Middlesex-London Health Unit: Anti-Black Racism Plan

2021

Prepared by: Wright of Way (WOW) Consultancy Inc., London, Ontario

Table of Contents

Acknowledgements ... 4

Definition ... 4

Prologue ... 5

Ways of Working ... 6

Executive Summary ... 7

Background ... 9

Goals and Objectives ... 12

Literature Review and Jurisdictional Scan ... 12

Community Engagement Process ... 14

Self-Administered Survey ... 15

Key Stakeholder Interviews and Focus Groups ... 15

Key Findings ... 17

Access of Health Unit Services and Perceived Barriers to Accessing Those Services ... 17

Perceptions of What MLHU Does (Chart 1) ... 17

MLHU Services Used by Survey Respondents (Chart 2) ... 18

Perceived Barriers to Service (Chart 3) ... 19

Barriers and Facilitators to Equitable Access and Delivery of Public Health Services Identified through Focus Group and Interviews ... 19

What Can Improve Experience and Access to Public Health Services in London and Middlesex County (Chart 4) ... 21

Experience of the Impact of Race on Services ... 22

Perceived Impact of Race on Service, Treatment, or Access to Health Care (Chart 5) ... 22

Experience of Racism and/or Discrimination when Accessing Public Health Services (Chart 6) ... 22

Interaction with Public Health Providers ... 23

Perceptions of the General Impact of Racism on Health and Wellbeing (Chart 7) ... 24

Perspectives on the Broader Determinants that Impact Overall Health (Chart 8) ... 24

Where People Seek Out Information on Public Health-Related Topics (Chart 9) ... 25

Preferences for Communication on Public Health-Related Topics (Chart 10) ... 26

Additional Survey Comments ... 26

Limitations ... 28

Recommendations ... 30

Assess and Report ... 32

Modify and Orient ... 33

Partner with Other Sectors ... 35

Engage in Healthy Public Policy ... 37

Governance and Leadership ... 39

References ... 40

Appendix A - Additional Resources to Support MLHU's Deeper Understanding of Anti-Black Racism ... 41

Appendix B – Literature Review and Jursidictional Scan ... 43

Appendix C - Survey Questions ... 55

Appendix D - Interview Questions ... 60

Appendix E - Additional Information on Community Engagement Process ... 64

Appendix F - Additional Findings ... 67

- Age and Gender Distribution of Survey Respondents (Chart 11) ... 67
- Sexuality of Survey Respondents (Chart 12) ... 67
- Ethnic Self-Identity of Survey Respondents (Chart 13) ... 68
- Proportion of Survey Respondents Born in Canada (Chart 14) ... 68
- Year of Arrival to Canada for Survey Respondents not Born in Canada (Chart 15) ... 69
- Top 10 Languages Spoken (Chart 16) ... 69
- Relationship Status of Survey Respondents (Chart 17) ... 70
- Self-Identified Religion of Survey Respondents (Chart 18) ... 70
- Highest Level of Education Completed by Survey Respondents (Chart 19) ... 71
- Highest Level of Education Completed Based on Birthplace (Chart 20) ... 71
- Employment Status of Survey Respondents (Chart 21) ... 72
- Proportion of Survey Respondents with a Family Doctor (Chart 22) ... 72

Appendix G - Recommendation Change Areas ... 73

Acknowledgements

With respect and appreciation, we extend thanks to the following individuals who shared their expertise and perspective to support the development of this Anti-Black Racism Plan.

Malvin Wright
Taha Tabish
Mariam Malu
Dr. Timothy Dapo Fawehinmi
Dr. Chidi Akanu
Dr. Henry Otoo
Ebenezer Narh
Nafisa Gillani
Carl Cadogan
Divya Raman Santhanam
Brintha Sivajohan
Shaily Brahmbhatt
Enobong Udofa

Community Contributors

Congress of Black Women, London Chapter
Black Health Alliance (BHA)
African Canadian Federation of London and Area (ACFOLA)
London Inter-Community Health Centre (LIHC)
Regional HIV/AIDS Connection
Black London Network (BLN)
Pillar Not for Profit
WAIN Community Centre
Yaya's Kitchen
STEDA Tropical Foods
Payless African Market
theblacklondonproject
Roswen Enterprise Marketplace
Festival Food Mart
Best Bargain African and Caribbean Market
The Fix Inc. Beauty
K-LABA Hair & Beauty Supply

We also want to recognize members of the Black Community in the London Middlesex community who dedicated their time and shared with us their knowledge, know-how, and personal experiences within the health system. We want to thank the community members and the health practitioners who came together, spoke their truth, and shared their lived realities with us. Their dedication is witnessed throughout this document.

Definition

For the purpose of this report, the terms "African, Caribbean & Black (ACB)" and "Black" are used interchangeably to mean individuals and groups from various cultures and countries originating from Africa, the Caribbean, and the Diaspora and also includes members of the Black community who have no immigration history and are the descendants of enslaved peoples who had escaped slavery, or descendants of "Freemen" and have been living in London and Middlesex County since the 1800s.

Prologue

"We know that Black people regardless of their socio-economic status consistently have the worst health outcomes of any population in Canada next to Indigenous Peoples."

Jennifer Bernard, President and CEO of Women's College Hospital Foundation

This is a call for change.

The year 2020 brought an opportunity to reflect on the systemic ways in which the Black community experience social and health inequities, both globally and in our own backyard. The death of George Floyd and Brianna Taylor, the emergence of the Black Lives Matter (BLM) movement in Canada, and the documented health disparities Black people face during the COVID-19 pandemic have galvanized a call for action to eliminate Anti-Black Racism through change and new outcomes to old problems.

Old ways of thinking and the reliance on the orthodoxy of the past; the old language and the old tools will not be effective in bringing about the change and transformation that communities are demanding. For the ways of the past have left far too many of us behind.

But where do we begin?

We must recognize that the conversations about anti-Black racism are difficult to understand and address without understanding the history of this nation and the actions that have led to vulnerabilities, disparities, and systemic inequalities faced by Black and Indigenous people.

We must acknowledge that the history of Canada is one of European settlement that is marred by the genocide and exploitation of Indigenous peoples and the theft of their land and the continuing violence of their marginalization.

We must acknowledge that Indigenous peoples' dispossession of land and identity is based on legal constructs and a deeply rooted history of the nation, the region, and the narratives of the London and Middlesex County.

We must recognize that the marginalization was deliberately manufactured and set in motion to create binaries of wealth and poverty, have and have-not, healthy and unhealthy.

We must recognize that Public Health, in order to move forward, cannot create, exist and flourish in orthodox systems of change.

Lastly, we must empower the most vulnerable to drive change and lead their own health.

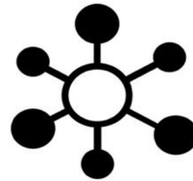
This is the time to act.

Ways of Working

In striving to mitigate and eliminate anti-Black racism and its myriad of impacts, it is critical to consider not only what actions are taken, but also the attitudes and intentions behind the actions, and the manner in which those actions are implemented.

Anti-Black Racism Plan
Ways of Working

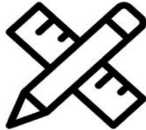
CREATE CIRCLES, NOT LINES
Create less hierarchy and more dialogue, inclusion,and empowerment.



CHOOSE CRITICAL CONNECTIONS OVER CRITICAL MASS
Quality over quantity. Focus on creating critical and authentic relationships to support mutual adaptation and evolution over time

MOVE AT THE SPEED OF TRUST
Grow trust and move together with fluidity at whatever speed is necessary.

BE HUMBLE LEARNERS WHO PRACTICE DEEP LISTENING
Listen deeply and approach the work with an attitude towards learning,without assumptions and predetermined solutions. Take criticism without dispute

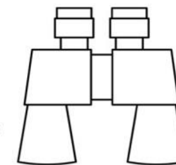


PLAN WITH, DESIGN WITH
Walk with people as they imagine and realize their own futures.Be connectors, conveners, and collaborators.

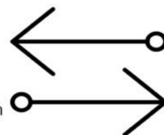
CENTER LIVED EXPERIENCE
Lived experience is an important expertise; center it so it can be a guide and touchstone of all work.

CELEBRATE, CATALYZE, & AMPLIFY BLACK JOY
Black joy is a radical act. Give due space to joy, laughter, humor, and gratitude.

SEEK PEOPLE AT THE MARGINS
Acknowledge the structures that create,maintain and uphold inequity. Learn and practice new ways of intentionally making space for marginalized voices, stories, and bodies



RECKON WITH THE PAST TO BUILD THE FUTURE
Meaningfully acknowledge the histories, injustice,innovations, and victories of spaces and places before new work begins. Reckon with the past as a means of healing, building trust, and deepening understanding.



Executive Summary

The work of the Middlesex-London Health Unit (MLHU) has steadily been focused on ensuring that the delivery of services in the Public Health sphere has been grounded in equity and dignity. The commissioning and funding of an Anti-Black Racism Plan shows the commitment of MLHU to this work, with the following objectives identified for this assessment and planning initiative:

- Understand the current best/wise practices around the implementation of anti-Black racism in a Public Health context
- Understand the Public Health related needs and expectations of the diverse Black communities in London and Middlesex County
- Inform Public Health and organizational prioritization and action relevant to Public Health's mandate

The Anti-Black Racism Plan was developed through the engagement of the African, Caribbean, and Black (ACB) communities in the London and Middlesex County. Engagement strategies included a survey, focus groups, and one-on-one sessions with community members so they were able to contribute their voices to the plan. Participants' shared their views and experiences of racism, what needs improvement, and what's most important to them when it comes to their health, health care, and accessing public health programs. The inclusive process engaged a total of 375 members of the ACB community of different ages, cultural, and linguistic backgrounds from across London and Middlesex County to ensure his plan reflected the views and priorities of the diverse ACB community.

The sampling frame was dynamic as sampling options were structured to capture the demographic profile of the community. Community members, community organizations, community health centres, ACB community leaders all served as recruiting channels where participants were referred to the consulting team and informed about the creation of MLHU's anti-Black racism plan.

Quantitative and qualitative data were then analyzed. The feedback received indicated ACB community members want high quality, easy-to-access to programs, services and care that looks like them, in their language, understands their culture, and is aware of their realities as members of the ACB community and the social determinants of health they come up against every day. They want to to co-develop services and programs designed around their needs. They are concerned about their data and want a say in how it is governed, used, and managed. They want a seat at planning, collective action, and decision-making tables.

From the literature review and jurisdictional scan, and the findings from the community consultation, a list of recommendations was developed that encompass the areas of information, education, and communication; creating safer spaces; strengthening community capacity; building trust; research, data collection and use; governance and accountability; equitable access and service delivery; and effective collaboration.

The recommendations are organized according to the framework for Public Health Roles for Health Equity Action, as outlined by the National Collaborating Centre for Determinants of Health, with the addition of a category related to governance and leadership. There are a total of 45 recommendations within the following categories:

- Assess and Report (8 recommendations)
- Modify and Orient (11 recommendations)
- Partner with Other Sectors (10 recommendations)
- Engage in Healthy Public Policy (9 recommendations)
- Reorient Governance and Leadership (7 recommendations)

These recommendations are the first step to dismantling anti-Black racism within and by Public Health through ongoing engagement with ACB community members in a direct and respectful way while placing value on the personal lived experience of Black people within the community and modifying the current ways of work to include co-creating when planning and delivering Public Health programming. These recommendations will help the Health Unit to make progress that can be measured and tracked for improvement. It is critical that MLHU adequately fund the recommendations in the Anti-Black Racism Plan in their work towards health equity and are held to account for the work ahead.

ACB community members' responses has directly influenced the actions and priorities outlined in this plan, and by learning what matters most to members of the ACB community a plan was crafted that reflects the uniqueness and diversity of thought, culture, and perception of the ACB community within London and Middlesex County.

This plan is a call to action.

Background

"It is important to underline that the experience of African Canadians is unique because of the particular history of anti-Black racism in Canada, which is traceable to slavery and its legacy, through specific laws and practices enforcing segregation in education, residential accommodation, employment, and other economic opportunities. History informs Anti-Black racism and racial stereotypes that are so deeply entrenched in institutions, policies, and practices, that its institutional and systemic forms are either functionally normalized or rendered invisible, especially to the dominant group." (Mount Saint Vincent University, 2018)

Today 1.2 million people in Canada self-report as African, Caribbean, Black (ACB). Notably in the 2016 Canadian Census Data from Statistics Canada:

- 620,000 are women and girls
- There are 35,000 more women than men
- 57% of the Black population in Canada lives in Ontario

As of 2016, Statistics Canada data presents London and Middlesex County with a population of 455,526, with an average population growth of 3.7%. The data for London, Ontario presents a population of 383,822 people with a population growth rate growth of 0.94% per year over the past 15 years from 2001 to 2016. In the last two censuses ,the London population grew by 17,671 people, an average growth rate of 0.97% per year from 2011 to 2016 (Statistics Canada, 2016).

London and Middlesex County

	London	Percentage of total City of London Population	Middlesex County	Percentage of Total Middlesex County Population
Population	383,822	100%	71,704	100%
Age 0-14	61,885	16.1%	12,955	18.1%
Age 20-24	30,230	7.9%	4,144	5.8%
Visible Minority	75,125	19.6%	1,335	1.9%
Black Population	11,325	3.0%	200	0.3%

According to 2016 Census Data from Statistics Canada (2016), visible minorities in London, ON make up 19.6% (75,125) of the overall population. The Arab community is the largest visible minority population in London, making up 18.18 % (13,655) of the total visible minority population. The second-largest visible minority group in London is the South Asian community, making up 15.52% (11,660). The third-largest visible minority group in London is the Black community which makes up 15.08% (11,325) of the visible minority population and 3% of the of the total population.

However, given that the findings from the Our Health Counts research project in London identified that the urban Indigenous population is 3-4 times more than the estimated Urban Indigenous Population by Statistics Canada, the actual size of the Black community is up for debate. Many members of the community believe that the number is larger than what is being reported by Statistics Canada (2016). There are several factors that may account for an underreporting of racialized and black populations: a) accessibility (so-called black neighbourhoods) are often underreported, b) language proficiency (survey numerators) often don't speak the languages of these neighbourhoods/communities/houses), c) census hesitancy within many racialized communities (people who are distrustful of government and the collection of census data).

The term "race" carries its histories of stereotyping, exclusion, and other forms of social injustice. There is a long historical record of sorting populations into racial taxonomies reflecting perceived gradations of human worth. Settlers and immigrants, particularly those who came under the promise of multiculturalism, must recognize that this promise is held in it the erasure of Indigenous histories; furthermore, it brought explicit divisions by the Canadian state, which positioned immigrants as more desirable than the Indigenous people(s) whose lands they were brought to possess. Those, descendants of African people forcibly brought here through the trans-Atlantic slave trade, were brought here as stolen people to a stolen land.

The creation of this Anti-Black Racism Plan must be anchored in history, while also articulating the hopes and aspirations within the Black community regarding their health and wellbeing. Although Canada's universal health care system is often understood as a central pillar of a national commitment to social equity and social justice, such an understanding makes it difficult to raise the issue of racial inequalities within the context of the Canadian health care system. In recognizing that one's health is influenced by many factors it is important to consider inequities and inequalities experienced by Black communities across a range of indices. In reality, Black communities face higher rates of poverty, and have higher rates of incarceration in the criminal justice system, Black workers experience income disparities, and Black youths experience a widening educational gap. While race is not regularly recorded with health data in Canada, which makes it difficult to truly understand the impact of racism on health, strong and consistent findings in the United States where race data is collected highlight that Black communities experience higher rates of hypertension, heart disease. diabetes, low birth weight, negative mental health outcomes, and substance use (alcohol, cigarette smoking, other substance use). In Canada, the experience of racism has been found to have a significant association with self-assessed poor or fair health (CPHA, 2018). Although there are many Black individuals in London and Middlesex County, Black people are not significantly represented in influential roles within the social, economic, and political spheres. One of the members of a focus group stated that "we are the most visible yet most invisible people in this community". Black individuals are present in popular culture but absent in so many other places and spaces that matter.

It is also critical to define and redefine the role of Black people in confronting and addressing anti-Black and anti-Indigenous racism within Public Health while naming colonization and the construct of race and racism as operating forces that produce and perpetuate systemic

inequalities and inequities, as well as poor health and wellbeing for racialized and Indigenous communities on this land.

The community engagement that informs this plan examines ACB community members' views of their relationship, interaction and knowledge of the Middlesex-London Health Unit (MLHU), as well as its programs and interactions with the Black Community. The engagement also examines how ACB community members' views help or hinder their personal and community participation with Public Health. Information gathered from ACB community members supported the development of an Anti-Black Racism Plan for the MLHU which consists of community-based strategies to effectively link the ACB community to MLHU.

