as they are overrepresented in frontline, low status positions in health care, there are no plans for such actions to be taken concerning these communities in Quebec, assumingly because race remains contested as a social category and thus, no data that officially names race is available. Recently, the COVID-19 related death of Marcelin François, an asylum seeker occupying one of these high risk jobs, was widely publicized in the media³³, with no mention of the fact that he was Black. Similarly, Quebec recorded its youngest COVID-19 fatality on August 16th, 2020. The fact that nineteen-year-old Don Béni Kabangu Nsapu was Black was also omitted from the narrative³⁴. The absence of race-based data in Quebec hinders a thorough investigation of the role of race and racism in relation to COVID-19, even though the commonality of blackness across various detrimental situations is undeniable. Racism negatively affects Black peoples' health³⁵ and experiences of discrimination within healthcare settings impact Indigenous and racialized populations³⁶. Race is in fact, a recognized social determinant of health given the discrimination that can be experienced by racial groups ascribed with lower status³⁷. These experiences can also fuel reluctance among these groups to seek healthcare, further compounding the effects of COVID-19. Thus, the need to rigorously study the social status of race, racialization processes, and various contextualized manifestations of racism, including anti-Black racism, is as important in Quebec as it is in the rest of North America. This could inform an effective and comprehensive anti-racist policy, co-designed with grassroots and community organizations, with the goal of addressing racism specifically (as opposed to only focusing on inclusive diversity or interculturalism)³⁸, and saving lives.

Conclusion

Social class and migration status are relevant objects of study but are insufficient to comprehend why Black people in several jurisdictions are more likely to contract COVID-19 than the rest of the population³⁹. Similarly to sexism or linguicism, racism in its different forms requires attentive theoretical and empirical study by recognizing race as a meaningful and significant social status and social category. Understanding racism as a singular form of stratification is necessary to contextualize and analyze its subtle and insidious manifestations. We cannot only focus on overt caricatural or extraordinary occurrences of racism, especially anti-Black racism. In fact, we still live with the consequences of the colonial slave trade, segregation, and the dehumanization of Black people in the Americas through the media, in our language, popular culture, and stereotypes. We therefore support the call to action made by the United Nations Human Rights Council⁴⁰ concerning the need for race-based data collection and the attention to Black Canadians' human rights. In Quebec, several public reports include a gendered analysis to assess the impact of different policies on women. By collecting race-based data, we could do the same with race, to better address the discrepancies and persistent access barriers of various groups, including health disparities. While the medical community is scrambling to contain, control and immunize against the COVID-19 virus, we echo the sentiments of well-known Haitian-Quebecois novelist Dany Laferrière that the virus of racism is just as urgent.

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Colonialism as a Precondition of Uneven COVID-19 Experiences

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Abstract

During a challenging time such as the COVID-19 pandemic, historical geographies of oppression are expressed not only in differential rates of infection, but in differential impacts of public health solutions, including economic effects, complications of community-based underlying health conditions, increased opioid poisonings, and worsening housing situations. As such, addressing these complex impacts of colonialism during the pandemic requires a similarly complex approach. Successful health care policy interventions will need to incorporate such understanding.

Why is an understanding of colonialism important to understanding the uneven occurrence of COVID-19 in Canada today? Although Canada's history of colonialism does not in itself provide any explanation, today's racialized and Indigenous communities, which were formed by past colonial practices, continue to be adversely affected by ongoing colonial practices. During a challenging time such as the COVID-19 pandemic, historical geographies of oppression are expressed not only in differential rates of infection, but in differential impacts of public health solutions, including economic effects, complications of community-based underlying health conditions, increased opioid poisonings, and worsening housing situations. As such, addressing these complex impacts of colonialism during the pandemic requires a similarly complex approach.

The practices of colonialism have racialized Canadian society in four main ways. First and foremost, colonialism displaced, diminished, and marginalized Indigenous peoples. COVID-19 outbreaks therefore occur either on reserves, or in urban communities—for example, Vancouver's Downtown Eastside—where Indigenous peoples experience concentrated poverty. Second, the African-Canadian population originated during the late 18th Century as a result of northward migration from the American colonies, founded on enslavement. Third, the Canadian government demanded a very large labour force in building the railway and in extractive industries such as forestry and mining. Indentured and contract labourers came from Asia in the tens of thousands to form a geographically concentrated labour force, mainly in Western Canada. They were paid substandard wages and denied the benefits of citizenship until well into the 20th Century. Fourth, as Canadian immigration rates increased from World War II until the 21st Century, a very high proportion—in many years, the majority—of immigrants have come from other former British colonies, including Caribbean countries, India, and Hong Kong. These immigrants and their descendants make up the majority of communities of colour in Canada today. They live and re-live colonial racialization practices in myriad ways.

For example, among urban Indigenous communities, which represent among the poorest urban communities in Canada, the knock-on effects of the pandemic have been horrendous. In Vancouver's Downtown Eastside (Kobayashi and Masuda 2020), public health measures resulted in the closure of important services such as shelters, food banks, drop-in help centres, and safe injection sites. Within days, food scarcity became an issue. Within weeks, the supply of illicit drugs was contaminated by fentanyl as the supply chain was disrupted, resulting in a rapid rise in opioid poisoning deaths. Isolation, lack of information, lack of services, combined with poor living conditions in crowded and dilapidated single-room-occupancy buildings, have meant that people living in this community, already marginalized by poverty and racialization, have suffered enormous health consequences. The single most important issue concerns the situation of

Indigenous peoples, who live the effects of colonialism on a daily basis, and who experience COVID-19 most destructively because of higher levels of underlying conditions (e.g., diabetes, substance dependence) and insufficient levels of social services.

Among Asian communities, the prevalence of everyday racism, well in place since the advent of indentured labour as a colonial strategy, has skyrocketed. Although we lack Canadian research data, there is ample anecdotal evidence to show that people who are Asian in appearance have had fearful and potentially violent experiences in public. A Japanese-Canadian community partner in one of my own research projects related a visit to a grocery store where she was followed, taunted, and threatened. A U.S. study showed that a quarter of young Asian Americans have been targets of verbal racist abuse in the past year¹. In this case, the secondary emotional impact of the pandemic has far-reaching community effects.

For a variety of reasons such as educational patterns, immigration histories and policies, and a number of community factors, racialized individuals are disproportionately concentrated in front-line occupations, ranging from cleaning to transportation to health care provision, where the dangers of COVID-19 exposure in the workplace are greatest. Such workers include Latinx cleaners, people of Caribbean origin in transportation and health care, Filipina workers in health and domestic care jobs, and temporary workers in agriculture and meat packing—all labour segments that have been among the highest rates of exposure to and transmission of COVID-19. The jobs that racialized people perform today are in significant ways the result of patterns of immigration and employment established throughout the 20th Century.

These three brief examples provide merely a window into a society where patterns of poverty, racialization, and labour market segmentation are all the continuing results of colonial practices put in place centuries ago. They are not just demographic statistics that have emerged over time.

So, what is colonialism?

Colonialism is one of the major ways in which capitalist political and economic systems have been established worldwide. It is a paradigm of domination and exploitation of a country in the developing world by a metropole country. There are two major forms: 1) exploitation of the developing world (much of Africa and Latin America) to extract both resources and cheap labour; 2) settler colonialism – the case of Canada – which involves settling and developing a country by people from the metropole, where the main initial form of population growth is through European migration. In many instances, including that of Canada, the United States, Australia, and much of Latin America, the Indigenous population is greatly reduced and physically distanced from the white settlers (reserves in Canada and the U.S., townships in South Africa). People of colour are brought from various parts of the world, either through enslavement or indentured labour, to support development, working in agriculture, mining, forestry, and the like. Thus, colonialism involves the exploitation of both people and the natural environment. Settler colonialism could not have occurred as it did in Canada without migrant labour and at the expense of Indigenous peoples.

In more recent years, the majority of immigrants to Canada, including permanent migrants as well as those who come through the domestic worker or temporary agricultural programs, are people of colour. They are overrepresented in those areas of labour where the incidence of COVID-19 is high: health care, cleaning, transportation, agricultural labour, and meat packing. We need to recognize that the patterns of population movement, settlement, and development that were

established in the early days of colonialization continue and have lasting repercussions. People live the conditions of their historical geographies for generation after generation.

Colonialism is fundamentally a process of racialization. With very few exceptions, colonialism involves the exploitation of people of colour and Indigenous peoples by white Europeans. The two systems are inextricably connected. Colonial racialization involves both the exploitation of colonized people in situ (through extraction of labour or, in some cases, denial of labour), which leads to the underdevelopment of those populations; or, the movement of colonized peoples through enslavement or indentured labour. (In some cases, such as China, formal colonization did not occur, but millions were still ensnared in the process of indentured labour upon which much colonial development rests).

Both colonialism and racialization are recursive processes through which political, economic, social, and interpersonal connections are systemically produced and reproduced. The human relationship becomes one of colonizer–colonized² and racializer–racialized³ (Kobayashi).

The colonial relationship extends into both systemic (e.g., labour, education, health care, residential concentration) and personal racism today, and therefore takes specific forms at a time when social and economic conditions are stressed and stretched. We need to recognize, therefore, that present-day expressions of colonialism are complex. There are historical reasons for the concentration of people of colour in dangerous front-line occupations as well as for the production of Indigenous poverty and the ongoing vilification of people of Asian descent. It is significant that we need to understand these patterns in systemic ways—not as individual choices and anomalies. People who express racist views, whose expressions are often ramped up at times of crisis such as with this pandemic, are not just individuals choosing to be nasty. They are part of a long process of colonial oppression and marginalization that have taken many forms and expressions over time, in different places and toward different communities. Addressing systemic practices will always require systemic solutions. The effects of ongoing racialized colonialism therefore need systemic actions in the time of COVID-19.

Addressing the Systemic Effects of Colonialism during the Pandemic

Teasing out the ongoing effects of a history of colonialism is, of course, far from straight forward. Colonialism is long established, has a hugely varied geography with differential effects on demography, the labour market, and social practices. At the most basic level, Indigenous peoples and people of colour cannot sever their lives from generations of racialized colonialist practices and policies. The effects of colonialism were not erased when it ceased to be an official form of political control; therefore addressing present challenges, such as the pandemic, requires recognition of this complexity.

Successful health policy makers will understand that while the main thrust of their actions will apply directly to forestalling infections through practices such as hygiene, social distancing, and mask wearing, they must also recognize the complexity through which COVID-19 works its way through the population. That recognition requires a thorough understanding of complex historical community experiences of racialized colonialism and its impact on present-day levels of racist discourse, impoverishment, and residential and labour market segregation, among other effects. Health care policy will therefore need to incorporate this understanding as part of any successful amelioration of the pandemic.

