Samson Chama

EXPLORING THE EXPERIENCES OF MARGINALIZED COMMUNITIES DURING THE COVID PANDEMIC

Implications for Social Justice

Activism and Social Movement Studies

Collection Editor
R. ANNA HAYWARD

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Abstract

The COVID-19 pandemic had a negative and profound impact on different population groups. In the U.S., the final official tally of deaths due to the pandemic was 350,831 in 2020 (CDC, 2020). However, the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS) posted an even higher number that was closer to 385,000 deaths (CDC, 2020). The overall impact of the COVID-19 pandemic could not be underestimated as it literally altered social, cultural, political, environmental, and economic spheres of the U.S. population. These spheres are critical for survival as they affect psychological growth and sustainability, including people's living standards and quality of life. As the pandemic spread like wildfire, its impact on different populations was experienced at different levels. The pandemic highlighted social justice issues such as socio-economic and health inequities, including structural injustices. These were manifested in a plethora of challenges which included inaccessibility to healthcare and inadequate support for particularly vulnerable populations. The pandemic also led to increased burnout in professional settings, moral dilemmas, and injuries, as well as unintended shifts in institutional and agency work dynamics. In general, it underscored the importance of social justice, advocacy, and brought attention to the need for more equitable healthcare access, social and economic support for different populations, especially the marginalized groups. Ultimately, this reflected broader implications for practice and

social justice. Certainly, the COVID-19 pandemic profoundly reshaped the lives of diverse populations, thereby exposing and amplifying existing social, economic, and health inequalities. Despite its universal threat, its impact was uneven, especially on marginalized populations who included low-income workers, the elderly, and those with pre-existing health conditions. These populations faced heightened vulnerability due to limited access to healthcare, unstable employment, and inadequate social protections. Further, the pandemic not only revealed systemic gaps in public health infrastructure but also underscored the urgent need for equitable social and economic policies that protect all segments of society in times of crisis. This book takes a deeper dive into some of the critical social areas and concerns mentioned above. The six chapters provide a robust overview of specific areas of the impact of COVID-19 on different populations. They highlight and discuss areas pertaining to social justice, racism and discrimination, poverty, homelessness, jail and prison system, underlying health conditions, and policy implications for practice and social justice. Each chapter is punctuated by learning objectives and discussion questions that aim to generate engaging and interactive discourse on the subject.

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Preface

My idea to write this book emerged from the post-pandemic reflections I had over time regarding the COVID-19 pandemic and its impacts on different population groups, especially the marginalized. I constantly pondered what might have been done or put in place to reduce the devastating effects of the pandemic. My knowledge of those who had lost their lives to COVID-19, including those who had lost loved ones to the pandemic, propelled me to seriously start thinking about how I could make a tangible difference in this crisis so that we were better aware and prepared for any future pandemics that might occur. Over time, my thoughts and inclinations led me to ask thought-provoking questions about the world around me. I wanted to dig deeper and explore the intersection of social justice and the challenges brought about by past and future pandemics. I also wanted to highlight how this intersection might provide a platform from which to create awareness around social justice while at the same time providing and suggesting ways to combat the vestiges of the COVID-19 pandemic. Therefore, in writing this book, my goal is not only to share useful and pragmatic lessons vis-a-vis the COVID-19 pandemic but to also to share and inspire readers to engage with their own questions and observations. Each chapter attempts to illuminate a different aspect of the pandemic while suggesting ways to effectively correct the imbalances that we often witness when different populations are assisted differently during times of pandemics and related crises. My hope is

that this book serves as a timely reminder of the need for readiness and preparedness for any future pandemics. It is an essential conjoiner that highlights some of the voices that were impacted. It also sheds light on the need for different social elements to come and pull together in times of uncertainty. It encourages hope and optimism in the face of danger by laying out useful measures and lessons that could reduce the overall impacts of any similar pandemics in the future. I am grateful to all the contributors whose commitment and efforts shaped these pages. Without their unwavering support and involvement, this book would not exist. It is my hope that readers find in these chapters not only knowledge and reflections but also the reassurance that exploring the unknown is a shared human endeavor regardless of one's background. This preface sets the stage for what follows, inviting readers to open the pages with interest and curiosity, an open heart, and a willingness to join me on a scholarly journey that is as much theirs as it is mine.

