OXFORD

Perspectives

Black Lives Matter in health promotion: moving from unspoken to outspoken

Stephanie Leitch[1], J. Hope Corbin [2,*], Nikita Boston-Fisher[3],
Christa Ayele[4], Peter Delobelle [5], Fungisai Gwanzura Ottemöller[6],
Tulani Francis L. Matenga[7], Oliver Mweemba[7], Ann Pederson[8], and
Josette Wicker[9]

[1]TT Black Lives Matter, WOMANTRA, University of the West Indies, Trinidad and Tobago, St. Ann's Port of Spain, [2]Western Washington University, Bellingham, WA, USA, [3]McGill University, Montreal, Canada, [4]IUHPE's Student and Early Career Network, Philadelphia, PA, USA, [5]University of Cape Town and University of Western Cape, and Vrije Universiteit Brussel, Brussels, Belgium, [6]University of Bergen, Bergen, Norway, [7]University of Zambia, Lusaka, Zambia, [8]University of British Columbia, British Columbia, Canada and [9]IUHPE's Student and Early Career Network, Seattle, WA, USA

*Corresponding author. E-mail: hope.corbin@wwu.edu

Summary

Racism is a public health crisis. Black communities (including Africans, the African diaspora and people of African descent) experience worse health outcomes as demonstrated by almost any measure of health and wellbeing—e.g. life expectancy; disease prevalence; maternal mortality rates. While health promotion has its foundation in promoting equity and social justice, it is clear that however well-intended, we are not affecting meaningful change for Black communities quickly enough. Through this article, we outline the intersection of social determinants of health and anti-Black racism. We describe how in the first 8 months of 2020 Black communities around the globe have been disproportionately affected by COVID-19, while also having to respond to new instances of police brutality. We assert that the time has come for health promotion to stop neutralizing the specific needs of Black communities into unspoken 'good intentions'. Instead, we offer some concrete ways for the field to become outspoken, intentional and honest in acknowledging what it will take to radically shift how we promote health and wellbeing for Black people.

Key words: COVID-19, anti-Black Racism, structural inequity, Black Lives Matter, race, social justice

I have come to believe over and over again that what is most important for me must be spoken, made verbal and shared, even at the risk of having it bruised or misunderstood. —Audre Lorde.

Health promotion has rooted its purpose and identity in its commitment to reducing health inequities and working to achieve health equity through healthy public policy, supportive environments, community action,

reorienting health services and developing personal skills (WHO, 1986). While there is recognition of, and some research on health inequities as they relate to Black communities globally, often addressing these unique inequities gets subsumed into a general focus on 'marginalized' or 'vulnerable' populations. (The authors would like to acknowledge that Indigenous and Aboriginal peoples of Australia, New Zealand, the Americas and other areas have also endured genocide, family separation, intergenerational trauma and structural violence in unique ways and would benefit from specific and historically grounded forms of health promotion). It is comforting for some of us to assume that, as a field, we are doing 'enough' because we hold good intentions.

But the reality, as demonstrated by almost any measure of health or wellbeing—e.g. life expectancy (Bond and Herman, 2016); disease prevalence (Gadson, 2006; Geronimus et al., 2006); maternal mortality rates (Fang et al., 2000; Lu and Halfon, 2003; Owens and Fett, 2019)—is that, however well-intended we are in our approach, health promotion is not affecting meaningful change for Black communities quickly enough. Clearly, it is not sufficient to hold an unspoken intention—to research and publish about health inequities or to craft piecemeal interventions to patch up the divide experienced in Black communities—without centering race as a primary and legitimate determining factor. If we are to make any significant difference, we need to bring to the fore the knowledge, methods and strategies we have honed over the last 34 years. We must move to intentionally dismantle oppressive structures and address the historic injustices of colonialism and slavery, the resulting intergenerational trauma, as well as racist laws and policies, institutional practices rooted in racial biases, and the economic deprivation that continues to harm Black communities.

This perspective article has been written through collaborative, intergenerational and transnational discussions among a group of members of the International Union of Health Promotion and Education. We situate ourselves variously—as academics, front-line workers, researchers, students and activists; as new and established members of the formal health promotion field; as differently abled, gendered, aged individuals of various racial identities—who share a commitment to questioning how the field of health promotion has been blind or complicit in perpetuating anti-Black racism, scholarship and practice and challenging ourselves to remain silent no longer. We offer our thoughts with the intention that they are part of an essential conversation within a field such as ours, which is designed to value and uphold human dignity, equality and action.

