The Deadly Intersections of Covid-19

Research Report

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Table of Contents

The Deadly Intersections of COVID-19

Principal Investigator:

Sunera Thobani (Asian Studies, University of British Columbia)

Research Team Partners:

Farida Akhter (Social Movements, UBINIG, Bangladesh)

Radha D'Souza (International Law, University of Westminster, UK)

Jin Haritaworn (Environmental Studies, York University, Canada)

Sabiha Hussain (Women's Studies, Jamia Millia University, India)

Suvendrini Perera (Cultural Studies, Curtin University, Australia)

Mieka Smart (Human Medicine, Michigan State University, US)

Zhao Yuezhi (Communication, SFU & Tsinghua University, China)

The Deadly Intersections of COVID-19: Introduction

The speed and force with which COVID-19 spread across the globe caught political leaders and public health officials unprepared. Initial measures implemented by governments of all political stripes were based on the premise that the pandemic would be 'an equalizer', its impact similar across the population. However, this assumption fell apart immediately as infection and death rates proved to be disproportionately high among communities already marginalized by race, class, age, gender, caste, religion, and sexuality. In the US, for example, elderly, Black, Latino and Indigenous communities were the hardest hit, and hate crimes began to escalate against Asian-Americans (CNN, May 8, 2020; The Washington Post, May 26, 2020); meanwhile in India, Muslims, Dalits and migrant workers from rural areas were devastated by the pandemic and its economic fallout (BBC, May 20, 2020; The Conversation, May 20, 2020).

The need to understand exactly how, where and why the pandemic intersected with underlying processes of marginalization in specific national contexts, as well as the global linkages between them, brought together this international research team. Taking an interdisciplinary and comparative approach, our project examined how the COVID-19 pandemic interacts with structures and practices of socio-economic and political marginalization in a number of national contexts, namely Australia, Bangladesh, Canada, China, India, UK and US.

Furthermore, drawing on the activism and lobbying networks of the research team, this project also builds a conceptual model to study the overall socio-economic and political effects of COVID-19; map out its intersections with national and global structures of power; and identify and analyze the impact of key pandemic measures to track how these rework existing social divides. Producing such grounded knowledge is crucial to developing effective pandemic measures that can lead to a more just and equitable post-pandemic world. This Report presents the summary findings of our research project for the first year of the COVID-19 pandemic, March 2020 - April 2021.

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The Deadly Intersections of COVID-19: A Racial Pandemic: The Canadian Case

Sunera Thobani

Introduction

Canada was considered an early "success" story during the first wave of the COVID-19 pandemic. As was the case elsewhere, the initial warnings from the World Health Organization (WHO) in January 2020 did not spur concerted action from the federal government or public health officials (although travel alerts to China were issued). But as the spring school break loomed in mid-March - a period of high vacation travel for the middle classes - travel restrictions, social distancing, masking, quarantines and lockdowns were introduced. The country's southern border with the US was closed off to all but essential travel as the virus spread rapidly on the other side. Hospital beds and other resources were earmarked for pandemic related health care, and the government began to provide assistance to corporations and small businesses to help mitigate the economic effects of the lockdown. The country became the envy of much of the world now that the federal government had decided to take action. Canadians would be spared the devastation the pandemic was already wreaking elsewhere in the world – or so it seemed.

This Canadian exceptionalism was lauded through the pandemic's first phase. As the second wave hit, however, infection and death rates increased beyond the forecasts of public health officials through to December 2020 (with 581,982 cumulative cases and 15,472 deaths at year's end, Public Health Agency of Canada, 2020). Excess deaths were also reported in this first year (close to 14,000, 5% higher than anticipated). By early January 2021, infections and death rates began to soar, and the upward trend continued into May 2021 (for a total of 1.35 million cases and 25,189 deaths at time of writing, Statistics, Canada, Wikipedia). This time, it was younger people who were being infected in larger numbers. In this third wave, health-care services were pushed to the breaking point and demands on health care workers were severely overextended. Moreover, full lockdowns and curfews had to be implemented in two of the most populous provinces, Ontario and Quebec. This monumental turnaround raised the question - What had happened?

The pandemic took hold in Canada along the structural stratification of settler colonialism and its hierarchal system of relations. It was evident from the beginning of the pandemic that infection and death rates were disproportionately higher among Indigenous Nations, communities of colour, the elderly and low-income communities. For example, many Indigenous peoples on reserves did not have access to either healthcare services or the means

to follow basic pandemic safety measures, including adequate housing or even clean water. For another example, early COVID-19 outbreaks occurred in residential care homes, staffed largely by part-time, underpaid workers of colour. Outbreaks soon followed at meat-packing plants and farms that relied heavily on migrant workers. Unemployment skyrocketed (Labor Force Survey, Statistics Canada, October 2020) even as the pressure intensified on front line workers to keep going to work even in the absence of Personal Protective Equipment. The lockdowns increased women's reproductive labour within the home, as well as their economic dependence on their families. Violence against women in the home increased, as did levels of depression and mental health problems due to the increasing social isolation (The Canadian Women's Foundation, 2021). Pandemic measures, however, neither acknowledged nor explicitly countered the deep inequalities of Indigeneity, race, gender, class, age, etc., in Canadian society that led to these uneven effects. More ominously, these measures did not explicitly seek to protect the populations that were known to be at much greater risk of illness.

Racializing the Pandemic

Although the SARS-CoV-2 virus first emerged in the Netherlands in 2004, followed by several variants, COVID-19 was defined as an "Asian" problem as soon as the virus was publicly identified (Norton, 2020). With the virus linked to China, and in Canada to Chinese-Canadians, it became fixed in the national imaginary as a "foreign" threat. The (in)actions that followed from this racist construction served to racialize the pandemic itself. As such, COVID-19 became more than a public health crisis, it sparked a race crisis. Hate crimes began to target diasporic Chinese and Asian communities early in the pandemic, deepening this form of racism in tandem with the racial violence directed against Black, Indigenous and Muslim communities. In the case of South Asians, their extended family structures were identified as facilitating the spread of the virus. These communities' religio-cultural events were seen in similar light, despite strict adherence to pandemic measures. Even as Canada's international stature as a multicultural haven grew during the first phase of the pandemic, anti-Asian hate crimes in the country overtook those in the US by the second phase.

The racialization of the pandemic was manifest also in the patterns of COVID-19 infections and deaths. Anecdotal evidence and media accounts in the first wave indicated that the virus was having an alarmingly uneven impact on communities of colour, already disenfranchised by pre-existing social and economic inequalities. Yet the public health measures implemented were 'race-blind', and as such, compounded the country's racial and colonial hierarchies to deadly effect. Predictably enough, as the pandemic worsened so too did the toll it would take on these particular communities.

First Nations: Unsafe Reserves, Violent Cities

Indigenous communities were among the most economically dispossessed in Canada when the pandemic hit. Atrociously unsafe living conditions had long been documented on reserves, and many communities have had no access to safe drinking water, adequate housing or healthcare services for decades (Levesque and Theriault, 2020). More than half of Indigenous peoples live in urban centers, where they have fared little better. Concentrated in inner cities and falling between the cracks of federal and provincial jurisdictions, these communities experience significantly higher levels of poverty, unemployment, homelessness, addiction and violence (Anderson, 2019). Aboriginal women in particular have been subjected to high levels of sexual violence, their activism has highlighted the severe consequences of such violence as thousands of Indigenous women and girls have been murdered or gone missing in the past three decades. Moreover, the combined effects of these conditions, along with the racism that shapes their interactions with the health care system, have left many Indigenous people with higher levels of chronic health conditions (Starblanket and Hunt, 2020).

Recognizing the heightened risk to the health of their communities as a result of these socio-economic conditions, many Indigenous nations set up checkpoints to control travel onto their lands when the first lockdowns began (Leonard, 2020). This move is now credited with curtailing the spread of the virus among these communities, but the pandemic's second wave saw infection rates increase 'tenfold' on First Nations reserves (Greene, 2021). For example, First Nations in the Prairie provinces made up almost half the hospitalizations in some of these areas, 90% of all on-reserve infections were also to be found in these provinces (Stefanovich, 20210). In Manitoba, 50 % of all COVID-19 cases in January 2021 were among Indigenous peoples (Stefanovich, 2021). Of those living on reserves, 5% were infected, a figure double that of the national rate; the infection, hospitalization and death rates for off-reserve Indigenous communities are estimated to likely be even higher (Greene, 2021). As the first anniversary of the pandemic was marked, overall infection rates among Indigenous communities were estimated to be 40% higher than in the rest of the population (Somos, 2021). In this context, vaccinations were prioritized for First Nations communities on remote reserves to avoid a total catastrophe (Talaga, 2021). However, Indigenous peoples in the cities did not receive priority access (Talaga, 2021).

People of Colour: Life and Death On the Frontlines

Canadian racial politics are refracted though multiculturalism, a discourse premised on the denial of structural and systemic racial inequality in the nation's socio-economic and political institutions (Bannerji, 2000; Thobani, 2007). This denial has made race disaggregated data very difficult to come by. Anecdotal evidence and community activism in the pandemic's early phase pointed to its racially disproportionate impact on communities of colour, which was markedly

high among Black and South Asian communities. Soon, official studies also began to document the phenomenon. For example, a Statistics Canada report of COVID-19 mortality rates between March-July 2020 found these to be highest in the metropolitan areas of Montreal and Toronto, cities that have the greatest concentrations of communities of colour, including Black communities. Quebec and Ontario were two of the hardest hit provinces during this first phase, and death rates were found to be three times higher in neighborhoods with large communities of colour, whereas those areas with smaller such communities had lower mortality rates. In the province of British Columbia, the racial disparities were starker still; here, death rates were 10 times higher in neighborhoods with higher residents of colour, especially South Asian Canadians (Subedi, Greenberg and Turcotte, 2020).

Workplace infection rates were also shockingly higher among workers of colour, who are overrepresented in front-line services and in the low wage economy. In Canada's racially segmented labour market, workers of colour are found in very high numbers in health, medical and personal care services; in transportation, agriculture, food services; and in other essential sectors that maintain supply chains and ensure the country's food security. So vital is the role of these workers that immigrant women, for just one example, made up 31% of the nurse aides, orderlies and other service aides in the country in 2016. These ratios were even higher in the major urban areas (78.7% in Toronto; 71.7% in Vancouver; 70.5% in Calgary; 62.4% in Edmonton).