1
How we survived the impacts of COVID-19: Implications for practice and social justice

Samson Chama and Bwalya Chama

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Abstract

When the COVID-19 pandemic began to unfold in the U.S., the final official tally of deaths due to the pandemic was 350,831 in 2020 (CDC, 2020). However, the Centers for Disease Control and Prevention and (CDC) and the National Center for Health Statistics (NCHS) posted an even higher number that was closer to 385,000 deaths (CDC, 2020). The overall impact of the COVID-19 pandemic could not be underestimated as it literally altered social, cultural, political, environmental, and economic spheres of the U.S. population. These spheres are critical for survival as they

affect psychological growth and sustainability, including people's living standards and quality of life. As the pandemic spread like wildfire, its impacts particularly on African Americans at different levels of society were greater than any other population group. It is in this light that this chapter discusses how African American lives were impacted and shaped by the COVID-19 pandemic. The chapter provides an overview of specific areas of the impact of COVID-19 on African American health. The ensuing chapters 2 through 6 highlight and discuss areas pertaining to social justice, racism and discrimination, poverty, homelessness, jail and prison systems, underlying health conditions, and policy implications for practice and social justice.

Learning objectives

The following are the learning objectives of this chapter:

1. Articulate the key terms and concepts related to COVID-19.
2. Identify how different factors related to COVID-19 are interpreted in the context of social justice and health.
3. Discuss access barriers and access to treatment for populations affected by COVID-19.
4. Identify challenges to normal functioning during the pandemic.
5. Highlight policy implications for COVID-19.

The context

When the COVID-19 pandemic emerged, its impacts in the U.S. were characterized by two worlds: one was the epidemiological effects of the pandemic and the other was social injustices that were driven by race and discrimination. Racial injustice,

which was already an embedded social problem in American society, took a different turn as its devastating effects on the African American population became more evident. The situation was exacerbated by the fragility that was a part of many African American communities. This was expressed in healthcare disparities and in diseases such as diabetes and other cardiovascular diseases. Other social factors such as a fragmented healthcare system created excess morbidity and mortality within this population.

Introduction

African Americans and other marginalized groups have higher rates of the chronic conditions that increased the risk of COVID-19-related morbidity and mortality. Up to the time of the pandemic outbreak, inequities experienced by African Americans were not broadly considered in the context of systemic injustice (Simms, Fortuny & Henderson, 2009). This "*was a clear manifestation of the health and justice inequities that already existed in the U.S. The health and economic devastation of the COVID-19 pandemic was also evidenced in tandem with the continued unfair practices done against African Americans some of whom were captured on video*" (Nelson, 2016, p. 57). Some of the injustices, which took place in a COVID-19 atmosphere, resulted in a broad call for accountability and racial justice reform, including in academic and biomedical spaces (Campbell, Hudson & Tumin, 2020). Of special concern were the ordinary African Americans and professionals whose lives and various roles were unequally impacted by the pandemic. The rest of the chapter discusses and highlights some of the lived experiences of this population group.

African Americans were overrepresented among those who got infected and died from COVID-19, and experts recommended that more testing needed to be done in Black communities and that more medical services needed to be provided. Although the law requires insurance companies to "*cover testing for patients who go to their doctor's office or who visit urgent care or emergency rooms, generally African American patients were fearful of ending up with a bill if their visit did not result in a COVID-19 test. Furthermore, African American patients who lacked insurance or were underinsured were less likely to be tested for COVID-19, even when experiencing alarming symptoms*" (Lovelace, 2020, p. 129). These inequitable outcomes suggested the importance of increasing the number of testing centers and contact tracing in communities where African Americans resided. It also required providing more testing beyond symptomatic individuals and ensuring that high-risk African American communities received more healthcare workers. Strengthening social provision programs to address the immediate needs of this population, such as food security, housing, and access to medicines became very apparent. The provision of financial protection for currently uninsured workers serving the African American population was another area of concern.

Discussion

Impact on African American health and social justice

In international human rights law, the right to health is a claim to a set of social arrangements, norms, institutions, laws, and an enabling environment that can best secure the enjoyment of this

right. Further, Article 2 of the International Covenant on Economic, Social and Cultural Rights sets out the core provision relating to the right to health under international law (Mendenhalla, 2020; Maness et al., 2021). The United Nations Committee on Economic, Social and Cultural Rights is the body responsible for interpreting the covenant. In 2000, "*the Committee adopted a general comment on the right to health recognizing that the right to health is closely related to and dependent on the realization of other human rights*" (United Nations Committee on Economic, Social and Cultural Rights, 2000). In general, the health of the African American population during COVID-19 was driven by four factors, which were racism and discrimination, poverty, residential segregation, and underlying medical conditions (Pirtle & Whitney, 2020).