The Black Lives Matter (BLM) movement emerged out of a historical and urgent need to reflect on the realities of Black communities and their own understandings of how both structural and interpersonal racism experienced daily and for the past 400 years under the many cloaks of colonial rule is unique to Africans, the African diaspora and people of African descent (Powell, 2020). Through this article, we outline the intersection of social determinants of health and anti-Black racism. We describe how in the first 8 months of 2020 Black communities around the globe have been disproportionately affected by COVID-19, while also having to respond to new instances of police brutality. We assert that the time has come for health promotion to stop neutralizing the specific needs of Black communities into unspoken 'good intentions'. Instead, we offer some concrete ways for the field to become outspoken, intentional and honest in acknowledging what it will take to radically shift how we promote health and wellbeing for Black people.

Black Lives and the disproportionate death toll due to COVID-19

The impact of the COVID-19 pandemic on the health and economic wellbeing of people around the world has been devastating and even more so for Black communities. The pandemic has exposed inequities that have existed for hundreds of years between the descendants of enslaved Africans and those of European descent. In all contexts tracking such data, Black communities experience disproportionate numbers of infections, more severe complications and higher death rates than other racial or ethnic groups. For example, analysis of federal data in Brazil reported that, of those hospitalized with COVID-19, one in three Black Brazilians had died compared with one in 4.4 White Brazilians (Agência Publica, 2020).

This pattern holds to a greater or lesser extent in other countries with significant Black populations. In the USA, a recent report highlights discrepancies indicating that Black people are 2.3 times more likely to die of COVID-19 than White and Asian people. The age-adjusted rate is 3.7, meaning that younger Black people are dying much more frequently than White and Asian people of the same age (APM, 2020). This may reflect the concept of 'weathering', which was originally observed among young African-American women who experience early health deterioration as a consequence of the cumulative experience of ongoing social, economic and/or political exclusion and which may take the greatest toll among Black people in racially charged contexts, who must engage in high-effort coping mechanisms (Geronimus et al., 2006).

Canada has not historically collected or reported race-based health data (Veenstra and Patterson, 2016). This practice is being challenged in the context of the COVID-19 pandemic, as various sources have called attention to the disproportionate impact the pandemic has had on Black and Brown communities (Alliance for Healthier Communities, 2020). In response, jurisdictions (like Toronto) have begun to collect race-based data in relation to COVID-19 (Bingley, 2020). A press release from Toronto Public Health of a small sample of respondents for example found that '83% of people with reported COVID-19 infection identified with a racialized group' (Bromley, 2020). Research suggests that Personal Support Workers, one of the groups at highest risk for COVID-19 infection in Ontario, are disproportionately visible minorities and immigrants (Lum *et al.*, 2018).

Looking at proportions—Black people make up 12.4% of the US population and 23.3% of the COVID-19 deaths (APM, 2020). In South Africa, which has the fifth highest number of cases worldwide, COVID-19 is hitting the Black townships harder than areas predominantly occupied by White people (Harrisberg, 2020). For example, in mid-June nearly 12% of total infections were found in Khayelitsha, a large and predominantly Black township in Cape Town, in spite of it having just 6% of the province's population. In contrast, Stellenbosch (a predominantly White area), which makes up about 4% of its population had just 1% of total cases (Al Jazeera, 2020). These patterns hold even in country contexts with relatively homogenous populations such as Norway, where the Somali community, especially in Oslo, has been disproportionately affected by COVID-19, accounting for 6% of all cases—or more than 10 times that of the general population (Masri, 2020; Yaya *et al.*, 2020).

Higher risk of infection and complications

While the Black community must contend with disproportionate death rates due to COVID-19, the risk of infection is also greater due to increased exposure to the virus. The world over, Black people are overrepresented in jobs that expose them to greater risk of person-to-person transmission on the frontlines—such as health care and personal support work, taxi driving, housekeeping, grocery store clerks, factory and farm workers (McClure *et al.*, 2020). It is also likely that Black people in low-income jobs and the large numbers working in the informal sector [still comprising more than 60% of the world's employed population and 86% in Africa (ILO, 2018)], lack access to paid leave and are unable to stay-at-home when ill or after exposure to an infected person. Workers across the spectrum have been impacted by COVID-19. In Trinidad and Tobago for example, nurses and sanitation workers have been protesting for increased wages, including hazard pay and better working conditions, as a result of the increased risks posed in their day-to-day work due to COVID-19 (Hamilton-Davis, 2020).

African countries with predominantly Black societies have not been spared from racist and capital-driven measures that have weaponized the fears of a community spread outbreak. As the pandemic took its toll on Zambia's economy, reports began to emerge about Chinese business owners who allegedly did not allow local workers to return home to their families and kept them on-site during the pandemic to increase the factory's productivity. Zambian workers were made to sleep in small containers with up to six people on mattresses on the floor. In response to this gross example of human rights violations, factory owners claimed that workers were not being held against their will but that these measures protected them from the pandemic (Phiri, 2020).

