THE OUTCOMES OF OPPRESSIVE SYSTEMS
And a Collective Call to Co-Design an Equitable and Inclusive Health System in Peel – February 01, 2021

WHO WE ARE

We are a collective of community organizations, community and health service providers and individuals committed to meeting the health and social service needs of people who identify from racialized communities in Peel, Halton and the GTA. We have been working together through partnerships to address systemic discrimination and anti-Black racism within our local institutions. Members have a proven track record of collaboration and providing culturally-appropriate and sensitive care over several decades.

It is vital that we all work together to provide culturally-responsive and safe healthcare services and use an anti-racist and anti-oppressive framework to create health systems and services that support health equity. As described in the Ministry of Health and Long-Term Care's Health Equity Guideline 2018[1], "**health equity** means that all people can reach their full health potential without disadvantage due to social position or other socially determined circumstance, such as ability, age, culture, ethnicity, family status, gender, language, race, religion, sex, social class, or socioeconomic status". As the guidelines explain, we are <u>all</u> responsible.

COLLECTIVE COMMUNITY ACTION FOR SYSTEMIC CHANGE

Community organizations in our collective have already come together to lobby for change in the following ways:

- Advocated for the collection of race-based data of COVID-19 infections, which has revealed that Blacks, South Asians and Latinos have been disproportionately impacted throughout the pandemic.
- Initiated conversations with Peel Regional Police and Ontario Provincial Police regarding anti-Black racism and systemic discrimination
- Established a community of practice focused on anti-Black racism within health services and systems
- Created numerous community tables within the Region that are well-attended by a diverse group of community organizations across sectors and institutions to address the needs of individuals, families and communities

ANTI-BLACK RACISM & SYSTEMIC DISCRIMINATION HEALTHCARE COLLECTIVE

- Bereaved Families of Ontario (Halton/ Peel)
- Boys & Girls Club of Peel
- Canadian Mental Health Association Peel Dufferin
- Coalition for Persons with Disabilities
- Elizabeth Fry Society of Peel/Halton
- Family and Child Health Initiative (FCHI)
- Heart House Hospice
- Indus Community Services
- LAMP Community Health Centre
- Moyo Community Health Services
- Peel Newcomer Strategy Group
- Punjabi Community Health Services
- Roots Community Services
- Wellfort
- Representation from the Black Community Advisory Council and the South Asian Community Advisory Council

We understand that many health organizations and services have recognized and agree that the health sector has a problem with systemic discrimination and anti-Black racism. In support of the many people who identify from racialized communities that we serve and in the best interest of equity-seeking people and groups, we seek greater clarity on how healthcare services are eliminating barriers for marginalized members of our communities – and we are approaching you with a renewed request for strong collaboration to address health inequities.

PURPOSE

The purpose of this document is to provide personal examples of inequity, racism and discrimination within the larger health system. It serves as a record of personal experiences and population-level statistics that illustrate how current systems create barriers for people who identify from marginalized groups in our community.

This document also shares recommendations for collective action and ways that we can work together to improve health equity for individuals, families and communities within Peel, Halton and the GTA. Through this document, we invite the following leaders and institutions to join our collective action for systemic change:

Brock Hovey, Central West LHIN & Mississauga/Halton LIHN
Chair Nando Iannicca, Region of Peel
Matt Anderson, CEO, Ontario Health
Mayor Bonnie Crombie, City of Mississauga
Mayor Patrick Brown, City of Brampton
Mayor Allan Thompson, Town of Caledon
Donna Cripps, Transitional Regional Lead for Ontario Health (Central)
Christine Elliott, Deputy Premier and Minister of Health
Dr. Lawrence Loh, Medical Officer of Health, Region of Peel
Michelle DiEmanuele, President & CEO, Trillium Health Partners
Dr. Naveed Mohamad, President & CEO, William Osler Health System
Local Members of Provincial Parliament: Deepak Anand (Mississauga – Malton) Rudy Cuzzetto (Mississauga – Lakeshore) Sylvia Jones (Dufferin – Caledon) Natalia Kusendova (Mississauga – Centre)

Kaleed Rasheed (Mississauga East – Cooksville) Sheref Sabawy (Mississauga – Erin Mills) Amarjot Sandhu (Brampton West) Prabmeet Sarkaria (Brampton South) Sara Singh (Brampton Centre) Gurratan Singh (Brampton East) Nina Tangri (Mississauga – Streetsville) Kevin Yarde (Brampton – North)
Various media

We also offer the following **key questions** that we believe collective dialogue can help answer:

1. People from diverse and underrepresented groups comprise 73%[2] of the population in Peel. How are your organizations specifically addressing the unique health issues facing these groups within our community?

2. What measurable actions are being taken to reduce and eliminate systemic discrimination and anti-Black racism internally within your organization and within diverse communities across your Region?

3. Service providers are mandated by funders to collect a tremendous amount of data, yet there is often little to no follow-up or knowledge exchange with community members and organizations. We would like to understand:

    - How are community members and organizations involved in decisions about data collection and indicators?

    - What is currently being done with the data that are collected, and how are these data used to make meaningful change in the community?

    - How these data are shared and made accessible to community members and organizations?

    - How can we work together as a collective to co-design health care institutions within the Region of Peel, Halton, GTA, using an integrated approach to data collection, data sharing and program development?

4. Funding equity and transparency is desperately needed. Can the Ministry of Health, through their intermediaries (LHINs and Ontario Health), share their funding model with us to help the community understand gaps that exist within and across these funding bodies?

5. Food security, or not having everyday access to healthy and safe food, continues to be a significant social determinant of health impacting the overall physical and mental health of many individuals, families and communities in Peel, Halton and the GTA.[3] As such,

    - Why is food security still a major issue for our racialized and marginalized residents?

