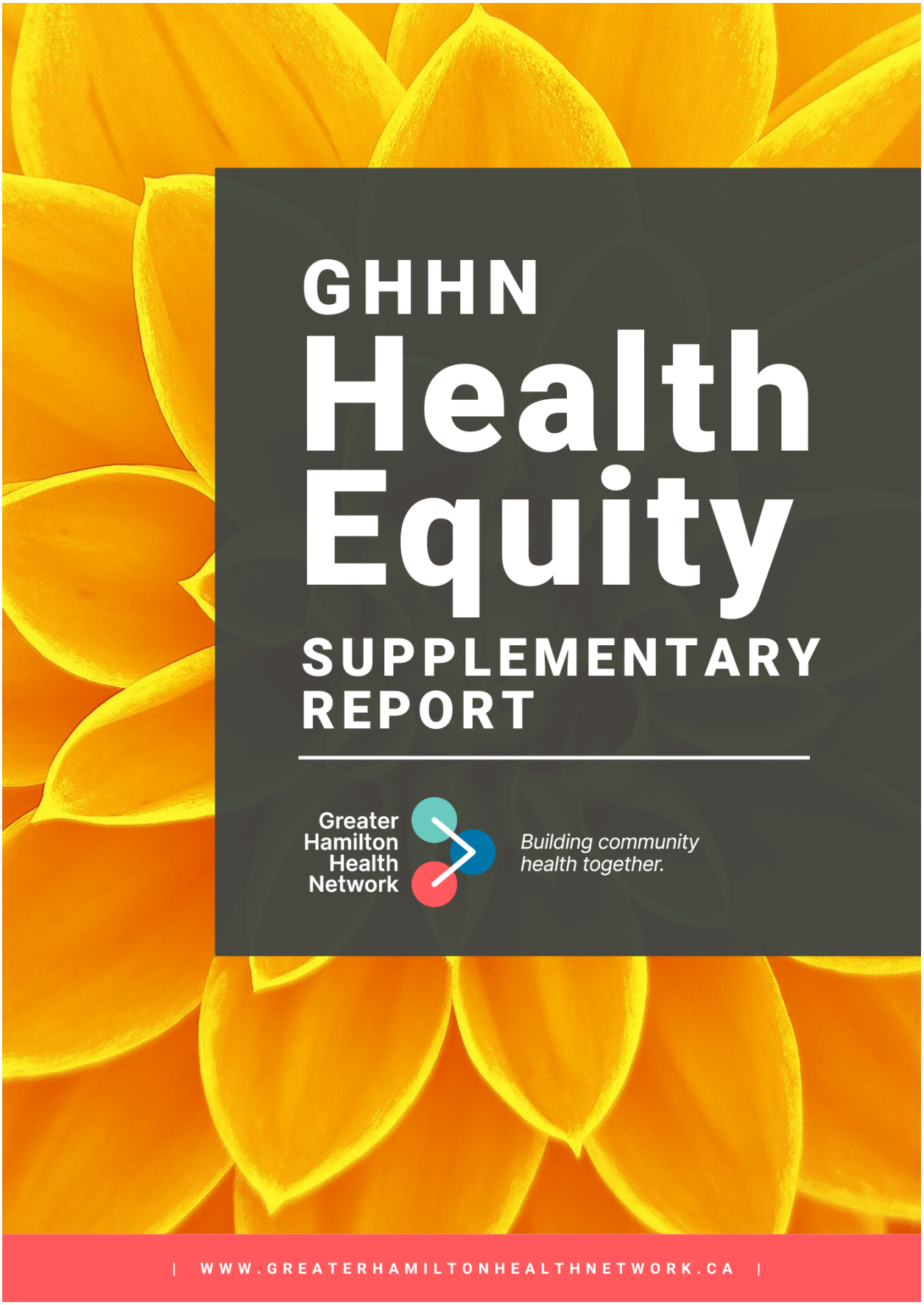
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Greater Hamilton Health Network
Health Equity Supplementary Report
with a focus on Population Specific Communities
Final

Submitted to
GHHN Executive Council
June 24, 2021

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Context

The GHHN *Health Equity Supplementary Report with a Focus on Population-specific Communities*, is a particularly important report to read along with the main GHHN Health Equity report. It captures the experiences and population-specific recommendations that inform and provide more specific direction to the recommendations in the main report.

