

# Health Equity and Racialized Groups: A Literature Review

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Aussi disponible en français.

This document in English and French is found on-line under "resources" at <http://www.healthequitycouncil.ca> and at [http://www.healthnexus.ca/projects/building\\_capacity/index.htm](http://www.healthnexus.ca/projects/building_capacity/index.htm)

A "Resource Guide" on Addressing Health Inequities is also found at the above site.

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# 1. Introduction and Purpose

## 1.1. Précis

This literature review supports an initiative led by Health Nexus and the Health Equity Council and funded by the Ministry of Health Promotion and Sport's Healthy Communities Fund. The aim of the initiative is to build capacity for equity in health promotion as it relates to racialized groups, especially those living in low income communities. This includes working with an Advisory Group and Local Planning Teams to facilitate events, meaningful discussion and partnership/network development on this topic across Ontario. A preliminary literature review supported the planning of five events held across the province in English and French between October 2010 and March 2011. These events and conversations further identified knowledge gaps that the literature review could address.

Gaps identified in healthy communities work, health promotion and healthy equity practice include the lack of integration of systemic racism as a 'determinant of health' and the lack of integration of 'racial' justice in existing 'equity lens.' Given growing diversity in the population and growing evidence of health and social disparities within and between communities, it is imperative that these gaps be addressed. Greater awareness is needed so that actions, analysis and investments will reduce rather than further widen (and further 'racialize') existing health inequities.

The literature review is written primarily for people and organizations engaging in health promotion. Health promotion is "the process of enabling individuals and communities to increase control over the determinants of health" (WHO 1986). The primary objective of the literature review is to support awareness and action based on understanding systemic racism that is embedded (often hidden) in institutional policies, practices, ideology, discourse, and social environments. The literature review asks: "*What would health promotion look like if it used an anti-oppression/anti-racism approach?*"

The literature review identified the importance of understanding how structural racism, and white privilege create and perpetuate racialized health disparities. This includes the need to expose historical injustice and systemic racism; stand up against current injustice including white privilege, racialization and social and economic exclusion; and take an anti-racist anti-oppression approach in health promotion. This needs to go beyond individual awareness (how individuals can become anti-racist allies and empowered anti-racist agents of change) to changes in health promotion practice and organizational and policy change. Health promotion practice and search for causes and pathways needs to be rooted in an analysis of structural racism, power and privilege.

The literature review proposes a continuum from colour blind/universalism to cultural competence to anti-oppression/anti-racism, that aims to make it easier to see these distinctions when planning strategies.

## 1.2 About the Literature Review: Approach and Limitations

While the Healthy Communities Fund includes 'ethnocultural communities' as one of the listed priority populations, this project focuses on 'racialized groups' in order to make visible the social, economic, political and health disparities faced by communities experiencing systemic racism. The specific health promotion areas considered in this analysis were: healthy eating/food security, physical activity and mental health promotion. Because of the increasing racialization of poverty we expand the Healthy Communities Fund focus area of 'healthy eating' to include 'food security' i.e. that all people at all times have physical and economic access to nutritious, safe, personally acceptable, and culturally appropriate foods, and their production and distribution is environmentally, socially and economically just (Just Food, 2010).

A literature review is one type of evidence that can inform understanding, explanation and the development of action plans to tackle problems such as health inequities. As a source of evidence to support planning or decision making, it is important to recognize that all analysis and knowledge production is located within a paradigm or world view (way of knowing) influenced by ideology, history and structure.

This literature review applies the 'racial' justice equity analysis approach it recommends.

Individuals/researchers "who are not willing to inquire about alternative constructions in other cultures or sub-cultures must either admit from the beginning that their knowledge is particular, Western-focused, and Eurocentric or they must accept the assessment that they are part of the hidden euro-centrism in their society (Teo & Febbraro, 2003)

An anti-oppression/anti-racism approach asks that researchers and writers examine ways in which what we say, write and do are socially located. In this case, the Anglo-Eurocentric bias in the published academic research is one of the limitations of this literature review. This Anglo-Eurocentric bias would best be addressed by what Teo & Febbraro (2003 on-line) describe as "affirmative action for alternative cultural knowledge, that targets unheard voices, suppressed knowledge and neglected ideas from

cultures and subcultures."

The published literature has been supplemented by community reports, community-based research, workshop reports, input from the project advisory committee and other documents (prose, dub poetry). These sources are used to 'check' or validate published work with activist and lay expertise/lived experience (Popay, 2003). Since the methodology for the literature review did not include community-based research, it would be inappropriate to include excerpts or quotes reflecting community voices from other works into this document.

The limitations of the Anglo-Eurocentric literature is especially clear when we consider the diversity within Francophone communities. The context (and historical oppression) of Franco-Ontarians, Quebecois, Acadian, and immigrant and/or racial minority French-

speaking communities have similarities and differences that make it difficult to use a single "Francophone lens" to conduct a literature review. While this literature review drew on Francophone input and looked at Francophone (as opposed to bilingual) literature and is translated into French, a complementary report is planned under the direction of a group of Francophones and French-speaking persons participating in this project. This would create the "space" to expand on diverse Francophone perspectives.

The systemic racism experienced by First Nations, Métis and Inuit communities is internationally noted and monitored (UN, 2010, Report of the UN's Special Rapporteur). The legacy of colonial oppression, constitutional rights and other issues require expanded

<p style="text-align: center;"><b>On Stolen Land</b> <i>"everything we are trying to reorganize and redistribute in this country rests on stolen land."</i> (Neigh, 2008, p 195 )</p>
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consideration beyond the focus of this literature review. Recent articles in the Canadian Journal of Public Health, under the title of "Apartheid in Canada" describe the unacceptable conditions that Aboriginal

communities face (Paradis, 2009). Bowering, (2009, p 397) comments on this "inconvenient truth" of the "intentional, structural" determinants of aboriginal health inequities that result from what can be described as "apartheid" (i.e. legislated structural differences in governance that have the effect of reducing the opportunities and living standards of one 'ethnic or racial' group with respect to another)." Aboriginal communities have experienced systemic racism for centuries, and they have distinct status as Canada's Original Peoples compared to other groups experiencing racism who are commonly defined as 'racialized groups.'

This literature review is a "synthesis" that builds on a large body of past work. The relevant literature can be categorized according to the following topics:

- racialization of poverty
- racism in access to determinants of health such as housing, employment, income security, justice, education
- racism as a determinant of health
- health disparities reported according to racialized groups
- bibliographies, literature reviews, glossaries and guides to organizational change (i.e. diversity-competence, cultural competency, anti-racist/anti-oppression)
- timelines and examples in the history of structural racism in Ontario and Canada
- key concepts regarding equity, racism and interlocking oppressions (such as Race Critical Theory, politics of difference)
- resources specific to structural racism in our three action areas:
  - mental health promotion
  - access to physical activity, recreation and sport, and
  - healthy eating/food security
- 

The literature review draws on historical documents while focusing on resources in English and French produced since 2001. Appendix C describes the literature search method.

This review includes ideas that emerged from discussion or synthesis that goes beyond the referenced literature. The development of Resource Guide on promising practices and tools is a separate component of this project.

### 1.3 Information Gaps and Issues Addressed by the Literature Review

Definitions and examples to support discussion of health equity, anti-racism/anti-oppression and structural determinants of health are provided because:

- Health Equity is not a well understood or applied concept.
- Organizations are at differing levels of operationalizing an anti-oppression/anti-racism approach into staff training, policies, practices, labour relations, decision making and governance.
- Individuals in different work and community settings experience different levels of comfort and opportunity to talk about issues discussed here.

This report tries to include and respect the diversity of views and multiple sources of information and levels of comfort with discussion of the topic. Through the initiative, we learned that discussion spaces are needed:

- where it is possible to envision a world without racism and discrimination that enables people with discomfort in talking about racism to feel included;
- where it is safe to challenge and critique the embedded domination/oppression in various discourses so that they can be critically examined and exposed; and
- where divergent views and minority, marginalized, socially excluded and often silenced voices can be expressed.

Also needed is an open discussion of concepts that cause discomfort because they challenge dominant values and ideology (e.g. that Canada is a peaceful, welcoming nation where every resident has rights protected under legislation and enforced by policies, laws and resources). History proves otherwise (Curry-Stevens, 2005; Henry & Tator, 2009; Commission on Systemic Racism, 1995; Ontario Human Rights Commission, 2005). A timeline on racism in Canada is provided (Appendix A).

#### White Privilege

*" unearned advantages which are conferred systematically to members of a social group, in virtue of their group membership." (Carastathis, 2008, p8; See McIntosh, 1988)*

*Recognition of how health is "shaped by structural inequities like economic position and/or experiences of racism and racial discrimination is necessary if we are to move towards the creation of an equitable and just society for all Canadians" (Kobayashi et al, 2008:8).*

The literature review identified the importance of understanding how structural discrimination, racism, and white privilege are embedded in our society and how this perpetuates racialized health disparities. Privilege (white privilege) must be taken beyond the level of individual awareness/how individuals can become anti-racist allies.

Meaningful organizational change and health promotion practice should be rooted in an analysis of structural racism, power and privilege. The language and methods used to talk about these issues needs to be adapted to the varied demographics and contexts of communities and organizations (Rogers & Bowman, 2005).

Systemic racism and social inequities threaten physical health, mental health and well-being. Health inequities can be seen as “biological expressions of race relations” (Krieger, 2004, 2007). Equity in health promotion requires an understanding of ‘race relations’ and the social process of ‘racialization.’

As research on health inequities according to racialized group categories increases, it becomes even more important that an analysis of this information be informed by awareness of the structural determinants and an anti-oppression/anti-racism approach. Otherwise there is a risk that the observed differences will be misunderstood and wrongly attributed to biology or stereotyped behaviours related to ethnic or racial group categories. Opportunities to prevent and reduce health disparities will be missed and health inequalities will become further racialized. The focus needs to shift from “high risk” ethnic groups, genetics and culture to the “root causes” of health inequities largely beyond individual/community control.

Despite diversity of the population of Ontario since pre-Confederation, monoculturalism (Eurocentrism) has been the norm. Ethno-racial groups are seen as special interest groups with little attention to how ethno-racial health inequalities emerge within the broader social, political economic context (van Ryn & Fu, 2003). In Ontario, the failure to develop health policy, programs and services in “a framework that acknowledges the entire population as essentially diverse” (Sabloff et al, 1991), has marginalized (subordinated) and made invisible racialized community health inequalities. Racialized groups in Ontario are projected to increase 250% between 2006 and 2031 (from 22.8% to 40.4% of the population) (Caron, 2010). It is necessary that anti-racism, Francophone community experiences, Aboriginal self-determination, equity, and social justice approaches be integrated into health promotion.

## 2. Laying the Foundation: Key Concepts

### 2.1 Towards Understanding Health Equity

We begin with concepts relevant to the health equity and racialized health disparities. In the 1800s, Rudolf Virchow promoted the idea that “all diseases have two causes: one pathological and one political” (Pinchuk & Clark, 1984 in Labonte, 1988). A more recent

*“ All diseases have two causes, one pathological and one political.”*

Virchow in Pinchuk & Clarke (1966).

influential voice in public health, Geoffrey Rose, is often quoted for a similar conclusion: i.e. “The primary determinants of disease are mainly economic and social, and therefore its remedies must also be

economic and social. Medicine and politics cannot and should not be kept apart" (Rose, 1992, p.129 in Warren, 2008, Hofrichter 2010).

Health equity as it relates to health status, care and promotion since the Alma Ata Declaration of Health for All (1978) includes notions of fairness and social justice (WHO, 1978; People's Health's Movement, 2000, 2005). "Achieving equity in health" was the first objective in Ontario Health Goals (1987) and "reducing social inequities in health" was the government of Canada's first objective in *Achieving Health For All* (Epp, 1996).

Today, the *Ontario Public Health Standards* (2008) require Boards of Health to report on health inequities. Under legislated requirements, the Ontario Agency for Health Protection and Promotion (now Public Health Ontario) provides scientific and technical support to the health system and Government to protect and promote health of Ontarians and reduce health inequities. The list of health service organizations that have made explicit commitments to health equity or reducing health disparities is growing.

### Health Equity, Health Inequities, Health Disparities

*"Equity means social justice or fairness: it is an ethical concept grounded in the principles of distributive justice."*

*"Equity is the absence of socially unjust or unfair health disparities."*

Braverman & Gruskin, 2003

'Equity' is distinct from 'equal' or 'same.' Equitably distributing services, providing equitable access, equitable resources etc., means responding differently according to different needs in order to reduce or compensate for unequal barriers, risk, vulnerability, resources, etc., in order to support the attainment of equal outcomes among different population groups. Treating the population as if everyone could equally benefit from a service, program, policy change, or

information etc., has created health and social disparities that could have been avoided by treating groups equitably (taking differences into account) (Frohlich & Potvin, 2008; Macintyre, 2007; Culyer & Bombard, 2011).

The most widely quoted definition of health inequity, first proposed by Margaret Whitehead in 1990 (see 1992, p 430) is "differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust". Expanding on this, Braverman (1998 p 10) defined health equity as "minimizing avoidable disparities in health and its determinants between groups of people who have different levels of social advantage or privilege, i.e. different levels of power, wealth or prestige due to their position in society relative to other groups." Differences in social advantage reflect social hierarchy according to socioeconomic, geographic, gender, racial/ethnic, religious, occupational class, education, sexual orientation, disability, age or other status (Braverman, 1998; Braverman & Gruskin, 2003). The International Society for Equity in Health's (2000) definition of equity in health is similar: "the absence of systematic and

potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups."

Sudbury & District Health Unit's health equity planning tool (2007) defines health inequities (based on a report by PHAC, 2007) as: "those health inequalities that are systematic, socially produced (and therefore modifiable by society's actions), and are judged to be unfair and unjust." In attempting a plain language form of communicating this, the Canadian Institute for Health Research (2010) notes that "People in Canada should not be disadvantaged from reaching their full health potential because of their race, ethnicity, religion, income or other socially determined circumstance."

Fabienne (2000) and Braverman & Gruskin, 2003 further clarify that 'unavoidable' refers to unjust social determinants or social structures and that unfair and unjust imply

*"D]ifferences in health outcomes [are] inequitable if they are the result of unjust social arrangements." (Fabienne P, in Anand et al, 2004).*

*Health disparities can be understood as health inequities when existing knowledge indicates that their causes are strongly associated with unjust social structures or the social determinants of health at some point (CASSA, 2010).*

*Inequities are differences in health that stem from inequalities in the underlying social and economic conditions that are essential for health (Edwards & DiRuggiero, 2011)*

'avoidability.' More recently, Edwards at the University of Ottawa, DiRuggiero at the Canadian Institute for Health Research (2011) and researchers at the Council for Agencies Serving South Asians (CASSA, 2010) have restated ideas in Braverman & Gruskin in useful ways (see box).

This literature review concludes that because health inequities are differences in health that result from unjust social structures (social and economic conditions and policies and practices that can be changed), action for health equity requires tackling unjust social structures. This includes a focus on injustice rooted in the structural determinants of health inequities such as racism, classism, and gender discrimination embedded in society's structure

and institutions and how power and resources are distributed.

Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. These comparisons are essential to assess whether policies contribute to or further reduce social justice in health. The health status of the most socially advantaged group represents an attainable standard of health for all socially defined groups (Braverman & Guskin, 2003; Wilkins, 1987, 2002) and is typically used in comparisons and social gradients.

Edwards and DiRuggiero (2011, p 43) write that "inequities are shaped by long-standing structural influences such as global-, macro-, and meso-level social and economic policies that unevenly distribute power and resources and benefit some social groups over others. Other influences include social norms that reinforce racism and discriminatory and stigmatizing practice and the perceived complacency towards differential class exposures to health threatening conditions such as poor housing and unsafe working conditions."

### Key Points

Health inequities are deeply rooted in unjust social structures and unjust social conditions.

Understanding the legacy, history and context of social injustices is a key step in explaining and deciding how to respond to health inequities among socially defined groups such as racialized groups.

Programs and services even those which are culturally competent are not enough and can reinforce social injustice.

Health equity practice includes tackling unjust social structures.

Through a literature review and case studies, Edwards and DiRuggiero demonstrate how understanding of context and historical injustice can shed light on observed health inequities to enable a valid understanding of the differences. The examples they use are how the layers of historical injustices influence Aboriginal health in Canada and how a multi-level contextual re-analysis of education policies explained illiteracy variation by 'race' in the US. Given the deep roots of health inequities in social injustice, it is

necessary to recognize that even culturally competent interventions can inadvertently reproduce unjust social processes. They point to the importance of bringing an analysis of historical injustice into the research, analysis and planning process.