Official and community reports, like the political campaigns organized by community activists, highlighted the perilous work conditions of these front-line workers in elderly care homes, hospitals, schools and grocery stores (CFNU et al., 2020; Bains, 2020; Bailey, 2021); in public transit systems and long-distance trucking (Aguilar, 2020; Irvine, 2020); on farms and in meat packing plants (Migrant Workers' Alliance, 2020); in prisons, for guards as well as prisoner-workers (House and Rashid, 2021). These warnings and campaigns went largely unheeded. The racialized effects of COVID-19 only worsened.

As the pandemic moved into its second phase, 21% of Black people in Toronto reported knowing somebody who died from COVID-19 in contrast to 8% of non-Black Canadians. Neighborhoods with diverse communities (over 10% Black) reported four times higher COVID-19 hospitalization rates and twice the number of deaths (age-adjusted) than less diverse areas (less than 0.5% Black) in a national survey (DasGupta et al, 2020). Moreover, Black women have higher rates of pre-existing conditions (diabetes at three times higher rates and hypertension at 1.7 higher levels) than white women. These pre-existing health conditions have been tied to systemic racism, they continue to worsen as Black neighborhoods are served by under-equipped hospitals.

Black, Asian, Indigenous and other communities of colour are demonstrably ill-served by the healthcare system, even though the survival of this system relies heavily on the nurses, doctors, dentists, medical staff and technicians, nursing aides, and support and cleaning staff who come from these very communities. The situation of all healthcare workers in the country

during the first two phases of the pandemic was nothing short of dire as they comprised a full 20% of all COVID-19 cases in the country (Possamai, 2020). This was double the rate for healthcare workers at the global level as per the data reported by the WHO (Possamai, 2020). Healthcare workers in Canada also reported 75% of all COVID-19 related injuries in the workplace. Yet protective equipment was not provided to many of these workers, the demands of the unions who represent them were dismissed by health authorities, and the workers themselves were often given misleading information about the safety conditions in their workplaces.

Closing Comments

The emergence of COVID-19 has transformed societies around the world. While its lasting effects cannot be fully predicted, we do know how devastating the immediate effects of the pandemic have been for Indigenous peoples and communities of colour in Canada. Their racialized vulnerability to infection and premature death is compounded by their unequal access to healthcare services, and by the different layers of racism to which these communities are subjected. Among the poorest, lowest paid and most exploited communities, Indigenous women and women of colour were situated directly on the front lines of the pandemic. These communities have taken the brunt of the high infection and death rates in urban centres, even as they are exposed to the full force of the racism and hate crimes directed against their communities.

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The Deadly Intersections Of Covid-19: Snapshots Of Australia's Experience

Suvendrini Perera and Ayman Qwaider

Australia ranked as the eighth most successful country in a global Covid Performance Index conducted by the Lowy Institute in January 2021. As of March 15, 2021, approximately a year since the official declaration of the pandemic, Australia's official statistics record a total of 129,130 diagnosed Covid-19 cases. There were 909 deaths across the country, a low figure by most counts. A closer look behind the statistics shows highly differentiated results among specific groups, and the social structures and institutions with which they are enmeshed.

First Nations: "Sing it from the rooftops"

The most distinctive aspect of Australia's Covid response is the proportionately low impact of the virus on the Indigenous population. No more than 149 of the over 129,000 recorded cases have been among Indigenous Australians, with no cases of infection found in remote communities. Not one Indigenous person has been among the 909 fatalities caused by the virus as of March 2021. As one expert said, "we should be singing this from the rooftops."

Australia's remarkable success in preventing the virus from taking hold among Indigenous communities is in stark contrast to the devastating impact of the pandemic on Indigenous communities in the comparable settler states of Canada and the U.S. This success is directly attributable to strong and coordinated Indigenous leadership from the very outbreak of the pandemic, including pre-emptive closures of remote communities and localised targeted messaging across multiple media (Power 2020). The approach underlines the success of strategies that are Aboriginal-led, locally based and predicated on self-determination.

This success story, however, is confined to the immediate context of Covid management. Since March 2020 at least five Indigenous people have died in custody, suggesting that underlying structures of racism remain untouched outside the crisis situation of the pandemic. Police violence against Indigenous people was very much in evidence in this period, both during the Black Lives Matter protests of July 2020 and in the policing of the lockdown rules (Taylor 2020, Boseley and McGowan 2020).

Refugees and racialised migrants: A "theatre of policing"

In the case of refugee communities and migrants of non-English-speaking background, existing racist structures were exacerbated by the pandemic. The distinctive features of many migrant groups, such as large, close-knit family networks, were stigmatised, casting them as inherently more likely to be "superspreaders." At the same time, the low-paid, high risk and heavily casualized industries in which many migrants and refugees work (abattoirs, supermarkets, aged care, food delivery) rendered them disproportionately vulnerable to infection. In the early months of the pandemic young refugees were subject to fines and warnings for alleged breaches of gathering rules, based on unwarranted assumptions and stereotyping by police (Taylor 2020).

These destructive assumptions were brought home in the hard lockdown, imposed without notice and under police guard, on nine social housing towers in Melbourne in July 2020. The lockdown left 3000 people, largely migrant, refugee, Indigenous, disabled and low-income residents, without access to food, essential medication or specialist support. In a report, the state Ombudsman of Victoria found that: "Documents relating to the lockdown asserted there were security concerns, suggesting the towers were a hotbed of criminality and non-compliance. But the evidence was the vast majority were law-abiding people, just like other Australians. It is unimaginable that such stereotypical assumptions, leading to the 'theatre of policing' that followed, would have accompanied the response to an outbreak of COVID-19 in a luxury apartment block" (Victorian Ombudsman 5).

The Aged: "A disaster that is still unfolding"

Of the 909 total deaths attributed to Covid, over 680 occurred in residential aged care facilities. Despite the low overall total of casualties, this is an overwhelming statistic of over 75 per cent, and "one of the highest rates worldwide of deaths in residential aged care as a percentage of total deaths" (Cousins, 1322). Most of these deaths occurred in the privatised health care system. The naturalization of the deaths of aged residents in institutions of "care" might be considered in the context of their overall invisibilization and expendability within the population. However, a closer look shows that the number of deaths in this category can be traced back to specific systemic weaknesses—in particular the deregulation of institutions for the aged, making them lucrative investments for private, for-profit, operators, and leading to an erosion of professionally trained staff and their replacement by cheap, casualized and largely unskilled labour (Morton 2020). The absence of crisis planning by the state, and especially the decision that those critically ill with Covid would not be transferred to hospitals from aged care homes, is responsible for these high mortality rates.

Gendered Inequities: "a man's pandemic"

Many studies have pointed to the compounding effects of the pandemic on women. As reported across the globe, reports of family violence and coercive control increased during the lockdown. Women working from home assumed the bulk of on-line schooling for their children, an additional toll on their energies in addition to other domestic tasks which disproportionately fall on women. Women who could not work from home were often ineligible for targeted income support measures from the government because of the precarious and casual nature of their employment or because the sectors in which they are concentrated were decreed ineligible for these subsidies. In the words of gender historian Chris Wallace, "The pattern of [the cabinet's] pandemic policy decision-making suggests an active if not explicit 'men first, women and children second' approach." An important instance of a workplace to which this type of covertly gendered policy-making applies is higher education. As universities were excluded from three successive income support schemes put in place by the government (Moodie 2020), the loss of thousands of academic jobs became inevitable. Women, who make up the bulk of junior and mid-level academics, bear the brunt of these losses— and assume the increased workload for those who remain.

Non-Citizens: "as if we weren't humans"

The punitive measures against universities also extended to international students who, unlike their counterparts in Canada or New Zealand or the U.K, were excluded from government income support measures. Unable to "go home," as directed by the Prime Minister, due to border closures and a lack of flights, many international students set up collectives to organise food donations in collaboration with local charities. Asylum seekers in the community were similarly reliant on non-state sources to access support, while around 60 men, brought to Australia from off-shore detention centres for medical treatment were held in a detention hotel for over a year. Tellingly, the detained men used almost identical terms as the international students to describe their conditions: "We are human, we are not animals" (Hall and Eddie 2020).

To conclude: The deadly intersections of the pandemic can be located, to borrow a phrase from Steven W. Thrasher, in "the societal structures that make viral transmission possible" (2020). Such structures do not only render certain types of racialized, gendered and abled corporealities susceptible to infection; they also infect corporate bodies. The co-morbidities and pre-existing conditions (deregulation, privatization, casualization) that weakened bodies corporate, for example in aged care homes and universities, over previous decades render them newly vulnerable to the depredations of the pandemic, leading in turn to casualties among the corporeal bodies who inhabit these institutions.

Our snapshots of the pandemic in Australia, however, suggest that the "societal structures that make viral transmission possible," structures of economic precarity and racialized disposability, are not immutable. Under certain conditions they may be themselves overtaken or rendered inoperative— as they were through the collective First Nations effort to block the pandemic at the threshold of Indigenous communities. In the words of Pat Turner, chief executive of National Aboriginal Community Controlled Health Organisation (NACCHO), this was, literally a life-and-death effort for the protection of elders and all they stood for: "They are our universities: the holders of our knowledge, our cultural history, our culture, our history, our customs and our languages" (Power 2020). From this fight for the survival of a world surely there are lessons to be learned.

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The Deadly Intersections of COVID-19: The Case of Bangladesh

UBINIG - Farida Akhter

By the start of the year 2021, the people of Bangladesh had lived through nine months of COVID-19. The loss of life due to delayed and erratic pandemic control measures revealed the fragile condition of the national health care system caused by neo-liberal economic policy. While the dead could be counted, the long-term emotional and psychological impacts on society of grief, loss of livelihood, and prolonged uncertainty about the future cannot. By end of December, 2020, total infections were numbered at 513,510; 7,559 people had died, and the daily death toll was 28 people. In January and February 2021, there was a sharp decline in the number of COVID-19 cases from over 1000 to less than 400 per day and the number of deaths per day fell to an average of 5. This was seen as a huge success of government, and foreclosed the necessity to learn from bitter experience of pandemic management. At this time the vaccines also arrived and the first doses of vaccines were administered in a well-managed manner.

At this time, the government undertook celebration programs for the 101st birth anniversary of Sheikh Mujibur Rahman, the father of the nation, on March 17, and of the 50th anniversary of the liberation of the country, on March 27. On this occasion, Indian Prime Minister Narendra Modi was invited to attend the ceremony. Thousands of people were on the streets since early March protesting against Modi's visit because of his party's anti-Muslim and anti-Bangladeshi racist remarks. The leftist political student groups as well as the Islamists groups chanted common slogans against Modi, reminding the government of his role in the killings of Muslims as Chief Minister of Gujarat in 2002. In these protest rallies, police killed 17 madrasa students. Hundreds more were injured, and thousands were arrested.

