LESSONS LEARNED

in advancing healthcare for African, Caribbean, and Black (ACB) communities in Ontario during the COVID-19 pandemic:

a Canadian Institutes of Health Research-funded study conducted in Ottawa and the Greater Toronto Area.

Collaborative Critical Research for Equity and Transformation in Health
CO-CREATH
Recherche Collaborative Critique Pour L'équité Et La Transformation En Santé

CIHR IRSC

Lessons learned in advancing healthcare for African, Caribbean, and Black (ACB) communities in Ontario during the COVID-19 pandemic: a Canadian Institutes of Health Research-funded study conducted in Ottawa and the Greater Toronto Area.

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FOREWORD

Visible minorities in Canada share a disproportionately higher risk of getting communicable diseases, and the consequent socioeconomic impoverishment poses great challenges for their upward mobility.

Arguably, they are also more vulnerable to COVID-19 infection, owing to widespread risk factors such as inferior socioeconomic standing, substandard housing, underlying health conditions, and higher engagement in frontline services including retail, nursing homes, community care facilities and hospitals.

Minority populations are also the least likely to be able to afford preventive equipment, and to access and seek care owing to experiences of racism and stigma in healthcare settings.

Ensuring equitable access to healthcare is a key element for fostering diversity and promoting ethno-cultural citizenship that can not only help tackle this novel pandemic, but also develop better resilience and healthcare capacity during the post-pandemic era.

However, there is no data regarding the factors contributing to higher vulnerability of COVID-19 infection among the visible minorities, and what challenges the healthcare providers are encountering in serving these groups during the pandemic.

To this effect, this proposed project aimed to bridge the knowledge gap and provide data-driven evidence for effective policy interventions.

The underlying goal was to inform clinical practice and public health management to ensure adequate preparedness for pandemic situations and provision of equitable care for marginalized populations.

I hope you enjoy this insightful read.

Josephine Etowa

Principal Investigator

EXECUTIVE SUMMARY

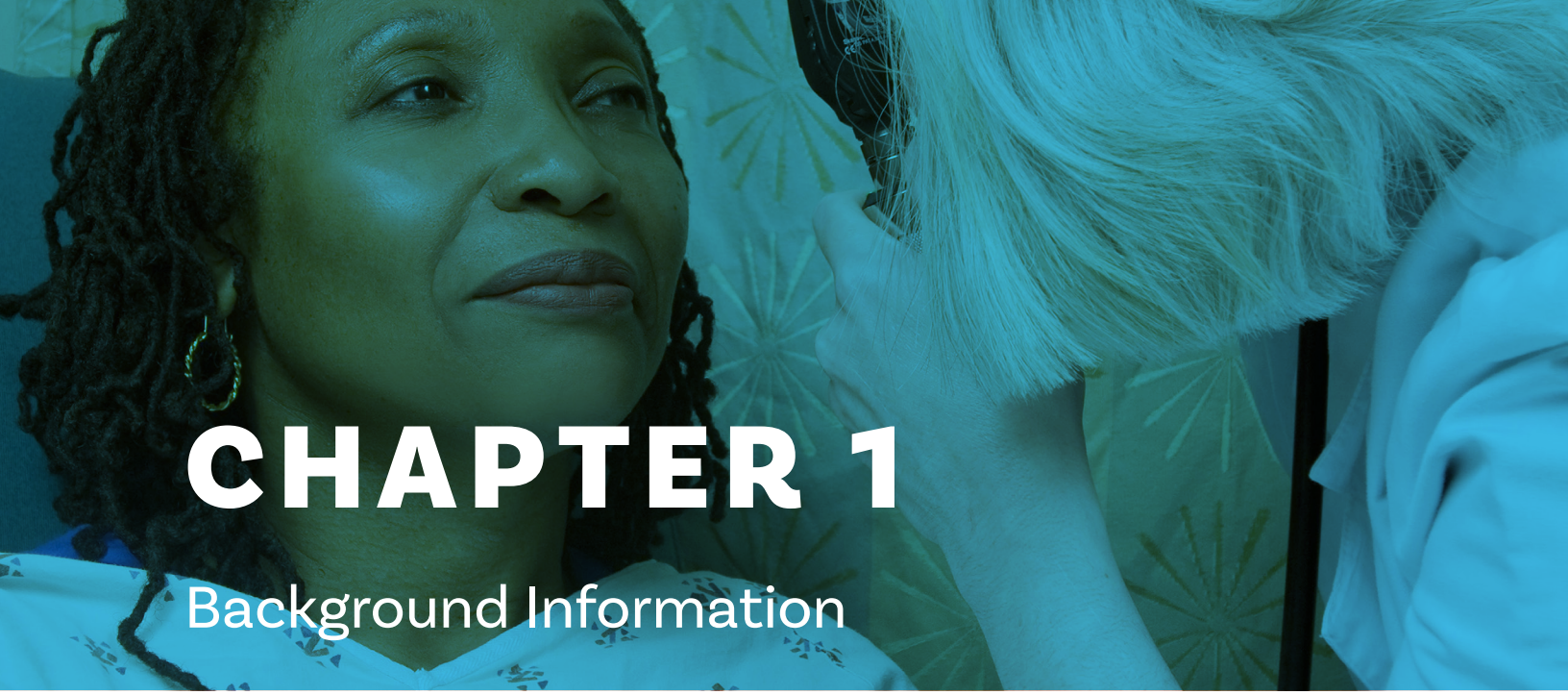
Racialized communities across Canada commonly experience disparities in health and healthcare. In the context of the COVID-19 pandemic, minority and racialized individuals, including members of African, Caribbean, and Black (ACB) communities, have reported less pandemic preparedness and added barriers to healthcare access.

The COVID-19 ACB Providers Project engaged ACB communities, healthcare providers (HCP) and policy makers (PM) over the past year to examine the challenges experienced by ACB communities and subsequently identify strategies to build providers' capacity to address their COVID-19 related-health outcomes. The CO-CREATH lab at the University of Ottawa collaborated with the HIFI lab at St Michael's Hospital, Toronto, and several community partners including the Canadians of African Descent Health Organization (CADHO), Women's Health in Women's Hands (WHIWH), AIDS Committee of Ottawa, Somerset West Community Health Centre (SWCHC). This project used community based participatory research informed by the socio-ecological model and a mixed methods research protocol comprising of three components: 1) a systematic review of existing research, 2) qualitative interviews of ACB people, health care providers and policy makers, and 3) a cross sectional survey of healthcare providers to assess COVID-19 knowledge and practices, providers' preparedness, critical cultural competence, discrimination and ACB people's access to COVID-19 related services.

Most ACB participants described having some preparation for the COVID-19 pandemic. However, some identified challenges with accessing personal protective equipment (PPE) initially in the pandemic. While many COVID-19 protocols were adhered to, the pandemic public health guideline described as most challenging was the social / physical distancing from family and community members. ACB community members faced barriers to pandemic preparedness which stemmed from their racialization as Black people, such as lacking access to personal protective equipment or pandemic safety information. This was evidenced by a lack of adequate accommodations and support which failed to address or recognize the inequitable impacts of the social determinants of health on ACB communities. When vaccination was discussed as a means to possibility to lower the impact of COVID-19 on one's health, some ACB community members expressed mistrust and worry about the effects of the vaccine on their family members. Some erroneously believed that they should only be administered to individuals experiencing illness. HCP

participants acknowledged that they were not prepared for the current pandemic. However, they did actively engage in several pandemic preparedness protocols and identified several essential guidelines dealing with COVID-19.

Anti-Black racism training was identified as a need by ACB community members, and few healthcare providers indicated that they work in settings that have explicitly mandated anti-Black racism practices in their organization. Workplaces often did not provide outreach to increase awareness of COVID-19 to ACB communities. Minimal policies or programs for ACB peoples were identified amongst HCPs. The ACB community requested for HCPs to understand the realities of ACB communities. This was also identified as a way to build empathy. Community collaborations can also improve access, including ways to understand and medically treat ACB communities. HCPs said they are interested in and willing to learn about ACB communities.



CHAPTER 1

Background Information

Members of minority and racialized communities across Canada commonly experience disparities in health and healthcare. In the context of the COVID-19 pandemic, minority and racialized individuals, including members of African, Caribbean, and Black (ACB) communities, have reported less pandemic preparedness and added barriers to healthcare access. ACB communities are disproportionately more vulnerable than White persons to experience adverse outcomes from COVID-19, including infection, hospitalization, and death[1]. This means that the impact of COVID-19 is felt even greater amongst ACB communities due to existing disparities in healthcare and social systems stemming from historic structural, institutional, and individual racism, as well as the intersecting influence of the social determinants of health. This study sought to address the disproportionately negative consequences of COVID-19 on ACB communities and improve local and global responses to the COVID-19 pandemic related health inequities.

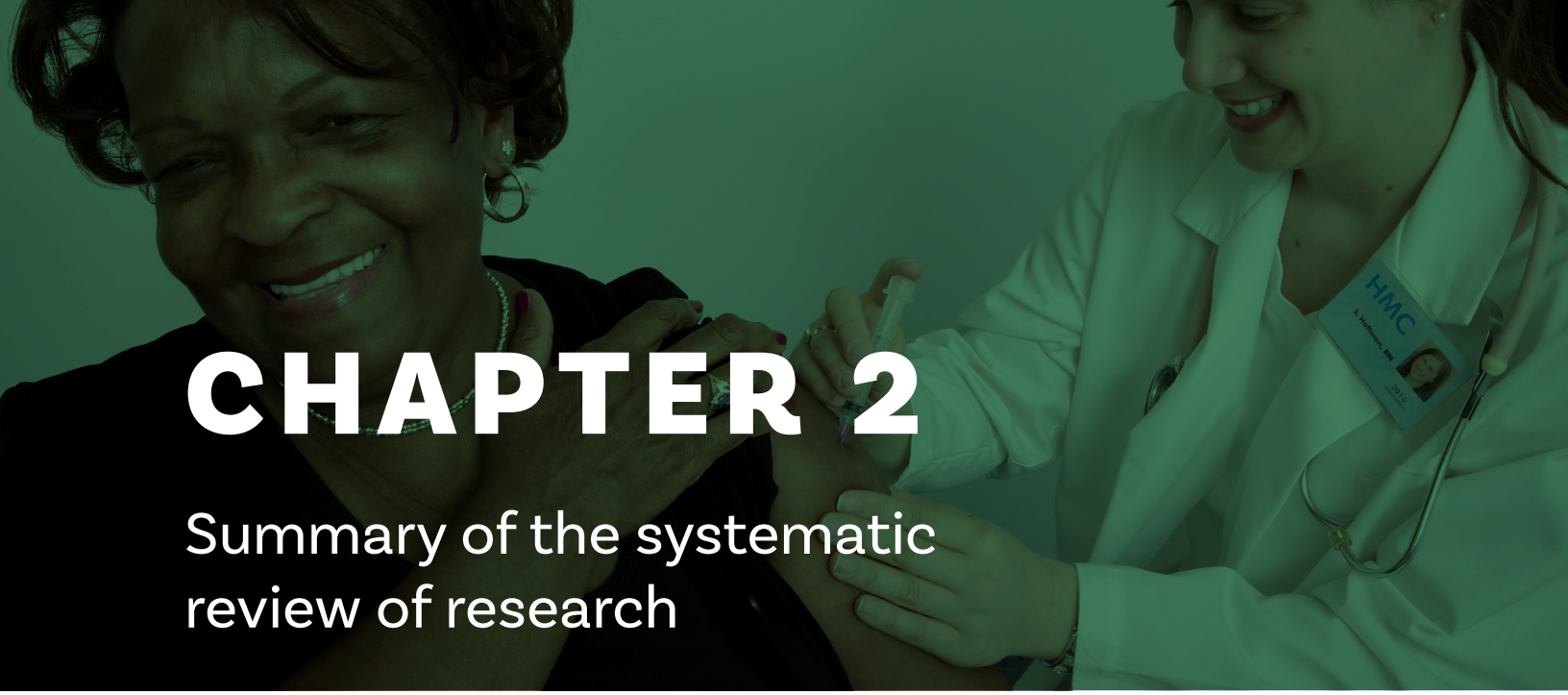
Three methods were employed by this study:

First, we performed a systematic review of existing literature in which 49 scientific articles were extracted for analysis. Four principal themes emerged from the review and are expanded upon: Vulnerability of ACB communities, Racism and racial discrimination, Knowledge, attitudes and practices, and Resilience and spirituality.