Each chapter reflects the dialogues with population-specific groups within the GHHN, including Indigenous, Francophone, black communities, immigrants and refugees, Two Spirit and LGBTQIA+, people who use drugs (PWUD) and the rural communities.

The GHHN, in its full OHT application, committed to developing specific strategies for the Indigenous and Francophone communities. Chapter 1 and 2 provides the road map for these specific strategies.

As the GHHN embarks on adopting a population health approach with a focus on the populations with the most significant barriers to good health, the remaining chapters provide context for each specific population in Hamilton and provides recommendations on how to move forward to improve the health outcomes of each specific population.

The context is specifically relevant to GHHN and all its sector partners. Some of the recommendations may currently seem out of scope of the GHHN, but these recommendations should provide the opportunity for thoughtful reflections for all partners, their own organizations, and the services they offer.

Each chapter was co-authored with members of the GHHN EDI ARAO Steering Committee and other community partners who facilitated the conversations. According to one member of the GHHN EDI ARAO Steering Committee, the reports “do justice to our voices and showcase our experiences that usually get dismissed.”

Chapter One
Indigenous Health in Indigenous Hands

This report was co-authored with Coalition of Hamilton Indigenous Leaders (CHIL) and the Indigenous Primary Health Care Council. A special thanks to Constance McKnight, member of the GHHN EDI /ARAO steering committee and CEO of De dwa da dehs nye>s for her ongoing leadership and vision and Victory Banbury (CHIL) for her diligence in ensuring that the report reflected decolonizing language and commitments.

The Greater Hamilton Health Network, in its full application, recognized the unique historical treaty rights of Indigenous peoples and made a commitment to working with Indigenous partners in Hamilton to develop specific engagement, consultation, and service delivery strategies for Indigenous peoples. This chapter begins to set out how this commitment can be implemented. This is a living document and willevolve as the partners work together.

In doing this work, GHHN acknowledges that systemic racism exists and will actively confront the unequal power dynamics and structures that discriminate against and oppress Indigenous Peoples.

An important development for this work is the emerging partnership with the Indigenous Primary Care Council in developing an Indigenous framework for OHTs to meaningfully collaborate and partner with Indigenous organizations. This chapter draws significantly on their work.

It concludes with recommended first steps to begin the journey.

I. Existing Commitments to Indigenous Peoples in Legislation & Policy

Connecting Care Act

The Connecting Care Act, 2019 states in its preamble that:

> The people of Ontario and their Government:
> Believe that the public health care system should be guided by a commitment to equity and to the promotion of equitable health outcomes.
> Recognize the role of Indigenous peoples in the planning, design, delivery and evaluation health services in their communities.

Ontario Health

Ontario Health, the agency whose mandate is to plan and fund the delivery of the health care system, recognizes the importance of partnership to advance Indigenous Health Equity as foundational. It "recognizes that strong relationships with Indigenous leadership and communities - founded on respect, reciprocity, and open communication - are critical to ensuring that the new health care system in Ontario reflects and addresses the needs of Indigenous Peoples."[1]

Ontario Health's Equity Framework further states "that all health care planning must be grounded in the philosophy of Indigenous health in Indigenous hands and that Indigenous health must be planned, designed, developed, delivered and evaluated by Indigenous governed organizations. This includes honouring and respecting Indigenous voices, leadership, governance frameworks, and

[1] Building a Framework & Plan to Address Equity, Inclusion, Diversity & and Anti-Racism in Ontario, p.3. Ontario Health https://www.ontariohealth.ca/sites/ontariohealth/files/2021-01/CorpusSanchezInternationalReport.pdf

seeking out authentic relationships. Indigenous knowledge systems will be recognized. Indigenous teachings, world views, and lived experience must be valued sources of evidence and expertise."[2]

Ontario Health Team Guidance documents

Grounded in the Connecting Care Act, the Ontario Health Teams are directed to develop specific engagement, consultation, and service delivery strategies for Indigenous peoples.

II. Indigenous Population in Hamilton

Greater Hamilton Health Network is located on the territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee and Mississaugas. It is located next to Six Nations of the Grand River and the Mississaugas of the Credit First Nation.