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A Historical Account of the Pandemic: Health, Colonialism and Racism in Canada

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Abstract

In this paper, I situate the Covid-19 pandemic within a longer historical context in Canada. I argue that settler colonial state has produced the conditions in which certain (white) lives are valued, protected, and nourished while other lives (Indigenous/ Chinese) are left to die. I make this argument by focusing on two examples: the role of the Indian Act and the enactment of Canadian Immigration legislation. While the former has produced unliveable conditions for Indigenous peoples on and off reserves, the latter has suggested that certain migrants – particularly the Chinese – were “foreign” and diseased. The racial inequalities that have surfaced in the current pandemic, I suggest, requires us to consider the long histories of racial violence in Canada, the ways in which certain bodies have been made vulnerable to disease, while others have been blamed for its proliferation, all in the interests of white (re)settlement.

Introduction

Canada is a settler colonial state. Over the course of the nation’s history, European lives have been (and continue to be) respected and protected, whereas the lives of Indigenous peoples and migrants of colour have been devalued and destroyed. “At the heart of the colonization of Turtle Island,” Kwakwaka’wakw scholar Sarah Hunt argues, “lies the settler colonial project of Native disappearance, which is necessary for the development of a prosperous settler society.”¹ This disappearance has taken place over hundreds of years. It has been deliberate, state sanctioned, and remains ongoing. The settler colonial project requires the dispossession of Indigenous peoples from their lands, resources, and waterways, the governmental denial of sovereignty, the violent effects of the *Indian Act*, assimilationist agendas of residential schools, the coercive force of the criminal justice system, the disregard for murdered and missing Indigenous women and girls, and the lack of infrastructure, including clean water, on reserves. The settler colonial project of Indigenous disappearance in Canada has depended on the destruction of Indigenous people’s health.

Settler colonialism in Canada, and “Native disappearance” has been a project of *white* European resettlement.² The unequal racial distribution of life and death, of value and disposability that has become so visible during the COVID-19 pandemic thus far, are not new. According to the First Nations Health Authority, epidemics reached the Northwest Coast as early as 1500, following along Indigenous travel and trade routes. However, the introduction of disease following European contact—including small pox, influenza, and measles—was devastating and irreparable for many communities.³ People died in mass numbers, and some communities have never fully recovered. The effects of disease on Indigenous bodies, historian Mary-Ellen Kelm argues, has been “made by history.” Following the first epidemics, “infectious diseases continued to affect Aboriginal people well into the twentieth century, not because they were genetically ill-equipped to fight disease, but because of decisions made by the governments of British Columbia and Canada.”⁴ That the current pandemic has disproportionately impacted Indigenous, Black, and communities of colour, and that Indigenous peoples are more likely to experience “complications” due to

COVID-19, are not part of a natural order. These conditions are the generational effects of settler colonial violence.

At the same time that disease has been central to creating the vulnerability, death, and “disappearance” of Indigenous peoples, it has also been critical to the regulation and deportation of non-European migrants, especially from China, Japan, and India. Immigration, racism, and disease control are deeply entangled.⁵ Canada’s first Immigration Act, which was passed in 1869, two years after Confederation, established quarantine stations along the Atlantic coast in Halifax, St. John, and *Grosse Ile*. These stations were sites of primary landing, where travelers and settlers were inspected for signs of infectious disease and were denied entry if their health was found wanting. The Immigration Act of 1906 was more restrictive than its predecessor. It expanded the Dominion’s health regulations, denying entry to those suffering from biological *and* social diseases including “moral turpitude.”⁶ Immigration restrictions and racial exclusions have been integral to Canada’s national identity as a white Dominion. “Mythologies or national stories are about a nation’s origins and history,” critical race scholar Sherene Razack reminds us. “They enable citizens to think of themselves as part of a community, defining who belongs and who does not belong to the nation.”⁷ In Canada, these national stories have erased Indigenous peoples, but they have also obscured the presence of Chinese and other migrants of colour who built the railway, worked in 19th century industries, and continue to contribute to Canada today. Part of this erasure has been reinforced through racial tropes of healthy and diseased bodies.⁸

In this paper, I discuss the history of Indigenous health and the entanglements of disease, racism, and immigration law, especially as it pertains to migrants from China. The paper draws selectively from examples in British Columbia (BC), one of the last regions to be settled in Canada and a province with the highest rates of Chinese immigration, both historically and in our present day. The histories of settler colonialism and structural racism recalled here must be remembered and (re)told, especially if we are to address the racial inequalities and urgencies of the current pandemic.

Colonization and Indigenous Health

The current health challenges facing Indigenous peoples must be situated within the long history of colonization as evidenced by federal and provincial colonial laws and policies, including the appropriation of land, the creation of treaties, the *Indian Act*, residential schools, and the state’s “structures of indifference.”⁹ Indigenous peoples in Canada experience higher rates of diabetes, high blood pressure, HIV/AIDS, mental health issues and mortality rates than non-Indigenous peoples.¹⁰ This health data cannot be viewed in terms of individual or community vulnerabilities, but must be considered within the conditions of colonization that have produced these vulnerabilities in the first place.

There are many examples from which one can draw to critically examine the links between settler colonialism and Indigenous health. One of these is diet and nutrition. Land and natural resources are vital to the health and well being of Indigenous peoples across Canada. In BC, communities have relied on hunting, fishing, shell fishing, and collecting plants and berries. With British resettlement, however, came the appropriation of lands and resources, and the enactment of repressive and coercive legislation. The *Indian Act*, which was passed by the Dominion government in 1876, regulated every aspect of Indigenous peoples’ lives. Under the Act, Indigenous peoples were dispossessed from their lands and forcibly placed on reserves. The Act was aimed at destroying

languages and cultures, including traditional practices of health and healing.¹¹ The transformation of land ownership systems, and the legal restrictions and prohibitions that made this possible, had a devastating impact on Indigenous peoples' diets. "Hunting territories were cut off from reserves, fenced, and put under the plough or converted to pasturage. Fishing technology was forcibly regulated to favour the commercial fishery at the expense of Aboriginal harvesters."¹² Although on-reserve communities kept gardens and many residents worked as wage labourers, store-bought foods were not as nutritious as those consumed in traditional diets.¹³ The Dominion's legislation, which violently appropriated Indigenous lands and resources and restricted the movements of Indigenous peoples, also dramatically altered local ecologies and began a process of destruction that today is termed climate change.¹⁴ Environmental destruction produced by the laws and policies of settler colonial states has devastated certain species of salmon, further impacting the diets of coastal Indigenous communities.

Since its enactment, the *Indian Act* has created unliveable conditions on reserves. For many Indigenous communities in Canada, water quality has been a serious concern, both historically and in the present. In BC, for example, the provincial government passed regulations in 1888, which sought to separate water from land ownership. Under these changes, on-reserve communities were expected to lease their water from the provincial government.¹⁵ In 1919, the City of Winnipeg built the Shoal Lake Aqueduct. In the interests of the project, which was aimed at securing safe drinking water for non-Indigenous city residents, the city dispossessed the Anishinaabe peoples of Shoal Lake First Nations from their lands and ultimately deprived them of clean drinking water. "The story of the aqueduct is modern Canadian colonialism in microcosm," explains historian Adele Perry. It takes land and resources from Indigenous peoples for the benefit of non-Indigenous peoples. It "works to create conditions of non-Indigenous demographic dominance and to naturalize it, making it hard for people, especially non-Indigenous ones, to imagine a different world."¹⁶ Concerns over water continue to be an urgent problem on many reserves. According to the Regional Health Survey of 2008/2010, one third of Indigenous adults view their water as unsafe to drink.¹⁷ Some reserves, including Attawapiskat in Northern Ontario, have been on a water boil advisory for over three decades.¹⁸

Given the violent effects of settler colonialism on Indigenous lands, resources, food, water, and diets, many Indigenous peoples experience serious health issues today. The *Indian Act*, combined with the Dominion's indifference to Indigenous health has created structural forms of racism and a racial distribution of life and death that continues to value non-Indigenous lives over Indigenous ones. The failure to provide adequate health care and treatment for Indigenous communities in Canada, some scholars have argued, is historically rooted in assumptions of the "vanishing Indian."¹⁹ As Lunaape scholar and historian Mary Jane McCallum and Adele Perry argue, "hospitals [and health care] are part of a range of institutional systems in Canada shaped by settler colonialism, Indigenous dispossession and marginalization, Canadian nation-state building in the nineteenth century, and the maintenance of white settler prosperity and priority through the twentieth and twenty-first."²⁰ The COVID-19 pandemic has made structural racism and the violence of settler colonialism clearly visible. In June 2020, amidst the pandemic, several Indigenous people reported their experiences of racism in BC hospitals to local media. According to Adrian Dix, the provincial health minister, "in some BC emergency rooms, health-care workers are playing a 'game' to guess the blood alcohol level of patients, 'in particular Indigenous people.'"²¹ These instances cannot be viewed in terms of individual attitudes but must be considered as symptoms of a wider colonial and racial structure. As McCallum and Perry explain, "structures of settler colonialism that draw

on and in turn create ideas about race and indigeneity...reinforce claims of European settler populations as those first and most rightfully served by the state” and most deserving of health care.²² These racial erasures and entitlements are central to understanding Indigenous health and the current pandemic in Canada.

Immigration Law and the Legalization of Anti-Chinese Racism

Immigration, racism, and disease control have a long and tangled relationship in this country. From the 19th century onwards, state authorities regularly denied entry to immigrants thought to be carrying disease, many of whom were from East and South Asia. These prohibitions were central to keeping Canada white.²³ Chinese men arrived along the Pacific Northwest before Canada became a nation. By the mid-19th century, however, they were actively recruited to the west coast to complete the Canadian Pacific Railway. These men worked in deplorable conditions produced by a virulent and growing anti-Chinese racism. Once the railway was complete, the province, followed by the Dominion, proposed and eventually passed legislation making it financially difficult, if not impossible, for Chinese men to migrate to Canada.²⁴

The late 19th and early 20th centuries were marked by the legalization of anti-Chinese racism. In 1864, seven years before BC joined confederation, Victoria authorities proposed a motion to tax the Chinese. In the absence of widespread political support, the motion was dismissed. Over the next two decades, however, these sentiments changed. Between 1884 and 1904, BC politicians successfully passed 22 restrictive acts aimed at regulating Chinese immigrants in various capacities, including where they lived and worked. The most egregious anti-Chinese legislation was the head tax and exclusion act. In 1885, the Dominion government required all Chinese immigrants to pay a \$50 head tax on arrival. In 1901, the amount was increased to \$100 and then to \$500 in 1903, making it prohibitive for Chinese migrants to enter Canada. In 1923, the Dominion government passed the Chinese Exclusion Act. Legal restrictions on Chinese migration were central to defining who was a “citizen” (white/European) and who was a “foreigner” (Asian).