The terms health inequalities, health disparities and health inequities are often interchanged. 'Health inequalities' are used commonly in the UK while 'health disparities' are used more commonly in the US. Statistics Canada (2005), the Public Health Agency of Canada and the Federal/Provincial Territorial Advisory Committee on Population Health and Health Security (2006) have often used the term 'health disparities.'

Because the health disparities we are talking about are related to the structural determinants of health which produce unfair distribution and access to opportunities for health, we use the terms "health inequities" from this point forward.

### Health Equity Charters, Equity Lens, Equity Impact Assessment, Equity Audits

Health Equity in practice typically uses some type of equity lens. Using some type of equity lens or tool is like putting on a pair of eye glasses that make it easier to see the object of interest. Most Equity Tools include some consideration of income or poverty and ethnic groups. Many reference living and working conditions and some include broader social conditions. However, few make explicit mention of racism/racialization or include

specific action on the structural determinants of health. Some examples that embed an explicit attention to structural racism were selected and are listed below.

**The Health Equity Council's (2005) People's Charter for Health Equity and Diversity:**

**"Fair and equitable health outcomes across diverse communities will result from utilizing an inclusive health framework for publicly-funded and other universally accessible health services. This requires policies, planning, education and training, funding, and research that clearly recognize racism/racialization and all other forms of exclusion and oppression as fundamental social determinants impacting health and wellness."**

**Racial Equity Impact Analysis: Assessing policies, programs, and practices. Annie E. Casey Foundation (2006). Race Matters. This tool includes 5 questions:**

- 1. Who are the racial/ethnic groups in the area? For this policy/program/practice, what results are desired, and how will each group be affected?**
- 2. Do current disparities exist by race/ethnicity around this issue or closely related ones? How did they get that way? (our emphasis) If disparities exist, how will they be affected by this policy/program/practice?**
- 3. For this policy/program/practice, what strategies are being used, and how will they be perceived by each group?**
- 4. Are the voices of all groups affected by the action at the table?**
- 5. Do the answers to #1 through #4 work to close the gaps in racial disparities in culturally appropriate, inclusive ways? If not, how should the policy/program/practice be revised? If so, how can the policy/program/practice be documented in order to offer a model for others?**

**Aboriginal Health Impact Statement (Australia) New South Wales Dept. of Health 2007.**

**The purpose is to ensure the needs and interests of Aboriginal people are embedded into the development, implementation and evaluation of all NSW Health initiatives. It describes impact and how input from Aboriginal people was sought and incorporated.**

**Race Equality Impact Assessments (REIA). Health Care Commission (2006).UK**

**The purpose of the REIA is "to ensure that public bodies identify and root out racism from any and every aspect of public service, and that they contribute actively to creating a just society." This includes policy development, program and policy review**

**A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities, Office of Minority Health (2008) U.S.**

**This is a reflective step-by-step planning guide using a logic model approach. It emphasizes system-level factors, and starts with long-term problems.**

Racial Equity Theory of Change, and Racial Equity Worksheets, Aspen Institute, 2009.

This is a series of tools that integrates structural racism and includes building empowered community processes in shaping vision and action. Aspen Institute.

Other examples:

- Safehouse. Tools for Liberation Packet For Building a Multi-Ethnic, Inclusive & Antiracist Organization (2007)-Abridged Version
- Colour of Poverty/Colour of Change (2010)- Racial Equity Report Card Framework Dismantling Racism Tool Kit (Western States Centre, 2003) US
- Community Action Partnership Racial Equity and Economic Security (2011) Website hosts many racial equity tools and resources, mostly US-based.
- Racial Equity Tools, includes Evaluation Tools for Racial Equity. Centre for Assessment and Policy Development (2009)
- Race for Health (2008), uses peer review and peer training to drive race equality in the National Health Service (UK) (primary care, community development).
- Health & Racism Working Group (2011), East Mississauga Community Health Centre

There are movements underway to expand self-identified racial group data collection that would be used in monitoring health services access, quality and outcomes. The literature on this topic was not reviewed for this report but has been a topic of research of the Health Equity Council and several of its members.

## 2.2 The Practice of Health Promotion

Equity and social justice are identified in the Ottawa Charter for Health Promotion (WHO, 1986) as prerequisites for health.

Health equity/health inequity research has focused more on health care inequities than health promotion inequities.

Wallerstein (1992) notes that empowerment, equity and participation are contained in the WHO definition of health promotion which is defined as "the process of enabling individuals and communities to increase control over the *determinants of health*" partly through political actions, creating a healthier environment (WHO, 1986a, 1986b). Health promotion actions include: developing personal skills, strengthening community action, reorienting health services, creating supportive environments for health and building healthy public policy.

*"To be healthy and to have physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living". Ottawa Charter for Health Promotion, WHO, 1986)*

### Health Promotion – Current Status

Alvaro et al (2011, p1) note that in "the past two decades, health promotion programs and policies have had what some call a 'lopsided' emphasis on individual lifestyles, with limited attention given to addressing the broader social, economic and political factors that create and produce health inequities." One the one hand there is much public discourse that could be described as individualism-blaming victims for being socially

disadvantaged (for not being privileged) rather than changing policies that increase social disparities. At the same time there is some clear support for tackling policy determinants of health. This is demonstrated by: discussion of "Health in All Policy" approaches and Health Impact Assessment (HIA) tools; funding support for action on policy change to create physical, built and social environments that support healthy communities (Healthy Communities Fund); and advocacy by health organizations on poverty reduction, food security, housing, built environment, etc.).

It remains to be seen how this polarization in discourse will evolve alongside increasing social polarization (in occupations, income, wealth, etc.). None-the-less the practice of health promotion has the potential to pay greater attention to the unjust social structures and historical injustice. Given widening social disparities (Social Planning Network of Ontario, 2010), it is more important to do so.

### Health Promotion Issues in Francophone Communities (potentially relevant to other communities)

Three issues in health promotion for Francophone racial minorities include:

- the limitations of multicultural/ethnoculturalism for addressing access to health care, preventable health problems and discrimination;
- inadequate cultural competency in health care, health promotion, research, policy, decision making, and
- availability of funding for issues important to these diverse groups (Handy, 2010).

Minorities within the Francophone group are left out when Francophone communities are treated as one single linguistic entity and where racial minority needs are not addressed effectively. This includes where communication, community engagement and governance structures operate without awareness of or attention to this diversity.

Several studies have shown that Francophone communities have limited access to health services of any kind in French (CCCFSM, 2001 and 2007; FCFA 2001; RFSNO, 2006; Toronto Region FLHS Planning Committee, 2006, M'Bala et al, 2005, Groupe de travail sur les services santé en français, 2005). Services and providers often are not culturally competent to the needs, values and assumptions of the diverse Francophone population and clients and providers may have very different definitions of health and illness, health care and decision-making around health services (Irvine, 2010). Access to basic linguistically accessible health services remains an essential priority for action (CCFSMC, 2007). The lack of attention to serious health issues affecting racial minority Francophones is more important to the community than health promotion (Handy, 2010).

From a gender perspective, there has been an absence of women's issues in Francophone health profiles in the past and the challenge that women face is in getting recognition as first as women and then in terms of their cultural, ethnic, religious, sexual and other issues" as well (ROSF-OWHN, 2010 p ). Action strategies that have been proposed include taking diversity in all forms into account (TFFCPO, 2000).

Black Francophones experience triple marginalization - as members of racialized groups, as a linguistic minority and as a racial minority within the Francophone language group. Similar to studies of marginalization of racial minority Francophones in Quebec, Madibbo (2005, 2006) writes that in Ontario white Francophones while struggling against their own oppression have not fully integrated minority Francophones into planning, decision making and access to resources. Other communities such as Tamil, Spanish, Somali, Urdu, Punjabi speaking communities have large numbers of people who speak neither English nor French, live in precarious immigrant/refugee status, and also face multiple marginalization, that is further multiplied by the lack of health service and health promotion that includes them.

A survey of public health and community health promoters conducted by Ontario Health Promotion Resource System in 2004-05, found a lack of appropriate documents in French, lack of training opportunities in French, limited resources for translation, and limited financial resources to offer services in French. The survey reported a "double duty" of engaging in this work within a minority language community. Those working more than 50% of their time with the Francophone community were twice as likely to rate their access to information as difficult or very difficult, and they reported lower access to virtually all sources of health promotion information, formal or informal (Rush, 2005).

The Healthy Communities Consortium (2009, 2010) conducted several needs assessment with the Coordinators of the Healthy Communities Partnerships to gain insight into the capacity of local partnerships to engage francophone partners. Health Nexus also conducted a survey of Francophone and bilingual organizations (in October, 2009: 235 participants completed the survey). The 2009 results indicate that many coordinators were not familiar with the diversity of the Francophone community, or the reports, and resources available to assist them. Francophone organizations are smaller than their Anglophone bilingual counterparts, making it more difficult to develop more sustainable initiatives and meet the funding contribution requirements of the Healthy Communities Fund. Francophone organizations are also less specialized and tend to work more from a generic perspective, *observations that likely also apply to ethnic-specific community organizations*. The Alliance des Réseaux Ontariens de Santé en Français is supporting local 'healthy communities' partnerships in 2011 to address some basic gaps but the needs of minority Francophones may remain under-addressed.

In addition to lack of services to promote health and prevent diseases the Réseau francophone de santé du nord de l'Ontario et al (2006, p6) also "deplored the fact that the organization of services occurs without the participation of the Francophone community." Structures have been set up in Ontario to improve both Aboriginal and Francophone engagement in health service planning and priority setting that may help to correct this. The question must always be asked is who is at the decision making table and how are the perspectives of Aboriginal, Francophone and racialized groups sought, included and responded to as part of routine health promotion practice.

### 2.3 Concepts for Anti-Racism/Anti-Oppression Health Promotion Practice

This section describes main concepts relevant to understanding structural racism and anti-racism. This section draws on glossaries, literature reviews, theoretical frameworks and debates among theorists, investigative commissions, reporting frameworks, activists and advocates, writers and poets, and anti-racism tool kits in English and French. While the term 'racialized group' is the predominant term in English discourse, the term 'racial minority' is the more common terminology used in the Francophone documents reviewed. The literature provides helpful ways of working through the discomfort in naming racism and the fear of perpetuating racialization by drawing attention to it. The themes and definitions across the time and in various forms of expression are very consistent.

Federal and provincial government reports have noted that "racism and racial discrimination are facts of life in Canada" (Multiculturalism and Citizenship Canada, 1989 p7, in Commission, 1995 p 43, Canadian Encyclopedia, 2010). Sometimes spokespersons and other powerful voices deny this. In 2011, the public funding of organizations that use an anti-racism/anti-oppression approach and acknowledge that racism and oppression exist in Canada was challenged by a small group of persons in positions of influence. This contributes to fear of naming racism in Canada. The evidence of and the theoretical writings and teaching on racism and oppression in Canada is massive and filled with rich debates and helpful ideas. See for example *the Theoretical Framework for the Racism Violence and Health Project* which explores Race Critical Theory, Anti-Black Racism, Afrocentricity among others (Warner, 2006). This literature review cannot reflect this thinking in these few pages. What has been attempted is to pull out main concepts to 'unhouse' (JnoBaptitse, 2011) the closed doors to talking about racialization and white privilege and to create a space to do so.

We start with ethnocentrism, move to the social construction of 'race', racialization and racism, consider intersectionality and end with anti-racism/anti-oppression.

#### Eurocentrism:

##### Ethnocentrisme

*"Tendance à prendre comme modèle le groupe ethnique auquel on appartient et à ne valoriser que la culture de celui-ci, à en faire le seul modèle de référence."* (Phaneuf, 2009).

##### Ethnocentrism

*"the view of things in which one's own group is at the centre of everything and all others are scaled and rated with reference to it"* (Sumner 1906 in Neuliep et al, 2005).

Eurocentrism is a form of ethnocentrism.

Manifestations of Euro-centrism include:

- 1) racism - certain groups are constructed as inferior to European groups and European groups are conceptualized as the champions of evolution, and social progress;
- 2) individual ethnocentric prejudices in the production of knowledge, framing of research questions, developing of hypothesis and interpretation of data;
- 3) hidden ethnocentrism in which only Euro-American/Euro-Canadian perspectives are

discussed and other perspectives are not seen as important to the practice of science and truth-seeking and the evidence about a subject (resulting in exclusion neglect or assimilation or alternate world-views/understanding; and

4) the cultural apparatus that privileges euro-centric knowledge and expertise such as funding criteria, research and knowledge exchange infrastructure, publishing policies, etc.) (Teo & Febbraro, 2003; Thompson, 2004).

### Racialization and the Social Construction of 'Race'

'Racial' categories were created during colonial expansion (17<sup>th</sup> and 18<sup>th</sup> century) to rationalize the subjugation and enslavement of people, the appropriation (stealing) of land and resources, the denial of citizenship, and the concentration of wealth and privilege (Peterborough, 2010, AAA, 1998, Commission, 1995; Ryerson ACT, 2010). 'Racial' beliefs are myths." ..."To recognize that 'race' is a myth is not to deny the power of racialization" (Commission 1995, p 40).

*"Racialization"* in Canada was first defined as "the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life" (Commission on Systemic Racism in Ontario, 1995; see also Galabuzi, 2001). The Commission (p. 39) goes on to say that this includes:

"- selecting some human characteristics as meaningful signs of racial difference;

- sorting people into races on the basis of variation in these characteristics;
- attributing personality trait, behaviours and social characteristics to people classified as members of particular races; and
- acting as if race indicated socially significant differences among people."

#### The experience of racialization

*"People defined or stereotyped based on ethnicity or race have started to describe this as the 'experience of racialization'. For example, a woman looks Asian. People on the street assume she is an immigrant. In fact, she is a fourth generation Chinese-Canadian. A young adult may be black, but he is not always West Indian. Two men speak in an unfamiliar language. Another customer assumes they are speaking a foreign language. Actually, they speak Ojibway". "A young women talking to a friend is told by a passerby to 'go back to Africa'- she was born in Canada and was speaking French. (Health Nexus, 2005; Madibbo, 2005)*

The Ontario Human Rights Commission (2008) describes communities facing racism as 'racialized'. Society constructs the idea of 'race' based on geographic, historical, political, economic, social and cultural factors, as well as physical traits (OHRC, 2005, 2009). Various reports in English and French note that in various social contexts, communities can also be racialized, "othered" or "socially excluded" on the basis of language, ethnicity, country of birth, religion, etc. without belonging to one of the main racialized group categories defined by Statistics Canada (OHRC, 2009; CRIAW, 2002; Labelle & Levy, 1995; Madibbo, 2005, 2006). Potvin (2000) describes the impact of "racializing and ethnicizing" second generation youth of Haitian origin in Quebec. Stanley

(2000, p96) notes that it is possible to have racialization, or race-thinking without 'race' such as representations of the French in some English Canadian discourses.

OHRC recommends the term "racialized person" or "racialized group" over terms like "racial minority" or "visible minority" or "person of colour" or "non-white" as it expresses "race" as a social construct rather than as a biological trait. The terms 'people of colour', 'ethnoracial group' are common in English writing and 'racial minority' or 'ethnocultural minority' (*des minorités visibles et ethnoculturelles, communautés francophones en situation minoritaire, communautés ethniques, les minorités raciales francophones*) are common in Francophone writings (Mujawamariya, 2002, ROSF-OWHN,

2010; l'Office des affaires francophones, 2010).