Second, we gathered and analyzed qualitative data from interviews with 27 members of the ACB community, and eight policymakers, derived from the principles of participatory-based research. The participants, who were from the Greater Toronto Area (GTA) and Ottawa, were asked a series of questions about their experiences of the COVID-19 pandemic as members of the ACB community. Their responses were divided into five themes: Knowledge, awareness, and vulnerability regarding COVID-19, Race, health, and COVID-19, Healthcare and cultural competence during COVID-19, Healthcare providers' interpersonal communication skills, and Current and post-COVID-19 pandemic preparedness.

Thirdly, we gathered and analyzed quantitative data by administering a survey to 514 healthcare providers from public health and community health facilities, hospitals, mental health agencies, and long-term care and home care facilities the GTA and in Ottawa. Participants were engaged on topics pertaining to their knowledge of COVID-19 and access to care, their cultural competence and comfortability treating patients from ACB communities, their experience of discrimination and racism in the workplace, as well as the pandemic preparedness exhibited by their city and place of work.

In the chapters that follow, we summarize the systematic review of literature (chapter 2), the data gathered from the qualitative interviews (chapter 3) and the quantitative data gathered from the GTA-Ottawa survey (chapter 4). In chapter 5, we analyze the complementarity of our methodology. In chapter 6, we provide an overview of the many lessons learned throughout this research project. Chapter 7 lists some best practices to work with ACB communities, and finally, chapter 8 concludes the document.



CHAPTER 2

Summary of the systematic review of research

PURPOSE AND DESIGN

In the previous chapter, we outlined the main objective of this study: We wanted to examine the negative impacts of COVID-19 on the African, Caribbean, and Black (ACB) communities in Ontario, Canada. To help us determine those impacts, we had to perform a systematic review (SR) of existing literature on COVID-19 impacts on ACB communities. The SR captured studies on this subject published between December 2019 and October 2020. This allowed us to identify the knowledge gaps related to the impact of COVID-19 on ACB communities by researchers, narrowing down several key themes that would be echoed in the Ontarian ACB communities' experience of COVID-19.

More specifically, the SR's sought to explore the association between the social determinants of health (SDH) and negative COVID-19 health outcomes in ACB populations in high-income countries (UK, US, Australia). We were able to apply the results of the SR and infer similar conclusions for ACB communities in Ontario because Canada is demographically and economically similar to the United Kingdom, the United States and Australia. When the SR was performed, no Canadian studies were found. Canadian studies also often lack access to disaggregated race-based data on which to draw conclusions, either because this data is rarely collected, or not made public. Moreover, despite Canada being a wealthy country that can offer healthcare to all, the specific needs of ACB community members and those of other people of color tend to be forgotten or ignored, indicating significant disparities in healthcare overall. To help determine the reasons for these disparities, Canadian studies look at other high-income countries to learn more about existing health disparities and the lessons those countries have learned that could be applied domestically.

The main purpose of this component of the research project was to investigate the effects of the SDH on the ACB communities' risk of negative COVID-19 health outcomes, including on the incidence of COVID-19 infection, severity of disease, hospitalization, mortality, and barriers to the treatment and management of COVID-19 for Black people in Canada.

For the SR, our research question was:

What are the social determinants of the disproportionately higher rates of COVID-19 infection among the African, Caribbean, and Black (ACB) population?

The initial literature scan identified 2643 potential articles on the topic of COVID-19 impacts on ACB communities. After several rounds of parsing through the articles, applying the inclusion and exclusion criteria, we ended up with 49 articles that were used for the SR.

SYSTEMATIC REVIEW FINDINGS

Four major themes became apparent during the SR. They were: Vulnerability of ACB communities, Racism and racial discrimination, Knowledge, attitudes and practices, and Resilience and spirituality.

Each major theme had sub-themes that we will summarize further.

2.1. Systematic Review Theme 1: Vulnerability of African, Caribbean, and Black communities

The historical and ongoing systemic racism experienced by racialized communities like ACB communities result in critical racial and health disparities for Black community members. These in turn were the source of several compounding factors that increased the vulnerability of Black community members to negative COVID-19 outcomes.

The SR revealed that ACB communities faced higher rates of infection from COVID-19 and suffered disproportionately higher rates of hospitalization and mortality (death) from COVID-19[2-13].

Three sub-themes emerged from the SR which increased ACB community members' vulnerability to negative COVID-19 outcomes: higher rates of comorbidities and chronic illnesses; environment and living conditions; and low socio-economic status and employment conditions.

2.1.1. Higher rates of comorbidities and chronic illnesses

When trying to understand why mortality was higher amongst Black community members, researchers looked at two factors: higher levels of comorbidities ("additional" diseases that people live with) and higher levels of chronic illness.

The relationship between higher levels of comorbidities in ACB communities and mortality (death) from COVID-19 could not be determined, since the results were often inconclusive and conflicting in some of the articles analyzed.

However, higher levels of comorbidities and chronic illnesses was associated with higher rates of admission to the hospital and to the intensive care unit due to COVID-19 illness[7-9,11,14,20].

Several comorbidities and chronic illnesses increased ACB community members' vulnerability to COVID-19, including but not limited to: hypertension and cardiovascular or cardiometabolic disease, diabetes mellitus, kidney disease, obesity, living with HIV and / or living with a disability[15,17,21-23]. Other factors such as being an older adult or middle aged and being male increased ACB persons' vulnerability to negative COVID-19 outcomes[3,8,10-13,14,17,24,25].

2.1.2. Environment and living conditions

Various articles in the SR concluded that the environment in which ACB communities live increased their vulnerability to negative COVID-19 outcomes, since their living environments were found to contribute to or were the result of racial inequities[2-4,10,13,16,20,22,24-28].

Areas with higher ACB population density - such as urban areas - correlated with higher case rates of COVID-19 infection, hospitalization, and death[4,8,12,13,21,30,31].

On higher mortality rates in particular, factors that increased this outcome amongst urban ACB communities were if they lived in or were faced with:

- Urban areas with large populations
- Neighborhoods with low air quality
- High density neighborhoods
- High density housing
- Large households or multi-family dwellings
- Neighborhoods with high COVID-19 case counts
- Neighborhoods with high concentration of dependent youth
- Neighborhoods with high concentration of older adults above 65 years of age
- Seniors' residences and communities
- Congregate care settings (like communal HIV care homes)
- Housing and transportation insecurity
- Lower levels of health literacy

The same factors were found to contribute to COVID-19 vulnerability in non-urban, rural areas with larger populations of ACB persons, who were even more impacted by COVID-19[4,8,12,13,21,30,31].

2.1.3. Low socio-economic status and working conditions

This sub-theme, identified by the SR, was that being of low socio-economic status and certain working conditions increased the vulnerability of ACB communities to negative COVID-19 outcomes[32,33].

Experiencing financial insecurity[24], being unemployed[26], and not speaking English[30] were some of the independent factors that were found to increase COVID-19 vulnerability. These factors often are indicators of low socio-economic status due to the limited upwards social mobility that these factors can allow[12,21].

The specific type of occupation was also found to be a risk factor that increased vulnerability to the impact of COVID-19[30].

Essential industries and occupations that predominantly employed ACB workers were:

- Healthcare support
- Food preparation and serving
- Moving and transportation
- Personal care
- Construction
- Cleaning and maintenance

Additionally, and interestingly, those that worked in farming also had increased risks of contracting and dying from COVID-19[34]. In line with the sub-theme previously mentioned, an ACB person would be more at risk of dying from COVID-19 if they lived in an urban counties with a high concentration or percentage of farm workers[34].

Other factors such as occupational segregation and inequalities in decent work were found to increase vulnerability to COVID-19 infection[32].

Furthermore, ACB persons were more likely to be employed as essential workers[25]. This is especially true in low-income households[28]. Essential work is often performed in high-risk industries that involve working in close proximity with other people and in work environments with increased risks to exposure, like those mentioned above[32].

Finally, ACB essential workers who lived in high-density housing were sometimes unable to physically distance themselves from others, which increased vulnerability to themselves and those they lived with to negative COVID-19 outcomes[28].

2.1.4. Conclusion

The findings for this theme of the SR not only emphasize the disproportionate vulnerabilities within ACB populations in terms of morbidity and mortality, living in poor neighborhoods with limited resources, but they also demonstrate discriminations within the healthcare system that we will explore in the next theme.

2.2. Systematic Review Theme 2: Racism and Racial Discrimination

The second theme revealed by the SR was one of racism and racial discrimination. We will elaborate on three sub-themes: *systemic racism*, *institutional racism*, and *interpersonal racism*.

2.2.1. Systemic racism

The SR has found that the greatest impact of COVID-19 has been felt by those already affected by health and socioeconomic disparities[12,21]. These disparities have been caused, in part, by existing structural inequities which reflect the embedded bias that are perpetuated through the policies and practices of governance and healthcare systems[28,35].

Studies showed that the embedded biases and structural inequities that are ingrained in systemic racism caused additional, undue burden to ACB communities[21]. This undue burden was found to be particularly high in families with dependent children, for pregnant ACB women, and ACB migrants[24,36]. ACB pregnant women were more likely to have their employment negatively impacted, to have more concerns about a lasting economic burden, and to have worries about their prenatal care, birth experience, and postnatal needs[27]. Migrants, in particular, were more susceptible to job loss, were less likely to have reduced work hours and were more likely to have difficulty paying bills[36].

In addition, the COVID-19 pandemic exacerbated pre-existing health related disparities, including those associated with living with disabilities and managing illnesses[22]. For example, those with asthma were found to be more likely to lose their healthcare insurance and physicians were reported as finding ACB individuals more challenging to care for[26].

Finally, many studies flagged that there was a lack of collection of race-based data[35]. There remains a need for the collection and public availability of disaggregated race/ethnic based data, to show disparities in COVID-19 outcomes within ACB communities[4]. Policies mandating the breakdown of racial/ethnic data are needed to ensure equitable, evidenced- based recovery efforts from COVID-19, as well as to identify areas with high case burden in order to appropriately allocate resources[28,37].

The method of collection of ethnic / race-based data varies by location or is non-existent[4]. Ethnicity data was either not made publicly available, was not collected, was limited or incomplete, and not being recorded on death certificates (in England)[6,16,19,20,28]. This is a symptom of ongoing systemic racism that affects ACB communities and people of color, since the specific needs of these communities are ignored or not acted upon due to lack of actionable data[21,28]. This is why race-based data is important to collect, and, upon their collection, it is critical to design targeted interventions that are made by and for these communities.

2.2.2. Institutional racism

Racist policies deter ACB persons from seeking medical care[38,39]. Biases and medical mistreatment in healthcare institutions, especially during a pandemic, had devastating consequences on those already carrying a greater disease burden[38]. Distrust of medical institutions and avoidance of them were high in ACB communities[40], and ACB women were less likely to participate in research studies on pregnancy and COVID-19[27], which is concerning given the increased vulnerability of ACB communities to negative COVID-19 outcomes.

Some studies brought the institutional racism of healthcare access to light, showing disparities in COVID-19 testing, treatments, and outcomes, as well as a lack of primary care physicians, a lack of affordable medications, and a loss of health insurance[21,26].

Moreover, institutional inequities resulted in additional challenges created by telemedicine or virtual care for ACB persons, since those were technologically dependent[41]. Telehealth access by ACB persons was shown to increase during COVID-19, mostly by women and youths, but remained at a lower rate of access compared to White persons[41]. In addition, disparities in healthcare access showed differences in the rate of diagnosis for suspected COVID-19 in telehealth, which had a higher rate of suspected COVID-19 compared to in-person visits for ACB persons[41].

The findings suggest there is a need for digital health equity and mitigating institutional racial disparities further than healthcare access alone.

2.2.3. Interpersonal racism

The SR revealed that the lack of support for racialized individuals indirectly led to their increased exposure to harms (of all sorts), especially when it was institutionally rooted.