The legalization of anti-Chinese racism in BC was partly accomplished through concerns about sanitation and disease. Government officials and white settlers did not only see BC’s Chinese residents as a social and economic threat to the province and the Dominion but also as a serious public health risk.²⁵ Many argued that the supposedly unsanitary habits among the Chinese, combined with their poor living conditions were perilous to the province and to the nation’s health. For example, in 1885, one white resident of Nanaimo claimed that the Chinese “live amongst so much filth and neglect of sanitary arrangements, that they cannot but be a danger to public health.” He cautioned that the Chinese quarters in Nanaimo could become “centers from which contagion would spread all around,” and “diseases not otherwise dangerous might readily become epidemic.”²⁶ By the 1880s, the links between disease and Chinese migration along the west coast were manifest in rising concerns about “Chinese leprosy.”²⁷ The commissioners for the *Royal Commission on Chinese Immigration* (1885), established by Sir John A. MacDonald and mandated to investigate all matters connected with Chinese immigration, asked witnesses about the prevalence of leprosy among the Chinese.²⁸ Although there were no reported cases of leprosy in BC at the time, the commissioners justified their questions by insisting that their objective was to determine whether there was any factual basis to claims that Chinese were more prone to leprosy than Europeans.

The racial arguments linking leprosy to Chinese communities had serious implications for health care and immigration. Leprosy was long associated with Chinese men in BC and in other settler colonies, but it was not until the 1890s that several cases were detected in Victoria's Chinatown.²⁹ In March 1891, the city's Health Inspector was called to investigate several Chinese men who were sleeping on the sidewalks in the Chinese quarter. During his visit, he discovered five men thought to be afflicted with leprosy. The city's Sanitation Committee recommended that the men be quarantined on an island lazaretto, and so they were. In consultation with the province, the city of Victoria established a leprosy colony on D'Arcy Island, located 17 miles northeast of Victoria on Lekwungen territories. The leprosy colony was operative from 1891-1924, bookended by the head tax (1885, 1901, 1903) and the Chinese Exclusion Act (1923). During this period, 49 men were banished to the island — 43 of them were Chinese, all of them had leprosy.³⁰ There were no doctors or caretakers, and the men had little contact with the outside world; they awaited deportation or death, whichever came first.³¹

In settler colonies, including Canada, Australia, and the U.S., there is a long historical association between Chinese immigration and disease.³² "Health discourses and the policy concerning the problematic 'Chinese' or 'Oriental' body," historian Nayan Shah argues, designated Chinese communities as diseased (as was the case in BC), but also "revealed how whiteness and white identity were performed."³³ The history of disease control, it bears repeating, is a history of settler colonialism. Racial mythologies of foreignness and disease, as the COVID-19 pandemic makes clear, remain an integral part of Canada's national story.

A History of the Present

For sociologists, race is a social determinant of health. However, the unequal distribution of disease across racial lines has been historically produced over hundreds of years through the violence of British and French resettlement in what is now Canada and in immigration restrictions and regulations directed at Chinese and other Asian migrants. We cannot understand the current pandemic — its devastating effects on Indigenous, Black, and communities of colour, or the resurgence of anti-Asian racism in Canada and globally — without situating the present within an ongoing history of settler colonialism.

As a settler colonial state, Canada has created the conditions in which certain lives have been valued, nourished, and protected while others have been devastated and destroyed. As Kelm emphasizes, "Aboriginal ill-health was created not just by faceless pathogens but by the colonial policies and practices of the Canadian government."³⁴ These include the appropriation of land and resources, the denial of sovereignty, the violence of the *Indian Act*, the coercion of the criminal justice system, and the ongoing racism in health care. Through immigration regulations and anti-Asian violence, Canada has produced a climate in which some communities are designated as "foreign" and as carriers of disease while others are seen as "innocent" and undeserving victims. The rise in anti-Asian racism that we currently witness in the COVID-19 pandemic has a much longer history. The racialization of disease, as the case of leprosy makes clear, has a dramatic impact on how communities are treated and whether they are granted treatment and care. As we investigate the racial inequalities witnessed in the current pandemic, it is crucial to remember that settler colonialism and state-sanctioned racism has produced the conditions in which some lives continue to matter and others do not.

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Race and ethnicity data collection during COVID-19 in Canada: if you are not counted you cannot count on the pandemic response

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Abstract

This paper discusses arguments for race and ethnicity data collection during COVID-19 and theories of how and why differences risk and the impacts of COVID-19 are related to race and ethnicity. It summarizes Canadian data on race ethnicity and COVID-19 before presenting ways to promote equity. There have been calls for race and ethnicity data collection to identify health disparities and promote health equity in Canada for decades. They have not been heeded. COVID-19 has acted like a social x-ray, highlighting problems in our body politic. The higher rates and greater impacts of COVID-19 on racialized populations in Canada could be attributed, in part, to a lack of available data to identify inequities. But the fact that these data were not being collected; the fact that they still are not collected in most provinces; and, the fact the knowledge of disparities not has led to significant change in the pandemic response points to an underlying systemic resistance to pursuing health equity. Collecting race and ethnicity data, developing appropriate processes for governance and analysis, and ensuring that data is used for action are vital parts of a health system fit for Canada in the 21st century. But it will only happen if there is legislative change to deal with the systemic resistance to health equity for racialized people. It should not be legal to set up health care or pandemic strategies that predictably do not meet the needs of Canada's diverse populations. It should not be legal to be deliberately blind to health disparities.

Canada is a multi-cultural country which claims diversity as a strength. There is social and cultural heterogeneity rarely seen in high income countries. And this has been used to develop a high standard of living. Canada consistently ranks as one of the best places to live in the world.

But this is not the case for all. There are significant socio-economic disparities and these lead to health disparities. Indigenous and racialized groups, particularly Canada's Black populations, have an increased risk of a number of illnesses, poorer access to care and worse health outcomes. (1, 2)

The COVID-19 pandemic feeds on and exacerbates existing inequalities. Because of this, Canada's social and health disparities have major implications for the development of evidence-based effective pandemic response. A one size fits all strategy is unlikely to work in a population with diverse needs.

Numbers have been vital in the fight against COVID-19. Countries have relied on the number of cases and the R- number to monitor the effectiveness of pandemic interventions and to decide when to move through lockdown phases. And the same numbers can be used to identify whether our interventions are working for everyone. To do this we need to collect socio-demographic data which can be disaggregated during analysis. If you are part of an aggregated sum you can be invisible in the numbers, your story will not be told, your needs will not drive policy action and your needs will not be met. In addition, disaggregated data are particularly vital in pandemics because the need for collective action. A response is as strong as its weakest link.

Good sociodemographic data and race based data are important tools for health equity but data collection it is not an end in itself, it has to be linked to action.

There are valid concerns about governance, accountability and protections against misuse of data. These issues need to be addressed because data is vital to the proper functioning of public health. Every doctor must take a history from their patient to ensure they make the right diagnosis and identify the most effective treatment. In public health, the patients are the population and the history is data. Public health needs good data to develop effective equitable interventions for communities and populations. We have already seen in Ontario that disaggregated data can save lives. Once Cancer Care Ontario were able to show that Black women were not being screened for cancers they were able to deploy one of the legion of evidence based strategies available to decrease disparities (3).

Collecting race and ethnicity data is now considered standard practice in health worldwide. Countries such as the UK and even our much-maligned neighbours to the south are able to report race and ethnic disparities in health. But Canada has lagged behind in the collection of these data. Race and ethnicity data is rarely routinely collected or reported at the Federal, Provincial or local level. This is despite evidence that it is feasible, there are Canadian evidence based tools to aid collection, there is a wealth of evidence that these data are useful in improving the quality of health systems in general and that they can be important specifically in pandemics. A study by Public Health Ontario during the H1N1 influenza pandemic reported that those who identified as South-East Asian were 3 times more likely to be infected, those who identified as South-Asian group were 6 times more likely to be infected and Ontario's Black population was 10 times more likely to be infected (4). And, because Indigenous populations were at such high risk, the Ontario Government culturally adapted their public health response to try to improve outcomes.

Federal bodies such as Statistics Canada and health providers, planners and funders at all levels have resisted developing good race and ethnicity data streams. Because of this Canada went into the COVID-19 pandemic unable to identify or monitor crucial factors for the effectiveness and equity of our pandemic response.

During the response, they did not use the data they already had at an area level or attempt data linkages to try to understand whether there were race or ethnic differences in rates of COVID-19.

Later decisions to analyze existing data and collect race and ethnicity data during the COVID-19 response followed reports of clear race and ethnicity differences in illness rates from the USA and the UK, more acceptance of the concept of anti-Black and anti-Indigenous systemic racism in Canada and pressure from community organizations.

Manitoba was the first province to start collecting race and ethnicity data in its COVID-19 response (5).

Three public health units in Ontario; Peel, Middlesex-London and Toronto started collecting data between April and May 2020 and then the province of Ontario followed suit (6). Quebec initially said it would consider collecting race and ethnicity data for its COVID-19 response and then did not (7). Local Black entrepreneurs and community groups eventually launched their own website in and app in August 2020 to try to get data collected. They hoped this would spur their government to action (8).

By the end of the first wave the collection of race and ethnicity data in COVID-19 was not widespread. Most Federal COVID-19 linked programs were not collecting these data, and only 2 provinces were routinely collecting data. There were no adaptations of the public health or social pandemic response.

Why would race and ethnicity impact the rates of COVID-19 and the risks of harm?

Canada's COVID-19 response has been good. In fact, our death rate of 23 per 100,000 is better than many other high-income countries. But it is worse than many others such as Germany (9)

One reason for this is that our initial response was focused on flattening the curve not who was under the curve. The focus on public health interventions for the whole population had some success but countries that were more successful added specific public health measures to protect at risk populations.

