



Racially equitable responses to hunger during COVID-19 and beyond

BY MARLYSA D. GAMBLIN AND KATHLEEN KING

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Meet the Team



Co-Author and Researcher

Marlysa D. Gamblin is the Senior Policy Advisor for Racial and Gender Divides at Bread for the World Institute. Her expertise is providing research and analysis to narrow the racial and gender hunger and income divides. She has traveled and continues to travel around the country to speak on these issues. In 2019, Marlysa was the lead author on the first-ever report to help policymakers understand how to apply a racial equity lens to federal anti-hunger policies. She is also the founder of the Racial Equity and Hunger National Learning Network, a network that convenes hundreds of anti-hunger and poverty organizations

across the country to help them promote racial equity in their policies, programs, and services. At Bread, Marlysa also staffed the Advisory Council on Faith-Based and Neighborhood Partnerships during the Obama administration, where she proposed key recommendations to the White House on race, justice, and poverty. Marlysa designed the Racial Wealth Gap Learning Simulation, an interactive tool that has reached more than 2 million people and helped hundreds of organizations understand how structural racism was created, the connection between race and hunger, and the importance of applying a racial equity lens. Marlysa holds her Master in Public Policy from the Harvard Kennedy School of Government and a B.A. with honors from the University of California, Berkeley.



Co-Author and Researcher

Dr. Kathleen King is the President of Mosaic Economic Consulting, LLC. She has decades of experience doing economic analysis in areas that range from hunger, poverty, and the distribution of wealth, to commodity and financial markets, and the energy sector. She has provided economic analysis and consulting advice, as well as expert testimony and consulting support in litigation or arbitration cases, and pre-complaint investigations. Her clients have included non-profit groups, government agencies, law firms, and regulated and unregulated companies. Her public policy work has included analysis of

issues related to food insecurity, poverty, and their relation to outcomes from COVID-19; the distribution of wealth; and market design and reliability in electricity markets. Her work in contested proceedings has included issues related to market manipulation, contract disputes, pricing of complex structured transactions, trading and risk management, and power plant construction. Her advisory work has included surveillance of traded markets, modeling energy markets, economic due diligence and risk assessment of energy company portfolios, estimation of electricity demand, and design of retail electricity price structures. Dr. Kathleen King has a Ph.D. in economics and is currently completing a Master of Theological Studies specializing in Public Theology.



Editor

Michele Learner is Managing Editor with Bread for the World Institute, where she works to ensure that anti-hunger advocates have access to clearly written, nuanced, and interesting information about policies designed to end hunger and malnutrition by resolving their root causes. Michele has also worked as an Africa specialist with the National Endowment for Democracy. She has a master's degree in international affairs from Columbia University's School of International and Public Affairs and a bachelor's degree summa cum laude from DePauw University.



Graphic Designer

Doug Puller is the Senior Manager of Design & Art at Bread for the World and Bread for the World Institute, where he uses visual methods to contribute to achieving their mission of ending hunger. He is a multi-award-winning artist, illustrator, graphic designer, and art director with more than 25 years' experience. Doug has been at Bread for the past 10 years, designing projects ranging from the book-length annual Hunger Report to a variety of other publications to logos, memes, signage, and illustrations.

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Racially Equitable Responses to Hunger During COVID-19 and Beyond

By Marlysa D. Gamblin and Kathleen King

Introduction

Black, Indigenous, and Other People of Color (BIPOC)¹ have historically had higher rates of food insecurity in the United States as a result of structural racism. Before the COVID-19 pandemic began, 24.2 percent of African American households, 22.6 percent of Indigenous households, 20.2 percent of Native Hawaiian households, 18.8 percent of Latino/a households, and 7.6 percent of white households were food insecure. The average for the U.S. population, with all communities included, was 11.3 percent.² Some Southeast Asian ethnicities also had higher rates of food insecurity than the overall population (see endnotes for specific data points),³ even though the larger Asian community had a food insecurity rate lower than the U.S. population as a whole.

The U.S. Department of Agriculture defines food insecurity as when a person or household does not have regular, reliable access to the foods needed for good health.⁴ In 2015, the U.S. government set a goal to end hunger in the United States by 2030.⁵ Achieving this goal requires that food insecurity rates among communities with higher rates of food insecurity be reduced at faster rates, but this is not happening.

The rates of food insecurity among female-headed households of color were much higher—37.1 percent for Indigenous, 34.3 percent for Latina, 33.3 percent for African American, and 30 percent for Native Hawaiian female-headed households—than the rate for the U.S. population as a whole, which, as mentioned above, was 11.3 percent.⁶ This data shows the importance of specifically considering food insecurity among BIPOC women within the larger context of BIPOC communities.

Structural racism is a historical, cultural, institutional, and interpersonal system of hierarchy that routinely advantages white people⁷ and subjects BIPOC to cumulative and chronic inequities.⁸ Policies that reflect structural racism date back to the 1400s with the colonialization of Indigenous land, followed by the enslavement of people of African descent, and continuing to this day.⁹ Because structural racism has been here from the beginning and is embedded in U.S. policies, institutions, and systems,^{10 11} BIPOC face racial discrimination in virtually every aspect of their lives (see Figure 7 on page 17). One result is significantly higher rates of hunger and food insecurity.

Data on food insecurity since the COVID-19 pandemic began is sparse and preliminary. Some of the data is disaggregated by racial and ethnic group, but it is generally not further broken down by gender, nor does it

WHY USE BLACK, INDIGENOUS, AND OTHER PEOPLE OF COLOR (BIPOC) INSTEAD OF PEOPLE OF COLOR?

The term BIPOC has come into use relatively recently. Two of its main advantages are that it more clearly identifies different groups rather than risk indiscriminately lumping together groups of people with very different histories and contexts, and it centers Black and Indigenous communities. These two groups are generally subjected to the most severe racial inequities, but this can go unrecognized within a more general term such as communities of color. By specifically naming Black and Indigenous people, including Black and Indigenous Latino/as, the term BIPOC is an ongoing reminder that it is essential to center anti-Black and anti-Indigenous racism in all analysis involving larger communities of color.

include disaggregated data for every U.S. racial and ethnic group. The available data indicates that the historical and pre-pandemic trend, of far higher rates of food insecurity among BIPOC than among whites, continues. According to preliminary findings from the Urban Institute, families of school-aged children with Black and Latino/a parents are three times as likely to report being food insecure as households headed by white parents during the pandemic (40.8 percent and 39.1 percent, respectively, compared to 15.1 percent).¹²

COVID-19 Responses Must Promote Racial Equity

The COVID-19 pandemic has laid bare the racial divides in food insecurity in the United States. Coupled with higher rates of infection and death from COVID-19 among BIPOC, this lends urgency to making racial equity that centers Blackness a top priority.¹³ This can begin the process of repair from policies that have inflicted harm on Black communities, as shown in the graphic below.

WHAT DOES CENTERING BLACKNESS MEAN?

Centering Blackness calls for considering the Black experience as unique and foundational to shaping both U.S. past and present economic and social policies, and our nation's future. It requires policies and programs to lift up and protect Black people in order to begin to reverse several centuries of anti-Black racism, beginning in 1616 with the enslavement of people of African descent in the United States and continuing today. Since Blackness is the antithesis of whiteness, and policies were specifically designed to target Black communities, the burden of racism falls more heavily on Black people than on other people of color. Within centering Black people, we center Black women, who experience the consequences of anti-Black racism as well as gender inequity. Centering Black women ensures that their needs and leadership are proactively addressed.



AUTHORS: Anne Price, Jhumpa Bhattacharya, and Dorian Warren
SOURCE: <https://insightcced.org/centering-blackness-framework/>

Racial equity is *a process* that focuses on centering the needs, power, and leadership of BIPOC, as well as *a goal* of achieving equal, and ultimately optimal, outcomes for BIPOC relative to their white counterparts.^{14 15}

The evidence indicates that COVID-19 is not impacting all communities equally. Whether the data is from the county, state, or national level, Black communities have the highest COVID-19 infection and death rates of any racial or ethnic group.

This report discusses the unique impacts of COVID-19 on Black communities in the context of anti-Black racism, which specifically targets the well-being of Black people and thus leads to these inequitable impacts. It is important to focus on this type of racism because structural racism in the United States is rooted in the history of enslavement and the concept of Black as the antithesis of white.

The analysis in this report reinforces the importance of applying a racial equity lens that centers Blackness.

Anti-Black racism includes lynching, physical abuse, and other forms of violence against Black bodies. Black people also suffer from forms of economic, political, and social oppression that are unique to them rather than common to all communities of color. Policies dating back to the 1600s that targeted Black people have not been corrected. This is why the report argues that anti-Black racism is the root cause of the higher rates of infection and death from COVID-19 among Black people.

It is important to note that many people in other communities of color have also experienced the harmful impacts of anti-Black racism, e.g., being excluded through practices such as redlining and racial job discrimination. This is because although they may not be “Black,” they are also not considered “white.” Centering anti-Black racism within racial equity approaches also helps begin to repair the harm done to other communities of color whose people face inequities because of institutions and policies rooted in anti-Black racism.

Anti-Black Racism and Gender Inequities Are Dual Oppressions

While anti-Black racism lifts up the unique racism experienced by Black people, Black women also confront sexism. As a result, terms such as “Blackness” hide the full realities of Black women.¹⁶

Research, data, and policies that are not disaggregated by gender and are historically based on Black men and their experiences effectively silence the needs, voices, and leadership of Black women.^{17 18}

Often, Black women have been characterized as the “backbone” of their communities,¹⁹ and have been expected to play the roles of advocate, supporter, and caregiver to the larger Black community²⁰ while not being supported in these ways themselves. This “invisibility” is a construct of patriarchy that only further oppresses Black women and by extension Black communities. If we are to truly center Blackness, all Black voices must be heard.

This is precisely why it is important to take into account the intersectionality of Black women’s experiences—to affirm the intersections of identities²¹ so as to acknowledge the full humanity of every person. In the case of Black women, this intersection is where anti-Black racism and sexism come together.²² This combination subjects Black women to a unique duality of oppression. Centering analysis and policies on Black women and the intersections of their two interwoven identities is a way of ensuring that

“My liberation as a southeast Asian woman is tied to the liberation of Black women... What is happening to Black people is unique. We have to come together as other communities of color to name this and center this.”



—Jhumpa Bhattacharya,
VP of Programs and
Strategy, Insight Center
for Community Economic
Development

SOURCE: “Rebuilding the House that Racism Built in Our COVID Response.” Economic Policy Center, Webinar. Direct Quote. June 1, 2020. <https://www.epi.org/event/rebuilding-the-house-that-anti-blackness-built-in-our-covid-response/systemic>

the entire Black community is uplifted. By extension, all women, men, and children of color experience liberation from the impacts of anti-Black racism.^{23 24}

At its heart, applying a racial equity lens to COVID-19 response efforts means first centering the needs, leadership, and power of the entire BIPOC community and then going two steps further by centering Blackness and centering Black women. In response to this imperative, the stories and scholarship of Black women are featured throughout this report. The recommendations and analysis have been informed, led, and guided by Black women who are experts by way of lived experience, as on-the-ground leaders, practitioners, or scholars from across the country and from different fields.²⁵

In centering the stories and scholarship of Black women, this report also seeks to address the historical racial and gender trauma that Black women have experienced and continue to experience. This analysis guided the report's recommendations on caring for Black women during and after the COVID-19 crisis. The unique dual oppression of Black women because of both anti-Black racism and sexism can, if centered properly, also help inform the care that other BIPOC women, men, and children receive during and after the pandemic. This is especially important since Indigenous and Latino/a communities have also been hit hard by the virus.

Looking Ahead

In 2019, Bread for the World Institute published a report, "Applying Racial Equity in U.S. Federal Nutrition Policy,"²⁶ that included a working definition of racial equity and explained why applying a racial equity lens is essential to ending hunger and food insecurity in the United States for good. This report, written several months into the COVID-19 pandemic, builds on that analysis of racial equity and hunger and seeks to provide initial analysis of the deep connections between racial divides in food security and in susceptibility to contracting and dying from COVID-19.

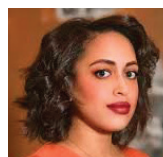
This new report features a case study of racism, hunger, and COVID-19 in Louisiana and their connections to the larger national context. It also explains how structural racism in the United States exacerbates both hunger and COVID-19 in BIPOC communities, looking at inequities in the key areas of employment, health care, housing, education, and wealth. The report then offers a series of short-term and longer-term recommendations. The latter explain how COVID-19 responses over the long term can promote racial equity, reduce food insecurity, and help contain the pandemic by centering Blackness, more specifically Black women.

Race Matters: Analysis of New Data on Hunger and COVID-19

Structural racism is a root cause of both higher hunger rates and disproportionate health and economic impacts of COVID-19 among Black, Indigenous, and Other People of Color (BIPOC). This was the overall finding of the case study below, which features Bread for the World Institute's original analysis from publicly available data on COVID-19 in Louisiana.^{27 28} Louisiana is consistently among the five states with the highest rates of food insecurity, and the state collected and made available detailed COVID-19 data earlier than many other states. The findings also build on food insecurity data that the Institute previously collected and analyzed.²⁹

This report seeks to provide initial analysis of the deep connections between racial divides in both food security and susceptibility to contracting and dying from COVID-19.

"If Black women—who, since our nation's founding, have been the most disadvantaged by the rules that structure our society—can one day thrive in the economy, then it must finally be working for everyone."



—Kendra Bozarth,
The Roosevelt Institute

SOURCE: <https://rooseveltinstitute.org/2020/03/31/corporate-america-owes-black-women-a-lot-we-all-do/>

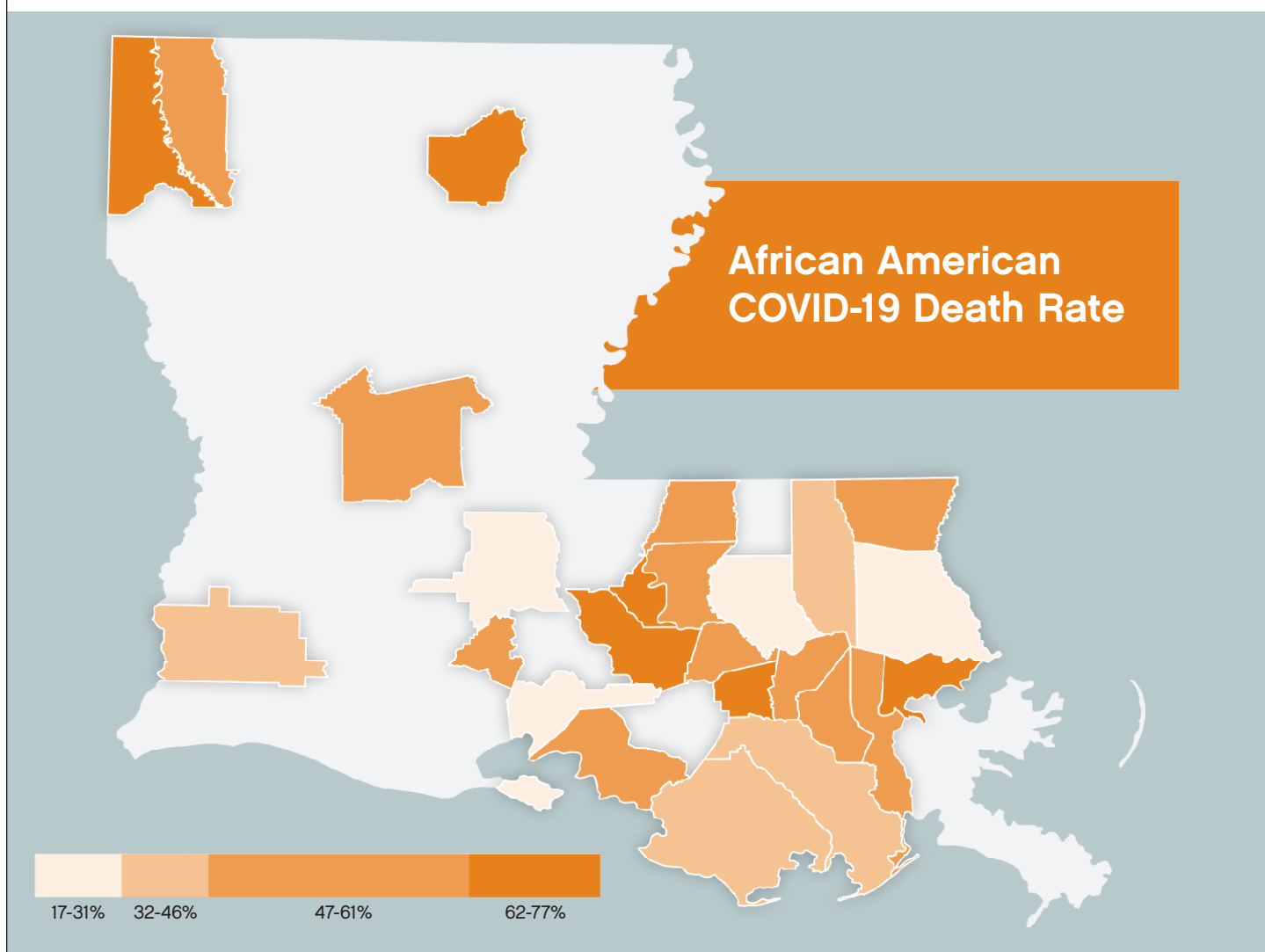
While this case study focuses on the state of Louisiana, the trends found in the analysis are not unique to this state or region. All states and the District of Columbia have systems and policies that lead to the realities of racialized concentrated poverty, racialized over-policing, and racialized health inequities, as discussed later in the report. Our hope is to provide general learnings that can be used in counties and states across the country.