#### 'Race' Myths and Realities

*"While the application of the term 'race' is problematic and misleading because it has been and continues to be used to justify the subordination of certain populations, the significance of using the terminology of racialization and racialized individuals lies with our understanding that 'race' has been assigned meaning through historically specific processes and practices (Fernando, 1991; Henry, Tator, Mattis, & Rees, 2000). "Race" is realized through material practices and harmful discourses that gives subscription to the ideology of "race". We often use inverted commas around 'race' to indicate that we do not take the application of 'race' and history of racism for granted, and stress that "the biological foundation of race is a persistent myth" (Cauce, et al., 2002, 45). At the same time, we are asserting that the notion of 'race' retains significance in the current socio-political context as it continues to be socially, politically, and economically consequential for racialized people on a day-to-day basis. Belonging to a particular 'race' or racial group is, therefore, essentially a political declaration (Fernando, 1991)." (Lovell & Shabsia, 2006)*

The term 'visible minorities' remains in common use because it is the label for the data collected in the census for categories defined under the Employment Equity Act as "persons other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour" (Statistics Canada, 2007). The Canadian Human Rights

Commission (2010, p 15) notes that the term 'visible minorities' is not well accepted by racialized groups in Canada and has been criticized by the Independent Expert on Minorities (HRC, 2009 in United Nations, 2010 p 20). When 'racial' categories are used in collecting or reporting data such as income, employment, or health, it is usually a combination of these categorizes (i.e. Black, South Asian, Chinese, Other East/Southeast Asian, West Asian, Arab, Latin American, Other, Multiple/mixed race groups). In June 2009, Statistics Canada ended use of the label 'Visible Minorities' replacing it with 'Population Groups' ..'or groups to which the person belongs.' Now data posted on the website or purchased, uses the new label but includes the same categories.

The Ontario Human Rights Commission notes that the terms 'Black' and 'White' are widely used to describe individuals, and are not viewed by most as inappropriate and may even be the terms people prefer to use in describing themselves. However, it is important to remember that they refer to racialized characteristics.

At this point it is useful to note the important limitations of the ways that racialized communities are named and categorized. The category 'Black' includes many diverse communities of people who have been in Canada for many generations, people from communities with roots in the Caribbean, Africa and other parts of the world, and people who do not identify as 'black' (UN, 2010; Benjamin 2003 in Warner 2006; Benjamin et al, 2010). Also for example, South Asians are a single "world regional" category (one of the 15 visible minority categories under the *Employment Equity Act*) despite very distinct language, ethnic, faith and country diversity. In contrast, several other categories are more specific: Chinese, Filipino, Korean, Japanese, Southeast Asian are all listed and reported as separate categories. Aggregating diverse communities can be beneficial for the purposes of reporting and demonstrating health and social inequities. However, it is important to also ensure that the diversity within these constructed categories is recognized, and that important disparities often exist within these categories if we look deeper into gender, age, faith, geography and other identity differences that are blocked out when using single category constructs.

It is important that many of these categorizing decisions in research or reporting purposes (sometimes called 'lump or split', Karter, 2003 p26) that are made for these reasons (sample size, etc.) be seen as for that purpose and not used to further racialize groups. It is recommended that people self-identify rather than being ascribed a category by others (Ong et al, 1996). When data are lumped into categories to make it easier to make comparisons, these basic realities are lost.

The phrase 'members of a racialized group' is also problematic - as the categories are externally ascribed, not chosen, although self-identification can be a political act. In most cases the term 'members of racialized groups' is used by writers describing 'others' not by people in a group proclaiming their membership in it.

### Genes, Biology, 'Race' and Ethnicity

The use of 'race' as a category of evolution or a major division in the human species is unsupported by science. The idea of genetically distinct sub-species has been discredited. (Ellison, et al 2006). Human beings do not inherit "race" but genes. Human beings are 99.9% genotypically identical. Where there are gene differences, there is more variation within population groups than between them. The genes associated with skin colour, hair texture etc., (typically used to create racial groups) are few, varied and not associated with genes linked to disease (Bophal, 1994, Pearce et al, 2007). Diseases based on autosomal recessive disorders such as sickle cell anemia and Tay-Sachs which are usually associated with specific groups (occurring if both parents contribute the genetic variant) have been shown to result from a combination of closed population, ancestral migration and geographic location (Brookes & King 2008). Most differences in diseases observed among different 'racial' groups result from a combination of gene-environment interactions, environmental exposures, individual factors and conditions rather than genes alone. In most cases, environmental exposures, and individual factors

and conditions (gene-environment interactions, etc.) influence gene expression (Levin, 1997, Corcos, 1997 in Teo & Febbrara, 2003; Ellison et al, 2006).

Gene mapping, and gene research is suggesting genetic susceptibilities to things such as weight gain, addiction, depression, certain diseases, etc. and different ways that molecules (elements in drugs) influence these susceptibilities or how side effects vary to some degree in ways that can be linked to continental ancestry (Kennedy, 2011; Caspi, 2003, Ellison et al, 2008). This new biologism and DNA databases are contributing to a new form of racial profiling of disease (Reardon, 2008). 'Geneticizing' diseases that are largely determined by social and environmental condition is a danger of the expanding focus on gene/genome research (Brooks & King, 2008; Cooper, 2003; Kartner, 2003).

Ethnicity is often defined according to culture, origin or ancestry not necessarily biology, but it varies by time and place and context. Afshari & Bhopal (2010) conclude that 'ethnicity' has overtaken 'race' as a medical science research category. This is definitely so in Europe, with the compound term 'race/ethnicity' increasing in North America.

## Racism

### Racial Discrimination

*In this Convention, the term "racial discrimination" shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."*  
(United Nations, International Convention on the Elimination of all Forms of Racial Discrimination 1965, Article 1)

There are many definitions and three main categories of racism 1) systemic/structural/institutional/organizational racism as well as 2) individual racism and 3) internalized oppression. Our focus in this paper is on systemic and structural racism as the overarching form of racism in which institutional and

organizational racism can be seen as subsets of structural racism. Selected examples of racism (in general) and its subtypes are included below.

Racism is a set of societal, cultural, and institutional beliefs and practices that regardless of intention subordinate and oppress one group for the benefit of another. Racism refers to the use of individual and institutional power to deny or grant people and groups of people rights, respect, representation and resource based on their skin colour (Regional Diversity Roundtable, 2008). "Racism is a system of privilege and oppression, a network of traditions, legitimating standards, material and institutional arrangements, and ideological apparatuses that, together, serve to perpetuate hierarchical social relations based on race..." (Thompson, 2002). New forms of racism are occurring such as Islamophobia. This includes stereotypes, bias, acts of hostility towards individual Muslims or followers of Islam, racial profiling or treating Muslims as a group as a security threat (OHRC, 2005).

Structural racism refers to "a system in which public policies, institutional practices,

**Systemic Racism**

**Commission on Systemic Racism (1995 p 39)**  
*The social production of racial inequality in decision about people and in the treatment they receive...It is produced by the combination of:*

- *social constructions of races as real, different and unequal (racialization),*
- *the norms, processes and service delivery of a social system (structure) and*
- *the action and decision of people who work for social systems (personnel)"*

**Canadian Council for Refugees (2000, p21)**  
*The social processes that produce racial inequality in decision about people and in the treatment they receive. It is the unequal distribution of power combined with institutional practices, policies and procedures which supports attitudes, practices and systems of discrimination and inequality."*

**Henry 2004 in OHRC online**  
*"the laws, rules, and norms woven into the social system that result in an unequal distribution of economic, political, and social resources and rewards among various racial groups. It is the denial of access, participation, and equity to racial minorities for services such as education, employment, and housing. Systemic racism is manifested in the media by, for example, the negative representation of people of colour, the erasure of their voices and experiences, and the repetition of racist images and discourse."*

cultural representations, and other norms work in ways which perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time" (Aspen Institute, 2004). The Ryerson ARC (2010) notes that institutional or structural forms of racism are pervasive, widespread, tend to remain obscure, and are legitimized by dominant norms. Structural racism refers to the functioning of economic and social institutions through which racialized groups become systematically marginalized, discriminated and disadvantaged as those who form part of how the dominant community asserts their authority and power. Structural racism occurs regardless of individual prejudices, beliefs or intentions and encompass both individual and

institutional forms of racism The terms "systemic racism," "systemic discrimination," "institutional racism," and "cultural racism" and "democratic racism" are also used to describe system-wide operations of society that exclude numbers of particular groups. Institutional and organizational racism are often linked to location (e.g. public institution and organizations such as workplaces) or social institutions of society (education, health care, media, law enforcement, business, housing). For example, Mckenzie & Bhui (2007, 397) write that "public service, choices or service configurations which inadvertently lead to disparities for black or ethnic minority groups are called institutional or structural racism." These include underfunding of translation services, and not recruiting community development workers which affect access and outcomes. Other examples include residential schools for aboriginal children, immigration policies, racial profiling by police, employment, housing, banking, and media policies and practices, etc. Examples related to racialized groups who are immigrants include the location of Canada Immigration offices across the globe systemically limiting access to people from Africa, selective

immigration policies (requiring some visitors to apply for a visa before entering Canada), and selective detention of refugees from some countries/modes of travel). These are in addition to employment practices (requiring Canadian experience, English fluency), and other employment (Oreopoulos, 2009), housing (Teixeria & Truelove, 2007; CERA, 2009) and discrimination in social assistance (Mirchandani & Chan, 2005) that newcomers and racialized groups disproportionately face.

These are all distinguished from overt or individual forms of racism and discrimination that stem from conscious prejudice/racism and individual acts of discrimination (Henry and Tator, 2005; Tehara, 2010; Delgado, 2001; Barnes-Josiah, 2004). Overt and visible forms of racism are the tip of the iceberg (Gee et al 2009). Most racism is hidden - built into the fabric of law, ideology and institutions.

Internalization (self-blaming) of recurring and systematic discrimination, and individual and community responses (coping, anger/externalization, community mobilization, etc.) to the experience of discrimination are also important (Noh & Kaspar, 2003; Williams et al, 2003). This can mean being emotionally, physically, and spiritually battered to the point of believing that oppression is deserved, is one's lot in life, is natural and right, or that it doesn't even exist. We return to these in the discussion of pathways through which racism harms health. While our focus is on the systemic discrimination and structural racism and discrimination, it is often "daily hassles" and everyday actions of individuals that produce and perpetuate systemic racism. There are minorities within minorities that experience discrimination from people in their "group. People in racialized groups can act in racist ways. With less power these remain as individual acts and do not become systemically ingrained in structures and institutions.

A section on racialized health disparities (later in this report) describes the mechanisms and pathways specific to how structural/systemic racism produces health inequities. Our focus on structural and systemic racism concerns impact - intent is not required. There are two main approaches to recognizing racism by its impact. One emphasizes the experiences of racialized people. The other compares the outcomes of decisions affecting racialized and non-racialized people (Commission, 1995).

In conclusion, racialization is active in any social system in which people act and institutions operate as if 'race' represents real and significant differences among human beings. This includes how we theorize about, research, analyze and describe health inequities. 'Racial consciousness' is a step towards anti-racism. It should not be equated with racism. Being blind to racism is a type of racism. Some examples of this include: 1) passive toleration (failure to see evidence of racism, not looking for it, not monitoring for it); 2) disregard (not making racial justice a priority, not doing anything about problems because they are seen as small/isolated incidents, not developing the necessary expertise to eliminate systemic racism); and 3) collusive toleration (operating norms encourage practices based on racialized standards) (Commission, 1995 p 54-55).

Omni & Winant (2002/1986 p. 135 in Warner, 2006) suggest that practices are by definition racist "only when they activate existing structural racial inequality in the system" or "reproduce structures of domination based on essentialist categories of race."

Does not talking about racism maintain the status quo? Most of the literature cited in this report says becoming conscious of white privilege, the processes of racialization and the global and historical scope of structural racism are essential to health equity. However, a few examples ask whether it is possible to sidestep discussion of structural and systemic racism and racialization, but still be effective in reducing health disparities. The Robert Wood Johnson Foundation's research (2010) investigated which words work most positively and negatively among those with conservative ideology and those with more liberal views, in order to be strategic in generating support for taking action on the social determinants of health. Fong (2008) analysed the contradiction in the work of TRIEC (Toronto Region Immigrant Employment Council) between explicitly evading discussion about racism in the labour market (in order not to alienate employers) while trying to combat it by influencing individual hiring practices. It is interesting to note on the one hand the many, many government reports that acknowledge structural racism in Canada, while at the same time there is denial, discomfort, avoidance of it. How to talk about racialization in different contexts is worth further discussion.

### Intersectionality and Interlocking Oppressions

The term intersectionality comes from a critical legal theorist (Kimberlé Williams Crenshaw) explanation in 1989 of how attempting to understand the causes of "race" and gender oppression of Black women is like attempting to piece together the causes of an injury that occurs in an intersection with traffic flowing in many directions (Carastathis, 2008). Intersectionality means taking into consideration all the factors that structure identities and experiences of oppression (gender, race and ethnicity, class and social status, sexuality, physical abilities, age, residency/nation/immigrant status, etc.). Intersectionality also shows how systems of power interlock. For example colonialism and imperialism in other parts of the world shapes patterns, relations and oppression of live-in caregivers, migrant workers, refugee policies, etc. in Canada now and through history (Carastathis, 2008, Walia, 2006).

Several authors warn against "Oppression Olympics" a hierarchy or competition among categories of oppression to determine which is the worst/has the most impact (Martinez, 1993 and Fellows and Razack, 1998 in Carastathis, 2008). An individual "does not possess a one-dimensional identity" but is "socialized into categories of race, gender and class" (Dei, 2000 p 31).

One of the elements of Race Critical Theory in Canada is the relationship between racism and other forms of oppression which demands a broader intersectional approach to racism. Anti-Black racism theorists support a strategic approach that gives priority to racism over other oppression and to greater impacts that this has had on the Black

community compared to other racialized groups (Lewis, 1992, Commission, 1995, Lawson et al, 2002 in Warner, 2006). Another point is to recognize the links between liberation and oppression in Canadian society and other parts of the world (e.g. the economic and trade policies which lie underneath migrant worker policies etc.).

One implication of this for explaining health inequities by racialized groups is to wherever possible, also include social position, (SES/income) and gender in addition to age in the analysis (Dahlgren and Whitehead, 2007).

### Anti-racism, Anti-oppression and Racial Justice

#### **Anti-Oppression:**

*Strategies, theories and actions that challenge socially and historically built inequalities and injustices that is ingrained in our systems and institutions by policies and practices that allow certain groups to dominate over other groups. (Canadian Race Relations Foundation, Glossary)*

#### **Anti-Racism:**

*An active and consistent process of change to eliminate individual, institutional and systemic racism as well as the oppression and injustice racism causes. (CRRF, Glossary)*

*The practice of identifying, challenging, preventing, eliminating and changing the values, structures, policies, programs, practices and behaviours that perpetuate racism. (George 1999 in AMSSA, 2001)*

#### **A Life-long Journey**

*"Dismantling racism, sexism, homophobia and unlearning the oppressive attitudes we have learned is a lifelong journey: there is no endpoint. The greatest commitment we can make is to keep paying attention to how these issues affect us and those around us..."*

*White people and people of color have different work to do. White people need to understand how their privilege operates, how they perpetuate racism, and how they can become allies to people of color. For people of color, the process of empowerment involves struggling with the impact of internalized racist oppression. (Dismantling Racism Project)*

Tackling something as big as structural racism can be overwhelming and far beyond stated organization or partnership mandates or a specific health promotion project. There is discomfort in talking about racism and issues which are "political." This section notes some strategies for organizational transformation and what individuals can do.

Across Ontario, communities mark March 21<sup>st</sup> the International Day for the Elimination of Racial Discrimination, with events and reports. In addition, there are many ongoing projects and partnerships. Some examples of what communities are doing are included in the references (e.g. Lakehead Social Planning Council's 'Building Social Inclusion and Combatting Racism' education resource package; the Thunder Bay Committee Against Racism Plan of Action; the Community Race Relations Committee for Peterborough; the Youth Environment Network's Action Plan for anti-oppressive organization change; and the Opening Doors Workshop Series to strengthen mental health, anti-racism and anti-discrimination literacy in Ontario communities especially for newcomers.

People can be oppressed and be an oppressor at the same time. Madibbo (2005) gives examples of white Francophones struggling against their own oppression, and reproducing injustice by subjugating Black Francophones. Most oppressors are unaware of the impacts of their 'unearned' privileged status/dominance (Bishop, 2002). Studies of "minorities within minorities" in the US (Eisenberg & Spinner-Halev, 2005; Blakely et al, 2006) and gender based analysis in Canada (Canadian Council for Refugees, 2004, 2006; Jiwani, 2001) points to the dangers of identity-based representation and the limitation of expecting an individual or organization to represent all the diverse views of a larger community. Diversity training can ask white people to change their consciousness while leaving their dominance intact. A racial justice approach requires organizational transformation of power relations.

Complex systems approaches have emerged that point to ways of understanding and tackling these types of issues which have been called "wicked issues" because they are complex, difficult to define, symptoms of larger problems, and the causes and symptoms are interrelated and multisectoral (Petticrew et al, 2009; Rittel & Webber, 1973 in Petticrew). The upside of this interconnectedness is that doing something can have a positive ripple effect.