Additional resources to support MLHU's understanding of anti-Black racism can be found in Appendix A.

Goals and Objectives

This plan was created to inform and guide public health decision-making and to address an expansive question about ACB community members' experience with and perspectives on Public Health programming in London and Middlesex County. More specifically, the key objectives of engaging the ACB community were to:

- Understand the current best/wise practices around the implementation of Anti-Black Racism in a Public Health context
- Understand the Public Health related needs and expectations of the diverse Black communities in London and Middlesex County
- Inform Public Health and organizational prioritization and action relevant to Public Health's mandate

Literature Review and Jurisdictional Scan

The primary objective of the literature review and jurisdictional scan was to support awareness and action based on understanding systemic racism that is embedded (often hidden) in institutional policies, practices, ideology, discourse, and social environments and its impact on the ability of members of the ACB community to access Public Health programs in an equitable and fair manner.

The literature review revealed that information and knowledge on anti-Black racism in relation to public health leadership, planning, and implementation were not part of the common literature. While there were large bodies of writing on racism in health and health equity that were available from many sources, including academic research, grey literature and opinion-based writing that can be applied across professions and structures, the presence of literature on anti-Black racism in public health was limited. Much of what was available counted as secondary sources, including opinion pieces, commentaries, and some grey literature. There was even less writing on anti-Black racism planning in the public health sphere.

There is a need for further empirical and theoretical research in the area of anti-Black racism in public health.

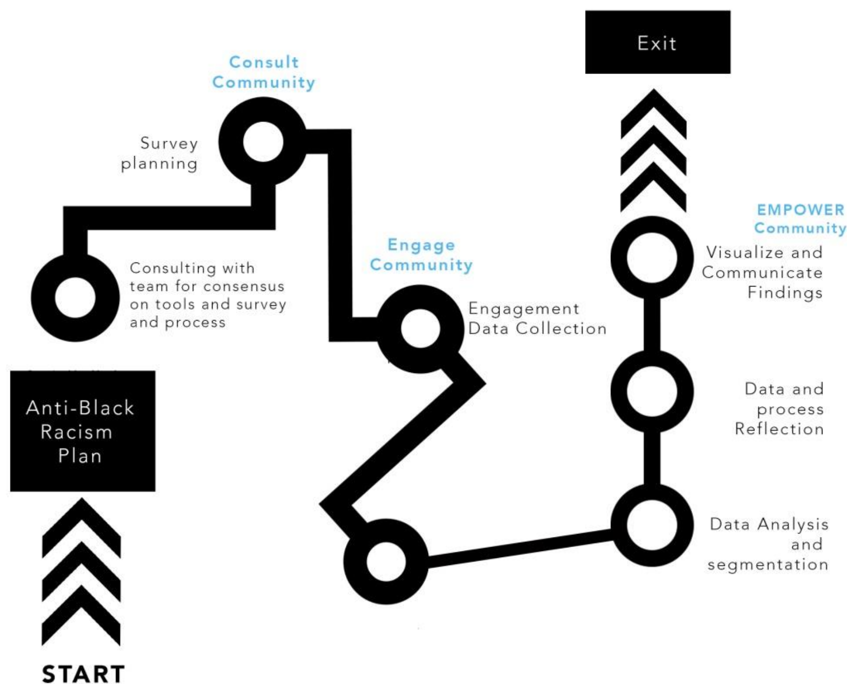
A number of areas for action and consideration were generated from information gathered through the literature review.

- All health professionals including physicians must take a stance against Anti-Black Racism and injustices especially black health professionals because research shows that most minorities are more likely to seek care from healthcare professionals of their own ethnicity (Noonan et al, 2016)
- Proactive efforts must be taken throughout our health systems to eliminate the conscious and unconscious lower quality of care provided to black people

- Public health should take the lead in advocating for and providing the expertise to ensure that the determinants of health are equally provided to members of the Black community and all races, through an integrated approach
- Care for the potentially pregnant women is crucial and may have long-term consequences for her and her offspring. Comprehensive care for the infant, child, and adolescent is the key to their lifelong health and also their ability to function as productive and creative people
- Health professionals should work with members of the Black community to co-create programs about their health in the language and culture of the client they serve to be effective. That is to say that the translation of health information into a form that black people can understand and use. Community members should be trained to become Health Systems navigators so that they can provide support to members of their community in their language and in a safe way
- The development of health policy is most often the responsibility of people with no public health expertise, no intimacy with the Social Determinants of Health and with no-too-little inputs from members of the Black community
- Health Policy should be vetted by Black health professionals and community members who are knowledgeable of the community's diversity and culture and committed to their well-being
- Politics is a key factor in the fight to eliminate the disparities in health provision and outcomes in our health system and we should be aware and engage accordingly
- Champion the interconnectedness of the social factors that have a significant impact on our health: income, housing, education, food, neighbourhood, sense of community, race and racism and access to health care as a way of working that cuts across all aspects of the organization.

For more details on the literature review and jurisdictional scan, see Appendix B.

Community Engagement Process



To inform the recommendations for the Anti-Black Racism Plan, quantitative and qualitative approaches were used through multiple engagement methods with ACB communities in London and Middlesex County.

To be eligible, participants needed to self-identify as African, Caribbean, or Black regardless of where they were born. Other intrinsic inclusion criteria included that the participants must be 18 years or older and have lived in London or Middlesex County for at least 3 years prior to the consultation process.

Twelve consultation sessions were held online through Zoom over a two-week period in the evenings. Consultation sessions were held with invited formal and informal leaders within the ACB community, as well as ACB community members. These sessions outlined the approach, methodology and guided the participants through the qualitative engagement tools and quantitative questionnaires. Participants of the consultation sessions were asked to become “Community Champions” who could promote the engagement methods and serve as informants to potential respondents. Individual responses to the questionnaires were recorded to combine with the information collected in the community engagement methods.

In addition to Community Champions, partner community organizations, such as community health centres, community organizations, ACB organizations, and community leaders, served as recruiting channels where participants were referred to the consulting team.

Information-gathering methods included a self-administered survey, focus groups, and key stakeholder interviews.

Overall, a total of 375 diverse members of the ACB community participated in the engagement processes, including representatives of local Black-led organizations, leaders of faith, youth, para-health, and health practitioners in London and Middlesex County.

Self-Administered Survey

The questionnaire (see Appendix C) was designed to capture information on respondents' socio-demographic background and their knowledge of the MLHU, their access to Public Health services and perceived barriers to accessing those services, their experience of the impact of their race on services provided, their perception of the general impact of racism on their health and wellbeing, their perspective on the broader determinants that impact their overall health, where they seek out information on public health-related topics, and their preferences for communication on public health-related topics. The quantitative survey was available online for 21 days and took an average of 15 to 20 minutes to complete. Paper surveys were available from the ACB enumerators located at participating ACB owned businesses. A total of 291 people completed the survey.

Key Stakeholder Interviews and Focus Groups

The interview questions (see Appendix D) were designed to gather information on the insights and experiences of the ACB population in London and Middlesex County in relation to racism and Public Health. More specifically, the main objectives included:

a. To examine the beliefs and expectations of individuals in Black communities within London and Middlesex County with respect to discrimination during their interactions with Public Health services
b. To identify perceived barriers and facilitators to addressing racism in Public Health services among Black populations in London and Middlesex County
c. To understand the Public Health related needs and expectations of the diverse Black community in London-Middlesex
d. To inform Public Health and organizational prioritization and action relevant to public health's mandate

The level of diversity within the ACB community demanded a wide net to be spread to engage and capture as many community members as possible within the stakeholder consultations. Consultation sessions were held with a) Members of the ACB community and b) ACB health and wellness professionals and para-health professionals.

The engagement with health and wellness professionals and para-health professionals (focus group discussions) was critical because of their assumed proximity and familiarity with the MLHU and the programs and services the organization provides, as well as their proximity and intimacy with the health system as a whole. Additionally, they have a unique perspective on working within, through, and around the systems of oppression/racism that exists within the overall health system. Many of the informal professional development structures that existed (e.g., weekly and biweekly professional development meetings) were relied on to engage with ACB health and wellness professionals, due to the lack of ACB professional associations in London. As a result, focus groups included 44 Health front-line workers such as Physicians (15 individuals), Nurses (9 individuals), Child Youth Workers (7 individuals), and Personal Support Workers (13 individuals).

There were also one-on-one semi-structured interviews held with community members over the span of the consultation process. There were a total number of 40 community members who participated in the one-on-one sessions.

Detailed explanations on the information collection process, including a heat map of participants' residence, and analysis can be found in Appendix E.

Key Findings

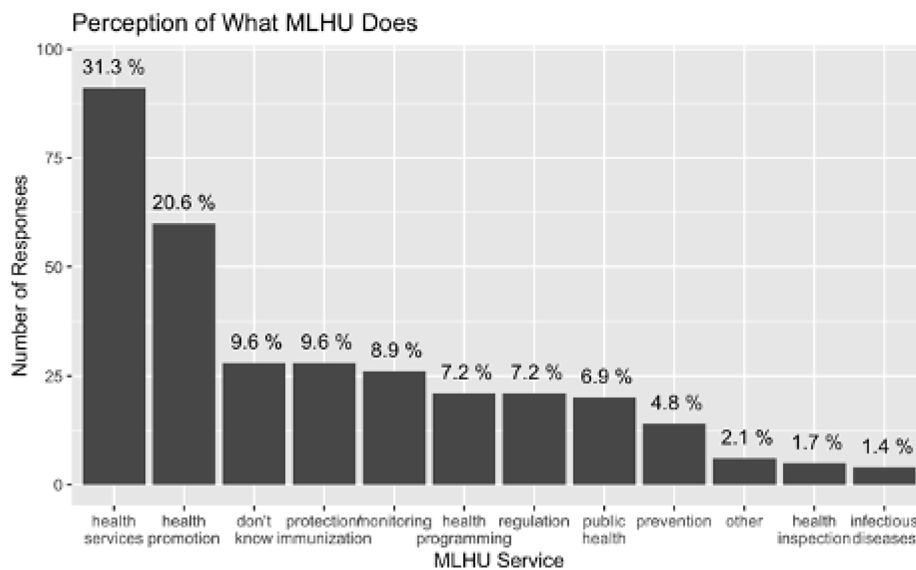
The following are the key findings from the results of the face-to-face interviews, survey, and focus groups conducted among a sample of people from the ACB community in London and Middlesex County. Findings from the quantitative and qualitative engagement tools were integrated because the insights drawn from the one-on-one interviews provided helpful context to the survey results. Respondents' demographic information and additional survey responses can be found in Appendix F.

The interviews and surveys were structured to include questions under six broad themes:

1. Access to MLHU services and perceived barriers to accessing those services
2. Experience of the impact of race on services provided by the MLHU
3. Perceptions of the general impact of racism on health and wellbeing
4. Perspectives on the broader determinants that impact their overall health
5. Where people seek out information on Public Health-related topics
6. Preferences for communication on Public Health-related topics

Access of Health Unit Services and Perceived Barriers to Accessing Those Services

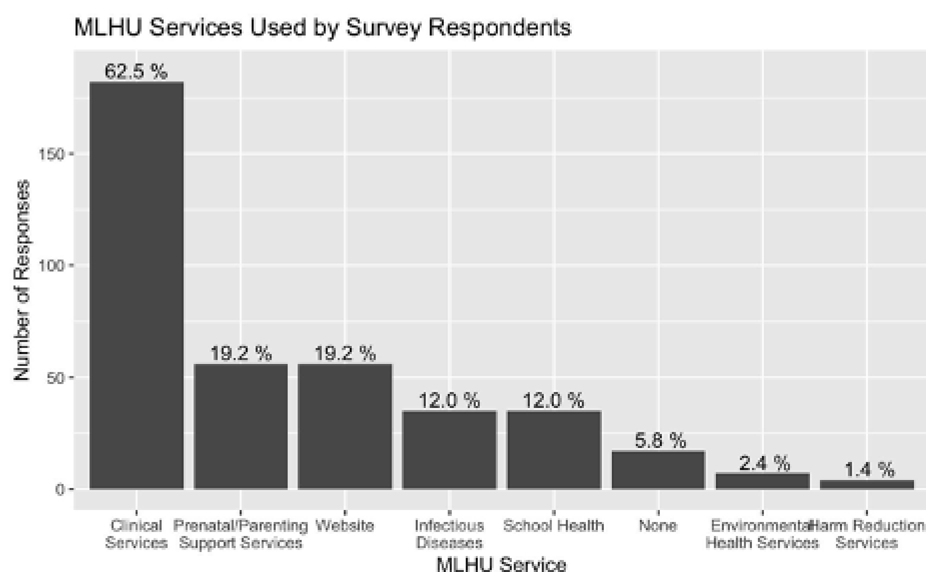
Perceptions of What MLHU Does (Chart 1)



Survey respondents were asked an open-ended question about what it is they thought MLHU did. Their responses ranged across an array of types of services. Of note, almost 1 in 3 respondents associated MLHU with providing health services, which included primary health care functions (i.e. hospitals and doctor's clinics). 9.6% of survey respondents stated that they do not know what it is that MLHU does.

Additionally, the 6.9% who mentioned "Public Health" did so with a perceived understanding implying "public health care delivery", as if to contrast it with "private health care delivery". Many countries, including those from which respondents may have emigrated, have public and private health systems, so this particular response cannot be clearly interpreted as "Public Health" in the sense of MLHU's actual function.

MLHU Services Used by Survey Respondents (Chart 2)



Survey respondents were asked which Public Health services they have accessed in London and Middlesex County, and their responses fell within the categories in Chart 2. It is important to note that the majority of respondents identified having accessed "clinical services". This, paired with responses in Chart 1, lead to the conclusion that respondents were not necessarily making a differentiation between health services (clinical or otherwise) that they receive from the Public Health unit compared to those services they access within other areas of the health care system, such as primary or acute care.

That said, for the non-clinical services, respondents were able to identify and attribute programs that they have accessed that were given as examples for the choices. The non-clinical service with the highest number of respondents were the prenatal/parenting support services such as breastfeeding support, home visits, and group programs, and those accessing information from MLHU's website.

Perceived Barriers to Service (Chart 3)

Barriers to Service	Total	Percent
Waiting lists or wait times	105	36.1 %
Inconvenient times for programs or services	45	15.5 %
Cost of service	42	14.4 %
Inconvenient location of programs or services	36	12.4 %
Service provider doesn't understand my needs	33	11.3 %
Racism	31	10.7 %
None	29	10.0 %
Issues with transportation	15	5.2 %
Language barrier	11	3.8 %
Legal status	7	2.4 %
Other	7	2.4 %
Do not see oneself in service/staff	2	0.7 %
Rude staff	2	0.7 %

Survey respondents were asked whether they had experienced any of the barriers listed in Chart 3 when accessing Public Health services in London and Middlesex County. Again, it is worth noting, based on the understanding from Chart 1 that there may be a conflation of Public Health services in London and Middlesex County with health care services at large in the community; these barriers should be interpreted as barriers people expressed to have faced in accessing health care in general.

Waiting lists or wait times were noted to be barriers by 36.1% of respondents. 11.3% of respondents mentioned that their service provider does not understand their needs, and 10.7% explicitly stated racism as a barrier.

Barriers and Facilitators to Equitable Access and Delivery of Public Health Services Identified through Focus Group and Interviews

Public Health strives to ensure its programs and services are accessible to all, according to the needs of prioritized populations and in recognition of the right to health for all. It is known that those of lower socio-economic status or those experiencing social exclusion often do not benefit equally in terms of utilizing various programs and services across many sectors *(United Nations, Leave No One Behind: Sustainable Development Goals, 2017, Chapter 1, Social Exclusion)*. Respondents identified factors that facilitated and acted as barriers to accessing Public Health services in MLHU. Quotes of responses are provided where appropriate.