Some of the factors that may have led to distrust of medical institutions were principally stemming from the racial injustices and oppression faced by ACB communities[38]. Racial injustices create a sense of oppression, which in turns spilled over into distrust of physicians and the medical system[38]. Studies from the SR showed that this sense of oppression was caused by increased police aggression leading to fatal injuries; financial strain; ignorance of health symptoms; and increased stress[12]. Additionally, these elements of distrust were mirrored in the prison system, where ACB persons had higher incarceration rates, and in parallel, COVID-19 rates were higher in incarcerated ACB persons[42].

Finally, ACB persons reported higher feelings of isolation[43]. People living with HIV, for example, reported that they felt lonely and like they had no one to turn to during the pandemic. This is significant because ACB communities have disproportionately higher rates of HIV[43]. These persons saw interruptions to their medical treatments, virtual appointments were challenging, and navigating the system along with deciphering what to do when faced conflicting information was burdensome[43].

2.3. Systematic review Theme 3: Knowledge, Attitudes, and Practice

The third theme that emerged from the SR was that of the different knowledge, attitudes and practices of healthcare providers towards ACB communities, or even the knowledge, attitudes and practices of ACB community members themselves. Two sub-themes were apparent: the Knowledge gaps and the importance of health literacy.

2.3.1. Gaps in knowledge and health literacy

Knowledge gaps in appropriate COVID-19 prevention and control methods may have exacerbated existing racial and ethnic disparities according to some studies[44]. For example, low health literacy was associated with a perception of lower infection susceptibility[45].

Surveys issued by these studies indicated being an ABC male was a risk factor for COVID-19 infection and negative outcomes[47]. ACB males were the most likely to report having had a COVID-19 infection, most likely to know someone who tested positive for COVID-19 and were most likely to be less knowledgeable on the spread of COVID-19[44,46]. Knowledge gaps were also found regarding COVID-19 symptoms and prevention practices like physical distancing[47].

ACB persons were also less likely to be able to correctly estimate or answer COVID-19 related questions correctly than Asian and White persons[47].

2.3.2. Previous health education increased health literacy around COVID-19

Interestingly, high levels of health literacy were shown in ACB persons living with HIV, who had a lot of knowledge pertaining to the prevention and transmission of COVID-19[47].

Despite reports of confusion over conflicting and emerging information, multiple credible sources were used by these persons to become more informed; potentially indicating that their health literacy may have been improved through previous engagements with healthcare intervention programs that aided in the identification, evaluation and use of online health sources[47].

Furthermore, the level of education attainment was also found to influence susceptibility to COVID-19, as rates were 60% higher in those with a high school degree versus a college degree[24].

2.4. Systematic review Theme 4: Resilience and Spirituality

The final theme that emerged from the SR was that of Resilience and Spirituality.

ACB communities' cultures and local support were a small but important theme revealed by the SR. Researchers identified the role of the church within the ACB community during the COVID-19 pandemic: churches have historically served as a space for ACB communities to build both individual and community capacity to recover from life difficulties and crises[48].

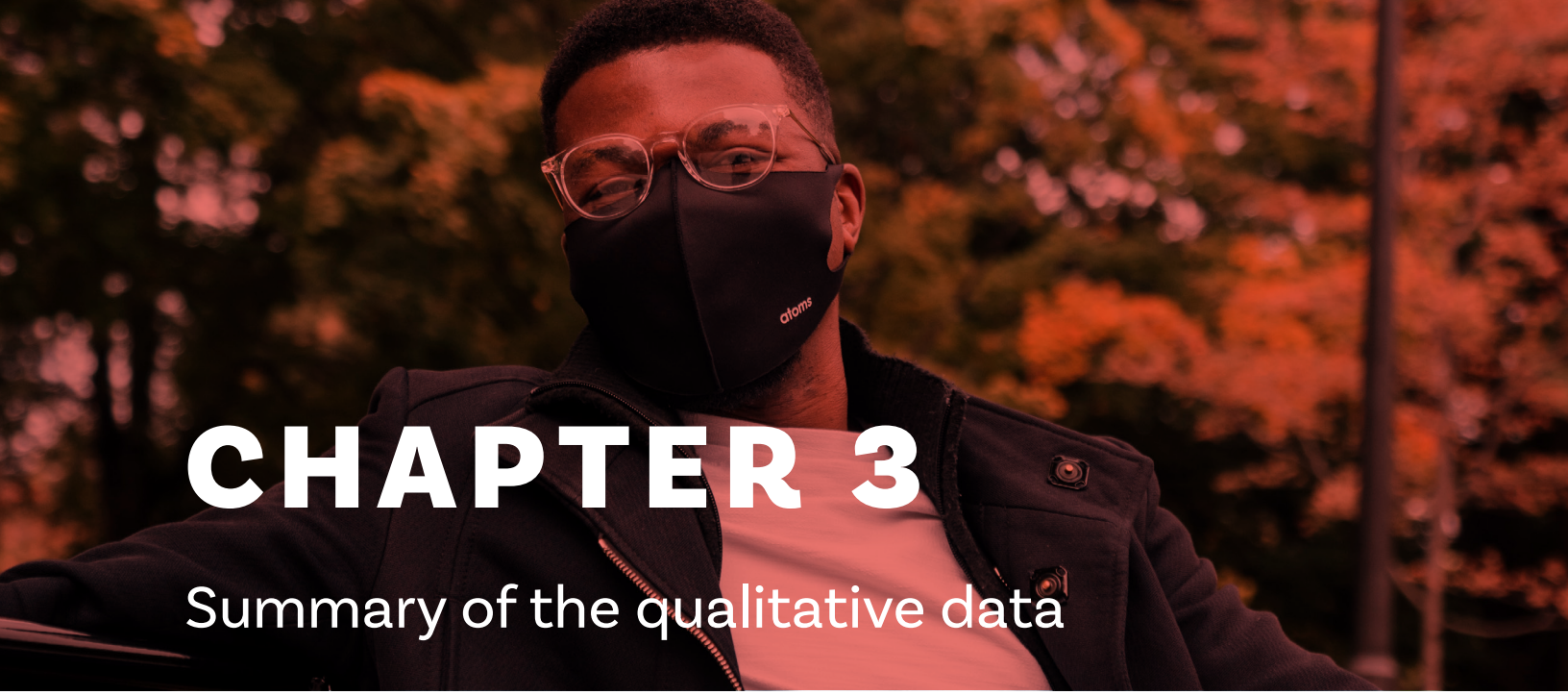
Churches were often a source of resilience since they viewed the COVID-19 pandemic through historical lenses and provided compassion and understanding to ACB churchgoers[48]. They understood that abiding by public health restrictions was difficult because adherence to them would incite traumatic historical anxieties resulting from medical institutions which they could distrust[48]. Churches were more trusted than public health authorities to receive health information[48].

Researchers also found that ACB communities faced ritual disruptions, public negative reactions to individuals and churches that did not adhere to public health guidelines, trauma, cultural disruptions, and distrust[48]. The pandemic restrictions, which kept ACB persons away from communal spaces like the church, became a source of anxiety, since culturally specific resilience and coping mechanisms hosted by churches were compromised[48]. There were also concerns of spiritual loss and disintegration of congregations, as ACB churches faced the loss of in-person rituals, further contributing to anxiety[48].

What can we learn from this?

- The findings from analyzing all four major themes stemming from the SR were that:
- ACB populations continue to experience anti-Black racism, poverty, and stigmas that contribute to reduced overall health.
- The Social Determinants of Health (SDH) are interconnected and influence the overall health and wellbeing of ACB communities. Changes to them caused by the social, community and societal disruptions from the COVID-19 pandemic resulted in ACB communities having disproportionately higher vulnerability to COVID-19, including higher testing, infection, hospitalization, and mortality rates.
- The (then) current public health messaging may not have been effectively reaching vulnerable communities. There was a need to create effective messaging to identify trusted sources of information related to COVID-19, to address conflicting information, and correct misinformation.
- Increasing knowledge of COVID-19 and its impacts may have translated into higher adoption of COVID-19 prevention behaviors. These findings indicate a need for targeted culturally responsive public health messaging.
- Responses to COVID-19 needed to include culturally sensitive and culturally specific health promotion and disease prevention messaging as well as respond to trauma at the individual and community level.

- There is a profound need to address the social inequities faced by ACB people, including addressing the impact of COVID-19 on social isolation, access to healthcare, as well as the economic impact.
- Interventions should create new policies and programs to build health equity for COVID-19 focused on protecting vulnerable populations. These interventions should combat racism, as well as promote health and disease prevention in a way that prioritizes groups most vulnerable to infection, while addressing the structural inequities that contribute to the risks identified in this SR.
- Interventions should consider racial/ethnic and income disparities when creating policies and restrictions such as physical distancing and needing to wear personal protective equipment (like a mask). Providing adequate protective equipment to essential workers may help reduce disparities and occupational risks.
- Resources should be targeted to improve care for high-risk patients and to examine racial associations with COVID-19 to prioritize vaccine deliveries and reduce disparities.
- Further investigations should also be made into the disproportionate impact of COVID-19 on persons with disabilities, prevention strategies to target urban areas with high poverty rates, and to target healthcare resources to areas with both known testing rates and high positivity rates.



CHAPTER 3

Summary of the qualitative data

The data presented in this report is taken from interviews with 27 members of the ACB community, as well as 8 policy makers. In the group of ACB community members, most were between 25 and 49 years of age, and of roughly equal gender division. Most respondents were born outside of Canada—most (n=15) had been in Canada for less than five years, with 5 participants indicating that they had been in the country for less than a year.

In the group of 8 policy makers, most respondents were women (n=6), and the majority were Black African or Black Caribbean (n=7). This was a highly educated group, with most respondents holding a Masters' degree (n=5).

These interview participants were asked a series of questions pertaining to their experiences as members of the ACB community during the COVID-19 pandemic. Following our analysis, their responses can be divided into five themes:

- Knowledge, awareness, and vulnerability regarding COVID-19.
- Race, health, and COVID-19.
- Healthcare and cultural competence during COVID-19.
- Healthcare providers' interpersonal communication skills; and
- Current and post-COVID-19 pandemic preparedness.

Respondents' experiences of anti-Black racism in healthcare and in day-to-day life is also an overarching theme throughout the interviews.

Theme 1: Knowledge, awareness, and vulnerability regarding COVID-19

In discussing their knowledge of COVID-19, ACB community members were generally well-informed about how COVID-19 is transmitted, and how to prevent transmission. Respondents

highlighted the fact that ACB community members experience important barriers in accessing healthcare services compared to non-ACB community members. These barriers are similar to those experienced by other underrepresented groups, such as indigenous persons and recent immigrants.

> "COVID-19, the information I have, (…) it's airborne. It spreads through when someone is coughing or sneezing or anything. It's easy to spread. And if someone was in contact with someone, who has it, he can pass it to someone without even having it, or any symptoms."

> "Wash your hands frequently, for 20 seconds, and it's recommended you avoid touching your face, (…) and you should stay at home when you are sick or when you have been exposed [to] COVID-19."

For several participants, the information they received about COVID-19 from news media sources appeared unreliable and confusing.

> Some were not sure how to assess the veracity of competing claims about COVID-19; and many mentioned having to compare several sources of information.

Barriers to healthcare faced by members of the ACB community

Respondents reported that a lack of trust in the healthcare system was a significant barrier to getting healthcare, because it leads to not seeking help when it's necessary, such as during a healthcare emergency.

> "I think we are less inclined to go to the doctor when something comes up. We are more inclined to try and self-medicate. Try to do it ourselves first. Even me personally, I really don't want to go to the doctor. I don't know why."

Risk of contracting COVID-19 and risk perception

Respondents had varied levels of understanding regarding the risks related to contracting COVID-19. Some felt at a higher risk because of prior or ongoing health issues; while others were confident that they would be able to prevent themselves from getting COVID-19 because they knew about and followed public health advice.

> "I'm in that vulnerable group. (…) I caught pneumonia in 2016, so that adds to my vulnerability in terms of asthma, which my doctor said that I had. (…) I also do not have a doctor. And that's a challenge for me with COVID."

Many participants also highlighted the measures they were taking to avoid catching COVID-19.

