**Title: Black Lives Matter and Health Inequalities in India and the USA**

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**Abstract**

With the recent Black Lives Matter movement, existing racial inequalities in various sectors of the USA have regained prominence. Due to the pandemic, statistics on racial disparities in the health sector are quite glaring. On a related note, while the #Black Lives Matter movement received substantial support from India’s online community, deeply entrenched inequalities in terms of caste and gender in India’s health sector need to be critically evaluated as well. Thus this editorial is an attempt to understand how the Black Lives Matter movement could be an opportunity to address structural inequalities in India’s public health system.

**Keywords:** Black Lives Matter, health inequalities, race, caste, gender

**Background**

The Black Lives Matter movement which has currently gained international recognition originated in 2013. The movement began on social media with the death of an African-American teenager, Trayvon Martin. In 2014, the movement shifted to street demonstrations and gained national recognition with the death of two more African-Americans, Michael Brown and Eric Garner (1). The main goal of the Black Lives Matter movement is to project non-violent forms of protest against police brutality and racial disparities against Black individuals. The main principles of this movement are restorative justice, empathy, loving engagement, diversity, globalism, queer affirming, trans affirming, collective value, intergenerational, restructure patriarchy in Black families, reinstate the notion of care embedded in Black villages, being unapologetically Black and building a space free from sexism, misogyny, and male‐centeredness for Black Women (Black Lives Matter Website) (2). Some of the major policy demands of this movement has been to end the war on Black people, reparations for past and continuing crimes, divestments from institutions that criminalize Black people, investment in health, education and safety of Black people, economic justice for all, community control of laws and independent Black power (3).

**Racism as a public health crisis**

On 25th May 2020, the death of George Floyd, a 46-year-old African-American man in Minneapolis, USA while he was being held down by the police sparked global outrage and resurged the Black Lives Matter movement. Following the death of George Floyd, Black Lives Matter organized several rallies from 30th May with the slogan, “defund the police” (4). A recent poll conducted by the Pew Research Centre in June 2020 indicated that two-thirds of adults in the USA support the movement (5). Owing to these recent protests, racial inequalities have resurfaced into global prominence. However, racial disparities always existed in the systems and institutions of the USA and health professionals have long declared racism as a public health issue (6, 7, 8, 9). Additionally, with the rising protests, several states such as Michigan, Nevada, Wisconsin, California and Ohio have declared racism as a public health crisis (6). Since racism affects living conditions, income levels, access to food, education and healthcare, health experts consider racism to be a public health issue (6). With Black Lives Matter escalating as a movement and garnering worldwide support, the need to recognize racism as a global public health concern becomes more urgent.

Reports published by the National Academies Press (2003; 2004) highlight that among all racial and ethnic groups in the U.S, African-Americans have the highest rates of morbidity and mortality (10, 11). For instance, in their 2004 report (11), they use the research of Lillie-Blanton et al, (1996) (12) and indicate that health deficits among African-American mothers in poverty affects the wellbeing of the infant. Similarly in another report (13) in 2014, they suggested that if State Governments engage with the local community members to understand their issues, racism as a social determinant of health could be eliminated. Despite this policy recommendation, several racial inequalities continue to persist in the public health system of the U.S.

**Recent Statistics: USA**

Covid-19 data on the USA compiled by the American Public Media (APM) Research Lab (2020) (14), revealed that African Americans have died at a rate of 50.3 per 100,000 people, compared with 20.7 for whites, 22.9 for Latinos and 22.7 for Asian Americans. A recent academic article by Webb et al (2020) (15), indicate that African Americans are more likely to be infected by the pandemic as they reside in poor and overcrowded neighbourhoods, work in unsafe conditions and have limited access to health care.

Recent statistics from the Harvard Centre for Population and Development Studies, also showed that African Americans have higher rates of diabetes, hypertension and heart disease than other groups (Bassett et al, 2020) (16). An earlier report by the Department of Health and Human Services (HHS) Office of Minority Health, USA (2017) (17) indicated that the average median household income for African Americans was $40,165, compared with $65,845 for white households. Additionally, 22.9% of African Americans were at the poverty level compared with 9.6% of whites, with an unemployment rate of 9.5% for African Americans compared to 4.2% for whites. Despite a lower annual household income, African Americans ended up spending a higher share of their income on medical care, 16.5% in comparison to 12.2% for whites (HHS, 2017) (17). Although the Civil Rights Act of 1964, has been passed, these distressing numbers suggest that institutionalized racial inequalities continue to persist in the USA.

**Health Inequalities in India**

With the death of George Floyd, #Black Lives Matter began trending on several social media platforms and garnered significant solidarity in India’s online community as well. Similar to racial inequalities, discrimination based on caste, gender and religion is inherent in the Indian public healthcare system. Jean Dreze and Amartya Sen in their seminal book, “*An Uncertain Glory: India and its contradictions*” (2013) (18), highlighted how inadequate access of basic facilities such as education and medical care among lower-income groups, women, lower caste groups, and tribal communities have hampered India’s overall growth. In particular, Dreze and Sen (2013) (18), suggest equal representation of all categories and communities at the policy level to accelerate India’s development goals.

Highlighting the poor health status of the tribal community in India, a report submitted by the Abhay Bang committee (2018) (19), indicated that the health condition of the tribal community in India is the worst when compared with other social groups. The report further added that the tribal community which consists of 8.6% of India’s population, are suffering from a triple burden of disease. Due to malnutrition and lack of resources, malaria and tuberculosis continue to be rampant among the tribal people. On the other hand, with rapid urbanization diseases such as cancer, hypertension and diabetes have also increased among the tribal population of India. Finally, the report points out that owing to lack of access and geographical isolation, mental health issues have also emerged among the tribal community of India (Abhay Bang Committee report, 2018) (19). In addition to this report, data from the All India Survey of Higher Education (2018-19) (20), under the MHRD Ministry found that in the last seven years for 43 medical courses the enrolment for only Scheduled Castes was 13.42% and 4.95% for Scheduled Tribes.