Dismantling racism is an approach that emerged from an understanding that health disparities are the result of the intersection of a complex system (health/health care) and a complex problem (racism) that requires addressing both proximal (close) and distal (macro) factors (Griffith et al, 2007).

*"In order for real change to occur, anti-racism activities must begin as a partnership between both the oppressed and the oppressors. People from the dominant culture need to find out ways that they can be anti-racist. Feelings of empowerment do not need to be sacrificed by anyone."* (Martha O'Campo in Edmonds, 2001)

Resistance to an anti-racism, anti-oppression analysis.

*In the non-profit sector, the discussions about anti-racism and anti-oppression of the 1980s and 1990s seem to have been replaced by a focus on "diversity" - a shift that blunts the drive to systemic change.* (Across Boundaries, 2009 p 27)

The experience from "dismantling racism" and "racial justice" initiatives in the US and "racial equity" in the UK also provide practical approaches as well as comprehensive anti-racist organizational transformation strategies. First steps, adapted from the Dismantling Racism projects in 8 western states in the US (Rogers & Bowman, 2005) include:

- Developing a shared language and analysis of institutional (structural) racism, power, privilege and the connections to other oppressions;
- Developing a shared assessment of the ways racism affect organizations, health promotion practice, and funding;
- Developing collective priorities and challenges to be addressed;
- Raising public awareness of racial injustice;
- Supporting the development of anti-racist

white allies and empowered people of color and the power of organizations working to eliminate institutional racism.

Examples include the Cherishing our Hearts and Souls project (COHS) which is based on the understanding that addressing racism is a necessary strategy for reducing health disparities. This initiative tackles differences in cancer and cardiovascular health outcomes related to institutional, interpersonal and internalized racism. Other tools and examples include the Racial Equity Theory of Change Approach (Aspen Institute) and the Kaiser Permanente (Meyers, 2007) policy opportunities for reducing racial and ethnic health disparities. There are useful anti-racism/anti-oppression tool kits for organizational change, challenging white privilege, becoming an anti-racist ally (Across Boundaries, 2009; Youth Environmental Network; Estable et al, 1997; Curry-Stevens, 2005; Dismantling Racism Project, 2005; Bishop, 2002, see also the Resource Guide prepared under this project).

Of particular relevance are suggestions provided by the Youth Environmental Network (<http://www.youthactioncentre.ca/docs/Green%20Justice%20Guide%20Part%201.pdf>); and "Characteristics of anti-racist white allies" (p.54) and 'Moving from Concern to Action (p 55)" in the Dismantling Racism Resource Book (<http://www.westernstatescenter.org/tools-and-resources/Tools/Dismantling%20Racism>)

Also, conversations are happening about unmasking discrimination of minorities within minorities, such as that faced by Black Francophones in Ontario (London Forum, l'Assemblée de la francophonie de l'Ontario (AFO), 2008).

#### 2.4 Social Determinants of Health:

There are two main types of frameworks for action on the social determinants of health. One type (Figure 1) are circle/rainbow models (Sudbury & District Health Unit, Dahlgren & Whitehead, 1991, Robert Wood Johnson Foundation, 2008; Hertzman, 1999). These show less causality and more interaction between levels than a second type.

A second type (Figure 2) are stream or flow models (King County, 2008; BARHII, 2009; WHO, 2008). These models promote tackling the root causes and structural drivers of social inequalities that produce health disparities. For example at the upstream end of the King County stream, the actions are to 'change structures, policies and institutional practices that maintain inequities.' The WHO Commission on the Social Determinants of Health Report (2008) describes two types of social determinants: structural determinants (root causes) and intermediate determinants. Structural determinants are the drivers of social inequality (racism, sexism, and classism) that operate at the macro or system level and are embedded in ideology, governance, policies and institutions. Class, racism and gender discrimination have throughout history determined social position, access to resources, and differential exposure to the threats and opportunities of different groups in society. Intermediate determinants of health include the living and

working conditions such as poverty, inadequate housing, unemployment, etc. These determinants and how they are distributed, result from the macro/structural determinants.

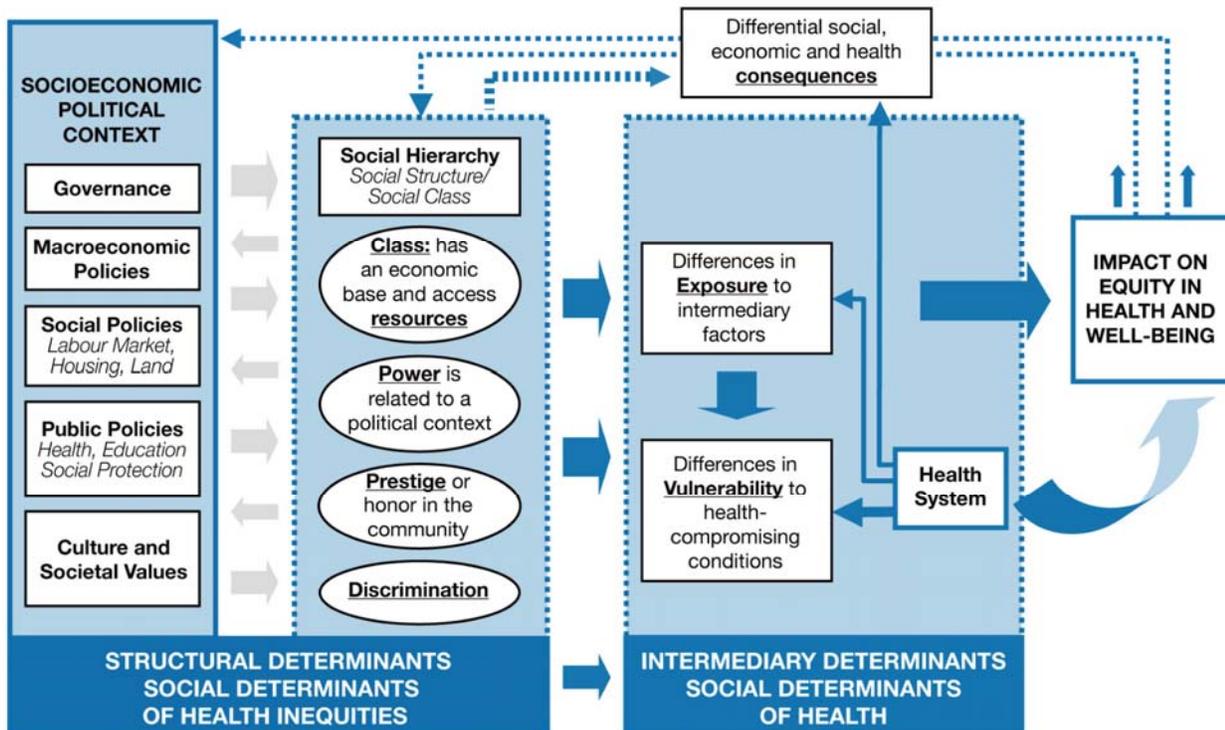
Figure 1. Example of A Circle or Rainbow Framework



Adapted from the work of Hertzman (1999), and G. Dahlgren and M. Whitehead (1991)

Adapted from Hertzman, 1999, and Dahlgren & Whitehead, 1991

Figure 2. Example of a Flow/Upstream-Downstream Framework



WHO. 2007, 2010. A conceptual framework for action on the social determinants of health.

The framework for the WHO Commission on the Social Determinants of Health is consistent with the call for an anti-oppression/anti-racism approach in health promotion planning. Uptake of the Commission's recommendations into national (and provincial) health strategies has varied. In Canada an example is the Senate Committee Report on Population Health (June 2009) but the report does not include structural determinants. Another example is a British Columbia health inequalities report (2009) which includes the simplified version of the WHO framework but does not suggest strategies to tackle structural determinants. The first report of the Chief Public Health Officer of Canada (2008) raised the social determinants of health and health equity. A recent environmental scan by the National Collaborating Centres for the Determinants of Health (2010); quotes the definition of health inequities as those that are "unfair or stemming from some form of injustice" but does not mention 'racism' and only includes 'discrimination' in a quote from the Ontario Public Health Standards (OPHS, 2008).

There is an explicit commitment to health equity in the mandate of the Ontario Agency for Health Promotion and Protection (Public Health Ontario); in the work of various health units (e.g. Sudbury and District Health Unit's health equity planning, social determinants of health reports and health equity training and research project; health equity frameworks and reports of several health units (e.g. Waterloo Wellington Health Unit, Toronto Public Health), etc., and several community health centres such as the Hamilton Urban Core's Inner City Health Working Group and Racialization and Health Inequity report (2010). Not all of these specifically name structural determinants of health inequities including systemic racism/discrimination.

Frameworks such as that of the WHO Commission on the Social Determinants of Health and an anti-oppression/antiracism approach can be used to guide equity-focused health promotion planning that embeds an anti-racist/anti-oppression approach.

## 2.5 Racism and Racialization of Poverty

The evidence show that structural inequalities in access to income security, housing, employment, education and justice produce income inequalities and the racialization of poverty and reproduce multiple forms of racism and discrimination. Poverty and income insecurity have become more concentrated among racialized groups and social inequality is

*...the increasing levels of poverty in Canada impact on racialized and Indigenous peoples in every aspect of their lives including employment, education, housing health, and systems of governance, including law enforcement and justice.*  
(Henry & Tator, 2009)

widening (Ornstein 2006, CCPA, 2010). In the province of Ontario while racialized groups make up 26% of the total population they are 41% of the population in low income households. More than one half (56%) of children in poverty in Ontario are in racialized groups (2006 Census). In many urban centres, racialized communities have higher than average rates of low income, unemployment or underemployment or precarious work (contract or

temporary work without health benefits, statutory entitlements, job security or good wages) (Galabuzzi, 2006; Ornstein 2001, 2006; Picot 2003, 2008). Higher un/underemployment among racialized communities despite equal or higher levels of education suggests labour market discrimination. With some exceptions, in most urban centres racialized groups have double the rate of poverty of white/European groups (see "other" in graphs below).

In addition to studies reporting income and employment inequalities and racialization of poverty (Galabuzzi, 2001, Ornstein, 2006, Colour of Poverty, 2009, CCPA, 2010), is the less well known research on racism and discrimination in access to housing (CERA, 2009; Quann, 1979; Hulchanski, 1994), employment (Oreopolus, 2009) business (Teixeira & Truelove 2007) and income security (Mirchandi & Chan 2005). A study of job applicants in the GTA (Oreopolus, 2009) found that those with English sounding names were 40% more likely to get a job interview than those with identical training and experience but with Chinese, Indian or Pakistani names. A study of barriers to access to housing in the City of Toronto (CERA, 2009) estimated that approximately 1 in 4 households receiving social assistance, South Asian households, and Black lone parents experience moderate to severe discrimination when they inquire about an available apartment. Mirchandi & Chan (2005) show how people of colour, particularly women have borne the brunt of policy initiatives designed to reduce eligibility for welfare benefits (means-testing, waiting periods, enforcement measures).

<i>% Experiencing Discrimination General Social Survey, 2004 Canada</i>	
• <i>Aboriginal People</i>	<i>31%</i>
• <i>Recent Immigrants</i>	<i>26%</i>
• <i>Established Immigrants</i>	<i>18%</i>
• <i>Racialized Groups (All)</i>	<i>28%</i>
- <i>Black</i>	<i>36%</i>
- <i>Latin American</i>	<i>36%</i>
• <i>Not in Racialized Group</i>	<i>13%</i>
• <i>Born in Canada</i>	<i>10%</i>
• <i>Gays, Lesbian, Bisexuals</i>	<i>41%</i>
• <i>(Heterosexuals 14%)</i>	
• <i>Youth Higher for immigrant than Canadian-born</i>	<i>34%</i>
<i>% Experiencing Discrimination Ethnic Diversity Survey, 2002 Canada</i>	
• <i>Caribbean</i>	<i>41%</i>
- <i>Jamaican</i>	<i>51%</i>
• <i>South Asian</i>	<i>40%</i>
• <i>Latin American</i>	<i>40%</i>
• <i>West Asian</i>	<i>28%</i>
• <i>Not in Racialized Group</i>	<i>5%</i>

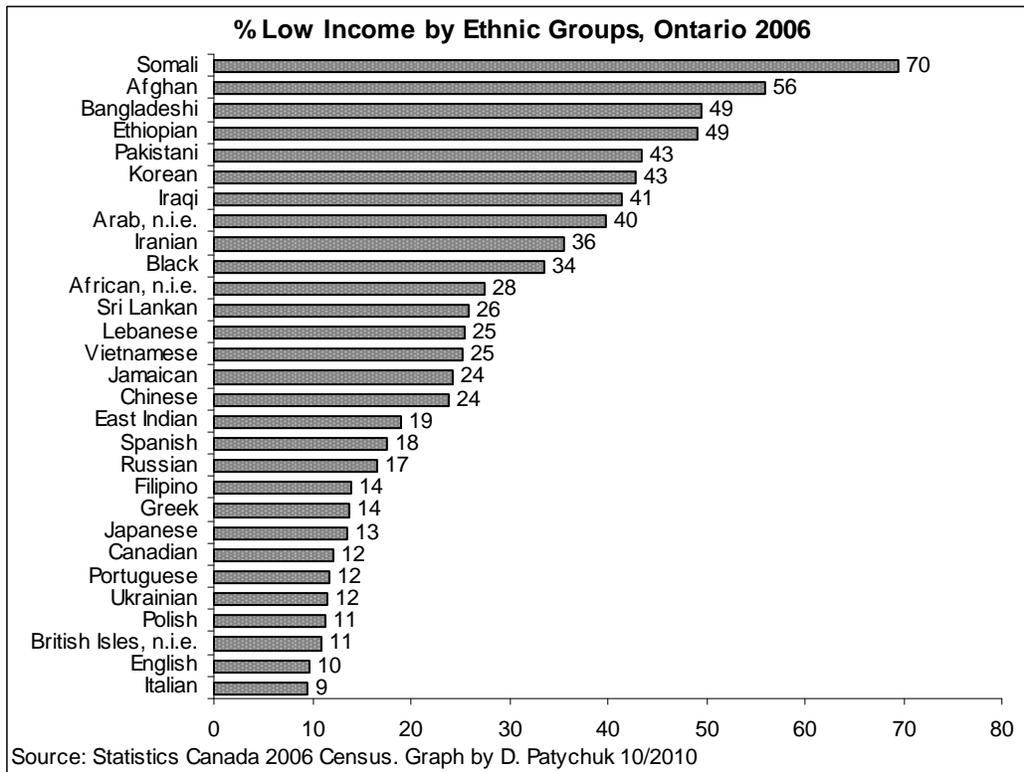
Systemic discrimination in the justice system (racial profiling, differential sentencing and incarceration, etc.) has received some attention, but the real costs of this are huge, direct and deadly.

For example, Kafele noted in 2005 that that the level of community violence, crime and death amongst African Canadians in Toronto had reached epidemic proportions with close to 200 African Canadians youth having been killed by other African Canadian youth, with weekly murders becoming almost routine, and close to 40% of all homicides in Toronto were African Canadians. He also noted that African Canadians were 27 times more likely to be imprisoned before trial on charges of drug trafficking and while at 3 per cent of the Ontario provincial population, African Canadians were 15 per cent of prison admissions. Hate crimes are also predominately due to race-based discrimination.

Reported experiences of racism and discrimination in surveys only tell part of the story. Other Studies have also shown high rates. Examples include: 1/5 young black women face discrimination in health care (WHIWH, 2003); in an Across Boundaries study, 30% of young males & 20% of young females experience physical attacks because of their 'race' (Lovell and Shahsia, 2006). In a Toronto research project on adolescent frequency of encountering eight discrimination-related experiences, Kaspar and Noh (2000) found that approximately 77% of youth experienced at least one incident of discrimination: 88% and 44% among racialized and non-visible minority youth, respectively.

There is an ethnic/racial vertical hierarchy in Canada in attitudes and group comfort, that align fairly closely with a vertical hierarchy of occupational class, income and discrimination by ethnic and racialized groups. See examples in researchers such as polls and surveys (Kalin & Berry, 1996, Berry et al, 1977) that show general consensus among groups about the social hierarchy in Canada and that even groups who are victims of prejudice and discrimination share many of the same hierarchical attitudes towards other groups), occupation, class and income hierarchies (Porter, 1985; Pineo 1977; Ornstein, 2006), and discrimination research (General Social Survey, Ethnic Diversity Survey, analysis of hate crime). In several studies Li (2003) has suggested that opinion polls in Canada about immigration are actually measuring racist attitudes hidden in concepts such as Canadian values, identity and way of life where immigrants are a "code" for racialized groups.