- Why are there no culturally-sensitive food options from Ministry-funded food providing agencies?

- How can health organizations work with community members and organizations to address food security and its impact on health and well-being for our racialized and marginalized residents?

WHAT ARE WE TRYING TO CHANGE?

We want community members, service users and service providers to have better health care experiences. Below you will find personal examples of systemic discrimination experienced by service users within our regions across various settings that offer support for health and well-being. We hope that sharing these experiences will encourage health providers and those that design health systems and services to consider these perspectives throughout their work. It is insufficient to leverage training to create change; it is imperative to understand and include service users' experiences and knowledge to create more effective and responsive systems and services that support health and well-being for everyone.

It is also important to recognise there are multiple intersections of oppression in these experiences and knowledges. However, what we see repeated in almost all these situations are themes such as "dismissive", "unseen" or "unheard", "lack of dignity and respect", and "lack of connection to meaningful resources or supports".

Dismissive/silenced	*"When I attended a healthcare visit, I was attended to by a white nurse. I noticed I didn't have much of a say during the visit, I felt like I wasn't heard. It was like they had the final say. I got a blood clot when I was getting insulin. The nurse inserted the needle wrongly. I complained that I had pain that the needle didn't go in well and I had a clot, but it was ignored. I also mentioned that my arm was swelling and felt my blood pressure was going down but my concerns were brushed aside. I had to find a Black nurse who listened and changed the insulin from one arm to another. I then had pain for some days. I mentioned the pain and it was brushed aside that the pain will go down. It wasn't 'till I was met by a Black doctor and told her about the pain before I was prescribed some pain-relievers. I spent 2 extra days than I needed to. I felt I was treated differently at different points."* *"I was on the gurney for 7 days. Made me wonder how they make decisions on who gets a bed and who doesn't. I spent unusually long at registration and even on the stretcher. It almost felt like I was forgotten. Like maybe people without health cards are expected to receive delayed treatment". I saw others, white people, moved when a space opened up who came after me. I don't know their conditions so theirs could have been worse but if they had at least explained to me, perhaps I wouldn't have felt like I was forgotten or invisible."* *"I remember a few months ago, I made an appointment for mental health sessions which I had been having. And then I was told that*

	my sessions will be expiring. I was told that other people needed the service. I felt very sad because I had to try to deal with the situation by myself and sometimes, I feel overwhelmed by my life journey so I still needed the sessions. I don't call for mental health services there since then."
Bias/stereotype	*"I feel like no one cares about my child's death because it was a result of gun violence – my doctor didn't seem to care because we live in 'a neighbourhood that should expect that type of thing'."* *"A Black child is diagnosed with ADHD and medication is recommended without a proper assessment or discussion with parent/caregiver."* *"A young ACB person is questioned by the school librarian about the book they are checking out because they assume it's too advanced for their reading level; A newcomer ACB youth is placed in a lower grade because school administrators assume his academic abilities do not meet Canadian standards; An ACB parent has their child apprehended by CAS because they use marijuana and are deemed a safety risk."*
Lack of dignity and respect	*"I had to explain in a loud voice about my immigration status so other people heard. The staff referred to me as 'illegal' instead of saying I don't have status or undocumented; I was very distraught. I had to explain over and over again that I had coverage from the community health centre and they were going to cover my health care costs. I was in the hallway on a bed for a few days. I felt I should have been moved but I didn't want to ask because I didn't want to draw attention to my lack of status. I was so uncomfortable.*" *"I was worried I'd have to pay out of pocket since I didn't have a health card. I was scared someone was going to call Immigration on me because I didn't have my papers. I was worried I was going to be treated differently because I don't have my papers and to complicate matters, I'm Black too. I know the doctor at the health centre had assured me it was going to be ok, but still you don't know, right? They can still be mean. It's different for us Black folks. People can still be mean so I was worried. I had to go to the Emergency on more than one occasion. My experience wasn't pleasant. I had to explain my status over and over again, which was scary because I didn't know if someone was going to call immigration and get me deported. Too many people around and no privacy."* *"During my baby delivery, the doctor wouldn't allow me to read information I was given, he wanted me to just sign, but my wife was in labour and in a lot of pain. I felt the doctor was rushing me to sign the documents and I didn't want to sign something that I did not read. I felt if I was a white man I would have been treated differently."*

Inaccessibility	*"Stigma regarding diabetes features prominently in South Asian cultures. Yet, hospitals went ahead and created a diabetes intervention for the South Asian community in Peel, and when they could not reach out to the community, only then was Indus Community Service and Punjabi Community Health Services approached. Even the hospital's internal setup created roadblocks for clients to access the services."* *"An ACB trans woman who is precariously housed is denied access to a shelter because agency policies are not trans inclusive; A Black newcomer woman has had to escalate her repair needs to the tenant board because the landlord doesn't see the needs as urgent."* *"Health care systems and services were historically designed through systemic racism and discriminatory practices which continue to be reproduced today. Particular individuals and communities are identified and labelled 'at-risk' for poor health outcomes based on their gender, race, immigration status, class, age, ability or body size. I have heard many health care providers make assumptions that individual caregivers and family members are neglecting their children's medical needs by not engaging in services or failing to show up to scheduled appointments. These caregivers are then described in medical records as "avoidant," "resistant" or "neglectful" demonstrating "poor" parenting practices and blamed for not accessing services. The reality is that most health care services and programs have been designed by professionals failing to acknowledge the unique experiences and insight of individuals and families that are needed in order to create services that can help them thrive and live well."*

SYSTEMIC RACISM AND DISCRIMINATION IN HEALTHCARE

Social determinants of health

There are many factors that influence and determine the health of individuals, families and communities. Social determinants of health are defined by the Government of Canada as, "a specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups."[4]

For example, United Way of Greater Toronto[5] has documented the growing phenomenon of precarious work and its connection to rising poverty in the Greater Toronto & Hamilton Area, which includes Peel. The research showed that almost 4 in 10 (37.2%) workers in the GTHA work in situations with some degree of precarity. Those in precarious jobs were found to earn 51% less than those in secure jobs and have a hard time moving into better opportunities. They lack access to important supports such as paid leave and risk losing income or their job if they call in sick. Only 12% of those in precarious employment were paid if they missed a day's work. According to the Peel Halton Workforce Development Group[6], many who work in precarious employment include racialized minorities, newcomers to Canada and women.