Since March 2021, the infection cases started rising again from over 1000 and by April the daily new cases rose to a peak of nine thousand. The death toll was as high as 101 people per day. The hospitals were full and there was a shortage of urgently needed ICU beds. Many COVID patients died from not being admitted into an ICU with high flow oxygen, or from the lack of a ventilator.

The Covid-19 National Technical Advisory Committee (NTAC) recommended lockdown for one week, to slow the pace of infection. Since April 7, the lockdown has been extended

twice and is still continuing in May. From mid-April to Mid-May the majority of the Muslim population is observing fasting in the holy month of Ramadan.

Vaccines

Nearly 7.25 million people have registered to receive Covid-19 vaccines in the country. Since the beginning of the vaccination campaign on February 7, more than 8.6 million doses of the Covid-19 vaccine have been administered. The Oxford-AstraZeneca vaccine is produced by the Serum Institute of India (SII); the only vaccine administered in Bangladesh.

Among those registered for vaccine, 5.8 million have received the vaccine, of whom only 2.8 million (48%) have received two doses, according to the Directorate General of Health Services (DGHS). But Bangladesh's Covid-19 vaccination efforts have been stopped after India halted coronavirus vaccine shipments. According to newspaper reports, India has paused exports due to the surge in new infections and a rising death toll in several states. Now, the government authorities are trying hard to secure vaccines from China and Russia, which means Bangladeshi people will have to wait a long time to be vaccinated enough to achieve herd immunity against COVID-19.

COVID variants

The South African variant of the novel coronavirus was found to be dominant among the 57 samples of COVID-positive patients collected during March 18 to 24. Of those, 46 (80%) were found as same as the South African variant of novel coronavirus, according to the genomic sequence analysis conducted by International Diarrheal Disease Research Centre (ICDDRB) in Dhaka.

The scientists identified the first UK variant on 6 January 2021 in the country, although the SARS-CoV-2 sequence database at GISAID.ORG indicated that the UK variant was already circulating in December 2020. The UK variant gradually increased over time until the second week of March 2021, with the highest positivity rate (52%)[Daily Star, April 7, 2021].

The Institute of Epidemiology Disease Control and Research (IEDCR) detected Indian variant of coronavirus in the samples of two patients. They were exposed to the variant while visiting India recently.

Increase in poverty

Studies [PPRC/BIGD, 2020] show that the initial poverty impact of Covid-19 crisis has been more severe for the urban poor. The finding of the survey showed the rapid emergence of a class of 'new poor' – informal sector occupations with income above the poverty line but within a band of vulnerability that saw 77% of this group falling below the poverty line income due to the impact of the Covid-19 crisis. In another rapid survey in October 2020, PPRC-BIGD researchers concluded that beyond the 20.5% of the population officially recognized as poor, there was a group of 'new poor' representing an additional 21.7% of the population that needed to be included in the discussion on poverty.

Loss of jobs of RMG workers

More than a third of a million RMG workers (357,000) lost their jobs in 610 factories, found in a study conducted by Centre for Policy Research (CPD) during January to September 2020. Although the official number of laid off workers is only 56372. Out of the 610 factories, 232 factories were closed down. About one third of factories experienced lower ratio of female workers compared to that pre-covid period [CPD-MiB study, 2021].

Government Response

On April 25, the government launched a national hotline for providing humanitarian assistance and basic food supply to the needy within 24 hours of the call for request during the nationwide shutdown. About 75,000 families in need have registered for relief; only about 19,000 (25%) relief seekers have so far received help [New Age, May 11, 2021]. There have been stimulus packages for the business communities, but none for the small entrepreneurs and to save the livelihood of the low-income group.

Lockdown response

"Lockdown" or the mobility restriction policies are suggested by the public health experts as central to fighting the coronavirus. These measures have shown diverse responses from different classes of people. The rich and middle class can "work from home" and get the necessities ordered by online home delivery services. But the poor and the daily wage earners, such as the rickshaw pullers, cannot comply with the mobility restrictions. They are subject to harsh law enforcement, suffering the violation of their human rights, just because they are compelled to go out into the streets to earn money to buy food.

Conclusion

The prediction that COVID-19 is not going away soon and new variants could be more viral has severe negative implications for public morale. The continuing pandemic is likely to further exhaust the energy of the people to defend their basic rights to livelihood and sheer survival. There is hardly any hope that the health care system and the economy could adapt to the new reality. Class tensions have surfaced in anti-poor and anti-worker prejudices among the middle class and wealthy: the poor are being blamed for spreading Covid-19. On the other hand, the rich and the middle class also like to believe that the poor have more immunity and they may get infected but the death rate is lower among them, meaning they don't die! This is not true as the government COVID dedicated hospitals are full of low income Covid patients. There is discrimination in the access to health care, with a lower quality of service available at the government hospitals, but private hospitals charge at least twice the price for their services. Discrimination between the rich/middle class and poor is also found in the plans for vaccination against the virus. The support services by the government are not in favor of the poor and the marginal people.

The divide between rich and poor is now shaped by a narrow choice: life or livelihood. The wealthy and middle classes, arguing that life must be protected, express fear towards the low-income/ working classes, accusing them of primarily spreading the disease because of their lack of awareness and education. Low-income and working-class Bangladeshis respond that they do not deny the threat of the virus, but insist that the lack of a stable income was already killing them before Covid-19 could infect them.

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Racism, Anti-Communism and Covid-19:

The Making of a Transnational Discursive War Against China

Yuezhi Zhao with Xuezhi Du

On April 8, 2021, the Chinese City of Wuhan celebrated its first anniversary of the ending of the 76-day lockdown after the outbreak of Covid-19 and its 10th month without reporting any locally transmitted Covid-19 cases. Earlier on, on February 25, 2021, the Chinese state held a grand gathering to mark China's accomplishments in eradicating absolute poverty and meeting the poverty eradication target set in the United Nations' 2030 Agenda for Sustainable Development 10 years ahead of schedule. These two milestones underscore China's domestic achievements in both fighting against Covid-19 and poverty. Meanwhile, the Chinese state is fulfilling its commitment to make the Covid-19 vaccine a global public good by sending Chinese vaccines to numerous countries, including many in the Global South.

Instead of focusing on how China achieved these and where the Chinese state has not done enough in fighting against Covid-19 in a more effective and equitable way, however, this paper foregrounds the weaponization of Covid-19 in the discursive domain by highlighting the symbolic violence that was unleased against China as the first country to report Covid-19 and lead the fight against this deadly virus. Specifically, it demonstrates how the outbreak of Covid-19 intersects with a pre-existing US-dominated racist and anti-communist "new Cold War" global media environment and intensified US-led geopolitical efforts to contain China to produce some of the most hateful media discourses against China during the early stages of the pandemic.

"The Real Sick Man of Asia"

The *Wall Street Journal* lived up to its ideological role as the mouthpiece of American racial capitalism with the publication of an op-ed piece entitled "China Is the Real Sick Man of Asia" on February 3, 2020, not soon after the outbreak of Covid-19 in China. To add salt to the wound, when the headline drew widespread criticism among Chinese-Americans who demanded an apology, the paper defended it as "echoing a description familiar to American readers."

“China’s Chernobyl”

The *New York Times*, among other leading Western media outlets, was also quick to describe Covid-19 as “China's Chernobyl”. Given that the Chernobyl nuclear power plant incident was widely seen as a pivotal disaster that led to the collapse of the USSR, the deployment of “China’s Chernobyl” analogy in the initial coverage of Covid-19 reveals the deeply anti-communist nature of the Western media. Not only did various US news media cite each other and build upon the reinforced “China’s Chernobyl” metaphor, but leading US politicians also took up the epithet and amplified it widely.

“China Virus” and “Wuhan Virus”

The ability to name or label an event is an extremely powerful form of communication. Although the World Health Organization used the medical term “Covid-19” quite early on to avoid inaccuracy and stigmatization, including the association of this virus with a particular country or a particular group of people, former US President Trump deliberately used the name “China virus” to strike a racist and xenophobic chord in the American public arena. This contributed to diverting attention and anger from the Trump administration’s own failures in taking decisive measures to fight against Covid-19, while provoking racial hatred against Asian Americans.

“Dr. Shi Zhengli Made Covid-19” and “China Must Pay”!

Among the various conspiracy about the origins of Covid-19, Dr. Shi Zhengli, a scientist at the Wuhan Institute of Virology who had collaborated with US scientists in studying coronaviruses in bats, became an easy target. With the assignment of responsibility, comes the demand for accountability. The next tactic in the racist and anti-communist weaponization of Covid-19, then, is to argue that China should pay for the virus. Disrespecting any notion of sovereignty immunity, a whole spate of political extortions, lawsuits, and other claims threatening to make China pay for Covid-19 related damage, are being made by politicians and lawyers. These highly dubious claims, have been duly reported by the media as news.

Fang Fang’s *Wuhan Dairy* and the Making of a Transnational Discursive Alliance

Racial capitalism is a globalized and globalizing political economic and discursive formation, and anti-regime voices within China are indispensable components. As was the case with the Soviet Union, anti-regime dissidents, in the most familiar embodiment of dissident writers, are pivotal subjects in a transnational anti-communist discursive formation. Fang Fang, a Wuhan based writer who already enjoyed domestic notoriety and Western literary attention for her liberal views, quickly became a powerful Chinese voice in the global media. Combining her own lived

experiences with unverified secondary sources as well as literary embellishments, peppering her accounts with an angry indictment against official incapacity and sensationalist depictions of “funeral parlors full of mobile phones”, Fang Fang’s Wuhan Dairy served as a perfect first-person narrative for the global construction of an anti-communist Covid-19 discourse.

Conclusion

It is not just racism, but the intersection of racism and anti-communism that is at the core of this study. Whether the PRC as it is today is a truly “communist” country is not the concern here. As far as the Western dominant discourse is concerned, so long as China remains a “one-party state” ruled by the CCP, it is a communist state, and as such, it is an evil force that is unredeemable. The implication of this analysis is also global: so long as communism as an alternative political economic system is being demonized through its association with a China that is discursively defined as the antithesis of freedom, justice, and equality, it will be very difficult to imagine “another world” in which the welfare of marginalized groups will achieve substantive improvement, with or without Covid-19 or other devastating disasters.