The three main research findings related to COVID-19 are:

1. **Race, particularly being Black, is the strongest determinant of death from COVID-19—a stronger indicator than risk factors such as older age or having diabetes.**
2. **After race, the indicator most highly correlated with COVID-19 death rates in a given area was the degree to which children faced structural inequities.**
3. **Areas with high rates of racial inequities in healthcare outcomes, particularly in maternal and child health, also have above average rates of death from COVID-19.**

Figure 1a below highlights the rate of African American death in Louisiana (for all counties that provided disaggregated racial data). The darker the county, the higher the COVID-19 death rate is among African Americans.

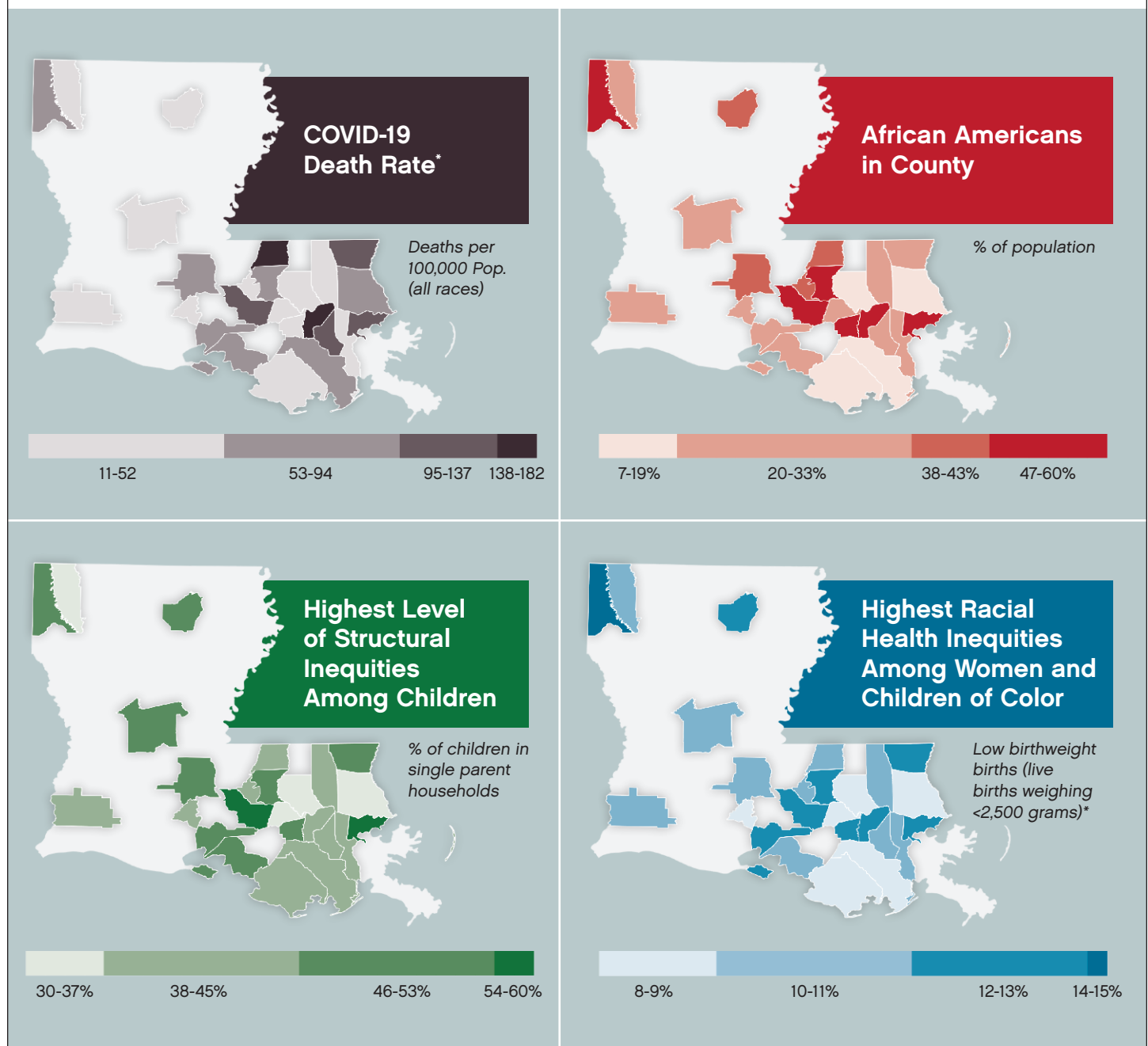
Figure 1a: African American COVID-19 Death Rate in Louisiana by County



SOURCE: <http://ldh.la.gov/coronavirus> (data reported 5/31/2020 and downloaded 6/1/2020)

Figure 1b below shows that the counties with the highest rate of African American death (shown in Figure 1a) overlap with the counties with the highest COVID-19 death rates, majority percentage of people of color, highest levels of structural inequities among children, and highest racial health inequities among women and children. In short, Figure 1b demonstrates that the rate of African American death is highly correlated and statistically significant with the three main research findings featured on page 8. This underscores how race is the strongest determinant of death from COVID-19 and why racial equity must be applied in all responses.

Figure 1b: African American Death Rate is Highly Correlated with Overall COVID-19 Death Rate and the 3 Main Findings



SOURCE: <http://ldh.la.gov/coronavirus> (data reported 5/31/2020 and downloaded 6/1/2020)

* Low birthweight births is one of several indicators used to analyze the racial health outcomes among women and children of color.

Finding 1: Race, particularly being Black, is the strongest factor predicting death from COVID-19, even stronger than risk factors such as age or diabetes.

Our research shows that racial inequities are statistically associated with likelihood of death from COVID-19 and that being Black is the strongest indicator of dying from COVID-19.³⁰ People are dying from the inequities of structural racism—for example, job segregation and longstanding inequities in social determinants of health such as food insecurity and racialized concentrated poverty. This requires a restructuring of our society to eliminate the structural racial inequity and anti-Black racism that is literally killing Black people, as well as other BIPOC people who bear to a lesser extent the impacts of anti-Black racism.

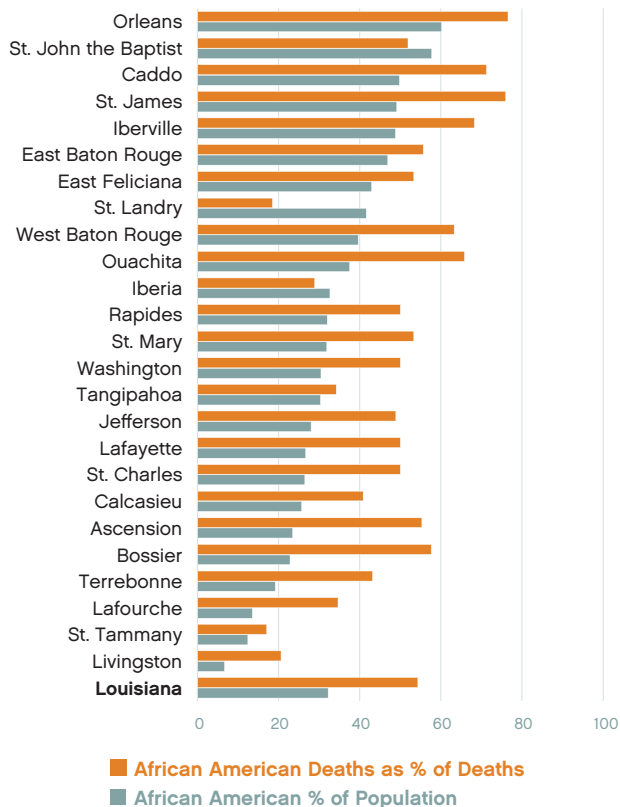
Specific Data Findings for Louisiana

To understand the factors that make one more likely to die from COVID-19, the Institute looked at county-level and sub-county-level data from Louisiana in conjunction with several sociodemographic characteristics of each parish (the equivalent of counties in most states), including race and ethnicity, household composition, health outcomes, and rates of food insecurity and poverty.^{31 32}

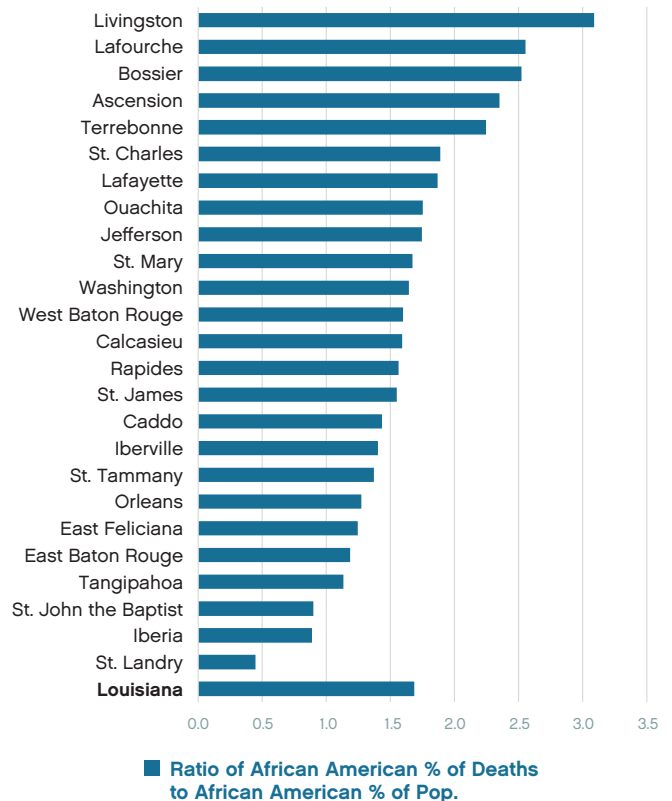
Data from the Louisiana Department of Health shows that the proportion of African American deaths from COVID-19 is nearly twice the proportion of African Americans in the population. Figure 2 below shows data for parishes that reported more than 25 deaths (and are therefore required to report the racial breakdown of deaths).

Figure 2: African American Death Rates from COVID-19 Are Nearly Twice Their Population Share

African American % of Deaths Exceeds % of Parish Pop.



Ratio of African American % of Deaths to % of Pop. is 1.7 statewide



SOURCE: <http://ldh.la.gov/coronavirus> (data reported 5/31/2020 and downloaded 6/1/2020)

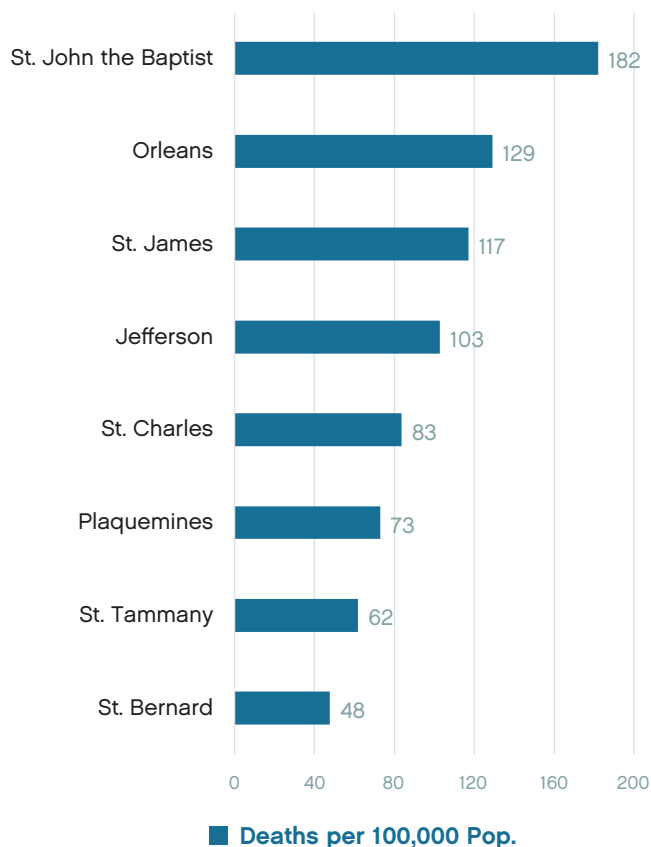
For all parishes in Louisiana analysis shows that the proportion of African Americans in the population is highly correlated with the rate of death from COVID-19. In all parishes, the COVID-19 death rate is also highly correlated with both the proportion of African Americans who live below the poverty line and the proportion of participants in the Supplemental Nutrition Assistance Program (SNAP) who are African American. Figure 3 shows this data for the eight parishes including and surrounding New Orleans, the state's largest urban area.

The portion of the population that is African American is a stronger predictive indicator of a particular area's rate of death from COVID-19 than more commonly accepted risk factors such as age or pre-existing health conditions such as diabetes. The data available as the Institute's analysis began in late April 2020 did not show that age, indicated by the proportion of the population over 65, was correlated with the death rate from COVID-19, but this changed as time went on because outbreaks in nursing homes became more frequent. While age became more strongly correlated with death rates in some areas, particularly rural and small metro contexts, race remained the leading predictive factor of death. The analysis did not find a significant correlation between the rate of cases of diagnosed diabetes and the overall rate of death from COVID-19.

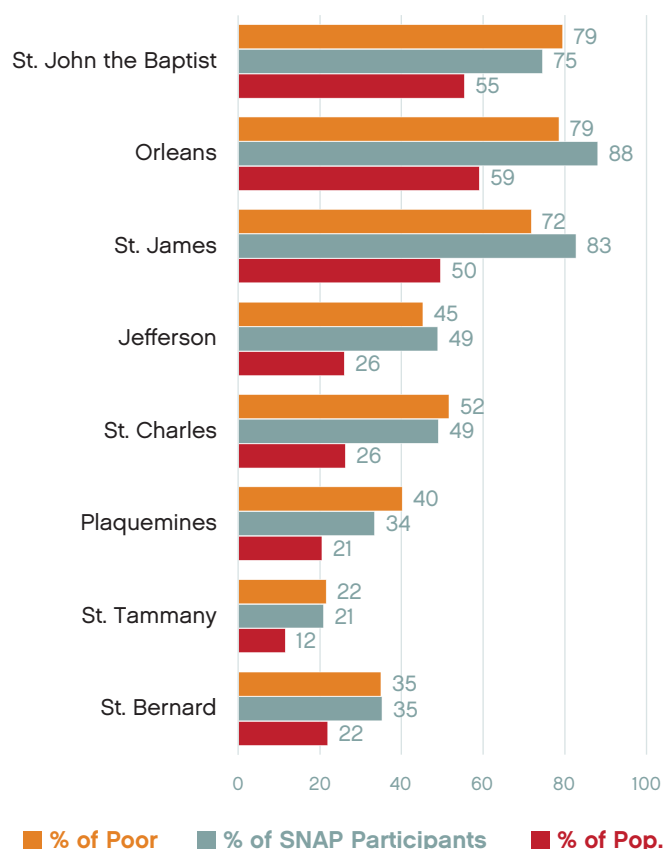
The proportion of the population that is African American is the strongest indicator of the rate of death from COVID-19.

