

“MORE EXPOSED AND LESS PROTECTED” IN CANADA: SYSTEMIC RACISM AND COVID-19

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In a recent interview in *Scientific American*, epidemiologist and anti-racist activist Dr. Camara Phyllis Jones states that “racism, not race, is a risk factor for dying of COVID-19” (Wallis, 2020). North American research has shown that racialized and immigrant populations face disproportionately high rates of infection and death, and Dr. Jones argues that this disparity is due to racial inequities deeply ingrained in society (Centers for Disease Control and Prevention [CDC], 2020; Choi et al., 2020, Guttman et al.; 2020).

Systemic racism has had a twofold effect on how the pandemic has impacted Black, Indigenous, and people of colour (BIPOC). As BIPOC are “more exposed and less protected” from the virus, and, once infected, are more likely to die because of racial inequalities relating to health and environmental factors (Wallis, 2020, para. 2). In this sense, Dr. Jones explains how

Race doesn’t put you at higher risk. Racism puts you at higher risk. It does so through two mechanisms: People of color are more infected because we are more exposed and less protected. Then, once infected, we are more likely to die because we carry a greater burden of chronic diseases from living in disinvested communities with poor food options [and] poisoned air and because we have less access to health care. (Wallis, 2020, para. 4)

Emerging research on race and COVID-19 appears to confirm the applicability of Dr. Jones’ analysis in the Canadian context. Canadian health researchers such as Dr. Upton Allen suggest that structural inequities in healthcare, labour, and community affluence have shaped the disproportionate harms of COVID-19 in Black communities (Slaughter, 2020). These inequities are in turn connected to intersecting systems of racial, gender, and class marginalization.

As the country continues to grapple with both the coronavirus pandemic and the prevalence of systemic racism, it is essential that the disproportionate impacts of the virus be identified and that the underlying social causes of these impacts be understood and resolved.

This Backgrounder provides a broad synopsis of publicly available research on the interrelationship between racism and COVID-19 in Canada and it seeks to highlight some of the ways that racism (and its intersections with class and gender inequality) has made BIPOC “more exposed and less protected” to harms during the pandemic. It explores this connection in the context of three key social issues noted by Dr. Jones and Dr. Allen:

1. Experiences with the healthcare system
2. The types of work that people do
3. The living conditions people experience in their homes and communities

The objective of this resource is to provide advocates, policymakers, and the public with Canadian examples of how intersecting oppressions impact the risks and harms people experience amidst the COVID-19 pandemic.

The information presented in this resource demonstrates how:

- Discrimination and systemic bias in healthcare contributes to poorer health outcomes for Black, Indigenous, and people of colour (BIPOC) in Canada.
- BIPOC women are overrepresented in jobs with high risk of exposure to COVID-19, particularly lower-paying positions in care work, food production, and in the “gig” economy.
- Race and class intersect in shaping how people’s living situations may place them at greater risk of harm during the pandemic.

1. HEALTHCARE

Racism reduces the quality of healthcare experienced by BIPOC

Although the health disparities faced by BIPOC in Canada may be biological in nature, addressing the causes of these differences requires a consideration of key social determinants of health as well. Liben Gebremikael, Executive Director at TAIBU Community Health Centre, writes:

Biological determinants are insufficient to explain these (health) disparities. They result from long-standing systems of oppression and bias which have subjected people of colour to discrimination in the healthcare setting, decreased access to medical care and healthy food, unsafe working conditions, mass incarceration, exposure to pollution and noise and the toxic effects of stress. (Quoted in Iroanyah & Cyr, 2020, para. 10)

Put simply, systemic racism within Canadian society produced a situation that made the impact of COVID-19 medically unequal from the start. As Gebremikael and other researchers cited throughout this Backgrounder have suggested, the practical manifestations of this oppression are wide-ranging. Below, we highlight a few examples of how racism operates as a barrier to needed supports within the health and medical fields.

Health Concerns Undervalued. Anti-racist advocates have raised concerns about the ways that lower quality of care for BIPOC leaves individuals and communities less protected from potential cases of COVID-19 (Li & Galea, 2020, p. 956). It may also lead to underutilization of health services and/or the failure to detect COVID-19 cases (Li & Galea, 2020, p. 956). In the United States, for instance, Dr. Jones reports:

We heard about people who were symptomatic and presented at emergency departments but were sent back home without getting a test. A lot of people died at home without ever having a confirmed diagnosis. (Wallis, 2020, para. 9)

In Canada, discriminatory healthcare treatment toward Black women (including dismissing, invalidating, and minimizing patient concerns) is well known in Black communities (Dixon, 2020). Disrespect and bias toward patients who are Indigenous, POC, 2SLGBTQ, homeless, and

migrants is also a recurring problem in Canada’s healthcare system (Skosireva et al., 2014; Morris et al., 2019; Wylie & McConkey, 2019). The abuse and neglect experienced by Joyce Echequan before her recent death similarly highlights the “heartbreakingly normal” mistreatment that Indigenous patients experience within medical institutions (Nakuset, quoted in Lowrie & Malone, 2020, para. 19). Nakuset, the Executive Director of Native Women’s Shelter in Montreal, notes that racism toward Indigenous women is so pervasive that her organization will often send support workers to accompany clients to hospitals to witness and document racist incidents (Lowrie & Malone, 2020, para. 21).