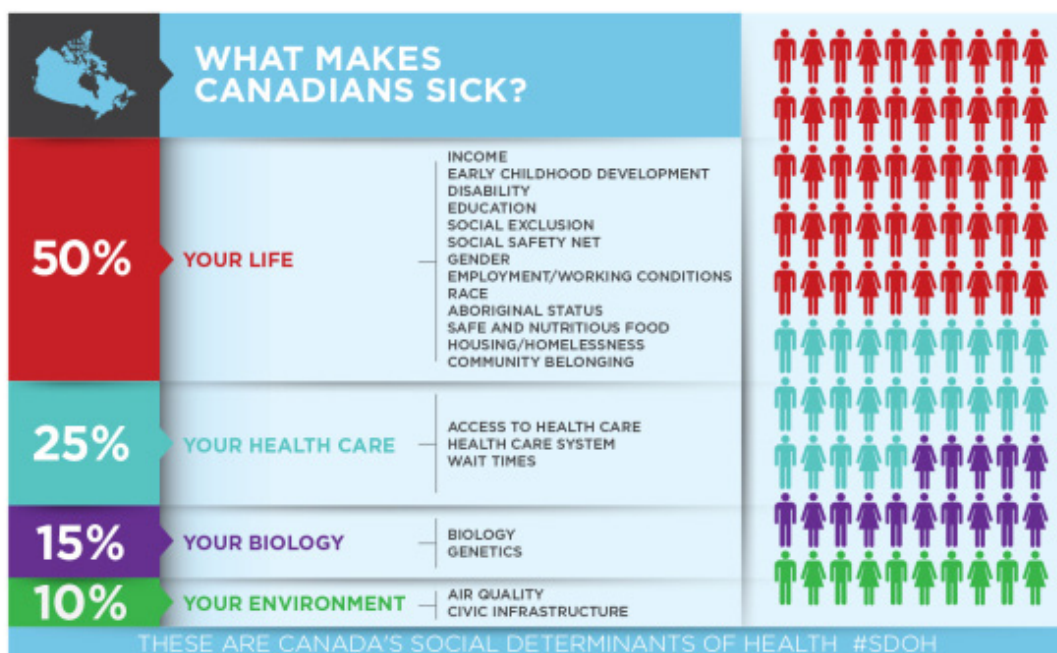
Long term care is perhaps the best example. CIHI has reported that 81% of first wave deaths in Canada were in long term care homes. Countries that had central control of long term care or developed clear early guidance for long term care at the time of their lockdowns did a better job at protecting this at-risk group and had much lower death rates. It has been calculated that at 4528 lives could have been saved if Canada's first wave pandemic response was as good as Germany's and much of that is because of their better performance in long-term care (10).

Focusing on who is under the curve as well as flattening the curve produces better outcomes.

Socio-demographic data is useful for understanding who is under the curve and once disparities in rates of infection have been identified, public health and social interventions can then be improved to ensure they equitably decrease risk. Subsequent data collection can monitor the effectiveness of interventions.

The Canadian Medical Association has calculated that 85 per cent of our risk of illness is linked to social determinants such as income, housing, education, systemic racism and access to healthcare. 15% is linked to biology (11). The COVID-19 pandemic adversely impacts health in four main ways:

- the disease itself;
- the public health response;
- changes in health services; and,
- the economic downturn. (5)



Canadian Medical Association, 2013

These interact with the determinants of health so that the health outcomes are different for different parts of our population (12).

Impacts of the disease: COVID-19 impacts vary. Some have mild symptoms, some have severe symptoms, some make a speedy recovery and some have a more chronic illness with longer term impacts. The death rate is significant. The risk of COVID-19 and its impacts are influenced by the social determinants of health. Some populations such as racialized populations and Indigenous populations are more impacted than others by most of the social determinants of health. They have multiple, intersecting factors such as racism, poverty and social exclusion which work together to increase their vulnerability to illnesses. For instance, they are more likely to be essential workers and that puts them at risk and they are much more likely to work in long term care homes or hospitals. They are less well served by social and health services.

(1, 2)

Biological factors such as Vitamin D have been offered as possible reasons for the high rates of COVID-19 in Black people in the UK and USA but the evidence is thin. It is based on the fact that the production of Vitamin D is dependent on sunlight and skin colour. People with darker living in the northern hemisphere are more likely to be Vitamin D deficient than others. Though appealing, this simple theory does not account for the high rates of COVID-19 in Black populations living in the sunny southern states of the USA. (13)

The more likely biological factors are actually the embodiment of social processes. For instance, racism has been shown to have significant impacts on health and risk of disease in part through hormonal changes and impaired functioning of the immune system (14). Obesity increases the risk of COVID-19 by up to 50% (15). Black populations in high income countries have higher rates of obesity and diabetes linked to poverty, low incomes, social inclusion and stress (1,2). Air pollution increases the risk and impacts of COVID-19 (16). Racialized populations in Canada are more likely to live in cities, (85% of the Black population of Canada lives in cities).

Impacts of the public health response: The public health response has an influence on the relative risk of infection. Those who can follow advice are more protected than those who cannot. Physical distancing and lockdowns also have direct impacts on physical and mental health. And, the inability to follow pandemic advice may increase mental health problems.

Those in congregate settings such as long-term care homes, the homeless and people in institutions find physical distancing difficult. But a bigger population is those living on the poverty line, in precarious work or in overcrowded homes. They are predictably less able to follow public health protocols and this puts them at increased risk of COVID-19.

And the harms of physical distancing and isolation such as stress, lower levels of exercise, substance misuse and domestic violence are more likely when people are overcrowded and when they have other social stressors such as workplaces that put them at risk or financial worries. Indigenous and racialized populations are more likely to be overcrowded, homeless or precariously housed than others.

Underlying the levels of stress linked to the public health and social response to COVID-19 is the concept of coherence and the factors that support health and wellbeing (17). In general people are happiest when they see that society has an understandable plan which could be effective, when they believe that the sacrifices they have to make for the plan are worth it and when they are

given the support, tools and resources to make progress on societies plan. Canadian governments did a good job is getting people to agree to and believe in their pandemic plans but racialized, Indigenous and low-income groups are less likely to have the full resources to keep to the plan. Because of this they are at increased risk of COVID-19 stress related problems. The echo pandemic of mental health problems is likely to be patterned by these social determinants in COVID-19.

Impacts of changes in medical care: When hospitals and clinics moved into emergency mode, preventive medicine clinics shut down, outpatient visits and surgeries were cancelled, and some services moved to tele-health. Groups with existing health problems, those with existing access problems, those with less alternative health coverage and those without good digital access are likely to be hardest hit.

The economic downturn: The economic downturn will have direct impacts on health through stress, it may increase the risks of mental illness, suicide and substance misuse and it will also decrease access to care as health benefits are lost. Many of the social determinants of health such as housing and food security are linked to income.

Public Health England investigated race and COVID-19. They concluded:

“The literature review and stakeholder feedback indicate that risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME (Black and minority ethnic) groups. The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure. They are more likely to use public transportation to travel to their essential work. Historic racism and poorer experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk.”

The situation in Canada for racialized, and especially Black and Indigenous populations seems no different.

Rate of COVID-19 for racial and ethnic groups in Canada

Data from the USA and UK reported that you were 2-3 times more likely to get COVID-19 and 2-3 times more likely to die if you are of African or Caribbean heritage. (18, 19, 20) These data coupled with community pressure led to studies in Canada. Because no individual level data was available initial analyses used the proportion of racialized groups in an area to try to get a handle on possible disparities.

Toronto Public Health reported that COVID-19 was more common in areas of the city with the highest Black populations (21) Public Health Ontario have found that infection rates are three times higher in areas where there were more racialized people. They also found that the mean age of infection was lower in these areas and the pandemic persisted in these areas when it had left other, (22). Quebec reported that more people died in Montreal Nord in the first wave of COVID-19 – a low income area with a high percentage of people of African and Caribbean heritage – than in the whole of British Columbia. In addition, the percentage of Black people living in a Montreal neighbourhood was the strongest predictor of the rate of COVID-19 infection. (23)

As individual level data became available the scale of the disparities started to become clearer.

Middlesex-London Public Health Unit in Ontario report that 27 per cent of those who tested positive were visible minorities compared to 17 per cent of the population (24). Toronto Public Health figures showed that people who identified as Arab, Middle Eastern, West Asian, Latin American, South East Asian or Black were 6-9 times more likely to test positive for COVID-19 than the White populations (25). And, Peel Regional Public Health Unit published figures that showed South Asian, Black and Latin American origin residents were 40-100% over represented in COVID-19 cases and White residents were 40% under represented compared to their proportion of the population (26).

Differential harms of COVID-19 for racial and ethnic groups

The UK found that deaths from COVID-19 were increased by 2-fold in the Black and Minority Ethnic populations but all-cause mortality has increased by 4-fold (18).

A geographic study of COVID-19 in Ontario reported that hospitalization rates and admission to ICU for covid-19 are 4 times higher and death rates are doubled in areas with highest proportions of racialized people (22). Statistics Canada has recently released a crowdsourced survey which reports higher rates of generalized anxiety and poorer mental health of visible minorities compared to white people during COVID-19. (27). There is not good data on differential substance misuse, domestic violence or homelessness because of COVID-19 for racialized populations in Canada. There is evidence that before COVID-19 eviction applications were double in areas with high Black populations in Toronto indicating that this is a population at higher risk of homelessness (28). BC have undertaken a population based survey of the impacts of COVID-19.. "Caucasian" groups were less likely to avoid healthcare, had fewer impacts on their physical activity and they had fewer worries about their own health (29).

There are some data on the economic impacts. In a recent Statistics Canada crowdsourced survey 22% of white people reported that COVID-19 had moderate to severe impacts on their ability to meet financial obligations or essential needs. This compared to 44% of South Asian, 37.5% of Black and 36% of Filipino Canadians (27) According to the poverty institute of Canada there was an estimated 16 per cent job loss for visible minorities and recent immigrants because of COVID-19. Nearly 350,000 people in this group lost their jobs between Feb 2020 and May 2020. The total job loss for visible minorities is higher than low income workers and other groups such as indigenous people (30). BC's population based survey of one in ten residents also reported significant differences in the social impacts of COVID-19. "Caucasian" groups did better than racialized groups. They had less difficulty making ends meet, fewer were not working and had less food insecurity. In addition, people with lower incomes (which is also more likely for racialized populations), were, less able to stay at home and work, were more likely to have a chronic illness, had more difficulty accessing healthcare and were less able to stay home from work when sick. Low income households reported more child stress (29).

What should we do with this knowledge?

The accumulated evidence supports the view that Canada has failed to properly and equitably protect its racialized populations from COVID-19. Racialized groups have increased risks of getting infected and increased medical and social impacts. In addition, our overall ability to flatten the curve and protect all Canadians is undermined by our inability to adequately protect our vulnerable

populations. Canada relied on data from other countries for the problem to be highlighted and then communities had to push for data collection.

The lack of race and ethnicity data meant that we could not identify disparities in rates of illness. Our lack of data also meant we could not identify for whom our interventions were working poorly. We have been unable to see whether the pandemic strategies are closing or widening social differences, even though closing social differences may decrease COVID-19 risks. We have little data on the differential impact on children of racial and ethnic groups in COVID-19, but the worry is that stress and disparities in access to education will have health impacts.