Figure 3: Being African American is the Strongest Indicator for Death from COVID-19

**Deaths from COVID-19 in Louisiana
Major Metro Parishes**



**African American % of Parish Pop.,
Poor, and SNAP Participants**



SOURCE: <http://ldh.la.gov/coronavirus> (data reported 5/31/2020 and downloaded 6/1/2020)

Connecting These Findings with the Larger National Context

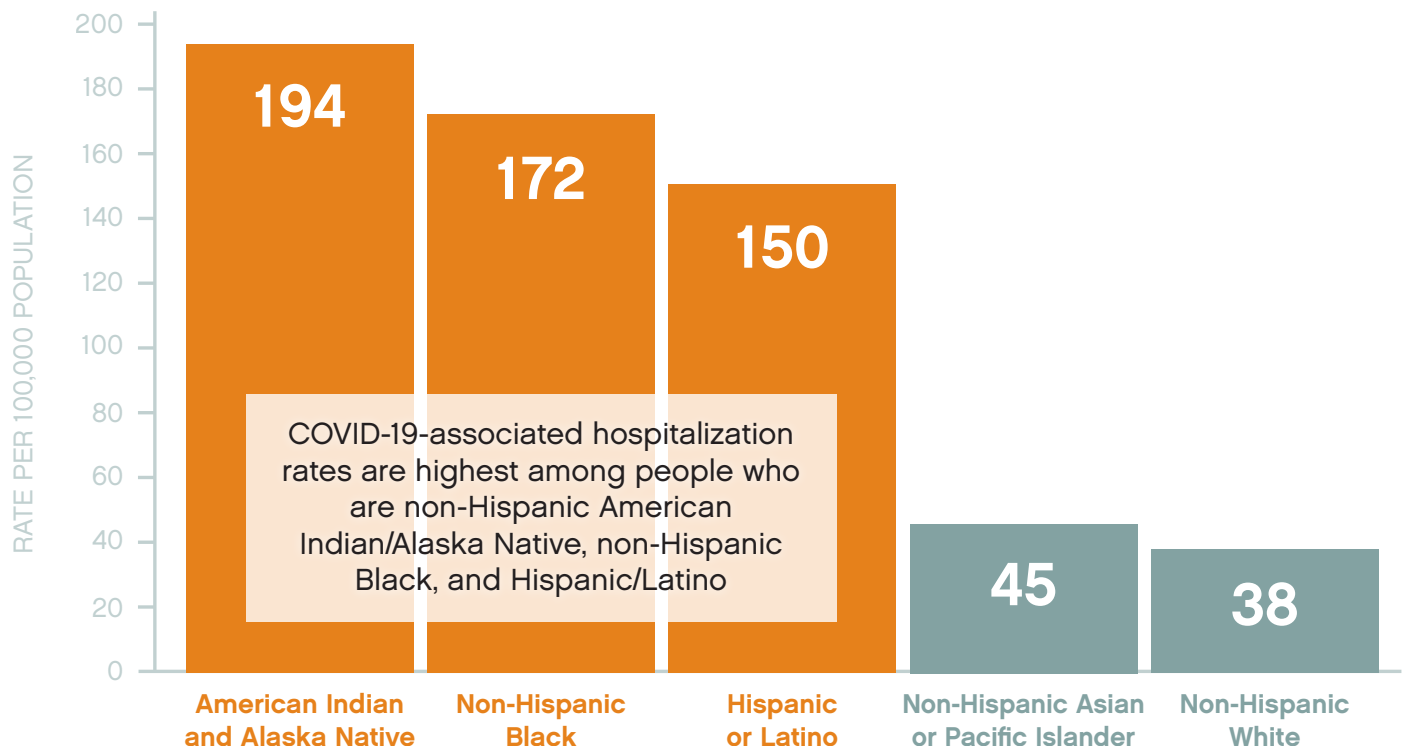
Beyond Louisiana, higher rates of death from COVID-19 among African Americans at county and state levels reaffirm the centrality of being Black to the likelihood of dying from COVID-19. In fact, preliminary data suggest that predominantly Black counties have three times the rate of COVID-19 infections, and *six times the death rate*, of predominantly white counties.³³ Section 2 of the general analysis, on page 18, points out the higher likelihood of death among African Americans who live in concentrated poverty and work in frontline essential jobs. Recent studies have found that race is also a significant factor in the death rates of higher-income areas.³⁴ A study by JAMA Network found that people in counties with medium to high income levels whose residents are largely BIPOC were three times as likely to contract and die from COVID-19 as substantially white counties with similar income levels.³⁵ Many of the places surveyed had significant Black communities. This reinforces the need to apply a racial equity lens to all COVID-19 response efforts, regardless of location, and to ensure that this lens centers anti-Black racism.

National-level data show that in most states, Black, Indigenous, and Other People of Color are dying at rates that substantially exceed their share of the population. According to the Color of Coronavirus study,³⁶ 37 of the 41 states that had disaggregated data available on the deaths of African Americans from COVID-19 showed death rates at least twice their representation in the population. In three of these states, Kansas, Wisconsin, and Missouri, Black patients died at rates three times their population size.

The inequities in death rates are even more glaring in data from the 22 states that reported specifically on deaths among Indigenous people. The death rate exceeds the Indigenous share of the population in 12 states. On average in these states, Indigenous death rates are twice their population share. In four states (Mississippi, New Mexico, Arizona, and Montana) there are more than four times as many deaths of Indigenous people as there would be if death rates were the same for every ethnic/racial group.

Figure 4: Race Matters in COVID-19 Cases Across the Country

Age-adjusted COVID-19-associated hospitalization rates by race and ethnicity



SOURCE: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/images/Age_Adj_Hosp_Rates_Jun11_1200x675_Site.jpg

Rates of hospitalization for COVID-19 are shown in Figure 4. In addition to the significant inequities shown, it is likely that the COVID-19 rate among Black patients is higher than indicated by hospitalization data because of anti-Black bias in whether patients with symptoms are admitted to the hospital. See page 21 for more on this.

Finding 2: After race, the indicator most highly correlated with COVID-19 death rates in a given area was the degree to which children faced structural inequities.

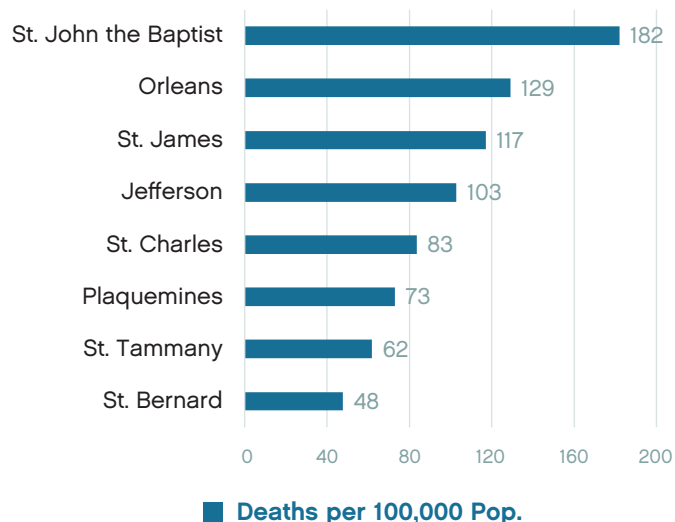
Louisiana Specific Data Findings

African American children suffer the consequences of anti-Black racism alongside their parents and households. One of several consequences that affect children in particular is living in a single-parent household, which is far more common among Black children. See the “Did You Know” box on page 14 for more on how single-parent households are linked to deep-seated roots of structural racism and forced separation. Our analysis found that the percentage of children who live in single-parent families has a significant correlation with death rates from COVID-19. This is illustrated in Figure 5, which shows this relationship in parishes in the New Orleans area.

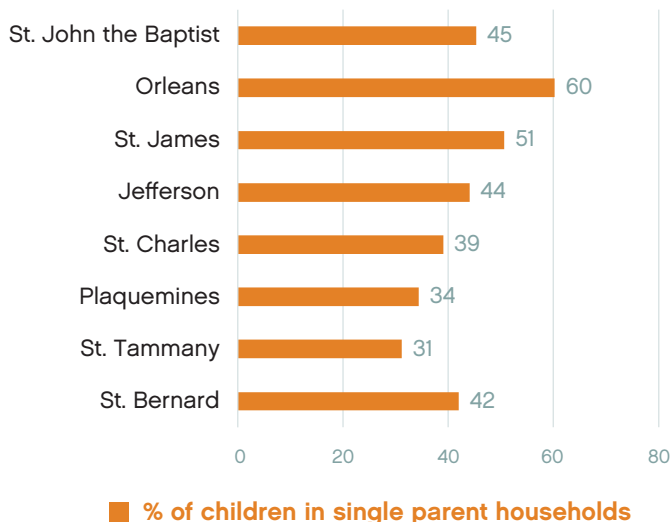
This finding underlines the importance of centering Black women. The proportion of single-parent households led by Black women is rooted in a history of separating Black families in order to secure free or cheap labor. This started with the transatlantic enslavement of people of African descent and continued during the period of enslavement (1616-1864), during which people in the same family were sold to different owners across different states for economic reasons. This harsh history of family separation continued after the end of legal enslavement of people of African descent, as Black men were targeted by

Figure 5: Percentage of Children in Single-Parent Families is the Second Most Important Indicator of Death Rates from COVID-19 in Louisiana

Deaths from COVID-19 in Louisiana Major Metro Parishes



% of children in single-parent families



SOURCE: <http://ldh.la.gov/coronavirus> (data reported 5/31/2020 and downloaded 6/1/2020)

the police and incarcerated for the purposes of retaining a free labor base. Black men were targeted for violating the “Black Codes”—a set of codes that formerly enslaved people had to follow that included restrictions such as curfews and limitations on the size of gatherings. People who were incarcerated had to work for free—a variation of slavery.

WANT TO LEARN MORE ABOUT THE HISTORY OF MASS INCARCERATION AS THE PRODUCT OF STRUCTURAL RACISM?

Read “[Mass Incarceration: A Major Cause of Hunger](#),” by Marlysa D. Gamblin of Bread for the World Institute.

The mass incarceration and free labor of Black men continued with practices such as convict leasing in the early to mid-1900s, when the labor of Black men was “leased” out to government and private companies to build railways, roads, and other projects that built wealth for historically white institutions. Mass incarceration continued with the “war on drugs” in the 1980s, the “tough on crime” bills in the 1990s, and today. From 1616 onward, Black women have had to bear the brunt of family separation³⁷ as a result of a concerted effort to extract free Black labor.^{38 39}

Today, 73 percent of African American children in Louisiana live in single-parent households, compared to 36 percent of Latino/a children and 29 percent of white children.⁴⁰ Of the people incarcerated in Louisiana, 63 percent of those in local facilities and 70 percent of those in state facilities are African American, but only 31 percent of the state’s population is African American.⁴¹ Whites, conversely, are 37 percent of people incarcerated in local facilities and 29 percent of those in state facilities, but Louisiana’s population is 59 percent white.⁴²

About 92 percent of people who are incarcerated in local facilities and 96 percent of those in state facilities are male.⁴³ Since Black men are the vast majority of people who are currently incarcerated, many African American women are left to continue being resilient leaders in their communities while raising their children. To compound these effects, Black women are paid less than white men, white women, and Black men.

DID YOU KNOW THAT...

Deep-rooted racism led to higher rates of female-headed households among Black, Indigenous, and Other People of Color, especially Black women?

Many families of color experienced the historical trauma of family separation (from enslavement onward), mass incarceration (from the early 1900s to present day), and policies for public safety net programs that discouraged families from living together (in the 1990s). All of these factors contribute to higher levels of single-parent households among Black, Indigenous, and Latino/a households than among their white counterparts.

When children lose a single parent to COVID-19, they are bearing the brunt of many aspects of structural racism—including mass incarceration as well as inequities in employment, housing, and health care. These impacts also combine to create an extremely high rate of food insecurity among Louisiana’s Black female-headed households—more than 57 percent.⁴⁴

Other factors that had statistically significant associations with the percentage of Black female-headed households in Louisiana were also associated with rates of death from COVID-19. These included rates of (1) children in poverty, especially children under 5; (2) households in extreme poverty (usually defined as less than half the poverty income threshold); (3) schoolchildren eligible for free or reduced-price school meals; (4) children whose families participate in SNAP; and (5) child mortality.⁴⁵

Connecting Our Findings with the Larger National Context

While this case study focuses on the state of Louisiana, the trends are not unique to this state or region. All states and the District of Columbia have criminal justice systems and policies that target and over-police Black, Indigenous, and Other Communities of Color. As a result, a higher percentage of individuals of color have been, and are still, separated from their families by incarceration. Nationwide, the combined impacts of structural racism have led to a greater likelihood of living in a single-parent family for BIPOC children: 65 percent of African American children,

53 percent of Indigenous children, and 41 percent of Latino/a children, compared to 35 percent of all children and 24 percent of white children.⁴⁶

National trends are similar to those in Louisiana: most people who are incarcerated are African American men, followed by Latino and Indigenous men. Thus, large numbers of Black, Indigenous, and Other Women of Color support their households as single parents. Because BIPOC women are paid less than men or white women, as noted above, causing additional harm to BIPOC children. Another consequence is a greater likelihood of living in a neighborhood of concentrated poverty, as discussed later in the report.

Finding 3: High rates of racial inequities in health outcomes, including issues accessing adequate health care for BIPOC pregnant women and infants, also serve as indicators of areas with above-average-rates of COVID-19 deaths.

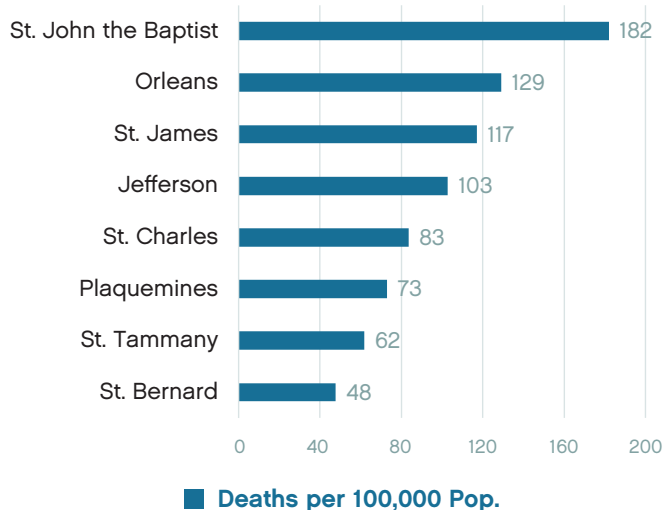
As just described, the areas with the highest death rates from COVID-19 had the highest proportion of African American residents and the heaviest impacts of structural racism on children. Since death from COVID-19 is in part a failure of the healthcare system, it is not surprising that areas with high COVID death rates also had racial bias in other aspects of health care, particularly maternal and child health.

Louisiana Specific Data Findings

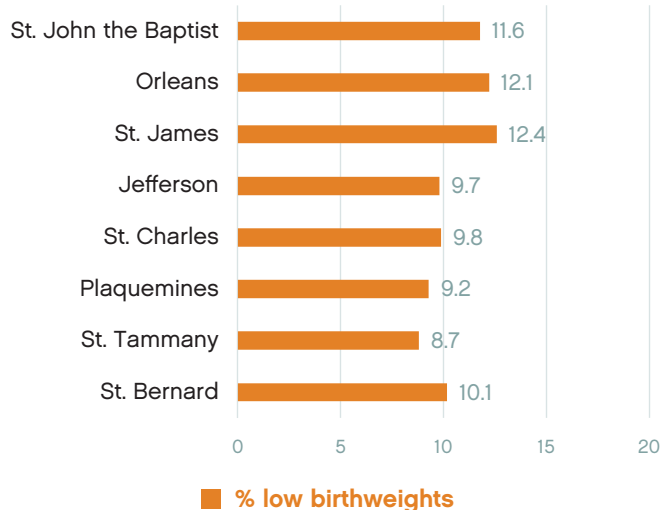
High rates of babies born at low birthweight (generally defined as less than 5.5 pounds) and high infant mortality among African Americans are two very visible signs of the serious damage to human health caused by racial inequities in access to health care. Because they are the result of not centering the needs of Black women, they shine a bright light on the urgent need to center Black women from now on.

Figure 6: Areas with More Babies Born at Low Birthweight are Also Areas with High Rates of Death from COVID-19

Deaths from COVID-19 in Louisiana Major Metro Parishes



Percent of low birthweight births



SOURCE: <http://ldh.la.gov/coronavirus> (data reported 5/31/2020 and downloaded 6/1/2020)

Louisiana has the second highest rate (after Mississippi), of babies born at low birthweight—10.7 percent of all live births.⁴⁷ The rate of low birthweight among African American babies in Louisiana is nearly twice the rate of white babies.⁴⁸ Louisiana has the fifth-highest infant mortality rate in the country, with 7.5 deaths before the first birthday for every 1,000 live births.⁴⁹ The mortality rate is more than twice as high for African American infants as for white infants.⁵⁰

The rate of low birthweight is the third most significant indicator associated with COVID-19 death rates, after race and the proportion of children living in single-parent families. The two have a statistically significant correlation whether this is calculated using the overall rate of low birthweight or as the ratio of African American to white rates.

Connecting Our Findings with the Larger National Context

Maternal and child health outcomes across the United States are similar overall to those in Louisiana. The national African American maternal mortality rate is up to five times that of the white maternal mortality rate,⁵¹ while Indigenous and Native Hawaiian mothers have mortality rates four times and three times, respectively, that of white mothers.⁵² Reports based on the early months of the COVID-19 pandemic from providers and beneficiaries of the Special Supplemental

Nutrition Program for Women, Infants, and Children (WIC) suggest that BIPOC mothers have experienced more difficulty than white mothers in accessing the food they need during pregnancy and after childbirth.⁵³ One of the problems is shortages of key foods in grocery stores that are accessible by public transportation. Another problem is that some states still issue checks rather than EBT cards to WIC participants. Banks are often closed and/or located far from where many BIPOC mothers live.

Barriers to accessing sufficient nutritious food during pregnancy, the additional stress caused by the pandemic, and ongoing racial biases are all factors that could increase both the likelihood of maternal mortality and the rate of low birthweight among BIPOC infants.

See the box at left for additional links between COVID-19 and food insecurity and poverty.⁵⁴

General Analysis

There are many contributing factors that have created the racial inequities featured in this report, that make BIPOC communities, and especially Black people, more susceptible to contracting and dying from the virus. Each of the following sections describes the origin of how these racial inequities were created along with analysis of how each factor is impacting BIPOC communities during COVID.

DID YOU KNOW THAT...

Food insecurity and poverty create obstacles to social distancing, which are also correlated with the three findings in this case study?