Racism and discrimination

The COVID-19 pandemic exposed the existing racism and discrimination. This was despite growing interest in understanding the association between the factors driving health and health outcomes for a long time by many academics, policymakers, and elected officials (Bailey, Feldman & Bassett, 2020). Unfortunately, many of the studies that were conducted to examine the effect of racism on health during the pandemic focused mainly on interpersonal racial and ethnic discrimination, with comparatively less emphasis on investigating the health outcomes of the pandemic. This would "*have required paying attention to the interconnected institutions whose linkages are historically rooted and culturally reinforced. In the context of the COVID-19 pandemic, acts of discrimination became very common and were taking place in a variety of contexts such as social, political, and historical*" (Walsh, 2020, p. 56).

Poverty

Data drawn from the 2018 Current Population Survey to assess the characteristics of low-income families by race and ethnicity shows that of the 7.5 million low-income families with children in the United States, 20.8% were Black or African American (while their percentage of the population in 2018 was only 13.4%) (Dubowitz et al., 2021). Low-income African Americans tend to live in densely populated areas and multigenerational households. These living conditions made it difficult for these low-income families to take necessary precautions for their safety and the safety of their loved ones on a regular basis during the pandemic.

In addition, many African American workers during the pandemic worked low-paying jobs that denied them even a single paid sick day. Workers without paid sick leave were more likely to continue to work even when they were sick, and this increased their exposure to other workers who may not have been infected with the COVID-19 virus (Carethers, 2020).

Similarly, the CDC noted that many African Americans who held low-wage but essential jobs such as food service, public transit, and healthcare were required to continue to interact with the public, despite outbreaks in their communities, which exposed them to higher risks of COVID-19 infection. According to the CDC, nearly a quarter of employed African American workers were employed in service industry jobs.. African Americans made up 12% of all employed workers but accounted for 30% of licensed practical and licensed vocational nurses, who faced significant exposure to the coronavirus Given the way the virus

spread, by the time a person knew that they were infected, they would likely already have infected many others in close contact with them both at home and at work.

Homelessness

Staying home was not an option for homeless people. African Americans in particular, despite making up just 13% of the U.S. population, account for about 40% of the nation's homeless population. This is according to the Annual Homeless Assessment Report to Congress (Allen, 2020). Given that people experiencing homelessness "*often lived in close quarters, had compromised immune systems, and were aging, they were exceptionally vulnerable to communicable diseases which included the coronavirus that causes COVID-19*" (Allen, 2020, p. 67).

Jail and prison system

The U.S. has nearly 2.2 million people in jails and prisons, the highest rate in the world (Carson, 2020). According to the U.S. Bureau of Justice, in 2018, the imprisonment rate among African Americans during COVID-19 was 5.8 times that of Caucasian men, while the imprisonment rate among African American women was 1.8 times the rate among Caucasian women (Amon, 2020). This overrepresentation of African Americans in U.S. jails and prisons became more pronounced during the COVID-19 pandemic. The Committee on Economic, Social and Cultural Rights' General Comment 14 states that *"states are under the obligation to respect the right to health by,* inter alia, *refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive,*

curative, and palliative health services" (Amon, 2020, p. 45). It further adds that "states have an obligation to ensure medical care for prisoners at least equivalent to that available to the general population" (Amon, 2020, p. 21). Despite this evidence, there was a very limited response to preventing transmission of the virus within detention facilities housing African American inmates. This included not achieving the physical distancing that was needed to effectively prevent the spread of COVID-19 (Tai, 2021).

Housing segregation

During the COVID-19 pandemic, "*segregation affected people's access to healthy foods and green space. It also increased excess exposure to pollution and environmental hazards, which in turn increases the risk for diabetes and heart and kidney diseases"* (Peek et al., 2021, p. 87). African Americans living in impoverished, segregated neighborhoods tended to live farther away from grocery stores, hospitals, and other medical facilities. These and other social and economic inequalities, more so than any genetic or biological predisposition, led to higher rates of African Americans contracting the coronavirus. Sociologist Robert Sampson noted that COVID-19 was exposing class and race-based vulnerabilities (Peek et al., 2021). He referred to this factor as "toxic inequality," especially the clustering of COVID-19 cases by community. He also pointed *out that "African Americans, even if they were at the same level of income or poverty as white Americans or Latino Americans, were much more likely to live in neighborhoods that had concentrated poverty, polluted environments, lead exposure, higher rates of incarceration, and higher rates of violence*" (Benfer et al., 2021, p. 87).

