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 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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