Barrier – Lack of Knowledge and Awareness

A significant number of the participants identified a lack of knowledge of the available services provided by the MLHU as a barrier to accessing Public Health services. The participants mentioned that:

"A lot of Immigrants are not aware of how the system works and the services and resources that are available to them. Even the doctors do not know about a lot of the services available"

"I have noticed that there is some confusion with the Public Health and the entire health system. The MHLU's work is in terms of prevention and there's no treatment per se done by the MLHU. The MHLU is putting out the messages but the message is not being heard"

Barrier – Language

The respondents identified inadequate language interpretation services and lack of language proficiency as barriers that prevented them from interacting with Public Health providers. In most situations, the participants were not aware of the breadth and type of interpretation services available at the MLHU. The participants mentioned that:

"I have not come across any other translators from Africa that MLHU provides"

"Availability of translation is a concern. I know it's available for Arabic but unsure about other languages like Swahili, Somali, other regions. This is definitely a barrier and something for Public Health to look into"

"I think that the MHLU provides translators but in my experience a lot of people, doctors inclusive do not know that these services are available"

Barrier – Religious Consideration

In many cases, respondents who accessed services felt their religious ideas were not taken into account. One participant explained that:

"Religious preferences for example in the Muslim communities, women prefer to be examined and seen by a woman, but I don't believe that that is a service that is provided".

Facilitator – Representation and Shared Values

Interview respondents were asked about what facilitated access to Public Health services at MLHU. Numerous participants indicated that having Black representation in staff as a major facilitator to Public Health services. Interview participants reported that *"people that look like us*

working at the health unit and developing programs/leading programs", encouraged them to access more services and feel more comfortable within the system.

Other participants described that their interactions with health care providers of similar race/background was much more fluent, particularly when they share their values and beliefs. One participant mentioned that:

"It helps to be inclusive with staffing. Maybe MLHU can start with that. It helps to see a face that you can identify with when you (the patient) go in"

What Can Improve Experience and Access to Public Health Services in London and Middlesex County (Chart 4)

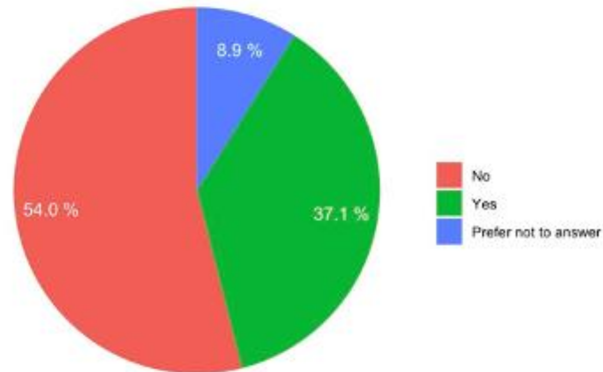
Areas to Improve	Total	Percent
Staff who provide a culturally safe experience	123	42.3 %
Programs/services that are relevant to my needs	111	38.1 %
A service provider who understands my needs	107	36.8 %
Easy access to support services	107	36.8 %
More affordable services	74	25.4 %
Being closer to the services	52	17.9 %
A service provider who can speak my language	34	11.7 %
Other	12	4.1 %

Respondents were asked what could, in their opinion, improve their experience of and access to Public Health services in London and Middlesex County. Based on the analysis of responses, these responses should likely be generalized to the experience of and access to health care services in general.

- 42.3% of respondents mentioned that having staff who provide a culturally safe experience would improve their experience/access
- 38.1% mentioned programs/services that are relevant to their needs
- 36.8% mentioned having a service provider that understands their needs

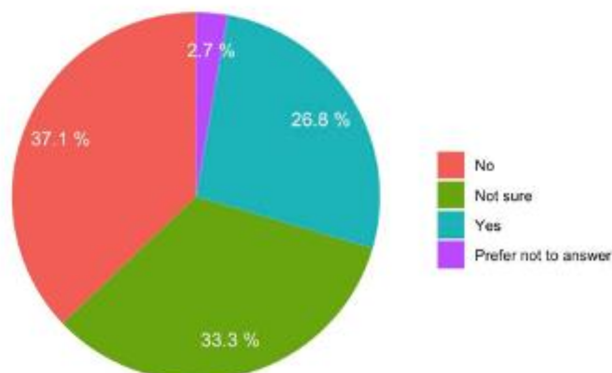
Experience of the Impact of Race on Services

Perceived Impact of Race on Service, Treatment, or Access to Health Care (Chart 5)



Fifty-four percent of survey respondents felt that their race had not impacted the service, treatment, or access to health care that they have received. However, 37.1% felt that it had. Coupled with the majority of the respondents having been in Canada not longer than 10 years it is felt this was reflective of the individuals' knowledge and awareness of how oppression works and manifests in structures of governance and power while creating systemic systems of inequity. It is important to note that this question was not worded in such a way as to capture perspectives specific to MLHU services, and responses are likely related to generalized experiences with the health system. However, MLHU must still consider these results as the organization identifies and implements needed changes.

Experience of Racism and/or Discrimination when Accessing Public Health Services (Chart 6)



When asked whether respondents had experienced racism and/or discrimination in accessing Public Health services in London and Middlesex County as a Black person and presented with the option of “not sure”, 37.1% of respondents said that they had not, whereas 26.8% said that they had.

One in 3 respondents said that they were unsure. Taking Chart 5 and 6 together, it could be posited that respondents were more likely to answer “no” when asked about having faced racism in general without a “not sure” option (Chart 5). However, when asked about whether they felt their race had impacted their access to health services in the city where they lived, respondents were more likely to respond, “not sure” instead of explicitly stating “yes” or “no” (Chart 6).

Interaction with Public Health Providers

The quality of a patient's interactions with their health care provider is critically dependent on the client’s perception of the quality of services that they receive (Beck et al, 2020). Many of the participants described their experiences in which they believed health care providers were unable to interact with ACB clients in a way that was respectful and that they were ill-equipped to understand their needs and values. Participants described a lack of translation services, a lack of cultural understanding, and an assumption that “all black people were the same & from the same place” irrespective of where they were from. In most cases, service providers did not appear to know how or had not received any non-bias or ACB culturally specific training. Several participants reported feeling unsatisfied having to explain their experiences as an ACB person in London and Middlesex County before getting the support they desired.

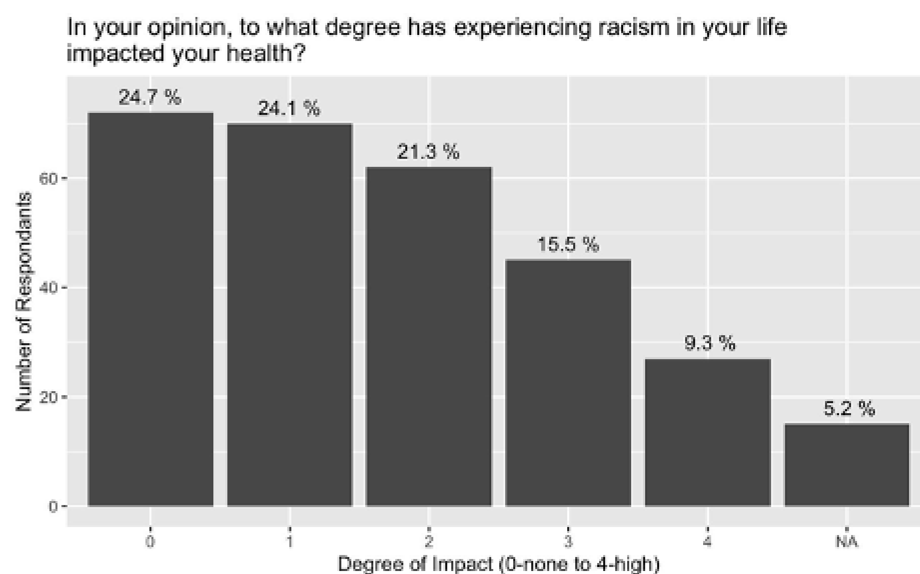
Other respondents described stories of racial discrimination that created mistrust. Participants reported fear of the system within the community and that this fear extends to perceptions of mistrust across the system, including Public Health. A participant stated that, *“Because there is no trust, so if they are not trusting then no one is going to hear what they want to say”.* The participants described their experience of the system by saying that:

“Race is a factor, it's always a factor and nobody talks about it. The MHLU doing this work now has to understand that race is a factor. They have to know it and address it. I have worked with Black kids and I have found in my experience that they do not have access to a lot of services that White kids and Indigenous kids get. I have talked about it, I have been demoted for it, and putting a plan together is a step but it needs to be talked about and we Black people need to be prioritized like everyone else”.

“We already know that we experience poorer Health Outcomes as a community; they like to tell us it’s about injustice, poverty BUT it’s about race and nothing else”

"There's a lot of distrust in the Black community based on our experience……For example anti-vaxxers have come from a history where Black people have been used for unethical and unsanctioned tests. Like the syphilis study".

Perceptions of the General Impact of Racism on Health and Wellbeing (Chart 7)



Survey respondents were asked how their experiences with racism impacted their health and wellbeing. Results indicated that:

- 70.2% of survey respondents felt that it had some impact
- 45.4% of survey respondents felt that the impact was more minimal (1-2 on a scale of 4) whereas,
- 24.8% of survey respondents felt the impact was more substantial (3-4 on a scale of 4)
- Only 24.7% of survey respondents felt that experiencing racism had no impact on their health

Perspectives on the Broader Determinants that Impact Overall Health (Chart 8)

**Please note that for the purpose of this survey both Social Determinants of Health indicators and the Community Health Survey framework (by Statistics Canada) was utilized when developing questions, the latter of which appear as health outcomes (perceived a better method for ranking overall health based on perception, actualization, and aspiration). Charts below reflect both.

Social Determinant of Health	Mean Rank	Count	Weighted Score
Income	2.62	174	4.38
Education	3.05	131	6.77
Housing	3.05	115	7.72

Community Health	Mean Rank	Count	Weighted Score
Mental health	2.92	172	4.95
Nutrition	2.85	146	5.68
Physical Activity	2.93	135	6.31
Being part of a Community	3.24	105	8.97
Disease Prevention	2.55	65	11.43
Child Welfare	3.21	58	16.09
Sexual Health	2.93	30	28.45

Survey respondents were asked to rank their top five determinants of health from a list of 10 selected by the consultants in order of how important they felt their impact was on overall health. A weighted score was calculated to account for the mean ranking received and weighted for the number of times a response was part of a top-five list.

The results are presented in Chart 8. Income, Mental Health, Nutrition, Physical Activity, and Education were the top five ranked by respondents.

Where People Seek Out Information on Public Health-Related Topics (Chart 9)

How do you get Public Health information?	Total	Percent
Searching on the Internet (i.e. Google search)	164	56.4 %
Friends/family	115	39.5 %
Health care provider	112	38.5 %
Social Media	105	36.1 %
Middlesex-London Health Unit website (www.healthunit.com)	81	27.8 %
Other	8	2.7 %

The majority of survey respondents (56.4%) self-report that they receive Public Health information through searching the internet, and 39.5% self-report that they receive information from friends and family. 38.5% mention that they receive information from their health care provider and 36.1% receive information through social media. Less than one-third (27.8%) of respondents mentioned MLHU's website as a source for public health-related information.

Respondents were also asked to provide examples of communication media, and they mentioned cultural groups/organizations (e.g. Nigerian Association), community churches/places of worship, CBC Radio/TV, ethnic and religious radio stations, and small newspapers. Due to the

cultural, linguistic, and religious diversity of the ACB community, engagement would need to be tailored for the specific sub-communities as part of a communication strategy.

Preferences for Communication on Public Health-Related Topics (Chart 10)

What is the best way to communicate Public Health information with you and your community?	Total	Percent
Email	178	61.2 %
Social Media	158	54.3 %
Community centres or groups	105	36.1 %
Faith Communities	104	35.7 %
WhatsApp	69	23.7 %
Radio	68	23.4 %
Phoning the Middlesex-London Health Unit	49	16.8 %
Newspaper	31	10.7 %
Other	8	2.7 %

To contrast Chart 9, respondents were also asked what they felt was the best way to communicate Public Health information with them and their communities. Though email was a top response (61.2%), more than half of respondents mentioned Social Media as a way to reach out, and more than 1 in 3 respondents also mentioned community centres and faith communities.

Additional Survey Comments

Questions 25 & 26 of the survey asked respondents for additional comments.

"MLHU needs more black health care providers - because of past experiences of other health care providers being discriminatory (not necessarily from MLHU), I'm automatically on edge to brace for a potential racist incident. Would be more reassuring to see Black people on the service end of those spaces."

"This is important work. There is such a gap existing in this community where consideration is focused on and given to members of the black community. We need to recognize as a community that one solution based on a defined construct cannot be sufficient for the health challenges of everyone."

"Consider the systemic racism we experience in the city (employment inequity, policy inequity, structural inequities for access to activities e.g. Hockey is open during COVID but not Basketball

which most of our community is involved in and the former supports the white community and how these experiences adversely affect our health and access to resources for our health. Our lives are devalued and therefore not considered in health and city decision-making and how these affect us."

"Provide educational seminar series/ workshops & classes on preventative health and promoting wellbeing for issues that are widely known to impact the Black community (ex. diabetes, heart disease, stress, etc.); consider community partnerships"

"Many Blacks are not aware of available resources. For those that are aware, they may not trust that they will get culturally sensitive services or that they won't be discriminated against. I don't want to be tagged or treated as someone who is prone to certain diseases or mental health issues. Socioeconomic status is a major predictor of health so if there's equity in quality of housing, education, employment, and income, health disparities will cease to exist."

"A strategy would be to use black medical service providers as your faces for outreach. You also have to consider that many immigrants come from locations where medical treatment is a last resort due to lack of accessibility and expense. Push out preventive care that costs less in the long run, encourage timely check-up through conversation with community leaders."

Limitations

The results of this survey are not meant to provide a complete representation of the ACB community in London and Middlesex County. It is important for those interpreting or using the data and findings from this report to be aware of the study's limitations. These include:

- The sample size was small, roughly 3.3% in comparison to the overall population of the ACB population in London and Middlesex County. The results should not be taken as the only concerns and experiences within the ACB population, nor as concerns and experiences are shared by all in this population.

- The ACB community is not homogenous. It is made up of people embodying various nations, cultures, languages, and experiences. It is therefore worth noting that the results of the survey exist within the confines of the diversity of the participants that were captured and their representativeness of the overall population.

- The language used to promote and conduct the research was limited to English. This restricted participation from those members of the ACB community who spoke French, or any number of the African languages highlighted in Chart 6 as their primary and/or only language.

- Through analyzing survey responses, it was noted that respondents may not have clearly understood the distinction between Public Health and the health care system, as well as the difference between clinical services offered through the MLHU and the broader health care system. This impacts the ability to fully understand how the results apply to MLHU programs and services specifically. In spite of this limitation, the results can still provide insight to guide MLHU's decisions, priorities, and approaches.

- The recruitment of participants to the study relied heavily on the cooperation and collaboration of community members, personal contacts, community champions and cultural organizations. Although the consultation team were able to easily recruit participants, there was no sampling frame and no specific hard or soft quotas were established to ensure specific sub-groups were included in the total sample proportionate to their representation within the wider ACB community, such as francophones, those of Muslim community, or the 2SLGBTQIA+ community. This would have been beneficial and ultimately would result in a more representative cross-section of the ACB population in the final sample. As participants were not randomly recruited and most participants were recruited from community-based organizations and personal contacts, the results may be biased toward the ACB population who are connected to any of the cultural organizations, community centres, churches, or personal networks leveraged to identify participants from the wider ACB London and Middlesex County population.

- It is also important to note that a large sample of the participants were from the Nigerian community (15.7%). This was primarily due to this community's attendance at the community consultation sessions.

- The community engagement activities were administered over a three-month period. This timeframe had an impact on the ability of the consultation team to reach more widely across the city and county to conduct larger-scale peer recruitment and to consider other avenues to further explore emerging themes in different phases of the study. A longer study duration may have yielded a larger sample size.

Recommendations

As the Middlesex-London Health Unit reconsiders its work through the lens of anti-Black racism, the mechanisms to engage people must be reassessed. Many strategies do not reflect or include Black experiences. As a result, they can contribute to the erasure of needs, concerns, preferences, and experiences of Black people, highlighting disparity as decisions are made without the inclusion of Black voices. The Health Unit needs to ensure Black communities are consulted in the development, implementation, and evaluation of Public Health programs, services, and initiatives.

The recommendations outlined involve activities at all levels and acknowledge the importance of community engagement and strengthening community capacity. They include key performance drivers, such as policies, that have the potential to impact health in all sectors, including governance, financing, management, capacity for implementation, social norms, and community participation. These recommendations aim to promote effective community engagement, ensure access to meaningful Public Health programs and services for Black communities, and result in sustained improvements in the provision, utilization, quality, and efficiency of services delivered to the ACB community. They provide direction to the Middlesex-London Health Unit as it focuses on ensuring its programs and services incorporate the voices of the various ACB communities in London and Middlesex County, and as it determines what public health actions must be taken going forward to address the long-standing and current crisis of anti-Black racism. Ultimately, these recommendations are intended to reduce health inequities and improve population health outcomes for ACB individuals, families, communities, and populations across London and Middlesex County.