Our inability to equitably protect racial and ethnic minority groups from COVID-19 is in part because data were not available, but also because the same systems that resist the collection and use of data undermine efforts to promote health equity. Seeing significant disparities and doing nothing active to deal with them is a form of systemic racism (31)

A health equity approach aims to decrease avoidable illness disparities between groups. It does this by ensuring that there is equal access to and outcomes from interventions. It takes a needs-based approach. When people or groups have similar needs the focus is on making sure they have similar access and interventions work equally well. (32)

If a group has greater need then the response increases and the interventions may change to ensure that their needs are met. Health equity would not mean that everybody gets the same COVID-19 response, but it should mean that the outcomes from the COVID-19 response are more similar. Evidence based tools such as health equity audit and health equity impact assessment tools have been used internationally and in Canada to promote health equity (32, 33). And, a variety of methods are available to improve equity by educating staff, adapting interventions and building better healthcare system access through the engagement and partnership with communities. There is no evidence that these strategies have been systematically deployed in the Canadian COVID-19 response.

A health equity approach recognizes the risk of illness and the ability to recover are also linked to social factors. Changes to the social determinants of health to promote wellbeing of vulnerable populations are considered important health equity interventions (32). The fact that 85 per cent of illness risk is linked to social factors offers significant policy opportunities for improving health.

Health equity has a clear evidence base. But effective action may also need to understand the systemic barriers that stop best practice approaches such as data collection and evidence based health equity being deployed. We need to understand why previous pandemic research results were ignored. We need to understand why most provinces still do not think that data collection is required. And we need to understand why Ontario did not use the tool it developed to ensure health equity - (health equity impact assessment tool). We then need to develop legislative interventions to protect populations from systemic neglect (20).

Between mid-May and mid-July 2020 there were 3861 cases of COVID-19 in Toronto outside long term care homes. 83% of these were in racialized people and their rate of infection was at least 4.5 times that of the White population. If the rate in racialized groups was the same as the white group 2560 cases of COVID-19 would have been prevented. The numbers for Montreal, the epicenter of the Canadian pandemic, are not available.

It is unacceptable that Canada prides itself on its diversity and does not offer equitable protections for its diverse populations. However, the systemic nature of the resistance to the collection and use of race and ethnicity based data argues that we need legislative changes and central investment in the development of good quality socio-demographic data streams if we are to be able to identify at risk groups and produce, deploy, and monitor the progress of interventions. We urgently need data streams that will allow us to monitor the differential impacts of COVID-19. Data will need to measure health and social impacts. If race and ethnicity data were routinely collected by provinces and in the short form census it would help us to be able to use data we already collect to assess health disparities for COVID-19 and into the future. But accurate analysis of data for diverse communities requires capacity building so that both academic and community based researchers are able to be involved.

A better Canadian first wave COVID-19 pandemic strategy would have been based on an evidence informed and data driven, health equity approach. This should be the template for any subsequent waves and the recovery.

Recommendations

Four groups of actions are recommended to ensure that current and future responses to pandemics are equitable: Legislation; Equity based Pandemic Plans; Equity Based Social Policy and Recovery Plans; and, Improved Data and Research.

1) Legislation

We need strong legislation that ensures that our public health responses, our health response and our social policy responses produce as equitable outcomes as possible. Public services should promote race relations, they should produce equitable access to services and equitable outcomes of services and they should be required to collect data to prove that they are compliant.

2) Equity based COVID-19 health and public health plans

There need to be clear and published plans focused for promoting health equity in COVID-19 at each level of government. There also needs to be someone with the right seniority and resources who is tasked to ensure that plans are in place. The plans should use evidence based tools such as the health equity impact assessment, evidence based medicine techniques and community partnerships to adapt interventions as needed to ensure they are equally effective.

3) Equity based social policy and recovery plan

In addition to public health plans there needs to be a health equity lens taken to all associated Federal, Provincial and Territory responses to COVID-19. Taking a health equity lens to policies that impact the social determinants of health is necessary to facilitate a fairer response and to make sure that equity-based health and public health plans are not undermined by social policy that promotes inequality.

4) Data and research

COVID-19 socio-demographic and race and ethnicity data should be collected at all levels of government. Data collection, data analysis and subsequent actions should be undertaken in partnership with impacted communities.

Federal agencies such as CIHI and Statistics Canada should perform and publish COVID-19 analyses using existing sociodemographic information at the individual or area level.

Socio-demographic data including race and ethnicity data should be added to the short form census so that we have a full picture of Canada and a data set that can be linked to others such as health data to allow disaggregated analyses.

All Federal surveys should collect socio-demographic data including race and ethnicity data until such a time when linked census ethnicity data will be available. All Federal surveys should include sufficient people from the major racial and ethnic groups so that meaningful disaggregated and intersectional analyses can be undertaken.

The Federal Government should work with Provinces to produce good quality socio-demographic data including race and ethnicity for their health systems. One way of doing this is by facilitating the collection of race and ethnicity and other socio-demographic data at the time when people apply for and renew their provincial health insurance cards.

Federal research funding programs should include specific calls for work on COVID-19 socio-demographic inequities and race and ethnicity. These calls and programs may need to include funds for outreach and capacity building. Federal research funding programs should build a pipeline of researchers from doctoral students through to post docs and Canada chairs who focus on health equity and health disparities and in particular on the health of Black populations.

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Race, Policing and Social Unrest During the COVID-19 Pandemic

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Abstract

Black Canadians have a historically tenuous relationship with the police. The negative perceptions of the police held by Black people result from high levels of police contact and perceived negative treatment during these encounters. Well publicized instances of police violence involving Black and other racialized individuals also foster hostility and mistrust of the police, sometimes resulting in social unrest. This paper situates the recent widespread social uprisings resulting from police violence in the context of the racial and social inequities exposed by the COVID-19 pandemic. A series of related recommendations are made.

Introduction

An article published in the September 5th edition of the *Toronto Star* newspaper ran with the following headline: “In 1999, cops pulled over Dee Brown, a Black Raptors player. Two decades later, CEO Masai Ujiri is shoved on the basketball court. Has anything changed?” The article refers to two cases of police misconduct involving high-profile members of Toronto’s professional basketball team, which reverberated through Canada’s Black communities. The opening paragraphs of the article read:

A Black man driving a fancy car is pulled over for speeding on the Don Valley Parkway in the early morning hours after a Halloween party. The arresting officer runs a licence plate check to see if the car is stolen before pulling the driver over, and prepares a second set of notes about the stop. The man is charged with impaired driving after failing a breathalyzer test.

At a subsequent trial, the judge called the man’s racial-profiling claims “conversation stoppers” and suggests he apologize for such allegations against the officer. The man is convicted, fined \$2,000 and banned from driving in Canada, a decision that is eventually overturned thanks to a “landmark” ruling by the Ontario Court of Appeal that acknowledges some police officers target racial minorities out of a belief that they are more likely to commit crimes.

Twenty years later, another Black man is making his way onto a basketball court in Oakland, Calif, where the team he runs is celebrating its first NBA championship. As he goes to pull out the credential that allows him access to the court, he is shoved twice by an on-duty sheriff’s officer. The man shoves back.

The sheriff’s office recommends criminal charges be laid. When the district attorney’s office decides against it, the officer files a federal lawsuit against the man, seeking damages. The man makes it clear he believes the incident occurred because he is Black. The sheriff’s deputy claims those are false allegations of “racial animus and prejudicial bias.”

Nearly two decades elapsed between the Nov. 1, 1999 night when a police officer stopped former Raptors guard Dee Brown in Toronto and the June 13, 2019 night when current Raptors president and CEO Masai Ujiri was involved in an altercation with Alameda County Sheriff’s deputy Alan Strickland. Local legal experts believe the

similarities between the two cases, namely the allegations of racial profiling, highlight how little progress has been made in the fight against anti-Black racism.¹

These instances of police misconduct have hit home for many Black Canadians and the question “has anything changed?” is an important one. Indeed, police race relations in Canada are strained at the best of times. Decades of research and Task Force reports have highlighted the gulf between Black communities and the police. While efforts to address this gulf have waxed and waned over time, police race relations have taken centre stage in the midst of a global pandemic and following the high-profile police killings and shootings of Black people in Canada and the United States. This paper provides a brief overview of Black peoples’ perceptions of and experiences with the police, highlighting the role of excessive force in shaping these perceptions and experiences and in prompting social unrest. This discussion is situated within the broader Black COVID-19 experience, examining how the pandemic exposed the grave social inequities experienced by Black and other racialized populations, provoking widespread fury and outrage.

Race and Perceptions of the Police

Research has consistently shown that Black people and members of some other racial minority groups (e.g. Indigenous, Latinx) hold more negative views of the police than white people.² As part of its research into systemic racism in the Ontario criminal justice system in the early 1990s, the Commission on Systemic Racism surveyed members of the general public in the Greater Toronto Area (GTA) about their perceptions of the justice system. Their research found that over half of Black, white, and Chinese respondents believed that the police treat Black people differently than white people.³ This study was replicated in 2007, fifteen years later, to examine whether there were changes in citizens’ perceptions of the system. Despite the myriad race relations initiatives that were implemented in the intervening period, the more recent study found that perceptions of bias had actually increased amongst both Black and white respondents. For example, in 1994, 76 per cent of Black respondents felt that the police treated Black people worse or much worse than they treated white people. By 2007, this figure had risen to 81 per cent.⁴

Outside of the GTA, researchers have used data from Canada’s General Social Survey (GSS) to examine perceptions of the police held amongst “visible minorities” as a collective group. Drawing on the 1999 and 2004 GSSs respectively, O’Conner and Cao both found that visible minorities held less positive views of the police than white people.⁵⁶ Recognizing that the visible minority category encompasses members of different racial groups with very different experiences, Sprott and Doob disaggregated those classified as visible minorities and included Chinese, South Asian and Black respondents in their analysis of 2009 GSS data and compared them with the views of Indigenous and white respondents.⁷ They also separated what they considered to be the interpersonal-interaction items contained in the GSS (whether the officers were approachable and easy to talk to, whether they treated people fairly) from the technical items (enforcing laws, responding promptly, supplying information to the public and ensuring safety). Sprott and Doob found that Black and Chinese people in Ontario rated the police more negatively than white people on the interpersonal questions, but not on the technical questions. Indigenous people held more negative views on both the interpersonal and the technical questions than did white respondents. Perhaps unsurprisingly, these negative perceptions are a product of the nature of police treatment experienced by these groups.

Experiences with Police

Research also shows that the negative perceptions of the police held by Black people and members of other racial minority groups stem, at least in part, from their interactions with law enforcement. My research with Prof. Scot Wortley, for example, has shown that Black people feel more negatively about their treatment at the hands of police than do members of other groups. Indeed, in one study we found Black respondents to be less likely than their white and Chinese counterparts to have been told the reason for their last police stop by the officer involved, less likely to feel that the officer treated them with respect, more likely to feel the stop was unfair, and more likely to report leaving the encounter feeling “upset.”⁸ We also know that perceptions of mistreatment during stops are compounded by the volume of police stops experienced by Black people. Multiple studies have shown that Black people experience higher levels of contact with the police (e.g., stop and search) than members of other racial groups.⁹¹⁰¹¹ As “Willie,” a young man I interviewed on the matter told me several years ago: “I get stopped a lot – I was stopped four times in one night and questioned. It is annoying because they don’t look at anyone else.”¹² The feeling of being “singled out,” also the title of the *Toronto Star’s* first groundbreaking series on racial profiling in Canada, is commonplace among Black Canadians and clearly fuels their frustrations with police.

