THE DEFINITION OF A MYTH—BLACK FOLKS AND COVID-19

As a proud Caribbean Canadian woman, **Lydia-Joi Marshall** strives to use her voice to represent her lineage and community in a positive light on every platform. Lydia-Joi earned a Msc. In Human Genetics from the prestigious Howard University. As President of the board of directors of Black Health Alliance, a not-for-profit organization, she diligently worked to galvanize leaders to promote health awareness and patient advocacy from within the community. Their mission is to reduce the racial disparities in health outcomes and promote health and well-being for people from the diverse Black communities in Canada with emphasis on the broad determinants of health, including racism. This message can be seen through her public advocacy including her Tedx talk on the impacts of being Black in Canada. Ms. Marshall also works with Health Commons Solutions lab, which focuses on equitable solutions to addressing population wellness, including supporting marginalized communities during the current pandemic.

Mythology can be defined as tools that are used to preserve cultural beliefs, entertain or to warn. They may be rooted in lived experience or be a creative expression of various forms of knowledge. During the COVID-19 pandemic we saw the revitalization of myth-telling on a Herculean level, both because of its inherent global impact and our ability to virtually share in real time our opinions and experiences about what was happening. What emerged were diverse narratives around how we access, define and communally relate to medical interventions. Unfortunately, during the pandemic many healthcare values, especially those in Black communities, were framed as being uninformed which led to a polarization between emerging medicine and traditional values. Instead of dismissing this knowledge as mythology, going forward we can strive to learn to utilize our diverse tools in medicine to rebuild a system that is sustainable for all.

MYTH 1 - UNIVERSAL HEALTH CARE MEANS EQUITABLE CARE

Canada often prides itself on having an equitable system because of universal health care, simply because it is offered to everyone. The mythical aspects of this became abundantly clear when almost immediately disparities in who became infected with COVID-19 and who had access to care began to emerge. This was further illustrated when our cries of "we are all in this together" were not reflected by the dissonance seen in some posting TikToks about becoming expert bakers while quarantining at home, while others were still working front line with inadequate personal protective gear.

Leaders from groups that are marginalized by race, such as diverse Black communities, were requesting routine collection of statistics of these disparities. Both to secure additional resources to support those being disproportionately impacted, but also as a public record of gaps that were already known across the board in chronic and acute care needs. Health Authorities were reticent to use resources to collect this data, as in their experience our "post-racial" system would not benefit from this information. When it was finally examined, what was seen was a disturbing trend of disproportionate impact. In cities like Toronto 21% of COVID-19 cases were in Black people, who only made up 9% of the total population.[1] Worse yet, in regions of lower socio-economic means, Black people were 3.5 times more like to die from COVID-19 than their ethnically diverse counterparts.[2]

The reason for these trends are multifactorial and are rooted in the social determinants of health. This includes a sense of belonging to the broader community, relationships with governing bodies and systemic anti-Black racism which has

manifested in generational differences in access to public services, and private opportunities.

For example, it became evident that public transportation was a source of increased risk of COVID-19 transmission. While areas serving a diverse majority often tend to have more frequent services, resulting in less crowded commutes, many geographies serving dense communities of Black folks have less consistent route service and divergent surge planning. This results in higher opportunities for contact and spread. This was true even when economic status was normalized. Simply providing the opportunity to access healthcare to all citizens, does not remove the barriers to fully participating in this care, especially for groups that have been purposefully not integrated into the system. This can in fact further contribute to the widening of gaps of who is infected and how they recover to acute infections such as COVID-19.

MYTH 2 – GOOD HEALTH IS A UNIFORM UNIVERSAL CONCEPT

As a society we have long had a curiosity as to how our body functions and how to maximize this, some of these explorations have been recorded in medical books, others orally passed down, depending on the society and how they record knowledge. This can range from foods and herbs that are known to soothe minor ailments, to drugs or surgeries to address larger needs. For example, many families have tried and tested teas that are administered to relieve gastrointestinal problems, infectious disease or hormonal rebalancing. These address a need both by the familiar practice of it, and through active ingredients that may work well in balancing our biological symbiosis.