Environmental and Economic Barriers to Health. Interconnecting experiences of stressful environments, economic inequality, and racism elicit conditions of chronically heightened anxiety and vigilance (Choi et al., 2019; Greenberg, 2020). The effect of this “allostatic load” is increased wear and tear on the body’s regulatory mechanisms (e.g. immune system, circulatory systems, and regulation of mood and blood sugar) (Greenberg, 2020). These health disparities in turn place BIPOC at greater risk of complications from COVID-19 (Veenstra & Patterson, 2017; Yaya et al., 2020).

Environmental and economic barriers associated with racial inequality also create practical barriers to health. For instance, lack of access to a car (or inadequate public transportation) imposes a limit on the choices of groceries and health services one can access—as well as increased risk of exposure to the virus on public transportation (Yaya et al., 2020).

Medicalized Racial Stigma. In the context of the COVID-19 pandemic, racial discrimination in the medical establishment may take place not only through a lack of treatment or access for BIPOC patients but also in the overreaction to more benign symptoms. This too can put patients at risk. For instance, one Black Toronto resident who visited the hospital for a fever described being taken to a “COVID ward” and facing resistance to her questions about why some staff were not wearing personal protective equipment, or whether there were risks to using a shared washroom (Canadian Press, 2020).

Circumstances like these are not always captured in large data samples, but they match a pattern of lived experiences for BIPOC living in Canada when navigating the healthcare industry. They reflect the “everyday” forms of racism that place BIPOC at disproportionately higher risk of exposure and harm from the pandemic.

2. LABOUR

COVID-19 infections in the workforce reflect wider problems of racism in our economy

Systemic inequalities in race, class, and gender shape heightened risk of exposure and poorer protection from COVID-19 among Canada’s workforce. Some of the largest outbreaks of COVID-19 have occurred in long-term care facilities and meat-packing industries, in which racialized people are disproportionately employed (Bouka & Bouka, 2020).

The health risks faced by workers during the COVID-19 pandemic are each different in nature and deserving of critical analysis to ensure the safety of all workers. However, it is important to note the fact that many of the jobs most severely impacted by the virus tend to be lower paying and disproportionately occupied by BIPOC and immigrant workers.

Precarious Labour. Black women are overrepresented in the “gig economy,” precarious employment, and long-term entry level jobs (Katshunga et al., 2020; Robertson et al., 2020) and may have minimal power over enforcing job-site protections such as personal protection equipment (Bowden & Cain, 2020). In situations where precarious work is deemed “non-essential,” workers are especially vulnerable to layoffs, creating increased economic insecurity and decreased bargaining power. In situations where precarious labour is deemed “essential,” workers are at a heightened risk of exposure to COVID-19 (Robertson et al., 2020).

Job losses also have the capacity to compound the negative economic and health factors described in the previous section. Here too, racism is a significant factor in shaping patterns of labour market precarity. A Canadian study found that experiences (or anticipation) of unemployment or reduced income were higher among Black (64%), South Asian (65%), and Filipino (70%) Canadians than the general population (TD Bank Group, 2020). This precarity is compounded at the intersection of race and sexuality. For instance, an American report found that Black LGBTQ people were more likely to have lost their jobs or experienced reduced hours during the pandemic than the rest of the Black population, LGBTQ population, and the general sample population (Human Rights Campaign Foundation & PBS Insight, 2020).

Healthcare Work. The elevated risk of exposure to coronavirus faced by healthcare workers has also been widely publicized. However, this risk is experienced unequally throughout the healthcare sector. Among the men and women who tested positive for COVID-19 in Ontario, 35.7% of women were employed as healthcare workers, compared to 9.2% of men (June 13 data, Guttman et al., 2020).

The high proportion of women healthcare workers infected with COVID-19 in Ontario is punctuated by the fact that 44.9% were immigrant or refugee women. In fact, the number of COVID-19-positive female healthcare workers who were immigrants or refugees (1,986) was more than double the number of all male healthcare workers (978) (June 13 data, Guttman et al., 2020, p. 38).

In addition to the risk of exposure to COVID-19, Black women and women of colour in the healthcare industry are exposed to persistent forms of abuse and harassment that may compound the stress of working amidst a pandemic (Estabrooks, & Keefe, 2020).