Housing also factors into increased risk of exposure. Housing in Black communities is a complex modern and historical issue, with wide-reaching health consequences. For instance, in South Africa, township layouts, which are a legacy of the apartheid regime, limit safe housing options within Black communities (Noble and Wright, 2013). Poor Black families are squeezed into overcrowded one-bedroom shacks, where adherence to strict lockdown measures such as social distancing and regular hand washing is nearly impossible (Bartlett, 2020). This pattern holds true in other African countries with similar histories of legislated segregation (Hansen, 2005; Gough, 2008), including the former Portuguese colonies of Angola and Mozambique.

Similarly, in the USA, redlining policies, beginning in the 1930s, created unequal geographies through racially discriminatory lending practices, segregation and under-resourced tenement housing in predominantly Black neighborhoods and cities. These environments, by design, are more likely to provide unsafe housing (Rothstein, 2017), typically defined through higher prevalence rates of crime and homelessness, which are often a direct result of systemic racism and intergenerational poverty—further exacerbated by a lack of dedicated resources for community development (Greif and Morris-Compton, 2005). These housing environments and community spaces frequented by Black communities are neglected by the state because of their socioeconomic status and are hotbeds for COVID-19 transmission

(Yancy, 2020). Even beyond the compromised conditions of Black neighborhoods, the location of these housing settlements also increases the likelihood that Black people have to rely on public transportation to get to work and commute to city centers, further increasing their risk of exposure (Tan *et al.*, 2020).

Black people are not only more vulnerable to infection but are also more likely to have complications once infected with COVID-19, due to a lack of adequate care and pre-existing conditions. Those individuals with underlying medical conditions (e.g. diabetes, hypertension, asthma, respiratory disease) are generally at an increased risk of being hospitalized due to COVID-19 (Williamson *et al.*, 2020; Zheng *et al.*, 2020). However, Black individuals often face these medical conditions at a much higher rate than White individuals (Fortuna *et al.*, 2020). In the USA, for example, Black Americans are 60% more likely to be diagnosed with diabetes than non-Hispanic White people (HHS, 2020); are more likely to suffer with hypertension with a much earlier onset of symptoms than other racial groups (Lackland, 2014); and more likely to live with asthma and other respiratory diseases (Abrams and Szefler, 2020). These complications are reflected in the overrepresentation of deaths due to COVID-19, worsened by the fact that Black Americans face significant barriers to accessing adequate care. Contributing socio-economic factors include a lack of health insurance among Black populations and the biased attitudes of healthcare workers, which routinely leads to symptoms and pain being ignored or undertreated (Fiscella and Sanders, 2016). Many Black Americans have understandably lost trust in the healthcare system because of these negative experiences and developed help-seeking avoidance behaviors, further compromising their care (Fiscella and Sanders, 2016).

Health communication messages have also failed to meet the needs of Black communities (Airhihenbuwa *et al.*, 2020). For example, the Somali population in Norway, a small proportion of the population, has been disproportionately affected by COVID-19 (FHI, 2020). They are at greater risk of exposure due to their work as taxi drivers or as health and service industry workers, and their living situations (Yaya *et al.*, 2020). Still, despite this disproportionate risk, most official information about COVID-19 was presented in Norwegian and English (Masri, 2020). Galvanized by these gaps in the state response, members of the Somali community mobilized key gatekeepers to initiate a collaboration with the public health institute to develop an inclusion strategy, comprising targeted outreach and the production of knowledge products in Somali (Cookson *et al.*, 2020).

This community response revealed critical oversights in the Norwegian health system and strengthens the humanitarian call for equitable, flexible and inclusive strategies to be applied in emergency responses to ensure equal access for all. In the context of COVID-19, specific guidance has been developed around the dissemination of health information for migrants and refugees in the appropriate languages, given the higher health-related risks and vulnerabilities of these communities (WHO, 2020). Despite this, the challenge still remains in health and other field to disseminate, track, monitor and ensure compliance for protocols that are handed down by development agencies. Ground-up approaches that allow people to become aware of and challenge their own biases, like the example in Norway, build a strong foundation toward lasting change.

Police brutality, uprisings and COVID-19

On 25 May 2020 in Minneapolis, Minnesota, George Floyd was killed while in police custody, when an officer kneeled on his neck for nearly nine minutes, cutting off the air to his lungs (Hill *et al.*, 2020). The horror of this incident is indicative of the rampant brutality experienced by Black people at the hands of police in the USA dating back to the era of slavery (Alexander, 2012). The murder of George Floyd, which was witnessed firsthand and shared globally via social media, prompted uprisings in major cities across the country and solidarity marches worldwide. In the USA, thousands gathered across the nation, braving the risk of contracting the virus, to protest the brutality that countless Black people continue to face. The response from law enforcement highlighted the inhumane treatment Black people and their allies endure when fighting for racial justice—from the coordinated physical attacks on protestors with tear gas and pepper spray, to the destruction of water and first-aid supplies (Boyle and Wadington, 2020; Burke, 2020). In the midst of a viral pandemic that directly threatens human respiratory functions, this reaction from the state ultimately jeopardized the capacity of medical facilities that were already overwhelmed.