In addition to the three main findings, the research identified other factors associated with higher rates of death from COVID-19. Two of these factors are higher rates of food insecurity and poverty, and obstacles to social distancing. Poverty is the cause of many of these obstacles. One scenario, for example, involves someone who absolutely must bring home a paycheck if she and her children are to eat, even if her job involves significant contact with the public—not to mention more exposure on public transportation since she cannot afford a car. Another scenario is pre-existing or growing overcrowding at home as more family members or roommates share smaller spaces to cut costs.

The fact is that social distancing is a privilege that not everyone can afford. And while people of all races and ethnicities, particularly women, live in poverty in the United States, it is Black, Indigenous, and Other People of Color who are far more likely to be affected. Structural racism in employment, income, and housing is proving to be a significant reason for disproportionate COVID-19 death rates among BIPOC.

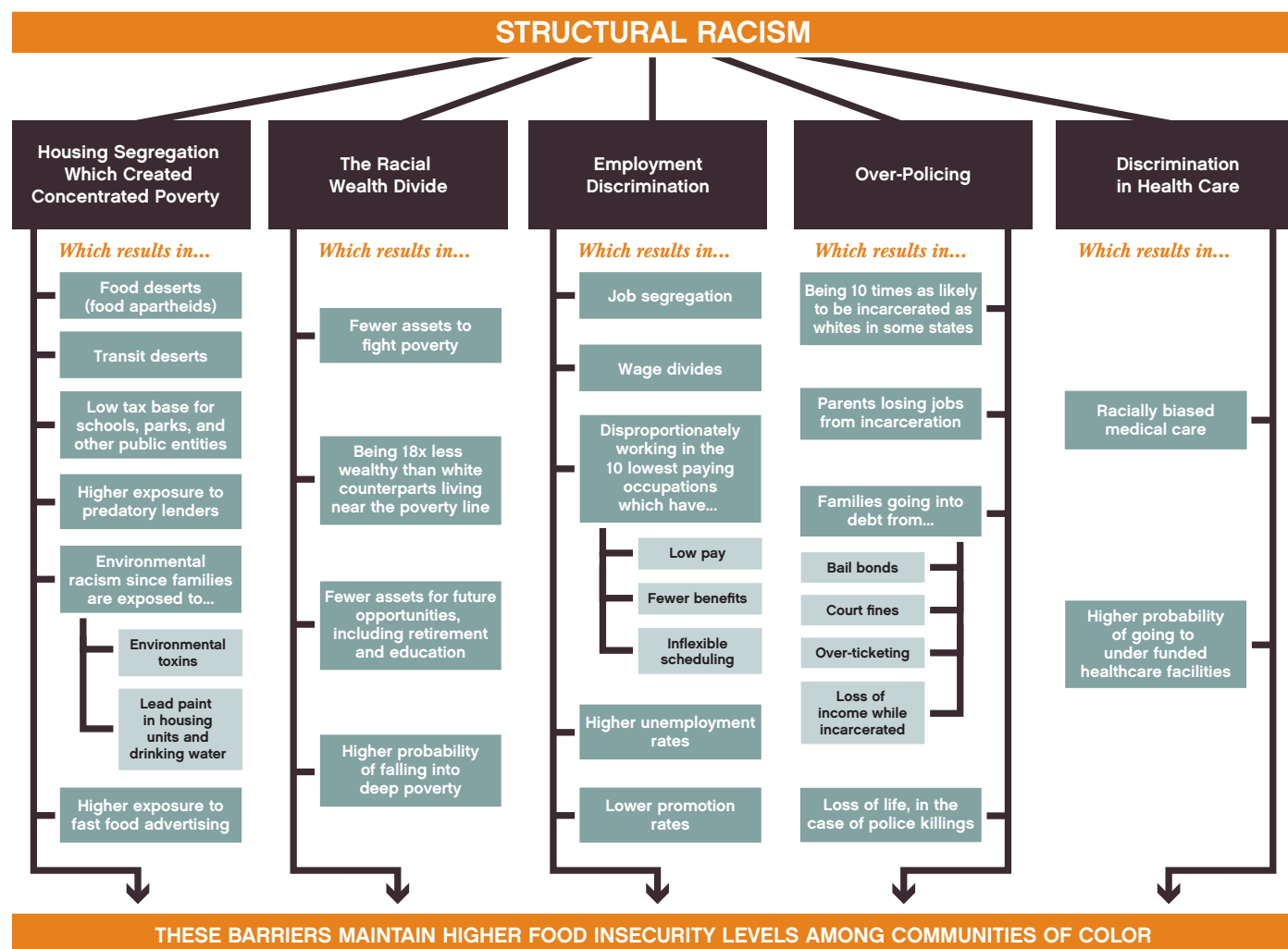
For more on this, see endnote 54.

What are the impacts of structural racism?

Structural racism, as mentioned earlier, is a system in which public policies, institutional practices, culture, interpersonal relations, and other norms reinforce racial inequities among Black, Indigenous, and Other People of Color (BIPOC).⁵⁵ The chart below shows how BIPOC face structural racism in every facet of their daily lives, from the neighborhood they live in and the jobs they work to the health care they receive and the amount of wealth they are, or are not, able to build. Structural racism reinforces white supremacy—a system that perpetually privileges white people and institutions at the expense of BIPOC people and institutions.

Figure 7 includes a variety of systems and institutions affected by structural racism. The section below it explains, for only a few of these systems, how COVID-19 has exacerbated the impact of structural racism on Black women in particular, as well as on larger BIPOC communities.⁵⁶ Black women are centered since they live with complex intersections of anti-Black racism and sexism and therefore experience structural racism differently and sometimes more deeply than Black men and other BIPOC women.

Figure 7: Structural Racism Sustains Higher Levels of Food Insecurity among BIPOC



SOURCE: Gamblin, Marlysa. *Applying a Racial Equity Lens in Federal Nutrition Policy*. Bread for the World Institute. Page 11.

Sec. 1. Racial job segregation into the lowest paying jobs, which are often also considered “essential” in the context of the COVID-19 pandemic

Among the racial inequities that BIPOC face is job segregation, a term used by economists to describe how different groups (usually defined by race and gender) are systematically overrepresented or underrepresented within and across various occupations.^{57 58} Job segregation has placed Black, Indigenous, and Other Workers of Color disproportionately in the country’s 10 lowest paying jobs, jobs that also have the fewest benefits and workforce protections. Some of these jobs, known as tip-based positions, can pay as little as \$2.13⁵⁹ an hour and are held disproportionately by BIPOC women.⁶⁰ Before the pandemic, one in three Indigenous workers, one in three Black workers, and one in four Latino/a workers were paid less than \$25,000 annually⁶¹—largely because they were concentrated in the lowest paying jobs. Disaggregating the pay data by gender shows that, as mentioned earlier, BIPOC women are paid least—less than white men, white women, or BIPOC men. This is why BIPOC women and their households have higher levels of food insecurity, reinforcing the importance of centering their needs, voices, and leadership.

Many jobs now deemed “essential” pay low wages and are structured by segregation

The reality of who is most likely to have a low-wage job in today’s economy is tied to the history of racial oppression. Just over 40 percent of all COVID-19 frontline workers are Black, Latino/a, Asian, Pacific Islander, or from other communities of color.⁶² Latino/as are overrepresented in the field of building cleaning services, such as custodial work (40 percent of all workers, more than twice their share of the U.S. population). Immigrant workers (of color) are 17 percent of all frontline workers but 38 percent of workers in building cleaning services. The majority of Black workers are Black women,⁶³ who are overrepresented in the categories of child care and social services (20 percent, nearly double their population size).

BIPOC workers as a group are overrepresented in frontline jobs, which include bus, transit, and postal workers as well as lower-paid health care and child care positions (e.g., nursing assistants, personal aides). Within these industries, immigrants of color are also overrepresented, particularly in the maid, housekeeping, child care, and meatpacking industries, where their share of the workforce is two to three times their share of the U.S. population.

There are more women than men from BIPOC communities working in frontline jobs during the COVID-19 pandemic, which helps to explain why more women than men have contracted COVID-19. Of all women in the United States, Black women have the highest rate, respectively, of COVID-19 infection (see box on page 37). For example, as of May 31, 55 percent of diagnosed cases in Louisiana and 60 percent in Mississippi were in women, disproportionately Black women.⁶⁴ Frontline industries where BIPOC women are overrepresented include cashiers, retail, customer service, fast food, child care, and social services.⁶⁵ These jobs usually do not offer benefits such as paid sick leave and health insurance—both of which were essential before the pandemic began and have only grown in importance since then. Access to group health insurance is even more important for Black women who work in low-wage jobs in states that have not yet expanded Medicaid coverage, many of them in the South.

DID YOU KNOW THAT...

Undocumented immigrant workers of color are racially and ethnically diverse?

They come from countries in Africa, Latin America, and Asia. They are overrepresented in many frontline jobs that increase an individual’s exposure to COVID-19. These jobs include cleaning, custodial work, child care, and farm work. But workers without documentation are not eligible for supports such as unemployment benefits or the stimulus checks that many citizens and documented immigrants received.

U.S. border control forces have detained both people who are undocumented and people who are seeking asylum, often in crowded conditions without nutritious food, access to running water, or supplies that are essential to protecting themselves from COVID-19 infection, such as hand sanitizer, masks, and gloves. Working in frontline jobs and being held in detention at the southern border are both factors that increase hunger among undocumented immigrants of color and make them more susceptible to contracting COVID-19.

SOURCE: Hye Jin Rho, Hayley Brown, and Shawn Fremstad. “A Basic Demographic Profile of Workers in Frontline Industries.” Center for Economic and Policy Research. April 2020. <https://cepr.net/wp-content/uploads/2020/04/2020-04-Frontline-Workers.pdf>

UNDERSTANDING THE HISTORICAL TRAUMA OF JOB SEGREGATION

Job segregation is linked to concerted efforts to suppress the wages of Black, Indigenous, and Other People of Color. Enslavement, which began in 1616, was the first of several tactics designed to force BIPOC to provide free labor.⁶⁶ The enslavement of African people via the transatlantic slave trade and their dispersal throughout the country took place over a period of 250 years. At the same time, the Spanish Empire, which colonized half of the U.S. West Coast, the Southwest, and parts of the Midwest,⁶⁷ legally enslaved Indigenous people until about the mid-1500s and legally enslaved people of African descent thereafter.⁶⁸ From the mid-1500s, it was illegal to enslave Indigenous people in the Spanish Empire, although the practice continued in various forms until the late 1700s.⁶⁹ The practice of enslaving people of African descent and exploiting Indigenous people continued when the United States took over much of the Spanish Empire—in 1803 with the Louisiana Purchase⁷⁰ and in 1845 after the Mexican American War.^{71 72}

Near the end of documented legal enslavement in the 1850s (see next paragraph), Indigenous people and Latino/as with an Indigenous lineage had already been forced into the lowest paying jobs⁷³ in the Southwestern region of the United States. The following decades were a continuation of colonial exploitation by the Spanish and the United States. Labor exploitation, particularly among Latino/a workers, continued well into the 1940s with meager wages, unlivable conditions, back-breaking labor, and other abusive practices. For many farmworkers, conditions today have not improved. The economic models and attitudes that produced U.S. agricultural conditions (see below) remain.

The Emancipation Proclamation formally ended *documented* legal enslavement in 1863, and the last remaining legally enslaved people were notified that they were now free two years later on June 19, 1865,⁷⁴ the date now celebrated as Juneteenth. Many say that the enslavement of people of African descent never truly ended,⁷⁵ since most of the 4 million formerly enslaved African Americans then became trapped in the economic bondage of sharecropping.

Sharecropping was made possible by the failure of the U.S. government to fulfill its commitment to give former slaves title to their own plots of land. This would have enabled them to eat nutritious food, create paid jobs, and gradually build wealth, as many white people were allowed to do as “homesteaders” in the West. Sharecroppers, being landless, were forced to work on their former master’s land. They were legally obligated to buy all farming supplies from the landowner, usually at inflated prices, and sell all crops back to the former master as well (usually for less than a fair price). Sharecroppers were tied to the land as debtors.

According to many records, the enslavement of people of African descent remained largely unchanged under this

revised system. Some former plantation masters refused to acknowledge to sharecroppers that they were not legally enslaved, and some continued the brutal abuses of chattel enslavement. In some southern states, such as Arkansas, Louisiana, Florida, and Mississippi, these illegal practices remained either undetected or unacknowledged by law enforcement and the courts until as late as the 1960s⁷⁶—a century after the Emancipation Proclamation.

Those in the African American community who did not work in their former master’s fields generally had only one other so-called choice, to take low-paid domestic positions, such as maids, that served white people. Domestic workers and farmworkers were intentionally excluded from eligibility for Social Security benefits during the Great Depression.⁷⁷ Latino/as, many of whom are of Indigenous descent, were also largely relegated to domestic work.

People of African and Indigenous descent, including Latino/as, have a shared history of colonial exploitation.^{78 79} During both the time of enslavement in the United States⁸⁰ and the colonial rule of the Spanish empire,⁸¹ abusive labor practices were designed to generate maximum profit for white people.⁸² Landowners and others considered these jobs “essential”—to their own profit.^{83 84} But the use of racial oppression, economic bondage, and other abusive practices to control “labor” meant that workers themselves were never truly valued.⁸⁵

Many of the jobs that African Americans, Indigenous people, and Latino/as now hold are structured to achieve the same goal—maximum profit for the CEOs and shareholders of large businesses.⁸⁶ During the pandemic, they have become known as “essential workers” in a different sense—as essential to the whole society. But many are still treated with disregard for their safety and the safety of their family members, as though they are disposable.⁸⁷

A national survey conducted by the National Employment Law Project in June 2020 found that of all ethnic and racial groups represented among respondents, Black workers were most likely to answer “yes” or “maybe” when asked if they or anyone at their company had been punished or fired for raising COVID safety concerns.⁸⁸ More than 70 percent of Black workers in the survey reported going to work even though they believed that they were seriously risking their health or the health of family members.⁸⁹

According to Rhonda Vonshay Sharpe, Founder and President, Women’s Institute for Science, Equity, and Race, they may be more accurately described as “people who work in ‘essential jobs,’ not as ‘essential workers.’”⁹⁰ The intersection of racism and sexism means that Black, Indigenous, and Latina women are disproportionately represented in jobs that, whether called “essential” or not, are among the lowest paid in the U.S. economy.

Essential jobs expose BIPOC workers to the virus at higher rates

It is also important to note that because these jobs pay such low wages, many BIPOC workers, especially women, must work multiple jobs. Being exposed to more people by traveling to two or more jobs increases their susceptibility, and their families' susceptibility, to contracting the virus, but there is little choice if the household is to pay rent and buy groceries.⁹¹

The flip side of being disproportionately represented in frontline jobs is that BIPOC workers are underrepresented among people who are able to work from home. Bureau of Labor Statistics data shows that before the COVID-19 crisis began, people who are Black, Indigenous, or Other People of Color—particularly women—were less likely to be able to work from home than white workers.

Sec. 2. Racial Discrimination and Higher Unemployment Rates

Racial discrimination reinforced racial divides in unemployment rates before and during COVID-19

SPOTLIGHT ON

Employment Discrimination against Indigenous Communities



Collecting and reporting employment data for Indigenous communities has not been a priority for the U.S. government. This is partly because fewer people are part of these communities, but also partly because of structural racism, whose impact includes consistently leaving Indigenous people out of the conversation.

Data on unemployment in the numerous different Indigenous communities is not readily available, but figures based on composite data from 2003 to 2018 show that unemployment among Indigenous people has consistently been significantly higher than the U.S. average. For example, in 2010 during the Great Recession, the national unemployment rate was 10 percent while the Indigenous rate was about 15 percent.

SOURCE: <https://www.bls.gov/opub/mlr/2019/article/american-indians-and-alaska-natives-in-the-u-s-labor-force.htm>

People from Black, Indigenous and Other Communities of Color have historically had unemployment rates that are higher than the national average, including during the country's recent period of very low unemployment. Between February 2020 and April 2020, unemployment among Latino/a workers quadrupled, to 18.9 percent.⁹² A Brookings Institution study of Latino/a economic losses found that one in three respondents reported that at least one person in their household had lost their job since the crisis began.⁹³ Unemployment rose to 16.7 percent among Black workers, which was three times the rate in February.⁹⁴ Indigenous workers had the highest unemployment rate before the pandemic. Data is not yet available, but it appears likely that unemployment rose significantly in this community as well.

According to a study conducted by the Economic Policy Institute, less than half of the adult Black population was employed as of April 2020.⁹⁵ A combination of economic inequities—including Black workers having higher unemployment rates, lower incomes, and fewer liquid assets than white workers—has meant that Black workers have been less able to cope with the economic crisis⁹⁶ than white workers. Digging further into disaggregated data reveals that Black women have lost jobs disproportionately, with an 11 percentage point drop in employment—more evidence of the importance of centering Black women in COVID-19 responses.