The recommendations consider the following change areas. Additional information on the change areas can be found in Appendix G.

- Information, Education, and Communication
- Creating Safer Spaces
- Strengthening Community Capacity
- Building Trust
- Research, Data Collection and Use
- Governance and Accountability
- Equitable Access and Service Delivery
- Effective Collaboration

The recommendations are organized according to the framework for Public Health Roles for Health Equity Action, as outlined by the National Collaborating Centre for Determinants of Health, with the addition of a category related to governance and leadership. The roles within the framework highlight the breadth of actions that public health organizations can take, support organizations to assess the strengths and weaknesses of their health equity work, identify where

leadership and action are needed to remove obstacles and enhance opportunity, guide decision-making about resource allocation, and choose strategies for action (NCCDH, 2013).

There are a total of 45 recommendations within the following categories:

- Assess and Report (8 recommendations)
- Modify and Orient (11 recommendations)
- Partner with Other Sectors (10 recommendations)
- Engage in Healthy Public Policy (9 recommendations)
- Reorient Governance and Leadership (7 recommendations)

As ongoing engagement and consultation occurs through the processes of planning and implementing recommendations within this Plan, MLHU will need to remain open to the evolving needs, insights, and direction from the ACB community so that the organization can be responsive to any necessary refinements or adjustments to these recommendations.

Some of the recommendations can be implemented over the short-term and intermediate-term, while many of them will take much longer to plan, implement, and embed into ongoing work. It is critical that the organization ensure ongoing and sustained commitment to and resourcing of this work over the long term in order for true change to be realized.

Assess and Report

In this area of action, public health assesses and reports on a) the existence and impact of health inequities, and b) effective strategies to reduce these inequities (NCCDH, 2013). This could include, for example, looking at the relationship between health outcomes and the experience of racism, identifying whether members of ACB communities are accessing public health services or not, increasing the understanding of the extent of racism in local systems and in the local community, and gathering information to inform public health practices to reduce health inequities.

1.	Prioritize the collection of race-based data
2.	Assess and report on the impacts of individual and systemic racism on health outcomes of individuals and communities in London and Middlesex County.
3.	Encourage health and other community partners to collect race-based data, and support and strengthen their capacity to do so (e.g., tools, processes, etc.).
4.	Assess potential unintended negative impacts of public health programs and services on ACB communities.
5.	In collaboration with community partners and the Black community, assess public health-related strengths within targeted ACB communities, including mapping where helpful, and identify strategies to leverage the strengths.
6.	In collaboration with community partners and the Black community, assess public health-related issues of concern within Black sub-populations, including mapping where helpful, and identify which public health programs and services are most needed for ACB communities and where they are needed.
7.	Identify existing barriers for members of the Black community to participation at decision-making and collective action tables that the MLHU leads or contributes to, and share / use information gathered to ensure barriers are eliminated.
8.	Ensure that race-based data, strengths and needs assessment data, and health outcome data is used to inform planning, implementation and evaluation of all public health interventions for ACB communities.

Modify and Orient

In this area of action, public health modifies and orients interventions and services to help reduce inequities, with an understanding of the unique needs of populations that experience marginalization (NCCDH, 2013). This could include, for example, collaborating with ACB communities when developing and evaluating programs and services, using evidence to tailor strategies to meet the unique needs and circumstances of ACB communities, and engaging with and serving those who experience barriers in accessing public health programs and services.

9.	Prioritize building trust with the ACB Community through interactions that are culturally safe and built on respect.
10.	Co-create MLHU-ACB community engagement strategy.
11.	Create and consistently implement processes that engage and include Black voices from the community in shared decision-making and in the planning, implementation, and evaluation of public health programs, services, and initiatives.
12.	Ensure ACB community members are effectively informed, on an ongoing basis, about interpretation services available through MLHU, and expand available interpretation services to include a wider range of African languages.
13.	Create a campaign focusing on the ACB community that highlights MLHU services and programs, using diverse languages and delivery mechanisms (e.g., social media, email, radio, WhatsApp blasts, community centres, barber shops, hair salons, Black-owned businesses etc.).
14.	Collaboratively develop communications, health promotion, and education materials that are grounded in Black culture and identified community need, are available in various languages, and are disseminated through multiple strategies with support from ACB-led organizations.
15.	Initiate and sustain anti-Black racism key messaging, including materials on the MLHU website and social media platforms.
16.	Ensure physical and virtual spaces are reflective of Black cultures (e.g., images, greetings in different African languages).
17.	Strengthen all facets of MLHU presence within the ACB community (e.g., join committees, attend launches, participate in capacity building initiatives, create liaison role).

18.	Create a an ACB paid position at MLHU that will focus on relationship-building, communication, and connection between the ACB community and MLHU.
19.	Consider innovative strategies to engage and enhance capacity of ACB organizations to support Public Health-related programs and community-based consultations (e.g., funding, project contracts, etc.).

Partner with Other Sectors

In this area of action, public health partners with other government and community organizations to identify ways to improve health outcomes for populations that experience marginalization (NCCDH, 2013). This could include, for example, working with community-based ACB-led organizations to remove barriers for optimizing health for ACB communities, bringing ACB and ally organizations together to identify and work towards collective goals to improve health outcomes in ACB communities, and partnering with local ACB influencers and community members to build community capacity.

20.	Lead and/or actively participate in local collective action initiatives focused on addressing and eliminating racism.
21.	Create and strengthen relationships and partnerships with ACB organizations, including the diverse faith institutions within the ACB community, in London and Middlesex County, to collaboratively enhance population health outcomes.
22.	Use a decision-making matrix that includes an anti-racism lens when choosing to engage in new partnerships or collaborative initiatives.
23.	Leverage the existing knowledge, expertise and wisdom of local ACB health workers to assist in identifying public health services and initiatives that could improve ACB health outcomes.
24.	Strengthen and facilitate collaboration efforts between ACB organizations and other racialized community groups to identify similar needs, challenges, priorities, goals, and opportunities for collaboration to improve population health outcomes.
25.	Lead and/or engage in a local health and service agency community of practice to promote, foster and extend interprofessional collaborative learning and practice, particularly around anti-Black racism and health equity best practices.
26.	Strengthen processes and tools for greater communication and collaboration between service providers to improve ACB access to available programs and services.
27.	Promote the creation and ongoing maintenance of an ACB health and allied health care professional directory so that ACB community members can more easily access practitioners from the ACB community if they wish.
28.	Increase informal and formal education and mentorship opportunities for ACB students from local post-secondary institutions and strengthen relationships with ACB students/student associations.

29.	Seek out and engage in research-specific partnerships with universities, research institutions (e.g., London Poverty Research Centre, the Canadian Institute for Health Information, and Institute for Clinical Evaluative Sciences) to help support race-based data collection, utilization and research.

Engage in Healthy Public Policy

In this area of action, public health leads, supports and partners? with other organizations in policy analysis and development, and in advocacy for improvements in the determinants of health (NCCDH, 2013). This could include, for example, examining existing policies and practices to better understand their potential contribution to the experience of anti-Black racism, reviewing and designing all policies – including institutional policies, municipal by-laws, and legislation – through an anti-Black racism lens, and advocating with others for changes in social, economic, cultural and environmental conditions to address racism and its insidious systemic influence.

30.	Develop a "ways of working" organizational policy to guide MLHU's work and to hold individuals and the organization to account.
31.	Develop and implement organizational policy to ensure Board of Health members, senior leaders, and all MLHU employees complete education related to ACB cultural safety training, cultural humility, Anti-Black racism, anti-oppression and decolonization.
32.	Develop an organizational policy related to the collection of race-based data, and advocate for the collection of race-based data to be provincially mandated within public health and across health and social service sectors.
33.	Seek out opportunities at community tables to advocate for increased Black representation and meaningful participation (including at decision-making tables), and call others to join in taking the initiative to challenge anti-Black racism and existing injustices.
34.	Review communication and visibility of procurement opportunities to enable bidding from Indigenous and Black-owned businesses and suppliers.
35.	Ensure that the MLHU has adequate funding and resources allocated to implement the recommendations outlined in the Anti-Black Racism Plan and maintain Black leadership of this work.
36.	Advocate with health system leaders for ACB "Connectors" that can support ACB community members with connection and navigation within and across the entire health care system.
37.	Lead and/or actively participate in healthy public policy initiatives focused on mitigating and addressing, at an upstream level, the negative and inequitable impacts of the social determinants of health which are priority for local ACB communities, and ensure the policy approaches take an anti-Black racism lens.

38.	Establish an MLHU-wide system for ensuring accountability and monitoring progress towards implementation of the anti-Black racism recommendations (e.g. annual performance reviews, senior leadership accountabilities, balanced score card indicators, bi-annual Board of Health status reports).

Governance and Leadership

In this area of action, public health must consider how governance and leadership structures and processes can be realigned and recreated to create new and enhance any existing approaches that share power and actualize racial equity and equality. This could include, for example, co-creating community-led mechanisms related to race-based data, identifying opportunities to share decision-making and leadership, and introducing structures to enhance accountability to the ACB community.

39.	Create an ACB Anti-Black Racism Plan Integration Table (ABRPIT), with compensated representation from the diverse local ACB communities (similar to a WatSAN* committee structure) to support the implementation of MLHU's anti-Black racism plan in an effective, responsive, collective and accountable manner. This Table would support and/or provide direction on the following, BUT not be limited to: a) community engagement, b) collaborative planning processes, c) program evaluation, d) data review and protection, e) accountability and implementation leadership, f) policies and praxis. One table with sub-tables could be created (structure of the committees could also follow a WatSAN framework). *Water, Sanitation & Hygiene (WatSAN)
40.	Support the ACB communities in creating community-led mechanisms and structures to have ownership, control and access, and possession of data collected to prevent the historical and potential misuse of data, and/or leverage existing efforts across the Province to do the same.
41.	Create safer spaces and mechanisms for MLHU staff who identify as ACB to voice concerns and provide leadership in decisions that impact Public Health practice within the ACB community.
42.	Increase visual representation and organizational leadership of Black and minority groups within the MLHU.
43.	Review Board of Health and senior leadership decision making processes with an anti-Black racism lens (e.g. PBMA).
44.	Work with the Black community and other providers to create/adopt an anti-racism charter document and issue a challenge to other organizations to do the same.
45.	Embed an equity, diversity and inclusion lens in strategic planning to ensure anti-Black racism efforts are at the highest priority within the organization.

References

1. Visible Minorities in Canadian Health Data and Research, https://ir.lib.uwo.ca/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1013&context=pclc
2. Wanzer, M. B., Booth-Butterfield, M. & Gruber, K. (2004). Perceptions of health care providers' communication: Relationships between patient-centered communication and satisfaction. *Health Care Communication, 16* (3), 363-384.
3. Mount Saint Vincent University, Acadia University, Queen's University, the University of Winnipeg and the Royal Military College of Canada
4. Wellesley Institute (2017). Socio-demographic data and equity in health services in Ontario: building on strong foundations. https://www.wellesleyinstitute. com/wp-content/uploads/2017/10/Collecting-Sociodemographic-Data.pdf
5. 2016 Canadian Census Data: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/Page.cfm?Lang=E&Geo1=CSD&Code1=3539036&Geo2=PR&Code2=47&Data=Count&SearchText=North&SearchType=Begins&SearchPR=01&B1=All
6. https://nccdh.ca/images/uploads/PHR_EN_Final.pdf
7. Ontario Human Rights Commission. (2009). "Count Me In, Collecting Human Rights Based Data". http://www. ohrc.on.ca/en/count-me-collecting-human-rightsbased-data#fn2
8. Statistics Canada (2016). Diversity of the Black Population in Canada: An Overview. https://www150. statcan.gc.ca/n1/en/pub/89-657-x/89-657-x2019002-eng. pdf?st=omj-D8zq
9. Health Quality Ontario (2016). Health Quality Ontario's Health Equity Plan. https://www.hqontario.ca/Portals/0/ documents/health-quality/Health_Equity_Plan_Report_En.pdf

Appendix A - Additional Resources to Support MLHU's Deeper Understanding of Anti-Black Racism

We have searched for the many answers to the question, "What does it mean to live and be well?" In particular, what does it mean as, and for, Black people in the face of global anti-Blackness?

Furthermore, what are Black people saying about what it means to be well and how we can write our own centered answers to that question? The resources in this section offer various perspectives and insights towards this question. They are by no means exhaustive looks, but invitations to begin the exploration. Included in the resource list are not only articles and books for learning, but also tools that each of us can use to explore our own personal states of wellbeing.

THERAPY FOR BLACK GIRLS
DR. JOY HARDEN BRADFORD | PODCAST
"Therapy for Black Girls is an online space dedicated to encouraging the mental wellness of Black women and girls."

- Podcast: https://therapyforblackgirls.com/podcast/
- Website: https://therapyforblackgirls.com/

CONQUERING THE BLACK GIRL BLUES
LANI VALENCIA JONES, BEVERLY GUY-SHEFTALL | 2015 | JOURNAL ARTICLE
In this article the authors explore the need for Black feminist response to mental health servicing for Black women.

A NOTE 2 SELF
ALEXANDRA ELLE (ALEX ELLE) | MEDITATION JOURNAL
This is a guided meditation journal created by Alexandra Elle. This journal contains daily reflective prompts. This journal is a meditative aid created by a Black woman.

THE FUTURE OF HEALING: SHIFTING FROM TRAUMA INFORMED CARE TO HEALING CENTERED ENGAGEMENT
SHAWN GINWRIGHT | 2018 | ARTICLE
This article discusses why trauma-informed care is incomplete in addressing the root causes of trauma.

RACE AND WELL BEING: THE LIVES, HOPES, AND ACTIVISM OF AFRICAN CANADIANS
DAVID ESTE, CARL JAMES, WANDA THOMAS BERNARD, AKUA BENJAMIN | 2010 | BOOK
This book explores how experiences of racism, combined with other social and economic factors, affect the health and well-being of African Canadians.

BLACK EXPERIENCES IN HEALTH CARE SYMPOSIUM REPORT
BLACK HEALTH ALLIANCE, SINAI HEALTH, HEALTH COMMONS SOLUTIONS LAB| 2020 | REPORT
Link to report:
https://drive.google.com/file/d/1s1ErqLKuwxJWbHuqPePrWWL_Czr7NOP4/view

Symposium Report: https://www.mountsinai.on.ca/about_us/health-equity/pdfs/SHS-BEHC-reportFINAL-aoda-final.pdf

The Black Experiences in Health Care Symposium report from the Black Health Alliance highlights how social determinants of health, anti-Black racism, and institutional practices in healthcare, disproportionately negatively impact Black communities. The report also advocates for race-based data collection in partnership with Black communities. They provide lived experiences within the healthcare system, as well as statistics.

BARRIERS AND FACILITATORS TO ACCESSING MENTAL HEALTHCARE IN CANADA FOR BLACK YOUTH: A SCOPING REVIEW
Tiyondah Fante-Coleman & Fatimah Jackson-Best | 2020 | Article
This scoping review takes an in-depth look at barriers to access for Black youth looking for mental health services in Canada.

HEAVY: An American Memoir
KIESE LAYMON | 2018 | BOOK
This memoir is as much about the life of one young Black man navigating trauma, self-reckoning, and weight as it is about the trauma that the Black body holds and how that trauma reverberates throughout our intimate lives. A number of interesting questions are posed throughout this text for us to consider.

BLACK WOMEN'S HEALTH MATTERS
CAITLIN DUNNE |2020 | ARTICLE
The authors review the lack of research, particularly in Canada, about Black women's health and some of the reasons why this may be so.

Appendix B – Literature Review and Jurisdictional Scan

> "History informs anti-black racism and racial stereotypes that are so deeply entrenched in institutions, policies and practices, that its institutional and systemic forms are either functionally normalized or rendered invisible, especially to the dominant group,"
>
> — Working Group of Experts on People of African Descent on its mission to Canada from the United Nations General Assembly Human Rights Council, 2017

Introduction

The literature review revealed that the literature on Anti-Black Racism in relation to public health leadership, planning and implementation was sparce at best. While there was a large body of writing on racism in health and health equity that were available from many sources, including academic research, grey literature and opinion-based writing that can be applied across professions and structures, the presence of literature on Anti-Black Racism in public health was limited. Much of what was available counted as secondary sources, including opinion pieces, commentaries and some grey literature. There was even less writing on Anti-Black Racism planning in the public health sphere.