> "I have to make sure that I have a proper mask, sanitize my hands and then stay [away], (…) not being close to people."

Some participants highlighted the importance of social gatherings to members of the ACB community, such as church services, while being mindful of the risk of spreading COVID-19 during these gatherings.

Respondents believed that members of the ACB community may be more prone to catching COVID-19 due to genetic traits, rather than as a result of increased risk factors such as working in person in essential sectors or crowded housing. The latter is true while the former is false.

> "It has been shown in research that Black people are more susceptible to catching COVID-19 than (White people)."

ACB community members had different levels of perception of their cumulative risk of contracting COVID-19. Some expressed the belief that members of the ACB community have similar levels of risk of contracting COVID-19 to the general population.

> "I don't think being from the ACB community really puts you at a higher risk or makes you get COVID-19 or exposes you to COVID-19 more. (…) I don't think COVID-19 really targets you with regards to where you come from. I would still maintain that the risk and impact of COVID-19 is the same, regardless."

Alternatively, some ACB respondents highlighted the existence of risk factors that put members of their community at a greater risk than the general population, including the precarious economic condition of many members of the ACB community, the over-representation of ACB community members in health-care and other front-line work, and factors related to living conditions such as high-density housing, discrimination in access to housing, and crowded living conditions resulting in difficulties in self-isolation:

> "I'd say due to the fact that a lot of Black Caribbeans are working class, that puts a lot of us at higher risk—(people) that work in service jobs, that work in warehouses, rubbing shoulders with other people. So yeah, I'd say they're higher risk for sure."

> « Les gens qui […] ont un bon travail, des bons salaires, une grande maison, ils n'ont pas de problèmes de COVID. La plupart sont des gens qui ont de faibles revenus et qui doivent se battre à chaque jour pour mettre quelque chose sur la table, ce sont ces gens qui sont à risque de contracter le COVID.» (Translation: "People who have good jobs, good salaries, a large house—they don't have problems with COVID. Most people who are not well paid and who have to fight every day to

> put something on the table, those are the people who are at risk of contracting COVID.")

> « Nous sommes une communauté qui est issue des grosses familles (…) Les logements sont petits et la liste d'attente est vraiment large : des années! Et après ça, (il y a) la discrimination raciale qui est très très très ancrée dans le système » (Translation: "We are a community made up of large families (…) Housing is cramped and the wait lists are long: sometimes years! And racial discrimination is very very very prevalent in the system.")

Finally, newcomer status was mentioned as a factor impacting ACB community members' health, due little knowledge of their rights or how to advocate for themselves, having insufficient access to information and services, and lacking trust in government services.

Respondents were well aware of key pandemic control measures around reducing transmission of COVID, such as physical distancing, handwashing, mask wearing, reducing in-person contacts, and being aware of the possibility of asymptomatic transmission.

> "You want to prevent the spread of the virus from the person wearing the mask to others. So, wearing the mask alone, it doesn't protect anyone from COVID-19: it has to be combined with physical distancing and (…) hand hygiene. Right? So, it's not about social distancing alone, but we have to encourage people to wear the mask and then washing hands and then staying at home."

Theme 2: Race, health, and COVID-19

Respondents described varied experiences of dealing with racism and discrimination in the healthcare system, both with regards to personal experiences and recounting the experiences of others. For many, the pandemic further uncovered inequalities caused by racism and raised concerns about unequal treatment of members of the ACB community in healthcare settings.

Roughly half of respondents reported that they had not personally encountered racism or prejudice in healthcare; others reported that they chose not to reflect on past racist encounters. Another prevalent theme throughout the interviews was an awareness of racist encounters despite many respondents not having experienced it firsthand.

> "Just because it does not happen to me, does not mean it doesn't happen, right."

Nine respondents explicitly described experiences of racism. These experiences ranged from feelings of powerlessness within the healthcare system, receiving insufficient information, being stereotyped and dismissed, and having their description of symptoms doubted.

Respondents also highlighted the pervasiveness of systemic racism.

> "Yeah, even in the health sector. Even in some of the industries, you know. You find it everywhere that, at any point in time one of the people that might be fired might be a Black person, you know. And then you work your ass off just to meet up with the demands and then any little mistake (…). So I think systemic racism is very much there. There's no two ways about that."

Respondents also highlighted experiences of racism specific to the COVID-19 pandemic. These experiences ranged from being avoided or feared, labeled as a virus spreader, and being subject to discrimination more, or in more subtle ways, than before the pandemic. Some respondents noted the pandemic was an excuse to discriminate more openly against members of the ACB community, both in healthcare settings and in daily life.

Respondents also commented on experiences of anti-Black racism combined with other factors, such as immigrant status or language barriers.

> "I am familiar with, not necessarily ACB populations but racialized populations, with respect to health outcomes, other than COVID, because some of these health outcomes are interrelated with material deprivation or socio-economic advantage or disadvantage … they are disproportionately affected by some of these health outcomes."

Theme 3: Healthcare and cultural competence during COVID-19

While some participants reported not using any healthcare services during or before the pandemic, many others mentioned their use of varied healthcare services, such as routine immunizations, diagnostic testing (including tests required for immigration and visa purposes), emergency care, care for chronic conditions that preceded the pandemic, pharmacy consultations, dental care, and non-urgent care from general practitioners. Several participants had been tested for COVID-19, but none had received a positive diagnosis. Further, none had received specific treatment for COVID-19. Several had experienced possible COVID-19 symptoms and chose not to get tested and instead chose to manage the symptoms at home.

> "I haven't had any symptoms that I'm aware of and no, I haven't been tested. And no, I haven't been hospitalized. I have had a cough, that's why I'm hoping that I can find a doctor soon. Because I had a cold in January, February and since then, a constant cough. So, I'm doing a whole lot of home remedies."

ACB community members expressed a mixture of satisfaction and dissatisfaction regarding their access or lack of access to healthcare services. Some examples of barriers to access are limited access to free healthcare services due to immigration or visa status, or lack of dental services available through the Ontario Health Insurance Plan (OHIP). During the pandemic, respondents mentioned longer wait-times due to reductions in some services, the need to make appointments at walk-in clinics, a greater number of people needing services, and more paperwork due to COVID-19 questionnaires and having to wear masks.

> "Yeah, the difficulty was that you can't get some care (…) because I remember at the beginning of COVID I was about to do my medical examination, I couldn't have that done. Because of COVID the clinics were closed, and you had to go in by appointment only, or (…) they were taking emergency cases only."

Some respondents expressed reluctance to go to a hospital, when necessary, for fear of contracting COVID-19 at the hospital and bringing it home.

Some respondents experienced racism in the healthcare system or knew of others who had been affected by racism in the healthcare system. They recognized that experiences of racism in healthcare settings would keep other ACB community members from using healthcare services when needed

> "If you know that you are not going to get good service, good treatment, then you are not going to go to the hospital."

Theme 4: Health care providers' interpersonal communication skills

Respondents put forward a detailed set of qualities and skills that make for a competent healthcare provider:

- Good listening skills; being willing to ask for additional information, and research further.
- Active listening; showing empathy and asking relevant assessment questions.
- Showing patients, they care.
- Adapting listening styles to different patients' communication styles.
- Working through language barriers.
- Reading non-verbal cues when assessing patients' well-being.

Some respondents highlighted special considerations for healthcare providers when treating members of the ACB community. Notably, respondents reported that practitioners' prejudices could result in unequal treatment, and that members of the ACB community's

recounting of symptoms could be discounted. In that regard, empathy and sensitivity were deemed particularly important.

> "I've heard stories, especially from women and especially from Black women about medical practitioners not taking seriously their complaints (…) people disregarding their concerns about pain and any sort of symptoms that they feel. And I think more empathy in that regard is important (…)"

Respondents also highlighted unacceptable practitioner behavior, such as being condescending, not respecting their patients' beliefs regarding health, and not taking patient concerns seriously.

In response to these concerns, respondents put forward detailed suggestions for training healthcare providers. Proposed training was divided between anti-racism training, interpersonal skills, and cultural competency training.

Suggestions for anti-racism training included highlighting the importance of diversity, racial sensitivity, and unlearning prejudice. One respondent highlighted the importance of long-lasting anti-racism training, as prejudices take time to unlearn.

> "I'm not sure that's something that someone that's well into their adult life can be trained [for]. It's not that easy. Like you're not going to create a class or a seminar or anything like that that last a few hours, you can't make a PowerPoint that's going to teach someone that"

Another respondent highlighted the need to evaluate healthcare providers' unconscious prejudices, especially since many practitioners may not believe that they are prejudiced in their work. Healthcare providers confirmed that many of them had never received or been offered any type of anti-racism training, which is a significant gap.

> "I think they need to implement racial sensitivity training because, from all the clinicals I've done, all the work in hospitals I've done, I have never once been offered racial sensitivity training, ever, from any organization."

Suggestions for cultural competency training included highlighting the importance of respecting differences and avoiding stereotyping. Respondents also suggested that healthcare providers should be explicitly trained on the social determinants of health and their effects on members of the ACB community, especially with regards to economic factors.

> "The type of training… it's about cultural sensitivity. It's about culture, cultural differences. It's about respecting human beings. It's just about seeing individuals not having (…) stereotypes."

Suggestions for interpersonal skills included highlighting the importance of empathy from healthcare providers, as well as respecting differences, better communication with people of different racial and ethnic backgrounds and avoiding judgment.

Many respondents also mentioned a preference for healthcare providers that are members of the ACB community, since members of the ACB community are more likely to trust and confide in healthcare providers that look like them. Respondents also highlighted the importance of having someone to whom young members of the ACB community could look up to.

> "We need more Black doctors who understand how things work with Black people and who listen and not just say okay, you're faking, or you just want drugs or oh, you just want this, and will actually listen to what Black people say and try to help them."

Barriers to accessing healthcare services

Many participants did not describe experiencing any barriers to healthcare services access, despite active probing by interviewers. However, other respondents identified language discordance with healthcare providers and office staff as a significant barrier to accessing healthcare.

> "Sometimes it can be difficult, (…) understanding the Canadian accent, usually for immigrants. (…) Even understanding the language, itself—because the ACB community, sometimes people come from countries where English is not their mother tongue."

Attitudes toward COVID-19 were also presented as another barrier to accessing healthcare services. On the one hand, some ACB community members may not take COVID-19 seriously, or fully understand its severity. On the other, fear of contracting COVID-19 in healthcare institutions, such as waiting rooms, proved to be an obstacle to accessing regular healthcare services.

> "The thing is that, just like I said, because of our orientation and value system, you know, some of us might not just take this stuff [services related to COVID-19] seriously."

Respondents also highlighted the lack of family doctors in Ontario, and lack of OHIP coverage in areas such as dental care, as significant obstacles to accessing non-COVID-related healthcare services.

To overcome these barriers, respondents provided several suggestions, such as:

- Providing interpretation and translation in healthcare settings.
- Having people in positions of power and of service provision who speak both English and French.

- Having people book COVID-19 testing appointments ahead of time rather than lining up, to reduce the possibility of transmission in the queue.
- Making more space for members of the ACB community to enter the medical field.

All participants described a range of services that would be appropriate or especially beneficial for ACB communities. Many comments focused on public health education and outreach, such as sharing information related to finding family doctors who speak languages other than English; finding services that are culturally relevant, and sharing information in a range of different ways, such as through videos, social media, and partner organizations.

Some comments also focused on alternative ways to deliver clinical care and other direct healthcare services, such as via mobile clinics, and in schools and neighborhoods where a need has been established.

Theme 5: Current and post-COVID-19 pandemic preparedness

Participants who were healthcare providers expressed concerns about their personal preparedness to dealing with the pandemic.

> "There are some situations that you are not just prepared for because you find yourself in that situation. But I have to (…) just find my way around it."

They also expressed that pandemic control protocols should have considered differing living conditions based on economic means and living situations.

> « Ce n'est pas tout le monde qui vit dans des situations sécuritaires. Ce n'est pas tous les enfants qui vivent dans une maison sécuritaire donc forcer l'isolement des gens, (…) forcer les gens dans des situations peut être abusives, des situations où est-ce que les enfants ne peuvent pas être éduqués, donc, ce n'est pas un environnement sécuritaire. (…) J'avais des inquiétudes au niveau de la santé mentale de mes clients, la sécurité de nourriture ainsi que la sécurité d'éducation. » (Translation: "Not everyone is living in safe situations. Not all children are in safe situations, so forcing people to isolate in situations that are potentially abusive, where children aren't necessarily receiving their education, that's not a safe environment. I had concerns about the mental health of my clients, their food insecurity and their education insecurity.")