The 2016 Census counted 12,130 Indigenous peoples living in the city of Hamilton, but Our Health Counts[3] research study, completed under the leadership of Indigenous peoples, estimates that the Indigenous population of Hamilton may be as high as 24,000 to 48,000. The discrepancy in findings between data collection by non-Indigenous entities and Indigenous-led research initiatives underscores why any collection of data related to Indigenous people must be done by Indigenous people for Indigenous people.

Poor health outcomes for Indigenous Peoples are rooted in the effects of more than five centuries of colonization -- including genocide, dispossession and displacement from traditional lands, forced assimilation and disengagement from ancestry, culture and language, residential schools, the Sixties scoop, and the Indian Act, among many other oppressive colonial policies, practices and legislation.

The historical and ongoing impact of the targeted disempowerment and dispossession of Indigenous peoples has resulted in significant health disparities. Over 78% of Indigenous peoples living in Hamilton earn less than $20,000 annually, 69% receive social assistance, 57% of adults have not completed high school, and 1 in 8 reported being homeless or living in precarious housing.[4] Each of these social determinants of health (income, employment, education, and housing) contributes substantially to poor health outcomes.[5]

Racism, including systemic racism within the healthcare system, is a significant contributor to the lower life expectancy and poorer health outcomes experienced by Indigenous Peoples. Racism is not limited to interpersonal issues during the provision of health services; rather, structural racism is evident throughout the Canadian health care system. Structural racism exists in the policies and practices of the Canadian public health system and other sectors, which has profound negative impacts on access to health care and health disparities. Racial discrimination in the health care system, as well as broader Canadian society, has direct effects on health.[6]

Despite the resiliency of Indigenous peoples, generations of historical and contemporary oppressive

[2] Ibid, p.11
[3] Our Health Counts https://www.ourhealthcounts.ca/images/PDF/OHC-Report-Hamilton-ON.pdf
[4] Greater Hamilton Health Network, Full Application
[5] Ibid, p.
[6] Indigenous Primary Health Care Council. Ne'iikaanigaana Toolkit: Guidance for Creating Safer Environments for Indigenous Peoples. https://www.iphcc.ca/publications/toolkits/Ne-iikaanigaana/

health and social policies have resulted in Indigenous peoples continuing to experience significant health inequities. "Our Health Counts" found that the Indigenous population in Hamilton faces significantly higher rates of infectious and chronic diseases and, thus are likely over-represented among older adults with medically complex conditions.

- Diabetes rates are 3 times greater and Hepatitis C rates are 10 times greater among urban Indigenous people compared to the general population.
- Substance use was more frequently reported among Hamilton's urban Indigenous population with 87% currently smoking tobacco, 19% reporting misuse of prescription opioids, and 55% reporting heavy drinking episodes (twice the rate of the general population in Hamilton.
- 42% of urban Indigenous people reported a psychological or mental disorder diagnoses.
- Over 1 in 10 urban Indigenous people (10.6%) are frequent users of the emergency department (5 visits annually) which is 7 times greater than the Hamilton average of 1.6%.[7]

In 2018, a Hamilton community survey found that 22% of people surveyed experiencing homelessness in Hamilton identified as Indigenous.[8]

III. Creating Safer Environments for Indigenous Peoples

Indigenous Primary Health Care Council - Reflections

To address the wellbeing needs of Indigenous peoples, "culture is treatment" must be at the core of all Indigenous programs and services. Culture-based care, inclusive of Traditional Healing and wellbeing, helps to address the root causes of historical trauma.

However, Indigenous organizations do not provide all services to Indigenous peoples, especially when accessing hospital and specialized care. Hospital settings are most frequently named as places where Indigenous peoples experience harm, especially emergency departments, maternity and social work departments.

It is imperative that non-Indigenous organizations provide safer environments when providing services to Indigenous people.

> *"It is fundamentally the belief of Indigenous organizations that it truly is only Indigenous people who can create a fully safe space for Indigenous people. That means a space that encapsulates holistic care, including physical, spiritual, mental and emotional healing. It ensures that there is a rightful place for people to have patient-centred choice and the integration of traditional healing methods."*
>
> *Caroline Lidstone Jones, CEO Indigenous Primary Health Care Council (IPHCC)*

It is also imperative that Indigenous partners are engaged in a true recognition of the importance of Indigenous Health in Indigenous Hands and allows Indigenous people to have a say in what services looks like. It is about establishing and creating a space where this work is done respectfully and doing that jointly between organizations.