With the unrest sparked by various direct actions of the BLM movement, Black people throughout the diaspora have experienced increased levels of violence, death and maiming at the hands of police. Examples from the Caribbean include the June 27th police shooting of three Black men, Joel Jacobs, Israel Clinton and Noel Diamond, who could be seen with their hands in the air surrendering to the police at the time of their shooting, which was captured by a neighbor on his mobile camera and also picked up by nearby CCTV cameras

(Reyes and Gahman, 2020). These extrajudicial murders triggered widespread protests throughout Trinidad and Tobago that lasted three days. During this time protestors were beaten, tear gassed and, to the country's horror, a 30-year-old pregnant woman, Ornella Greaves, was killed by a stray bullet when an officer allegedly discharged his gun into a crowd of peaceful protestors who were gathered in their own community. And if this story wasn't tragic enough, 7 years earlier in 2013, Ornelle's brother Christopher Greaves was also killed by police while walking home from the corner store (La Vende, 2020).

In South Africa, people also took to the streets in the spirit of the BLM movement and in protest of police brutality in townships. The violence with which COVID-19 lockdown regulations were enforced brought the culture of abuse and non-accountability of the South African Police Service into sharp focus. In the first three days of lockdown, three people were killed by police, and within a month, the UN Human Rights Office had received reports of excessive use of force by security officers (Knoetze, 2020), including the use of bullets, tear gas, water bombs and whips to enforce social distancing, particularly in poor and informal settlements. Due to mounting pressure from civil society, several court orders were issued to compel authorities to prevent police and army brutality during the enforcement of lockdown measures (Gumede, 2020).

Since April, the Canadian Civil Liberties Association has been tracking and visualizing the 'massive and extraordinary expansions of police power in response to the COVID-19 Pandemic and the unequal patterns of enforcement that may arise as a result' through their Policing the Pandemic Mapping Project (McClelland and Luscombe, 2020). The stated aim is to 'highlight COVID-19 related patterns of police intervention to help understand who is being targeted, what justifications are being used by police, and how marginalized people are being impacted' (Policing the Pandemic, 2020). In Trinidad and Tobago, police arrested scores of lower-income Black people during lockdown, citing the breach of COVID-19 regulations (La Vende, 2020). The intentions of police and circumstances around these arrests have however been scrutinized, given the state and police narrative that gang leaders were attempting to destabilize the country, versus an organic uprising of citizens affirming their right to peace and freedom from violence. This type of discursive reframing, much like the performative paternalism of the Chinese business owners in Zambia and the more visceral brutality of the South African police, all demonstrate how the pandemic has been racialized and politicized, resulting in detrimental effects for Black people's health and safety globally.

The overlapping and intersecting realities of Black communities are laying bare the harsh realities that Black people have endured since the dawn of the Trans-Atlantic slave trade, when they were stripped of their right to be considered human. How can we in good conscience assert that this history has no impact on the social determinants of health? Anti-Black racism—historical and current, structural and interpersonal—have unique and devastating consequences on the health and wellbeing of Black people today. The reckoning of historic violence, economic deprivation, under and precarious employment, underinvestment in education, inadequate access to food, environmental injustice—all now manifest in COVID-19 infection, complications and death—are juxtaposed with the profound present-day violence, inequity, and injustice faced by Black communities. The life and death threat posed by police violence has motivated people out into the streets to fight for their lives and to rise up in opposition to generations of structural violence. The response has been more police brutality, violence, and exposure to COVID-19.

So the question is, fellow health promoters: *what are we going to do about it?*

> *And of course I am afraid, because the transformation of silence into language and action is an act of self-revelation, and that always seems fraught with danger.—Audre Lorde*

Dismantling racism within our profession

The structural racism described in this editorial dates back to the slave trade and colonization of Africa and involved not only the theft and forced displacement of people, their land and wealth but also the trojan horses of 'education', 'health services', and religious indoctrination. The 'education' and 'services' ushered in by missionaries and other colonial actors very rarely served African people (Rodney, 1981), but instead were instrumental in stripping away Indigenous identities and knowledge and privileging Western ways of knowing (Chilisa, 2019), which has had devastating consequences, for instance, in HIV prevention work (Chilisa, 2005) and countless other examples. Indeed, chattel slavery was a system of extreme violence, where the Black body was considered property and animalistic, meant only to reproduce for the sake of creating more workers and forced to work under the most dehumanizing conditions.

Once African countries achieved independence from this iteration of colonialism—new forms of domination

were devised and mainstreamed through neoliberal financial dependence as implemented through economic institutions like the World Bank and International Monetary Fund. These policies included predatory trade agreements, and structural adjustment programs that mandate unfavorable currency manipulation, vulnerable cash crop economies, and the gutting of social and health infrastructure (Corbin, 2005).