Ironically, while some BIPOC workers are required to go to workplaces despite the risk of contracting the virus, others made up a disproportionate share of people who were among the first to be laid off, because the jobs they held were affected most immediately by stay-at-home orders. One of these sectors is the leisure and hospitality industry. Every subsector of this industry lost at least 25 percent of its employees.⁹⁷ Occupations in the arts, entertainment, and recreation saw a 54.4 percent drop in available positions between February and April 2020, while over the same time period, jobs in accommodations and food services fell by 47.3 percent.⁹⁸ As mentioned earlier, Latino/as and African Americans worked in job categories such as travel accommodations and restaurants at roughly twice their share of the U.S. population. About 25 percent of Indigenous workers are in the service industry, a higher rate than the U.S. national average.⁹⁹

Jobs in the service industry may be at any of a number of job sites, from sporting venues and historical tourism sites to restaurants and hotels. What nearly all of them have in common is that they involve in-person gatherings of large numbers of people—gatherings that were soon banned in many states because safe social distancing was impossible.

The combination of sexism and anti-Black racism pushes Black women into the lowest paying jobs and fuel higher unemployment rates, which explains why eviction rates among Black women were the highest of all communities before the pandemic. It is likely that this is still the case during the crisis, which would pose additional barriers to their efforts to shelter in place, maintain social distance, and remain safe during COVID-19. See section 4 for more on eviction.

Racial discrimination led to slower reductions in unemployment among BIPOC workers than among white workers

Cities and states continue to work to reopen and revive their economies, although even areas that had made significant progress on their test positivity, hospitalization, and death rates have had setbacks. Unemployment rates have fallen to some extent since the summer months of 2020, but they have not been falling at equal rates among different racial/ethnic communities. BIPOC workers, particularly women, are being recalled from furlough or rehired more slowly than their white counterparts. This carries consequences for hunger and for susceptibility to COVID-19 infection, among other concerns.

Sec. 3. Implicit Racial Biases in Health Care

Racial discrimination in the healthcare system is another facet of structural racism that puts BIPOC, particularly Black people, at greater risk of dying if they contract COVID-19. The impacts of structural racism in health care may include, for example, being less likely to have adequate health insurance or any health insurance, receiving subpar medical attention and follow-up treatment, or encountering longer delays in appointment scheduling or in waiting rooms. Such biases cause poorer health outcomes and increase the likelihood of being food insecure.

Food insecurity is exacerbated by health problems since people may lose income or lose a job altogether for taking time off from work for illness or medical treatment, and they may remain sick and unable to work for longer periods of time or not fully recover. The death of a caregiver and/or financial provider can push families into hunger for years to come.

Racial biases among healthcare providers before and during COVID-19

Several reports list instances of people of African descent going to the emergency room with COVID-19 symptoms but not being properly evaluated.¹⁰⁰ Patients often returned several times—for example, Deborah Gatewood in the story below. By the time patients are tested, they may be severely ill and later die from the virus.¹⁰¹ It would not be surprising if having one's symptoms dismissed by health workers increases the chance that family members will be accidentally exposed to the virus as well.

DID YOU KNOW THAT...

Among nearly 3,000 people surveyed in early April 2020, 67 percent of Black women were concerned about being able to pay their rent, compared to 29 percent of white men?

SOURCE: https://docs.google.com/document/d/19UkIM_LtTUj02EI9Hw7U03-ybv0sCGUNTYGdnhHz7FU/edit

SEEKING MEDICAL HELP IN VAIN

After experiencing symptoms of COVID-19 in mid-March, Deborah Gatewood sought repeatedly to be tested for the virus at the Michigan hospital where she had been a healthcare worker for more than 30 years. According to a Detroit news station, she was turned away four

times, with only the advice to go home and take a mild palliative such as cough syrup. Gatewood finally became so ill she had to be transported to a hospital by ambulance. She died in late March at age 63 in another hospital, where she tested positive for COVID-19.¹⁰²



Chayanorn/iStock photo

There is ample evidence that racist attitudes persist among healthcare providers and that these personal biases affect the quality of care that BIPOC receive, including the quality of treatment decisions.¹⁰³ For example, a study conducted by the National Institutes of Health (NIH) found that racial bias affected communications and patient ratings of interpersonal care during visits with physicians,¹⁰⁴ leading Black patients to report poorer interpersonal care than white patients. NIH later conducted a “study of studies,” systematically reviewing 15 studies of racial bias in healthcare providers. NIH concluded that the studies showed that, for Black patients and darker-skinned patients, implicit bias was significantly related to patient–provider interactions, treatment decisions, and patient health outcomes.¹⁰⁵

DID YOU KNOW THAT...

Researchers have found evidence that the impact of racism on Black women is a major reason for their far higher rate of maternal mortality compared to white women?

Chronic stress linked to structural racism, including racial bias experienced in the healthcare system, causes physical “weathering” or faster aging, which in turn makes pregnancy and childbirth less safe for Black women.

SOURCE: <https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html>

Anti-Black racism in healthcare algorithms

Researchers have also found that structural racism, particularly anti-Black racism, affects the results of algorithms that healthcare providers may use to gauge which patients need additional follow-up care. A study by the American Association for the Advancement of Science found that an algorithm that assesses patient healthcare needs did not assess Black patients accurately:¹⁰⁶ Black patients were more seriously ill than white patients who had been assigned similar risk scores. The bias was large, reducing the number of Black patients identified for extra care by more than half.¹⁰⁷ Upon investigation, this turned out to be because the algorithm used healthcare costs as a proxy for healthcare needs, rather than patients’ actual signs and symptoms of illness.

While little information is available as yet on what type of algorithms healthcare providers are using for COVID-19 patients and how often, some states have already started to develop guidelines for use of the Sequential Organ Failure Assessment (SOFA) score. The score is based on the functioning of major body systems such as the heart, lungs, kidneys, and liver.¹⁰⁸ In the event of an extreme shortage of ventilators or other equipment essential to supporting patients who are critically ill, patients with high SOFA scores would be lower on the priority list for access to ventilators.

Personal bias in healthcare providers is one way for racism to persist. Bias in healthcare algorithms is another.

penalizes BIPOC, especially BIPOC from low-income backgrounds, who are often viewed more through assumptions about them as members of a particular group and less as the individuals they are.

The lack of detailed information about the impact of various algorithms and plans for their use, combined with the fact that researchers have identified racial bias in at least one healthcare algorithm, means that those working toward racial equity must continue to monitor and revisit developments.

As mentioned earlier, anti-Black racism in the healthcare system contributes to high Black maternal mortality rates

Anti-Black racism in the healthcare system helps explain why Black women die during pregnancy, childbirth, or within the first six weeks of recovery—together known simply as maternal mortality—at rates three to four times those of white women.¹⁰⁹ The far higher rate affects Black women regardless of education or income.

Charles Johnson is the founder of 4Kira4Moms,¹¹⁰ a Black-led organization that advocates for the rights of Black women during pregnancy, childbirth, and postpartum, as well as for racially equitable maternal health outcomes for Black women. He started this organization after losing his wife to anti-Black racism in the healthcare system.

“My wife Kira was exceptionally healthy and lost her life after what we expected to be a routine scheduled C-section in Cedar Sinai Hospital in Los Angeles ... After she gave birth, I noticed blood in the catheter. I alerted the nurse. After a few hours, [Kira] began to lose color and shiver uncontrollably. She was allowed to bleed internally for more than 10 hours without a CT-scan [which we requested]. We begged and pleaded for the staff to take action. The staff at Cedar Sinai Hospital then proceeded to tell me that my wife was not a priority now.”¹¹¹ Kira died hours after giving birth.

Guidelines on a topic such as who gets medical care first raise immediate questions with no easy answers. Some proposals are particularly troubling in the context of the racist and/or sexist assumptions reflected in many past and present medical policies and practices. Other guidelines attempt to identify and remove criteria that could be proxies for race or socioeconomic status. An example is any assessment of “longer-term” survival, defined as beyond one year, because this

SPOTLIGHT ON Concerns About Black Maternal Mortality During COVID-19



Many people interviewed for this report shared concerns about the mental and physical health traumas that BIPOC, particularly Black communities and even more particularly Black women, are experiencing in 2020. This cumulative trauma may come from living in an area of racialized concentrated poverty (see page 24), added stress from COVID-19, and added stress from racist violence—particularly in the summer of 2020—that led so many people to take part in peaceful protests of anti-Black racism.

The situation is likely to be especially difficult for Black women who are pregnant, already nearing labor and delivery, or recovering from childbirth. The added stress and trauma of living in a society with significant anti-Black racism in the midst of a global pandemic could be weakening the immune systems of Black women and contributing to problems such as having difficulty establishing lactation.

For more, see the text box on page 24.

DID YOU KNOW THAT...

Racialized concentrated poverty was deepened by racially inequitable housing policies?

Racialized areas of concentrated poverty existed from the beginning of U.S. slavery, when African Americans were forced to live in slave shacks with no pay, poor living conditions, and no access to health care. After slavery was legally ended, many people continued to live in the same shacks while working as sharecroppers. It was the National Housing Act of 1934, however, that formalized, expanded, and exacerbated areas of racialized concentrated poverty. It established a new government agency that graded neighborhoods and decided which areas qualified to receive government-backed home mortgage loans. The communities that ranked highest were white (English, German, Irish, etc.) and BIPOC communities ranked lowest, with Black communities the lowest of all. This practice, known as redlining, made it nearly impossible for BIPOC communities to build wealth. Between 1934 and 1962, the federal government insured \$120 billion in home loans, creating the American middle class. Nearly all of the loans were made to whites, and only 2 percent went to African Americans.

This created room for a predatory “housing contract” system. White people purchased homes with insured loans and sold them to African Americans, who were forced to make monthly payments directly to them. The payments often totaled two or three times the house’s actual value before the “contract” was declared fulfilled and the deed given to the owners. The Center for Urban Research and Learning at Loyola University calculated that African Americans in Chicago, for example, lost more than \$500,000 due to costs associated with mortgage contracts from 1940 to 1970. Adjusted for inflation, this would be about \$3.2 million in 2018 dollars. While we do not have detailed data for other cities, it is likely that African Americans nationwide lost hundreds of millions of dollars to contract lending.

While these practices targeted African Americans, they also affected other people who were not considered white. This is one reason that Latino/as are twice as likely as whites to live in areas that were previously redlined and are now areas of racialized concentrated poverty.

Less wealth at the individual and household levels can only add up to less wealth at the community level. Home values are lower in and near BIPOC neighborhoods, so home equity amounts in these neighborhoods are also lower. In turn, less wealth in communities translates to fewer resources available to neighborhoods to attract and/or provide a customer base for businesses and services such as full-service grocery stores, transit, healthcare providers, and schools. You can learn more about how racial wealth gaps came to be by participating in the Racial Wealth Gap Simulation (see policies 3 and 4).

SOURCES: Racial Wealth Gap Learning Simulation Policy Packet. Pages 12, 13, and 14. http://files.bread.org/institute/simulation/Racial-Wealth-Gap-Policy-Packet.pdf?_ga=2.165977406.1234855146.1604428581-420106277.1599781385. The Plunder of Black Wealth in Chicago: New Findings on the Lasting Toll of Predatory Housing Contracts. <https://socialequity.duke.edu/wp-content/uploads/2019/10/Plunder-of-Black-Wealth-in-Chicago.pdf>

At the time of writing, there is little data available on health outcomes for women who are or have been pregnant, nearing labor and delivery, or in the six-week postpartum period during the COVID-19 pandemic. Any impact is almost certain to be negative, however, whether pregnant women and new mothers themselves have COVID-19, or their care is disrupted by “secondary” impacts separate from the virus itself, such as diversion of healthcare professionals and resources to fight the pandemic. The consequences of anti-Black racism are likely to be as strong or stronger during the pandemic as before it began, and Black women may face even higher levels of maternal mortality as the U.S. healthcare system continues to struggle to adapt to treating COVID-19 patients. The racial inequities in maternal/infant care carry consequences that are literally life and death as women work to achieve a vital goal—giving birth to the next generation. The maternal mortality divide, which may well be the strongest possible example of the impact of anti-Black racism, reaffirms the importance of centering Black women in efforts to eliminate racial bias in U.S. health care.

Sec. 4. Racially inequitable housing policies, concentrated poverty, and racial health inequities

A history of anti-Black housing policies (see box at left) had the effect of forcing BIPOC to live disproportionately in areas of racialized concentrated poverty, a term for racially segregated areas where at least 20 percent (often more than 40 percent) of all BIPOC households live below the poverty line.¹¹² One in four African Americans and one in six Latino/as live in an area of racialized concentrated poverty, compared to one in 13 white people who live in high-poverty areas.¹¹³ In counties with significant numbers of Indigenous people, one in two live in racialized concentrated poverty.¹¹⁴

Racially inequitable housing policies extracted wealth and created areas of racialized concentrated poverty

Housing policies based on structural racism have produced racial segregation that continues today. Segregated areas rarely attract investment from outside the community, and segregation destroys BIPOC communities’ own wealth (see box at left).¹¹⁵ This in turn makes it more likely for neighborhoods to be areas

of “food apartheid,” a term that describes the systematic lack of access to affordable, healthy food options in BIPOC communities as a result of racially inequitable policies.¹¹⁶ Food apartheid makes it far more difficult for families to get the nutrition they need, and dietary-related health conditions such as diabetes and high blood pressure are disproportionately high among BIPOC residents of these areas.¹¹⁷ Areas of racialized concentrated poverty with food apartheid also contribute to the likelihood of BIPOC facing hunger.

Availability and affordability of hospitals for BIPOC residents

Loss of wealth on the individual and household levels has contributed to racial hunger divides and health inequities because it leads to underfunding of community healthcare facilities and other institutions. In areas of racialized concentrated poverty, the nearest hospitals are often a considerable distance from where people live. Studies have shown that the hospital closures of recent years, in both urban and rural settings, have disproportionately impacted BIPOC communities.¹¹⁸ BIPOC patients have also reported that where hospitals are accessible, often the services are not affordable, patients are not offered care that is culturally appropriate,^{119 120} and/or there are not enough BIPOC healthcare providers to offer BIPOC patients care that is racially representative.^{121 122}

Lack of connection with a nearby hospital is often worsened by lack of access to public transit and by significant undercounting of the residents of areas of racialized concentrated poverty in the U.S. Census, which can hinder local government’s efforts to recognize and respond to the community’s actual needs. Strengthening local hospitals’ connections with the communities they serve could potentially promote longer-term improvements, such as the facilities’ taking steps to operate in racially equitable ways and/or individuals and families’ developing more trust in individual healthcare providers. Both of these would ultimately help improve patient care, which is essential both during and after the pandemic.

Support for BIPOC students and teachers

Schools are another key institution that is underfunded in areas of racialized concentrated poverty. Many teachers in underfunded schools located in such neighborhoods are now expected to teach remotely because of the pandemic. But too often, they are not offered additional resources to help with the extra costs attached to this, as teacher Khadyjah Thomas explains in the story at right. As some scholars have already warned, this is likely to increase racial education divides, which in turn are likely to worsen racial hunger divides for the next generation.

Racially inequitable housing policies enabled environmental racism

Structural racism is also embodied in environmental racism in areas of concentrated poverty. Environmental racism is the routine targeting of the places where BIPOC communities live, work, and play when decisions are made on where to locate facilities that harm the environment.¹²³ One result of environmental racism is that BIPOC are more likely to live in areas with higher levels of toxins and air pollution¹²⁴

SPOTLIGHT ON

Black Teachers During COVID-19

“As a Black woman teacher, I’ve noticed I do not have the resources that [many of] my white peers have. It would be helpful if policies helped with adequate resources that other teachers



Khadyjah Thomas, 3rd Grade Teacher in an area of racialized concentrated poverty in Las Vegas, Nevada.

from white backgrounds already had in their homes prior to the crisis. [I had] no printer, reliable computer, and/or internet ... The district did not even offer to help pay.

“And if I am struggling as a Black woman who is a teacher, compared to my white teacher counterparts, then imagine what my [BIPOC] students and their families are facing? They also face a digital divide and some of them can barely afford housing or food. Sure, a private internet company had a deal going for \$9.99 a month if parents are registered through the school. \$9.99 is still too much for some. Also, you have to have a social [security number] or good enough credit, so many are unable to get it. The technology [divide] is huge and is only making matters worse for our students and families.”

that compromise the human respiratory system and lead to lung problems such as asthma.¹²⁵ People with such conditions are more susceptible to dying from a respiratory illness such as COVID-19.¹²⁶ This is why environmental racism is another factor that adds to the greater likelihood of death among Black, Indigenous, and Other People of Color who contract COVID-19.

According to the U.S. Department of Health and Human Services, African Americans are almost three times as likely as whites to die of asthma-related causes.¹²⁷ African American children are four times as likely to be admitted to the hospital for asthma as white children¹²⁸ and Latino/a children are twice as likely to die of asthma as white children.¹²⁹ People from Puerto Rico have nearly twice the asthma rate of the overall Latino/a population.¹³⁰ Asthma affects Black and Latina women more frequently than men—African American women are diagnosed with asthma at twice the rate of African American men.¹³¹

As a result of environmental racism, there are higher levels of toxins in the water and air in the neighborhoods where Black, Indigenous, and Other People of Color live. Lead-poisoned water in Flint, Michigan, made headlines as the epitome of environmental racism. But Flint is far from an isolated incident. According to officials at the ports in Reliant, Michigan, the lead level in the water in some majority-Black neighborhoods was 100 times higher¹³² than the level that requires water utilities to take corrective action¹³³ under Environmental Protection Agency (EPA) regulations. Lead also disproportionately affects some residents of Indigenous reservations, because centuries of mineral extraction in parts of Indigenous reservations have resulted in lead levels that far exceed guidelines for safety.¹³⁴

The evidence of systematic noncompliance with laws and federal regulations on water quality helps explain why, in a Gallup poll before the COVID-19 pandemic began, 80 percent of BIPOC reported worrying “a great deal” about the purity of their drinking water.¹³⁵ Clearly, lack of access to clean running water also makes it nearly impossible to follow the pandemic safety guidelines of the Centers for Disease Control (CDC).