Migrant Agricultural Labour. The lack of public concern for the well-being of racialized, migrant “others” predates the coronavirus pandemic, and this failure to support migrant workers has been underscored by the numerous COVID-19 outbreaks in the agricultural sector. In Ontario, more than 1,300 foreign workers on farms have contracted COVID-19 (Pazzano, 2020).

Workers from the Caribbean, Mexico, and Central America enrolled in Temporary Foreign Worker Programs face overcrowded and unsanitary living quarters, increasing their risk of exposure to COVID-19. One anonymous report from Chatham- Kent, Ontario described workers

with positive tests being housed alongside those with negative tests, using the same utensils and bathrooms (Anonymous, 2020). Another showed bunk beds separated by sheets of cardboard (Pazzano, 2020).

These conditions are compounded by well-documented mental health struggles caused by the social exclusion of migrant workers from the broader community. Workers report experiences of racism from local communities, loneliness, depression, and anxiety related to structural forms of exclusion (e.g. fear that speaking out against dangerous work conditions may lead to deportation) (Basok & George, 2020; Haley et al., 2020).

3. HOUSING AND COMMUNITY SUPPORT

Racism, colonialism, and classism intersect to place BIPOC and newcomers to Canada in living conditions that put people at greater risk of exposure

Environmental conditions are a key determinant in individuals' vulnerability to exposure and harm from COVID-19. Communities with poorer food options, housing conditions, and air quality leave residents susceptible to chronic diseases, which in turn place COVID-19 patients at a greater risk of complications, including death (Wallis, 2020).

These factors are the result of government and corporate policymaking that has led to the impoverishment of racialized and working-class communities. Canada's "official multiculturalism" notwithstanding, the long-standing failures to support communities with large Indigenous, Black, POC, and migrant populations betray the deeply entrenched systemic racism in the living conditions people experience in Canada (CBC Radio, 2018; Maynard, 2017).

High Impact of COVID-19 on Black and Immigrant Communities. Communities with worse environmental conditions have been some of the hardest-hit by the pandemic in Canada (Abboud, 2020; CBC Radio, 2020) and elsewhere (Millett et al., 2020). They also have especially high proportions of immigrant and Black residents (Abboud, 2020; Bowden & Cain, 2020). Based on studies merging publicly available COVID-19 data with census data, sociologists at Western University found a disproportionately high prevalence of infection and death in Black and immigrant communities:

Black communities in Canada have been disproportionately impacted by COVID-19. This may explain why places like Montreal, with large numbers of Black immigrants, have emerged as Canada's COVID-19 epicentres. (Choi et al., 2020, p. 6)

The intersection among community-based inequalities, migration, and class during the pandemic is similarly reflected in Ontario-based research as well. One study by the research institute IC/ES found that individuals with positive COVID-19 cases are more likely to live in neighbourhoods with larger immigrant populations, poverty, and housing instability than those not tested for the virus (IC/ES, 2020).

Inequities in Housing and Living Conditions. Disinvestment in communities by governments and companies has led to substantial inequities for communities with high Black, Indigenous, POC, or immigrant populations. In this way, racial inequities in housing leave individuals "more

exposed and less protected” from COVID-19 (Jones, quoted in Wallis, 2020, para. 2). For instance:

- Advocates have cited the lack of access to healthy food in poor and racialized neighbourhoods as a major cause of health disparities experienced by BIPOC (Robertson et al., 2020). Dr. Jones points out that:

[It’s] not because we are not interested in health but because of the context of our lives. We are living in unhealthier places without food choices we need: no grocery stores, so-called food deserts and what some people describe as ‘fast-food swamps.’ (Jones, quoted in Wallis, 2020, para. 8)

- Race-based economic inequalities force individuals into tighter living spaces and crowded apartment buildings, creating a heightened risk of transmission (Bowden & Cain, 2020; Wherry, 2020).
- Over-policing of racialized communities has also placed Black and Indigenous men and women in the closed quarters of detention centres, which similarly heightens the risk of exposure and transmission (Robertson et al., 2020).

Successes and Challenges in Indigenous Communities. During the pandemic Indigenous Peoples face many health risk factors relating to systemic racism in health, economic, and living conditions, as well as other intersecting challenges caused by colonization. And despite noteworthy concerns about gaps in data collection by Indigenous Services Canada (Skye, 2020), COVID-19 cases appear to be lower in Indigenous communities than Canada’s national averages. As of July 31, 2020, the Government of Canada reported that the percentage of positive COVID-19 cases and fatalities for First Nations people living on reserve were respectively one-quarter and one-fifth that of the infection and fatality rates of the general Canadian population (Government of Canada, 2020).