It has been well-documented that the COVID-19 pandemic poses a significant risk to the physical health of precariously-employed workers. Peel residents with precarious employment have little choice but to work in essential roles or not turn down earning opportunities. These issues are reflected in the income gap between racialized and non-racialized people in Peel. An analysis using racialized status and income data from the 2016 census conducted by the Canadian Centre for Policy Alternatives[7, 8] revealed that, "for every dollar non-racialized men made, racialized men made 78 cents and racialized women only made 59 cents". Furthermore, a racialized person in Peel earned 70 cents for every dollar a white Peel resident earned[9].

While income is one key social determinant of health, food security – which undoubtedly plays a key role in maintaining positive health – is enjoyed in an inequitable way, amplifying systemically poorer outcomes for marginalized populations. For example, research cited in a *2019 Profile of Hunger in the Toronto Region*[10] reports that Blacks comprised 29% of surveyed households considered food insecure, while 26% identified as Indigenous. Blacks, however, comprise only 8% and Indigenous 1% respectively, of Toronto's census metropolitan area. They also reported "an overrepresentation of people born outside of Canada accessing food banks, even after living here for more than a decade".[10] For this segment of the population, the lack of culturally-appropriate and culturally-sensitive food options not only is a key concern but symptomatic of an oppressive system that affects marginalized community members in disproportionate ways.

While health systems, institutions, research, policies and practices may be designed with the intention of helping individuals and communities to be well, they have also been created through systemic racism and discriminatory practices directed towards people who identify from racialized, LGBTQ2S and disability communities creating health inequity.[5-10]

Systemic racism

We define **systemic racism** as the process by which institutional "norms" reproduce and normalize inequalities in the health, social, economic and political status of people who are marginalized based on physical characteristics, like skin colour, arbitrarily grouped together to form "races" or racial identities. Institutional norms may take the form of written policies or rules, ingrained processes or unspoken rules that are accepted by most people in the organization, professional group, or broader society as "just the way it is". While the province of Ontario and the Region of Peel do not collect data from people who identify from racialized communities in a consistent manner, there is growing dialogue across community tables advocating that these individuals often experience barriers to social determinants of health, including food security, housing, income and employment.[17, 18]

Most strikingly, in 2019-2020, the Central West LHIN, which covers Brampton and other nearby municipalities comprising the most diverse anywhere across Ontario, received only $979.69 in per capita health funding from the Province of Ontario – less than half of provincial per capita expenditures ($2,010.25).[19] This persistence of inequitable funding contributes directly to an unfair, inequitable system that not only results in disparities in healthcare access and health outcomes, but also perpetuate systemic inequities reinforcing and amplifying many of the barriers we are seeking to have removed.

Systemic racism is a social determinant of health that can significantly impact the overall health and well-being of individuals, families and communities in multiple ways, including:

- Stress on an individual's physical, emotional, and spiritual health through experiences of racism, stigma, bias, and discrimination within the system

- Lack of access to resources that are required for individuals to be well (food security, housing, health care services, medications)

- Racist stereotyping, stigma, discrimination, and neglect by medical professionals can create:

    - People who identify from racialized communities in Canada are 17% less likely to be admitted to the hospital than those who identify as white Canadians despite poor health status[20,21]

    - Experiences of feeling "unsafe" in health spaces and with particular health practices

    - Disparities in service utilization and access including intimate cancer screening,[22] dental care, optometry, sexual and reproductive health practices including taking supplements like folic acid during pregnancy, and end of life care[23]

    - Inaccurate medical assessments which can lead to negative health outcomes and, in some instances, death

THE CURRENT CONTEXT: HOW SYSTEMIC RACISM HAS IMPACTED RACIALIZED COMMUNITIES DURING THE COVID-19 PANDEMIC

Data collected throughout the pandemic at national, provincial and regional levels illustrate that particular individuals, families and communities are disproportionately impacted by COVID-19. Reports from the not-for-profit IC/ES[24] research institute that focuses on Ontario health data has reported that COVID-19 is disproportionately affecting the following communities (see Figure 1):

- About 25% of those tested for COVID-19 between January and June 2020 were newly settled immigrants and refugees; however, they represented 43.5% of positive cases in Ontario during that period