Mapping Multiple Vulnerabilities of Women Domestic Workers During Covid-19: A Report from India

Sabiha Hussain

Introduction

The estimated from large data sets (NSSO Employment Unemployment 61st Round 2004-2005; Census 2011) shows that there could be anywhere between 4.75 to 6.5 million domestic workers across India. Some unofficial estimates also claim that the number of workers employed in this sector are somewhere around 90 million (Tankha 2020). In India, per government records, it is estimated that there are 3.9 million domestic workers of whom 2.6 million are women. The Corona Virus lockdown announced on 24th March 2019 sharply increased domestic workers' vulnerabilities and struggles for survival, raising serious questions about both government policies and societal attitudes towards them. Generally viewed as performing feminine work requiring no special skill (Chigateri et al. 2016), domestic workers routinely work 6-8 hours a day, are denied holidays, are underpaid or not paid at all for long periods, are abused, harassed, confined in the house, restricted from contact with family members and friends, and can be terminated without notice.

All of these problems became even more pronounced during the Covid 19 pandemic. Irrespective of caste, communities, religion or region, part-time domestic workers in particular faced unemployment, violence, unwanted pregnancy, limited access to sanitary napkins and other risks to their health. While domestic violence also increased against women and girls throughout India generally, crowded homes, substance abuse, limited access to services, and reduced peer support exacerbated these conditions for domestic workers. Furthermore, along with income loss, domestic workers like many other migrant workers had to vacate rented accommodations, which further aggravated their hardships.

Though different studies on impact of COVID-19 are being conducted, but most of these studies fail to address the basic issue of policy related to the survival, job security, safety and security and health especially reproductive health. The present study consists of only part time informal domestic workers, majority of whom are migrants from small town/villages who migrated to metro cities in search of livelihood or marriage migration.

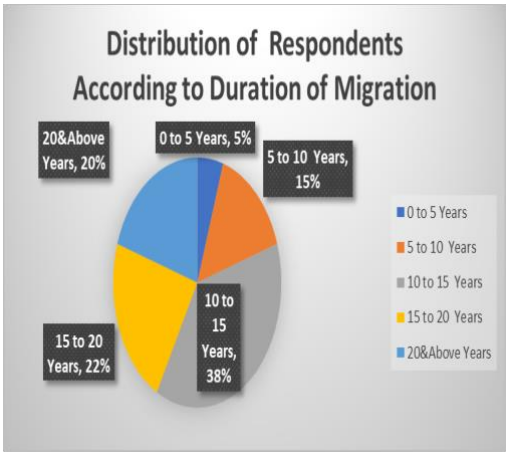
Material and Method

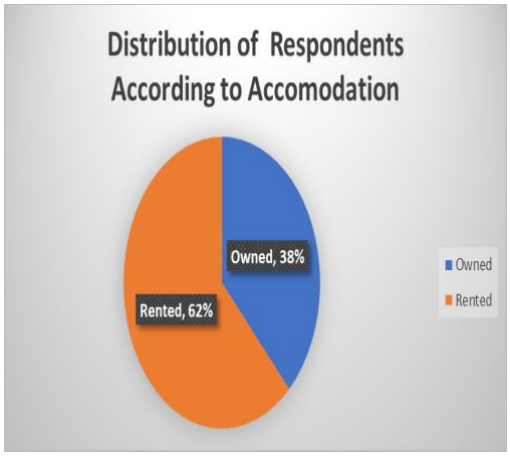
The present study addresses some of the issues that had made these domestic workers the most vulnerable during lockdown in terms of their livelihood, survival, health, safety and

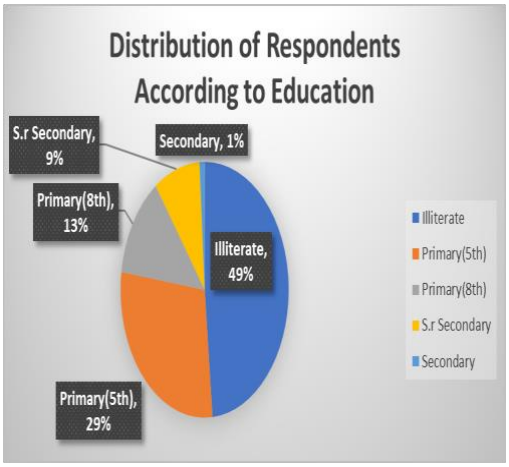
security. Also, given the unsecured nature of work, what were the psycho-social cost in terms of domestic abuse and violence faced by these workers during lockdown; to what extent they were able to access the aid/support in terms of food and ration from the government and what happened to them when the lockdown's restrictions on movement were lifted. The study also highlights the policy gap and lack of legal safeguards to protect the rights of these domestic workers.

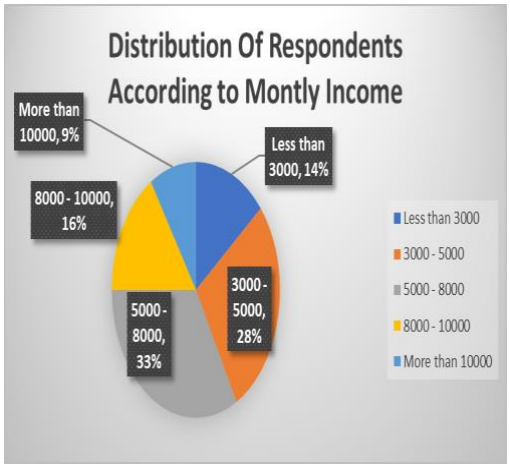
A sample of 100 respondents in the age group of 18-45, largely representative of migrants from Delhi/NCR, was selected through purposive sampling comprised of caste, community, religious background, age, etc. The data, collected both by direct interview and some case studies, allowed us to examine the variations, if any, in their experiences. The study is both qualitative and quantitative in nature.

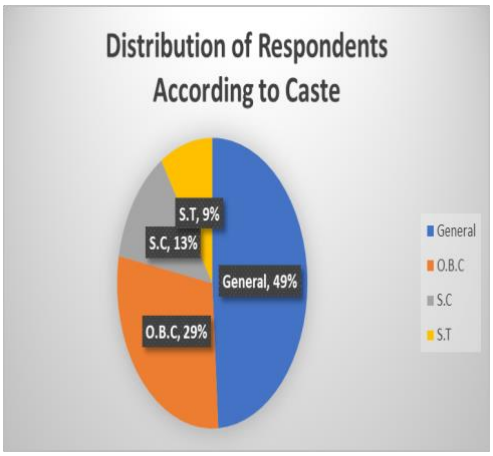
Socio-economic and demographic profile of the respondents

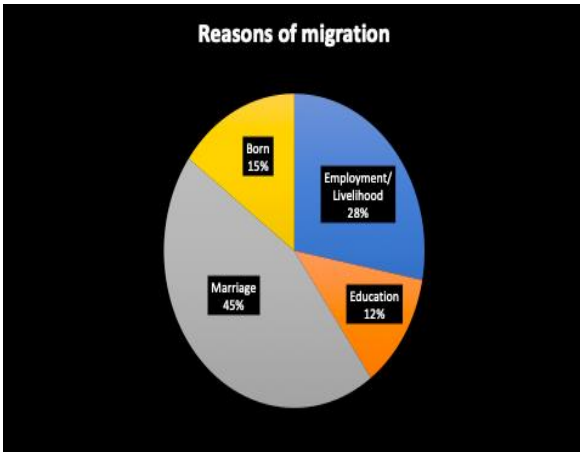


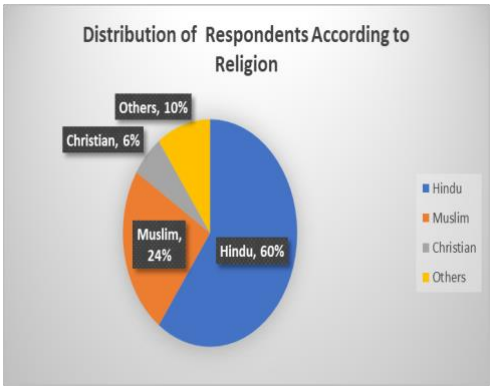


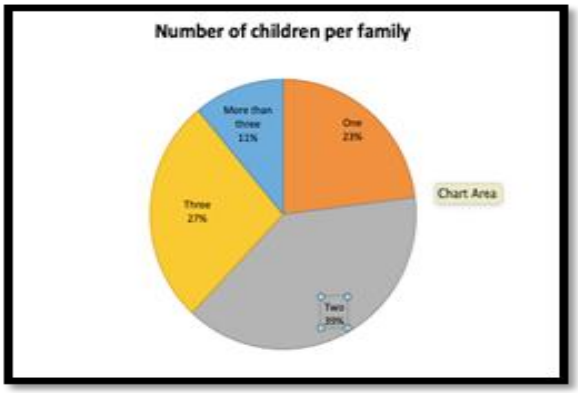


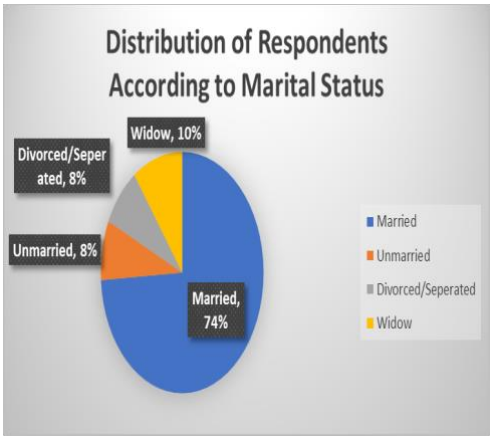



Distribution of Respondents According to Caste
S.T, 9%
S.C, 13%
General, 49%
O.B.C, 29%
General
O.B.C
S.C
S.T


Reasons of migration
Born 15%
Employment/ Livelihood 28%
Marriage 45%
Education 12%


Distribution of Respondents According to Religion
Others, 10%
Christian, 6%
Muslim, 24%
Hindu, 60%
Hindu
Muslim
Christian
Others


Number of children per family
Chart Area


Distribution of Respondents According to Marital Status
Widow, 10%
Divorced/Seperated, 8%
Unmarried, 8%
Married, 74%
Married
Unmarried
Divorced/Seperated
Widow

Results and Discussion

Livelihood and Survival

Data reveals that as the lockdown was enforced domestic workers were greatly impacted in terms of source of livelihood and income. Amongst all respondents 56% workers did not get their salary during lock down, 26% got half salary and 18% of them got full salary from their respective employer. These workers not only lost their source of livelihood and regular income, but also there was continuous uncertainty of reemployment. Many residents welfare associations restricted the entry at their own discretion. Those who were renting the house had paid rent after four months by taking loan from the private money-lender on high interest rate.