Canada's universal health care system is often understood as a central pillar of a national commitment to social equity and social justice. Such an understanding makes it difficult to raise the issue of racial inequalities within the context of the Canadian health care system. Indeed, far too little research has been conducted in Canada on racial inequality in heath and heath care. *(S. Nestel, 2020).*

Racism is a complex social problem found at every level of society both within and beyond the health care system. It involves power differences that are often enacted at the individual level through stereotyping *(racist beliefs),* prejudice *(racist emotions)* and discrimination *(racist behaviours and practices)*. It is also evident at the cultural level through an embedded network of beliefs and values that justifies **ethnocentric** practices, and at the systemic level through institutional practices and policies. While it is most commonly directed in the health system against visible minority and Indigenous clients/patients, it is also enacted against practitioners by peers and by clients/patients. A significant aspect of racism that remains even more deeply buried is that of a corresponding white privilege. A number of current studies argue that racism directly mediates health outcomes through cumulative stress-related impacts that increase vulnerabilities and thereby health outcomes. The effects of racism extend over time informing the lives, actions and health of those victimized by it. *(J. Etowa, 2014).*

The WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The WHO also highlights that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition and that the

health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and States. However, the impact of racism and its relationship to health inequities remains a significant challenge, particularly among the African, Caribbean, Black *(ACB)* population.

Black people also referred to as people of colour due to their diversity of skin colour are children of parent(s) of African and Caribbean descent who live in different continents across the globe. Health inequities among racial minorities are pronounced, persistent, and pervasive *(Sondik et al., 2010).* Racism is one cause of these inequities. Studies have found that individuals who report experiencing racism exhibit worse health than people who do not report it *(Williams and Mohammed, 2009)*. Black people in particular have persistently been discriminated against and have suffered organized deliberate killings, marginalization, and systemic attacks to keep them as lower-class citizens across continents from the United States, Europe, Canada, Asia and even on the Mother-land continent Africa itself as witnessed in Apartheid South Africa. About a century ago, W. E. B. Du Bois noted that "The Negro death rate and sickness are largely matters of [social and economic] condition and not due to racial traits and tendencies" and in the 1985 Heckler report, the influential Report of the Secretary's Task Force on Black and Minority Health alluded to racism in stating, "Blacks, Hispanics, Native Americans and those of Asian/Pacific Islander heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology" *(Heckler 1985, p. 1).* Reviews consistently find that persons who self-report exposures to racism have greater risk for mental and physical ailments *(Brondolo et al., 2009).* These associations are seen among many racial/ethnic minority populations, including Black people *(Mays et al., 2006).*

Researchers have long argued that racism operates at multiple levels, ranging from the individual to the structural *(Carmichael and Hamilton, 1967; Jones 2000)*. The metaphor of an iceberg is useful for describing the levels at which racism operates *(Gee et al., 2009).* The tip of the iceberg represents acts of racism, such as cross-burnings and the police kneeling on George Floyd's neck for minutes until he died on the street of Minneapolis when a store clerk alleged that George tried to use a counterfeit $20 bill, that are easily seen and individually mediated. The portion of the iceberg that lies below the water represents structural racism; it is more dangerous and harder to eliminate. Policies and interventions that change the iceberg's tip may do little to change its base, resulting in structural inequalities that remain intact, though less detectable" *(Gee and Ford, 2011).* To investigate racism seriously as a fundamental determinant of health disparities requires attending to the multiple manifestations of racism. Structural racism operates on the macrolevel of the socio-ecological framework; therefore, it more fundamentally influences outcomes than do proximal factors *(Gee and Ford, 2011)*. Additional forms of racism include social segregation, immigration policy, intergenerational transfer of assets and liabilities, prison industrial complex, historical trauma, emotional rules, police brutality, work discrimination, and media portrayals of black people.

Literature Review Objectives

The purposes of this literature review is to gather information on the context and impact of Anti-Black racism in relation to public health and its mandate. This literature review is intended to feed into the larger objectives of this project, which include the following:

i. To understand the current best/wise practices around the implementation of anti-Black racism in a public health context.
ii. To understand the public health related needs and expectations of the diverse Black community in London-Middlesex.
iii. To inform public health and organizational prioritization relevant to public health's mandate.

Academic papers and grey literature were reviewed that contextualizes the impact of Anti-Black racism on public health outcomes, and the manifestation of Anti-Black racism within the public health system *(i.e. systemic issues and barriers).*

Anti-Black Racism and Public Health Delivery in Canada

According to the Ontario Ministry of Health and Long-term Care, public health is focused on the daily lives of the whole population and is grounded in a population health approach based on upstream efforts to promote health and prevent diseases. The Ontario MOH policies are directed on four domains: social determinants of health, healthy behaviours, healthy communities, and population health assessment *(MOH, 2018).*

In Ontario research has shown a high burden of psychosocial distress among minorities that include black people who make up 2.9% of the population, and sadly many of these minorities are not accessing available mental health services partly due to cultural norms. It is not surprising that minorities experience greater exposure to negative effects of some social determinants of health like income insecurity and social isolation, especially immigrants and refugees who are separated from their social supports putting them at an increased risk of mental health problems and illnesses *(Nguyen et al., 2016)*. Research shows that mental disorders are the second leading cause of human disability and premature death, a significant public health concern with chronic debilitating course, depressive symptoms and decreased quality of life *(Grace et al, 2016).* Beyond mental disorders, social support and stressful life events have been shown to affect an individual's mental health and psychosocial wellbeing *(Nguyen et al, 2016).*

Minority populations are disproportionately burdened by having the highest risk of developing Chronic Heart Failure *(CHF)*, and experience poorer outcomes as compared to white counterparts. Although self-care activities can improve the quality of life for people living with CHF, adherence remains low among minorities due to lack of information, socio-cultural norms were recommendations from health care professionals might conflict with cultural practices of individuals *(e.g. staying physically active is a commonly recommended CHF self-care behaviour in Western health care, while resting when feeling ill is the norm in other cultures)*, some patients might have difficulty going on an healthier diet because they might be accustomed to

“unhealthier” traditional diets *(Surikova et al., 2020).* “A patient’s understanding of self-care for CHF is shaped by conventional dominant cultural guidelines by heart health professionals, individual ethnocultural values and beliefs about health, individual competencies for assimilating self-care information, and the individual’s established lifestyle habits and the broader practices of their family or social networks” *(Surikova et al., 2020).*

Arguably, expressions of Anti-Black sentiments heightened across the globe in 2020. For most Black people in Canada, racism is an everyday reality. Despite Canada’s reputation for promoting multiculturalism and diversity, Anti-Black racism has its deep roots in the history and experience of slavery, racial segregation, and colonization of Black people here in Canada *(City of Toronto, 2017).* Per their definition, the City of Toronto (2017) defines Anti-Black racism as policies and practices embedded in Canadian institutions that reflect and reinforce beliefs, attitudes, prejudice, stereotyping and discrimination that are directed at members of the Black community. The legacy of Anti-Black racism is thus experienced by people of colour through, inter alia, poor health and mental health outcomes. Indeed, Anti-Black racism is an important public health concern, especially for Black people in Canada. The fact that the American Medical Association *(AMA, 2020)* recognizes racism as a public health threat is telling of its importance.

Access to Public Health Resources

Even with the recognition that Anti-Black racism leads to health inequalities, studies related to Anti-Black racism and public health delivery are scant in Canada. Thus, we also rely far too heavily on the experiences of Black people in the United States of America to fill this void. Our environmental scan and literature review has told us that we need to shift our gaze and begin to look at the work that is being done in the United Kingdom *(UK)* as opposed to the United States of America. *Phelan (2015).* Based on the fact that the populations of ACB peoples in Canada and the United Kingdom are similar in origin *(histories)* and overall population representation (size). Negative health impacts due to unfair access to public health care may manifest in a variety of situations and processes that connect race to health outcomes *(Phelan and Link, 2015).* Studies have shown that discrimination begets social stress: a response to threatening or burdensome situations that induces physiological responses.

Health Disparities among Black Population in London

London is a growing city in Southwestern Ontario with an estimated population of 383, 822 according to the 2016 Canadian census *(Statistics Canada, 2020)*. According to sources, per the 2016 census visible minorities make up 16% of London's population out of which Black people make up 2.5% *(Statistics Canada, 2020).*

Given the gap in the research literature with respect to Anti-Black racism and public health care in London, Ontario, we draw insights from health-related studies; specifically, on HIV conducted by Konkor et al. from Western University. Konkor et al., 2020 examined healthcare access and HIV testing among heterosexual ACB men in London, Ontario and found that participants who had difficulty accessing healthcare, experienced discrimination, were young, and less likely to

test for HIV. Konkor et al. concluded that heterosexual ACB men may have good reasons to be cautious of their HIV status and who gets access to their health information given pervasive and racist tropes about defective Black bodies making it increasingly important to have culturally inclusive and safe spaces where heterosexual ACB men can feel a sense of belonging, connection and trust when testing for HIV and using other health screening services. Konkor et al. (2020) proposed a shift away from the longstanding behavioural and individual approaches to public health and towards integrating structural factors that could help us unpack the complex connections between structural and individual level factors among marginalised populations. Konkor et al. (2020) make the argument that everyday living conditions and experiences also known as the social determinants of health have been shown to be more paramount in explaining the health situations of Canadians than biomedical factors. The social determinants of health include income, education, employment and job security, housing, immigration status, race, power imbalances and discrimination *(Konkor et al., 2020)*. Their research also mentions how Black people in Toronto have limited access to professional healthcare, this would suggest that members of the Black community are vulnerable to poor psychological and physical health in Toronto and other cities across Canada.

In another HIV studies among bleck people in Ontario, Canada, Carmen et al. (2016) conducted a cross-sectional survey of African and Caribbean Black women living with HIV in 5 Ontario cities and concluded that "racial discrimination had significant direct effects on: HIV-related stigma, depression and social support, and an indirect effect on self-rated health via HIV-related stigma. HIV-related stigma and housing insecurity had direct effects on depression and social support, and HIV-related stigma had a direct effect on self-rated health" (Carmen et al., 2016).

Mechanism of Racism and Poor Health Outcomes

Noonan et al. (2016) report that Black people have the greatest health issues among the population in the United States. Institutional and systemic racism, stigmatization, marginalization, and exclusion are underlying factors in health disparities that black people face in the United States, Canada and/or other parts the Globe. Socially, racism is correlated with substandard employment, housing, education, income, and access to health services. Individually, Noonan et al. (2016) report that racism exerts its deleterious effects through negative cognitive and emotional phenomena leading to psychopathology and morbidity. Majority of Black people are religious, and it is important to realize that 30% of blacks in the USA believe that their health is dependent upon fate (Noonan et al, 2016) and this reduces accessing healthcare. "Historically structured racist practices and institutions are further reproduced by white-majority policymakers, decision makers, administrators, educators, and healthcare providers. Addressing "health disparities," "cultural competence," and "racial bias" at the individual level through healthcare services misses the social, institutional, and organizational levels underlying health disparities among blacks. At the individual level, this focus is translated into insufficient allocation of resources to black communities and populations" (Noonan et al, 2016).

Black people are most likely to live in poor neighbourhoods (Phelan and Link, 2015) with issues like low quality housing that affect asthma, reduce the benefits of exercise because of safety concerns, decreased access to healthy foods (Noonan et al, 2016). Some of the barriers to overcome include transportation, access to culturally friendly services, mechanisms that avoid stigmatizing clients and ensure confidentiality of information as well as dealing with physician and other healthcare providers biases that lead to a lower quality of care for blacks due to race, gender, and socioeconomic status. Bias, stereotyping, prejudice, clinical uncertainty on the part of healthcare providers and patients refusing care also contribute to racial disparities in healthcare (Noonan et al, 2016).

Jurisdictional Scan on Anti-Black Racism Public Health Initiatives

Studies has shown that racism and discrimination are significant drivers of inequalities in social determinants of health for numerous Black people globally. Several jurisdictions have implemented initiatives to address discrimination against Black people that is deeply entrenched and normalized in our health systems' policies and programs. These practices are often invisible to those who do not feel its effects. This section presents a scan of public health practices and programs that address racism on Black population. The jurisdictional scan was conducted between November and December 2020.

The overall objective of the scan is to determine and understand the current Anti-Black racism practices in a public health/health/organizational context. The aim of the scan includes:

1. Identify current public health initiatives across Canadian jurisdictions that help combat and address racism, and racial discrimination among Black people.
2. Identify Anti-Black racism practices, programs and models outside of Canada that can serve as promising practices for MLHU, Ontario.

Methodology

The methodological framework for the jurisdictional scan comprised of the following steps:

1. Development of criteria for inclusion which entails creating a working definition for key terms.
2. An initial online scan of health programs and models existing in relevant public health agencies and organizations across Canada.
3. A subsequent online jurisdictional scan of international public health initiatives and health models.

Numerous search operators were used to conduct the online jurisdictional scan, including Boolean operators such as (AND, OR), phrase-searching (", "), location searches (site:), website domain (e.g., Toronto.ca), and file type (e.g., MS Word, pdf).

For the purpose of this jurisdiction scan, anti-discriminatory practices, programs or policies that are not directed to Black population's health are not considered in this research. The scan

focusses on strategies, programs, services and models that address public health/ health-related racism and racial discrimination against Black people.

Findings

Canadian Context

A. Anti-Black Racism Programs/Practices/Models across Canada

1. Ontario's Anti-Black Racism Strategy - Ontario

The Government of Ontario created an Anti-Racism Directorate and launched "A Better Way Forward: Ontario's 3-Year Anti-Racism Strategic Plan". The Anti-Black Racism Strategy is about targeting systemic racism in policies, decisions and programs, and helping Ontario move toward long-term systemic change.

2. City of Toronto Anti-Black Racism Plan - Toronto

In 2016, the City of Toronto developed a five-year action plan specifically targeting and tackling anti-Black racism through the application of an intersectional lens. This is the first municipality to develop a comprehensive anti-Black racism plan that consists of 5 themes, 22 recommendations and 80 actions. Highlights of the Health and Community Services section Anti-Black Racism action plan entails recommendations to improve the quality and effectiveness of health and community services for Black Torontonians.

3. City of Vancouver - Towards a Healthy City: Addressing Anti-Black Racism in Vancouver

This project aims to contribute to the fulfilment of the City of Vancouver's healthy city goals by reviewing the City's policies through an anti-Black racism lens. The project identified long-term and short-term best practices and recommendations to address anti-Black racism in Vancouver. The project comprised interviews with City staff, the Hogan's Alley Society and selected Black community members.

4. Addressing anti-Black racism in Peel – Peel Region, Ontario

The Regional Council of Peel recognizes anti-Black racism as a crisis within the Region of Peel. The Council affirms its commitment to address systemic discrimination by supporting policies and programs that address the inequities that the black community and other marginalized groups continue to experience within Peel, including but not limited to:

- Engaging black communities to address racial inequities related to health outcomes.
- Providing funding to mental health/housing/harm reduction programming to support marginalized groups including the black community through Peel funded programs.
- Ensuring Black led or Black serving social agencies in Peel are funded equitably through the Regional funding mechanisms.
- Requesting that the local municipalities collaborate with the Region to carry out anti-racism public education.

5. *Taking Action Against Racism: What Albertans Told Us and What's Next – Alberta*

The Alberta Action plan was released in 2018 and it includes short- and long-term actions to combat racism. Two actions launched in 2020 summer: an advisory council and a community grant program. For the remainder, the Government of Alberta will continue to engage with Albertans to make sure they are on the right path.

6. *Richmond Intercultural Strategic Plan - City of Richmond*

To achieve the City of Richmond's Intercultural Vision: "for Richmond to be the most welcoming, inclusive and harmonious community in Canada", the Richmond City is committed to establishing and working towards addressing the perception and reality of racism and discrimination in the community as well as dispelling misconceptions related to culture that maintain stereotypes and foster prejudice.

B. Identified Anti-Racism Service Organizations / Agencies across Canada

1. *Across Boundaries – Toronto*

Across Boundaries provides a dynamic range of mental health support and services and works within Anti-Racism/Anti-Black racism and Anti-Oppression frameworks. These frameworks address the negative impact of racism and discrimination on mental health and well-being.

2. *Access Alliance - Toronto*

Access Alliance provides services and addresses system inequities to improve health outcomes for the most vulnerable immigrants, refugees, and their communities. The "Health With Dignity" Program was launched by Access Alliance in 2015 to help vulnerable clients navigate the health-care system and improve their capacity to manage their health. The program uses health coaches to connect people with health services for primary care, help them with ongoing management of chronic illness, and provide referrals to other community supports that address determinants of health such as housing, legal and food security.