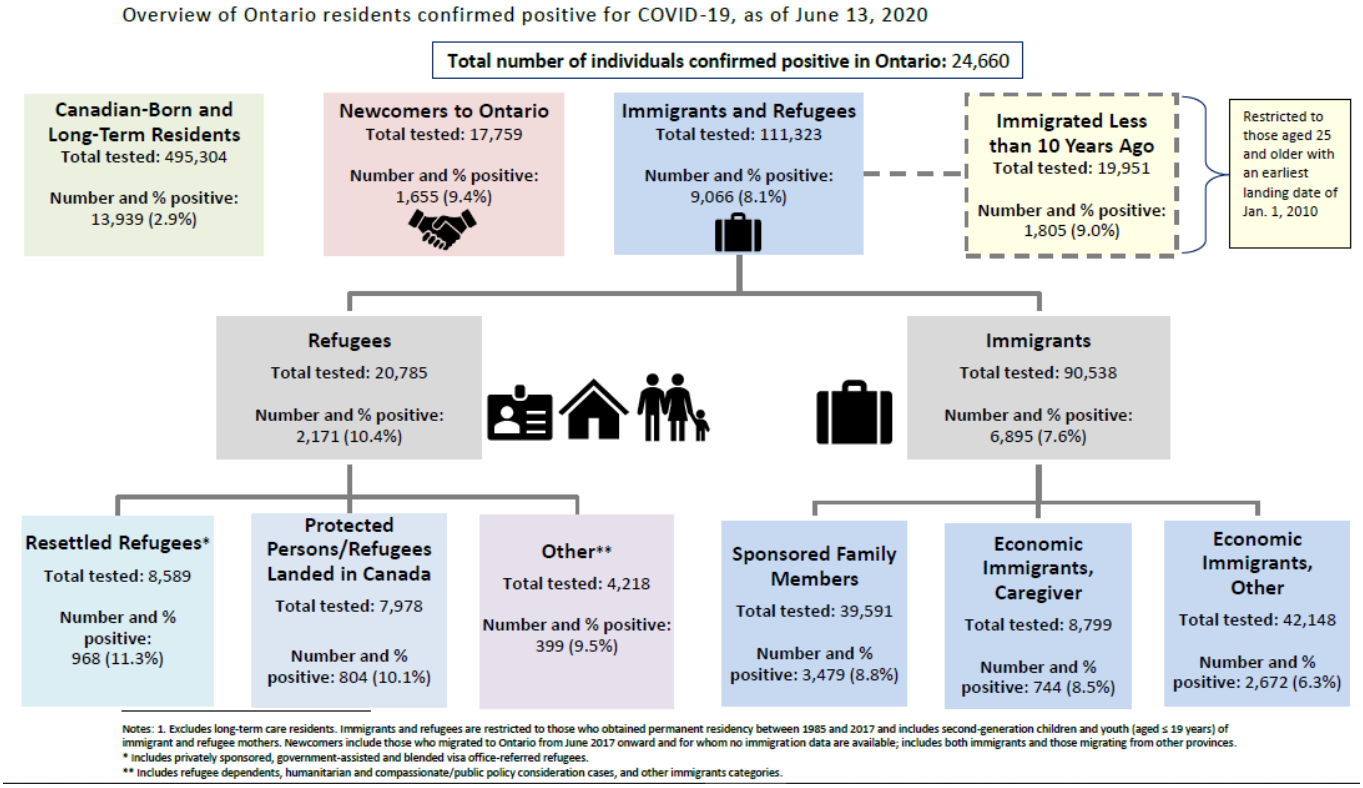
- People who identify from racialized communities

- Individuals and families who live in low-income neighbourhoods

- High density housing dwellings, greater residential instability, and material deprivation

- Residents with lower levels of education and language fluency

Figure 1: Overview of Ontario Residents Confirmed Positive for COVID-19 as of June 13, 2020 from IC/ES[25]



Early reports from IC/ES[24] highlight that the Region of Peel public health unit has reported the greatest number of individuals confirmed positive for COVID-19 in Ontario. In addition, key findings report that particular individuals and communities are being disproportionately impacted:

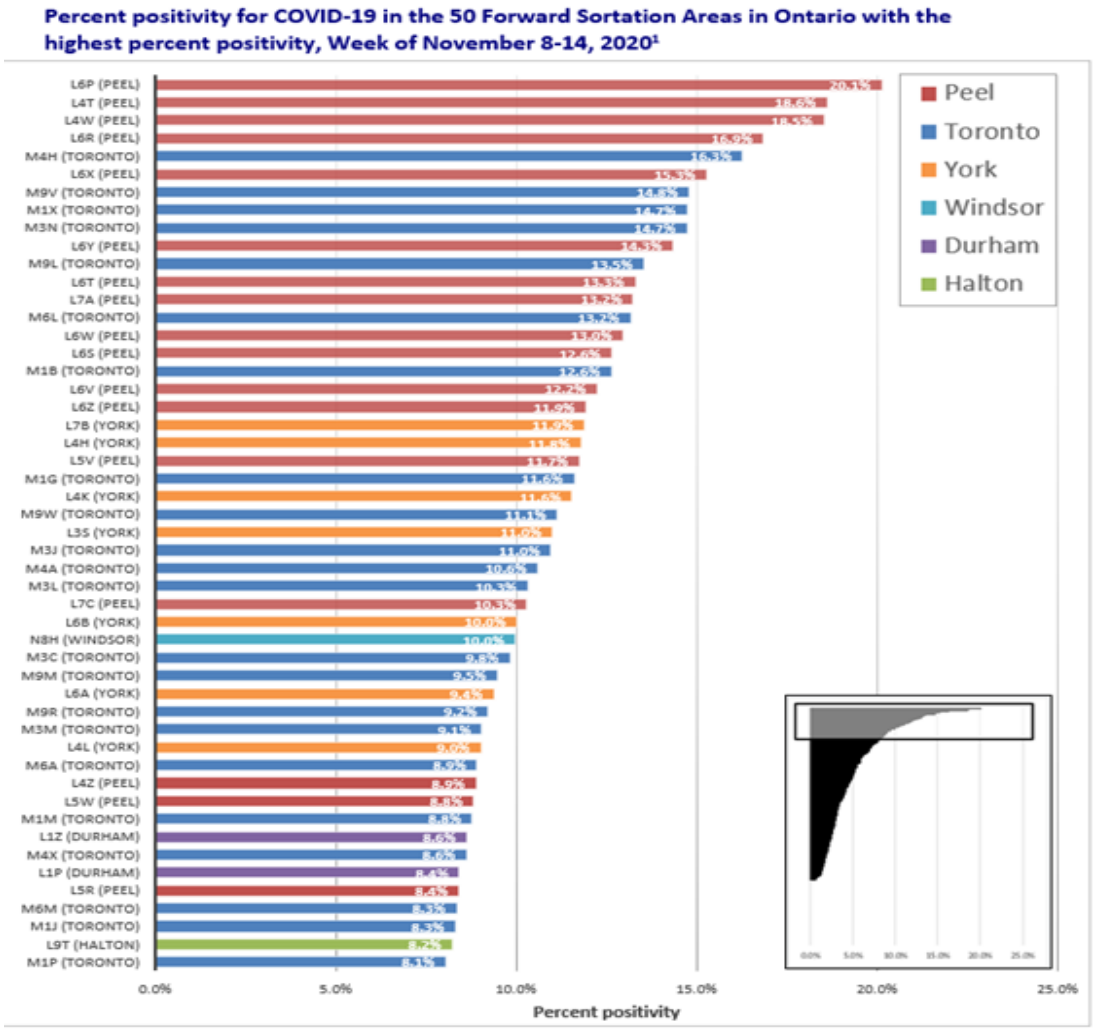
- As of November 30, 2020, 88% of known COVID-19 cases involved members of racialized communities (63% of Peel's population include members of racialized communities)
- South Asians in Peel accounted for 59% of COVID-19 infections, despite comprising 31.6% of the Peel population[26]
- Latinos in Peel were also disproportionately affected, comprising 4.6% of COVID-19 infections in August 2020 and 3.2% by November 30, 2020, despite accounting for 2.3% of Peel's population[26]
- Blacks in Peel comprised 13.5% of COVID-19 infections in August 2020, despite accounting for 9.5% of Peel's population[26] By November 30, 2020, this rate is now proportional to the population of Blacks in Peel.