Household consumption pattern during Lockdown

The majority of the respondents stated that staying home had meant not only losing their livelihoods but to have even one meal a day was very difficult. Data reveals that for 58% getting two meals became difficult. Initially there were two meals a day but as the lockdown increased, there was scarcity of food and they had to survive on one meal and some help they got from their employer and that's how they survived. There was no or hardly any help provided by the government to meet the demand of food. Surprisingly, the majority of the women (92%) were able to benefit from grains, Covid protection kit, sanitary napkins, medicine and baby food provided by the NGOs.

Reemployment: Post-lockdown Scenario

The agony of these workers was not limited to the crises of lockdown. When the pandemic restrictions were lifted, 48% of the workers were yet to find a job and 36% were allowed to work only in one house according to the rule of the respective societies, and 16% of them were working for a single employer under certain conditions and always regarded with distrust, even for a little coughing or sneezing.

As far as providing facilities by the employer and their attitude towards these workers are concerned, the majority of the workers (57%) stated that the attitude of their employer was always of suspicion as they are seen as carrier of corona virus, they were not provided with mask, gloves etc. They were asked to keep their soap, sanitizer and one pair of cloth so that when they enter the house for work they change their dress and wash their hand then start their work. Hence, the whole responsibility to maintain the hygiene was on the workers, for which they had to spend extra money in this difficult time. But they had no option but to accept.

(ii) Covid-19 lockdown and issues of Health and Hygiene

Fatigue and stress was reported by the majority of women (66%) due to increase in working hours, as all family members were inside the home and they had to meet their demands of food and other care work. To maintain health and hygiene during pandemic, the most popularly adopted measures were social distancing (42%), followed by personal cleanliness (20%) like using soap for washing hand, and clothes but not the other safety measures like using sanitizers, gloves or mask, as they were costly and they could not afford to buy them. However, 20% had taken no measures to maintain health and hygiene during pandemic.

Issue of Pregnancy and Family Planning

This was the biggest issue during lockdown as reported by the respondents. 72% women had to face problems related to pregnancy and family planning that had repercussion on their health. The clinics available in their vicinities were closed. The non-availability of contraceptives (30%) resulted in unwanted pregnancies (10%). The non-availability of sanitary napkins reported by 20% of respondents created post-partum and other gynecological problems (12%) which were exacerbated by lack of access to medical care. Domestic workers did not have access to ante-natal and post-natal checkups as most of the nearby private clinics were either closed or treating Covid patients. Finding conveyance to reach government hospitals was also difficult. A few respondents (3%) reported using home remedies to get rid of unwanted pregnancies. Eighteen women respondents had babies delivered during lockdown, and out of this, ten were assisted at home by a traditional birth attendant, for fear of going to hospital and the prohibitive costs of private care. During the discussion it was found that even if a couple decided not to have children, their plans were unintentionally disrupted during the pandemic, adding to respondents' burden of stressful reproductive labour.

Mental health and Stress: Silent killer during lockdown

The sudden ban on travel, quarantine rules and the loss of financial means to buy food increased respondents' levels of stress, anxiety, and in some cases, panic attacks. Data reveals that 72% of the women workers had faced or still facing stress, anxiety and sleeplessness which they termed as "*dimaghi pareshani*" (worried mind) arising out of loss of job and economic hardship, food insecurity, uncertainty of reemployment, emotional burden, rules of quarantine, and living with the abuser in cases of domestic violence.

More precisely, anxiety was reported by 20% mainly caused by loss of job and economic hardship, followed by stress 16%, due to the division of labor in the home that placed a heavier emotional burden on women, loneliness due to social distancing by 15% and 13% reported problem of sleep due to stress of survival and reemployment. To cope with the mental stress, 40% of the responded tried to keep themselves busy in household work though it was very tiring, followed by 26% who sought recourse to talking to friends on mobile, 20% said they cried, and 10% spent time on prayer.

(iii) Experiences of Domestic Violence during COVID-19

Domestic violence complaints have increased by 2.5 times since the nationwide lockdown began in India. An analysis report of NCW showed a total of 800 complaints were received of various crimes against women and out of which 40% constituted domestic violence.[1]

Data reveals that 82% of the women were victims of violence irrespective of caste, communities, religion and region. Incidents of physical violence was reported by (48%) including physical beating like slapping, pushing against the wall, pulling of hair etc. followed by verbal abuse (28%) use of abusive language and throwing of utensils or water on faces. Sexual abuse, such as being forced into unwanted sex, was reported by 11% and emotional abuse by 13%, in the forms of silent treatment, mocking physical appearance, and other emotionally hurtful behaviour. However, 55% of respondents reported that they kept quiet, 24% shouted and cried, 11% hit back to defend themselves, while 10% used to lock themselves in another room for safety. The incidents of domestic violence reported by the respondents were irrespective of caste, communities, religion and regional boundaries. The loss of income, having to stay inside the house with abusers, and the increased burden of domestic labour, increased the severity of abuse suffered by respondents.

One of the respondents narrated, *"Those were the worst days of my life, we were without food for almost two days; loss of job of ours and hardship of survival had made my husband more irritated resulted in physical abuse; I had no option as there was lockdown, neither I could go anywhere nor seek protection outside; no idea of helpline and there was no money to recharge mobile'*

However, the majority of the respondents did not report the violence because during lockdown firstly, their mobility was restricted and secondly, they had to live with their abuser, so any complaint would have increased the danger they faced.

(iv) Listening to the Voices of Domestic Workers for Policy Interventions

What did these surveyed workers tell us about their most urgent needs during lockdown? Their responses demonstrate that their employers and government authorities of Delhi/NCR either stigmatized them or completely ignored their need for personal safety, income support, and protection against violence, when the lockdown was announced. It was very disheartening and disappointing to know that notifications were issued overnight that all the domestic helpers would not be allowed in the society vicinity and this sudden announcement of lockdown and Societies made them the most vulnerable in terms of workload and the violence they had to face in the family. The women were hired but in limited houses as per the rule of respective societies.

Further, they strongly stated that the government provision of immediate relief to domestic workers through cash transfers (*Jan Dhan Yojna*) should continue for as long as the pandemic lasts. To ensure personal and workplace safety for all domestic workers, a government authority or other advisory system must be created to regulate the practices of employers and resident welfare associations and to establish health and safety standards.

Respondents stated that they must be supported to resume their jobs without the fear of prejudice or the stipulation of unreasonable conditions to being able to resume their work, and to be compensated for lost wages during the lockdown period. They strongly objected to employers who suspected or accused them of carrying the Sars-Cov2 coronavirus, or, as reported in some cases in Delhi/NCR, prevented them from using the lift. They also demanded that employers provide domestic workers with protective equipment such as sanitizers, masks, and gloves.

Increased vulnerabilities: Questioning the responsibility of the State

Considering the several forms of violence and emotional distress that threatened the survival, health, safety and livelihood of domestic workers, combined with constraints on their ability to seek health care and government facilities during the pandemic, the results of this study raise serious questions about the responsibility of the State in protecting the rights of Domestic workers.

Over the years there have been different attempts at passing laws to ensure the rights of domestic workers such as minimum wages, regulating the number of working hours, mandating regular holidays as well as addressing physical and sexual harassment, but till date nothing has been formalized and the domestic workers are still sidelined from the State policies

and laws.[2] As early as the year 1959, a private member's bill sought to regulate the depreciating condition of domestic workers, and the domestic workers (condition of services) bill was moved in the Rajya Sabha, but failed to become law.

In 1972 and 1977, more private member's bills were introduced in the Lok Sabha that too lapsed. In 1974, the Committee on Status of Women in India recommended the government to look over the condition of domestic workers, which was again neglected. In 1988 a recommendation was made by National Commission of Self-Employed Women and Women in the Informal Sector for registration of workers to protect them. The 1989 House Workers bill also failed to become law.

While some legal instruments provide a degree of protection, such as the Unorganised Social Security Act 2008, the Sexual Harassment against Women at Workplace Act, 2013, and some minimum wage provisions at the state level, there is no comprehensive legislation to address the domestic workers' sector dominated by women. It remains almost impossible for women to avail themselves of legal protections against sexual harassment. The Unorganized Social Security Act of 2008, furthermore, did not provide much to the workers except for an identity card and advisory board at both state and centre (national government) levels.

This history of government inaction brings us to the conclusion that we need to recognize domestic workers as essential service providers, whose working and living conditions are of importance to the economy and to the harmonious function of society as a whole. At the policy level, the bill drafted by the National Platform for Domestic Workers (the Domestic Workers Regulation of Work and Social Security Bill, 2016, to the government in January 2020**)**, must be passed and implemented immediately. The government must create an easy process for domestic workers to register as 'workers' under the Labour Department through established systems. A minimum wage must be fixed, medical leave and expenses be covered by the employer, provision of leave, a notice of termination of employment period to be included to avoid the hardship of domestic workers especially in a situation like pandemic. A domestic labour standards authority, appointed by government or independent civil society organizations, is urgently needed to regulate all resident welfare associations and employers, to establish clear workplace safety and security standards that will protect domestic employees.

Conclusion

On the basis of the quantitative and qualitative analysis, we find that while civil society groups did come forward to support workers with relief packages, programs and schemes to cope with the COVID-19 crisis, substantial action must be taken by government at the local level to

account for the workers whose primary needs were not met and for whom no support was provided. To conclude, domestic workers need attention from all concerned: the employer, the state and civil society.

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Life or Livelihood:

Covid-19's Challenge to the UK

Radha D'Souza

Impact of Covid-19 on Marginalised Communities

In this short summary of my project, I will begin by juxtaposing the impact of Covid-19 on marginalised communities in the UK on the one hand and the perception that the UK itself is marginalised internationally and nationally on the other. I do this firstly to set up the context for Covid-19. Secondly, I wish to highlight the importance of developing a different approach to post-crises restructuring of economy and society from those adopted in the past. Covid-19 pushes us to think deeper about the relationship between social marginalisation and the economy.

Below, I examine how the Equalities Act 2010 frames approaches to the big question that Covid-19 presents to the UK government and policy makers namely: life or livelihood? I argue that delinking economy and society, a handiwork of liberal legal systems, gives with one hand what is takes away from the other for marginalised communities. The life or livelihood dilemma must be located within the disjuncture between economy and society that characterises liberal capitalist societies such as the UK.

In the UK the meaning of "marginalised communities" is shaped by the Equalities Act 2010. The Equalities Act 2010 was a watershed moment when equality impact assessments of state policies and non-discrimination became statutory duties for decision makers in the public and private sectors. The Equalities Act 2010 protects certain social groups that possess what is called 'protected characteristics' in the Act. The Act protects people with 'protected characteristics' from direct and indirect discrimination, harassment and victimisation. 'Protected characteristics' include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Thus, individual identities are the basis for protections under the Equalities Act 2010. Individual identities are also the basis for recognising social groups as "communities". Individual identity as the basis for non-discrimination and community formation invites questions about identity and community formations and their connections to political economy, in particular the labour market.