Respondents who were healthcare providers reported feeling anxiety, confusion, and workplace stress due to COVID-19. Respondents from the ACB community reported several methods for dealing with COVID-19-related stress. Common themes were using their faith as a source of strength, reaching out to friends, and asking for support, trying to exercise and spending time outside, seeking time alone away from the rest of one's household, maintaining a positive

attitude, seeking professional help, and using anxiety related to COVID-19 as a way to stay motivated about sticking to public health guidelines.

Several respondents who were members of the ACB community described the impact the pandemic had on the community as a whole. Some thought that the pandemic's impact had been greater on the ACB community, at least to some extent, because of job losses and more difficult working conditions for members of the ACB community who are essential workers.

> "This pandemic has led to a dramatic loss of jobs, which has a big impact on everyone, especially Black people."

Analysis of qualitative data

The analysis of this qualitative data highlights a few key themes in the experience of members of ACB communities during the pandemic:

- The desire for increased anti-racism, cultural competency, and interpersonal skills for healthcare providers.
- The concern related to social determinants of health regarding members of the ACB community's experience of the pandemic.
- The concern for and experience of different and discriminatory treatment in healthcare settings.
- The barriers to accessing healthcare, which were present pre-pandemic but were exacerbated during the pandemic.

From a health equity standpoint, these themes highlight the importance of addressing the issues raised by the ACB community in terms of access to healthcare, experience of and quality of healthcare provided, and eliminating discrimination in healthcare. Given the higher incidence of COVID-19 within the ACB community, better education regarding the social determinants of health, such as housing and working conditions, is essential to bridging the gap in healthcare outcomes.

Lessons learned and identification of best practices

Best practices at the community level

Pulling from interviews with members of the ACB community, suggestions for best practices at the community level were mostly related to providing more accessible resources, addressing stigma and discrimination, and increasing training for healthcare providers.

In terms of providing accessible resources, respondents suggested increasing access to personal protective equipment (PPE), increasing COVID-19 testing levels, providing more information in multiple languages, increasing testing, healthcare, and vaccinations in existing mobile clinics.

Additionally, the recommendations captured a need to increase channels for the dissemination of information, ensuring that information is available in several different languages and shared using different types of media such as phone lines, written communication, and using video. Further suggestions included having healthcare providers who speak different languages available to those who don't speak English or French and having multilingual interpreters available, increasing information interactions between ACB community members/institutions and healthcare institutions, and increasing mobile clinic visits and home visits by healthcare providers.

Strategies for addressing stigma and discrimination were mostly related to actions that members of the ACB community could take to protect themselves in healthcare settings, such as: addressing racist incidents immediately, reporting racist incidents to relevant authorities (and creating systems to report racist incidents to hold people accountable if those systems did not yet exist), educating others when confronted with stereotypes, and advocating for oneself and for others to get better treatment.

Strategies for healthcare providers were mostly related to increased and better training, as explored in Theme 4 of this report. Suggestions for training included: education related to communication, such as speaking more slowly when addressing someone whose first language is not English or French and working on listening skills when there is a language barrier; and mandatory and ongoing anti-racism training, addressing issues of diversity and integration, including normalizing conversations about racism. Respondents also suggested increasing the representation of ACB community members in the healthcare sector.

Best practices at the policy level

The first theme highlighted at the policy level is transforming the healthcare system's capacity to improve service delivery for ACB communities, regardless of pandemic status. This can be accomplished by building the capacity for organizational change from within; adopting hiring practices that promote diversity in general and during pandemic times, such as recruiting from ACB communities and implementing targeted and equitable hiring practices; and through training and the development of desired competencies.

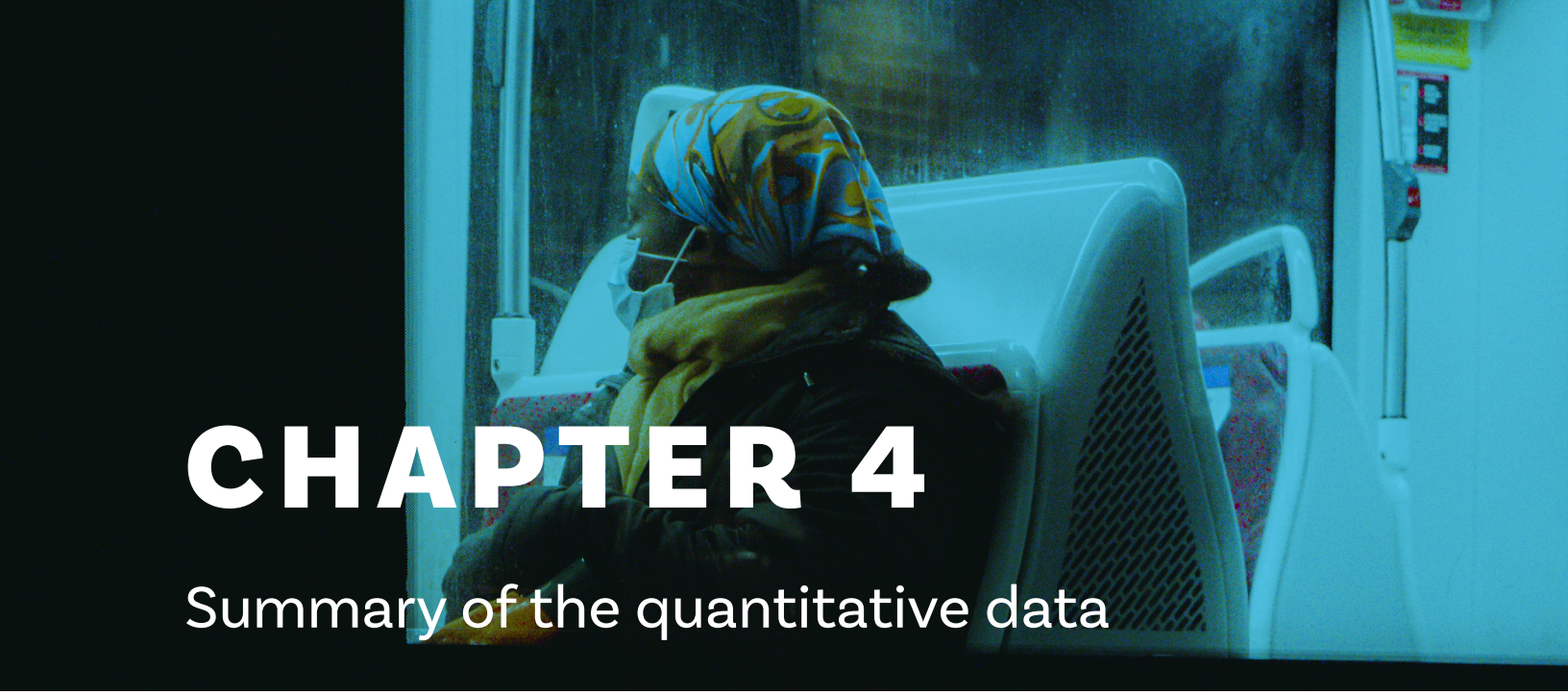
Second is strengthening the ACB communities' capacity for authentic participation in health policy, practice research, education, and leadership. This can be accomplished by expanding programming and services specifically to address COVID-19 within ACB communities, in response to disproportionate risks and incidences of the disease.

This includes measures such as focused testing and assistance navigating the healthcare system; information and programming presented in a way to avoid stigma and discrimination; and community organization programs that engage ACB communities and connect them to COVID-19 healthcare services.

Next, respondents suggested creating programs and policies that foster disaggregated race-based data collection. This would allow for ACB community members to push for systemic change through advocacy and community organizing, as well as through the creation of specialized municipal positions which would be responsible for the development of

mechanisms that promote community dialogue opportunities and that deploy mandatory training on disaggregated race-based data locally.

Finally, respondents suggested developing strategic partnerships between policy makers, government, researchers, and the ACB community to adopt appropriate pandemic prevention strategies, as well as to create accountability measures for anti-Black racism in healthcare. This includes sharing health information in a way that ACB community members can receive it more easily, through videos, social media, and partner organizations, as well as through programming that responds to the expressed priorities of the ACB community. It also includes increasing services delivered by Black healthcare professionals, and providing healthcare services that are not biased, or discriminatory, and take the concerns of ACB community members seriously.



CHAPTER 4

Summary of the quantitative data

A cross-sectional online survey was administered to healthcare providers, who were based in the Greater Toronto Area (GTA) and Ottawa, to collect data on and analyze the following themes:

- Knowledge and perception of risk of COVID-19.
- Providers preparedness for COVID-19.
- Critical cultural competency.
- Experience with everyday discrimination.
- Knowledge of ACB communities' access to COVID-19 related services.
- Provision of support to ACB clients during the COVID-19 pandemic.

A total of 514 healthcare providers participated in this survey, of which 56% resided in the Greater Toronto Area (GTA) and 44% resided in Ottawa. The highest proportion of participants (47%) were nurses, and 37% of all respondents worked in hospitals. Most participants had been working in healthcare for less than five years (31% in GTA and 26% in Ottawa).

Among all participants, 80% identified as women, 18% as men and <1% as gender non-conforming or non-binary. The participants' ages ranged primarily between 25-29 years (21%) and 35-39 years (18%). The most frequent educational attainment level among participants was a bachelor's degree (47%). The highest proportion of participants identified as Black African (50%), while 23% identified as Asian, and 28% indicated having other ethno-racial identities.*

* Black Caribbean; Black North American; White European; White North American; East Asian; Southeast Asian; South Asian; Middle Eastern; Indian Caribbean; First Nations, and Latin American.

Finding 1: HCPs had high levels of knowledge of COVID-19

Most survey respondents (>90%) were aware of the way in which COVID-19 is transmitted as well as the practices to prevent this transmission within their workplace, while also avoiding contracting the virus themselves. Additionally, most respondents (>90%) said they had the adequate tools to advise clients and patients on how to prevent the transmission of COVID-19 (see figure 1, below).

Finding 2: HCPs felt that their work environments were mostly safe in the face of COVID-19

With regards to their work environment, >80% of respondents felt they had adequate measures in place to protect staff against COVID-19, and >90% understood these protective measures and were able to navigate them appropriately.

While a high proportion of respondents (>80%) also stated that they felt their workplace cared about their safety with regards to a COVID-19 infection, some respondents did not have access to up to date COVID-19 information at their workplace and nearly one quarter reported not feeling confident about the policies employed in by their institution to prevent future COVID-19 outbreaks (figure 2, below).