Key findings released by IC/ES[27] for the week of November 8-14th, 2020 (see Figure 2 and Figure 3), illustrate that the Region of Peel continues to experience disproportionate impacts of COVID19:

- Using postal codes, specific neighbourhoods (L6P, L4T, L4W) in the region have Ontario's highest positivity rates (greater than 18 %)

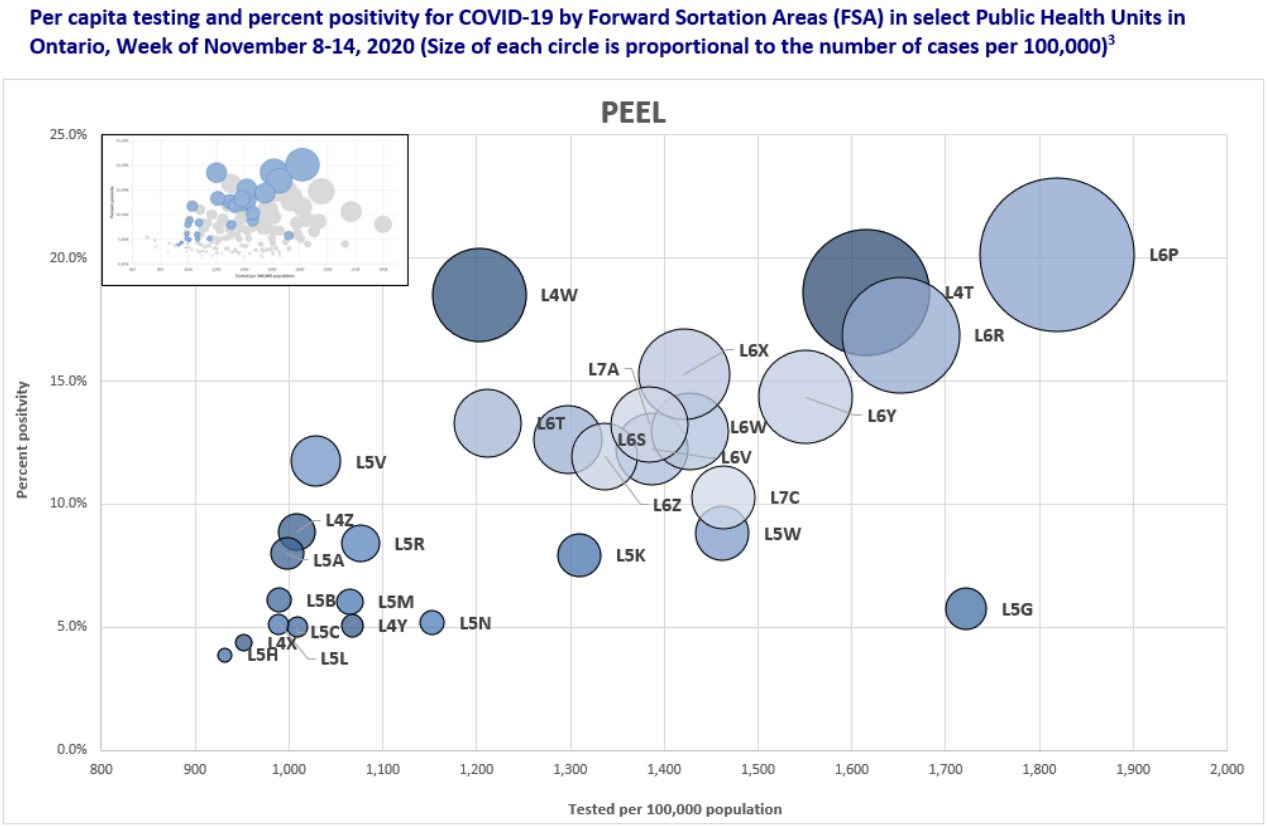
- Peel Region leads the Public Health Units in Ontario with the highest percent of positivity above 2.5 percent with 11.7 percent.