The first WHO Conference for Health Promotion, organized in Ottawa in 1986, coincided with an expansion of privately provided social and health services in the wake of neoliberal trade and structural adjustment policies that emerged around that time and remain largely intact. As governments were forced to scale back their services, non-governmental organizations swooped in to fill in the gaps—at times, employing health promoters as a part of those efforts. As health promoters, it is important that we understand how the field of health promotion was ushered in along this timeline. Our field is indelibly part of a colonial history and therefore demands that we be transparent, reflective, and explicit in our attempts to actively dismantle these systems (McPhail-Bell *et al.*, 2013; Chandanabhumma and Narasimhan, 2019). As a profession, we must share our commitment to promote equity and dismantle racism and engage collaboratively far and wide.

To echo the title of this article, it is high time for health promotion to become authentic, and outspoken in acknowledging what it will take to radically shift how we advocate, promote and demand inclusion in our field that prioritizes the health and wellbeing of Black people. To that end, we offer the following suggestions to fight anti-Black racism on at least three planes: health promotion policy work to dismantle structural racism; health promotion interventions to fight anti-Black interpersonal racism; and critical self-reflection on anti-Black racism as a core tenet of our professional preparation and ongoing development.

Dismantling structural racism

We have covered many aspects of present-day structural violence and racism as illustrated through the current COVID-19 pandemic. We have described ways in which the historic and modern deprivation of all the prerequisites for health including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (WHO, 1986) impact Black communities (Jackson, 2020). The precise policies, processes and practices that dictate this deprivation vary from context to context, but the universality of anti-Black racism and its effects are undeniable. Health promotion, the action arm of public health, has honed powerful tools for promoting health through policy change at state and institutional levels (e.g. intersectoral action, Health-in-All Policies, settings approaches) and we need to work collectively to harness the full potential of these tools to identify and uproot policies and practices that harm Black communities. Inevitably, what can be unearthed by this process, is a fundamental recognition that the injustices faced by Black communities, influences every aspect of their health and well-being.

And so armed with this information, we must act. In nearly every country where Black people exist, there are organizations already working to bring about positive change (e.g. Black Lives Matter local chapters, The Movement for Black Lives, Black Student Unions, etc.). With most of the heavy lifting already being done by communities of color, we can find the alignment of our goals and seek partnerships that leverage our skills, resources, and platforms to meaningfully collaborate with existing initiatives, led by Black organizers.

Dismantling structural racism requires, among other things, linking health promotion research to decolonization efforts and equality struggles (Chandanabhumma and Narasimhan, 2019). The research we do influences intersectoral structures and the social determinants of health, through our technical advice to policy makers, contributing to professional preparation, and guiding practice. It is incredibly important that health promotion research asks some fundamental questions: Whose worldview is prioritized in our research? Who funds the research and what does that buy them? Whose questions are being asked? What methods are being used? Who gets to analyze the data (Matenga *et al.*, 2019)? What knowledge are we creating and who is it for? Are there Critical and/or Indigenous methodologies that might be more appropriate to apply (Denzin *et al.*, 2008; Chilisa, 2019)? Is this particular research addressing questions that will illuminate dimensions of intersectionality of how this issue is experienced? Who is conducting this research and who will benefit from the findings (Mweemba *et al.*, 2019)?

We also need to fundamentally question the status quo and what we are willing to accept as 'normal'. During the pandemic, there have been lots of discussions of a 'new normal' or returning to the 'normal' way of doing things. COVID-19 has presented the world with a new opportunity to rethink the utility of the 'ways things were' and who the beneficiaries of these handed down systems really are. Significant harm has resulted, particularly harm to Black communities, in the reinscription of the status quo, as evidenced by premature reopening strategies that have caused disproportionate

depredation. Relevant questions to ask during this pandemic, but also more broadly are: Is 'normal' just? Who does 'normal' serve? And at whose expense? As we look at the actions of governments and companies—who seems to be expendable in a pandemic?