Figure 1: Healthcare providers' institutional confidence in their employer's COVID-19 transmission information, employee safety, and prevention measures

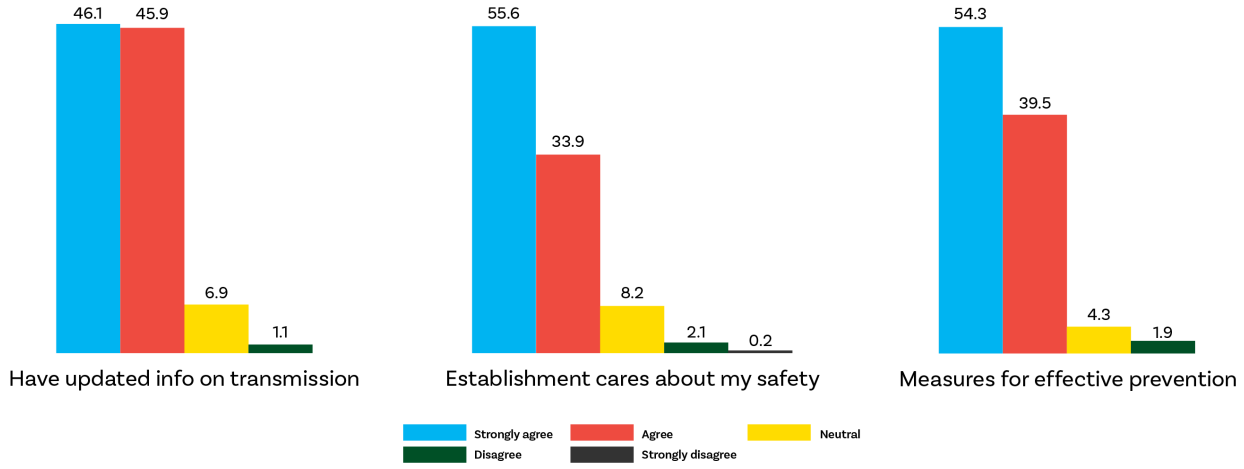
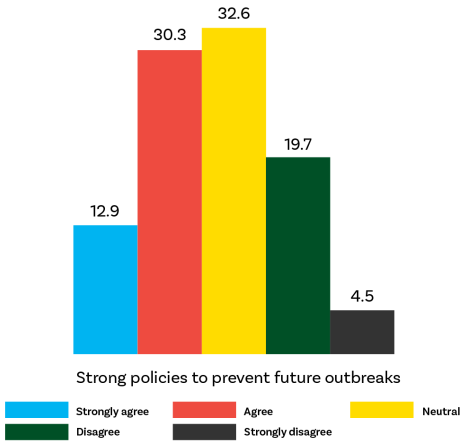


Figure 2. Healthcare providers' confidence in their institutions having strong policies to prevent future outbreaks



Critical competence scale

Finding 3: The critical competence scale revealed conflicts caused by cultural differences

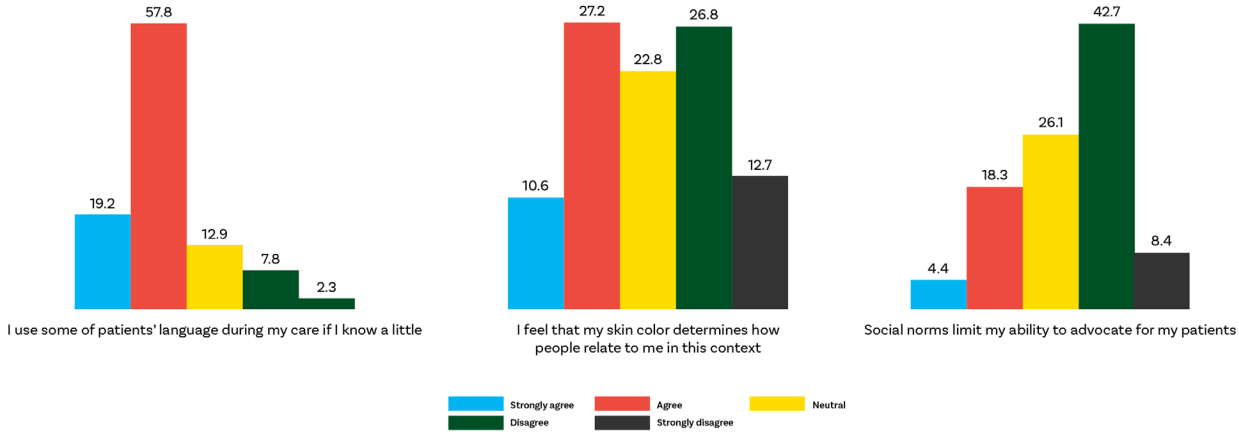
The use of this scale revealed that approximately 31% of respondents strongly agreed that cultural differences cause conflicts, and 23% strongly agreed that cultural differences affect patients' wellbeing.

HCPs aged between 18 and 24 and Asian HCPs agreed the most with the first statement [25%, 29%] while respondents aged >54 years and ACB care providers agreed the most with the second statement [40%, 35%].

However, collectively, respondents disagreed on the following: feeling alienated as a result of cultural differences (40.6%), being treated differently as a result of cultural differences (40%) and being disrespected because of their gender (47%).

Figure 3 (below) displays some key results of the CCCS evaluation which highlight the impact that differing cultures can have on language of care, quality of interactions, and capacity for HCP-led advocacy.

Figure 3: Select results from the critical cultural competence scale evaluations.



Finding 4: HCPs admitted to feeling uncomfortable working with clients from ACB communities, and also indicated that most ACBs had challenges accessing care for their non-COVID-19 related conditions during the pandemic

Approximately one quarter of providers in Ottawa (25%), and one-third in Toronto (33%), said they were unsure about or were uncomfortable working with clients from African, Caribbean, and Black (ACB) communities, and (63% in Toronto, and 61% in Ottawa) said Black patients could not access care for their non-COVID-19 related conditions before the pandemic. Most providers (60% in Ottawa, and 46% in Toronto) thought most Black patients also had challenges accessing care for their non-COVID related conditions during the pandemic.

Knowledge of access to COVID-19 care

Finding 5: Access to COVID-19 related healthcare services

More than half of respondents (>60%) stated that healthcare providers did not currently understand the barriers ACB clients face in accessing COVID-19 related healthcare services.

However, most of the providers (57% in Ottawa, and 71% in Toronto) said most Black patients do not understand how to access COVID-19 related healthcare services, and (51% in Ottawa, and 66% in Toronto) said most Black patients cannot access COVID-19 related services whenever they need them. Many respondents (47% in Ottawa, and 50% in Toronto) also reported that they did not have enough training to provide adequate COVID-19 related healthcare services during the pandemic.

Experience of discrimination

Finding 6: Nearly four out of ten HCPs experience discrimination daily

Almost four in ten participants (38%) agreed or strongly agreed that they faced biased remarks and racism at work (Figure 4). Of those in concurrence, an equal amount (45%) were ACB and Asian providers. The various forms daily discrimination identified included being treated less respectfully, being insulted, being harassed, and being a source of fear for strangers with varying frequency (Figure 5).

Figure 4. Healthcare Providers' experience of biased remarks and racism at work.

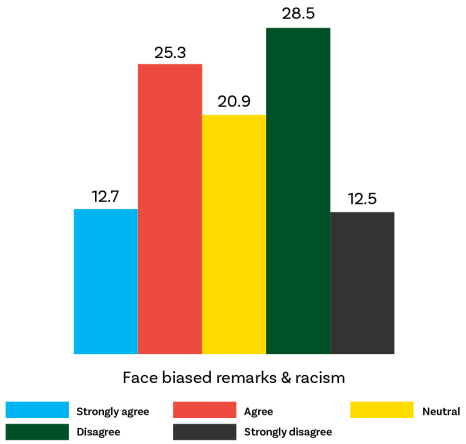
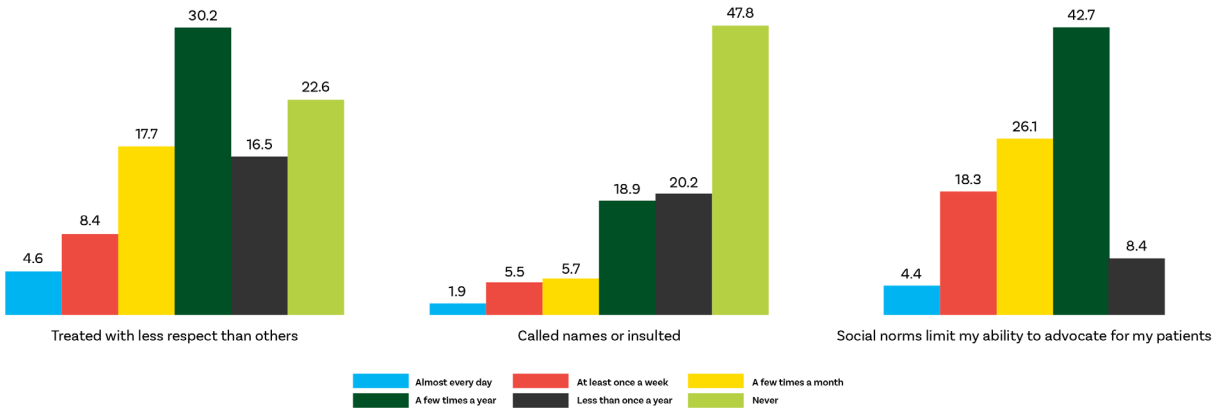


Figure 5: Frequency and type of discrimination faced by healthcare providers based on skin color at work.



Pandemic preparedness assessment of the healthcare system

A fifth and unique feature of the survey was the assessment of the level of preparedness of the healthcare system in handling the pandemic in terms of having enough personal protective equipment (PPE), diagnostic equipment, healthcare professionals, and capacity of the existing policies to prevent future outbreaks.

Finding 7: Black providers were disproportionately more likely to feel unprepared at the onset of the pandemic.

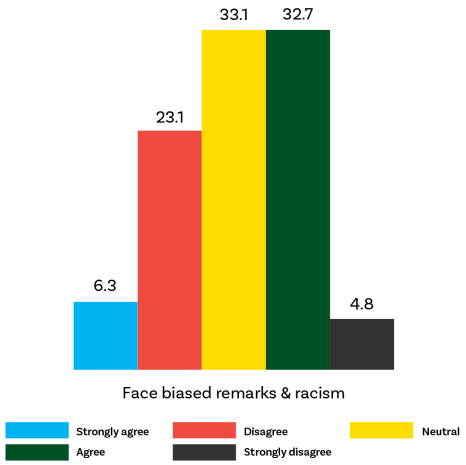
ACB respondents were less likely to agree that the healthcare system had effectively handled the pandemic. Providers in public health facilities were concerned that the hospitals were not well-equipped with diagnostic services and did not have enough skilled staff to handle the consequences of the pandemic.

Lastly, 37% of the participants revealed that they did not have enough training to provide COVID-19 care for ACB communities, and approximately half reported that there were not enough resources in their establishment to provide adequate care to these communities.

Finding 8: Only 55% of providers agreed that providing care for ACB clients was easy for them, and less than a third agreed that there were sufficient COVID-19 related healthcare services dedicated to caring for ACB peoples.

Approximately 55% of providers agreed that it is easy to provide COVID-19 care to the ACB population. Only 28% agreed that there are sufficient COVID-19 related healthcare services directed at the ACB population. Figure 6 (below) displays participant beliefs regarding access to COVID-care for ACB patients.

Figure 6. Healthcare providers' belief in the level of access to COVID-19 care specifically for African, Caribbean, and Black communities