Health service providers need to realize that they need to be strong fundamental partners, but they don't necessarily need to lead that service. A health service provider can follow and still be a good leader in following what that service might look like and shaping what that might be. It does not mean that an organization segregates itself from that relationship; it just becomes a different role in supporting that relationship.

[7] Our Health Counts https://www.ourhealthcounts.ca/images/PDF/OHC-Report-Hamilton-ON.pdf
[8] Ibid.

> *"We've been learning through our Indigenous Cultural Safety (ICS) Program the importance of co-designing the curriculum rollout. It is about realizing that both parties must come to the table to make it work, that both parties need to be respectful. I think fundamentally that everyone has to come together and support what you're doing – from a community perspective, but also from a wellbeing perspective."*
>
> *Caroline Lidstone Jones, CEO Indigenous Primary Health Care Council (IPHCC)*

Given the pervasiveness of structural and interpersonal anti-Indigenous racism, mainstream healthcare institutions, coupled with the inevitability that Indigenous people will still need to receive services in such institutions, all mainstream organizations have an obligation to eliminate anti-Indigenous racism and provide care that is as safe as possible.

This begins by the organization making an organization-wide commitment to anti-racism, inclusion and equity. A critical first step would be that all leadership, board members, and staff take Indigenous cultural safety training. ICS is one step in the process toward an effective means of identifying and addressing anti-Indigenous racism and helping ensure that Indigenous clients feel comfortable, understood, respected,and in control of their healing journey.

NE'IIKAANIGAANA: All Our Relations Toolkit

Evidence has shown that the health care system, and institutions within it, are not always the safest places for Indigenous Peoples to access and participate in, as both service providers and service receivers. We reflect on the stories of Michelle Labrecque, Brian Sinclair, Joyce Echaquan, and many more, as examples of how a system meant to protect and heal, has resulted in harm.

Systemic racism occurs when an institution or set of institutions working together creates or maintains racial inequity.[9] Although there may be some individuals that hold negative perceptions towards the Indigenous population, the focus for combatting systemic racism should be on both individual and organizational change. While some elements of the cultural safety approach includes addressing individual level bias, it is also essential that institutions reflect on organizational policies and structures that unintentionally perpetuate discrimination and exclusion.

Evidence shows that systemic racism is often caused by hidden institutional biases in policies, practices and processes that privilege, or disadvantage people based on race.[10] It can be the result of doing things the way they have always been done, without considering or recognizing how they impact particular groups differently.

To genuinely strive towards creating safer environments for Indigenous participation as both service providers and service receivers, it is essential that organizations acknowledge that systemic racism exists and actively confront the unequal power dynamic between groups and the structures that sustain it.[11]

To assist non-Indigenous organizations on their journey to create safer environments for Indigenous people, the Indigenous Primary Health Care Council developed a toolkit called Ne'iikaanigaana: All Our Relations Toolkit.[12]

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[9] Anti-oppressions framework. Marigold Capital marigold-captial.com
[10] Ibid.
[11] Ibid.
[12] Indigenous Primary Health Care Council. Ne'iikaanigaana Toolkit: Guidance for Creating Safer Environments for Indigenous Peoples. https://www.iphcc.ca/publications/toolkits/Ne-iikaanigaana/

While the entire toolkit is relevant to the development of the GHHN at the governance, organizational andservice delivery levels, the overall principles and strategy commitments related to partnership agreements are the most relevant for the purpose of this document.

These principles and strategy commitments for partnership must guide the discussion for building ally relationships with Indigenous people and Indigenous service providers in the Greater Hamilton Health Network.

Overall Principles (Toolkit p.6)

The following principles have been applied in the development of the toolkit:

- Inclusion has been embraced as a core competency and embedded within the organizational culture at all levels.
- Indigenous self-determination and governance processes will be respected and overtly supported wherever possible.
- Indigenous laws and governance systems are recognized & treated as equal entities.
- Approaches are strength-based and inclusive of Indigenous worldviews.
- There is a recognition of diversity and uniqueness within the Indigenous population.
- Truth and Reconciliation Calls to Action and the United Nations Declaration on the Rights of Indigenous Peoples are recognized and meaningfully actioned across the organization.
- Relationships are built upon trust and mutual respect.
- Engagement is purposeful and reciprocal.
- The growth and development of Indigenous Peoples is acknowledged and promoted at all levels of the organization.
- Human rights and responsibilities are promoted and respected. Employees are free of concerns related to basic equity issues.
- Indigenous clients/patients feel safe receiving services across the organization.
- Traditional healing methods and medicines are accepted and promoted among all practitioners within the organization.
- The organizations value and respect Indigenous employees, volunteers, and learners' cultural identity.