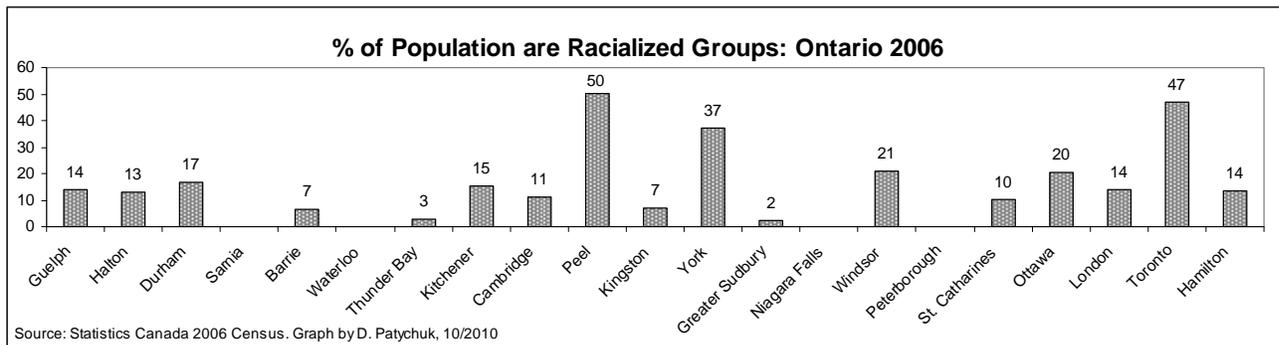
The 'hierarchy' graph below shows the poverty rate of major 'ethnic groups' in Ontario according to the Statistics Canada, before tax low income cut-off (LICO).



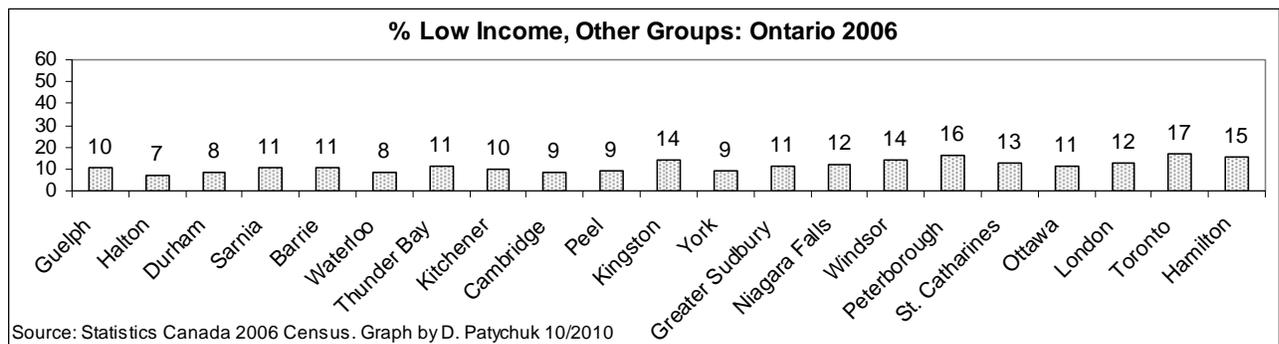
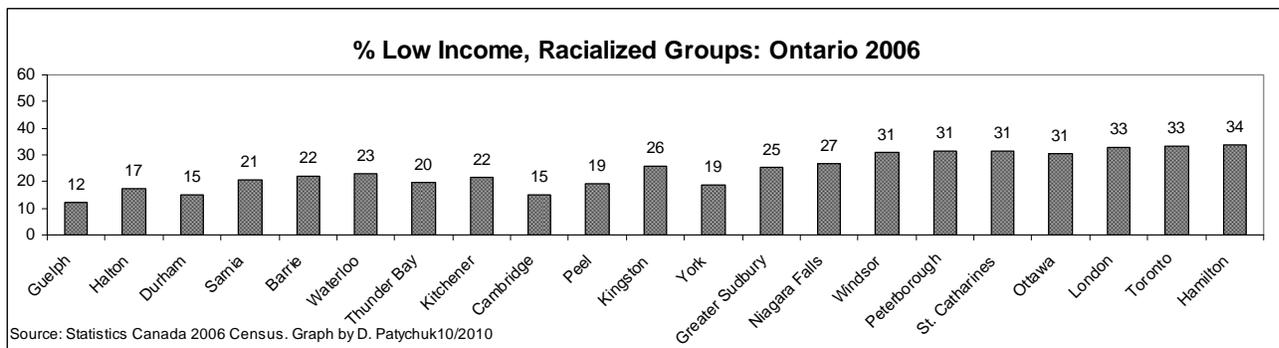
## 2.6 Across Ontario

In 2006, 23% of Ontarians were in racialized groups. With 38% of the population of Canada, Ontario had over 54% of all persons in Canada in racialized groups including over 60% of people in Canada who are of South Asian, African Caribbean or West Asian. These groups are projected to triple by 2031 (Caron, 2010). Demographic projections indicate that tackling structural racism is an important health equity strategy.

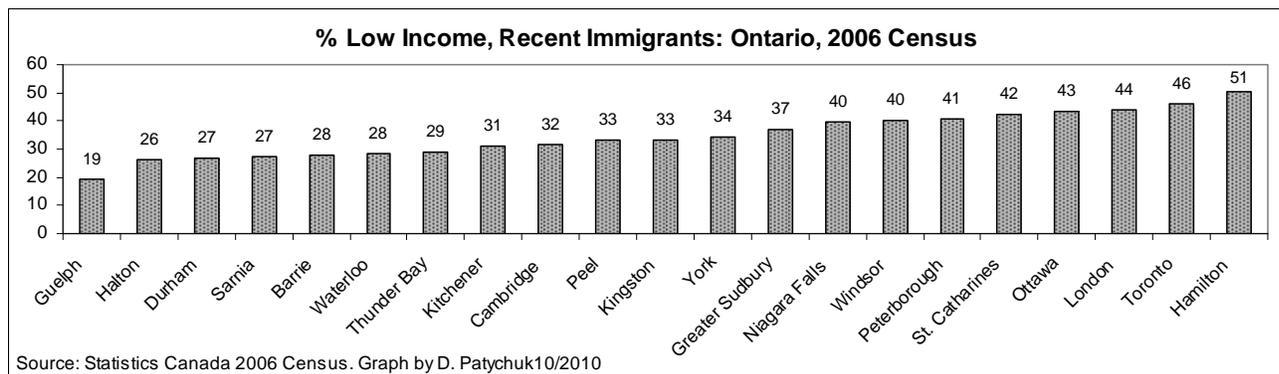
The diversity of the population varies across Ontario. The first graph below shows the percent of the population that are racialized groups in major Ontario cities.



The following graphs show the percent low income (before-tax low income cut-off) of total racialized groups, other (white), recent immigrants and aboriginal populations.



Over 78% of recent immigrants are in racialized groups. While recent immigrants (2001-2006) make up less than 5% of the population in Ontario, they are 13% of the population in low income households. The earning gap between recent immigrants and the Canadian born has been widening despite higher educational levels among recent immigrants. In 2006, recent immigrants were twice as likely to have a university degree as the Canadian born. After 15 years, immigrants with university degrees are still more likely than Canadian-born to be in low skill jobs. (Galarneau & Morissette, 2008; Picot, 2008). After initial settlement challenges, underlying determinants such as racism, social exclusion, housing and employment discrimination, lack of social support, continue to be important to the life chances and health of newcomers (Khanlou, 2009; Smich et al, 2005, Wayland, 2010). DeMaio & Kemp (2009) demonstrate through longitudinal analysis that racialized group status and the experience of discrimination and unfair treatment play an important role in the decline in immigrant health over time. Refugee claimants, migrant workers and non-status/undocumented persons face additional barriers and threats to health.



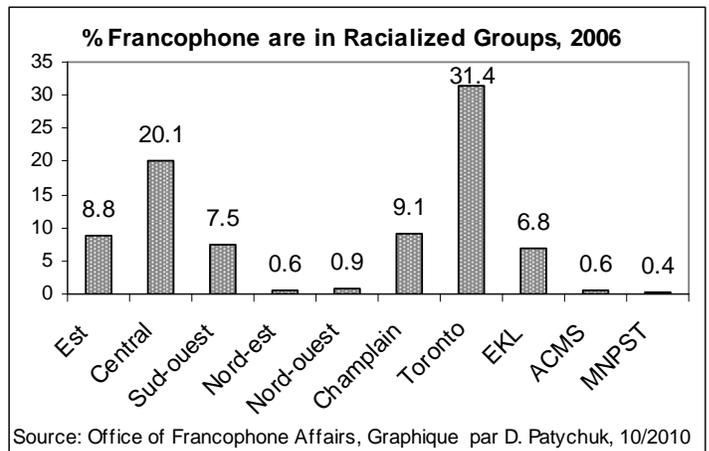
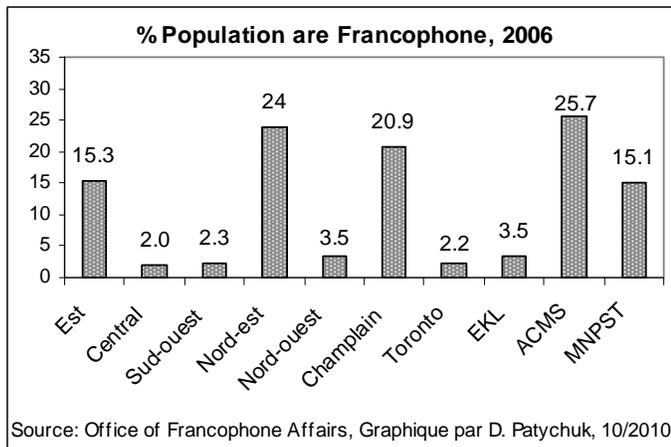
It is important to de-link racialization from immigration. An increasing proportion of racialized groups are Canadian born. Canadian history of racism against Aboriginal population and Black Canadians and other multigenerational racialized groups can get lost when the focus is on recent immigrants. For example, despite a history in Canada that goes back 400 years, many African-Caribbean communities experience high rates of poverty, discrimination, incarceration and institutionalization and racial profiling (Milan & Tran, 2004; Galabuzi, 2001).

The Ontario Human Rights Commission (2005) reports that "It is no coincidence that communities which historically experienced racial discrimination continue to be placed on the lowest rungs of the social, economic, political and cultural ladder in Canada. The legacy of racism in Canada has profoundly and lastingly permeated our systems and structures."

As a result of a new inclusive definition of Francophone (IDF) that counts more newcomer and racialized french-speaking communities, Ontario's Francophone population increased by almost 10% from 532,855—the number determined by mother tongue alone—to 582,690 (using the IDF). Under the new definition, there are 58,390 Francophones who are in racialized groups up from 52,590 using the first official language spoken (Bastien

2009). 5% of Ontarians are Francophone and 10% of Francophones are in racialized groups. The percent of Francophones that are in racialized groups are:

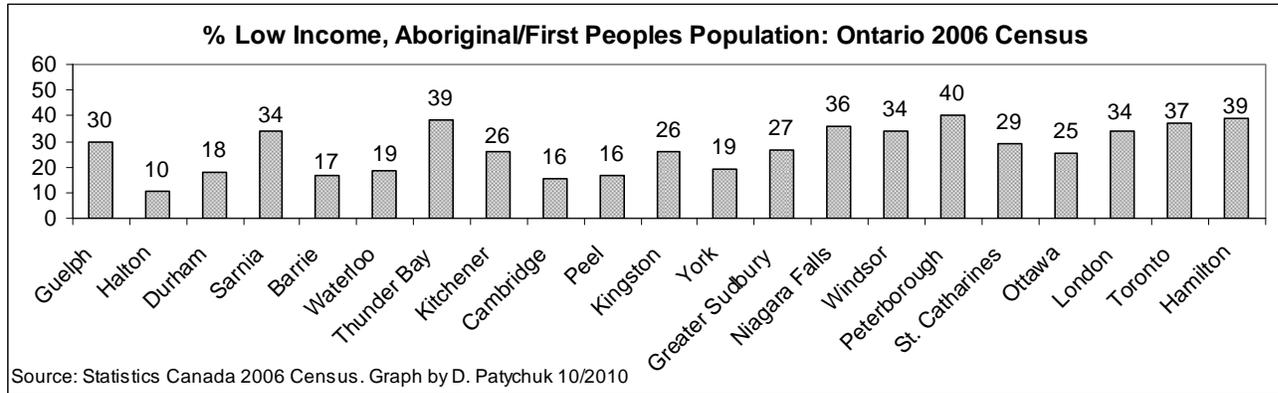
- 8% of Francophones in Southwest Ontario
- One in three Francophones in Toronto
- 9% of Francophones in Ottawa and East Ontario; (one-third of all racialized group Francophones in Ontario live in Ottawa (20,000))
- Less than 1% of Francophones in northeast and northwest Ontario



EKL: (Essex, Kent, Lambton); ACMS (Algoma, Cochrane, Manitoulin, Sudbury); MNPST (Muskoka, Nipissing, Parry Sound, Timiskaming). Source: Office of Francophone Affairs. Statistical Profiles.

Francophones have lower incomes than the population average in southwest Ontario, higher incomes than the population average in Northern Ontario and similar income levels compared to the Ontario average. Black Francophones are among the lowest income groups in Canada (Galabuzi 2001; Madibbo, 2005). In Toronto, visible minority Francophones earn roughly 33.3% less than Francophones as a whole (median income). In Ottawa and surroundings, visible minority Francophones earn roughly 40% less than francophones as a whole (median income). In Ontario, visible minority Francophone women have an unemployment rate twice as high as that of Francophones as a whole.

Genocide in several parts of the world has occurred on categories such as religion, tribe, ancestry, "ethnic cleansing" etc. Race-based exploitation is an inherent part of our western colonial history and economic development. Therefore it is useful to see other forms of "othering" from the larger lens of antiracism. In some communities in Ontario, the major groups experiencing racialization may be for reasons other than belonging to one of the categories defined as "visible minorities" in Canada (e.g. Eastern Europeans, Kosovar refugees, Roma populations, religious communities, etc.)



**Aboriginal people are considered separately from other racialized communities in recognition of their status as original peoples and the types of exploitation and discrimination they have faced including “state-based/legislated” discrimination for which the strongest words (genocide, apartheid) have been used to describe. Good public policy (Aboriginal Healing and Wellness Strategy, Tri-Council Research Guidelines, etc.) recognizes the self-determination of Aboriginal people in designing, controlling and delivering strategies for Aboriginal people and the diversity among Aboriginal peoples and “nations” (e.g. many First Nations groups, and Inuit and Métis). There are many aboriginal nations, but Statistics Canada reports only three clusters (First Nations, Métis and Inuit). In the last census 10 Indian reserves did not participate in or complete the census. There is no data reported for many Indian settlement and reserves. Therefore, these numbers and the poverty rates are likely undercounted.**

**The theory, concepts, frameworks and demographic pictures that have been laid out, provide the backdrop for taking a deeper look at the three health action topics.**

## 3. Approaches to Achieving Equity

### 3.1 At First Glance

At first glance, the means to achieving equity for racialized groups in health promotion might seem straightforward:

- provide culturally appropriate recreation programs such as women-only swimming lessons, swim times and gym classes; a variety of organized sports classes including ethnic dance and games; and remove culturally and linguistic barriers to access to information and participation
- identify ethnic groups with the increasing rates of obesity, chronic diseases and food insecurity and invest in strategies to ensure these communities have access to affordable, nutritious, culturally appropriate and personally acceptable food
- integrate indigenous and alternative forms of stress reduction and mental health promotion strategies other than western allopathic medicine (drugs, talk therapy, behavioural modification) and culturally diverse awareness and anti-stigma campaigns that better meet the needs of diverse communities.

These efforts and responses are not enough to achieve equity for several reasons.

Many of the above strategies, policies, programs and services were identified over twenty years ago (Sabloff et al, 1991; Ontario Multicultural Health Coalition et al, 1992). And while some of these are in place (swim times for Muslim women in London, Peel, Ottawa, etc. FCM, 2010), we are often still talking about them as things that could be done. Even if these types of strategies were everyday health promotion practice, they still would not address the fundamental causes and determinants that produce racial disparities in health (Link & Phelan, 2005). The literature includes many lists of recommended actions. Achieving equity cannot be reduced to checklists and cookie cutter approaches (Rogers & Bowman, 2005; Culyer & Bomard, 2011).