These factors led to long-term health consequences. The pandemic was concentrated in urban areas with high population density, which was, for the most part, characteristic of neighborhoods where African Americans lived. These concentrations placed a high burden on the residents themselves and on already stressed hospitals in these regions. Recommended practices to control the spread of COVID-19, such as social distancing and frequent handwashing were not always practical for those African Americans who were incarcerated or for the millions who lived in highly dense communities with precarious or insecure housing, poor sanitation, and limited access to clean water (Benfer et al., 2021).

Impact of underlying health conditions

African Americans have historically been disproportionately diagnosed with chronic diseases such as asthma, hypertension, and diabetes, underlying conditions that made infection with COVID-19 more lethal. The pandemic brought these disparities so vividly into focus. Dr Anthony Fauci, an immunologist who had been the director of the National Institute of Allergy and Infectious Diseases since 1984, had noted that "*it is not that African Americans are getting infected more often. It's that when they do get infected, their underlying medical conditions … wind them up in the ICU and ultimately give them a higher death rate*" (Carethers, 2020, p. 45). One of the highest risk factors for COVID-19-related death among African Americans was hypertension.

A recent study by Khansa Ahmad et al. analyzed the correlation between poverty and cardiovascular diseases, an indicator of why so many African American lives were lost during the pandemic.

They noted that the "*American healthcare system had not yet been able to address the higher propensity of lower socioeconomic classes to suffer from cardiovascular disease. Besides having higher prevalence of chronic conditions compared to Caucasians, African Americans experienced higher death rates*" (Carethers, 2020, p. 67). These trends existed prior to COVID-19 but the pandemic made them more visible, worrisome, and troublesome.

Policy implications for practice and social justice

The racially disparate death rate and socio-economic impact of the COVID-19 pandemic and the discriminatory enforcement of pandemic-related restrictions stood in stark contrast to the United States' commitment to eliminate all forms of racial discrimination. For example, in 1965, the United States signed the International Convention on the Elimination of All Forms of Racial Discrimination, which it ratified in 1994 (Wilder, 2021). Article 2 of the convention contains fundamental obligations of state parties, which are further elaborated in articles 5, 6, and 7 (Shim & Starks, 2021). Article 2 of the convention stipulates that *"each State Party shall take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists*" and that *"each State Party shall prohibit and bring to an end, by all appropriate means, including legislation as required by circumstances, racial discrimination by any persons, group or organization*" (Shim & Starks, 2021, p. 112).

The pandemic not only greatly affected the health of the most vulnerable African American community members but also

focused public attention on their rights and safety or lack thereof. Disparate COVID-19 mortality rates among the African American population reflected longstanding inequalities rooted in systemic and pervasive problems in the United States. This is reflected in the racism and the inadequacy of the country's healthcare system. Audrey Chapman noted that *"the purpose of a human right is to frame public policies and private behaviors to protect and promote the human dignity and welfare of all members and groups within society, particularly those who are vulnerable and poor, and to effectively implement them."*

"*A deeper awareness of inequity and the role of social determinants highlights the importance of using right*-to-health paradigms and models in response to the pandemic" (Wilder, 2021, p. 104). The Committee on Economic, Social and Cultural Rights has proposed some guidelines regarding states' obligation to fulfill economic and social rights. These are availability, accessibility, acceptability, and quality. These four interrelated elements are critical and essential to the right to health. They serve as a framework to evaluate states' performance in relation to their obligation to fulfill these rights. In the context of the COVID-19 pandemic, it would have been worthwhile to raise the following questions: What would governments and nonstate actors have done to avoid further marginalizing or stigmatizing African Americans? How might health justice and human rights-based approaches have grounded an effective response to the pandemic and built a better world afterward? What would have been done to ensure that responses to COVID-19 were respectful of the rights of African Americans? It is obvious that these questions might have

demanded targeted and well-thought-out responses not just in treatment but also in prevention.