In its seventh year of operation, the Non-Insured Walk In Clinic (NIWIC) is a crucial service that operates under the umbrella of Health With Dignity. The NIWIC provides health with dignity to a population that is often ignored, invisible or avoided. It is one of the few clinics in the city dedicated to serving the medically uninsured and the only clinic to date that provides a pathway to ongoing primary care for this marginalized group of residents, particularly Black people.

3. *Canadian Anti-racism Education & Research Society – Vancouver*

The Canadian Anti-racism Education and Research Society is a Canadian non-profit organization that tracks hate groups and extremism, provides direct support to victims of racism and discrimination, and lobbies government and governmental agencies for the development of effective policy and legislation to stop racism. Programs and initiatives include: "Diversity Training Workshops" and "Advocacy and Research."

International Context

The jurisdictional scan found that there is a paucity of public health practices, initiatives or programs on Anti-Black racism outside Canada. This could be attributed to the unavailable health data for Black people which could have helped inform the development of health initiatives to address racism in this context. Without consistent collection of health data on black population, the gaps in public health services and health challenges for Black people remain invisible, making much-needed targeted public health programs difficult.

Advice for Public Health

Drawing from the literature review and jurisdictional scan, the following are recommended for consideration:

- All health professionals including physicians must take a stance against Anti-Black Racism and injustices especially black health professionals because research shows that most minorities are more likely to seek care from healthcare professionals of their own ethnicity (Noonan et al, 2016)
- Proactive efforts must be taken throughout our health systems to eliminate the conscious and unconscious lower quality of care provided to black people
- Public health should take the lead in advocating for and providing the expertise to ensure that the determinants of health are equally provided to members of the Black community and all races, through an integrated approach
- Care for the potentially pregnant women is crucial and may have long-term consequences for her and her offspring. Comprehensive care for the infant, child, and adolescent is the key to their lifelong health and also their ability to function as productive and creative people
- Health professionals should work with members of the Black community to co-create programs about their health in the language and culture of the client they serve to be effective. That is to say that the translation of health information into a form that black people can understand and use. Community members should be trained to become Health Systems navigators so that they can provide support to members of their community in their language and in a safe way
- The development of health policy is most often the responsibility of people with no public health expertise, no intimacy with the Social Determinants of Health and with no-too-little inputs from members of the Black community
- Health Policy should be vetted by Black health professionals and community members who are knowledgeable of the community's diversity and culture and committed to their well-being
- Politics is a key factor in the fight to eliminate the disparities in health provision and outcomes in our health system and we should be aware and engage accordingly
- Champion the interconnectedness of the social factors that have a significant impact on our health: income, housing, education, food, neighbourhood, sense of community, race

and racism and access to health care as a way of working that cuts across all aspects of the organization.

Conclusion - State of the literature and research gaps

While many features of Anti-Black Racism identified in the literature may apply to a public health setting, much of the research does not consider the unique characteristics of the public health practice environment, how public health action for equity depends on collaboration with health and non-health partners, or the focus on change and transformation at the population/ community engagement level.

There were a number of sources on racism theory, health equity and diversity and inclusion BUT sources that were specific to Anti-Black Racism and Public Health there was very little literature that looked closely at how Anti-Black Racism could be combated in the public health space. Again, there is even less literature that specifically considers Anti-Black racism in public health and what has been done and needs to be done to advance health equity within the system or how public health can be strengthened or expanded to confront Anti-Black Racism internally, within practice, policy, theory and administration of public health programs.

Literature did exist that looked at racism with public health and the overall health system. These were more general and inclusive of other racialized groups.

Future Areas for Research - Public Health Specific to Anti-Black Racism

There is a need for further empirical and theoretical research in the area of anti-Black Racism in public health. In particular, further research would enrich the field of Anti-Black Racism in public by exploring the following topics:

- The relationship between public health organizations and Black communities
- Areas of focus for strengthening public health leadership specific to reducing health inequities within Black communities *(i.e., what works)*
- Relational components within public health programs and how communities can address health equity
- Redefining definitions and descriptions of public health's lexicon that specifically include the concepts of health equity, racism, Anti-Blackness and social justice
- Development of leadership knowledge and skills at all levels of public health organizations, including the front line and across disciplines on Anti-Black Racism
- Working with communities to develop leadership within communities and within community, organizations in partnership with public health
- How can Public Health support knowledge and skill development to advance health equity approaches, policies and planning specific to Black communities

References

1. Brondolo E, Brady ver Halen N, Pencille M, Beatty D, Contrada R. Coping with Racism: A Selective Review of the Literature and a Theoretical and Methodological Critique. Journal of Behavioral Medicine. 2009; 32(1):64–88. [PubMed: 19127420]
2. Carmen H. Logie, Jesse I. R. Jenkinson, Valerie Earnshaw, Wangari Tharao, and Mona R. Loutfy. 2016. "A Structural Equation Model of Hiv-Related Stigma, Racial Discrimination, Housing Insecurity and Wellbeing among African and Caribbean Black Women Living with Hiv in Ontario, Canada." Plos One 11(9). Retrieved November 14, 2020. DOI: 10.1371/journal.pone.0162826
3. Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities. *Du Bois Review: Social Science Research on Race*, *8*(1), 115–132. https://doi.org/10.1017/S1742058X11000130
4. Grace, S. L., Tan, Y., Cribbie, R. A., Nguyen, H., Ritvo, P., & Irvine, J. (2016). The mental health status of ethnocultural minorities in Ontario and their mental health care. *Bmc Psychiatry*, *16*, 47–47. https://doi.org/10.1186/s12888-016-0759-z
5. Heckler, MM. Report of the Secretary's Task Force on Black and Minority Health. Washington, DC: U.S. Department of Health and Human Services; 1985.
6. Konkor, I., Lawson, E. S., Antabe, R., McIntosh, M. D., Husbands, W., Wong, J. & Luginaah, I. (2020). An Intersectional Approach to HIV Vulnerabilities and Testing Among Heterosexual African Caribbean and Black Men in London, Ontario: Results From the weSpeak Study. Montague Cobb-NMA Health Institute 2020. Journal of Racial and Ethnic Health Disparities. https://doi.org/10.1007/s40615-020-00737-3.
7. Ministry of Health and Long-Term Care. (2018, January 1). Protecting and Promoting the Health of Ontarians. Page 6
8. Mays VM, Cochran SD, Barnes NW. Race, Race-Based Discrimination, and Health Outcomes among African Americans. Annual Review of Psychology. 2006; 58:201–225.
9. Nguyen, Han et al. 2016. "The Mental Health Status of Ethnocultural Minorities in Ontario and Their Mental Health Care." Bmc Psychiatry 16(1):1–10. Retrieved November 14, 2020. DOI 10.1186/s12888-016-0759-z.
10. Noonan, A. S., Velasco-Mondragon, H. E., & Wagner, F. A. (2016). Improving the health of African Americans in the USA: An Overdue Opportunity for social justice. Public Health Reviews, 37, 12–12. https://doi.org/10.1186/s40985-016-0025-4
11. Sondik EJ, Huang DT, Klein RJ, Satcher D. Progress toward the Healthy People: 2010 Goals and Objectives. Annual Review of Public Health. 2010; 31(1):271–281.
12. Surikova, Jelena, Ada Payne, Karen-Lee Miller, Arian Ravaei, and Robert P. Nolan. 2020. "A Cultural and Gender-Based Approach to Understanding Patient Adjustment to Chronic Heart Failure." Health and Quality of Life Outcomes 18(1). Retrieved November 14, 2020. https://doi.org/10.1186/s12955-020-01482-1.

13. Williams D.R. and Mohammed S.A. (2009). Discrimination and Racial Disparities in Health: Evidence and Needed Research. Journal of Behavioral Medicine. 2009; 32:20–47. [PubMed: 19030981]
14. World Health Organization (WHO). (December, 2020). Constitution. Retrieved from hppts://www.who.int/about/who-we-are/constitution
15. Leblanc D. Federal Government to launch Canada-wide consultations on systemic racism....The Globe and Mail, 2018 March 21. (Accessed March 21, 2018)
16. Crenshaw K. Mapping the margins: Intersectionality, identity, politics and violence against women of color. Stanford Law Review 1991;43(6): 1241-1299
17. Rutherford A, Zwi AB, Grove NJ and Butchart A. Violence: a glossary. Journal of Epidemiology and Community Health 2007;61(8): 676-680
18. Paradis Y. A systematic review of empirical research on self-reported racism and health. International Journal of Epidemiology 2006;35:888-901.
19. Nestel S. 2012. Colour coded health care: The impact of race and racism on Canadians' health
20. College of Family Physicians of Canada. 2016. Health and health care implications of systemic racism on Indigenous peoples of Canada, Fact Sheet.
21. Loppie S, Reading C, and de Leeuw S. 2014. Aboriginal Experiences with Racism and its Impacts, National Collaborating Centre for Indigenous Health.
22. Reading C. 2014. Policies, Programs and Strategies to Address Aboriginal Racism: A Canadian Perspective, National Collaborating Centre for Indigenous Health

Appendix C - Survey Questions

Public Health Experience of the Black Community in London and Middlesex County

The Wright of Way Consultancy in partnership with the Middlesex-London Health Unit (MLHU) hope to hear from you about your perception, understanding and experiences in relation to Public Health services and programs for the black community in the London and Middlesex area. We are working with the MLHU to identify strategies to develop an Anti-Black Racism Plan. Your input and ideas are important to us and we appreciate the time you are taking to provide your feedback.

You are not obligated to answer any question and can skip whatever questions you feel uncomfortable answering. Any information you provide in this survey will be used for the purposes of improving health services and reducing health inequities for the black community by the Middlesex-London Health Unit. Any personal information you share will not be made public.

If you have any questions about this survey, feel free to contact Malvin Wright at malvinwright@hotmail.com.

Do you consent to participating in this survey?
- Yes
- No

Personal Information

1. What are the first three characters of your postal code?

2. Which of the following do you identify as? (Check ALL that apply.)
   - Black African
   - Black Caribbean
   - Black Canadian
   - Black American
   - Black Latin American
   - Other: _____________

3. How old are you?

4. What languages do you feel most comfortable speaking?
   - English
   - American Sign Language
   - Amharic
   - Arabic
   - Creole
   - Somali

- Swahili
- French
- Yoruba
- Other: ___________
- Prefer not to answer

5. Were you born in Canada?
   - Yes
   - No, I arrived in ______ (write year)
   - Prefer not to answer

6. What is your gender identity?
   - Female
   - Male
   - Non-Binary
   - Other: _____________

7. What is your sexual orientation?
   - Asexual
   - Bisexual
   - Gay
   - Heterosexual/Straight
   - Lesbian
   - Pansexual
   - Queer
   - Questioning
   - Two-Spirit
   - Other: ___________
   - Prefer not to answer

8. What is your CURRENT relationship or marital status? (Check ALL that apply to current relationship or marital status)
   - Single
   - Married
   - In a relationship with a steady partner (living together)
   - In a relationship with a steady partner (not living together)
   - Widowed
   - Separated/Divorced
   - Other (specify):
   - Prefer not to answer

9. What, if any, is your CURRENT faith or religion?

- None
- Muslim
- Christian
- African traditional
- Other: _____________
- Prefer not to answer

10. What is the highest level of education or training that you have completed?
    - No formal schooling
    - High School
    - College
    - University
    - Trade School
    - Other: ___________

11. How would you describe your employment status?
    - Employed part-time
    - Employed full-time
    - Unemployed
    - Underemployed (i.e. do you feel that you are overqualified for your position?)

SURVEY

12. Do you have a family doctor?
    - Yes
    - No

13. If No, where do you go for your health care needs?
    - Walk-in Clinic
    - Emergency Room
    - Traditional remedies
    - Other: _________

14. What do you think the Middlesex-London Public Health Unit does?

15. Which Public Health services have you accessed before at Middlesex-London Health Unit?
    [List of services]

16. Overall, how would you rate your experience with public health?
    - Very good
    - Good
    - Fair
    - Poor
    - Very poor

- N/A

17. Have you had any difficulty accessing health care in London due to the following:
    - Wait times
    - Inconvenient location of programs or services
    - Inconvenient times for programs or services
    - Language barrier
    - Cost of service
    - Service provider doesn't understand my needs
    - Legal status
    - Issues with transportation
    - Other: _______________

18. In your opinion, what would make your experience and access to Public Health services better?
    - Access to service provider who can speak my language
    - Access to service provider who understands my needs
    - Culturally sensitive staff
    - Being closer to the services
    - More affordable services
    - Easy access to support services
    - Programs/services that are relevant to my needs
    - Other: _____________

19. In order of importance, which of these do you feel are important for good health? [Ranked list]
    - Nutrition
    - Education
    - Housing
    - Child care
    - Addictions treatment
    - Mental health
    - Physical activity/exercise
    - Disease prevention
    - Sexual health

20. How do you get health information?
    - Friends/Family
    - Social media (e.g. Facebook, Instagram, Twitter, etc.)
    - Health care including your physician, nurse practitioner, nurse or hospital
    - Searching on the Internet (i.e. Google search)
    - Herbal or alternative medication

- Other: ___________

21. What is the best way to communicate Public Health information with you and your community?
    - Email
    - Social media (e.g. Facebook, Instagram, Twitter, etc.)
    - Radio
    - Newspaper
    - WhatsApp
    - Community centres or groups
    - Other: _________

For the above, please give examples: __________

22. Do you feel your race has impacted the service, treatment, or access to health care?
    - Yes
    - No

23. As a Black person in London and Middlesex County, do you believe you have experienced racism and/or discrimination in accessing health care?
    - Yes
    - No
    - Not sure

24. In your opinion, to what degree has experiencing racism impacted your health?
    - Not at all
    - A little bit
    - A moderate amount
    - Quite a bit
    - A lot

25. Do you have any last comments you would like to share about your experience and strategies to improve the Public Health services of African, Caribbean and Black communities in London and Middlesex County?

Appendix D - Interview Questions

QUALITATIVE INTERVIEW RECORD

Name of Person Interviewed: ____
Institution/Organization:
____
Date of Interview:
____
Person conducting the interview:
____

General Interview Process

1. Greeting/Introduction: Introduce yourself, WoW Consultancy, Anti-Black Racism Plan
2. Identify the expected length of time for the interview and confirm that this is still a good time for the interviewee.
3. Review Purpose of Stakeholder Interviews
    1) To understand the current best/wise practices around the implementation of Anti-Black Racism in a Public Health context
    1) To understand the Public Health related needs and expectations of the diverse Black community in London and Middlesex County
    1) To inform Public Health and organizational prioritization and action relevant to public health's mandate
4. Confirm confidentiality.
5. Receive permission to record conversation.
    1) willingness to share their experience and insight into accessing Public Health services; perception, beliefs and attitudes about Public Health services; and barriers and facilitators to equitable access and delivery of Public Health services/programs
    1) Their insight will be instrumental in informing the implementation plan as part of this project.
    1) If they have any follow up thoughts, they are welcome to email/contact: ________

Interview Questions - MHLU staff / Govt staff / Health care Workers

General/Objective	Describe your role. Experience. ● Can you describe your current role in your organization?
Based on theme	**Racism and Diversity in Workplace** • Within your workplace, can you tell us about your experience and/or witness of overt or covert anti-Black racism and discrimination • Have you ever raised the issue of racism with any staff member? If you did not raise the issue, please share the reason why • How would you describe your current place of employment diversity in terms of race and ethnicity?
	Access to opportunities • Can you share your experience and/or witness the impact of having an English name on your resume increase the likelihood of getting an interview? • Describe how your workplace policies, hiring practices, and/or orientations has enhanced recruiting and retaining Black persons? • Can you share strategies/plans your organization is using to facilitate more Black Persons in executive/senior positions?

Interview Questions - Students

General/Objective	Describe your role. Experience. • Can you describe your current/previous educational studies/program?
Based on theme	**Racism and Diversity in Educational Setting** • Within your school/university, can you tell us about your experience and/or witness of overt or covert anti-Black racism and discrimination • Have you ever raised the issue of racism with any staff member/ authorities? If you did not raise the issue, please share the reason why? • Can you share if your program/course curriculum encompass any of the following topics or themes: (cultural competence, cultural humility, Black history, anti-racism, anti-oppression, trauma-informed care, race as a social determinant of health)? • As a current or past student, how has systemic racism in the academic environment influenced your learning?

	Access to opportunities • Can you share your experience and/or witness the impact of having an English name on your resume increase the likelihood of getting an interview/job/position? • Describe how your university policies, admission processes, and/or orientations has enhanced enrolment of Black persons? • Can you share strategies/plans your organization is using to facilitate more Black Persons in senior positions?