Another report compiled by the Sachar Committee (2006) (21), indicated that 40% of villages dominated by the Muslim population of India do not have any medical facilities. Additionally the Sachar Committee report (2006)(21) also found that only 4% of Muslims are enrolled in the top medical colleges of India. Another report on the Health of Muslims in Maharashtra (Contractor and Barai, 2014) (22), highlighted that there is a dearth of health infrastructure in the highly populated Muslim areas of the State.

Based on the 71st round (2014) of the National Sample Survey Organization, Ladusingh et al (2018) (23) found that married women in rural India have to cope with communicable, non-communicable and reproductive health diseases. Despite, this triple burden of disease women in rural areas spend much less on their health. Shedding light on the situation of the transgender community in India, Amnesty International recently pointed out that none of the relief packages during the nationwide lockdown announced by the Government of India to tackle COVID-19 included the transgender community (Amnesty International India, 2020) (24).

Scholars of Medical Sociology and Sociology of Health and Medicine have used the Marxist and the Feminist framework and argued that race, caste, class and gender are the main axes of stratification in the health sector. Schnall and Kern (1981)(25) in their study on hypertension in the US found that due to unstable jobs, hypertension is high among low-income groups of African Americans in the US. Demonstrating caste discrimination, a study on Dalit construction workers highlighted how Dalits in India face unequal treatment by the medical staff in health centres (Priya, 1995)(26). Another study by George (2015)(27) illustrated that tribal communities of India continue to be isolated and no Primary Health Centres or Community Health Centres were built from 2006 to 2014 in tribal areas of India. Finally, a recent study by Shaikh et al (2018)(28) found that lower caste groups have to wait longer to be attended in private facilities.

Similarly to caste based inequalities, studies have also indicated how women in India have often had to bear the brunt of unsafe abortions (Tharu and Niranjan, 2004)(29), and use of new reproductive technologies on their bodies (Pandey, 2014)(30). Highlighting the discriminatory behaviour of the medical community towards the transgender community in India, Ming et al (2016) (31), suggested that despite receiving legal recognition, transgender people continue to be subjected to psychological and verbal abuse by the doctors and other medical staff (Ming et al, 2016)(31).

In addition to lack of access to healthcare, women and lower caste groups have often been coerced into unethical clinical practices as well. In line with the USA which performed various medical experiments on Africans and African Americans, lower caste groups and women have also been subjected to various forms of clinical trials without following proper rules of informed consent. Sunder Rajan in his book titled, *Biocapital* (2006)(32), illustrated how mill workers in India became human subjects for new chemical substances in the experimental stage while the tested drugs were sent to North America. Several journalistic articles have highlighted how lower caste men from states such as Madhya Pradesh (Roberts, 2012)(33) and Rajasthan (Dixit, 2018) (34) were made to consume pills without proper information regarding the drugs being revealed to them. Similarly, women in India, have often been coerced into sterilization without their consent (Pandey, 2014) (35).

**Intersectionality**

Patricia Hill Collins and Simon Bilge in their book *Intersectionality* (2016) (36) argued that it is important to recognize the intersections between race, class and gender to address institutionalized inequality. Similarly, Gita Sen and Aditi Iyer (2009; 2012; 2016) (37, 38, 39), examining intersectionality in India, highlight the significance of gender in determining the health status across class groups. Through their studies, Sen and Iyer (2009; 2012; 2016)(37, 38, 39), demonstrate the similarities between rich women and poor men. The rich women faced restrictions on mobility, no control over decisions related to their education, marriage and childbearing and no recognition of their health needs during pregnancy or illness. On the other hand, poor women stopped their treatment prematurely, while poor men used household resources or took loans to continue treatment for their long-term illnesses. Likewise, Ravindran (2017)(40), suggests that the intersectionality-informed approaches require policymakers to take note of multiple identities and diversity within the single axis of social stratification such as class, caste and gender. For instance, cash transfers for institutional deliveries for women living below the poverty line, failed to reach the poorest women among the Scheduled castes (Ravindran, 2017)(40).

**The way forward**

With the pandemic uncovering India’s poor healthcare system, Dipankar Gupta in a recent article (2020)(41) critiqued privatization of medical care and insisted on a Universal Health Plan in India. Though a Universal Health Plan seems desirable, it may not necessarily remove health inequities. For instance, according to the Report of the Working Group on Inequalities (1980)(42) in Health published by the United Kingdom Department of Health and Social Security (also referred as the Black report) found that socio-economic inequalities were the main cause for overall mortality and widening health inequities in Britain. In particular, the report showed that since the establishment of the National Health Service (1948), ill-health and death were unequally distributed in Britain. As the National Health Service did not take into account social inequalities such as diet, income, housing, education, conditions of work and employment influencing health, ill-health and mortality rates varied across the British population (Inequalities in Health Report, 1980)(43). Another report published in 2018 by the Centre for Reproductive Rights, Geneva, found that Universal Healthcare in Europe excludes the most vulnerable and marginalized sections of society. For instance, undocumented migrant pregnant women (a vulnerable subgroup) in most European countries are prevented from accessing free and subsidized care. Hence, it may be suggested that before implementing Universal Healthcare, it is important to take note of the health needs of the various sub-categories and diversities within the main social determinants of health such as race, caste, gender, nationality, religion and ethnicity.

Focussing on the social determinants of health could help identify the inherent health inequities of India. This is a potential research area and future studies in India could use the intersectionality approach, to expand on the various health inequities embedded in the public healthcare system of India.

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