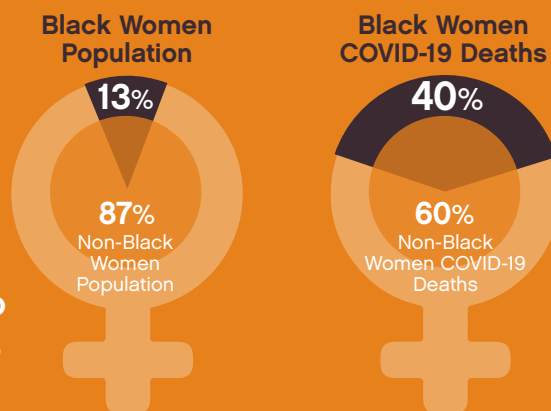
BIPOC residents are racially targeted for water shutoffs and eviction

Residents of areas of racialized concentrated poverty are also targeted for water shutoffs and eviction. Both practices increase residents’ susceptibility to contracting and dying from COVID-19.

According to recent analysis, water shutoffs have been concentrated in southern states, in rural areas, and in areas nationwide that have become COVID-19 hot spots.¹³⁶ In Detroit, for example, the local government has shut off the water of a total of more than 140,000 households since 2014,¹³⁷ 90 percent of them headed by Black women.¹³⁸ Many of these households were already facing food insecurity.

Reverend Rosslyn Bouier, executive director of Brightmoor Connections, a Black-led food pantry in Detroit that also works on water shutoffs, described the consequences of these practices as devastating.

Although Black women only account for **13 percent of the female population**, they represent almost **40 percent of women who are dying from COVID-19**.



That means Black women are dying **3x** their population rate. This reinforces the importance of centering the needs and circumstances of Black women.

SOURCE: <https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e3.htm>



“Without water, people can’t follow CDC guidelines to stay hydrated and wash their hands regularly, let alone do things like wash their clothes or flush the toilet. This increases the likelihood that our mothers and our children will contract and die from the virus, and even be exposed to other unsafe bacteria. This is a human rights offense that is blatantly targeting Black women and it is not acceptable.” Water shutoffs in Detroit are a tactic used as part of efforts to achieve an even larger goal—eviction. The households in Detroit that have had water shutoffs largely overlap with the group of predominately Black female-headed households that has been targeted for eviction. Some of these eviction proceedings are illegal.

Bouier continues, “Without a place to live, how do you shelter in place? You can’t. Plus, we have seen Black women experiencing illegal evictions ever since the moratorium [on evictions that was in effect early in the pandemic] was lifted. Their clothes [have been] thrown away and not even placed on the curb. And no Marshall has even served a noticed to them. They have just been kicked out illegally.”¹³⁹ It all adds up to very heavy burdens for Black women—and the high levels of stress that come with it.

New Orleans, another COVID-19 hot spot, has hundreds of households that have had their water shut off and not reconnected. The majority of these household are headed by Black women. According to Consumer Reports, the city does not know how many such households remain without water,¹⁴⁰ which is clearly an obstacle to solving the problem.

Still other U.S. communities do not have access to running water at all. Many are Indigenous households in the more remote parts of reservations, where water pipes have never been connected and residents must drive for hours to fill their water tanks with drinking water.¹⁴¹ A significant portion of residents of reservations are affected by lack of access to running water. One indication is that one in three Navajos do not have indoor plumbing.¹⁴²

Section 5: The Racial Wealth Divide Causes the Racial Hunger Divide

The racial wealth divide is often overlooked, but it is one of the most significant and far-reaching aspects of structural racism. Bread for the World Institute's [Racial Wealth Gap Learning Simulation](#)¹⁴³ describes policies that led to today's nationwide racial divides in hunger, income, and wealth between Black and white communities.

The households with the least wealth are most likely to face hunger during an economic crisis, including the current one caused by COVID-19. This is because there is little or no financial cushion if an income earner loses her or his job.

The racial wealth divide is wider among food insecure households

It may seem logical that households with similar incomes will be affected by hunger and poverty in similar ways, but in fact, the racial wealth divide between Black and white households with incomes near or below the federal poverty line is even larger than the overall national wealth divide. Low-income white families are far more likely to have an emergency fund, however modest the amount, than low-income Black families.^{144 145} This is why both wealth and income are important to ending hunger and food insecurity in a way that is sustainable. It also shows why it is important for anti-hunger efforts to center the role of structural racism.

The racial wealth divide was felt among Black-owned businesses and community organizations before and during the pandemic

The wealth divide affects Black women most significantly. Before the pandemic began, Black women as a group had less wealth than Black men and significantly less wealth than white women and white men. Similarly, the racial wealth divide already affected Black-led community organizations and nonprofits, particularly Black women-led organizations that had the least wealth. The pandemic is making the situation worse, as the director of a Black-women-led organization explains below.

BIPOC-LED NONPROFITS FACE THE RACIAL WEALTH DIVIDE

BIPOC-led nonprofits had to deal with tight budgets, exacerbated by the racial wealth gap, before the pandemic began. The wealth divide is widening as the pandemic continues.

Brightmoor Connections is a Black-led food pantry in Detroit that also advocates against policies that increase food insecurity among Black families, including eviction and water shutoffs. Rosslyn Bouier, executive director, explains that funders have not been responsive to addressing the true needs of Black-women-led organizations.

“Before COVID-19, our organizations had to do more to get less. White-led organizations would get \$30,000 to \$50,000 grants, while we [Black women] would only get \$5,000 or \$10,000 and had to fill out a lot more paperwork. In addition, we are asking for funding that is more justice-oriented. Not just charity. We want to create a food co-op that is owned by the community. But they don't want to fund initiative for economic equity. Any large grant that we [Black-led organizations] do receive is often overseen by white-led organizations. This is racially problematic and it shows the overseer mentality, which was born out of slavery in the U.S. The racial wealth divide for Black-led organizations hurts our ability to serve our own communities and this needs to be addressed.

“This has only amplified during the crisis. Now we have seen white-led organizations who are not frontline service providers applying to receive COVID-19 service provider emergency funding. The result—making organizations like mine that really need it get drowned out. We need this support.”



Reverend Rosslyn Bouier, executive director of Brightmoor Connections.

Black-owned businesses were a small share of the country's total businesses before the pandemic. They were also disproportionately in sectors and industries that were affected by the earliest COVID-19 shutdowns.¹⁴⁶

A COVID-19 response effort that seeks to close the racial hunger divides between BIPOC and white households must also take action to reduce the racial wealth divide among individuals, public institutions, and BIPOC-led organizations and businesses. With more wealth, of course, BIPOC individuals, families, households, and communities will be less likely to experience hunger.

Section 6: The Compounding Impact of Structural Racism on COVID-19 Susceptibility and Death Rates

Given these impacts of structural racism, in addition to the many others not discussed in detail here, it is not surprising that Black, Indigenous, and Other People of Color have higher rates of contracting and dying from COVID-19 than whites—nationwide and in every state.¹⁴⁷ Nationally, Black and Indigenous communities have had the highest death rates, followed by Pacific Islanders and Latino/as.¹⁴⁸ As mentioned earlier, according to the Color of Coronavirus Project, the death rates per 100,000 people in each group are 80 Black people, 67 Indigenous people, 59 Pacific Islanders, and 46 Latino/as, compared to 36 white people.¹⁴⁹ Adjusting death rates for age—to take into account that white people who die are on average much older than BIPOC who die—leads to the conclusion that *three times as many* BIPOC die as whites of similar age.¹⁵⁰

The Navajo and Hopi Reservations have the highest per capita rate of COVID-19 infection in the country.

State-level data yield similar findings. In New Mexico, for example, as of June 2020, people from Indigenous communities made up more than 55 percent of those who have died,¹⁵¹ but only 10.6 percent of the state population is Indigenous.¹⁵² This means that Indigenous people are five times more likely to die from COVID-19 than their share of the population. In Wyoming, Indigenous people are just



3 percent of the population but one-third of those who test positive for COVID-19.¹⁵³ In May 2020, the Navajo (or “Dine” in their own language) and Hopi Reservations had the highest per capita rate of COVID-19 infection in the country¹⁵⁴—surpassing New York and New Jersey, the states with the highest per capita rates that month.¹⁵⁵

In Michigan, African Americans are 18 percent of the state population, but 40 percent of those who died. In Wisconsin, in the county that includes Milwaukee, 26 percent of the population, but 70 percent of those who have died from the virus, are Black.¹⁵⁶ Of all states reporting data, African Americans made up an average of 13 percent of the population, but more than one-third of the deaths confirmed to be from COVID-19.¹⁵⁷

Stark racial inequities prove that COVID-19 is not the “equal opportunity” virus that many initially claimed.

Thus far, people in disproportionately Black counties have made up at least half of the deaths nationwide,¹⁵⁸ the highest proportion of any one racial or ethnic community. Perhaps this explains why relatively early in the pandemic, in June, nearly one in three African Americans reported knowing someone who had died from COVID-19, compared to one in eight white people and one in six Latino/as.¹⁵⁹

In New York, Latino/as are contracting and dying from the virus at the highest rates. In Iowa, more than 20 percent of coronavirus patients have been people either from Latin America or of Latin American descent,¹⁶⁰ but the two groups combined are only 6 percent of the population. Latino/as are 13 percent of the population of Washington State, but one-third of COVID-19 cases.¹⁶¹

Inequities affecting Latino/as appear to be more pronounced in newer and less-established communities, such as those in Iowa and Washington, than in states such as California, Arizona, and New Mexico. In some states, including Arizona, New Mexico, and Texas, state data shows that Latino/as have been contracting the virus at rates not much higher than their share of the population.¹⁶²

Despite ample evidence that COVID-19 is not the “equal opportunity” virus that many initially claimed, early state and federal responses to COVID-19 have largely been universal. Policies and resource allocations have rarely been modified to take into account the many factors that make people more susceptible to the virus, including the unique circumstances of different BIPOC communities and the historical trauma of racism. As mentioned earlier, the inequities that predate the pandemic include higher rates of food insecurity and housing insecurity, lower-paying jobs and higher unemployment rates, little or no financial cushion, less access to health care, and more environmental toxins known to cause health problems that exacerbate COVID-19.

DID YOU KNOW THAT...

As of August 19, 2020, if the death rate for each racial/ethnic group had been the same as the death rate for whites, more than 19,500 Black people, 8,400 Latino/as, 600 Indigenous people, and 70 Pacific Islanders who died of COVID-19 would still be alive?¹⁶³ Racially equitable responses to COVID-19 are urgently needed.

What We Are Called To Do

The COVID-19 pandemic has exposed, in ways that are clear and undeniable, the structural racism that has always been part of the United States, from the first encounters between Indigenous people and white colonizers from Europe, and the institution of chattel slavery of people of African descent thereafter. The pandemic is killing Black and Indigenous people disproportionately and worsening other racial inequities of all kinds. We cannot support a return to the old “normal” since structural racism is an inherent part of it.

Instead, we must support a new “normal” that prioritizes racial equity in all we do, at all levels, and in all topic

areas, to dismantle structural racism, undo its consequences, and stand in solidarity with BIPOC. It is particularly important to center anti-Black racism, a type of racism that explains why Black people are dying of COVID-19 at higher rates than any other racial or ethnic group. Within anti-Black racism, we must center Black women, who face barriers due to both racism and sexism and who have been and continue to be leaders in their communities.

Below are this report's recommendations, developed in accordance with our research findings, those of others, and general trends in the United States.

Recommendations

The United States cannot afford to continue ignoring race and structural racism. Racial equity must be centered in the COVID-19 response and long-term recovery. If structural inequities are not acknowledged, BIPOC will continue to face generational food insecurity, and the United States will continue to face racism.

As this report has discussed, the analysis confirms that we must center Blackness and the anti-Black racism that has led not only to African Americans being the group hardest hit by the pandemic, but also the group that has faced particularly harsh and extreme forms of structural racism. Centering the needs, leadership, and power of this population is the right strategy—the one that will enable the United States to make the most progress against structural racism.

Centering Black women within the population affected by anti-Black racism is the most effective way to pinpoint the impacts of two deep-seated social ills, racism and sexism, on the real lives of individuals—and then to find solutions. Experience has shown that it is essential to deliberately center Black women in anti-racism efforts in order to avoid further marginalizing them and failing to respect their needs, leadership, and power. Measures that center Black women will also be liberating for all groups, including other women, men, and children of color.¹⁶⁴

The analysis in this report confirms that we cannot focus only on race generally, but must center Blackness...

Immediate Recommendations

Decision makers should have applied a racial equity lens (as explained on page 7) that centers Black women from the earliest days of COVID-19 in the United States. This would have ensured that the needs of everyone are being identified so that they can be met. Because this was not done, the country will need to repair the damage and correct the mistakes made since March 2020.

For this reason, the report's immediate recommendations focus on ensuring that COVID-19 response efforts, particularly those that reduce hunger and food insecurity, apply a racial equity lens in their design and implementation.

The longer-term recommendations lay out policies to break the cycle of food insecurity—including eliminating the racial wealth divide, racialized concentrated poverty, and racial bias in the healthcare system.

IDENTIFYING AREAS WITH THE HIGHEST RATES OF DEATH FROM COVID-19, ECONOMIC LOSS, AND FOOD INSECURITY

A key finding from Bread for the World Institute's analysis of data from Louisiana is that county-level data is not always specific enough to pinpoint areas with the greatest needs. Combining data from areas of racialized concentrated poverty with data from wealthier, less racially diverse areas nearby may obscure the level of need. Therefore, data that is broken down by race as well as data at the sub-county level are essential, while neighborhood-specific information is very useful where available.



Food Security:

- **Recommendation 1: Policymakers should use available racial equity resources as they design and implement legislation and policies.** One such resource is Bread for the World's Racial Equity Scorecard Tool, which outlines how to determine to what degree a proposal applies a racial equity lens. To center Black women, the data used in planning must be cross-sectional and disaggregated by race *and* gender rather than only by race *or* gender. Effective policies also require providing support to Black women in proportion to both their generational experience with anti-Black racial trauma and the historical gender trauma they have faced.
- **Recommendation 2: USDA and Congress should work together with a racially diverse set of stakeholders to analyze how nutrition and agricultural programs can promote racial equity.** Anti-hunger programs have traditionally supported individuals, families, and communities based on need. However, financial need has only considered household income and has not considered the impact of racism on Black, Indigenous, and Other Households of Color at the same income level. To consider the role of racism, financial need would acknowledge the impact of the racial wealth divide in an individual or family's ability to financially support their household. It would also consider historical racial trauma that many BIPOC communities have experienced, and still do experience, within existing anti-hunger programs¹⁶⁵ as well as in society at large.
- **Recommendation 3: Make SNAP responsive to the needs of all participants by applying a racial equity lens to the program.** The Supplemental Nutrition Assistance Program (SNAP) has been tremendous in supporting individuals and families experiencing food insecurity, including communities of color. This report outlines that as a result of unresolved structural racism, BIPOC communities experience higher rates of contracting and dying from COVID-19, as well as higher rates of food insecurity and unemployment during the pandemic. In addition, BIPOC households at or below the poverty line (who are also eligible for SNAP) face a growing racial wealth divide with their white counterparts at the same income level.¹⁶⁶ This has often resulted in many BIPOC households running out of food more quickly than their white counterparts.¹⁶⁷ To address that and make SNAP more responsive to the needs of BIPOC, the program should apply a racial equity lens by changing the SNAP benefits formula to provide additional support to BIPOC households, accounting for gender inequity, in proportion to how COVID-19 has impacted their households and communities. This would achieve the desired outcome of SNAP, which is for every individual and family to become food secure. Accounting for gender inequity has the added benefit of ensuring that BIPOC women, particularly Black women, who experience both anti-Black racism and sexism, receive the targeted support they need to become food secure.

Many organizations are calling for an increase ranging from 15 percent to 30 percent in the SNAP maximum benefit, a broad-based policy that raises the floor for all participants. These efforts are really important and need to happen in conjunction with efforts to undo the impact of structural racism on hunger and health, the longer-term goal of this report. Congress should authorize changing the SNAP benefits formula to provide additional support to BIPOC households, in proportion to two factors: (1) the racial wealth divide before the pandemic began, disaggregated by gender, and (2) the impact of the crisis on each BIPOC community, also disaggregated by gender. The impact can be measured using indicators such as higher death rates and unemployment rates, income divides, and other economic factors that prevent a family from being food secure.



- **Recommendation 4: Change the USDA interpretation of the regulations governing emergency SNAP benefits to be racially equitable, account for gender inequity, and be in proportion to the impacts of COVID-19 on participants' households and communities.**

Current SNAP policies are excluding 7 million households that already receive the maximum monthly benefit—households that presumably have some of the highest levels of food insecurity of all households eligible for SNAP— from receiving additional support during the pandemic.

