**RACE AND COVID-19 IN TORONTO: EXAMINING THE DISPROPORTIONATE REPRESENTATION OF RACIALIZED GROUPS IN TORONTO’S COVID-19 CASES**

**ISSUE**

How should the disproportionate representation of racialized groups in Toronto represented in the city’s COVID-19 cases impact the vaccination distribution process?

**BACKGROUND**

With the vaccination process beginning across the country, it is important to consider how racialized groups are disproportionately represented in COVID-19 statistics because understanding the impact of these statistics can help curb the spread of the virus through the vaccine distribution process. Risk of illness is often associated with an individual’s place of residence, type of employment, and level of income. Recent studies have brought awareness to the existing influence of race on an individual’s risk of illness. Racialized groups are at higher-risk of illness, including for COVID-19. Race is a proxy which can be used to measure the social determinants of health, referring to economic and social factors related to the lived experiences that influences their health. The social determinants of health are strongly affected by systemic racism present in Canada. This leads to racialized groups being more vulnerable to viruses, such as COVID-19, as well as poorer overall health outcomes in general.

**CURRENT SITUATION**

Individuals in racialized groups hold a disproportionately high share of COVID-19 cases in comparison to the share of people living in Toronto. This sample includes 13,291 observations collected by Toronto Public Health (2020), and it is important to consider that the list of ethno-racial groups are non-exhaustive and certain ethno-racial groups in the study were categorized together. The following points outline the percentage of the population each ethno-racial group holds and their share of COVID-19 cases, with overrepresented groups bolded.

* **Arab, Middle Eastern or West Asian people** represent 4% of Toronto’s population and 8% of COVID-19 cases.
* **Black people** represent 9% of Toronto’s population and 20% of COVID-19 cases.
* East Asian people represent 13% of Toronto’s population and 4% of COVID-19 cases.
* **Latin American people** represent 3% of Toronto’s population and 9% of COVID-19 cases.
* **South Asian or Indo-Caribbean people** represent 13% of Toronto’s population and 21% of COVID-19 cases.
* **Southeast Asian people** represent 7% of Toronto’s population and 13% of COVID-19 cases.
* White people represent 48% of Toronto’s population and 23% of COVID-19 cases.

Analysis of statistics from the beginning of the pandemic collected by Toronto Public Health suggests that Black neighbourhoods in Toronto had disproportionately high cases of COVID-19 (Open Data Toronto, 2019). Comparison of two maps of Toronto divided by neighbourhood, one showing COVID-19 cases per 100,000 and the other the percentage of people identifying as Black, demonstrates a visible association between higher cases of COVID-19 being present in neighbourhoods with higher percentages of Black people (Open Data Toronto, 2019; Toronto Public Health, 2020). Population density in these communities is a contributing factor for increased exposure due to economic and social inequalities. Research conducted in the United Kingdom found that the likelihood of Black people contracting a COVID-19 infection is twice as likely compared to white people (Sze et al., 2020).

**DISCUSSION**

Understanding how racialized groups are disproportionately represented in COVID-19 statistics is a key consideration for policymakers as this information provides a better understanding of how different communities in the city are being affected by the virus. In order to have an effective policy implementation strategy, the vaccination distribution process should account for the disproportionate representation of racialized groups in COIVD-19 cases in the City. This key consideration can help curb the spread of the virus. Academic research has revealed disparities in likelihood of receiving regular influenza vaccinations, with Black people being significantly less likely than white people (Quinn et al., 2011). Differences observed in regular influenza vaccine-seeking behaviour have the potential to further aggravate existing disparities with the COVID-19 vaccination rollout (Hutchins, 2009). Racial minorities should be considered a priority during the vaccination distribution process.

The distribution process must directly respond to the systemic racism present in the healthcare sector. Policy options for vaccination distribution must focus on enhancing access to and education of vaccinations for minority groups. First, placement of vaccination sites should be located directly in racialized communities. This will allow for vaccination access within disproportionately affected communities through direct distribution. Second, outreach programs should be implemented within racialized communities to educate minority populations about the benefits of receiving both regular influenza shots, as well as the COVID-19 vaccination specifically. Education given by the outreach program should also provide understanding behind priority groups (Quinn et al., 2011), the benefits of vaccinations, and where to seek the vaccinations. Creating this knowledge-based communication strategy in minority communities is essential to provide equal access to vaccination information for individuals who would otherwise not seek the vaccination, ultimately leading to effective action. Third, outreach programs and vaccination centres would also benefit from being accessible for non-English speakers. If the vaccination process is not made equitable for racialized groups, there are significant risks that this will further contribute to the current pattern of systemic racism in access to health care.

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