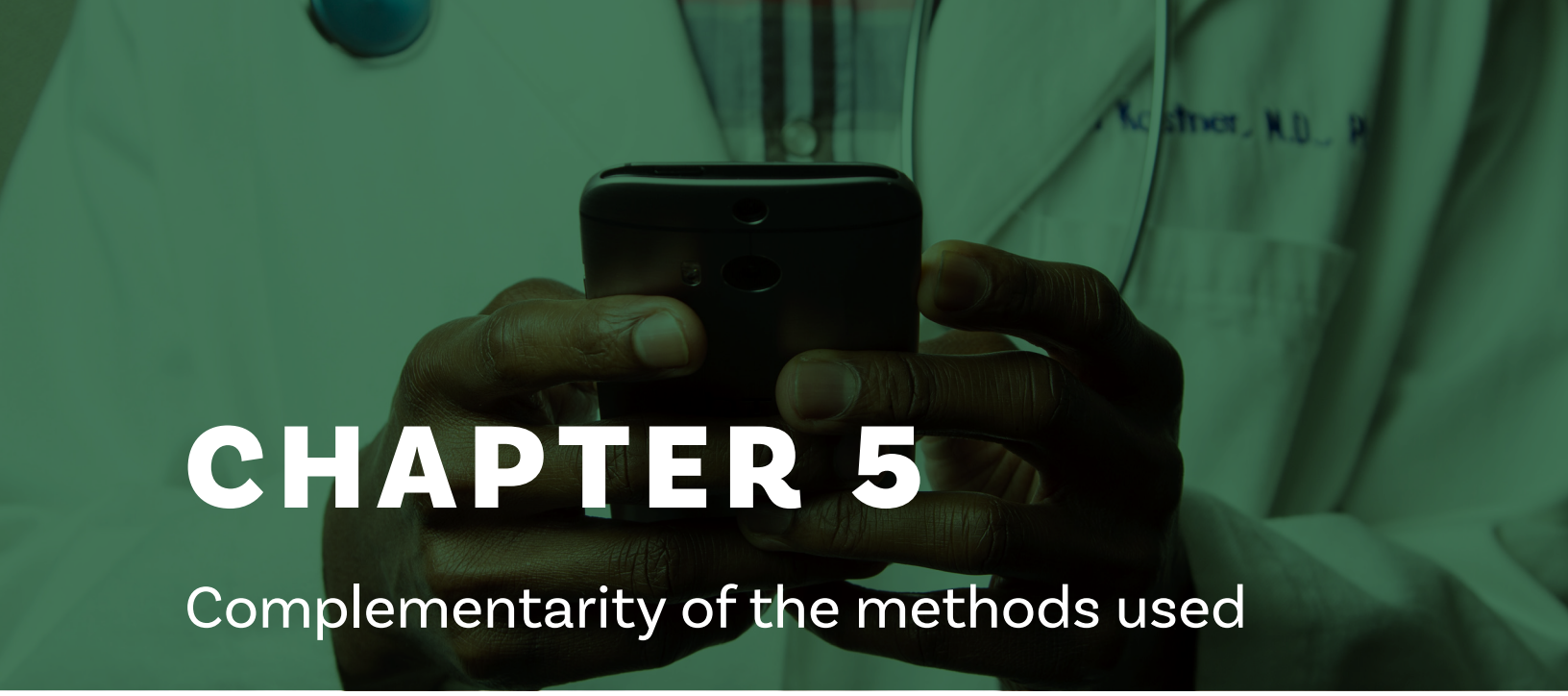


Analysis of the quantitative data

Results demonstrated that many HCPs in general felt uncomfortable providing care to patients from ACB communities. These findings highlight the importance of HCP training regarding equity, diversity and inclusion both in workspaces and clinical settings. A symptom of this lack of training may be present in the results of our survey, as it was found that ACB HCPs in particular were more likely to report experiences of discrimination at work. Members of all racial and ethnic groups deserve to feel safe at work and well cared for when seeking healthcare. These data teach us that barriers remain in the equitable provision of care to members of ACB communities, and that these communities remain devoid of resources allowing them to develop pandemic preparedness and to subsequently receive adequate care in the case of a COVID-19 infection.

Additionally, we learned that it is important to:

- Promote health equity for all individuals seeking care during the COVID-19 pandemic and beyond.
- Address the negative consequences of the COVID-19 pandemic on ACB communities.
- Improve both national and international responses to the health inequities highlighted throughout the COVID-19 pandemic.
- Create space for discussion regarding interventions for the issues raised in this study, and
- Improve critical health literacy among ACB communities and other vulnerable populations in the context of COVID-19 related healthcare.



CHAPTER 5

Complementarity of the methods used

The systematic review (SR), we presented in chapter 2, was helpful in identifying what was already known about the experiences of COVID-19 in ACB communities. It was clear through analysis that the themes of discrimination and racism would play a major role in increasing the vulnerability of ACB persons to negative COVID-19 outcomes.

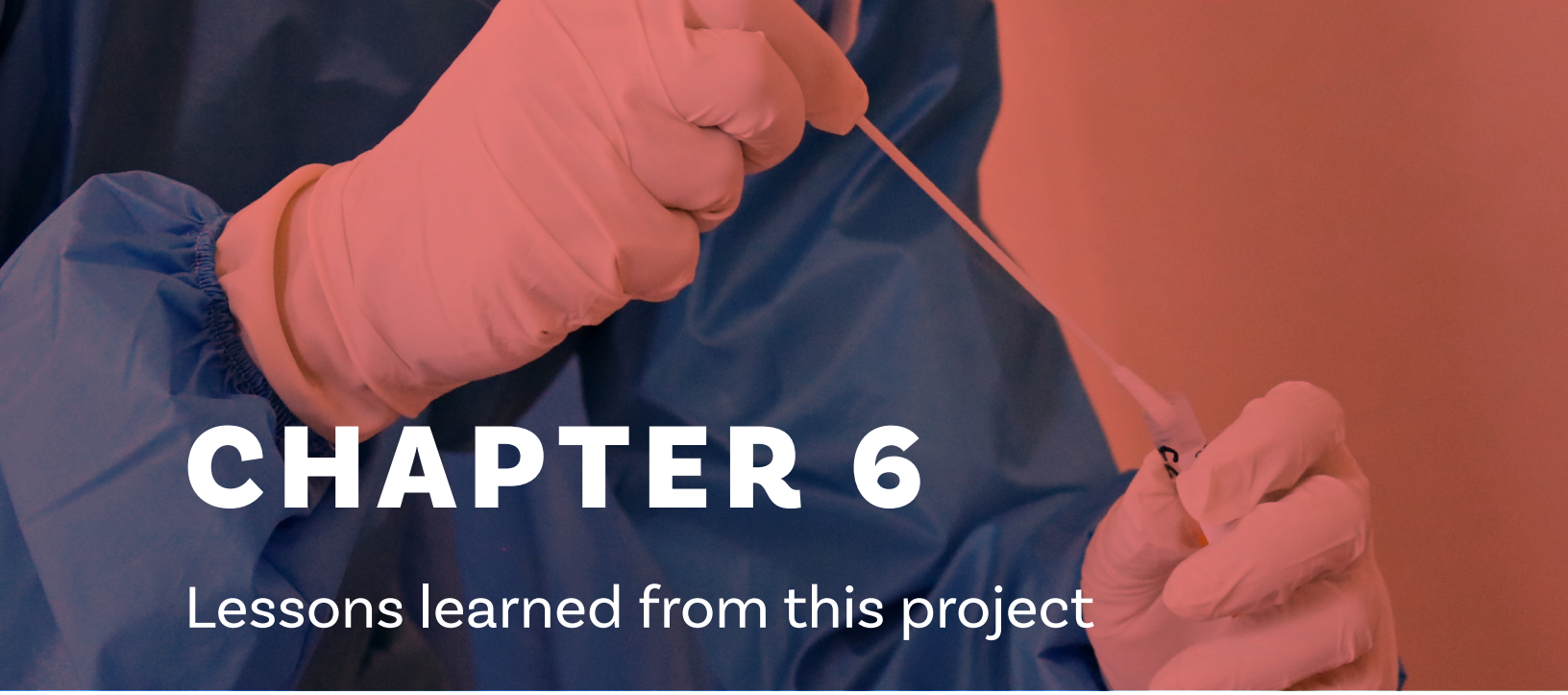
Equipped with the knowledge of the four themes that emerged from the SR, we could better contextualize, nuance, understand and interpret the findings that emerged from the qualitative interviews conducted with 27 members of the ACB community, as well as eight policy makers who were all from the Greater Toronto Area (GTA) and from Ottawa. We were able to detail the experiences of COVID-19 and of healthcare from ACB communities, supported by community member testimonials, and get a better sense of how discrimination impacted healthcare delivery and policy creation and adoption for ACB communities. Some of the findings from the qualitative interviews mirrored the conclusions drawn in the SR, especially around levels of health literacy and knowledge regarding COVID-19 transmission and prevention methods and continued racial and systemic discrimination.

Finally, the theme of racial, systemic, and institutional discrimination was once again present upon analyzing the quantitative data gathered from the survey to 514 healthcare provider respondents from the GTA and from Ottawa.

Healthcare providers reported being uncomfortable treating members of ACB communities and stated that ACB communities experienced discrimination and/or racism daily due to their race, ethnicity and/or culture. Almost four in ten participants (38%) agreed or strongly agreed that they faced biased remarks and racism at work, and of those in concurrence, an equal amount (45%) were ACB and Asian providers. Some of the various forms daily discrimination identified included treated less respectfully, being insulted, being harassed, and being a source of fear for strangers with varying frequency.

Overall, all three methods were helpful in assessing the impact that discrimination (personal, systemic, or institutional) had on the experiences of COVID-19 in ACB communities. The most frequent theme was that of distrust of healthcare institutions and of providers, as

well as increased vulnerability to negative COVID-19 outcomes, stemming in part from the disproportionate disadvantages incurred by the effects of the social determinants of health (SDH) on their individual, social, and cultural health, and wellbeing.



CHAPTER 6

Lessons learned from this project

Lessons learned from the systematic review:

- ACB populations continue to experience anti-Black racism, poverty, and stigmas that contribute to reduced overall health.
- The Social Determinants of Health (SDH) are interconnected and influence the overall health and wellbeing of ACB communities, and changes to them caused by the social, community and societal disruptions from the COVID-19 pandemic resulted in ACB communities having disproportionately higher vulnerability to COVID-19, including higher testing, infection, hospitalization, and mortality rates.
- The (then) current public health messaging may not have been effectively reaching vulnerable communities. There was a need to create effective messaging to identify trusted sources of information related to COVID-19, to address conflicting information, and correct misinformation.
- Increasing knowledge of COVID-19 and its impacts may have translated into higher adoption of COVID-19 prevention behaviors. These findings indicate a need for targeted culturally responsive public health messaging.
- Responses to COVID-19 needed to include culturally sensitive and culturally specific health promotion and disease prevention messaging as well as respond to trauma at the individual and community level.
- There is a profound need to address the social inequities faced by ACB people, including addressing the impact of COVID-19 on social isolation, access to healthcare, as well as the economic impact.
- Interventions should create new policies and programs to build COVID-19 health equity and address racism, as well as promote health and disease prevention in a manner that prioritizes the most vulnerable groups to infection, while addressing the structural inequities that contribute to risks identified in this SR. Interventions should also be geared to protect vulnerable populations.

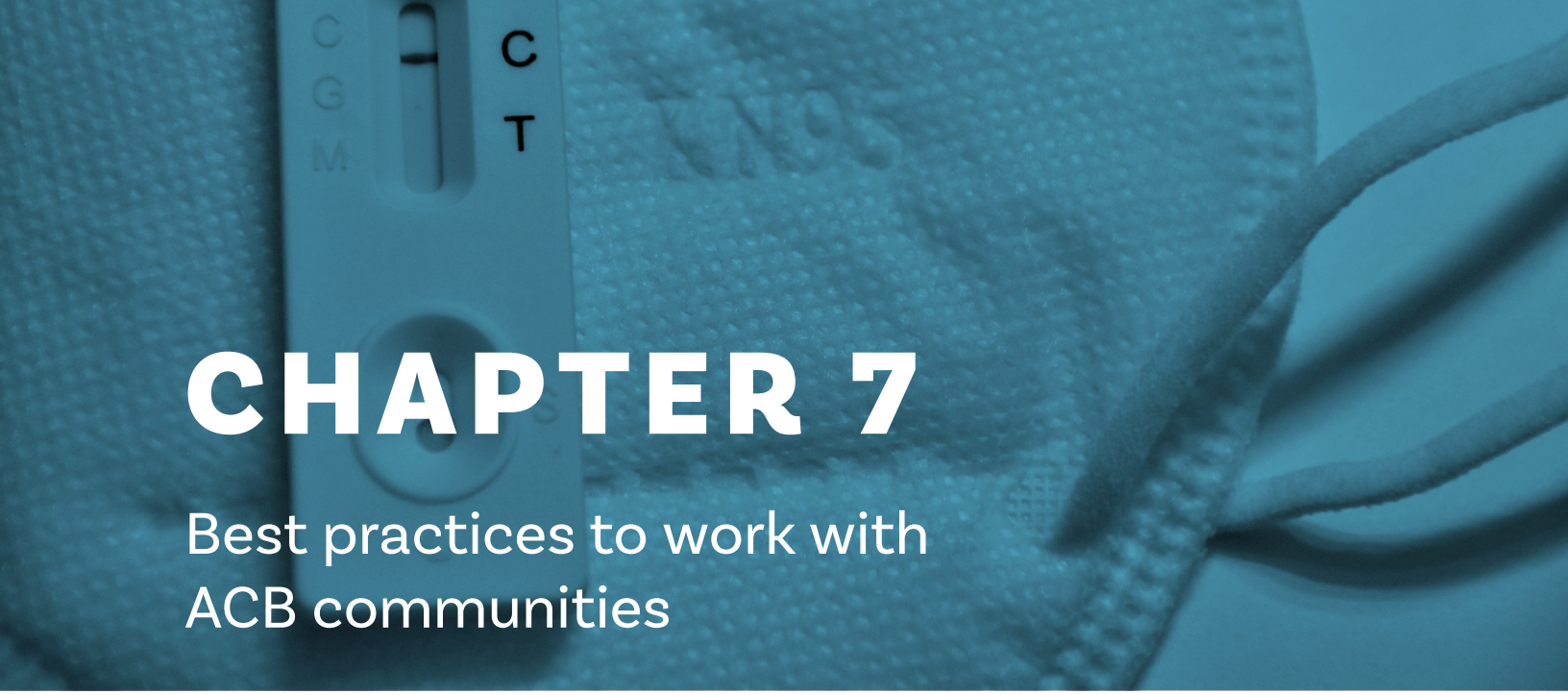
- Interventions should consider racial/ethnic and income disparities when creating policies and restrictions such as physical distancing and the need to wear personal protective equipment (like a mask). Providing adequate protective equipment to essential workers may help reduce disparities and occupational risks.
- Resources should be targeted to improve care for high-risk patients and to examine racial associations with COVID-19 to prioritize vaccine deliveries and reduce disparities.
- Further investigations should also be made into the disproportionate impact of COVID-19 on persons with disabilities, prevention strategies to target urban areas with high poverty rates, and to target healthcare resources to areas with both known testing rates and high positivity rates.