Indigenous Partnerships (Toolkit p.10)

"Nothing for us, without us" - Indigenous partners are included at all stages of planning, from concept to implementation.

- When initiating strategic and/or operational planning that potentially includes Indigenous foci, ensure engagement with Indigenous partners occurs up front and is not an afterthought.
- Do not presume to know what the Indigenous community would benefit from.
- Invite them to be an integral part of the planning process from the initial stages.
- Be willing to take the lead from communities - they will specify the level of involvement they wish to have in different initiatives.
- Ask for input at the early planning stages of quality improvement projects to ensure they are inclusive of Indigenous voices.
- Co-develop agreements with your Indigenous partners that indicate how the organizations intend to work together.
- Develop implementation plans to support work that is described within agreements. Ensure that implementation plans include:
    - Clear, co-developed indicators
    - Measurement strategies to support data collection.
    - Evaluation plans to reflect upon the partnership.
- When designing and implementing Indigenous-specific programs and services or programs and services that are targeted at Indigenous populations, reach out to key partners.

IV. Greater Hamilton Health Network Commitments

Statement of Commitment (Draft: to be developed in partnership)

- GHHN acknowledges that systemic racism exists and will actively confront the unequal powerdynamics and structures that discriminate against and oppress Indigenous peoples.

- GHHN commits to prioritize the local health needs of Indigenous Peoples living in Hamilton, and to support local Indigenous autonomy and self-determination and Indigenous health systems.

- GHHN recognizes that the work to advance Indigenous health equity stands apart from the broader commitment to health equity and is shaped by inherent rights, specific histories and current realities of First Nations, Inuit and Métis peoples in Canada.

- GHHN recognizes that Indigenous health equity is rooted in our mutual commitment to reconciliation, meaningful ally relationships and Indigenous people's inherent rights to self-

determination, which includes the commitment to Indigenous Health in Indigenous Hands.

- GHHN affirms that Indigenous Health in Indigenous Hands will be respected and supported. Thismeans that Indigenous health care must be planned, designed, developed, delivered and evaluated by Indigenous-governed organizations.
- GHHN takes responsibility to identify and address racism and inequity in a way that does not burden Indigenous partners and leaders.

In recognition of these commitments, the Greater Hamilton Health Network is committed to:

- Build, nurture and invest in ally relationships, ensuring Indigenous leaders are equitably positioned at relevant decision-making tables, especially senior tables, in order to develop a health care system that respects and upholds the GHHN commitment to Indigenous Health in Indigenous Hands. GHHN acknowledges that this will require dedicated time and resources to achieve this.

- Embed Indigenous Health in Indigenous Hands in each of the initiatives under the authority of the GHHN.

- Identify and address racism and inequity in a way that does not burden Indigenous partners/leaders.

- Initiate a formal organization-wide education plan to educate all board, staff and partners to understand cultural safety and the impact of racism on Indigenous peoples and Indigenous health outcomes.

- Genuinely strive towards creating safer environments for Indigenous collaboration at the organization level and within all initiatives led by GHHN. The GHHN to be guided by local Indigenous leadership and supported/informed by the NE-IIKAANIGAABNA: All Our Relations Toolkit.

V. Starting the Journey

1. The GHHN, through collaboration with the Indigenous Primary Health Care Council, develop an ally partnership agreement with the De dwa da dehs nye>s and local Indigenous community partners that is built on the principles in the NE'IIKAANIGAANA toolkit and the commitment to Indigenous Health in Indigenous Hands. This agreement will outline the ally governance relationships between the GHHN and De dwa da dehs nye>s and local Indigenous community partners.

2. The GHHN participates as an active member of the IPHCC and Ministry of Health OHT Advisory Panel to develop the overall framework for Indigenous organizations to meaningfully participate in the OHT framework.

3. The executive leadership and staff of the GHHN and the Boards of Directors, leaders and front-lineproviders of GHHN partners who participate in GHHN initiatives be required to ongoing education addressing anti-Indigenous racism that is developed and delivered by Indigenous experts.