Interview Questions – Community members/ Black Business Owners/ Religious Leaders

General	Describe your role. Experience. ● Can you mention some of the Public Health services and programs that are available in London and Middlesex County? *(MLHU Public Health services and programs include clinics include for birth control, dental, needle exchange, immunization, STI, Breast feeding, TB, Travel, Healthy start Infant drop-ins)*
Based on theme	Accessing Public Health services and programs • Can you tell us about your experience accessing Public Health services? (Prompts: What helped make this service accessible? Was there anything that made accessing these services difficult? What would make your experience and access to health services easier?)
	Interaction with Public Health providers. ● Are your Public Health service care providers and staff willing to listen carefully to you and answer all your questions? ● Do you experience any mistreatment or unfair treatment when you interact with your provider? ● Do the Public Health service care providers respect your beliefs about your health?
	Barriers to equitable access and delivery of Public Health services/programs • What are the obstacles/challenges to equitable access and delivery of Public Health services/programs? (Prompts: Are there policies, practices, infrastructure, resource issues that make this difficult?).

	Facilitators to equitable access and delivery of Public Health services/programs • What are the existing strengths to enhance equitable access and delivery Public Health services/programs or that will support equitable access and delivery of Public Health services/programs? (Prompts: Are there policies, practices, infrastructure, resources, activities that would support or are supporting this change?).

Appendix E - Additional Information on Community Engagement Process

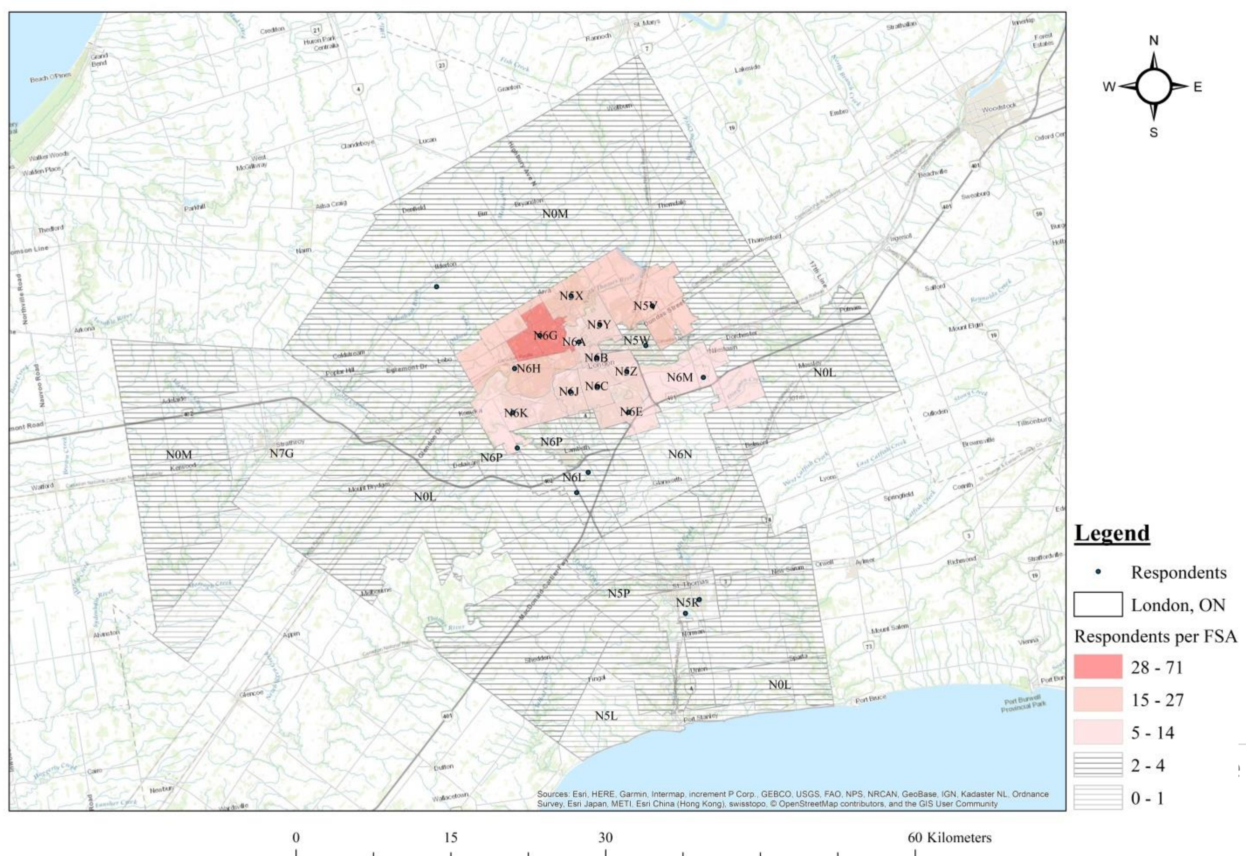
The work, funded by MLHU, was conducted over 3 months using a mixed-method approach, comprising both quantitative and qualitative components. The research design was informed by a deep awareness of the colonialist history of biomedical research and research in general as it pertains to Black bodies and Black people. The quantitative component involved a self-administered survey and the qualitative component involved focus groups and semi-structured interviews with key stakeholders.

To be eligible participants needed to self-identify as African, Caribbean or Black regardless of where they were born. Other intrinsic inclusion criteria included that the participants must be 18 years or older and have lived in London or Middlesex County for at least 3 years prior to the survey.

The sampling frame was dynamic as sampling options were structured to capture the demographic profile of the target population. Partner community organizations such as community health centers, community organizations, ACB organizations and community leaders served as recruiting channels where participants were referred to the study team.

A total of 375 people from the London ACB community participated in the research study: 291 completed an online survey which was self-administered online or written. A total of 44 individuals participated in focus groups, and an additional 40 participated in a series of key stakeholder interviews conducted by the Wright of Way team. To inform the recommendations for the Anti-Black Racism Plan, a quantitative and qualitative approach were used.

Anti-Black Racism Plan Survey Response Map



Quantitative Survey

The quantitative survey included 23 self-administered questions, components of which mirrored the qualitative questions. The survey questionnaire was designed to capture information on respondents' socio-demographic background and their knowledge of the MLHU, their access of Public Health services and perceived barriers to accessing those services, their experience of the impact of their race on services provided, their perception of the general impact of racism on their health and wellbeing, their perspective on the broader determinants that impact their overall health, where they seek out information on Public Health-related topics, and their preferences for communication on Public Health-related topics.

The quantitative survey was available online for 21 days. It had to be completed over a single session with an average completion time between 15 to 20 minutes. Participants who completed the survey could also enter their names into a draw for a $100 gift card from selected ACB businesses across the city of London in recognition for their time and effort.

Participants could elect not to answer any question in the survey without penalty. Participants were also able to withdraw from the online survey at any stage. We utilized ACB enumerators who were positioned at several ACB owned businesses that were participating in the study. The enumerators were positioned at the business to inform patrons/customers about the survey and provided them with a QR Code that took them directly to the online survey. They were also equipped with a paper version of the survey in case the individual did not feel comfortable with the QR code.

The confidentiality of study participants was maintained through various processes at each stage of data collection. All identifying information was anonymized by creating a unique code for each participant. The code was created after obtaining informed consent, and no personal information was used in the process. With respect to confidentiality, data records and computers were properly secured. Participant data was coded and files/folders and computers where data was stored were all password protected.

All study participants consented to be part of this study. They were recruited through an analog based approach that focused on community relationships, connections and one-on-one interactions. Community members participating in the information sessions were asked to become "Community Champions" for the outcomes of the study. Being a community champion required that the individual:

- Share the survey link with friends and family who identify as ACB via email, text or WhatsApp
- Follow up the initial interaction with a confirmation call of receipt
- Answer any questions or concerns that the recipient might have
- Ask the recipient to share the survey link with anyone in their network that identifies as ACB via email, text and/or WhatsApp

Qualitative Survey

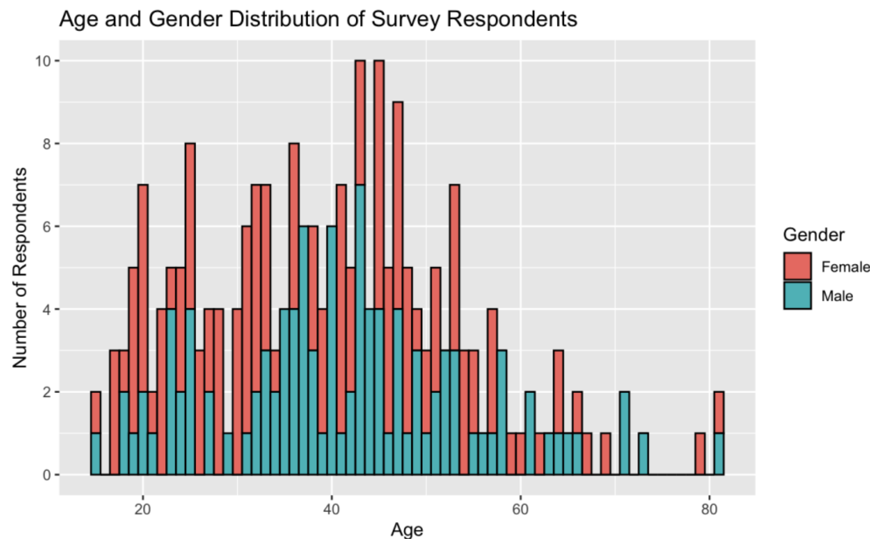
An exploratory qualitative interview approach was utilized to understand the ACB population's beliefs and experiences as well as barriers to and facilitators to equitable access of Public Health services/programs at MLHU. Participants were recruited via a purposeful randomized sampling method and conducted focus-group interviews and one-on-one semi-structured interviews. The participants were provided information about the project study aims through an information sheet, and verbal clarification was instituted as appropriate. The sheet contained respondents' consent, participation criteria, and confidentiality requirements. All the respondents were completely informed about the project survey goals and the participants were asked to consent to the interview and the use of data.

Overall, participants for this project were diverse members of the ACB community- representatives of local Black-led organizations, leaders of faith, youth, para-health and health practitioners in London and Middlesex County.

The audio from the survey interviews was recorded and the data collected was transcribed via NVivo Version 12. We conducted appropriate coding, and word frequency queries were conducted to generate themes. Furthermore, all codes were reviewed and further refined into thematic groupings. Upon completion of the data analyses, we reverted to respondents to briefly share, and confirm, if the findings and interpretations following interviews reflected participants' experiences. The respondents consented with the deductions reached.

Appendix F - Additional Findings

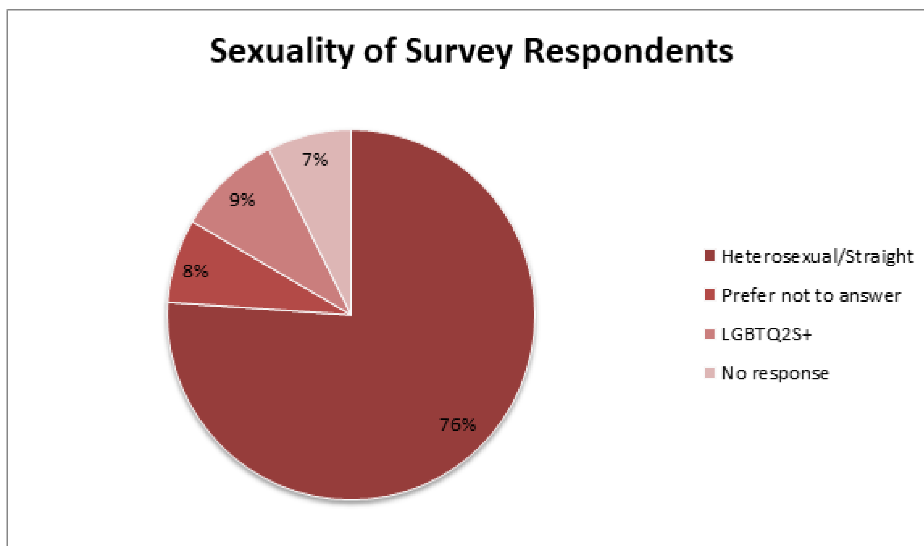
Age and Gender Distribution of Survey Respondents (Chart 11)



61.2% of respondents were female and 37.5% were male. One respondent chose not to provide their gender. The mean age of female respondents was 38 years old, and the mean age of male respondents was 41 years old. There were almost twice as many female respondents to male respondents, and the female respondents were on average 3 years younger than the male respondents. It is important to note that the data from the surveys, therefore, skews more heavily to female experience. *(One participant identified outside of the binary of male and female and has been removed from this chart for concerns around possible identification.)*

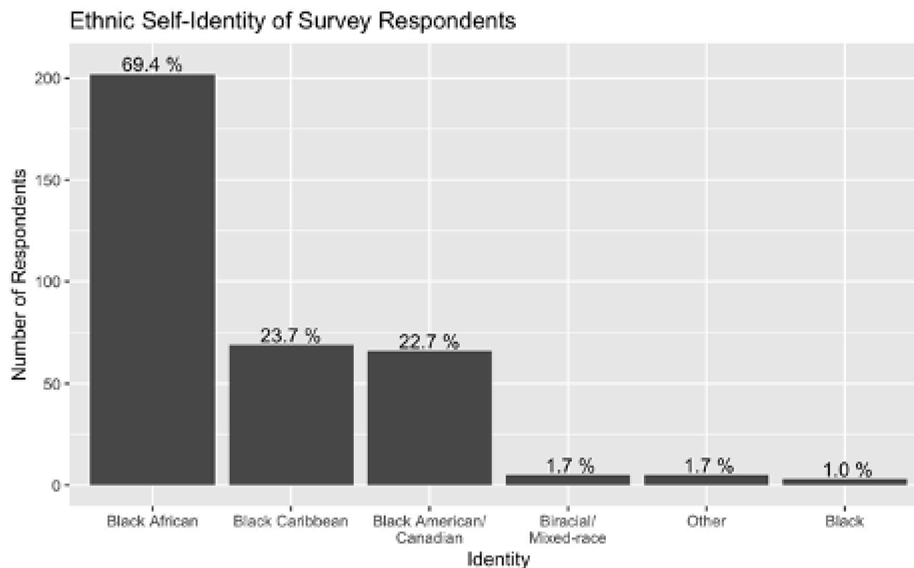
This skew was a possible indication of the cultural and social structures that exist within ACB families and the role of the female as the care provider and caretaker in the home.

Sexuality of Survey Respondents (Chart 12)



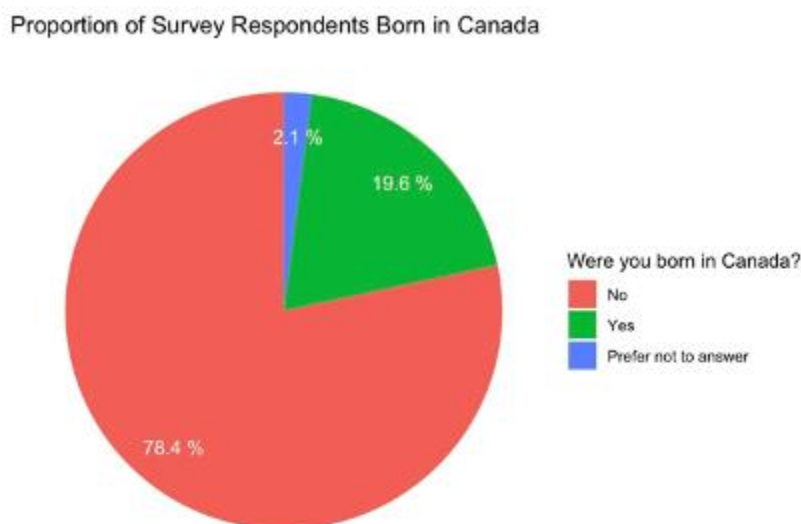
The vast majority (81.8%) of survey respondents self-identified as heterosexual/straight. A small proportion of respondents identified as LGBTQ2S+ (9.9%). 7.9% of respondents preferred not to identify their sexuality.

Ethnic Self-Identity of Survey Respondents (Chart 13)



The majority of respondents self-identified as “Black African” (69.4%), and significant numbers also identified as “Black Caribbean” (23.7%) and “Black American” or “Black Canadian” (22.7%). There was a small number of respondents who identified as “Biracial” or “Mixed-Race”, and only 1% preferred to self-identify as “Black”.