Future recommendations

It is important to keep in mind that treating people with respect and human dignity, regardless of their backgrounds, is a fundamental obligation, and the first step in a health crisis. This calls for the recognition of the inherent dignity of people, the right to self-determination, and equality for all individuals. A total commitment to cure and prevent future COVID-19 infections must be accompanied by a renewed commitment to restore justice and equity.

Second, there needs to be a balance between mitigation strategies and the protection of civil liberties, without destroying the economy and material supports of society, especially as they relate to African Americans, and other minorities. As stated in the Siracusa Principles, *"state restrictions are only justified when they support a legitimate aim and are provided for by law, strictly necessary, proportionate, of limited duration, and subject to review against abusive applications"* (Wilder, 2021, p. 56). This means that future decisions about individual and collective isolation and quarantine will need to follow standards of fair and equal treatment and avoid stigma and discrimination against individuals or groups. Vulnerable populations require direct consideration regarding the development of policies that can also protect and secure their inalienable rights.

Third, long-term solutions will need to be crafted, and these will require properly identifying and addressing the underlying obstacles to the fulfillment of the right to health, particularly as

they affect African Americans. Further, relevant policies aimed at providing universal health coverage, paid family leave, and sick leave will need to be formulated. Related to this is the need to reduce food insecurity, provide housing, and ensure that government actions protect the climate. For example, this may require strengthening mental health and substance abuse services, especially as the pandemic affected African Americans' mental health, including exacerbating ongoing issues with mental health and chemical dependency.

As discussed previously, violations of the human rights principles of equality and nondiscrimination were already present in U.S. society prior to the COVID-19 pandemic. However, the pandemic had caused "an unprecedented combination of adversities which presents a serious threat to the mental health of entire populations, and especially to groups in vulnerable situations" (Gemelas, Davison, Keltner & Ing, 2022, p. 67).

Dainius Pūras noted that *"the best way to promote good mental health during COVID-19 is to invest in protective environments in all settings"* (Gemelas, Davison, Keltner & Ing, 2022, p. 98). These actions should be rolled out as we engage in thoughtful conversations that would make it possible to assess the situation, to plan and implement necessary interventions, and to evaluate their effectiveness. Fourth, the role of research is critical. The epidemiological data that is collected during the pandemic should reflect meaningful, systematic data which is disaggregated by race, age, gender, and class. Such data will be useful not only for promoting public trust but for gaining a deeper understanding of the full impact of COVID-19. Further, such data will demonstrate how different systems of inequality intersect, including

how they affect the lived experiences of African Americans. It is also important that such data be made available as well as disseminated widely. This will enhance public awareness of COVID-19 and inform best practices and interventions including public policies that would work best for African Americans.

Fifth, a close examination and reflection on how to close this disparity needs to start immediately. Given that the COVID-19 pandemic was and is more than just a health crisis, it disrupted and affected every aspect of life, including family life, education, finances, and agricultural production. It therefore requires a multisectoral approach. There is a need to build stronger partnerships among the healthcare sector and other social and economic sectors. Further, working collaboratively to address the many interconnected issues that have emerged or became visible during the pandemic, particularly as they affected African Americans, offers a more effective strategy.

Conclusion

Dr Martin Luther King Jr. once said *that of* all forms of inequality, injustice in health is the most shocking and inhuman. . Similarly, Delan Devakumar et al. pointed out that the strength of a healthcare system is inseparable from broader social systems that surround it. Health protection relies not only on a well-functioning health system with universal coverage, which the U.S. could highly benefit from, but also on social inclusion, justice, and solidarity. In the absence of these factors, inequalities are magnified, and scapegoating persists, with discrimination remaining long after. Unfortunately, today, African Americans are still suffering from injustices that are at the basis of income and health

disparities. This is troubling as it creates more problems during a pandemic such as COVID-19. History has demonstrated that previous epidemics place increased demands on scarce resources and enormous stress on social and economic systems. The onus is on authorities to ensure these resources are shared equitably.

Gaining a deeper understanding of the factors driving health in the context of COVID-19, and of the role that these factors play in mediating the impact of the pandemic on African Americans' health, will increase general awareness of the indivisibility of all human rights and the collective dimension of the right to health. Therefore, what is needed is a more explicit equity agenda that encompasses and promotes both formal and substantive equality. Apart from nondiscrimination and equality, participation by all and accountability are equally crucial.

Unfortunately, the available data suggests that African American communities in the United States have borne the brunt of the pandemic. COVID-19 has served to unmask higher vulnerabilities and exposure among African Americans and other people of color.