Figure 2: Percent Positivity for COVID-19 in the 50 Forward Sortation Areas in Ontario with the Highest Percent Positivity, Week of November 8-14 2020 from IC/ES[27]



[1] Forward sortation area (FSA) is the first three characters of a postal code. FSAs with ≥6 COVID-19 cases in the past week were included in this ranking.

Figure 3: Per Capita Testing and Percent Positivity for COVID-19 by Forward Sortation Areas in Select Public Health Units in Ontario, Week of November 8-14 from IC/ES[27]



[3] Forward sortation area (FSA) is the first three characters of a postal code. FSAs with ≥6 COVID-19 cases in the past week were included in these graphs. Only FSAs that are solely in one public health unit are presented. Bubble size across PHUs cannot be compared due to the proportion of cases.

The availability of these data helps to underline the urgency to serve key community segments in reducing and eliminating the disproportionate impact of COVID-19 on marginalized members of our community. There are wide disparities in the availability of race-based health data

- A registry study[28] conducted in the United States shows that people who identified from racialized communities living with Sickle Cell Disease, who are from primarily Black, Filipino and South Asian communities, have higher rates of hospitalization, ICU admissions and death**. These data however are not available in Canada.**

- In Ontario, common medical conditions reported to be associated with COVID-19 related deaths have included: Dementia or Alzheimer's disease, Hypertension, Heart Disease, Diabetes and Cancer.[29] **Racialized individuals living with chronic health conditions are likely being disproportionately impacted; however no race-based data are available in these reports.**

A more recent data IC/ES publication, *Key findings from ICES Report on COVID-19 in Immigrants, Refugees and Other Recent OHIP Registrants*[25] reviewing data from November 01, 2021 noted that:

- In all of Ontario, the positivity rate for COVID-19 was "772 cases per 100,000 in immigrants, refugees and other recent OHIP registrants, comparted to 320 per 100,000 in Canadian-born and long term residents".

RECCOMMENDATIONS FOR COLLECTIVE ACTION

We all must come together through collective action, learning and problem solving to respond to the health inequities, systemic racism and discrimination that continue to impact the health and well-being of individuals, families and communities in Peel. To address these inequities, we recommend working collectively in the following ways:

1. We urge health system decision-makers to **co-design health services and systems with diverse groups that have been historically marginalized and underrepresented** in health research, education, policy and practice. Co-designing means more than convening a patient advisory table; co-designing represents a range of strategies and opportunities, from ensuring that the composition of boards of directors are reflective of the diversity of the individuals and communities being served to recruiting members of diverse community groups to persistently provide input into all levels of health system decision-making, including practices, policies, funding models, measurement and evaluation.

2. We recommend that the Ministry of Health, through the Mississauga/Halton and Central West LHINs and the newly formed Mississauga and Brampton/Etobicoke Ontario Health Teams, publicly declare **how equity is embedded in decisions about funding allocations**. Specifically how are funding decisions reflective of the diverse communities that health providers serve? This transparency will help build an environment of trust and accountability among service users, service providers, policy makers and funders of the health system at-large.

3. We recommend that **health professionals build personal capacity to work with diverse members of the community**. This can be accomplished by establishing equity-focused accreditation requirements for healthcare professionals in Peel. For example:

    - The Pan-Canadian Health Promoter Competencies document, [30] for example, requires health promotion practitioners to communicate health information effectively with diverse audiences using appropriate approaches and interact with diverse individuals, groups and communities to reduce health inequities. We recommend that to maintain accreditation in this field, practitioners should be required to complete a minimum number of training hours focused on topics such as undoing oppression and cultural sensitization per three-year certification period. Community members and organizations that have insight into cultural groups in Peel Region should be consulted when

training is coordinated to ensure that training meets the local needs of the individuals, families and communities they serve.

- And, it's not just about health promotion professionals. These types of training opportunities are relevant to many healthcare professions and would go a long way not only to ensure that anti-oppression and anti-racism training is embedded and reinforced over time within health care circles, but also contribute to meaningful change in the way services are delivered.

- We recommend that the colleges and regulatory bodies responsible for licensing health professionals embed anti-oppression and anti-racism learning into post-secondary and professional curricula so that new healthcare professionals will come into their careers with a strong equity lens.

4. We understand that tremendous data are collected by service providers at the request of LHINs and OHTs. However, little has been shared about how these data are driving evidence-based decisions. We ask the Mississauga/Halton and Central West LHINs and the Mississauga and Brampton/Etobicoke OHTs to **explain how collected data have been used to inform decision-making, particularly decisions aimed at addressing equity concerns.**

   We are aware of reports published by Peel Public Health, including *Destination Peel 2012*[31] and *The Changing Landscape of Peel Health Status Report 2019*[22]. We recommend that Peel Public Health compile a similarly comprehensive report focused on racialized populations. It would also be advantageous to invite collaboration with community members and organizations to inform key indicators and how data is presented and structured in future reports. Community members and organizations can also help shape programmatic recommendations to ensure these are culturally appropriate, safe and responsive. Conversely, community members and organizations can play a role in contributing qualitative data to these reports – to deepen and strengthen cross-cultural understanding using experiential knowledge.

5. Measurement and evaluation are key to collective endeavours. The National Collaborating Centre for Infectious Disease and the National Collaborating Centre for Social Determinants of Health have updated their list of 60+ Emergency Preparedness Equity Indicators[32] in response to COVID-19 and are encouraging public health associations to "understand inequities and the disadvantage they create… to measure what counts and to examine what is being counted, and who is being missed". We recommend that **existing indicator frameworks be leveraged to inform, enhance and augment collective health preparedness in Peel through an equity lens**.

6. We collectively acknowledge that Peel is linguistically diverse, and that hospitals have the resources to provide people with access to interpretation services. We are also aware that LHINs reimburse costs associated with interpretation. However, we continue to hear interpretation is not being consistently offered and that interpretation quality is lacking.