Unlike in some countries, data and information on how the pandemic was disproportionately impacting marginalised communities was never lacking in the UK. Very early

on in the pandemic, campaign groups, professional organisations, academic research funding bodies, scholarly communities, government agencies, the national statistical agencies launched studies and published reports on the disproportionate impact of Covid-19 on marginalised communities. Social sciences and humanities were out there in the research from the outset, and not as a belated appendage to medical sciences, as was the case in the past. Recently the British Academy published, what is to date, the most comprehensive study titled *The COVID Decade: understanding the long-term societal impacts of COVID-19*[2] together with a companion report *Shaping the COVID decade: addressing the long-term societal impacts of COVID-19*[3] that addresses policy recommendations. The British Academy report was commissioned by the Government Office for Science to provide an independent review of the societal impacts of Covid-19.

The report confirmed what was widely known: that Covid-19 exacerbated pre-existing structural inequalities in British society and accelerated existing trends; that sustained cutbacks to public spending on health, education and social services over four decades had left many communities vulnerable; that low paid jobs and wealth disparities had increased as had queues at food banks. The British Academy report is at pains to highlight the differential impacts along dimensions of race, ethnicity, gender, sexuality, age, abilities, and immigration status. The report was also clear that the impact of Covid-19 was going to be long term and likely to last a decade or more. What is interesting in the British Academy report and indeed numerous other reports on Covid-19 is that while the empirical data and analysis has emphasised the disproportionate impact of Covid-19 on marginalised communities these reports leave us with the question: 'and now what next?'.

The Wider Context

Turning to the context, Covid-19 struck the UK when there was heightened angst about marginalisation at multiple levels of society that overlaid the marginalisation of protected communities in the Equalities Act 2010. The impact of Covid-19 on marginalised UK communities unfolded against the backdrop of Brexit. The UK had just formally exited the European Union on 01 January 2020 when Covid-19 was declared a global pandemic by the WHO. The legal necessity to negotiate a complex trade deal with the EU by the end of 31 December 2020 shadowed responses to the pandemic throughout the year. The campaign to leave the European Union was driven by a sense that the UK was marginalised within the EU. Indeed, during the Leave campaign, the current prime minister Boris Johnson, repeatedly claimed that Britain risked becoming a "satellite state" within the EU.[4]

The Brexit campaign promised that "sovereign" UK would seek trade deals with other nations around the world that would put the UK on the road to prosperity again. The downturn in economies of countries around the world in the wake of Covid-19 put a question mark on these plans for expansion of global trade. These ambitions were scuppered due to another kind

of marginalisation that is known but rarely spoken about. The UK state as a political institution is inextricable entwined with the US state's giant military industrial technology complex. A maze of multiple defence, security, intelligence sharing agreements, extradition treaties, arms production and sale, revolving doors between defence personnel and the US defence establishment and much else makes the UK state politically already a "satellite state" of the US, politely referred to as the "special relationship".[5] The anti-China, anti-Iran drumbeats in the US, played out as Covid-19 unfolded. The economic necessity to seek trade with countries outside the EU and political necessity of maintaining the "special relationship", pulled the economy in different directions even as Covid-19 decimated the economy and the state's capacities for manoeuvre.[6] None of these issues informed post-Covid-19 recovery strategies for marginalised communities even though it is widely believed that they are bound to shape the recovery in multiple ways.

Turning from risks of marginalisation of the UK at the global level, to subnational ones, the pre-pandemic relations between the nations of the UK were already at its lowest point as a result of Brexit. Scotland, Northern Ireland, and Wales, nations that see themselves as marginalised within the United Kingdom, emerged from the Brexit campaign feeling even more marginalised. The three nations saw Brexit as economically disadvantageous to them. Covid-19 fuelled those sentiments as the UK government struggled to respond to the pandemic. Critical of the UK government's centralised responses, all three nations charted their own responses to the pandemic. These responses of marginalised nations fed into strident demands for independence in Scotland,[7] it reopened tensions between unionists and republicans in Northern Ireland,[8] and Welsh nationalism gained ground, by an estimated 39 percent even as the Welsh assembly acquired new confidence as it charted its own course out of the pandemic.[9] The UK passed the Internal Market Act 2020 to further centralise economic powers and integrate internal markets after Brexit, for which the Scottish and Welsh parliaments refused consent.[10] The British Academy report notes that whereas community solidarities and cohesion increased at local and hyper local levels during the pandemic, regional, subnational and national solidarities decreased.

Economy, Society and Covid-19

Given these tiers of marginalisation, at community, subnational and national levels, what can we say about the impact of Covid-19 on marginalised communities in the UK? Historically, pandemics like wars, lead to structural social change. The nature of these changes depends on the capacities of communities to rethink and re-envision structural changes in society. For example, during the world wars different sections in liberal capitalist societies re-imagined the world in three different ways: social welfarism or a humane capitalism, fascism as a model for a strong nation and socialism or a non-capitalist society. These reimaginations were critical in shaping the structural changes that emerged after the end of the world wars. What is unfolding before us today is a decade or more of social and economic restructuring and change. Are

marginalised communities able to radically reimagine a different social order based on equality, dignity and justice?

The extensive empirical studies, investigations and policy interventions accept the social architecture established by liberal capitalism as given, almost as a natural condition of social life. Liberal capitalism rests on the institutional separation of economy and society. Law establishes these institutions and manages the hiatus between economy and society. Equalities Act 2010 exemplifies the hiatus between economy and society.

The Equalities Act 2010 assumes that there will be a relatively stable labour market and employment opportunities. The assumption of opportunities provides the objective conditions within which equal opportunities for social groups with 'protected characteristics' plays out. The Equalities Act 2010 was the culmination of decades of struggles by Black Asian and Ethnic Minority communities (BAME), women, less-abled people and LGBTQ+ social groups for equal opportunities in employment and services. Marginalised communities argued that they were unable to compete in the labour market because of lack of social capital: health, education, skills, and opportunities. The Equalities Act 2010 seeks to level the playing field for marginalised communities at policy level and in social practices. By levelling the playing field, the law aims to enable marginalised communities to compete as equals for jobs and services.

The political trajectory of Equalities Act 2010 paralleled an economic trajectory that restructured the UK economy. Successive amendments to the Race Relations Act 1965 occurred alongside labour market restructuring and wider liberalisation and privatisation of the economy. The Equalities Act 2010 consolidates the *ad hoc* amendments to the Race Relations Acts of the past into one single codified statute. Labour market restructuring brought with it, deindustrialisation, de-unionisation and informalisation of work, the most recent variant being the controversial 'zero hour' contracts. 'Zero hour' contracts are employment contracts that do not oblige employers to provide minimum hours of work, but nevertheless require the contracted workers to be available for work when required. The number of people on 'zero hour' contracts increased during the lockdown from 896,000 in 2019 to 1.05 million in 2020.[11] Liberalisation and privatisation rolled back the state from public services and brought basic services like health, education and housing under market regimes and the private sector. Thus, what the Equality Act 2010 gave with one hand, labour market restructuring and liberalisation and privatisation of the economy took away with the other. Counterintuitive as it may appear, economic deprivation in marginalised communities increased after the Equalities Act for the majority while increasing individual social mobility for a few.

Class is not a 'protected characteristic' under the Equalities Act 2010. Conceptually, class is related to labour and work. Labour, or the human capacity to work, has dual aspects. On the one hand it is an economic category and commodity. As a saleable commodity labour is bought and sold in the labour markets. In economic theory markets are price fixing mechanisms where buyers and sellers agree to sale and purchase of any commodity including labour. Trade unions and collective bargaining seek to increase the price of labour whereas employer associations

adopt a range of strategies to reduce it including mechanisation, contracting out, and relocating production to cheaper destinations. The law permits both processes to enable labour markets to find the appropriate market price for labour.

Labour is also the working class – a social group categorised according to their wealth and income status as lower in the social hierarchy. Labour markets trade in abstract labour; that is, labour stripped of specific attributes of race, religion, colour, gender, nationality. As a commodity it is simply the capacity to work that is bought and sold. However, labour as a social class is never abstract. All persons with capacities to work must necessarily exist with a variety of social attributes – they must be of some colour, gender, race, religion, linguistic group, nationality. There is no worker or employee who does not have some kind of gender race nationality and such. It is significant therefore that the Equalities Act 2010 paralleled the labour market restructuring and liberalisation and privatisation. Understanding the causal connections between the two processes, both operationalised by law, will be the key to reimagining another kind of intervention in the social restructuring that will inevitably follow Covid-19.

Covid-19 brought the economy to its knees and with it the labour market, a possibility that no economist had foreseen. This collapse of the economy considered by some to be the worst in 300 years, comes at a time when the UK stands at a historic crossroad where multiple levels of marginalisation could impact the economy in ways that further disadvantage those communities already on the margins, even when more stringent policies for equality and non-discrimination are put in place to mitigate the effects of Covid-19.

While recognising the disproportionate impact of Covid-19 on marginalised communities, dominant liberal academics, policy makers and activists continue to seek solutions that do not address the structural disjuncture between economy and society, i.e., the hiatus between equality and non-discrimination on the one hand and a competitive labour market and deregulated economy on the other, that is at the very foundations of the UK social order. Parallel to the moves to address marginalisation, the far-reaching economic impacts of Covid-19 exacerbated by Brexit and the UK's national and subnational economic marginalisation are major factors to consider. The two parallel trajectories of economic and social developments are considered independently in insular ways in the post-Covid-19 recovery strategies. The British Academy report for example, did not consider economic reforms at all when recommending social policy supportive of marginalised communities.

Can critical scholars and activists in the UK take a root and branch approach that seeks to rebuild a more equal post-Covid-19 society that in turn gives shape to a new political economy, in which building social capital for marginalised communities and labour market competition do not work directly against each other? This is the challenge that Covid-19 presents to the UK. Can both Life and Livelihood flourish in a post-Covid-19 future?

Understanding Barriers and Facilitators' Research Participation Among Minority Populations: The Case of the US

Mieka Smart

Context of research project: Flint Water Crisis

Since the onset of the Flint Water Crisis, residents have been dealing with a wide range of psychosocial consequences, including government mistrust; therefore, maximizing racially representative participation may be especially challenging in Flint, where residents have become deeply distrustful and skeptical of the motives of those connected to both government and academic institutions (Cuthbertson et al., 2016).