Proportion of Survey Respondents Born in Canada (Chart 14)



The majority of the respondents identified that they were not born in Canada. This indicates the shifting demographic of the Black community; the immigration policies of the Federal government (fast tracked entry and skilled works programs) have shifted the community demographic.

Year of Arrival to Canada for Survey Respondents not Born in Canada (Chart 15)

Year

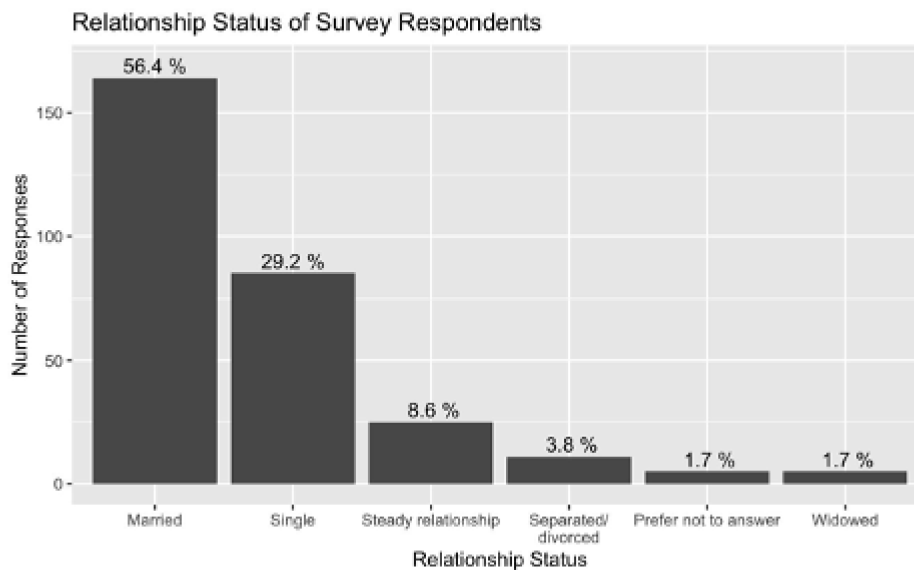
The survey respondents skew greater toward more recent arrivals to Canada, with a median year of arrival of 2009. 54% of survey respondents arrived in Canada in 2009 or later. We are unable to verify whether this demographic profile is reflective of the greater ACB community in London and Middlesex County, however it is important to note that the immigrant community is an important part of the ACB community and have valuable insights to offer for consideration in an Anti-Black Racism Plan.

Top 10 Languages Spoken (Chart 16)

Language	Total	Percent
English	279	95.9 %
Yoruba	34	11.7 %
French	28	9.6 %
Arabic	12	4.1 %
Swahili	9	3.1 %
Hausa	7	2.4 %
Igbo	5	1.7 %
Shona	3	1.0 %
Spanish	3	1.0 %
Somali	3	1.0 %

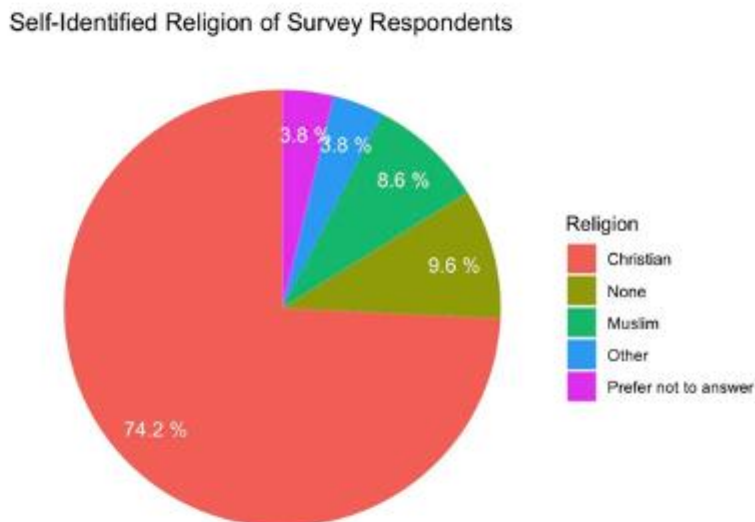
Survey respondents were asked which languages they felt comfortable speaking, and their responses ranged across 29 languages from various African, European, and Caribbean groupings. The top 10 languages are shown in Chart 16. This enforces that the ACB community is a linguistically diverse community.

Relationship Status of Survey Respondents (Chart 17)



The majority of survey respondents are either married or in a steady relationship.

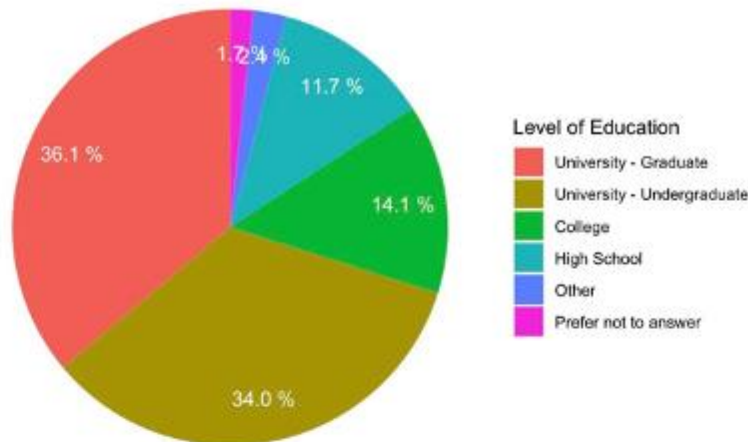
Self-Identified Religion of Survey Respondents (Chart 18)



74.2% of survey respondents identified as Christian, 8.6% identified as Muslim, and 3.8% identified as other religions (e.g. African Traditional, Buddhist, Baha'i, Rastafarian, etc.). Though the vast majority identified as one religion, there was diversity within their responses as well (i.e. Catholic, Roman Catholic, and Baptist). This posits that if faith

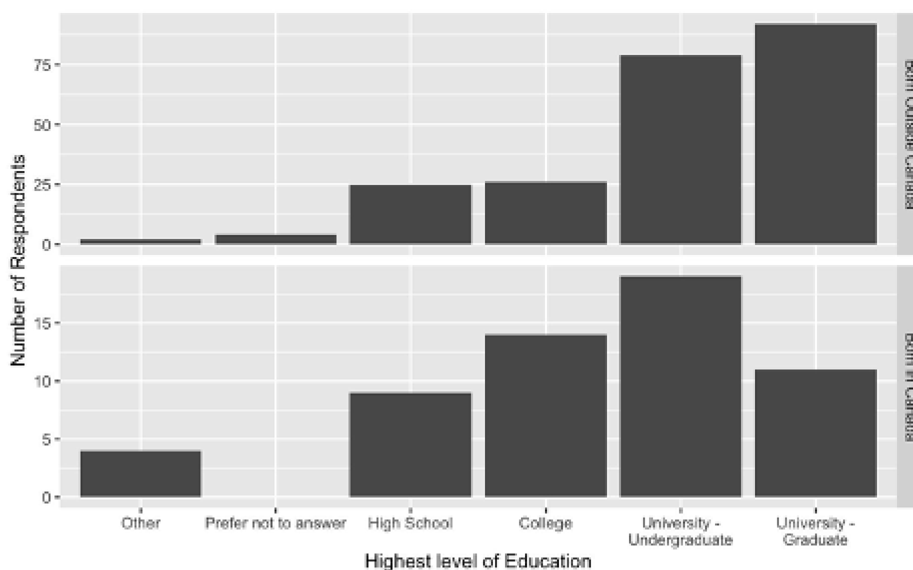
communities are to be engaged to reach the ACB community, this would require engagement with many different communities and places of worship.

Highest Level of Education Completed by Survey Respondents (Chart 19)



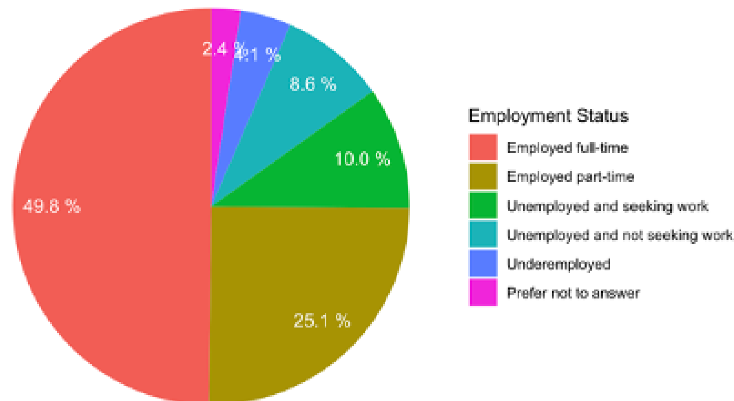
The survey respondents were a highly educated group, with 70.1% holding a university degree (undergraduate or graduate), and an additional 14.1% with post-secondary College qualifications. This is consistent with the evidence uncovered in the 2015, Needs Assessment for Labour Market Integration and Planning that was carried out by the African Caribbean Federation of London Ontario (ACFOLA)who discovered that 72% of the ACB population in London held a tertiary (post-secondary) education.

Highest Level of Education Completed Based on Birthplace (Chart 20)



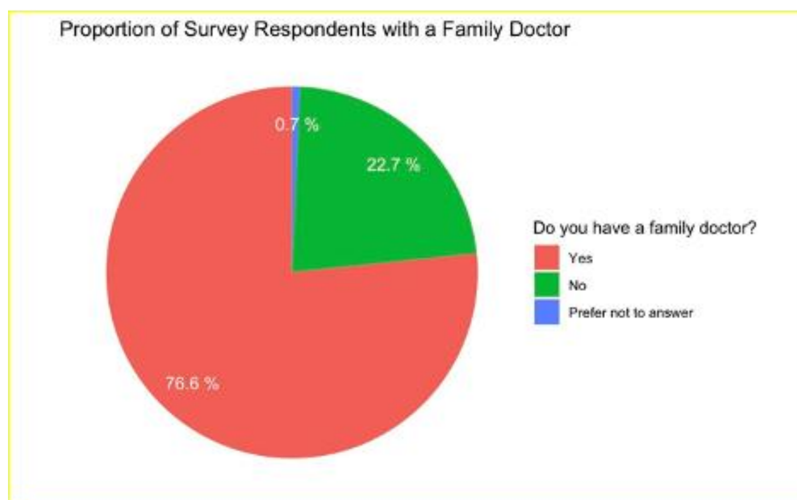
Further analysis of the data shows that respondents born outside Canada had a greater proportion of university degrees (undergraduate or graduate) compared to those born in Canada. Education levels within the ACB community in London and Middlesex County have been shifting and often are a point of intersection between perception and reality. The "new immigrant" is often highly skilled, educated, in possession of an undergraduate degree and post-secondary degree, is often foreign trained and more than likely working outside of their field.

Employment Status of Survey Respondents (Chart 21)



The unemployment rate was quite high, coming in at 18.6% when compared to the London employment rate of 13.1% according to (Statistics Canada, 2020). 49.8% of the respondents worked full-time, 25.1% held part-time jobs and 4.1% identified as underemployed (working outside of their field of choice).

Proportion of Survey Respondents with a Family Doctor (Chart 22)



76.6% of respondents stated that they have a family doctor. This poses a point of interaction with the health care system that could be leveraged for Public Health engagement, referral, and information dissemination.

Appendix G - Recommendation Change Areas

Information, Education and Communication

Health Information, Education and Communication (IEC) is not just about encouraging people to wash their hands or warning them about the dangers of STI's. The oversimplification of complex socio-cultural narratives and practices often undermine Public Health's approach to community engagement, communication and education. An inability to understand this nuanced reality often negates peoples' and a community's sense of agency and power over their health situation; which in turn has fueled fear and mistrust. Hence, health communication must be based upon a thorough understanding of local cultures, beliefs and perceptions – and their impacts on key preventative behaviours.

Creating Safer Spaces

It is important that the MLHU environment be welcoming to members of the ACB community. This can be achieved by welcoming a diversity of languages, accepting cultural food, outfits, symbols, ways of engagement and paradigms/mindsets as legitimate ways of working in health and engaging with the community.

Safer spaces are important because in the current climate, many members of the ACB community are experiencing trauma related to systemic racism and are feeling the impact of their humanity not being valued. The absence of trauma-informed, culturally safe health care in Black communities means we are not being properly served. Resources are often spent on programming that does not address our specific needs, aspirations or concerns and which can be re-traumatizing. Safe Black spaces provide culturally specific strategies and resources to help ACB people heal from historical and current wounds, both individually and collectively.

Strengthening Community Capacity

It is important that the MLHU provide leadership to and/or participate in community activities that can strengthen the capacity of ACB communities and ACB-led organizations, such as capacity assessments and community capacity mapping of technical capacity (financial and human resources). This would provide the community and the MLHU with a snapshot in real-time of the community capacity, gaps, assets and resources in relation to Public Health, health equity and governance.

Building Trust

Building trust and community engagement need to become key components of MLHU's approach and philosophy. MLHU needs to develop a community engagement approach that aims to ensure that communities are meaningfully involved throughout the different phases of Public Health planning and response: from program design, planning, implementation, through to monitoring, evaluation and learning.

Community engagement must become a planned and dynamic process to connect communities and other stakeholders to increase the community's control over the impact of Public Health programs and the responses to emergencies, outbreaks, etc.

Building trust takes time but is a worthwhile investment in resources and time. This will allow the MLHU to maximize and grow community influence on and acceptance of programming, campaigns, facilities and services within the community that they serve. This has the potential to in turn:

- Reduce Public Health risks to members of the community
- Preserve and ensure that the unique privacy, dignity and cultural needs of the community are addressed
- The communities' right to be involved in the decision-making process is upheld, through honest dialogue and the provision of information
- Program quality is strengthened through two-way communication, participation and feedback

Research, Data Collection and Use

Researchers and policy makers cannot easily answer questions about visible minorities and health, including: Are visible minority Canadians healthier or less healthy than their White counterparts? Do visible minority Canadians experience any differences accessing and receiving healthcare, compared with white Canadians? Do risk factors for poor health conditions differ for visible minority and white Canadians? How do different visible minority groups compare with one another on different health outcomes and measures?

These questions cannot be answered because there is a lack of race-based data across the continuum of care. Race-based data provides timely and important findings for policy makers, service planners and practitioners who seek more equitable and effective ways to meet the diverse needs of populations in our health care system. Yet there remains a gap in health data and research regarding the health of the ACB community. COVID-19 has shown us that without the intentional segmentation and reporting of race-based data and the impacts that the pandemic is having on the ACB community the health disparities might have gone unreported or ignored and any evidence would have been anecdotal.

Governance and Accountability

Governance and Accountability are key to achieving many of the outcomes highlighted within the document. For the MLHU to grow, rebuild and foster trust with the ACB community, the development of governance and accountability structures will be needed. In a shifting health care landscape, the MLHU must continue to push the equity mantle internally *(strengthening capacity to support and engage multi-stakeholder approaches)* and externally at tables of influence, governance and power. But, this is only one side of the Governance and Accountability paradigm. The MLHU can support the strengthening of structures within the ACB community to improve the governance of Race based data, community led research and the development of projects and programs to resolve priorities within the ACB communities.

Working with the ACB community, the MLHU can support the configuration of new ACB health tables tasked to provide insight and direction on how the MLHU can do better for the ACB communities in the region. The MLHU can also Advance health equity data collection by having it built into accountability agreements between partners, service providers and the MLHU. The MLHU can also use its position as an advocate to influence Ontario Health and Ontario Health Teams to have Black people identified as a priority population within the MLHU catchment area.

Equitable Access and Service Delivery

Strengthening equitable access and service delivery is crucial to the achievement of equitable health outcomes from a Public Health perspective. Service delivery is an immediate output of the inputs into the health system, such as the health workforce development, procurement and supplies, and financing. Increased evidence-informed inputs should lead to improved service delivery and enhanced access to services. Ensuring availability of Public Health services that meet a minimum quality standard and access to them are key functions of a Public Health system. Effective service delivery and equitable access is a vital element of any health system. Service delivery is a fundamental input to population health status, along with other factors, including the social determinants of health.

Effective Collaboration

A community-based collaborative practice works best when it is organized around the needs, strengths, priorities and aspirations of the population being served and considers the way in which local Public Health programs and services are delivered in those targeted populations. A population-based or needs-based approach that is grounded in participatory methods is necessary when determining the best way to introduce healthier behaviors within communities.

Governance models, structured protocols, shared decision-making processes, supportive management practices, communication strategies, conflict resolution strategies, space design and safe spaces must all be in place in order to achieve effective collaboration and strengthen ACB inclusion in Public Health programs and policies.