Strategies can be considered according to the extent to which they have incorporated a power analysis/anti-oppression/antiracism analysis and structural determinants of health. Some studies shift the focus from unique characteristics of specific groups to social practices, policies and conditions which determine that group's access to resources for health or exposure to threats and conditions which affect health.

The strategies listed above do not tackle or challenge racism, discrimination, social exclusion and socio-economic drivers of social inequality. They do not address upstream policies and forces which create, change or reduce exposure to threats, hazards and conditions which can increase the risk of health problems. Racism, systemic discrimination and other structural determinants of health have not usually been addressed in health promotion strategies despite the inclusion of public health policy advocacy in the definition of health promotion. Let us take a second look.

### 3.2 A Second Look

A second look at health promotion to achieve health equity for racialized groups at an upstream level includes strategies to:

- Tackle the policies and practices that discriminate against racialized groups in access to employment, income security, housing, freedom from violence and victimization and social exclusion (upstream policy advocacy)
- Ensure that racialized groups and communities have decision making roles and power and resources to participate in designing and delivering health promotion strategies (responsive, inclusive governance structures) (AOHC 2006, OCASI 2005b)
- Expose health inequities and commit to reducing them through comprehensive sustained inclusive multi-level strategies, expand the evidence base, data collection, evaluation, and setting of research agendas and priorities
- Institute antiracism/anti-oppression organizational change including: top level executive and board commitment that is reflected in organizational policies, practices and processes, training of staff, the design of health promotion working tools and resources, and in engagement, outreach, governance and communications
- Promote awareness and identification of systematic racism/discrimination, white privilege, and eurocentrism, so that this can be challenged (promote awareness of human rights and take organized action on discrimination)
- Ensure strategies for the effective participation of minorities within minorities, that reflect the diversity of perspectives within each community.

The literature review shows that:

- Health promotion strategies directed at individuals that do not also address environments and conditions are often not effective and that comprehensive multisectoral approaches that operate at multiple levels are more effective than strategies directed at individuals alone (WHO, 1990, PHAC, 2007, University of Ottawa, 2010, OPHS, 2008) including the "Health in all Policies" approach (WHO, 1988, MOHLTC, 2010)
- Strategies which do not take existing disparities into account can further widen health inequities (Frohlich & Potvin, 2008; Macintyre, 2007; Culyer & Bombard, 2011)
- Exposing and understanding the underlying structural and systemic drivers of social status inequalities that reproduce racism and discrimination in everyday interactions can lead to system, organizational and health planning strategies that get at root causes of racialized health disparities.

Some examples in each of the three health promotion areas served as concrete points of reference for the analysis presented in this literature review. This includes concrete examples of awareness of the white dominance in the community food strategy system (e.g. Tehera, 2010); the types of accessible recreation strategies and system change priorities most desired, and myths challenged when racialized communities participate in

deciding them, (e.g. Vengris, 2006); and new funding directions for population health research that include tackling structural determinants that influence community mental

### **What Works: Characteristics of Policies More Likely To Be Effective in Reducing Inequalities in Health**

- Structural changes in the environment: (e.g. area wide traffic calming schemes, separation of pedestrians and vehicles, installing affordable heating in damp cold houses)
- Income support (e.g. tax and benefit systems, professional welfare rights advice in health care settings)
- Reducing price barriers (e.g. free prescriptions, school meals, fruit and milk, smoking cessation therapies, eye tests)
- Improving accessibility of services (e.g. location and accessibility of primary health care and other core services, improving transport links, affordable healthy food)
- Prioritizing disadvantaged groups (e.g. multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless)
- Offering intensive support (e.g. systematic, tailored and intensive approaches involving face to face or group work, home visiting, good quality pre school day care)
- Starting young (e.g. pre and post natal support and interventions, home visiting in infancy, pre-school day care)

### **Interventions Less Effective in Reducing Inequalities in Health**

- Information based campaigns (mass media information campaigns)
- Written materials (pamphlets, food labeling)
- Campaigns reliant on people taking the initiative to opt in
- Campaigns/messages designed for the whole population
- Whole school health education approaches (e.g. school based anti smoking and alcohol programmes)
- Approaches which involve significant price or other barriers
- Housing or regeneration programmes that raise housing costs

Source: Macintyre S. Inequalities in health in Scotland: what are they and what can we do about them? MRC Social & Public Health. Sciences Unit: Glasgow, 2007. in NCC, 2010)

health - research that will "contribute to our understanding of how contextual conditions may intersect with population health interventions to promote health and health equity" (CIHR, 2010).

There are examples that show that it is possible and practical to use an antiracism/ anti-oppression approach to health equity in health promotion.

Macintyre's list (excerpted here) also includes legislative and regulatory controls, such as pricing and taxes,

etc., which reduce 'everybody's access to harmful substances and threats. However, Canadian researchers recognize that marginalized groups are more negatively affected by such measures especially where their dependency is greater and the burden that they must overcome is more challenging. When the policy strategy is increasing taxes (e.g. on tobacco products) to make access more difficult, researchers have suggested reinvesting a portion of the government tax gains from this into the marginalized communities most negatively affected by these taxes (SFO-SCA, 2010, p 149).

### 3.3 What are Racialized Health Disparities?

Several recent reports show that South Asian and Black/African Caribbean populations in Ontario have double the risk of diabetes, hypertension and heart disease when compared to other population groups (Chui et al, 2010; Creatore et al, 2010, CASSA, 2010). Higher rates of physical inactivity are reported by low income groups and racialized groups (Bierman et al 2009). Structural explanations are identified as more important than lifestyle differences in explaining these differences as well as health declines among racialized groups and recent immigrants (Newbold, 2009). Among newcomers, declines in health are greater among groups reporting highest levels of discrimination (De Maio & Kemp, 2009). There are many other examples of research, literature reviews and systematic reviews that demonstrate that racism/discrimination are associated with differential health effects over and above income differences, behavioural risk factors and genetic susceptibility (Khanlou, 2009, Women's Health in Women's Hands, 2003; CAMH, 2009; Lovell & Shahsia, 2006; Khanlou & Crawford, 2006; Hyman, 2009).

Most reports on health status by ethnic or racial group are based on administrative or survey data. Many community-based studies related to mental health describe discrimination, access barriers, and negative health experiences (Beiser et al, 2006; Elmi, 1999; Ethnoracial Coalition, 2003; Fenta et al, 2006, 2004; Noh et al, 2001; SAFE, 2003; Simich et al, 2005; Soroor, 2005). This experience is invisible in mainstream health system reports based on administrative data sets. Powerful views also come from qualitative research with titles such as: *'Racism makes you sick - It's a deadly disease'* (Lloyd et al, 2002); *'Institutional racism affects our well-being - We are dying from the inside'* (Este et al, 2003); *'Racism is violence'* (Ethnoracial Peoples with Disabilities Coalition of Ontario, 1996) and *"Racism really hurts"* (Health Equity Council, 2007). The Inquiry Report on the *Human Cost of Racial Profiling* (OHRC, 2003) is over 60 pages of examples and quotes more powerful than the statistics produced by the studies noted above.

#### Health Inequities

*"Given the growing empirical and theoretical sophistication of work on ethnic inequalities in health, it is worrying that crude explanations based on cultural stereotypes and claims of genetic difference persist...despite a lack of concrete evidence, more than 100 years of research exposing the limitations of the assumptions underlying such explanations, and growing evidence that the obvious social and economic inequalities faced ethnic minority groups are less likely to be a fundamental explanation."* (Nazroo, 2003 p277)

The purpose of this report is not to summarize all this existing research, but to provide a way of thinking about the types of differences that are being studied and reported to avoid faulty, simplistic explanations. For example, when we see Black youth being stopped by the police, we would ask not what is it that the youth are doing that is suspicious, but why are they being singled out for no apparent reason when this would not occur for other groups?

The same question can be asked about low rates of physical activity, high rates of diabetes, hypertension, heart diseases, etc. Given the mandate of health promotion, the question is not what is it about the specific ethnoracial group, but what is it about environments and conditions (and their underlying structural determinants) that increase exposure to and vulnerability to threats to health?

In this report, we define “racialized health disparities” as differences in health between racialized communities and other groups that are related to social injustice...i.e. they are unjust and avoidable because they are related to policies, practices and conditions that systematically privilege white/dominant European dominant groups and systematically disadvantage non-dominant racialized groups. This includes impacts that under-value the strengths, assets and capacity of racialized communities.

Intent is not as important as impact (Lopes & Thomas, 2006). Human Rights legislation is clear on this with its focus on ‘impact’ (intent is not required for a ‘finding of discrimination’ under the grounds in the Human Rights Code) whereas in criminal law ‘intent’ matters (i.e. whether an act is premeditated).

An Equity Lens asks about the evidence for the pathways that explain inequities so that strategies can be developed to address them (OAHPP, 2011). The danger is that the pathways won't be traced far enough upstream. Since the structural determinants are still operating, the inequalities will persist even though the strategies may modify the intermediate determinants (Williams et al, 1994, in Narzoo, 2003; Link & Phelan, 2005).

The section below describes how racism affects health through complex direct and indirect pathways (within a western biomedical paradigm). Direct physiological affects occur primarily through physiologic stress. Indirect effects occur primarily through access to goods, services and opportunities. The effects are interrelated, interwoven, not mutually exclusive and they accumulate over a lifetime.

Perceived discrimination is strongly correlated with mental and physical health problems (Williams et al, 2003). Other systemic examples include inaction in the face of need, selectively responding to issues (not addressing violence against women or discrimination as a health issue), ignoring minority health issues (lack of research, data collection, ethnospecific measures, and sample size) and avoiding social justice issues that create social disparities (discrimination in education, employment, housing, decision making, services, etc.).

Williams et al (2003) analyzed 53 studies that examined 86 associations between perceived discrimination and mental health (47 studies), physical health (34 studies) and health behaviours (5 studies). The majority (86%) showed a relationship between one or more of these health outcomes and perceived discrimination. Detailed descriptions of these mechanisms and pathways for direct effects include:

- how wear and tear 'turn on' hormonal mediators of stress that protect the body by providing adaptive responses in the short term but that result in chronic health problems in the long term (McEwen and Seeman, 1999)
- the "weathering hypothesis" of accumulated effects of life experiences (Geronimus, 2000), this also explains premature aging of the homeless (McDonald et al, 2006)
- embodiment - biological expression of race relations (Krieger, 1999, 2007)
- scaling up - how these effects produce persistent racial/ethnic disparities in multiple health outcomes within and across SES levels (Lillie-Blanton & LeVeist, 1996)
- other dynamic, latent and cumulative processes, dose-response effects and mediating factors (Barnes-Josiah, 2004; Williams et al, 2003)

Some descriptions of indirect effects (Kawachi et al, 2001; Kreiger, 2009, Jones, 2000; Wilkinson & Pickett, 2010; Winkleby et al, 1999, Williams et al, 2003) include:

- material - the gradient by socioeconomic position in access to tangible conditions, goods, resources and services (e.g. food shelter, housing, amenities, access to telephones, internet, transportation, services, etc.)
- psychosocial - direct or indirect effects of stress stemming from being lower on the socio-economic hierarchy, under-valued social group, living under conditions of relative socio-economic disadvantage (Shields, 2008; Nazroo, 2003).
- power and ability to take advantage of resources, the protective effects of privileged life (Frohlich & Potvin, 2007).

The above explanations are from a western paradigm, and would be different in Aboriginal spiritual views, Taoism and Eastern philosophy, etc.

### 3.4 A Continuum from Colour Blindness to Anti-oppression

Two strategies emerged from the literature. One is a way of thinking about racialized health disparities on a response continuum from colour-blind/universal approaches to anti-racism/anti-oppression. A second is identifying actions that lie within the anti-

**On Colour Blindness**

*"race consciousness as a necessary antidote in order to effectively oppose, resist and reveal the institutionalised, systemic, and normative character of racism in Canada.. moving beyond a liberal individualist framework with its stress on "neutrality," "colour-blindness," and "integration" into ...dominant society...remaining blind to the 'reality of race' ...amounts to... tolerance of 'racism'" (Essed in Warner, 2006)*

racism/anti-oppression realm. The continuum used here is based on several models in Canada including the Supportive Housing and Diversity Group (SHAD, 2008a; 2008b) and others (Janzen & Ochocka, 2006; James, 1996; Tehera, 2010). This continuum is similar to other anti-racism/anti-oppression organizational change strategies (Rogers & Bowman, 2005). We have compressed the categories into three. Specific references are noted in brackets and listed at the end.

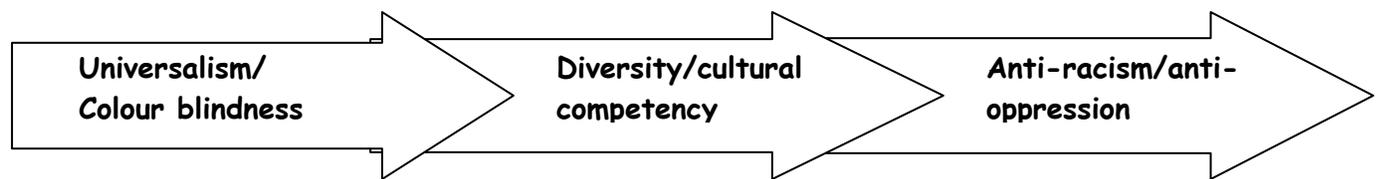
The use of a continuum suggests moving from 'less' on one end to 'more' on the other. In this continuum, 'more' means more explicit use of a structural/anti-oppression approach

in analysis and decision making. The purpose of this continuum is to locate theory, evidence and assessment of strategy options according to these categories.

While the literature reviewed for this paper is critical of colour blindness for contributing to inequity (by not seeing the reality of racism), there are health promotion strategies that aim to provide universal access to basic prerequisites for health that can move towards equity as long as they explicitly remove barriers to access. 'Race consciousness' is a beginning antidote to colour blindness. Cultural competency is necessary but not enough. Historical and current structural injustice in Canada comes into focus when using a racial justice lens.

**On Multiculturalism**  
 "The multicultural promotion of a politics of ethnic difference further erases from view not only intra-group diversities of class, gender and sexuality, and hence the necessity of their attendant political projects, it also works against the identification of a common systemic enemy - the Canadian racial state and the fundamentally unjust global political economic order of which it is a part" p (Warner, 2006)

strategies that aim to provide universal access to basic prerequisites for health that can move towards equity as long as they explicitly remove barriers to access. 'Race consciousness' is a beginning antidote to colour blindness. Cultural competency is necessary but not enough. Historical and current structural injustice in Canada comes into focus when using a racial justice lens.