Fighting against anti-Black interpersonal racism

The first step to becoming an ally to Black people and practicing anti-racism requires admitting that racist structures exist, are reproduced, and enforced through conscious and/or unconscious interpersonal racial bias. We all live in a world that was built on the subjugation of Black people, regardless of our location (Coates, 2014). The next step requires the intentional processes of uncovering, naming and preventing the violence that flows from this socialization. Health promotion is not new to such work. There are many examples of anti-violence work in our field [e.g. our use of critical pedagogy in gender-based violence programs (Nelson *et al.*, 2010)]. It is important for us to recognize that as much as any individual behavior change is part of a health promotion agenda (e.g. increasing physical activity, sexual health education, etc.) anti-racist education must also be considered a fundamental objective of health promotion practice. Employing relevant strategies such as the settings approach is particularly relevant for teaching anti-racism in schools, universities, workplaces, prisons, etc. We need to build on and develop theories and models that support this work. Some promising examples that health promotion can adopt include Critical race theory (Crenshaw *et al.*, 1996; Ford and Airhihenbuwa, 2010; Delgado *et al.*, 2017), theories of Whiteness (Owen, 2007) and decolonial approaches (Chandanabhumma and Narasimhan, 2019; Chilisa, 2019). We can also learn from the groundbreaking work of Aboriginal and Indigenous scholars who have been promoting health in diverse contexts and challenging harmful Western approaches of exclusion.

Professional preparation and development to address anti-Black racism in our profession and within ourselves

Lastly, it is incredibly important to recognize, as described above, that our field has roots in colonial dynamics and that those dynamics continue in our day-to-day interactions as professionals. Funding for research and programs is largely provided by former colonizing countries, whose medical and health fraternities may not have always had the best intentions or practices around race research. Eurocentric education and professional training reinforces the notion that Northern/Western episteme and social ideals are superior to other ways of knowing (Mweemba *et al.*, 2019). Not only do funds and ideas from predominantly White countries dominate the field of health promotion, White people dominate our ranks. The lack of representation of Black health promoters in the field reifies racist power differentials and is a fundamental hindrance to appropriately serving Black communities. How can we meaningfully change the dynamics of White dominance if the majority of health promoters are White? This raises important questions for our approach to professional preparation and outreach: How can we recruit and retain Black health promoters? How can we encourage Black students to see themselves in these spaces? Can universities design recruitment campaigns or summer pipeline programs for stand-out Black talent in scientific and other fields? What outreach can we do to engage high school students or to host 'visit the university' days that target schools and communities that are generally overlooked? Can we provide compensation or recognition for Black professionals who mentor Black students and young professionals? What alumni networks exist and how can early career professionals find Black colleagues with whom to connect?

We must also look deeply at our health promotion degree programs and curricula. Especially those curricula that claim to explore global contexts, while exclusively focusing on the exploitation and deficits of nations within Africa. These courses often fail to apply an equally rigorous critical lens to nations within the global North, specifically nations with the economic ability to provide comprehensive social services and continue to not do so. We can no longer run the risk of reinforcing racialized power structures that fuel anti-blackness in our class or staff rooms. As knowledge producers who also have the power to influence the thought and action of future generations, there are a number of questions we need to ask ourselves, including: who is teaching our classes? What are the topics we privilege over others? Are we examining the histories of the institutions we occupy to better understand the sources of inequity? What authors are we reading and requiring others to read—and where are they from? How are we demanding diversity in our faculties? Who is represented in our leadership within the field? What critical and self-reflective practices are being taught and at which levels?

Indeed, self-reflective praxis is important for all of us, but it is particularly crucial for White health promoters, who must be at the forefront of challenging racism in the field. We (this paragraph is specifically written by the White-identifying co-authors) must be continuously engaged in ongoing self-reflective practices. We must

constantly seek to learn about the neglected, buried and ugly histories that have been minimized and erased, largely to enable our retention of positions of power and authority. We must question our motivations, learn about and reflect on our own positionality within the discourses and materiality of White privilege, White fragility, White saviorism, White silence, White exceptionalism, White apathy, anti-Blackness and unconscious bias, which extends beyond the singular category of race (Saad and DiAngelo, 2020). We must also cultivate unflinching honesty and humility and hold ourselves accountable first. These efforts must be ever-present not only in our thinking but in our daily practices as well. Every project, initiative, course we plan must be interrogated according to these critical ideas. We are ethically compelled, as White professionals, to question the hegemony within which our work is situated. Returning to the question of 'normal'—what are the 'normal', taken-for-granted assumptions embedded in our health promotion programs? Is it normal to ignore questions of race? How have 'normal' health promotion programs worked for Black communities so far? Are we willing to do what is required to achieve equity for Black communities? Are we willing to dismantle systems we personally and collectively benefit from?

It is important to end by saying that while this commentary has laid out only a fraction of the ways in which Black communities and people have been deprived of fundamental access to health and wellbeing historically, recently, and profoundly in the current moment defined by COVID-19, the intention of this commentary is not to frame this work as some kind of new rescue effort but to affirm the humanity of Black people as a radical and necessary act of solidarity. As health promoters, we must acknowledge that modern society's dominant and postcolonial ways of working, educating, policing, and caring are harmful to Black communities and it is our responsibility to work toward correcting those wrongs. Dismantling these structures requires the re-envisioning and repurposing of existing health promotion tools and approaches but most importantly it requires imagination. We need new ideas, new goals, new knowledge, new models and new leadership—leadership that is not only different from but that directly challenges neoliberal and postcolonial frameworks and ways of thinking. It is time to turn toward the unrelenting strength, resilience, courage and leadership of our Black colleagues in health promotion and related movements and become outspoken that Black Lives Matter in our words and in our deeds. Anything short of that is complicity.