   We recommend that **interpretation statistics and interpretation services be made more public and accessible**, and that hospitals report on their use of

interpretation services as part of their care so that community partners can help augment these efforts.

7. We recommend that the **Mississauga/Halton and Central West LHINs and the Mississauga and Brampton/Etobicoke OHTs describe the work they have undertaken to fulfil requirements set out in the 2018 Health Equity Guideline**[1] published by the Ministry of Health and Long-Term Care, including whether the following were achieved:

    - Describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities
    - Engaging priority community groups to understand their unique needs, histories, cultures and capacities, as well as co-designing strategies to improve the health of the entire community while decreasing health inequities
    - Engaging in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders
    - Leading, supporting and participating with other stakeholders in health equity analysis, policy development and advancing healthy public policies

    We are also interested in learning about the status of intended equity work, such as:

    - Central West LHIN's plan to adopt a health equity charter by March 2019 and conduct impact assessments for sub-region planning by September 2019.[33]
    - Recommendations that appeared in Mississauga Halton LHIN's 2017 Final Report on Health Equity Data Collection[21], such as establishing a data repository, maintain equity champions or advocates, as well as implementation plans

    These recommendations can help set a baseline of work conducted to date and describe how to work with our diverse communities to fully achieve the requirements mandated in the guidelines.

NEXT STEPS

In order to move towards collective community action that reduces systemic discrimination and anti-Black racism within health systems and institutions in Peel we invite the identified health leaders and decision makers listed at the beginning of the report to confirm receipt of this document by February 26, 2021 and meet with representatives from our collective by March 26, 2021 to start a discussion about these recommendations and work towards health equity for all individuals, families and communities in the regions.

RESOURCES TO ADDRESS ANTI-BLACK RACISM AND SYSTEMIC DISCRIMINATION

Regional Diversity Roundtable	https://www.rdrpeel.org/
Peel Newcomer Strategy Group	https://www.peelnewcomer.org/
Anti-Black Racism Analysis Tool for a Radically Equitable COVID-19 Response. The City of Toronto's Confronting Anti-Black Racism Unit	https://www.toronto.ca/wp-content/uploads/2020/09/903d-ABR-COVID-19-Analysis-Toolkit_Final.pdf
Peel's Community Safety and Well-being Plan 2020-2024	https://www.peelregion.ca/community-safety-wellbeing-plan
Peel Poverty Reduction Strategy	http://www.povertyinpeel.ca/

REFERENCES

1. Ontario Ministry of Health and Long-Term Care. December 16, 2019. *Health Equity Guideline 2018.* Retrieved on January 5 2021 from www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Health_Equity_Guideline_2018_en.pdf

2. Statistics Canada. *Census Profile, 2016 Census Peel, Regional municipality [Census division], Ontario and Ontario [Province].* Retrieved in January 5 2021 from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?B1=All&Code1=3521&Code2=35&Data=Count&Geo1=CD&Geo2=PR&Lang=E&SearchPR=01&SearchText=Peel&SearchType=Begins&TABID=1.

3. Region of Peel. (2019) *Household Food Insecurity*. Retrieved on January 5 2021 from https://www.peelregion.ca/strategicplan/20-year-outcomes/household-food-insecurity.asp

4. Government of Canada (2020). July 10 2020. *Social Determinants of Health and Inequalities.* Retrieved on January 5, 2021 from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

5. Lewchuk, W. (2016). The precarity penalty: How insecure employment disadvantages workers and their families. *Alternate Routes: A Journal of Critical Social Research*, *27*.

6. Peel Halton Workforce Development Group. (2016). *Peel Halton Workforce Characteristics Report*. Retrieved on Jan 35 2021 from https://www.peelhaltonworkforce.com/wp-content/uploads/2020/07/Workforce-Characteristics-Report-Final-2-min.pdf

7. Block, S., Galabuzi-Grace, E., & Tranjan, R. (2019). *Canada's colour coded income inequality*. Canadian Centre for Policy Alternatives.

8. Canadian Centre for Policy Alternatives. (2016). *By the numbers: Race, gender and the Canadian labour market.* Retrieved on January 25 2021 from https://behindthenumbers.ca/shorthand/by-the-numbers-race-gender-and-the-canadian-labour-market/

9. United Way. (2019). *Rebalancing the Opportunity Equation.* Retrieved on January 25 from https://www.unitedwaygt.org/file/2019_OE_fullreport_FINAL.pdf

10. Daily Bread Food Bank. (2019). *Who's Hungry 2019: Profile of Hunger in the Toronto Region.* Retrieved on January 25 2021 from https://www.homelesshub.ca/resource/whos-hungry-2019-profile-hunger-toronto-region

11. Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and Facilitators to Accessing Mental Healthcare in Canada for Black Youth: A Scoping Review. *Adolescent Research Review*, 1-22.

12. Kusari, K., El-Lahib, Y., & Spagnuolo, N. (2019). Critical Reflections on the Process of Developing a Resource Manual for Service Providers Working with Immigrants & Refugees with Disabilities. *Canadian Journal of Disability Studies*, *8*(5), 98-119.

13. Lacombe-Duncan, A., Logie, C. H., Persad, Y., Leblanc, G., Nation, K., Kia, H., ... & Loutfy, M. (2020). 'Transgender Education for Affirmative and Competent HIV and Healthcare (TEACHH)': protocol of community-based intervention development and a non-randomised multisite pilot study with pre–post test design in Canada. *BMJ open*, *10*(7), e034144.