Universalism/colour blindness	Diversity/cultural competency	Anti-racism/anti-oppression
<p>Provide everyone with the same treatment.</p> <p>Majority-group behaviours, values are the norm, "neutral"</p> <p>Focus is on tolerating rather than accepting and valuing diversity.</p>	<p>Cultural competence emerged in the 1990s, is defined as "comprehension of the unique experiences of members from a different culture through awareness of one's own culture, empathetic understanding of oppression and critical assessment of one's own privilege, resulting in the ability to effectively operate in different cultural contexts" (B).</p> <p>Diversity competence includes valuing diversity moving beyond accommodating it. (J)</p>	<p>Antiracism calls for a critical examination of how dynamics of social difference (race, class, gender, sexual orientation, physical ability, language, religion, country of origin) influence daily experiences through inequitable access to resources and power and the historical, social, and political processes that have institutionalized and continue to maintain such unequal power (Dei, 1996; SHAD, 2008).</p> <p>Anti-oppression perspectives put structures of oppression and discrimination at the centre of analysis, attending to the diversity of interlocking oppressions.</p>

<b>A Description of the Continuum</b>			
	<b>Universalism/colour blindness</b>	<b>Diversity/cultural competency</b>	<b>Anti-racism/anti-oppression</b>
<b>Level</b>	Individual level of analysis	Individual and group level of analysis.(S)	From analysis to social change
<b>World View</b>	<p>Society is democratic and egalitarian so everyone has freedom of choice, and freedom to access and participate in whatever services/institutions they want. (J)</p> <p>Prejudice, racism, ethnocentrism anti-semitism, etc., are the result of ignorance. (J)</p> <p>Services are provided under the belief that all people are the same, and that ethnicity, race or culture makes no difference (S)</p>	<p>A. Diversity &amp; Multiculturalism “The world is filled with a multitude of complex cultures, constantly intersecting &amp; shaping each other. As people grow to understand and appreciate their own culture and cultures around them, they will be better able to cooperate and overcome mutual problems.” (S)</p> <p>B Cultural Competency/ Cultural Empowerment). “The world is filled with groups that have been traumatized &amp; victimized by historical events. When the oppressing group acknowledges &amp; apologizes for these injustices, individual and social healing, reconciliation &amp; transformation can occur.” (S)</p>	<p>The world is controlled by powerful systems with historically traceable roots. Once people are shown how they benefit from or are battered by those systems, they can work together to change them. (S)</p> <p>In order for culturally diverse populations to be served in an equally effective manner as dominant groups, their social, cultural and historical differences/experiences need to be taken into account (Toronto, 1998 in SHAD, 2008)</p>
<b>Reports</b>	Differences not reported by ethno-racial groups	Differences reported by ethnoracial groups where data permits. Danger of essentialism when difference is attributed to genetic, inherited, or cultural factors without intersectional and power analysis	Promotes the collection of data to permit intersectional analysis and reporting to promote and measure impact and action.
<b>Outcomes</b>	Contact with diverse groups will heighten awareness and eliminate prejudice. Education can promote understanding of differences (J)	<p>Awareness of cultural differences and tolerance (S)</p> <p>If individual transformation is achieved, transformed individuals can lead to structural change and build more equitable inclusive organizations (B)</p>	<p>Social change (S)</p> <p>Organizational transformation, system and policy change</p> <p>Inclusive and equitable structures will lead to the transformation of the individuals who work within them. (B)</p>

**A Description of the Continuum (Continued)**

	<b>Universalism/colour blindness</b>	<b>Diversity/cultural competency</b>	<b>Anti-racism/anti-oppression</b>
<b>Issues in Practice</b>	<p>Refusing to recognize colour is a way of sidestepping racism and maintaining white privilege, asserting “racelessness” is itself a racist act (Morrison, 1992 in Tehara, 2010), Macintosh 1988 (re: invisible knapsack of white privilege)</p> <p>Everyday racism goes unrecognized and unchallenged</p> <p>Lack of antiracism training for staff. Lack of hiring diversity.</p> <p>Sensitivity and tolerance to other cultures that poses no challenge to the status quo.</p> <p>“we don’t measure it, we don’t analyze it, we don’t strategize around it, we don’t talk about it” (T)</p> <p>Conflation of race and immigration producing otherness and social exclusion, people of colour automatically viewed as immigrants and immigrants not seen as “Canadian”</p>	<p>In practice cultural competence equips staff with tools to provide appropriate services to diverse clients, but may not address the scope and quality of programs available to racialized groups nor the structural issues that impact their health.</p> <p>Everyday racism may be unrecognized/unchallenged.</p> <p>Essentialism can occur – (i.e. that there is a “essence” associated with a specific ethnicity)/stereotyping can occur (assuming all persons in a categorized group shares the same traits or characteristic or risk factor or preferences, etc.) and not seeing distinctions within communities (political, historical, ethnic, social, SES) It is not meant to be using a cookie cutter approach (NS).</p> <p>“Activities such as cultural competence training that improve linguistic and cultural access to care may improve services for individuals, but are unlikely to create needed long term, fundamental changes in population health status” (B).</p> <p>Focus on culture alone, can undermine addressing other forms of oppression.</p>	<p>Proactive approach to intersecting forms of power and privilege, recognizing how everyday interactions perpetuate discrimination and social exclusion, and working to dismantle individual, organizational and structural racism.</p> <p>Ensure organizations reflect diverse communities in decision making and accountability strategies, ensure that the representation is not token but brings a social justice approach to an explicit organizational social justice commitment.</p> <p>White antiracist organizations create decision making processes that are accountable to communities of colour (T).</p> <p>Ongoing difficulty in seeing, exposing and acting on systemic discrimination and white privilege.</p>

**Healthy Eating/Food Security: Along the Continuum (Examples)**

<b>Universalism/colour blindness</b>	<b>Diversity/cultural competency</b>	<b>Anti-racism/anti-oppression</b>
<p>Culturally appropriate food seen as a luxury, rather than a necessity, expecting food service users to adapt, adjust and 'make do' with available food regardless of faith, health or dietary requirements,(i.e. accept what charity as is) (T).</p> <p>Using food as a form of assimilation, encouraging or pushing immigrants to eat/cook "Canadian" food and to fit in/get used to the food that is available in food programs (issues of children being embarrassed by taking ethnic food in school lunches which increases 'otherness' risk of bullying, etc. (Koc)</p> <p>Everyday racism goes unrecognized and unchallenged.</p> <p>"Organizational policies and attitudes that result in different levels of access and quality of service to different populations or that assume that all clients have the same scope of needs are major contributors to health disparities" (Barnes-Josiah, 2004).</p> <p>Universal school nutrition programs (OCDPA, HCF, SNP, etc) that are stigma free - everyone gets a healthy snack – (but ensure snack is culturally acceptable for all)</p> <p>Healthy Food Policies in schools and public facilities (B.C., Ont. partially) (H&amp;S, OCDPA, C)</p> <p>Increase food literacy by returning food preparation courses to the high school curriculum (H&amp;S).</p> <p>Restrict advertising of unhealthy food to children Campaign for a Commercial Free Childhood (CCFC)</p>	<p>Diversity of food choices in vending machines, grocery stores, school cafeterias, food banks</p> <p>Providing culturally diverse food options, translations, multi-lingual staff where resources are available.</p> <p>Differences in need are accommodated where known and where resources are allocated.</p> <p>Ensure LBW prevention and breastfeeding in low income groups (C).</p> <p>May not include antiracism training, and may lack knowledge and capacity in antiracism initiatives and lack of understanding of systemic racism.</p> <p>Everyday racism may be unseen and unchallenged.</p> <p>Employment and income security policies may continue to create food insecurity among racialized groups.</p> <p>Decisions to use weight loss medications and bariatric surgery should not be based on limited evidence about different effects of these in race/ethnicity groups (C)</p>	<p>Recognize aspects of the food system that are based on historical racism (low paid migrant workers without job security/safety; food processing workers are disproportionately low income racialized groups); nutritious food variety and cost differences disadvantage low income racialized neighbourhoods.</p> <p>Recognize that racism functions as a barrier to community self-determination and self-sufficiency and question white-dominated food initiatives (farmers' markets, food co-ops) (Slocum, 2006 in Tehera, 2010).</p> <p>Employment and income security policies which create food insecurity among racialized groups are tackled (H&amp;S).</p> <p>Reduce food strategies' dependence on corporate food industry donations that do meet the need for nutritious culturally appropriate food.</p> <p>Recognize food service organizations do not reflect the diversity of the population if only whites are in positions of power (S).</p> <p>Ensure food programs have resources to provide culturally appropriate food in low income racialized communities (C).</p> <p>Food systems/food production and distribution, community food organizations work to achieve fair prices, accessible, affordable and culturally appropriate nutritious food for all (Slocum 2006 in Tehera)</p> <p>Food systems/food production/distribution: ensure availability and accessibility of culturally appropriate healthy food.</p> <p>Measure inclusion and discrimination in the food system/ensure funding is contingent on adoption of antiracist organizational policy and practice.</p> <p>Use the Canadian Charter of Rights &amp; Freedoms protect migrant farm workers (CCR, 2006b).</p> <p>Food security impact assessment of government policies (H&amp;S)</p> <p>Public influence of the food industry (H&amp;S)</p> <p>Restrict targeted advertising of unhealthy food (C)</p>

Based on: Tehera (T), Barnes & Josiah (B), Shapiro (S), SH (SHAD), J (Jones) Heart & Stroke (H&S).HCF (Hamilton Community Foundation) SNP (Student Nutrition Program (CCFC Campaign for a Commercial Free Childhood), C (Caprio et al, Consensus Statement) NS (Nova Scotia Department of Health), Koc (Koc, M & Welsh, J. 2001), CCR (Canadian Council for Refugees)

## Access to Physical Activity/Recreation & Sport: Along the Continuum (Examples)

Universalism/col -our blindness	Diversity/cultural competency	Anti-racism/anti-oppression
<p>Universal access for all children and youth to free publicly funded recreation programs (H&amp;S OCASI, Vengris) to reduce stigma/shame and red-tape/ other barriers in applying for subsidies.</p> <p>(Lack of awareness that free programs exist must be addressed)</p> <p>Introduce a second physical education credit in schools (H&amp;S)</p> <p>Monitor and support implementation of school PA requirements (H&amp;S, OCDPA)</p> <p>Promoting organized sports as “integrating”, not seeing sport, recreation, games as ways that cultural institutions exclude and marginalize those without power to shape it and tht perpetuate Eurocentric notions of the physical ‘body’ (AK)</p> <p>Ignoring critiques of exclusivity and Eurocentrism in organized sports (Dyck)</p>	<p>Consider culture, gender and family preferences when planning physical activity, as well as specific barriers, influences/ societal norms, media, work, income, neighbourhood, environment, etc. (C)</p> <p>The need to address barriers faced by women in particular (multiple responsibilities, more perceived barriers) (Pan et al).</p> <p>Peer/community workers/ partnerships: women-multicultural, immigrant, low SES women (WA; GA)</p> <p>Existing models of fitness and lifestyle change developed and evaluated for white middle class adults and children may not be effective in all population groups (C. WG)</p> <p>Culturally adaptation may not be as important a barrier/facilitator as other aspects of access (WG)</p> <p>Women-only recreation programs, swim times, gym time etc. have been established in some places (Ottawa (FCM), H&amp;S funded strategies to enable East African, Bangladeshi, new-comers, communities who are Muslim, etc., to research barriers and plan acceptable strategies (H&amp;S).</p> <p>Provide sport/ recreation program options consistent with ‘collectivist’ rather than ‘competitive’ Western models. (OCASI)</p>	<p>Challenge ‘exceptionalism’ i.e. (Jiwani; Dyck) profiling the achievements of a few persons of racialized groups in competitive sports (e.g. basketball, running etc.) while there is overall a highly unrepresentation of most racialized groups on competitive “Canadian” Olympic and world cup teams, etc.</p> <p>Racial stereotyping in media and discourse is monitored, assessed and corrected.</p> <p>Make access to safe neighbourhoods a priority: fear and unsafe neighbourhoods is disproportionately experienced by racialized communities in low income areas victimized by crime (C; BARHII; Cusimano; Toronto Police Service Surveys).</p> <p>Equitable access to built environments that support physical activity, includes, sidewalks, bike lines, walking trails, facilities, public access to space ‘after hours’, less traffic congestion, street lighting, less unattended dogs, safety from crime, affordable social supports, etc. (Pan et al, Casagrande et al)</p> <p>Assess and address inequitable distribution of indoor &amp; outdoor space, fitness recreation/team sport resources and programs, transportation, cost barriers, etc., according to the distribution of population groups to identify and eliminate inequities (BARII).</p> <p>Provide funding for and decision making authority for access to physical activity, recreation and sport for racialized communities to be led by those communities and involve a diversity of under-represented and marginalized minority community voices (gender, youth, low income, newcomer, LGBT, disabled, etc.) include sustained funding, infrastructure, evaluation supports (Teufel-shone et al, 2009). Don’t assume the type of sports a community prefers – ask and support communities to develop and lead its own initiatives (W-G, OCASI, Vengris)</p> <p>Remove cost barriers to equitable access to recreation and sport through public policy (distribution of funds, subsidies, income security, living wage, employment, housing, transportation equity, etc.) (H&amp;S)</p> <p>Tackle “time” barriers - a huge issue for low income people, long work hours, exhausting work, seeking ‘rest’ not exercise’ after-work hours (C)</p> <p>Multilevel strategies are more effective than individual ones. Focus upstream on policy change (Casagrande, BARII)</p> <p>Use an equity lens in planning that includes historical injustice and structural determinants.</p> <p>Anti-racism training for staff; explicit protocols to outreach/include racialized communities (Vengris)</p>

Alkemeyer T., & Broskamp B. 1996; Dyck N. (2001) C (Caprio et al. Consensus Statements, 2008), Teufel-shone et al 2009. WG (Whitt-Glover & Kumanyika SK, 2009a, 2009b).BARHII (Bay Area Reducing Inequities Initiative, Strategic Plan, 2009), Casagrande et al, (2009), OCASI Ontario Council of Agencies Serving Immigrants, Vengris/Sport Hamilton, 2009; Pan et al (2009); WA (Women Alive); GA (Fondation Filles d’Action Girls Action Foundation)

**Mental Health Promotion is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental Health Promotion requires access to economic resources, freedom from violence & discrimination, social inclusion, and access to prevention/early intervention in order to foster environments that support resiliency (Ontario Chronic Diseases Prevention Alliance). Structures and policies that privilege whiteness and white culture messages about Canadian norms, food, recreation and bodies, especially marginalize, alienate and challenge the mental health, belonging and identity of racialized young people who are trying to make sense of who they are in the world (Fondation Filles d'Action/Girls Action Foundation, 2008).**

<b>Mental Health Promotion: Along the Continuum (Most Examples from Kwasi Kafele, 2006)</b>		
<b>Universalism/colour blindness</b>	<b>Diversity/cultural competency</b>	<b>Anti-racism/anti-oppression</b>
<p>Racism not being recognized/validated as critical determinant of mental health.</p> <p>Poor knowledge of specific mental health issues and needs of communities.</p> <p>Weak/ ad hoc partnerships with key community groups and agencies.</p> <p>Prevention, public education, advocacy, outreach strategies do not address racism specifically</p> <p>No focus on resource planning based on addressing systemic racism and that impact on target communities as well as impact on health promotion strategy</p> <p>Little focused research on racism related to mental health promotion</p> <p>Members of racialized communities not central to strategy, planning and execution of initiatives</p> <p>Orientation is Euro-centric</p> <p>Methodologies blind to culture and the effects of racism</p>	<p>Cultural Competence standards in place.</p> <p>Develop health promotion strategy which clearly identifies how knowledge of risk factors like racism, poverty, sexism, sexual orientation, etc., intersect to affect the mental health of the most vulnerable in communities (e.g. youth, women, elders, the poor) and their families.</p> <p>Provide information about services to communities in languages and formats that are culturally appropriate and clearly identify programs that address racism.</p> <p>Comprehensively integrate anti-racism principles and approaches in all health promotion planning.</p>	<p>Anti-racism leadership support and resource allocation</p> <p>Anti-racism training for staff, board, committees.</p> <p>Comprehensive communication promoting anti-racism and equity</p> <p>Accountability for racist behaviour at every level</p> <p>Support equitable community participation through targeted outreach, funding and expense reimbursement for small community organizations, community member participation.</p> <p>Staff from multi-racial and Aboriginal backgrounds are in decision-making positions to influence access decisions</p> <p>Effectively address issues of access and power in all aspects of planning</p> <p>Systems planning more fully and deliberately incorporates anti-racism and equity principles, measurements and accountabilities in all aspects</p> <p>Public policy work identifies racism as a serious health and mental health issues and prioritizes work on this.</p> <p>Public policy work include income security, living wage, employment, housing, transportation equity, etc.) (H&amp;S, OCDPA, CMHA)</p>

Examples above (except where noted) are from: Kafele, K. 2006. Racism and Mental Health: A Compendium of Issues, Impact and Possibilities. [http://www.healthequitycouncil.ca/dev/media/Racism\\_and\\_Mental\\_Health\\_chart\\_final.pdf](http://www.healthequitycouncil.ca/dev/media/Racism_and_Mental_Health_chart_final.pdf) The grid was first developed as an appendix to: Kafele, K. 2004. Racial discrimination and mental health. Racialized and Aboriginal communities. Paper presented at the Ontario Human Rights Commission's Race Policy Dialogue Conference, <http://www.ohrc.on.ca/en/issues/racisme/racepolicydialogue/kk/view>

### 3.5 Examples of Health Inequities that may be considered Racialized Health Disparities

There is a '*lack of looking*' for health inequities related to systemic racism as well as a lack of evaluation studies of what works from the perspective of racialized communities (Kumanyika & Yancey, 2009; Casagrande et al, 2009; OCASI, 2005). Health inequities can be described according to the following categories:

- **Determinants (greater exposure to threats, less access to formal supports/opportunities for health and well being, lower privileges/social status).**
- **Access to Services (less access to services the right kind of services at the right time in an acceptable respectful manner, different or lower quality treatment or care)**
- **Health Status (worse health outcomes)**