During the onset of the pandemic, commendably leaders were focused on mobilizing resources to secure the health of the global majority, an Imhotep-size task in a medically shifting landscape. This often meant choosing one narrative of health, and forming practices around achieving this. What did this feel like for those whose viewpoints had not been considered in the universal emergency plan? For many it felt like an erasure of their voice in the public conversation on health. A reinforcement that their cultures were not valued and that they would be forced to comply with a system that had historically marginalized them.

In response to the alarming statistics showing rates of COVID-19 in Black communities, we began to see mainstream headlines around hesitancy and strategic plans on how to "bust mythology" in these people. Equity and inclusion courses were put on sabbatical, as we routinely addressed unique Black communities as a monolith, and studied and reported on them as an entity to be swayed.

The debate was no longer about science and safety but became a competition of which voice was the acceptable normal, while the usual outliers were silenced.

Working on the front lines, what became evident was that most people did care deeply about their health and safety. Why the conversation had become divided was because we had not agreed on what these terms meant. The result was an increase of mistrust, not in modern medicine, but in the people enforcing power in how to use it.

MYTH 3 – WE ALL WANT TO "GET BACK TO NORMAL"

Black communities have often felt excluded from the broader discussions on healthcare. This comes in the form of systemic mistreatment which has been seen overtly in prejudices encountered when entering institutional settings. This is not only in reference to the now well catalogued clinical trials in Black populations, but rather to daily assumptions made about the capability to understand and engage in wellness practices, and the microaggressions that ensue based on this. This communal sentiment of being ostracized, was further exacerbated during the pandemic when public health care often focused on targeting Black people. The evidence showed that interventions to support demographics that were being impacted more severely were needed, but the way in which these strategies were presented often reinforced feelings of being further stigmatized. Many other groups had questions about COVID-19 care and vaccinations, where were their campaigns or tailored messaging? Instead, the media headlines presented many diverse Black communities as a monolith who were all making the same healthcare decisions.

Additionally, foundations of health from across the African Diaspora are rarely included in mainstream holistic health care conversation, even when discussing naturopathic or complementary services. For example, if you inform your primary care physician that you are also following an Ayurvedic practice of health care, it is generally understood, but if one said they followed an Ital lifestyle, subsequent line of questioning is often extensive.

This experience often makes members of marginalized communities reticent to share their practices and viewpoints, as they feel like they are being judged in a way that may impact the nature of their care. While legally part of this universal healthcare system, many Black Canadians have long been a part of a parallel system, because there is a feeling that full engagement is not in their best interest Participation in public health campaigns, research and even routine care has long looked very different, but prior to the pandemic few were paying attention.

This has an impact on the health outcomes of many, and it causes barriers to accessing care in both tangible and

psychosocial ways. If this was normal, there would be no desire to return to it.

LESSONS FOR THE FUTURE

What then is the goal for rebuilding in the era after the onset of COVID-19? We have learned of our incredible resilience, adaptability and compassion in circumstances that were new to a whole generation of people. The ingenuity that emerged and the progress of medical technology have been an amazing personification of the phrase survival of the fittest.

This progress must continue.

While we addressed the emerging health crisis, we learned how collecting disaggregated data helps give us a better picture of who we are serving and more importantly who are not. Often the solution to addressing any inequalities that are seen is to provide further education to the marginalized group, with the assumption that if we are all given the same information, we will value and interpret it in the same way. This has never been true of any philosophy, theory or practice. Instead, let us not dismiss our varied epistemologies of health as mythology and misinformation, but use them as a starting point to understand one another and what intersections we can find to achieve a healthy society. Reciprocal education on wellness is needed.

We have found pride in promoting our diversity as a society and creating safe spaces for individual expression, but diversity does not only exist in the food we eat or the spectrum of melanin expression but is also found in our individual core of belief systems around health maintenance. It is possible to enhance a healthcare system that strives to make space for varied conversations on healing, while maximizing the amazing clinical strides we are making as a collective to maintain this.

REFERENCES

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