14. Nwoke, C.N., Leung, B.M.Y. Historical Antecedents and Challenges of Racialized Immigrant Women in Access to Healthcare Services in Canada: an Exploratory Review of the Literature. *J. Racial and Ethnic Health Disparities* (2020). https://doi.org/10.1007/s40615-020-00907-3

15. Phillips-Beck, W., Eni, R., Lavoie, J. G., Avery Kinew, K., Kyoon Achan, G., & Katz, A. (2020). Confronting Racism within the Canadian Healthcare System: Systemic Exclusion of First Nations from Quality and Consistent Care. *International Journal of Environmental Research and Public Health*, *17*(22), 8343.

16. Varcoe, C., Browne, A., & Blanchet Garneau, A. (2019). Beyond stress and coping: the relevance of critical theoretical perspectives to conceptualising racial discrimination in health research. *Health Sociology Review*, *28*(3), 245-260.

17. Meighhoo (2020) Vivid Impact. *Planning for Impact. A Guide for Non-Profit Staff: Planning Community Programs Without Reproducing Systemic Racism.* Durlaksar Incorporated retrieved on January 5 2020 from www.vividimpact.ca/resources

18. Health Nexus and the Health Equity Council. (2011). *Addressing Health Inequities for Racialized Communities: A Resource Guide.* Retrieved on January 25 2021 from www.healthnexus.ca/projects/building_capacity/index.htm

19. Region of Peel. (2020) *Regional Community Response Table – Meeting #53. Central West LHIN per capita funding figures*. Meeting minutes from Wednesday, October 21st, 2020 at 2:00 pm.

20. Wellesley Institute. (2015). *Making the Connections.* Retrieved on January 25 2021 from http://www.wellesleyinstitute.com/topics/healthy-communities/making-the-connections/

21. Mississauga Halton Local Health Integration Network. (2017). *Health Equity Data Collection Project: Focused Implementation Sites in the Mississauga Halton LHIN – Phase II.* Retrieved on January 25 2021 from http://www.mississaugahaltonlhin.on.ca/~/media/sites/mh/Primary%20Navigation/GoalsAchievement/Program%20Area%20and%20Initiatives/Health%20Equity/FIS%20Phase%20II%20Final%20Report%202017.pdf?la=en

22. Region of Peel – Peel Public Health. (2019).T*he Changing Landscape of Health in Peel: A Comprehensive Health Status Report 2019*. Retrieved on January 5 2021 from https://www.peelregion.ca/health/resources/pdf/CHSR-changing-landscape-health-peel-full-report.pdf

23. Sheikh, A., & Dhami, S. (2020). *Ethnicity and "aggressive" end-of-life care*. *CMAJ*, 192(11), E287-E288.

24. Chung H, Fung K, Ferreira-Legere LE, Chen B, Ishiguro L, Kalappa G, Gozdyra P, Campbell T, Paterson JM, Bronskill SE, Kwong JC, Guttmann A, Azimaee M, Vermeulen MJ, Schull MJ. *COVID-19 Laboratory Testing in Ontario: Patterns of Testing and Characteristics of Individuals Tested, as of April 30, 2020*. Toronto, ON: ICES; 2020.

25. Guttmann A, Gandhi S, Wanigaratne S, Lu H, Ferreira-Legere LE, Paul J, Gozdyra P, Campbell T, Chung H, Fung K, Chen B, Kwong JC, Rosella L, Shah BR, Saunders N, Paterson JM, Bronskill SE, Azimaee M, Vermeulen MJ, Schull MJ. *COVID-19 in Immigrants, Refugees and Other Newcomers in Ontario: Characteristics of Those Tested and Those Confirmed Positive, as of June 13, 2020.* Toronto, ON: ICES; 2020.

26. Region of Peel. (Jan 4 2021). *Cases of COVID-19 in Peel.* Retrieved on January 5 2021 from https://www.peelregion.ca/coronavirus/case-status/

27. IC/ES. (2020). *IC/ES COVID-19 Dashboard.* Retrieved on November 18 2020 from https://www.ices.on.ca/DAS/AHRQ/COVID-19-Dashboard

28. Panepinto, J. A., Brandow, A., Mucalo, L., Yusuf, F., Singh, A., Taylor, B., ... & Schieve, L. A. (2020). Coronavirus disease among persons with sickle cell disease, United States, March 20–May 21, 2020. *Emerging Infectious Diseases*, *26*(10), 2473. https://doi.org/10.3201/eid2610.202792

29. O'Brien, K., St-Jean, M., Wood, P., Willbond, S., Phillips, O., Currie, D., & Turcotte, M. (2020) November 16 2020. *COVID-19 death comorbidities in Canada.* Retrieved on January 5 2020 from https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00087-eng.htm

30. Heath Promotion Canada. (2015). *The Pan-Canadian Health Promoter Competencies and Glossary, 2015*. Retrieved on January 5 2021 from https://www.healthpromotioncanada.ca/wp-content/uploads/2016/07/2015-HPComp-CompletePackage3-new-logo.pdf

31. Region of Peel. (2012). *Destination Peel 2012: Key Findings for Immigrant and Ethnocultural Health.* Retrieved on January 5 2021 from https://www.peelregion.ca/health/resources/pdf/MOH-0072-web.pdf

32. Haworth-Brockman, M., & Betker, C. (2020). *Measuring What Counts in the Midst of the COVID-19 Pandemic Equity Indicators for Public Health.* Retrieved on January 5 2021 from https://nccid.ca/publications/measuring-what-counts-in-the-midst-of-the-covid-19-pandemic-equity-indicators-for-public-health/

33. The Central West Local Health Integration Network. (2017). *The Central West LHIN Annual Business Plan 2018/19*. Retrieved on January 25 2021 from http://www.centralwestlhin.on.ca/~/media/sites/cw/Documents/Accountability/IHSPs_ARs_and_ABPs/ABPs/2018-2019ABP_(ENG).pdf?la=en