Your silence will not protect you.—Audre Lorde

REFERENCES

Abrams, E. M. and Szefler, S. J. (2020) COVID-19 and the impact of social determinants of health. *The Lancet Respiratory Medicine*, 8, 659–661.

Agência Publica (2020) In Brazil, COVID-19 death rate for Black community is higher than for other populations. *Global Voices*, 29 June. https://globalvoices.org/2020/06/29/in-brazil-covid-19-death-rate-for-black-community-is-higher-than-for-other-populations/ (last accessed 16 August 2020).

Airhihenbuwa, C. O., Iwelunmor, J., Munodawafa, D., Ford, C. L., Oni, T., Agyemang, C. et al. (2020) Culture matters in communicating the global response to COVID-19. *Preventing Chronic Disease*, 17, E60.

Al Jazeera (2020) Coronavirus pandemic exposes South Africa's "Brutal Inequality". *Al Jazeera*, 12 June. https://www.aljazeera.com/news/2020/06/coronavirus-pandemic-exposes-south-africa-brutal-inequality-200612161408571.html (last accessed 16 August 2020).

Alexander, M. (2012) *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. The New Press, New York.

Alliance for Healthier Communities (2020) Statement from Black Health Leaders on COVID-19's impact on Black Communities in Ontario. *Alliance for Healthier Communities*, 2 April. https://www.allianceon.org/news/Statement-Black-Health-Leaders-COVID-19s-impact-Black-Communities-Ontario (last accessed 16 August 2020).

APM (2020) COVID-19 deaths analyzed by race and ethnicity. *APM Research Lab*. https://www.apmresearchlab.org/covid/deaths-by-race (last accessed 16 August 2020).

Bartlett, K. (2020) In South Africa, racial tensions simmer amid a pandemic. *Foreign Policy*, 12 June. https://foreignpolicy.com/2020/06/12/south-africa-coronavirus-pandemic-racial-tensions/ (last accessed 16 August 2020).

Bingley, M. (2020) Coronavirus: city of Toronto to start gathering race-based data connected to COVID-19. *Global News*, 22 April. https://globalnews.ca/news/6855794/coronavirus-toronto-public-health-race-based-data/ (last accessed 16 August 2020).

Bond, M. J. and Herman, A. A. (2016) Lagging life expectancy for Black men: a public health imperative. *American Journal of Public Health*, 106, 1167–1169.

Boyle, J. and Wadington, K. (2020) Fact check: police did destroy a medic area during protests in Asheville, North Carolina. *USA TODAY*, 3 June. https://www.usatoday.com/story/news/factcheck/2020/06/03/george-floyd-protests-police-destroy-medic-station-asheville/3124847001/ (last accessed 16 August 2020).

Bromley, L. (2020) Toronto Public Health releases new socio-demographic COVID-19 data. *City of Toronto*, 30 July. https://www.toronto.ca/news/toronto-public-health-releases-new-socio-demographic-covid-19-data/ (last accessed 16 August 2020).

Burke, M. (2020) N.C. police chief apologizes for officers destroying medic tent set up for protesters. *NBC News*, 5 June. https://www.nbcnews.com/news/us-news/n-c-police-

chief-apologizes-after-video-shows-officers-destroying-n1225716 (last accessed 16 August 2020).

Chandanabhumma, P. P. and Narasimhan, S. (2019) Towards health equity and social justice: an applied framework of decolonization in health promotion. *Health Promotion International*, **35**, 831–840.

Chilisa, B. (2005) Educational research within postcolonial Africa: a critique of HIV/AIDS research in Botswana. *International Journal of Qualitative Studies in Education*, **18**, 659–684.

Chilisa, B. (2019) *Indigenous Research Methodologies*, 2nd edition. SAGE Publications, Inc., London.

Coates, T.-N. (2014) The case for reparations. *The Atlantic*, June. https://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/?gclid=Cj0KCQjwhIP6BRCMARIsALu9LfmZ3QITsDmsoVPVGkpclPue6NdkV_mAOkTs7gEza-iyEjkygK7jzbgaApuAEALw_wcB (last accessed 16 August 2020).

Cookson, C., Kuchler, H. and Milne, R. (2020) Nations look into why coronavirus hits ethnic minorities so hard. *Free to read*, 29 April. https://www.ft.com/content/5fd6ab18-be4a-48de-b887-8478a391dd72 (last accessed 16 August 2020).

Corbin, J. H. (2005) Health for all by the year 2000: a retrospective look at the ambitious public health initiative. *Promotion & Education*, **12**, 77–81.