**Social Determinants: Lack of access to determinants of health where racism is likely a contributing factor or through structural racism embedded into institutional policies, ideology, practices and interactions:**

- **Marketing strategies target specific ethnic groups and influence beliefs and practices about food (Capri et al, 2008, Kumanyika & Grier, 2006). Targeted advertising is an issue in the US. African-American prime time television shows contain 60% more commercials about unhealthy food (fast food, sweets, high calorie cereals) than general prime-time shows (Outley & Taddese, 2006); especially of concern as children may be unable to distinguish a 'health' message from 'advertising campaigns'. Analysis of content of advertising is not being done in Canada.**
- **Readers of magazines directed at African American and Hispanic women were exposed to proportionately fewer health promoting advertisements and more health diminishing ads than readers of magazines directed at white women; and more African American females were used to advertise negative products compared to positive products while the reverse was true for white models in the mainstream magazines (Dureksen et al, 2005). Research questioning content analysis of such media in Canada was not found.**
- **Canadian research shows that 'perceived barriers' to physical activity are an important factor in explaining rates among young people and women. Facility availability was more important to people with university degree and higher income than lower income people (Pan et al, 2009). As shown here and elsewhere (McNeil et al, BARHII, Caprio et al, 2008; WG) higher income and better health are associated with higher rates of physical activity due to better access to health resources, facilities and opportunities, living in more pleasant activity-friendly environments, and less barriers to physical activity. Other studies show these barriers and inequities are exacerbated for immigrant and racialized communities (OCASI, 2005; Vengris/Sport Hamilton, 2006; Kumanyika & Grier, 2006; Caprio et al, 2008)**
- **Growing price differential between healthy food and unhealthy food over time systematically disadvantages lower income communities which are more likely to be racialized groups and newcomers (Caprio et al, 2008)**

- School suspensions, academic streaming, differential education quality, inequitable access to resources for schools programs, education outcomes affect employment, income (Jackson, 2005; Lovell & Shabsia, 2006; People for Education, 2008)
- Media stereotypes, few positive representations and discrimination are risk factors for youth aspirations, school achievement, self-esteem, and increase the risk of youth depression, conduct disorders, feelings of social exclusion, lack of belonging, anger, and turning to substance use as a coping mechanism (Cooper et al, 2008; Brody et al, 2006; and Sellers et al, 2003, in Hardaway & McLoyd, 2009; Anisef & Kilbride, 2000; Khanlou & Crawford; WHIWH 2003; CAMH, 2006)
- Living in underserved neighbourhoods with less access to services, recreation, transit, banks, safe playgrounds and play spaces in low income communities (Glazier et al, 2005; CPHI, 2011). For example when assault-related ER visits are mapped in Toronto, rates are highest in lower income neighbourhoods (Cusimano et al, 2010).
- Taunting, isolation, stigma, rejection because of being out-of-style, poverty, passive/non-violent responses (Lovell & Shabsia, 2006)
- Blanket requirements for Canadian experience and 'excellent' English communication in job advertisements
- Employment and housing discrimination that result in not having enough money, threat of eviction/poor quality/unsuitable housing/unsafe neighbourhoods/working conditions
- Fear for safety, racial slurs, racial attacks, police harassment, police brutality
- Having a criminal record as a result of racial profiling in policing/justice system (differential access to sentencing/differential treatment (Commission, 1995; Lewis, 1992; Kafele, 2006; deSilva, 2006)
- Reduced access to health benefit coverage (dental, prescription drugs, glasses) due to unemployment or precarious work situations
- Lack of privileged access to information and resources because it is determined by Anglo-Eurocentric dominant social groups
- Under-representation and social exclusion from decision making in media, business, education, government, boards etc.(Maytree, 2011)
- Lack of right to unionize, (e.g. live in caregivers); migrant workers and undocumented persons inability to access health care, or protection from employment standards or Canadian Charter of Rights and Freedoms (Walia, 2006; CCR, 2006b)
- Greater risk of deportation, arrests, detention, criminal record, institutionalization of racialized groups especially when accompanied by the stigma of mental illness, victimization or substance use (Jarvis, 2006; Schizophrenia Soc. of Ont., 2010)
- Toronto Police Service reports (2008, 2009) that in focus groups with youth, Chinese, South Asian and Black participants, in contrast to others, the Black participants felt relatively more unsafe in their neighbourhoods
- In the Toronto Police Service high school student survey (994 surveys returned), students were more likely to state that they believed that officers target minorities for enforcement (27% in 2008) than did the general population (21% in 2008).
- Lack of nutritious food in community programs in low income racialized neighbourhoods (e.g. after school homework help programs) (Lovell, 2010)

- Racialized groups disproportionately experiencing food insecurity, lose their farms/less access to agricultural land (did not benefit from free land given to white immigrants), face the dangerous work of food processing and agricultural labor, migrant workers have no right to unionize (need to be recognized by community food movement)

#### Access to Programs, Services, Funding

- Invisibility of racialized groups in health promotion campaigns (eg. anti-stigma mental health campaigns that don't address racism)
- Underfunding of organizations and services for specific groups results in inequitable access barriers, unfair/inequitable competition for resources and grants, reduced capacity to influence policy and program changes, and less self-determination in community development/community mobilization, etc.
- Differential treatment (insensitive communications, misdiagnosis, lack of referral to specialists)
- Lack of access to culturally appropriate health promotion and health information
- Overrepresentation of African Caribbean and Aboriginal youth in institutions (jails, inpatient psychiatric units) and under-representation in community-based services in Montreal and Toronto (CAMH (African Diaspora report, 2007; Durbin, 2002)
- Bias in the diagnosis, Eurocentric interpretation of symptoms, misinterpretation of physical symptoms) (CAMH (African Diaspora Phase I), 2007; WHIWH, 2003; Choi, 2003 in Lovell & Shabsia, 2006)
- Greater reported experience of discrimination in police treatment and health care (black women in Toronto, WHIWH, 2003, people in certain racialized low income neighbourhoods and black women were more likely to say that police prejudged them (Toronto Police Services, 2009)

#### Health Status - measurement and reporting

- Invisibility of racialized groups in research and evaluation (standards set based European populations that are applied without adjustment to all racialized groups)
- Invisibility of racism as a determinant of health in health inequalities reporting
- Higher rates of conditions (e.g. mental illness and substance abuse in community based research (Across Boundaries survey) than population surveys (CAMH survey, summary reports based on Canadian Community Health Survey data) suggest issues with using undisaggregated population surveys as prevalence rates for planning for diverse populations
- Lack of oversampling in populations surveys, lack of analysis of health disparities, masking and "invisibility" of racial group inequities'
- There appear to be myths about genetic causes of disease. For example the "thrifty genotype" is often provided as an explanation for obesity and diabetes in some racial groups but despite expansion of genetics research, no genes or gene variants have been found that support this (Caprio et al, 2008). A consensus conference concluded that there was circumstantial evidence for some metabolic biological differences

(insulin sensitivity, basal lipolysis, body fat distribution) by racial/ethnic groups but that the relationship was 'far from definitive' (Caprio et al, 2008).

- Lack of ethno-specific measures where warranted and lack of use of validated and internationally recommended ethnospecific measures (e.g. ethno-specific BMI, alternative measures of obesity), lack of use of culturally validated measures of depression/stress

#### Health Status - lack of appropriate responses to health disparities

- Lack of access to services for some groups with higher degrees of distress (e.g. refugees) (Soroor & Popal, 2005); only 1 in 10 Tamil Sri Lankans with Post Traumatic Stress Disorder who qualified for a PTSD received treatment (Beiser et al, 2003).
- Treatments that focus on medication (that people may not be able to afford or that are seen as dangerous) accompanied by lack of information, lack of attention to symptoms and questions (Whitely et al, 2006).
- Continuing to attribute higher rates of chronic diseases (diabetes, heart disease) among some groups to the characteristics and behaviours of these groups, ("at risk" or "high risk" groups) instead of tackling the conditions, environments and determinants ("risk conditions") which can be changed through policy advocacy.

## 4. Conclusion

The Canadian Institute for Health Research (2010) notes that "People in Canada should not be disadvantaged from reaching their full health potential because of their race, ethnicity, religion, income or other socially determined circumstance." Despite increasing racialization of poverty and growing awareness of racialized social inequalities, there is a noticeable absence of attention to racialized social exclusion in population health and health promotion. Chronic disease prevention in particular is an important place to bring an awareness of structural racism/discrimination to build more equitable, inclusive and effective strategies. This includes going beyond diversity programs and cultural competence to organizational change and tackling racialized social exclusions based on acknowledging racial inequalities and historical injustices (HEC, 2007; Edwards & DiRuggiero, 2011).

The literature review identified the need for health equity-oriented organizational change and health promotion practice to be rooted in an analysis of structural racism and the historical and ongoing dynamics of power and privilege in Canadian society. Health inequities can be seen as "biological expressions of race relations" (Krieger, 2007). This approach requires a shifting the focus from "at risk" or "high risk" groups/populations, genetics and culture to the "root causes" and structural determinants of health and health inequities largely beyond individual/community control. Equity in health promotion for racialized groups is about more than strategies that increase access to culturally diverse food and culturally appropriate recreation programs or integrating diverse types of stress reduction approaches into mental health programs. While useful, strategies

such as these do not tackle or challenge racism, structural/systemic discrimination, social exclusion and socio-economic drivers of social inequality.

Racialized communities need to be at the centre of health promotion decision making to ensure relevant, credible, effective strategies tackle root causes, build on community strengths, respond to health inequities in order to reduce them and prevent perpetuation of social exclusion. This includes decision making using an anti-oppression/anti-racism approach, equitable representation of racialized groups in decision-making positions, and processes that directly involve racialized communities in planning and evaluation.

### Strategies in the Anti-Racism/Anti-oppression Realm of Action

A health equity approach to health promotion that tackles racialized health inequities may include:

- Expose and measure racialized health disparities and commit to reducing them through comprehensive, sustained, multilevel strategies and through expanding the evidence base, data collection, evaluation, and setting of research agendas and priorities
- Make examination of systemic/structural oppression a central feature of health promotion planning; recognize Eurocentrism, white privilege, and historical injustice when seeking to explain the pathways and causes of health inequities
- Ensure racialized groups and communities have decision making roles and power and resources to participate in designing and delivering health promotion strategies; ensuring minority perspectives in diverse communities are heard; support communities to ensure that this happens meaningfully and in multiple formats
- Advocate for change in the policies and practices that discriminate against racialized groups in access to employment, income security, housing, freedom from violence
- Institute anti-racism/anti-oppression organizational change that is reflected in policies, practices, staff training, working tools, community engagement, governance and communications.
- Support the development of anti-racist allies and the voice, resources and power of communities experiencing racialization and the power of organizations working to eliminate systemic racism
- While data collection and data disaggregation are important for equity monitoring, the inherent Eurocentric bias in research needs to be addressed through preferentially expanding knowledge that reflects unheard voices, and suppressed and neglected ideas from racialized communities and minorities within them.

The issues addressed in the literature review were sparked by lively conversations that occurred throughout the province during the Health Nexus/Health Equity Council project on "Building Capacity of Equity in Health Promotion for Racialized Communities" in 2010/11. These conversations will continue as organizations and communities work together and continue to share ideas and strategies for social justice and equity in health for all.

## Appendix A. Timelines/History of Racism in Canada

For examples see:

Curry-Stevens, A. (2005). Expanding the circle: people who care about ending racism. Centre for Social Justice. P 5 <http://www.socialjustice.org/uploads/pubs/ExpandingtheCircleENG.pdf>

Gushulak, B. (2010). Migrant Health in Canada: Legislation and policy over the centuries. Health Policy Research Bulletin, 17p:12-16  
<http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/bull/2010-health-sante-migr/index-eng.php#7>

History of Blacks in Canada. <http://www.histoiredesnoirsaucanada.com/>

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## Appendix B. Anti-racism and Health Equity in Ontario in the 1990s

The Ontario Public Service Anti-Racism Strategy introduced in 1991 built on the multiculturalism policy adopted in 1987 and the extensive consultations that resulted in the production of guidelines on multicultural health (1988). Multicultural health guidelines were formally adopted as ministry policy in 1991. In 1992, Cabinet approval of the recommendations of the *Stephen Lewis Report on Race Relations* and the formal adoption of employment equity legislation further laid the groundwork for the *Ministry Antiracism Strategy (MARS)* (1993) and the *Anti-Racism Protocol* (1994). The Commission on Systemic Racism in the Ontario Criminal Justice System (appointed in 1992) is an example of a comprehensive analysis of causes, experience and results of systemic racism.

Racism was recognized as a determinant of health in the Ministry Anti-Racism Strategy (MARS). MARS began with an anti-racist vision of health and laid out a comprehensive set of strategies to change attitudes, processes, practices and policies which systematically produce and reproduce racial inequalities in Ontario. The strategy went beyond access to services and service equity, to systemic issues including anti-racist organizational change. This included leadership, governance, employment, community partnerships and communication.

The Ontario Public Health Association (OPHA) passed resolutions on anti-racism in 1992 and in 1994 made a commitment to advocate for guidelines for ethnoracial data collection. OPHA stated that the lack of data maintained systemic racism in the health system because it became a justification for withholding resources and maintaining the status quo in services which were inaccessible or inappropriate for ethnoracial communities.

Henry and Tator (2009) note that in the late eighties and mid-nineties there was increased attention to racism in and across Canada in response to demands for equity. Government and public sector organizations developed policies and programs, modified practices, hiring and appointments included small numbers of racialized people. This changed from 1995 onward including the abrupt end of all anti-racism initiatives in Ontario with the change in government in 1995. Other changes included cancellation of employment equity and social housing programs; funding cuts for many programs for marginalized groups and a 22.6% reduction in social assistance benefits.

## **Appendix C. Literature Review Methodology**

The geographic scope is Canadian provinces (including local and regional), selected OECD countries (UK, Australia, New Zealand, United States) and global/international resources e.g. World Health Organization.

Resources in both English or French were sought. Other than a brief historical overview, the focus was on resources produced during the last decade - 2001 to 2010.

Data bases searched included: Medline search of journal articles using OVID conducted by the librarian at CAMH, the references compiled for the CAMH paper for the Mental Health Commission, updating for the mental health literature (2009-2010) building on research compiled for the consultations documents and reports written for the Mental Health Commission and for two research projects on mental health for racialized groups prepared for Across Boundaries (concurrent disorders and seniors mental health).

An additional search was done on Scholars Portal (social sciences subject areas, multiple data bases) at University of Toronto. Search terms includes: Canada, French, racism or equity or discrimination, mental disorder, mental illness, diet or nutrition or food intake, physical activity, immigrants or ethnicity or race, health. In addition search on Goggle and Google Scholar was done using the terms: health - santé, mental health - santé mentale, physical activity - activité physique, equity - l'équité, racism - racisme, racialized - racisée(s), health eating - saine alimentation, racialized - racisé(s) = masculine/group, racisée(s) = feminine, santé, santé mentale, activité physique.

Resources reviewed included published studies in journals, reports produced/published and posted on organizational websites as well as reports and documents that are unpublished.

A scan was conducted for resources produced by organizations in the locations where the community conferences were held.

Literature reviews that have been conducted on these topics were compiled: (PHAC, OPHA, WHO Collaborating Centres, WHO, OECD countries, international agencies, Health Nexus and members of HEC - Toronto Public Health, CAMH, Access Alliance Multicultural Health and Community Services; other organizations including Across Boundaries Ethnoracial Mental Health Association, GPI Atlantic, CASSA, Black Health Alliance, the Racism, Violence and Health Project, Canadian Race Relations Foundation, Mental Health Commission, other Government and Senate Committees reports and documents requested from participants in the "building capacity for equity" project.

Additional search on Google using specific terms intersectionality, anti-racism/anti-oppression etc., in English and French

Input was sought on the draft of the literature review from the Planning Group, the HEC Research Committee and the project Advisory Committee to ensure the usefulness to the project objectives.

Although the literature review was conducted in English, a list of French language references was also compiled. Some of the French language resources that did not have an English translation were read and included in the analysis. A Francophone consultant to the project provided literature, summaries and analysis. Other Francophone members of the Advisory Group, staff at Health Nexus, and community researchers at Steps to Equity gave input on Francophone perspectives and resources.

For examples and other sources for conducting a literature review on anti-racism see also: <http://www.crr.ca/content/view/249/538/lang.english/>

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