The phenomenon of police “carding” in Canada also contributed greatly to antipathy towards the police as a result of excessive stops. In addition to a stop, carding involves the gathering of information about the person stopped by the police which is then entered into a police database for “intelligence purposes.” The practice is controversial, not only because of the racially disparate way in which it is practiced, but also because there have typically been few controls over how the information collected was to be stored and used, including who it could be shared with and under what circumstances. Data from across the country shows that Black people are overrepresented in the carding activities of a range of police services, including those in Vancouver, Halifax, Peel, Waterloo, Hamilton, London, Ottawa and Toronto. The *Toronto Star’s* analysis of more than 1.7 million “contact cards” filled out by the Toronto police between 2003 and 2008 found that Black people comprised almost 25 per cent of those documented by the police, while representing only 8.4 per cent of the population. Importantly, the data also indicates that Black people are overrepresented in police “contact cards” for all areas of the city, regardless of neighbourhood crime rate or racial composition, debunking the assertion that Black people are only stopped in high crime areas of the city.¹³¹⁴ While the practice of carding has come under increased scrutiny and oversight, we still see various forms of discriminatory policing playing out. Most recently, this has occurred in the context of “pandemic policing” or the enforcement of social distancing regulations. Data from London and New York both show stark racial disparities in who is ticketed for violating social distancing laws with Black people being overrepresented in both cities.¹⁵¹⁶ While comparable data is not available for Canada, media attention to Black people being targeted by public officials and members of the public for violating similar rules in this country suggests the same phenomenon may be at play here.¹⁷¹⁸

Use of Force

There is perhaps no greater driver of the negative perceptions documented above than high-profile cases of use of force. Indeed, the gravity of issues relating to race and racism in the context of police use of force was recognized recently by Justice Joseph Di Luca in his decision in *R v.*

Theriault, a case involving a white Toronto Police officer and his brother who stood trial for the vicious beating of Dafonte Miller, a young Black man they allege to have found stealing from a vehicle in their parents' driveway.¹⁹

At the outset, Justice Di Luca carefully acknowledged the "racialized context" in which the matter before him arose. He wrote:

My task is also not to conduct a public inquiry into matters involving race and policing. In stating this, I want to make one thing very clear. I am *not* saying that race has nothing to do with this case. Indeed, I am mindful of the need to carefully consider the racialized context within which this case arises. Beyond that, I also acknowledge that this case, and others like it, raise significant issues involving race and policing that should be further examined. To give but one example taken from the evidence in this case, one could well ask how this matter might have unfolded if the first responders arrived at a call late one winter evening and observed a black man dressed in socks with no shoes, claiming to be a police officer, asking for handcuffs while kneeling on top of a significantly injured white man.

While Justice Di Luca did not conduct a public inquiry into race and policing, he did offer a careful consideration of the influence of race in his judgement of the evidence presented. I have no doubt that this careful consideration stemmed from the fact that Justice Di Luca recognized the importance of his decision given the high level of attention paid to police use of force cases.

In Canada, public attention to issues of police violence facing Black people increased in the 1970s and 1980s with the growth in Black immigration and following high-profile shooting deaths of Black men by police in the GTA. The first series of deaths involved the shooting of 24-year-old Buddy Evans by a white officer in a Toronto nightclub in 1978 and the shooting of 35-year-old Albert Johnson by two white officers in his own apartment. These shootings and the officers' acquittals in both cases sparked community mobilization and the establishment of the public complaints commissioner in Toronto. A second series of police shootings involving Black men in the late 1980s, including those of 44-year-old Lester Donaldson in his Toronto rooming house apartment and 17-year-old Michael Wade Lawson, who was shot in the back of the head by a Peel regional police officer using an illegal hollow-point bullet prompted further community organizing and mobilization, and the establishment of a provincial Task Force on Race Relations and Policing.²⁰ Despite action by government, a significant overrepresentation of Black people persists in police use of force cases. Drawing on data collected by the Special Investigations Unit, for example, a recent Ontario Human Rights Commission Inquiry found that although Black represent just 8.9 per cent of Toronto's population, they accounted for:

- 25.4 per cent of Special Investigations Unit cases;
- 28.8 per cent of police use of force cases in;
- 36 per cent of police shootings;
- 61.5% of police use of force cases that resulted in civilian death and;
- 70 per cent of police shootings that resulted in civilian death.²¹

As in the United States, widespread social unrest has followed high-profile instances of police use of force in the Canadian context including in response to the recent deaths of Andrew Loku in Toronto and Abdirahman Abdi in Ottawa.²² Unlike the current unrest sweeping across North

America and around the world, demonstrations following these deaths, however, have not been quite so sustained.

Protesting the Police in the Midst of a Global Pandemic

The moment we find ourselves in now appears to be different from those of the more recent past. While the demonstrations following the beating of Rodney King prompted widespread public and political action in the 1990s as did the deaths of Michael Brown, Eric Garner and others in the mid-2010s, the unrest and action prompted by the deaths of George Floyd, Breonna Taylor and the shooting of Jacob Blake have spurred discussions and mobilization to tackle anti-Black racism on a scale not seen since the Civil Rights era.²³²⁴ Importantly, the protests and demonstrations that have been seen from New York to Portland, Toronto to Thera, and Rome to Rio de Janeiro have taken place during a global pandemic. Those individuals who have taken to the streets to protest police brutality in particular and anti-Black racism in general have put their physical health at risk to do so. This is no coincidence. Indeed, the same factors that put Black people at increased risk of experiencing violence at the hands of the police, including various forms of social, political and economic marginalization, also increase their risk of contracting COVID-19.²⁵²⁶ Not only are Black people disproportionately likely to be the recipients of police use of force and to die at the hands (or knees) of the police but they are also more likely to be infected with and die from the coronavirus.²⁷²⁸

As mentioned, in Toronto, Black people represent 8.9 per cent of the overall population, yet they accounted for 21 per cent of COVID-19 cases reported by the end of July 2020.²⁹ Similarly, the mapping of COVID-19 cases in Toronto by Toronto Public Health reveals stark geographical differences with the city's northwest corner being particularly hard hit.³⁰ As the *Toronto Star* reports, Toronto Public Health's map mirrors other maps showing where chronic disease, socioeconomic disadvantage, such as poverty and low post-secondary outcomes, and high percentages of residents living in high-rise buildings exist.³¹ The *Star* quoted Toronto's medical officer of health as saying "[t]he fascinating thing about COVID-19 is that it has actually really laid bare where the health inequities are in the city, in a way that frankly all the reports that we have done over the years just haven't done as effectively." Of course, these health inequities are strongly correlated with social and economic inequities present in Toronto and other cities across North America and around the world. Indeed, Toronto Counsellor Joe Cressy noted, "[a]ll levels of government have a responsibility for the continued health inequities that have long plagued certain neighbourhoods and all levels of government have failed to do enough. And COVID has made that painfully visible for everyone to see."³² By laying bare these inequities, the fear and unease caused by the pandemic created an environment where protest against racism and anti-Black racism have taken place.

Conclusion: A Global Awakening?

The death of George Floyd and the ravages of COVID-19 on Black communities has furthered a growing recognition, not only that we do not live in a "post-racial" world, but in fact, the legacies of both slavery and colonialism continue to play a major role in shaping the life outcomes and social positions of Black, Indigenous and other racialized people.³³ In addition to increased public and political dialogue about racism generally and anti-Black racism in particular, acknowledgement of the continued impact of the legacy of colonialism and slavery is perhaps best captured by the recent toppling of statues depicting the architects of colonial machinery and the defenders and

benefactors of slavery, such as Canadian Prime Minister John A. Macdonald in Montreal, Quebec, Confederate President Jefferson Davis in Richmond, Virginia and British merchant Edward Colston in Bristol, England.^{34,35,36} As we move forward in addressing the underlying inequities that result in the racial disparities observed in both levels of police violence and in vulnerability to the coronavirus, it is important to acknowledge the potential of the pandemic to further entrench these inequalities. Indeed, not only has inequality influenced who is impacted by COVID-19, but the pandemic itself threatens to deepen inequality as economic slowdowns and quarantine measures disproportionately harm those on the margins of the labour force.³⁷

Recommendations

Police recruiting efforts should prioritize the selection of candidates that can demonstrate broad life experience over candidates narrowly trained in police foundations and criminal justice programs.

Police education, training and policy be revised to emphasize disengagement with civilians who pose no immediate danger to the officer(s) at the scene or to other members of the general public.

Police policy should dictate that a service weapon can only be discharged in circumstances where a civilian has a firearm or in situations where a civilian with another weapon (e.g., knife) poses a clear and immediate threat to human life.

Canada should develop a national police use of force database in order to foster a greater understanding of the nature and extent of police use of force in the country.

Given the unique role they occupy in society and in light of the immense authority granted to them, police officers should be compelled to cooperate in investigations into the use of force against a civilian.

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Data or Politics? Why the Answer Still Remains Political

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Abstract

This essay suggests that a significant gap exists between calls for race-based data collection and the claim it will lead to better policy making. Instead the paper argues that there is a gap between data collection and the political decision making needed to implement sound policy. The paper uses Toronto as a case study to demonstrate how recent COVID race-based data collection did not lead to immediate good policy decisions and implementation that would benefited those currently being the most impacted by COVID infections.

In the Canadian context, the race to collect race-based data is on. Beginning in Ontario and now spreading across the country, the collection of raced-based data has been offered as an important element for evidenced-based policy-making with the assumption that policy will be better made. Indeed, raced-based data are now offered up as necessary for moving forward on any policy that might impact the lives of racialized Canadians in health, education, employment, poverty and so on. It is not easy to pinpoint when the demand for change shifted from clearly articulated calls for policy reforms of all kinds to a singular demand for the collection of race-based data before any policy reform might be possible. Race-based data therefore have become a middle ground, so to speak, before reform can happen. There are indeed some truths about calls for race-based data, but there are many half-truths too. Evidence is important and few would dismiss evidence as unnecessary, however race-based data can quite frankly slow down reform. In that context, “doing the research,” when a problem is already identified and its solutions known, means that the collection of race-based data does not actually add much to policy-making. In fact, in some cases, it can do more harm than good. Race-based data collection, as currently articulated, is a response to a set of political concerns masquerading as if it is the answer.