Currently, there is limited qualitative research that examines why racial disparities in research participation persist. Furthermore, research aimed at understanding how to rebuild trust and increase minority participation is limited. The aim of our study was to identify barriers and facilitators to research participation within the context of mistrust. In 2019, a brief survey was deployed to residents of Flint, Michigan in order to confirm whether hypothesized key factors affect research participation. This is important because it can help to clarify reasons for hesitancy among minority populations to participate in COVID-19 vaccination trials as well as hesitancy to be vaccinated.

Initial response to the pandemic: COVID-19 vaccine trials

Recent data show that although Black people make up 13% of the U.S. population, they account for 21% of deaths from COVID-19 (Warren et al., 2020). In order to produce an efficacious vaccine, the amount of minorities enrolled should reflect the diversity of the population, with attention given especially to those most affected by the disease (Artiga et al., 2021). Failure to do so threatens the validity and the generalizability of the trial, as differences in environmental exposures and lived experiences can result in different immunologic responses to the vaccine (Artiga et al., 2021; Warren et al., 2020).

Due to this, there has been a substantial push for diversity in the COVID-19 vaccine trials (Artiga et al., 2021; Jaklevic, 2020). In April 2020, 15 U.S. democratic senators sent letters to pharmaceutical companies declaring that trials for COVID-19 vaccines and drugs "must include participants that racially, socioeconomically, and otherwise demographically represent the

United States" (Jaklevic, 2020). In late June, the FDA strongly encouraged "the enrollment of populations most affected by COVID-19, specifically racial and ethnic minorities" (Artiga et al., 2021; Jaklevic, 2020).

Despite these recommendations, pharmaceutical and biotechnology companies, like Moderna, had difficulty with enrolling minority populations. In early October, it was reported that Moderna's private contractors were experiencing trouble recruiting Black, Latino and Native American participants to their COVID-19 vaccine trial (Artiga et al., 2021; May, 2020). As a result, enrollment was slowed down and Moderna's research centers focused on recruiting more participants from minority populations (Artiga et al., 2021; May, 2020).

Who was left out: Vaccine trials

Throughout the months of July and August 2020, a team of researchers conducted 3 focus groups and 47 semi-structured interviews with *n* = 70 individuals from different ethnic and vulnerable groups (Ekezie et al., 2020). Their findings revealed that there was broad agreement amongst participants that clinical research was necessary, but many were extremely uncomfortable with the idea of visiting hospitals for vaccine trials and any research requiring physical examinations or blood tests (Ekezie et al., 2020). Fear of contracting the virus, experiencing potential side effects or lack of support if problems arose, language divides, and suspicion of hidden agendas behind the vaccines were also noted as barriers to participation (Ekezie et al., 2020). Additionally, researchers found that a lack of adequate information had influenced widespread apprehension, skepticism, and low levels of trust towards vaccine research (Ekezie et al., 2020).

To date, the total amount of participants that were enrolled in the U.S. Pfizer and BioNTech vaccine trials were 10% Black, while 13% of the U.S. population is Black, and 13% were Hispanic, although 19% of the population is Latino (Olsen, 2020). Asian and American Indian participation was approximately the same as their percentage of the U.S. population (Olsen, 2020). In the Moderna vaccine trials, 20% of participants were Latino, 10% were Black, and 4% were Asian, despite Asians' comprising 6% of the U.S. population (Olsen, 2020).

Who was left out: Vaccine uptake

In a recent interview with the Journal of the American Medical Association (JAMA), Dr. Linda Rae, MD, MPH, discussed the health inequities and racism present in the U.S., emphasizing that "African Americans have every right to distrust clinical medicine, and not just for Tuskegee, but for the structural racism in medicine as an institution—in our hospitals, and our health clinics,

and our insurance plans—and how we talk about and think about people of color and Black bodies" (Abbasi, 2020).

Historically, people of color, particularly Black adults, have had lower vaccination rates and expressed more concerns about getting a COVID-19 vaccine compared to their White counterparts (Artiga et al., 2021). In an effort to assess perceptions of the COVID-19 vaccine, Momplaisir and colleagues (2021) held 4 focus groups (*n* = 24 participants) with Black barbershop and salon owners living in zip codes with high COVID-19 prevalence between July and August 2020. Results showed that hesitancy towards getting the COVID-19 vaccine was due to mistrust in the medical establishment, concerns with an accelerated vaccine development, limited data on short and long-term side effects, and the political environment promoting racial injustice (Momplaisir et al., 2021). Researchers emphasized that some participants were willing to consider getting the vaccine if they received a recommendation to do so from a trusted health care provider and if the safety profile was shown to be robust and reassuring (Momplaisir et al., 2021). These findings are consistent with a Pew Research Center survey that was distributed in late April and early May 2020, in which 54% of Black adults reported that they would definitely or probably get a COVID-19 vaccine in comparison to 74% of White and Hispanic adults (Jaklevic, 2020).

With regard to the current COVID-19 vaccine distribution, there is a largely consistent pattern of Black and Hispanic people receiving fewer vaccinations compared to their share of cases and deaths and their percentage of the total population (Ndugga et al., 2021). For instance, in Texas, 20% of vaccinations have gone to Hispanic people, even though they account for 42% of cases, 47% of deaths, and 40% of the total population in the state (Ndugga et al., 2021). Across 35 states reporting data on vaccinations by race and ethnicity, White people have a higher vaccination rate in comparison to Hispanic and Black people, but the size of these differences varies widely (Ndugga et al., 2021).

Outreach recommendations to facilitate community engagement, participation, and knowledge sharing

Current outreach efforts have utilized the expertise of many, including the NIH's National Institute on Minority Health and Health Disparities as well as academic medical centers that serve minority populations (Jaklevic, 2020). Additionally, investigators have built on strategies cultivated through decades of HIV research, such as partnering with Black churches and other trusted community leaders (Jaklevic, 2020). For instance, several historically Black colleges and universities became sites for the COVID-19 vaccine trials as a way to encourage participation within their communities (Artiga et al., 2021).

In order to garner greater participation rates amongst minority populations and encourage vaccine uptake, continued efforts must be rooted in grassroots initiatives that involve trustworthy individuals and organizations with well-earned reputations in minority communities, including respected elected representatives, local and national faith leaders, and community advocates (Warren et al., 2020). Furthermore, sharing information about the diversity of participants in the clinical trials and the trials' findings on safety and efficacy for people of color must be an essential component of education campaigns and vaccination efforts (Artiga et al., 2021). Previous genomic-based research has shown that barriers to participation rates were associated with a lack of knowledge or awareness about genomic studies (Scherr et al., 2019). Since many lack internet access, participation could be increased through the distribution of an informational pamphlet about the coronavirus and the importance of the vaccine. Contact information could be included for people to reach out and ask questions as well. However, previous literature has demonstrated that educational interventions alone yield minor changes in attitudes or beliefs, suggesting that community leaders must address existing attitudes and beliefs in addition to providing educational materials and seminars in order to effectively overcome minority concerns about participation (Scherr et al., 2019). Furthermore, it is imperative that younger generations be targeted. In her JAMA interview, Dr. Linda Rae, MD, MPH, recommended using social media platforms to engage those not "watching the evening news or CNN" (Abbasi, 2020).

Lastly, future qualitative studies should explore clinicians' and research coordinators' perspectives on ways to reduce barriers and enhance facilitators for minority participation in research. Obtaining information from key stakeholders could reveal practical approaches to increasing public engagement, as these professionals hold almost all responsibility for enrolling study subjects.

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RECOMMENDATIONS

The COVID-19 global catastrophe is the result of the neoliberal economic model, centered as this is on deregulation, privatization and free market policies. The profit-driven growth calculus that drives this model is economically, socially and environmentally unsustainable. It produces wealth that becomes concentrated in the hands of a small group of elites, whose billions in profits during one year of the pandemic make a stark, dispiriting contrast against the illness, destitution, and premature death that continue to devastate the communities of millions of ordinary people around the world. As our report demonstrates, existing inequalities at the national and global level have shaped the pandemic, which is now in turn deepening these inequalities. If the health and welfare of people around the world, and of the planet itself, is to be secured, the neoliberal model must be rejected. National as well as international socio-economic structures and relations must be transformed. Pandemic measures can play a crucial role in setting out this path to transformation.

During the course of our research, we discussed many of the policy recommendations that were coming from numerous quarters as soon as COVID-19 was identified as a public health threat. Instead of repeating these recommendations, many of which are now circulating in the public arena, we highlight what we consider to be the most pressing issues that require attention, and situate these in a context that goes to the root of the problems that have contributed to the present crises.

1. Global Pandemic, International Response:

Given the global reach of the pandemic, measures to eliminate the virus must be global in scope. This requires international coordination, which is presently possible only through the WHO. Equitable financial contributions from western states and enhancement of the capacity of the WHO to lead this coordination is vital, as is the need to prioritize supplies of vaccines to high-risk populations in the Global South as in the North. What activists in the Global South have dubbed 'vaccine apartheid' must be brought to an immediate end. State-funding of vaccines and all COVID-19 health care services should be secured and provided without distinction of legal status, length of residency or citizenship. Vaccine rollouts and healthcare services should be provided in a manner that explicitly counters the divisions of race, class, caste, gender, religion, age, sexuality, disability and any other axis of social power.

2. Responsible Action, Holistic Response:

Most countries have developed a lockdown, quarantine and vaccine-centered response to COVID-19. While vaccines play a vital role in containing the pandemic, vaccinations can only be part of a multi-pronged, long-term strategy. The "sustainable suppression strategy" as outlined by Independent SAGE in the UK begins to map out this strategy and has five pillars: (1) vaccination of entire population; (2) widespread testing, tracing and isolation; (3) full provision of resources for self-isolation; (4) promotion and regulation of "Covid secure spaces"; and (5) border control and limited international travel. This strategy requires a sixth pillar: implementation and ongoing monitoring of the five pillars to ensure just and equitable application. For example, international leisure travel could be limited while allowing the travel of political and economic refugees.

3. Political, Economic, Social Accountability:

With few exceptions, political leadership has utterly failed to protect public health and the welfare of populations. Adopting instead measures to protect economic growth, most states have redirected public resources to support corporations, including big pharmaceuticals, agri-business, and other big businesses whose profits have actually increased during this pandemic. The support provided to workers, where this has been the case, was in line with protection of the long-term profitability of their employers. More outrageous, state funding as well as government scientific expertise was provided to corporations to develop COVID-19 vaccines, these companies were then allowed to charge governments for provision of these very vaccines. For one example, Forbes reported that Moderna received over $1 billion dollars from the US government to develop the COVID-19 vaccine; Moderna then charged the US government $1.5 billion dollars for 100 million doses of its vaccine (Forbes, 'The People's Vaccine', December 3, 2020). This situation calls for an immediate waiving of Intellectual Property Rights over COVID-19 vaccines and the free sharing of knowledge and technology to ensure the production of vaccines around the world. Such a move could serve as a model for the production of vaccines and medicines to protect public health care from privatization, and from the profiteering of corporations in the post-pandemic era.