Black households experience what USDA terms “very low food security” at three times the rate of their white counterparts,¹⁶⁸ and thus they are more likely to be among the 7 million households that have been excluded from emergency assistance. Black women are even more likely to fall into this category than Black households as a whole since job segregation by race and gender raises their representation in the country’s 10 lowest paying jobs. USDA should amend its regulations to provide additional support to these households proportionate to the impact of COVID-19.

- **Recommendation 5: Promote racial equity in the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).** In addition to the seven recommendations on WIC featured in “[Applying a Racial Equity Lens to Nutrition Programs](#),”¹⁶⁹ published by Bread for the World Institute in 2019, numerous action items would enable WIC to promote racial equity during COVID-19. Three of these are: (1) provide BIPOC women with grocery funds, breastfeeding support, pre-labor support, and post-partum support proportionate with current racial divides, historical trauma, and the negative impacts of COVID-19 that each community of color has experienced; (2) continue to work with states to provide all participants with EBT cards rather than checks; and (3) offer culturally competent mental health support related to the impacts of racism during a pandemic. The stress of the combination of racism and the pandemic exacerbates health conditions—for example, disproportionate problems with lactation among BIPOC new mothers.

- **Recommendation 6: Continue funding meals for BIPOC families when school is not meeting in-person by supplementing this cost in Child Nutrition EBT,** proportionate to racial inequities as shown by rates of COVID-19 infection and death; economic losses such as unemployment and food insecurity; and the racial wealth divide. The funding calculations should also account for gender inequities. This would mean that Black women would receive the highest level of Child Nutrition EBT per child.
- **Recommendation 7: Increase supplemental funding targeted to BIPOC-led organizations, especially BIPOC women-led organizations,** serving their communities during COVID-19, including by providing food, clothing, and other emergency supports that BIPOC households need. Resources should be provided in ways that are both proportionate to the rates of COVID-19 infection and death in BIPOC communities and congruent to the racial wealth divide in their communities.



Housing Security

- **Recommendation 8: Work with states to extend eviction moratoriums for BIPOC households, especially BIPOC female-headed households,** in areas with the highest levels of COVID-19 deaths, economic loss, and food insecurity. Black women have been targeted by racially inequitable eviction policies before and during the pandemic. Eviction prevents families from sheltering safely in place during COVID-19, and it also increases their susceptibility to contracting the virus and facing food insecurity.
- **Recommendation 9: Prohibit utility shutoffs during the pandemic.** This includes water shutoffs, which have been used as a targeted tactic toward eviction of female-headed households in particular. Having access to clean water is critical to adhering to CDC safety guidelines.
- **Recommendation 10: Work with states to cancel rent, provide emergency assistance to BIPOC renters, and prohibit eviction.** Eviction moratoriums for BIPOC households should be extended (see recommendation 8). Once moratoriums are no longer in effect, however, many BIPOC households, especially households headed by Black women, will be responsible for paying months of back rent that accumulated during the pandemic. This will likely increase evictions since few people can afford to make large extra rent payments. Evictions exacerbate both food security and susceptibility to COVID-19 infection and death; two main reasons for this are that sheltering in place becomes impossible and the renter's credit record is damaged. States should cancel rent and/or BIPOC renters should be given rental assistance in proportion to the impact of the virus on their community. No one should be evicted during the pandemic and the post-pandemic economic recovery.



Income Security

- **Recommendation 11: Increase stimulus payments to BIPOC families in areas with the highest rates of COVID-19 infection, death, economic loss, and food insecurity,** in proportion to these racial inequities and accounting for gender inequity. The spring 2020 stimulus payments were universal and did not account for the disproportionate economic and physical impacts of COVID-19 on BIPOC communities. Centering Black women would result in their receiving the largest increase in stimulus payments, followed by other BIPOC men and women.
- **Recommendation 12: Continue unemployment compensation for BIPOC households in areas with the highest rates of COVID-19 death, economic loss, and food insecurity.** This approach would redistribute resources to BIPOC households who have lived with the greatest

inequities. It would also include eligibility for BIPOC undocumented immigrants living in these areas with no Public Charge penalty.

- **Recommendation 13: Provide racially equitable support and safety for BIPOC workers in “essential” jobs.** Enforce worker safety standards by mandating that employers offer protective equipment, restructured work environments, improved ventilation systems, and regular testing to reduce COVID-19 transmission, regardless of workers’ documentation status. Also mandate an increase in pay by raising the minimum wage to a living wage and requiring specified employee benefits. In addition to these broad-based approaches, a racial equity lens should be applied to employer-based benefits—for example, sick leave and child care—for BIPOC workers, proportionate with the impact of the crisis on their racial/ethnic community. For example, because African American workers are more likely to contract the virus or have family members who contract the virus, they would be given additional sick leave to care for themselves and family members.
- **Recommendation 14: Provide retroactive hazard pay for all workers who worked in person at workplaces earlier in the pandemic, including additional targeted amounts based on disproportionate susceptibility to contracting or dying from COVID-19 because of race and/or gender.** Currently, hazard pay is capped based on what particular jobs pay, but it should instead account for the degree of exposure people had at work and the degree to which they are more susceptible to contracting and dying from the virus. This is particularly important since exposure at work or while commuting is the top cause of increased susceptibility to contracting the virus.
- **Recommendation 15: Apply a racial equity lens to plans to reduce unemployment as states and municipalities reopen.** The plans should be co-created by BIPOC community members and leaders, and they should include enforcement of laws against racial discrimination in employment. Congress or administrators at the federal or state level should allocate funds to increase monitoring and other anti-discrimination efforts for a range of jobs and pay grades in each sector. Racial equity can be applied by enforcing anti-racial discrimination employment laws at each stage in the hiring process. Policy makers could require employers to report all of the applications they receive, and the demographics of who they hire, to identify potential gaps and racially implicit biases, and they could allocate funds to monitor this data.



Health Security

- **Recommendation 16: Apply a racial equity lens to current COVID-19 prevention and treatment efforts.** Beginning now, decisions concerning the locations, hours of operation, and staffing of COVID-19 testing sites should be based on what is most equitable and useful to communities most susceptible to developing COVID-19 and to becoming seriously ill if they do contract the virus. A racial equity lens should also be applied to distribution plans for treatments as they become available, vaccines as they become available, PPE, and other equipment and supplies.
- **Recommendation 17: Release people who are currently incarcerated based on applying a racial equity lens to the policies for release now in place.** Releasing people to limit transmission of the virus is the goal, but the pace of releases has been far too slow to accomplish this. Also, the process of determining who is to be released is not racially equitable. Black men and other BIPOC, as the majority of those incarcerated, should be the majority of those released, but so far this is not happening. People eligible for release include women who are pregnant, women and men with preexisting health conditions, elderly people, and people identified as a “low risk” for reoffending. Both people who are being released and people who remain should receive adequate personal protection equipment. This is legally required for incarcerated people, but it has not been enforced, nor have sufficient resources to fulfill it been allocated.



Education Security

- **Recommendation 18: Co-develop a plan to support BIPOC children who are unable to learn successfully in the online settings required during the pandemic.** Support should be given in a racially equitable way and proportionate to the historical trauma of BIPOC communities, and students should be provided support proportionate to the impact of COVID-19 on their racial and ethnic communities.
- **Recommendation 19: Co-develop a plan to support BIPOC teachers who are supporting BIPOC students living in areas of racialized concentrated poverty during the pandemic.** This would include financial support for computers, Internet subscriptions, and other equipment and services required to teach online, as described by teacher Khadyjah Thomas earlier in the report.

Recommendations for Longer-Term Systemic Responses

Beyond meeting immediate and ongoing needs and ensuring that current and upcoming COVID-19 relief programs are framed and implemented in racially equitable ways, the United States must adopt a comprehensive longer-term approach to breaking the cycle of structural racism and food insecurity. Along with being racially equitable and centering Black women, the strategy needs to address structural problems to achieve justice rather than remain oriented toward charity. A charity model does not identify and respond to the causes of the problem, and in the development, implementation, and evaluation of solutions, it does not center and respect the needs, leadership, and power of the BIPOC communities most impacted.

The recommendations below should be implemented in conjunction with one another to achieve racial equity in the context of food insecurity and COVID-19. Pursuing these recommendations in isolation will not succeed in finding sustainable solutions to the full scope of structural racism as it affects hunger and health.



Reduce and Then Eliminate the Racial Wealth Divide

Plan and implement targeted efforts to reverse the racial wealth divide between BIPOC and white communities and to reduce the gender wealth divide within all BIPOC communities.

- **Ending structural racism in the financial sector will require a systematic plan that applies to all financial institutions,** including banks, brokerages, Community Development and Financial Institutions (CDFIs), credit unions, and other institutions that make capital available. The largest area of concern is racial and gender discrimination in access to mortgages, business loans, and other methods of accessing capital and building wealth—in matters such as who is eligible to borrow and the rates and other terms they are offered. Another need in the financial sector is establishing and enforcing equitable hiring and other personnel policies.
- **Support a community-driven response to build assets, capital, and wealth among BIPOC-led organizations and institutions that center Black women.** The racial wealth divide at the community level needs to be addressed through funding for existing and new community owned and operated organizations and service providers. BIPOC women have been overlooked by financial institutions. They need to be supported and respected by investors, with their voices heard, their needs acknowledged, and their expectations met.
- **Provide funding to break generational cycles of racialized concentrated poverty,** including funding efforts led by Black women^{170 171} to build infrastructure for robust, physically accessible, reliable, and affordable transportation systems, educational institutions, and housing; healthy and affordable food; and green space and other community resources that enhance quality of life.

- **Support the efforts of Community Development Financial Institutions (CDFIs) in general, BIPOC-led CDFIs, and BIPOC depository institutions.** Legislation such as H.R. 7993 titled “Promoting and Advancing Communities of Color through Inclusive Lending Act”¹⁷² is a good step in the right direction, but the legislation must provide support to each BIPOC community based on its unique historical traumas. In addition, the legislation must include details on how it will appropriate funding in a racially equitable way.
- **Implement an individual and household-level strategy to bridge the racial wealth divide.** In addition to support for homeownership, building equity, and debt relief initiatives, this strategy can include retirement savings support programs and intergenerational wealth accumulation instruments such as child savings accounts^{173 174} or baby bonds,¹⁷⁵ an approach that has been credited with reducing racial wealth inequities. Applying a racial equity lens would mean that the amounts allocated to children would be tailored to the racial wealth and income divides that affect them. Black women and other women of color would receive additional resources for their children to help make up for the gender divides in wealth and income that leave them with less money to invest in their children’s education and future.
- **Support the creation of a commission to study reparations for African American descendants of U.S. slaves.** This commission should center the leadership and scholarship of African Americans. It should explore what could be done to reverse or otherwise mitigate the impacts of more than 400 years of historical trauma. These impacts include higher hunger and malnutrition rates, higher poverty rates, segregation, health inequities, and the very large racial wealth divide.



Reduce and Then Eliminate Racialized Concentrated Poverty

Racially inequitable housing and tax policies, as well as de facto housing segregation, have created and fueled the growth of racialized concentrated poverty. BIPOC neighborhoods in areas of racialized concentrated poverty do not have access to a wealthy tax base to fund public institutions and community resources, including schools, banks, grocery stores, recreational spaces, and healthcare centers. The United States must eliminate areas of racialized concentrated poverty in ways led by BIPOC through community and household level approaches that are closely aligned with efforts to reduce and then eliminate the racial wealth divide. Black public health expert David R. Williams of Harvard University advocates a “Marshall Plan” to accomplish this.¹⁷⁶

In its 2017 Hunger Report, Bread for the World Institute urged policymakers to set a goal to eliminate areas of racialized concentrated poverty by 2025. New information and analysis in this report, such as that from Louisiana, emphasizes the importance of setting and reaching this goal since it outlines the intergenerational impacts of food insecurity experienced by BIPOC adults, youth, and children who live in such areas.

Some key elements of a plan to do this include:

- **Models that aim to eliminate concentrated poverty should be made racially equitable.** There have been proposals to eliminate areas of concentrated poverty, including but not limited to the 10:20:30 plan,¹⁷⁷ so named because it calls for at least 10 percent of any agency’s appropriated program funds to be invested in persistent poverty communities, defined as counties where 20 percent or more of the population has lived below the federal poverty line for at least 30 years. To be racially equitable, plans such as 10-20-30 must incorporate data at the sub-county level to identify areas of racialized concentrated poverty in BIPOC communities. These areas could be missed in counties that do not have a BIPOC majority. Funding to support each community should be proportionate to the historical trauma it has experienced and should be provided directly to BIPOC-led and operated community institutions, businesses, nonprofits, and initiatives.

- **End the practice of funding public services and resources such as schools, hospitals, and social services with local property taxes.** This promotes a charity model—financial need will be greater in areas that have been segregated by race and systemically impacted by racism. Neighborhoods whose residents are primarily BIPOC often have large numbers of households living below the poverty level as a result of racially inequitable policies.
- **Fund community-led and community-owned efforts to revitalize affordable housing units.** A plan should be co-created by BIPOC residents of areas of racialized concentrated poverty to determine a process for building and restoring affordable housing units. Community members should identify top priority sites for improvements as well as lists of code violations and repairs that are needed to bring housing conditions up to code—an uncontaminated water supply, no toxins in items such as paint and water pipes, etc. Ideally, BIPOC residents should be able to view their new homes as sanctuaries—the opposite of the places where many low-income people have had to live. Racially equitable policies should be in place to make these housing units affordable for BIPOC renters. For example, families could be charged at most 20 percent of their income for rent, and have the option to save 10 percent of their income to prepare for homeownership.
- **Fund community-led and community-owned efforts to help BIPOC renters become homeowners in a racially equitable way.** This plan should also be co-created by BIPOC residents. Financing should take into account the wealth these communities lost to redlining and predatory housing contracts. For this reason, financing should be offered in the form of grants rather than loans. These plans should have attainable dates for the actual home purchases. Buyers of homes should be offered coaching and technical assistance through programs such as the Neighborhood Assistance Corporation of America (NACA),¹⁷⁸ which should be scaled up to meet the needs in a racially equitable way.

Implementing recommendations to reduce and then eliminate the racial wealth divide will lead to the establishment of more community-level institutions such as BIPOC-owned and operated banks. These banks should be given racially equitable capital proportionate to the historical trauma each BIPOC community has experienced, thereby enabling them to make needed loans to BIPOC homeownership and revitalization efforts rather than these initiatives relying on outside developers and institutions. Cumulatively, such capacity-building will increase the wealth of BIPOC communities and eliminate racialized concentrated poverty. The plan should also include other means of increasing property ownership in BIPOC communities, including but not limited to housing and business co-ops.

- **With BIPOC experts, co-develop a plan to end environmental racism.** The greater likelihood of death among BIPOC who contract COVID-19 is, in part, a consequence of practices such as targeting areas of racialized concentrated poverty for facilities that emit toxins.¹⁷⁹ Neighborhoods of racialized concentrated poverty are more likely to have contaminated water, lead paint, and other environmental hazards.^{180 181 182} A plan to end environmental racism would also create more green spaces, with trees to make the air cleaner, and make communities more walkable.

DID YOU KNOW THAT...

Data is rarely cross-tabulated by race and gender?

Many datasets distinguish between genders or among races, but not both simultaneously. And some state data is still not disaggregated by race. This means that the intersectional realities of a Black woman are often lost, resulting in policy responses that may not be congruent with her needs.

- **End predatory and oppressive practices that persist in areas of racialized concentrated poverty.** Examples of actions that reduce racial divides include removing predatory financial services and replacing them with non-predatory, racially equitable, community-based and led alternatives; enacting policies that discourage the current over-saturation of fast food chains and advertising in BIPOC neighborhoods; and rethinking school and voting boundaries in a racially equitable way.

- **Co-develop a plan with BIPOC communities that eliminates the structural inequities BIPOC children experience in their schools, homes, and communities.** The plan should be co-developed with BIPOC children, families, teachers, and community members. It should be holistic and include support for BIPOC children in the environments where they live, learn, play, and receive care, proportionate to the racial historical trauma each BIPOC community has experienced. Efforts to eliminate racialized concentrated poverty and the racial wealth divide at the community and household levels should work in concert with efforts to remove inequities in access to nutritious, affordable, and accessible food options, clean air to breathe, safe water to drink, and well-funded schools to attend. See also Finding 2 of the case study on Louisiana.
- **Undo job segregation and increase pay of BIPOC workers, especially BIPOC women.** Increasing household income is critical for any plan seeking to address racialized concentrated poverty. The Institute has been advocating for the end of job segregation by race and gender, particularly practices that leave some people with little choice but to work in one of the 10 lowest paying jobs in the United States.
- **End the mass incarceration and racialized over-policing of BIPOC people, especially Black people.** This report discusses the devastating impact that racially targeting Black people, and Black men in particular, has had on Black women. Any plan to end racialized concentrated poverty must also end racialized policing. Shift investments instead to public services, such as education, mental health support, parks and recreation, and other community-led social services.
- **Center the needs and leadership of BIPOC returning citizens to develop a racially equitable reentry plan that accounts for gender inequity.** The plan should include a mandate to collect and report data by race *and* gender, so that the needs of Black women who are either returning from incarceration or impacted by the return of a family member from incarceration are taken into account. Black women who are returning citizens, for example, have a higher unemployment rate than Black men (43.6 percent versus 35.2 percent),¹⁸³ yet this information is lost when race is the only dimension examined. It is imperative that within the application of a racial equity lens, gender inequity is centered so that the needs of Black women are seen and addressed.



