# Chapter 8: Racialized Communities and COVID-19

As early as April 2020, it was clear: Black Americans were disproportionately dying from COVID-19. The statistics were shocking: in the 12 states that were keeping race and ethnicity data as of April 17, 2020, Black people were 2.5 times more likely to die than the general population. In Chicago, Black Americans accounted for approximately 70% of COVID-related deaths (and 52% of cases), despite making up only 30% of the population. As the months rolled on, these trends continued. What was less clear was whether similar trends were occurring in Canada. Why? Because most of our health units did not collect "race"-based data. It wasn't until June 15 that one of the largest, most diverse, and most impacted provinces, Ontario, considered mandating that health units collect such data to inform strategies and responses. Nevertheless, evidence gathered by sociologists at Western University suggests racialized people in Canada were also disproportionately affected by the disease. Black, immigrant, and migrant communities saw higher infection rates and deaths, and were more likely to be virus "hotspots."

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The causes of social inequalities caused by "race" are many and complex. Many of us are familiar with—and horrified by—the history and continued manifestations of anti-Black racism in the US: from slavery through segregation to the police brutality that sparked protests during the pandemic. The systemic racism that plagues the US also exists here in Canada and explains, in part, why racialized populations were so impacted by the pandemic. Barriers and discrimination mean that Black, immigrant, and Indigenous communities tend to be poorer than other communities. They live in closer quarters, making it harder to self-isolate. They are more likely to work low-paying frontline jobs and less likely to be able to stop working even if they do have underlying conditions, putting them at greater risk. Even in Canada with our universal healthcare, these communities may have less access to medical facilities (especially true on Indigenous reserves). In the US, being poor can mean you have no access to healthcare at all. Health outcomes are also determined by factors like access to clean water, clean air, and food—all of which can be issues in Indigenous and other racialized communities. COVID-19 did not create systemic discrimination and racism, but it did exacerbate it. By tracing its effects on racialized populations, we can start to recognize sociological patterns—the first step to changing them.

## As you read the chapter, consider the following questions:

- When asked why Ontario wasn't collecting data on race and ethnicity, provincial chief medical officer Dr. David Williams noted the most at-risk were old people and those with underlying medical conditions. He said "So those are all priorities to us, regardless of race, ethnic or other backgrounds." How do you interpret the reluctance of governments in Canada to collect "race"-based data on COVID-19 patients? (Consider Canada's master narrative of multiculturism, systemic racism, economic factors, or other social mechanisms.) Do you agree with this decision? Why or why not?
- Canada's chief public health officer during the pandemic was Dr. Theresa Tam, a familiar face during Ottawa's daily televised briefings. In April 2020, MP Derek Sloan drew attention to her Asian heritage by tweeting, "Dr. Tam must go! Canada must remain sovereign over decisions. The UN, the WHO, and Chinese Communist propaganda must never again have a say over Canada's public health!" After receiving censure from his government colleagues and the public, Sloan wrote, "None of my arguments for Dr. Tam's removal were based on Dr. Tam's race or her sex: they were based on her performance." What form of racism did Sloan's comments represent? Do you agree with his assertion that his primary critique was of her performance?
- Consider the impacts of intersectionality on racialized women in Canada. How might their intersectional identities have contributed to the impacts of COVID-19 on their lives? (Consider what additional challenges women faced due to the pandemic.)
- The lack of "race"-based data at the beginning of the pandemic poses challenges to conducting sociological studies on the impact of the pandemic on different "races" and ethnicities. How would you overcome this problem if you wanted to undertake a study on how the pandemic affected a particular racialized neighbourhood or community? What methodology would you use? How would you address gaps in data?

## Additional online resources

This article describes how some Black Canadians struggled in isolation as Black Lives Matter protests broke out around the world.

- Friend, D. (2020, June 4). *Anxieties over racism heighten for many black Canadians in COVID-19 isolation*. CP24.

This article provides a more in-depth look at health disparities based on race in the United States.

- Grey Ellis, E. (2020, May 2). *Covid-19 is killing Black people unequally—don't be surprised*. Wired.

A doctor explains ways the practice of medicine is racist too.

- Medlife Crisis. (2020, June 5). *Is COVID racist too? | How science & medicine get it wrong* [Video].

A sociologist weighs in on the number of Black people dying of COVID-19 in the US.

- TRT World Now. (2020, April 9). *Coronavirus pandemic: Rashawn Ray, Associate Professor of Sociology* [Video].

This article reveals some of the many barriers to access and quality care faced by Indigenous people in Canada.

- Whyon, M. (2020, July 9). *Indigenous people don't feel safe accessing health care. Here's what has to change*. The Tyee.