4. Devastated Communities, Community Based Leadership:

The pandemic has unfolded along racialized, class, caste and gendered lines, its heaviest burden borne by the most dispossessed and politically disenfranchised communities. COVID-19 also brought into stark visibility the enormous North/South divide, which was already being intensified by neo-liberal economic policies and the global war on terror. It is vital that pandemic research, policies and measures account for these gross disparities and that they are designed toward ending their unequal impact on populations.

This COVID-19 global emergency has revealed how deeply entrenched remain colonial/imperialist relations and how deadly remain their effects. Pandemic measures should be designed and implemented in a manner that furthers the sovereignty of Indigenous and other colonized peoples, as well as the redress for Black and other dispossessed and disenfranchised peoples in the North and in the South. These measures should work to root out structural racism, sexism and transphobia from state and economic institutions, and to explicitly counter the demonization of particular states and communities who are being blamed for the pandemic. Moreover, grassroots organizations and trusted community leadership should be involved in policy, *as well as* decision making, and in delineating and monitoring how, where and when pandemic measures are to be implemented. Pandemic related public education campaigns must be led by community leaders, researchers and organizations, working in conjunction with public health officials.

5. Borders, Migrations, Travel:

The pandemic has intensified the exploitation of undocumented and migrant workers, as well as of refugees fleeing conflict zones and environmental devastation. Border control policies need to be redesigned to maximize safe travel and protection from the virus for these groups. Upon arrival, these communities should be granted residency and full access to social entitlements, including health care and financial support. Leisure travel that puts Indigenous peoples and other native communities around the world at risk of infection should be stopped for the duration of the pandemic.

AUTHORS

FARIDA AKHTER

Women's Rights Activist, Bangladesh

Farida Akhter is a women's rights activist and founding Director of Policy Research Organization and the women's Book Store in Bangladesh. She is a leading exponent of biodiversity-based ecological agriculture. She is campaigning against the harmful, unethical, deceptive and coercive introduction of GM crops in Bangladesh since the late 1990s by both raising awareness and demonstrating successful alternatives. She writes regularly in Bangla and English language in national daily newspapers, and spends most of her time working with farmers in the village and organizing farmer's rallies in the capital city Dhaka to draw the attention of policy makers, and press conferences to brief journalists on the issue. She also arranges workshops and trainings with researchers, NGOs, activists, women's groups and consumers groups on various issues related to health, food, agriculture and ecological lifestyles.

RADHA D'SOUZA

Professor, School of Law, University of Westminster, UK

Radha D'Souza is professor of Law, Development and Conflict Studies at the School of Law, University of Westminster where she chairs the Law, Development and Conflicts research group. Radha's research and writing straddles a number of disciplines and focuses on the Global South, law colonialism and neo-colonialism, history of imperialism in South Asia, and comparative theory and philosophy. She has written and published extensively on a range of subjects and issues concerning social and global justice. Her recent book What's Wrong With Rights? Social Movements, Law and Liberal Imaginations (Pluto, 2018) maps the transformations in the regime of international rights to the transformations in post-World War imperialism. She has written on activism and the security state, anti-colonial movements in South Asia, and on militarisation and ethno-national conflicts in South Asia. Her current research focuses on corporations and international development. Radha is a critical scholar, social justice activist, barrister and writer, from India.

XUEZHI DU

School of Communication, SFU, Canada

Xuezhi Du graduated from Huaibei Normal University with BA in Journalism in 2016 and graduated from Communication University of China with an MA in Theory and History of Communication in 2019. He has been pursuing his doctoral degree in the School of Communication at Simon Fraser University since 2020. His research mainly focuses on Global Communication, Political Economy of Communication, Rural Communication. Now he is trying to combine these three areas with doing his research on China's media policy and media transformation and its interaction with the world (especially with the Global South countries) under the context of (anti-)globalization. He has published several papers in leading Chinese communication journals including China Publishing, Television Research and External Communication.

SABIHA HUSSAIN

Professor, Jamia Millia Islamia University, India

Dr. Sabiha Hussain is Professor and Director at Sarojini Naidu Centre for Women's Studies, Jamia Millia Islamia University, New Delhi. Before joining the Centre for Women's Studies, she worked as Associate professor and Professor/Director in the Centre for Social Exclusion and Inclusive Policy under KR

Narayanan Centre for Dalit and Minorities Studies, Jamia Millia Islamia. She worked as junior fellow (I & II) in the Centre or Women's Development Studies, New Delhi for more than a decade before coming to Jamia Millia Islamia. She has obtained her Masters' M.Phil and Ph.D degrees from Centre for the Study of Social System, School of Social Sciences, Jawaharlal Nehru University. Apart from teaching she has been extensively engaged in research on gender issues and the problems faced by women in contemporary times. She has guided M.Phil Ph.D scholars and Master's dissertation.

She has authored six books, including: *Gender Inclusion in India: Challenges and Strategies*, 2021, *Women and Livelihood: Assertion for Visibility: A Study of Home based Workers in Northern India* (2020), *Women in Higher Education* 2019, *Pervasive Exclusion and The Challenge of Inclusion: Gender Patterns in South And Central Asia* 2014, and *Exposing the Myths of Muslim Fertility* 2008. She has also published many research articles in national and international academic journals and edited books. Her areas of interest are Gender and development, health and livelihood issues, minority issues including issues of Muslim women and their struggle for rights and entitlements both in the public and private domain, and identity issues. She has presented research papers in national and international seminars both within and outside the country. She has completed both minor and major research projects funded by various government agencies (University Grants Commission, New Delhi, Indian Council of Social Science Research, New Delhi and Ministry of Women and Child Development). She has been selected for International Visiting Leadership Programme in United States of America and also sponsored by UN-HABITAT and International Islamic University, Malaysia, to attend a Workshop on Land, Property and Housing Rights in the Muslim world.

SUVENDRINI PERERA

Professor of Cultural Studies at Curtin University, Australia

Suvendrini Perera completed her B.A at the University of Sri Lanka and her PhD at Columbia University, New York. She is John Curtin Distinguished Professor Emeritus at Curtin University in Australia. She is author/editor of 8 books, including Australia and the Insular Imagination: Beaches, Borders, Boats and Bodies. A book based on the Deathscapes project, Mapping Deathscapes: Digital Geographies of Racial and Border Violence, coedited with Joseph Pugliese, is due from Routledge in 2021.

AYMAN QWAIDER

Ayman is a researcher from Gaza, Palestine, now based in Australia with a Masters degree in Peace, Conflict and Development from The University of Jaume I (Spain). Throughout his career, he has participated in various research projects, latest of which was the Deathscapes Project (www.Deathscapes.org) and worked with several international organisations including UNESCO Paris and UNESCO Palestine. He is particularly interested in inclusive education and education in emergencies. Ayman has experience with community-based education projects in post-conflict contexts and working with people with disabilities. He is co-founder of Gaza Children Cinema (www.gazachildrencinema.org) a community-based education initiative in Gaza that aims to provide a peaceful and a creative space where children can be children and where the overwhelming realities of siege, loss and war can be temporarily forgotten.

MIEKA SMART

Assistant Professor, College of Human Medicine, Michigan State University

Dr. Mieka Smart is an Assistant Professor in the College of Human Medicine (CHM) at Michigan State University, with appointments in the Division of Public Health and the Department of Epidemiology and Biostatistics. Currently, she evaluates global drug and alcohol policy, and investigates methods for overcoming barriers to clinical and public health research participation among marginalized populations, most especially in the context of COVID-19. She directs the Research to Reduce Disparities in Disease program, a competitive NIH-funded research-training program for medical students. She directs the CHM Leadership in Medicine for the Underserved (LMU) graduate certificate program. Dr. Smart teaches in the CHM Master of Public Health program and the Master of Science in Global Health program in the College of Osteopathic Medicine. Dr. Smart earned her BA in public health, and MHS and DrPH in mental health from Johns Hopkins University. Link to Dr. Smart's publications in NCBI.

SUNERA THOBANI

Professor, Department of Asian Studies, UBC, Canada

Sunera Thobani is Professor in the Department of Asian Studies at the University of British Columbia. Her scholarship focuses on critical race, postcolonial and transnational feminist theory and politics; intersectionality and social movements; colonialism, indigeneity and racial violence; globalization, citizenship and migration; Islam, Gender and Muslims in South Asian and Western media; South Asian Diaspora; and South Asian Women's Gender and Sexuality Studies. She is the author of Contesting Islam, Constructing Race and Sexuality: The Inordinate Desire of the West (Bloomsbury Academic, 2020) and Exalted Subjects: Studies in the Making of Race and Nation in Canada, (2007). She is also co-editor of Asian Women: Interconnections, (2005); and States of Race: Critical Race Feminist Theory for the 21st Century, (2010). Her research is published in numerous edited volumes and peer-reviewed journals, including Borderlands, Atlantis, Feminist Theory, The Supreme Court Review, International Journal of Communication, Hypatia and Race & Class.

Dr. Thobani served as Ruth Wynn Woodward Endowed Chair in Women's Studies at Simon Fraser University and as the President of the National Action Committee on the Status of Women. She is a founding member of the cross-Canada network, Researchers and Academics of Colour for Equity (RACE); the recipient of the Sarah Shorten Award of the Canadian Association of University Teachers; and a member of the Ethics Advisory Board for the Deathscapes project.

YUEZHI ZHAO

Professor, School of Communication, SFU, Canada

Yuezhi Zhao is Professor and Canada Research Chair in Political Economy of Global Communication at the School of Communication, Simon Fraser University, Canada. Dr. Zhao has written extensively on the political economic and socio-cultural dimensions of China's rapidly transforming communication industries and the role of communication and culture in China's global integration. Her publications include Sustaining Democracy? Journalism and the Politics of Objectivity (1998), Media, Market and Democracy in China (1998), Democratizing Global Media: One World, Many Struggles (co-edited, 2005); Global Communications: Toward a Transcultural Political Economy (co-edited, 2008), Communication in China: Political Economy, Power and Conflict (2008), Communication and Society: Political Economy and Cultural Analysis (2011, in Chinese), and Communication and Global Discursive Power Shifts (coedited, 2019, in Chinese).