Lessons learned from the qualitative data:

- Members of ACB communities have a desire for increased education on anti-racism, cultural competency, and interpersonal skills for healthcare providers.
- Policy makers and healthcare providers should have more awareness related to the intersecting impacts of the SDH on the experience of the COVID-19 pandemic for ACB communities.
- Discriminatory treatment and experience in healthcare settings is still prevalent
- The barriers to accessing healthcare, which were present pre-pandemic, were exacerbated during the pandemic.

Lessons learned from quantitative data:

- Discrimination remains present in the healthcare sector, both with regards to care providers and patients.
- ACB communities are disproportionately impacted by a lack of training and resources specific to their care needs amid the COVID-19 pandemic and beyond. This is exhibited through the discomfort of care providers in treating patients from these communities.
- ACB communities also face health inequities with regards to their access to COVID-19-related care. They reported feeling unprepared at the onset of the pandemic.
- These findings display the need for interventions to promote health equity across all communities seeking care during global crises and in stable times; including, denouncing systemic racism and biases in the healthcare sector and establishing interventions that strengthen the health system's capacity to care for vulnerable populations such as the ACB community.



CHAPTER 7

Best practices to work with ACB communities

Best practices emerged from the systematic review:

- Create effective messaging to help ACB communities identify trusted sources of information related to COVID-19, address conflicting information, and correct misinformation.
- Public health messages should be targeted and culturally responsive.
- Responses to COVID-19 need to include culturally sensitive and culturally specific health promotion and disease prevention messaging as well as respond to trauma at the individual and community level.
- Address the impact of COVID-19 on ACB communities by offering solutions to social isolation, access to healthcare, and address the economic impact.
- Consider racial/ethnic and income disparities when creating policies and restrictions such as physical distancing and the need to wear personal protective equipment (like a mask).
- Provide adequate personal protective equipment to essential workers, which can help reduce economic disparities and occupational risks.
- Resources should be targeted to improve care for high-risk ACB patients and to examine racial associations to prioritize vaccine deliveries and reduce disparities.

Best practices at the community level that emerged from the qualitative data:

- When working to provide information or services to ACB communities, it is critical to provide more accessible services and health care resources, address stigma and discrimination in institutions and governments and increase training for healthcare providers.

- Provide accessible resources, through increasing access to PPE, increasing testing levels; providing more information in multiple languages, increasing services offered by existing mobile clinics, including vaccinations, increasing channels for communication of information in several different languages, and using different types of media such as phone, video, and print.
- Train and retain healthcare providers who can speak different languages and make them available to those who don't speak English or French.
- Increase sharing information and knowledge between ACB community members and institutions and healthcare settings
- Increase mobile clinic visits and home visits by healthcare providers.
- Create opportunities and processes to report racist incidents, to hold people accountable.
- For ACB persons, to protect themselves from discrimination in healthcare settings, address racist incidents immediately, report racist incidents to relevant authorities, educate others when confronted with stereotypes; and advocate for oneself and for others to get better treatment.
- Increase training and education for healthcare providers related to communication, such as speaking more slowly when addressing someone whose first language is not English or French and working on listening skills when there's a language barrier.
- Implement mandatory and ongoing anti-racism training, addressing issues of diversity and integration, including normalizing conversations about racism in workplaces and healthcare settings.
- Increase the representation of ACB community members in the healthcare sector.

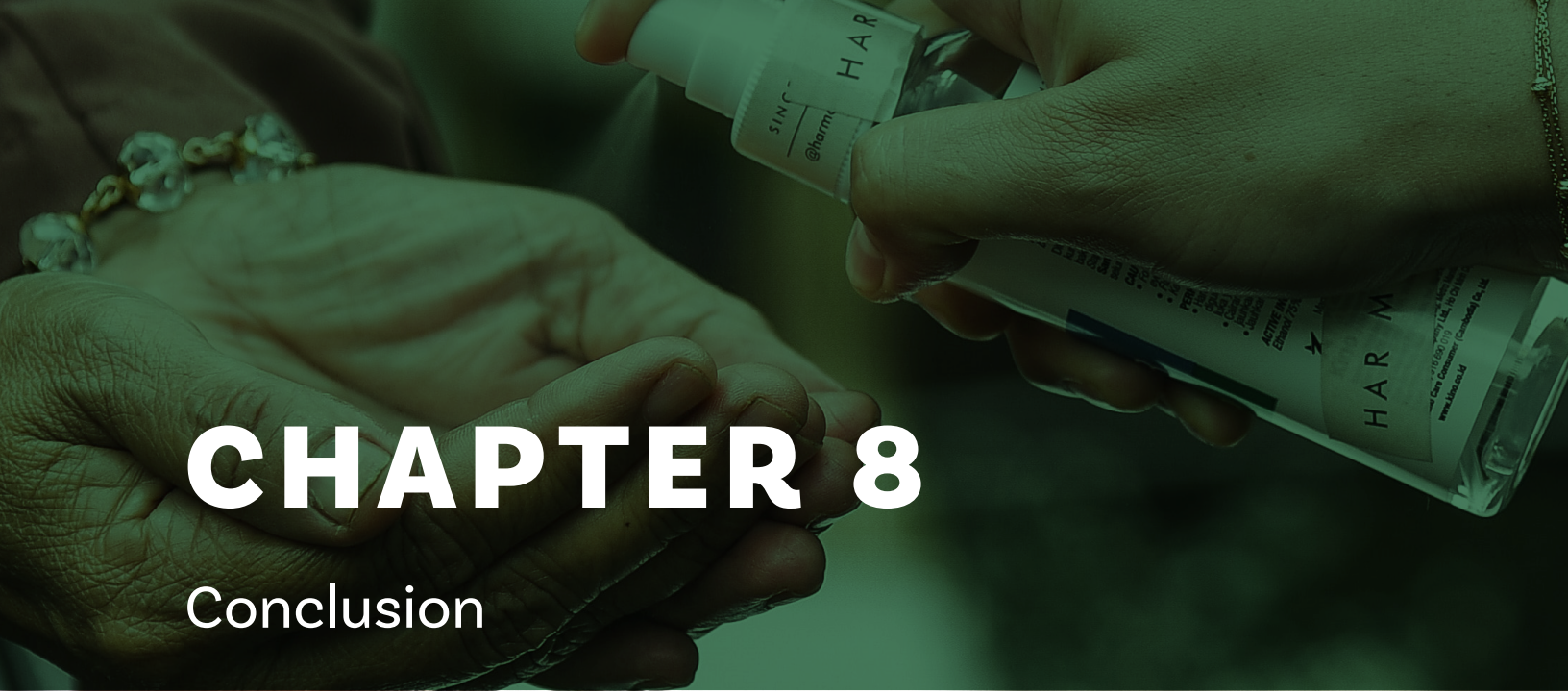
Best practices for policy makers working to improve health services for ACB communities:

- Adopt hiring practices that promote diversity in non-pandemic and pandemic times, recruit workers from ACB communities and implement targeted and equitable hiring practices.
- Strengthen ACB communities' capacity for authentic participation in health policy, practice research, education, and leadership.
- Expand programming and services to specifically address COVID-19 within ACB communities, in response to disproportionate risk and incidence of the disease.
- .Focused testing for COVID-19 for ACB communities and provide assistance navigating the healthcare system.
- Provide information and programming in such a way to avoid stigma and discrimination, and support community organization programs that engage ACB communities to connect them to COVID-19 healthcare services.
- Create programs and policies that foster disaggregated race-based data collection.
- Develop strategic partnerships between policy makers, government, researchers, and ACB communities to adopt appropriate pandemic prevention strategies, as well as to create accountability measures for anti-Black racism in healthcare.

- Share health information in a way that ACB communities can absorb more easily, via videos, social media, and partner organizations, as well as through programming that responds to the expressed priorities of the ACB community.
- Increase services delivered by Black healthcare professionals, and provide healthcare services that are not biased, or discriminatory, and that take the concerns of the ACB communities seriously.
- Compensate any ACB community members that are being consulted on how to improve services to ACB communities by HCPs and healthcare institutions.

Summary of best practices emerging from quantitative data:

- Implement mandatory awareness training for HCPs to improve their comfortability in treating and interacting with members outside of their race, ethnicity and/or culture.
- Increase health literacy skills and health-seeking behaviors among ACB communities via outreach programs.



CHAPTER 8

Conclusion

The COVID-19 ACB Providers Project (CAPP) has engaged ACB communities, healthcare providers (HCP) and policy makers (PM) over the past year to examine the challenges experienced by ACB communities and identify strategies to build providers' capacity to address their COVID-19 related-health outcomes. The CO-CREATH Lab at the University of Ottawa, in collaboration with High-Impact Field-Based Information (HiFi) Lab at St Michael's Hospital in Toronto, as well as with a number of community partners such as the Canadians of African Descent Health Organization (CADHO), Women's Health in Women's Hands (WHIWH), AIDS Committee of Ottawa, and the Somerset West Community Health Centre (SWCHC) used a community based participatory research approach informed by a socio-ecological model and an intersectionality lens to guide the research.

This Canadian Institutes for Health Research (CIHR) grant funded a two-site (Ottawa and Toronto) mixed methods research project comprised of three components: A systematic review of existing research, qualitative interviews of ACB people, health care providers and policy makers, and a quantitative survey administration. The qualitative and survey components addressed topics such as COVID-19 knowledge and practices, healthcare providers' preparedness to a pandemic, critical cultural competence, discrimination and ACB people's access to COVID-19 related services.

This extensive research project allowed us to bring to light many important findings. Common themes were echoed in all three components of this research project, namely that of the continued and exacerbated existence of racism and discrimination in the healthcare system, ACB persons distrust of healthcare providers and authorities, and the intersecting influence of the social determinants of health that increase ACB communities' vulnerability to negative COVID-19 outcomes.

Critical gaps in providing culturally sensitive health information and education to ACB persons about COVID-19 preventative policies were prevalent, and if they would have been addressed, could have increased adherence to them. Interviewing ACB persons, HCPs and PMs revealed that systemic and institutional racism in healthcare settings persisted throughout the pandemic and that anti-Black racism training and cultural competency training was necessary to build more trust between ACB persons and healthcare providers. Data gathered through the quantitative survey of healthcare providers showed that just over half (55%) of the 514 healthcare providers

agreed that it was easy to provide COVID-19 care to ACB populations. Every day discrimination was once again apparent, since nearly four in ten respondents mentioned experiencing everyday discrimination of various forms, and of those in concurrence, an equal proportion were ACB and Asian HCPs. This work ultimately highlighted the need for more education on how to better serve ACB communities in the healthcare sector during a pandemic and beyond one.

The CAPP research team is hopeful that these project findings will contribute to addressing the negative consequences of COVID-19 on ACB communities and improve both local and global responses to the COVID-19 pandemic-related health inequities. The team looks forward to continuing to meaningfully engage in conversations around the improvement of care for ACB communities.

APPENDIX A

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