Crenshaw, K., Gotanda, N., Peller, G. and Thomas, K. (eds.) (1996) *Critical Race Theory: The Key Writings That Formed the Movement*. The New Press, New York.

Delgado, R., Stefancic, J. and Harris, A. (2017) *Critical Race Theory*, 3rd edition. NYU Press, New York.

Denzin, N. K., Lincoln, Y. S. and Smith, L. T. (eds.) (2008) *Handbook of Critical and Indigenous Methodologies*, 1st edition. SAGE Publications, Inc., London.

Fang, J., Madhavan, S. and Alderman, M. H. (2000) Maternal mortality in New York City: excess mortality of black women. *Journal of Urban Health*, **77**, 735–744.

FHI (2020). Status koronasmitte onsdag. *Folkehelseinstituttet*, 1 April. https://www.fhi.no/nyheter/2020/status-koronasmitte-onsdag-1.-april-2020/ (last accessed 16 August 2020).

Fiscella, K. and Sanders, M. R. (2016) Racial and ethnic disparities in the quality of health care. *Annual Review of Public Health*, **37**, 375–394.

Ford, C. L. and Airhihenbuwa, C. O. (2010) Critical race theory, race equity, and public health: toward antiracism praxis. *American Journal of Public Health*, **100**, S30–S35.

Fortuna, L. R., Tolou-Shams, M., Robles-Ramamurthy, B. and Porche, M. V. (2020) Inequity and the disproportionate impact of COVID-19 on communities of color in the United States: the need for a trauma-informed social justice response. *Psychological Trauma: Theory, Research, Practice, and Policy*, **12**, 443–445.

Gadson, S. L. (2006) The third world health status of Black American males. *Journal of the National Medical Association*, **98**, 488–491.

Geronimus, A. T., Hicken, M., Keene, D. and Bound, J. (2006) "Weathering" and age patterns of allostatic load scores

among Blacks and Whites in the United States. *American Journal of Public Health*, **96**, 826–833.

Gough, K. V. (2008) "Moving around": the social and spatial mobility of youth in Lusaka. *Geografiska Annaler Series B, Human Geography*, **90**, 243–255.

Greif, G. L. and Morris-Compton, D. (2005) Group work with Urban African-American parents in their neighborhood schools. In *Group Work with Populations at Risk*, 2nd edition. Oxford University Press, New York. pp. 349–360.

Gumede, W. (2020) Human rights focus needed in police and army's Covid-19 lockdown enforcement. *Democracy Works*. https://democracyworks.org.za/human-rights-focus-needed-in-police-and-armys-covid-19-lockdown-enforcement/.

Hamilton-Davis, R. (2020) SWMCOL blanks workers seeking better wages. *Trinidad and Tobago Newsday*, 10 July. https://newsday.co.tt/2020/07/10/swmcol-blanks-workers-seeking-better-wages/ (last accessed 16 August, 2020).

Hansen, K. T. (2005) Getting stuck in the compound: some odds against social adulthood in Lusaka, Zambia. *Africa Today*, **51**, 3–16.

Harrisberg, K. (2020) Coronavirus exposes "*Brutal Inequality*" of South Africa townships. *Reuters*, 12 June. https://br.reuters.com/article/idUSKBN23J2BS (last accessed 16 August 2020).

HHS (2020). *Diabetes and African Americans—The Office of Minority Health*. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18 (last accessed 16 August 2020).

Hill, E., Tiefenthäler, A., Triebert, C., Jordan, D., Willis, H. and Stein, R. (2020) How George Floyd was killed in police custody. *The New York Times*, 31 May. https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html (last accessed 16 August 2020).

ILO (2018). More than 60 per cent of the world's employed population are in the informal economy [Press release], 30 April. http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_627189/lang--en/index.htm (last accessed 16 August 2020).

Jackson, A. (2020) Nine ways to improve health for African Americans in Chicago after COVID-19. *Chicago Sun-Times*, April 20, 2020. https://chicago.suntimes.com/2020/4/20/21224469/african-american-health-care-chicago-black-community-covid-19-racial-disparities-ottowa-charter (last accessed 9 September 2020).

Knoetze, D. (2020, April 1) Police kill three people in three days of lockdown. This is normal for South Africa. *GroundUp News*, 1 April. https://www.groundup.org.za/article/police-kill-three-people-three-days-lockdown-normal-south-africa-data-reveals/ (last accessed 16 August 2020).

La Vende, J. (2020) [UPDATED] Pregnant woman shot dead. *Trinidad and Tobago Newsday*, 30 June. https://newsday.co.tt/2020/06/30/woman-dies-after-protest-shooting/ (last accessed 16 August 2020).

La Vende, J. (2020) Group arrested at Belmont Bar. *Trinidad and Tobago Newsday*, 4 July. https://newsday.co.tt/2020/