The history of data collection—with Black people in particular—is a difficult and torturous one. Most often, the collection of data benefits the researchers collecting the data more than the people being researched. Indeed, if we were to account for all the SSHRC funded projects on racialized Canadians we know quite a lot about them. Add the national census and various school board and health data routinely collected and we know even more. Yet, race-based data calls entirely ignore these already existing bodies of data to make a different kind of claim – a claim that must begin from scratch and one of absence. So, where did the idea that we have no data arrive from then? Why is this the case? The positivism of the call for race-based data is one of the principle half-truths of its call. The claim that collecting such data will inevitably lead to better policy-making is a significant half-truth. In the Canadian context, it is clear that race-based data benefits the researchers and not communities. Indeed, those benefits are so clear that research protocols were developed for Indigenous communities because of prior research extraction that did not benefit those communities.¹ In the arena of calls for race-based data, it is currently a wide-open field on collecting data on non-white people in Canada. This wide-open field means that anyone can apply for funds, conduct research using whatever methods their ethical review boards find acceptable, seek out willing populations using all kinds of methods of “consent” and benefit from the research without communities themselves also benefiting. And if this characterization appears to be too stark a claim, HIV/AIDS research and Black people in Canada can be used as an example to bear it out (further discussion to follow).

But something more complicated and potentially troubling is at stake now that data across all areas of our lives is one of the most significant currencies of our time. Ethically, researchers committed to collecting race-based data need to think about how their work is not only extractive, but also how it will and can be monetized beyond their individual projects, again, without any benefit to the communities studied. The ethics of race-based data are particularly acute given how extraction in terms of racialized labour has already positioned specifically poor racialized people as reserved populations for exploitation and or wasted populations in the most extreme cases.

In Canada, excluding the national census, and various school boards and health units collecting basic data on demographics that included race, nationality and ethnicity, the infrastructure for collecting race-based data is deeply flawed. Indeed, when the Ontario government agreed to collect race-based data, one could not help but ask who would collect the data—the very people who had previously said it was impossible to collect? Who would design the data collection instruments? Who would analyze the data? The announcement garnered more questions than answers for me. And furthermore, given the specificity of race as a key component of the data collection, what kind of training would the data collectors have in terms of antiracism in all its many manifestations that would allow them not to reproduce racist ideas? These kinds of questions remain unanswered in the race for race-based data collection. What we are certain of is the institutions being asked to collect this data do not possess the kinds of knowledge necessary to do so. . And furthermore, no monies have been made available to either hire or train people who have the requisite knowledge. In the absence of serious and significant infrastructure for collecting race-based data, the arena for race-based data remains one that is open to all kinds of potential abuse, misuse and exploitation.

Indeed, in the realm of HIV/AIDS research in Canada, we have witnessed many research projects carried out on Black, Caribbean and African people given the prevalence of the virus in our communities.² Yet, this research has not impacted the health outcomes of those infested. That is to say, the research has had no affect on seroconversion (the time period during which the HIV antibody develops and results in an HIV positive status) numbers in our communities and all of the other problems that can accompany an HIV positive diagnosis. It is therefore my assessment of the context that more specifically, what this research has accorded is for researchers to excel in their fields, garner more research funding, expand their arenas of research, be nominated for and win awards and so on.

Importantly, what we have witnessed is that research and the link to better policy is not self-evident and that researchers and the populations researched can constitute a range of unequal relations in which the benefits of the research flow to the most advantaged in the relationship. And finally, when the social determinants of health were eventually articulated this had little to no impact on Black communities. In fact, while white gay men can see the endgame of HIV, HIV remains an epidemic for Black populations not just in Canada but across the world. Additionally, this example is rarely referenced because HIV remains linked to the “perverse” sex of queers. I would also suggest that calls for race-based data are premised on the assumption that a racialized (Black) middle-class desires to prove why they should be further and better included since their calls for justice using available evidence have been largely ignored. Indeed, my argument is that race-based data calls are deeply classed – the poor will be studied, and any potential benefit will accrue to the racialized middle class.

The case of the HIV epidemic and Black people is one of the most significant in terms of demonstrating how race-based data does not automatically lead to any impact on policy-making. It is a half-truth to link data and in particular race-based data collection with good policy-making. The most that can be garnered from race-based data collection is a wish for good policy-making and setting the terrain for a political fight. The race then for race-based data collection is both a slowing down of implementing better policy, but also an acknowledgement that those who hold power reserve the right to decide whether to trust racialized people's articulation of their own experiences and what requisite reforms are necessary. Given what we have learned from the social determinants of health, there should be no surprise then that COVID-19 affects mostly poor racialized communities the hardest.

Late into the pandemic, Ontario has yet to create sites where families not able to fully isolate because of their home spaces could be billeted at hotels at no cost to them. Indeed, this lack of policy exists in spite of the evidence demonstrating who is experiencing the most severe impact of COVID-19. One can only ask the researchers why they perpetuate the myth that race-based data collection will lead to better policy-making when the body of evidence continues to demonstrate otherwise?

COVID-19 in Toronto: A Brief Case Study

First, it is important to note that at the time of writing, we remain in a pandemic. It is jarring to hear people continually use the phrase "during the pandemic" as if it is already over. The reopening of the economy has led many to behave as if the pandemic was only happening when national isolation was mandated and conversely, many seem to see the lifting of strict national isolation as the end of the pandemic. Nothing can be further from the truth. The logic that the pandemic might be over as "reopening" progresses is one that again alerts us to the gap between data-driven calls for equity and justice and the absence of policy-making that produces equity and justice. Poor racialized people have been working throughout the pandemic in long-term care homes, hospitals, food services, on farms and in the food-processing industries. We can examine the city of Toronto as a case study in this gap and the consequences of the gap.

In June 2020, Toronto Public Health published its interactive COVID-19 map.³ The map allowed Torontonians to see where concentrations of COVID-19 infections were by postal code. What the map demonstrated was that COVID-19 infections were concentrated in poor racialized communities. The map confirmed what frontline health-care workers were already making plainly clear in the news media, even as they too joined the bandwagon call for race-based data. A number of things are worth observing here. I think there is a nuance between the health-care workers' call for data collection and professional researchers' call. The health-care workers are hoping to redirect funds and practice in the midst of the emergency.⁴ For example a health care worker is quoted as saying, "she wants to see political will and money put into improvements such as higher pay to retain personal support workers, sick leave and in some cases safer commuting options for those without private vehicles."⁵ There is clearly a gap between various elements involved in the research process that any careful analyst can discern.

The professional researchers are seeking to cement their own relevance in their workplaces. This is an important nuance to hold on to. Also, health-care workers already knew who would count as "essential workers" and how these low-paid workers would occupy at least two data points in any COVID-19 data collection – poor and racialized. Health-care workers at the lowest rungs are

among the most vulnerable and live in the postal coded areas of concentrated infection. What was being asked for was already known. The second moment in making sense of COVID-19 and race-based data collection is the plan to reopen schools. A searchable database was released in which elementary schools with potential for infections was released.⁶ The schools marked for potential problems were in the same areas that the interactive map had already singled out as zones of and for infection.

The Mayor of Toronto could be heard on CBC Radio on September 1, 2020, acknowledging that no specific policies had been implemented for affected areas. Again, the link between data and policy-making, even in a crisis, is a fiction especially when racialized poor people are the beneficiaries of such policy. Significantly, one of the most important outcomes of the COVID-19 era is the focus on housing and unhoused people. City of Toronto statistics suggest that that about 30 per cent of unhoused people are Black and Indigenous.⁷ The data act as evidence, but that evidence has in no way led to policy-making meant to stem the tide of the growing unhoused. Indeed, the science of COVID-19 alerts us to the importance of housing to slow the rate of infections and community spread. There is a gap between data collection, evidence, policy and action, and that gap requires attention. It is the gap that represents a political question.

What does it mean then to say that the way to create a better society is to collect race-based data? It is apparent that response works to delay good policy-making and action in the face of demands for transformative change that has been articulated by social movements. My argument is not in opposition to the collection of race-based data, but that the evidence or data needed to make good and better policy already exists. I repeat, race-based data collection does not correlate with good policy-making, as shown by the history of African American life. In Canada, the belief that the collection of race-based data will result in better policy-making urgently needs to be uncoupled from policy conversations. All data can do is inform policy-making, if anything at all. Policy-making, after all, is ultimately about political decisions.

What Is to Be Done?

Recommendations:

1. Trust communities and their experiences. Know that communities can and do diagnose their problems/issues and have evidence for their conclusions. Additionally, actively refuse the idea that communities require professional researchers to validate their evidence.
2. Political demands based on communities' experiences of the world must be accorded the same measure as professionally researched driven analyses.
3. Seek out community research protocols that take the research relationship between communities and professional researchers seriously. For example, the Indigenous health research protocols that attempt to limit and or mitigate against research extraction, exploitation and harm that can be caused to Indigenous peoples by professional researchers is a case in point. Scholar-activists in Black communities are building a similar protocol: LLana James (doctoral candidate, Medicine UofT)⁸ and Ciann Wilson (Associate Professor, Waterloo) community research protocol and the REDE4BlackLives protocols.⁹
4. Empower community researchers and work with them to make sure that they have the adequate resources to run their own identified research projects in the interests of their communities.

5. Recognize that local community organizations are fully informed about their localities and when given the resources, they can and do enact practices that improve lives based on the evidence they already have and know.
6. Be honest about the differences between what professional researchers need data for (it rarely is about helping communities) and what communities actually need for their well-being.

These recommendations are not an attempt to place professional researchers outside communities, but to stem the parasitic tide of research extraction from marginalized and vulnerable communities while the issues affecting those communities continue unabated. In terms of race-based data collection, professional researchers need to make clear to communities that research aims to influence policy, but that good policy is not always the outcome of research. The political nature and context of research therefore needs to be highlighted. Lastly, professional researchers need to alert racialized communities through public education campaigns that data can be heavily monetized and also used across many different platforms. It can be used and abused to potentially harm communities for years to come, and we should be more than cautious.

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- 2 <https://www.blackhivday.ca/about.html>; Also see the long list of research partnership Women's Health in Women's Hands has conducted for further evidence of how I make my assessment. <https://www.whiwh.com/hiv-aids>
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COVID-19: The Pandemic & Histories of Inequities Unveiled Impact on Black Communities

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Abstract

In this paper, I will provide a brief description of pandemics, but paying particular attention to COVID-19 and its impact on Black communities in Canada. I will situate my analysis on Anti-Black Racism because black people have been disproportionately impacted by this pandemic. I will also briefly discuss historical inequalities and how the pandemic has unveiled long standing anti-black racism.