The COVID-19 pandemic demonstrated that we are all interconnected and that our well-being is contingent on that of others. A reimagined, renewed healthy society is possible only if governments and public authorities commit to reducing vulnerability and the impact of ill health by taking steps to respect, protect, and fulfill the right to health and protection. It requires that government, nonprofit actors, and stakeholders establish policies and programs that promote the right to social justice and health in crises such as those experienced during the COVID-19

pandemic. In the end, this calls for a shared commitment to justice and equality for all.

The next chapters expound on important areas discussed previously that pertain to disruptions to normal functioning resulting from COVID-19, perceived vulnerability and health disruptions, access to treatment, lessons and implications for social justice.

Discussion questions

1. Compare and contrast the main socio-cultural and economic challenges experienced during the COVID-19 pandemic?
2. Discuss four ways in which the challenges discussed above could be addressed?
3. What are some policy challenges that would make service delivery for COVID-19 treatment difficult?
4. Why is social justice a core element of access and treatment for COVID-19 patients?

References

Allen K. (2020, January 22) *More than 50% of homeless families are black, government report finds.* ABC News. https://abcnews.go.com/US/50-homeless-families-black-government-report-finds/story?id=68433643.

Amon J. J. (2020), COVID-19 and detention, *Health and Human Rights, 22*(1), 367–370.

Bailey, Z. D., Feldman J. M., & Bassett, M. T. (2020). How structural racism works — racist policies as a root cause of U.S. racial health inequities. *New England Journal of Medicine, 384*, 768–77.

Benfer, E. A., Vlahov, D., Long, M. Y., Walker-Wells, E., Pottenger, J. L., Gonsalves, G., & Keene, D. E. (2021). Eviction, health inequity, and

the spread of COVID-19: Housing policy as a primary pandemic mitigation strategy. *Journal of Urban Health*, *98*, 1-12.

Campbell, K.M., Hudson, B. D., & Tumin, D. (2020). Releasing the net to promote minority faculty success in academic medicine. *Journal of Racial and Ethnic Health Disparities, 7*(2) 202–206.

Carethers, J. M. (2020). Insights into disparities observed with COVID-19. *Journal of Internal Medicine*, *289*(4), 463–473.

Centers for Disease Control and Prevention. (2020). *Health equity considerations and racial and ethnic minority groups*. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

Lovelace Jr., B. (2020, April 7). *White House officials worry the coronavirus is hitting African Americans worse than others*. CNBC News. https://www.cnbc.com/2020/04/07/white-house-offici als-worry-the-coronavirus-is-hitting-african-americans-worse-than-others.html

Maness, S. B., Merrell, L., Thompson, E. L., Griner, S. B., Kline, N., & Wheldon, C. (2021). Social determinants of health and health disparities: COVID-19 exposures and mortality among African American people in the United States. *Public Health Reports*, *136*(1), 18–22.

Mendenhalla E. (2020). The COVID-19 syndemic is not global: Context matters. *The Lancet, 396*(10264), 1731.

Nelson, A. (2016). The longue duree of Black Lives Matter. *American Journal of Public Health, 106(*10), 1734–1737.

Peek, M. E., Simons, R. A., Parker, W. F., Ansell, D. A., Rogers, S. O., & Edmonds, B. T. (2021). COVID-19 among African Americans: An action plan for mitigating disparities. *American Journal of Public Health*, *111*(2), 286–292.

Pirtle L., & Whitney N. (2020). Racial capitalism: A fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States. *Health Education and Behavior, 47*(4), 504–508.

Shim, R. S., & Starks, S. M. (2021). COVID-19, structural racism, and mental health inequities: Policy implications for an emerging syndemic. *Psychiatric Services*, *72*(10), 1193–1198.

Simms M., Fortuny K., Henderson, E. (2009). *Racial and ethnic disparities among low-income families*. Washington, D.C.: Urban Institute Publications.

Tai, D. B. G., Shah, A., Doubeni, C. A., Sia, I. G., & Wieland, M. L. (2021). The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. *Clinical Infectious Diseases*, *72*(4), 703–706.

Walsh C. (2020, April 14). *COVID-19 targets communities of color*. Harvard Gazette. https://news.harvard.edu/gazette/story/2020/04/health-care-disparities-in-the-age-of-coronavirus/

Wilder, J. M. (2021). The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. *Clinical Infectious Diseases*, *72*(4), 707–709.