In addition to job and education support, as well as improved policies in housing, parole, probation, and corrections, this reentry plan should:

- include legislation that prohibits employment discrimination against returning citizens;
- enforce laws against racial discrimination that some employers resort to when it is no longer legal to discriminate against returning citizens;
- connect returning citizens with capital and other resources to build sustainable businesses, secure assets, and create jobs;
- change parole and probation laws to eliminate restrictions that make it almost logistically impossible for returning citizens to get jobs, find a place to live, and effectively reintegrate;
- change housing laws for returning citizens, including laws that permit discrimination against them and laws that bar them from living with family members in section 8 subsidized housing;
- provide a copy of each person's birth certificate and/or other identification prior to release;
- allow eligibility for social programs, including but not limited to SNAP, WIC, and TANF; and
- provide proportionate funding for jobs, housing, education, and other supports for returning citizens based on the rate that their racial community has been over-policed and racially targeted.



Eliminate Racial Health Inequities in U.S. Healthcare Systems, with a Specific Focus on Maternal and Child Health Outcomes

The pandemic has exacerbated longstanding racial inequities in health care. The initiatives described below and other efforts would instead spur progress toward eliminating racial divides.

- **Conduct additional research and begin collecting disaggregated health data within BIPOC communities by gender and then by other identity factors such as ethnicity.**¹⁸⁴ Centering the needs of Black women requires that data be disaggregated by race *and* gender. The analysis in this report, along with analysis from other researchers, affirms that structural racism and the preexisting conditions it created explain why Black, Indigenous, and Other People of Color are experiencing the highest rates of contracting and dying from COVID-19. Black women are most seriously impacted due to their intersectional identity of being both Black and female. Another prominent identity factor is ethnicity—for example, the distinction between Black women who are Latina and Black women who are not Latina. Without data disaggregated by race *and* ethnicity, programs cannot be designed to fully meet community needs.

Additional research is needed to determine the most targeted interventions to prevent as many COVID-19 infections as possible.¹⁸⁵ Public health practices to prevent the transmission of COVID-19 will be vital for the foreseeable future, even after there is a safe and widely available vaccine. To design effective prevention efforts, it is essential to know which communities and subgroups within each community have the highest infection rates, where they are being exposed to the virus, and what specifically is causing deaths.

For example, it is not enough to say that “African Americans” are the intended audience for prevention efforts. Rather, “African Americans” needs to be disaggregated by gender and ethnicity, after which it is important to have access to further details.

Which people in the African American community are of most concern and why? Are they primarily African American grandparents who take care of their grandchildren while parents are at work, and then contract the virus from parents when they return for their children? Or is it the

numerous African Americans who take public transit to work and are more likely than others to become severely ill if they are exposed to the virus? Or maybe a large number of infections can be attributed to working conditions in industries that employ many African Americans? The relative importance of many other potential factors is also important. These can range from preexisting health conditions, to lack of health insurance and/or an established relationship with a healthcare provider, to testing facilities not being located in accessible areas.

- **Support efforts led by Black, Indigenous, and Other People of Color to improve the health outcomes of BIPOC mothers, including reducing maternal mortality and morbidity.** The Black Maternal Health Caucus, in concert with Black Mamas Matter and other initiatives led by Black women, has drafted legislation called the Kira Johnson Act¹⁸⁶ in honor of a Black mother who died shortly after giving birth (read her story on page 23). The bill would provide grants to community organizations led by Black women to scale up identified best practices tailored to Black women, designed to reduce and then eliminate racial divides in prenatal and postnatal health outcomes, mortality rates, and the much larger arena of social determinants of health. The act would also include grants for racial bias training for healthcare professionals.
- **Mandate ongoing training in active anti-racism, recognizing implicit racial bias, and disrupting white supremacist narratives** for all healthcare providers and staff of public health entities. Current and incoming hospital and healthcare staff, including doctors, nurses, medical school faculty and students, other practitioners, executive leadership, and administrators, should follow a schedule of training. In addition, identify and adapt monitoring and evaluation plans and oversight mechanisms for healthcare systems.
- **Design equitable pathways for representative racial representation of BIPOC healthcare providers, nutritionists, dieticians, and public health professionals.**¹⁸⁷ Representative racial representation means that the racial composition of these groups of professionals is congruent to the racial composition of the communities served. Entry points could include scaling up the Health Careers Opportunity Program or following the plan to “diversify” healthcare providers by race that is included in the Prenatal Workforce Act of the Black Maternal Health Momnibus.¹⁸⁸ The goal is not diversity, however, but equitable racial representation. In addition, this act should be expanded to include nutritionists, lactation consultants, and other providers that Black women and other women of color encounter during prenatal and postnatal checkups and treatment.
- **Mandate Medicaid expansion in every state.** This is a universal policy that is needed to raise the floor and provide affordable health care for Black, Indigenous, and Other People of Color. Many Black women in low-paying jobs work in southern states that have not yet expanded Medicaid. Lack of Medicaid benefits reinforces racial health inequities, including maternal mortality.



A Wider Strategy to End Structural Racism

Policymakers should convene a taskforce to outline a plan to end structural racism in all its forms, focusing particularly on anti-Black racism and centering Black women. Such a comprehensive plan will coordinate anti-racist efforts in individual policies and programs and also help identify topics that may have been overlooked. The plan should use anti-racism best practices, scaling them up whenever possible.

The plan should be developed with leadership from members of the BIPOC community representing various U.S. regions and a range of racial, ethnic, gender, and income groups. Leadership should include BIPOC people from communities that have been most impacted by economic marginalization and have

the highest rates of food insecurity, such as African Americans, other U.S. residents of African descent, people from First Nations/Indigenous communities, Latino/as, and Native Hawaiians and Pacific Islanders. White people who practice anti-racism and understand how to be a white ally against racism should also participate in formulating the plan.

The group should also include BIPOC who confront racism in their daily life in ways that are affected by other identity elements, such as gender, class, ability, citizenship status, or status as a returning citizen. Participation of people from a variety of income and wealth levels, ages, education levels, employment sectors, and household types is important. The group should also have racially equitable representation from various professional sectors, such as scholars, advocates, practitioners, and anti-racist organizations of color. The plan should include a priority focus, led by Black women, on centering Black women, and identifying and responding to the ways in which gender inequities affect Black women.

The plan should also articulate robust enforcement mechanisms. It should identify potential ways forward on an initiative to bring federal actors together with U.S. state and local leaders to co-lead anti-racist efforts with BIPOC leaders, experts, and communities. In addition, this plan should consider the creation of a Racial Equity Office in the White House.^{189 190} This office would be adequately funded and staffed and help provide an anti-racist framework to design and implement policies, in a way that not only centers BIPOC but also provides responses that are proportionate to the racial wealth divide and historical racial trauma that each BIPOC community faces. This office should be led by BIPOC leaders who have a proven track record of promoting racial equity. The office would help shape all policies and work closely with each agency to promote racial equity in non-legislative efforts. In addition to the outcomes of policies, this office would be instrumental to ensure that the processes for how policies are designed and implemented are racially equitable and co-created and led by BIPOC leaders already doing this work in their respective communities. In addition to overseeing these processes and promoting racial equity in non-legislative efforts, this office would also work closely with a newly created Office of Racial Equity in Congress. Together, these offices would use the same anti-racist framework to work directly with BIPOC communities to co-develop legislative policies that are racially equitable and led by BIPOC communities, eliminate racial wealth divides, and repair the harm from historical trauma.



Joseph Moller for Bread for the World

Endnotes

1 BIPOC is a term used by Race Forward, a racial justice BIPOC-led organization that includes a BIPOC Project. <https://facingrace.raceforward.org/speaker/fiona-kanagasigam>

2 SNAP. American Community Survey. 2018. ACS 1-Year Estimates Subject Tables. Table ID: S2201. <https://data.census.gov/cedsci/table?q=African%20american%20rate%20of%20SNAP&tid=ACST1Y2018.S2201&t=Black%20or%20African%20American%3ASNAP%2FFood%20Stamps&vintage=2018>

3 The five Asian communities with the highest levels of food insecurity before the COVID-19 pandemic were Burmese (42.9 percent), Hmong (32.2 percent), Cambodian (23.2 percent), Laotian (20.8 percent), and Vietnamese (13.3 percent). Since this data is disaggregated by ethnicity, some groups, e.g., Burmese, have higher rates of food insecurity than those of some other groups of color whose data was not disaggregated by ethnicity/tribe/country of origin (e.g., African American, Indigenous, Latino/a). If data was disaggregated within these communities of color, for example by ethnicity or home country, we anticipate that some groups would also have higher levels of food insecurity than others.. Source: Gamblin, Marlysa. "Applying Racial Equity to U.S. Federal Nutrition Programs." Bread for the World Institute. 2019. <https://www.paperturn-view.com/us/bread-for-the-world/applying-racial-equity-to-u-s-federal-nutrition-assistance-programs?pid=NTg58712&p=3&v=3>

4 SNAP. American Community Survey. 2018. ACS 1-Year Estimates Subject Tables. Table ID: S2201. <https://data.census.gov/cedsci/table?q=African%20american%20rate%20of%20SNAP&tid=ACST1Y2018.S2201&t=Black%20or%20African%20American%3ASNAP%2FFood%20Stamps&vintage=2018>

5 United States Department of Agriculture. Economic Research Services. <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx>

6 Sustainable Development Goals. United Nations. <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>

7 SNAP. American Community Survey. 2018. ACS 1-Year Estimates Subject Tables. Table ID: S2201. <https://data.census.gov/cedsci/table?q=African%20american%20rate%20of%20SNAP&tid=ACST1Y2018.S2201&t=Black%20or%20African%20American%3ASNAP%2FFood%20Stamps&vintage=2018>

8 The term "white" is not capitalized in order to avoid reinforcing current racial power dynamics between people of European descent and Black, Indigenous, and Other People of Color.

9 Lawrence, Keith, Aspen Institute on Community Change, and Terry Keleher, Applied Research Center at UC Berkeley. "Structural Racism." Presented at the Race and Public Policy Conference 2004. <https://www.racialequitytools.org/resourcefiles/Definitions-of%20Racism.pdf>

10 Gamblin, Marlysa. Racial Wealth Gap Learning Simulation. Bread for the World Institute. 2018. [Bread.org/simulation](https://bread.org/simulation); Gamblin, Marlysa. "Black and Food Insecure: Unpacking the Intersection of Race and Class." Harvard Kennedy School of African American Public Policy. <https://hjaap.hkspublications.org/wp-content/uploads/sites/14/2018/09/HJAAPP18-8.pdf>

11 "Types of Racism." Oppression Monitor Daily. January 2014. <http://oppressionmonitor.us/2014/01/31/four-types-racism/>

12 Gomez, Alan, Wyatt Grantham-Philips, Trevor Hughes, et al. "An unbelievable chain of oppression: America's history of racism was a preexisting condition for COVID-19." USA TODAY. Oct. 21, 2020. <https://www.usatoday.com/in-depth/news/nation/2020/10/12/coronavirus-deaths-reveal-systemic-racism-united-states/5770952002/>

13 Poonam Gupta, Dulce Gonzalez, and Elaine Waxman. "Forty Percent of Black and Hispanic Parents of School-Age Children Are Food Insecure." Urban Institute. December 8, 2020. <https://www.urban.org/research/publication/forty-percent-black-and-hispanic-parents-school-age-children-are-food-insecure>

14 "The color of coronavirus: COVID-19 deaths by race and ethnicity in the U.S." APM Research Lab. <https://www.apmresearchlab.org/covid/deaths-by-race>

15 Gamblin, Marlysa. "Applying Racial Equity to U.S. Federal Nutrition Programs." Page 35. Bread for the World Institute. 2019. <https://www.paperturn-view.com/us/bread-for-the-world/applying-racial-equity-to-u-s-federal-nutrition-assistance-programs?pid=NTg58712&p=3&v=3>

16 "Shared City-Wide Definitions of Racial Equity Terms." Office of Equity and Human Rights. City of Portland. "Racial Equity Framework" is defined as a process to deploy critical strategies to undo racist structures and a goal of replacing these structures to produce equitable outcomes. <https://www.portlandoregon.gov/oehr/article/581458>

17 Bell Hooks, African American author and thought leader, wrote "Ain't I A Woman: Black and Feminism" in 1981 to examine the effect of racism and sexism on Black women, the civil rights movement, and feminist movements from suffrage to the 1970s. She argues that the convergence of sexism and racism during slavery contributed to Black women having the lowest status and worst conditions of any group in American society. This framework also paved the way for the term "intersectionality" in 1989 coined by Kimberly Crenshaw (see endnote 21).

18 "Black women often ignored by social justice movements." University News. University of Michigan. <https://news.umich.edu/black-women-often-ignored-by-social-justice-movements/>

19 This webinar lifted up the voices of Black women who discussed the importance of centering Black women and disaggregating data by race and gender. Participants were: Valerie Wilson of the Economic Policy Institute, Naomi Walker of the Economic Policy Institute, Anne Price of the Insight Center for Community and Economic Development, Julianne Malveaux of the Economic Policy Institute Board, Jaribu Hill of the Mississippi Workers Center, and Rhonda Vonshay Sharpe of WISE. "Rebuilding the House that Anti-Blackness Built in Our COVID Response." Economic Policy Center, Webinar. June 1, 2020. <https://www.epi.org/event/rebuilding-the-house-that-anti-blackness-built-in-our-covid-response/>

20 Black women experience a phenomena known as "role accumulation" which is defined as having multiple, often conflicting roles that overload the individual and lead to role strain. As a result of role accumulation, African American women have historically been characterized as the backbone of their communities and have held other cohesive roles in their families and communities. This accumulation of roles has negatively impacted the physical, mental, and financial health of African American women. "Multiple Roles, Multiple Lives: The Protective Effects of Role Responsibilities on the Health Functioning of African American Mothers." U.S. National Library of Medicine. National Institutes of Health. 2009. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2743987/>

21 Ibid.

22 Crenshaw, Kimberly. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." University of Chicago Legal Forum. Volume 1989. Issue 1. Article 8. <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf>

23 Ibid.

- 23 Price, Anne, Jhumpa Bhattacharya and Dorian Warren. Centering Blackness: The Path to Economic Liberation for All. The Medium. Insight Center for Community Economic Development. June 18, 2020. <https://medium.com/economicsecproj/centering-blackness-the-path-to-economic-liberation-for-all-f6c2c7398281>
- 24 Anne Price, President, the Insight Center for Community Economic Development. "A Byproduct of White Supremacy: Anti-Black Racism." Racial Equity and Hunger National Learning Network, Webinar. September 15, 2020. <https://www.gotostage.com/channel/d7336b48d5274d218c32e3cad2d3bb1f/recording/c5fc014575fc4079895b327125c6e70c/watch?source=CHANNEL>
- 25 Refer to acknowledgements on page 3 that features the scholarship and expertise of the many Black women who have contributed to this report.
- 26 Gamblin, Marlysa. "Applying Racial Equity to U.S. Federal Nutrition Programs." Page 35. Bread for the World Institute. 2019. <https://www.paperturn-view.com/us/bread-for-the-world/applying-racial-equity-to-u-s-federal-nutrition-assistance-programs?pid=NTg58712&p=3&v=3>
- 27 The Louisiana Department of Health has been updating data on COVID-19 (on a daily basis for most of the data) at <http://ldh.la.gov/Coronavirus/>. We used data that was updated on 5/31/2020 on cumulative deaths per 100,000 population by parish, and deaths by race by parish for parishes reporting 25 or more cumulative deaths.
- 28 In addition to the data on COVID-19 from Louisiana, this new analysis on Louisiana was based on data collected previously by Bread for the World Institute, focused on multiple factors related to food insecurity among the five states with the highest hunger rates in the United States, which included Louisiana. Findings from that study are forthcoming.
- 29 Bread for the World Institute used data collected and analyzed in the summer of 2019 to build on current "real time" data sources that show the realities of the virus in Louisiana, which is one of the five hungriest U.S. states and includes counties whose hunger and poverty rates are among the highest in the nation.
- 30 Given the demographics of Louisiana, we only looked at the relationship of number of deaths to Black percentage of population (and percent of SNAP and percent of poverty), and non-white (which is mostly Black) percentage of population. If we had studied Texas, New Mexico, and New York, we might have a different finding that may in fact show a strong relationship with being Black, but may also show a strong relationship with being BIPOC more generally. Regardless, the top finding remains that race is the strongest indicator determining one's likelihood of contracting and dying from COVID-19.
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INSTITUTE

President, Eugene Cho | Director, Asma Lateef

425 3rd Street SW, Suite 1200, Washington, DC 20024

Tel 202.639.9400 Fax 202.639.9401

institute@bread.org www.bread.org/Institute

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