Introduction

A pandemic is the rapid spread of a disease to a large number of people in a very short period of time, across regions, countries and continents. A seasonal influenza is not a pandemic. The current pandemic, which was initially reference to as Coronavirus disease and later referred to as COVID-19, was first identified in December 2019 in Wuhan, Hubei, China. As I write this paper in September 2020, COVID-19 has touched every corner of the global, infecting over 31,762,607 and killing 973,956 around the globe. In Canada, we have 149,939 cases and 9,294 deaths (Henrik Peterson, Byron Manley and Sergio Hernandez, CNN, 23/09/2020). When COVID-19 broke out, there was a general feeling that everyone was being affected in the same way. COVID-19, supposedly, did not discriminate. However, this was an illusion because by June 2020, an analysis of those infected by the disease in Canada revealed that racialized, and in particular Black people, had higher numbers than the rest of the population (Global News Canada). That report further indicated there was a strong correlation between high COVID-19 rates and low income, types of employment, ethnicity and low levels of education. Bowden & Cain (2020) note that, unfortunately, many Black neighbourhoods in Canada find themselves in these conditions primarily due to systemic anti-Black racism. There has not been enough research to support these claims; initial findings have created a need to pay close attention to various communities in Canada, and in particular, racialized and Black communities. It's important to explore the following questions:

- What really is anti-Black racism?
- How can we as Canadians collectively address anti-Black racism so that if/when there is another pandemic Black people will not be affected disproportionately?
- What has held together systemic barriers to equal employment, education health and economic opportunities for people of African ancestry?

When the COVID-19 pandemic struck, the world came to a standstill. Most companies laid off (see more detail in COVID-19 jobs tracker: Layoffs, furloughs and hiring during the pandemic) employees as they tried to adjust to current economic challenges, a strategy that left many individuals jobless. For instance, Air Canada indicated that there would be lay off between 50 to 60 percent of its workforce (Michelle Zadikian, July 2020). Other companies moved their offices to their employees' homes while schools closed, and most universities moved their teaching online. Businesses closed, followed by fear gripping the world as more and more people got infected and the death toll kept rising. Paying close attention to these numbers or even stories in the media, it was clear that COVID-19's impact was not evenly distributed. Some of the health disparities are not new. For instance, Black people in the U.S. are two to three times more likely to develop

Alzheimer's disease than whites, and Hispanics are one to two times more likely to develop Alzheimer's disease than whites.¹ COVID-19 has infected dementia patients and their caregivers. In the U.S., data shows the number of Black people who have died due to COVID-19. Unfortunately, in Canada, race-based data about which groups have been impacted by COVID-19 hasn't been collected. Toronto Public Health announced on April 22, 2020, that it would begin to collect this information to address health inequities.² Racialized, and in particular Black people, were dying at a higher rate than the rest of the population. According to various news media reports and real-life stories, the COVID-19 pandemic has had a disproportionate impact on the lives of Black people in all aspects of life. Andrea Huncar (September 2, 2020, CBC) reported on a study done by Edmonton-based African Canadian Civic Engagement Council and Innovative Research Group that confirmed layoffs disproportionately reduced work hours for Black Canadians. The study further revealed that men over 45 years were hardest hit; and national wide, 56 per cent of Blacks had been affected, compared with the national average of 46 per cent.³ This is further articulated in the article: *Black neighbourhoods in Toronto are hit hardest by COVID-19 — and it's 'anchored in racism'* that indicated that the highest number of COVID-19 cases were in neighbourhoods with Black communities. These findings are similar in Montreal and New York. More generally, communities in which there are higher shares of Black residents also experience higher infection counts. Large cities such as Calgary (Canada's fourth largest) and Hamilton (with population of more than half a million) as well as areas in Nova Scotia (a province with fewer than 1 million people overall) have both relatively high COVID-19 counts and relatively high shares of Black residents (Patrick Denice, Kate H. Choi, Michael Haan and Anna Zajacova report).⁴ Other studies have shown that poorer access to health-care facilities by Black people has left many wondering why they are treated differently. A study of emergency room records in the U.S. found that health personnel rated the complaints of Black people as less serious than their white counterparts. The study also indicated that Black people experienced longer wait times in emergency rooms, even if they were facing medical emergencies where immediate intervention was necessary. Several studies have also found that physicians spend less time with Black patients and are less likely to see them as being honest about their symptoms compared to white patients.⁵

In Black business areas such as Little Jamaica, located on Eglinton Ave West in Toronto, many restaurants, salons, and clothing stores are Black-owned. Some of these businesses have been in operation since the 1960s. Unfortunately, in the last six years, many of these Black-owned businesses have only operated at half capacity because of the ongoing transit construction, gentrification and road closures. These businesses were therefore doubly affected with the outbreak of COVID-19. Many business owners were already under a lot of pressure to close down permanently because of the significant drop in revenue, and COVID-19 only amplified that pressure. This area, at its peak, brought Jamaicans together to celebrate community, belonging, and a sense of familiarity through food, dance, and services. If many of these business owners are forced to close, a piece

1 (COVID-19: Health Disparities Exposed - Alzheimer's Association: https://www.alz.org/aaic/downloads2020/DI_HealthDisparities_Covid.pdf)

2 <https://globalnews.ca/news/6892178/black-canadians-coronavirus-risk/>

3 <https://www.cbc.ca/news/canada/edmonton/black-canadians-covid-19-study-1.5708530>

4 https://westerngazette.ca/culture/how-black-canadians-are-disproportionately-impacted-by-covid-19/article_89293cc4-a033-11ea-ae15-631b3c049880.html

5 Relationship between racial disparities in ED wait times and illness severity; DOI: 10.1016/j.ajem.2015.08.052

of Toronto history will be gone permanently.⁶ Global News reports that since construction started six years ago, 40 percent of stores have closed down or relocated.

The pandemic has not only affected Black-owned businesses, it has also impacted Black health-care professionals. Dr. Eileen de Villa, Toronto's medical officer of health, commented that data shows that Black people account for 21 per cent of reported cases in Toronto while making up only 9 percent of the overall population. De Villa further stated that Arab, Middle Eastern, and West Asian people represent 11 per cent of the city's COVID-19 cases while only making up 4 per cent of the total population. De Villa confirmed that racialized people made up 71 per cent of those hospitalized with COVID-19. Also, lower-income households and households with more racialized people were also disproportionately affected by COVID-19.

Anti-Black Racism and COVID-19

COVID-19 has unveiled historical inequities and elevated race-based differences. As a result, anti-Black racism has become more visible. Anti-Black racism has not been addressed fully because of the discomfort it creates. Many find it easier to ignore it or sweep it under the carpet when mentioned. What many fail to see is how anti-Black racism illustrates the ways in which racism operates at personal, ideological and institutional levels. A discussion brings attention to Black-owned business closures, health inequalities, the disproportionate loss of jobs and the high death rate of Black Canadians. If COVID-19 had not occurred, these inequities could have continued undetected. With COVID-19 comes a spotlight on these long-ignored historical inequities.

Anti-Black racism, therefore, frames the discussion around the experiences of marginalized and in particular, Black people. Dr Akua Benjamin, professor emeritus from Ryerson University, defined anti-Black racism as "a particular form of systemic and structural racism in Canadian society, which historically and contemporarily has been perpetrated against Blacks" (2003, p. ii) The framework provides a tool for disrupting racism by identifying and analyzing how it functions⁷ (Henry & Tator, 2009). Anti-Black racism is deeply entrenched in Canadian institutions, policies and practices such that it is either normalized or rendered invisible to the larger white society (Morgan and Bullen, 2015). For many years now, different groups have been pushing to have race-based data on different topics, but somehow various authorities have resisted it. It is important to note that due to the pressure from social activists and academics, the government of Ontario has been compelled to start collecting race-based data as of June 2020. Anti-Black racism is embedded in our institutional structures, governing bodies, policies. COVID-19 managed to lift the lid to expose some of the historical inequities that have been in existence for centuries. Effectively, anti-Black racism has immobilized Black people and undocumented residents, not only in Canada, but other parts of the world where they are the minority.

Discrimination due to race is a common experience in Canada with one in five Canadians having experienced this regularly or from time to time, and another three in ten indicating it has taken place, but only very rarely. Not surprisingly, racial discrimination is most widely reported by Indigenous and Black people, to a lesser extent among other racialized groups, and even by four in ten white Canadians who say this has happened to them if only on rare occasions. These

⁶ Read more: Article: 'Little Jamaica could be lost to history': Advocates renew call for official recognition of cultural gem in wake of COVID-19, LRT construction and gentrification

⁷ Henry, Frances & Tator, Carol; (2009). *The Colour of Democracy: Racism in Canadian Society* Henry, Frances & Tator, Carol; (2009). *The Colour of Democracy: Racism in Canadian Society*

differences in the likelihood of reporting discrimination across racial groups are evident in several settings but are most apparent in situations involving the police and in the workplace.

Racial discrimination also takes the form of day-to-day experiences involving subtle slights or insults like micro-aggressions, such as being treated as not smart, as suspicious, mistaken for someone who serves others, or ignored when requesting services. Such experiences are reported by individuals from all racial groups especially in cases of being unfairly stopped by police. Different members of Canadian institutions have openly stated that anti-Black racism does exist. Anti-Black racism has brought to life a lot of frustrations and left individuals with many questions: How many more reports need to be written? What will it take to ensure the recommendations in these reports are implemented? There's this notion that Canada is somehow immune to widespread racism, an idea that is held up even by political leaders, showing a lack of awareness of the histories of the people they represent. An example is Doug Ford, Premier of Ontario who said in an interview with The Toronto Star in June 2020, "Thank God that we are different than the United States." Racism is more common in Canada than most people think. 40 per cent of racialized people in Ontario surveyed by the Ontario Human Rights Commission in 2017, report experiencing discrimination because of race or color in the last five years. The reality is that racism has been around a long, long time. It's deeply rooted in Canada's colonial past. The effects of inequality and the trauma racialized people faced in the past still linger in modern society. COVID-19 has made that apparent.

Conclusion

The pandemic has contradicted the notion of Canada being an inclusive and pluralist society. We are all implicated in this. Various surveys indicate that one in five Canadians have experienced racism. This is particularly so among Black people. (Race Relations in Canada 2019; A Survey of Canadian Public and Experience. P.5). Racial discrimination is an everyday experience for many racialized people. Most times, it involves subtle micro-aggressions or slights, but collectively, these small actions can and do have big impacts. It is quite clear that Black people have had a major share of the negative impact due to COVID-19. However, it is important to state that the pandemic has also created an opportunity for the country to revisit this concept of anti-Black racism as well as rethink issues of diversity, inclusion, equality and recognition. During these difficult times, we must refuse to be drawn to politics of hate, race, gender, sexuality, privilege and discrimination of Black people. I believe, we can collectively address the issues of pandemic and the racial inequality by writing about them, introducing histories of Black people as equity deserving and not victims. The pandemic should be taken a moment in time to re-evaluate who we are as Canadians. We must, seek ways to make this country fair for all citizens.

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