The “community-led, community-driven solutions” developed by Indigenous communities indicate possible models for success in non-Indigenous communities as well (e.g. the use of local knowledges to raise community awareness, respecting local restrictions on gatherings, support services for individuals experiencing mental health and addiction challenges) (Allen, 2020; Alhmidi, 2020, para. 7). As Indigenous and non-Indigenous communities face a recent spike of COVID-19 cases amidst Canada’s “second wave” (Alhmidi, 2020; Oleksyn, 2020), it will be important to learn from the successes of these community-driven strategies.

To Learn More about concerns regarding gaps in COVID-19-related data collection in Indigenous communities, see:

- [Colonialism of the Curve: Indigenous Communities & Bad Covid Data](#)
- [Community vs. Indigenous Services Canada Data: The Covid-19 Discrepancy](#)

SUMMARY & RECOMMENDATIONS

Promoting public health and strengthening resilience during and after COVID-19 requires a whole-scale commitment to anti-racism

The conditions highlighted above are a reflection of a broader system of racism and white supremacy in Canadian society. Amidst the COVID-19 pandemic, these conditions leave BIPOC “more exposed and less protected” from infection than others. Ensuring the protection of everyone in society therefore requires solutions that address the underlying ways that racism interconnects with social conditions like health, labour, and community support. Among the many things that must be done to address the issues described throughout this Backgrounder, three essential tasks include:

1. Collect data disaggregated by race, and critically examine findings in the context of intersecting systems of gender, sexuality, class, and migration. Racialized health inequities have been exacerbated during the pandemic, leading BIPOC to experience various harms (including death) at disproportionately higher rates than other people in Canada. Governments have been slow to meet the calls from researchers and advocates to collect data on how COVID-19 interconnects with race. Such data is crucial for ensuring an effective allocation of resources (including public health information, testing centres, economic support, and healthcare services) to the communities hit hardest by the pandemic.

Governments must work in service of researchers, healthcare workers, patients, and communities to develop evidence-informed policies to support BIPOC communities.

2. Adopt a critical race perspective in protecting workers’ rights. The economic pressures to assume risk of COVID-19 (and lower bargaining power among low-wage workers) highlights how the pandemic has magnified inequalities at the intersection of class and race. These issues have been further underscored by global protests against anti-Black racism after the killing of George Floyd, Breonna Taylor, Regis Korchinski-Paquet, and many more. Many employers have voiced support for the Black Lives Matter movement, but it remains to be seen whether they will implement deeper changes to racist practices within their own organizations. For instance, changes in hiring policies, anti-Black racism training, and pay equity.

The coronavirus pandemic presents a precarious situation for BIPOC workers who may face unsafe labour conditions, diminished protections from the virus or from workplace violence, and race-based discrimination when searching for employment.

If employers’ pledges about racial equality are to go beyond mere performative allyship, many will require fundamental changes in their support of BIPOC workers. They must also be held economically and socially accountable to these practices from publics and policymakers.

3. Emphasize strengths-based strategies that connect public health with anti-racism. As of November 2020, there has been increased attention to the disproportionate impact of COVID-19 on BIPOC communities. The aim of this Backgrounder has been to synthesize existing

information about the processes through which racism may leave BIPOC “more exposed and less protected” from COVID-19, as well as other harms connected to the pandemic.

There is, however, a risk that such a focus will obscure the agency, leadership, and strength of BIPOC activists, workers, and communities in surviving the pandemic. It is crucial that the analysis of structural violence not lead to the paternalistic misunderstanding that experiencers of this violence are “helpless” or in need of saving by governments or well-intentioned “allies.” It is also essential that the growing awareness of the racialized characteristics of the pandemic spread not result in further medicalized stigma toward BIPOC and immigrant communities.

Policymakers, service providers, and the public must rise to the occasion by challenging implicit racial biases and create platforms that amplify the leadership, insight, and lived experience of BIPOC and immigrant and newcomer communities.

READ NEXT:

The aim of this Backgrounder is to provide a broad summary of recent research and reporting on the intersections of racism and COVID-19 in Canada. It highlights these intersections in three key areas: Healthcare, Labour, and Housing and Community Support. It is far from a comprehensive analysis, however. Systemic racism is a deeply-rooted aspect of Canadian society that warrants a degree of analysis and action beyond what is covered in this Backgrounder.

Readers are encouraged to listen to the lived experiences and demands of BIPOC individuals and to dedicate the intellectual, emotional, and physical work necessary to undo white supremacy.

The “Read Next” resources recommended below may provide further insight into how this work connects to the current COVID-19 pandemic:

- [Access the Black Experiences in Health Care Symposium here](#)
- [Access the Black Legal Action Centre's COVID-19 Resources here](#)
- [Access the Migrant Rights Network's COVID-19 Response here](#)
- [Access the Yellowhead Institute's COVID-19 In Community Brief here](#)

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