4. The GHHN and the Indigenous leaders in Hamilton co-develop an annual action plan that is monitored and assessed with progress and outcome measures for GHHN initiatives that reflects Indigenous experiences, values and world experiences. The GHHN Executive Council/Board, De dwa de dehs nye>s and the Coalition of Hamilton Indigenous Leaders (CHIL) to approve the plan and monitor progress twice per year, with an annual report to the Indigenous community.

VI. Key Partners

Coalition of Hamilton Indigenous Leaders (CHIL): www.chileadership.com

CHIL is a collaborative of Indigenous organizational leaders founded on respect and wisdom. We respond to the needs of our community and support our member agencies by improving resources and advancing Indigenous voices in Hamilton.

De dwa da dehs nye>s: www.aboriginalhealthcentre.com

De dwa da dehs nye>s is an aboriginal health access centre with the mandate to improve the health and well-being of Indigenous individuals, families and communities through wholistic Indigenous, Traditional and Western health care in Hamilton and Niagara.

Indigenous Primary Health Care Council (IPHCC): www.iphcc.ca

IPHCC supports the advancement and evolution of Indigenous primary health care service provision and planning throughout Ontario.

Chapter Two
Francophone Population and commitment to French Language Services

This chapter was written in partnership with French Language Health Planning Entité 2 and the Centre de santé communautaire Hamilton Niagara. A special thank you to Sébastien Skrobos and Annie Boucher from the FLHPLE2 and Alain DoBi and Tara Galitz from CSC Hamilton Niagara for their participation in the several meetings and the drafting of this report.

The Ministry of Health identified the Francophone population as one of two priority populations for all OHTs to develop specific engagement, consultation, and service delivery strategies.

The Greater Hamilton Health Network, in its full application, recognized that the engagement of the Francophone communities needed to be more systematic, and include patient/client, caregiver, advisor, and other stakeholder's voices. It committed to embedding a French Language Services (FLS) lens in all working groups and initiatives.

GHHN specifically identified the need for engagement with the French Language Health Planning Entité 2. This chapter was developed with the French Language Health Planning Entité 2 and the Centre de santé communautaire Hamilton Niagara and begins to set out how these commitments can be implemented. This is a living document and will evolve as the partners work together.

I. Existing Commitments to FLS in Legislation and Policy

The Connecting Care Act, 2019

The preamble in the Connecting Care Act, 2019 outlines the vision for the health system that is the overarching legislation for the Ontario Health Teams. In its preamble, it "acknowledges that the public health care system should recognize the diversity within all of Ontario's communities and respect the requirements of the *French Language Services Act* in the planning, design, delivery and evaluation of health care services for Ontario's French-speaking communities."

French Language Services Act, 1990

The French Languages Services Act (FLSA) was enacted in 1990. This Act ensures that every person wanting to communicate with or receive services from the government or its agencies could so in the designated areas identified in the Act. The Act makes it the responsibility of the government to provide services in those regions and not on the individual to have to advocate or make a case in order to obtain services. Hamilton is a designated area under the Act.

- The French Language Services Act (FLSA) guarantees an individual's **right to receive services in French** from **Government of Ontario ministries and agencies** in **26 designated areas**, and at government head offices. The FLSA provides legislative and political recognition of rights acquired over 400 years in Ontario.
- **The right to receive services in French**: French-language services are not limited to correspondence, telephone or translation procedures. The needs of the French-speaking population are taken into account in the development and implementation of programs, policies and procedures. Furthermore, services received in French must be equivalent to those offered in English, offered at the same time, and of the same quality.

French Language Health Service Planning Entité 2 (FLHSPE)

Six regional French Language Health Service Planning Entités were established under regulation 515/09 and reaffirmed in 44(2)(6) of the Connecting Care Act. Entité 2 works with local, regional and provincial

partners, including OHTs in Ontario Health's West region.

It is mandated by Ontario Health to improve access to French Language Health Services. It facilitates community engagement, and provides advice on planning, organization and integration of FLS. It helps to build and sustain health care services for Ontario's official language minority population.

The Entité has identified the following principles to better support patient outcomes for Francophones in GHHN:

- Collaborate with Health planners (FLHPLE 2)
- Engage the Francophone community
- Identify and communicate FLS capacity to provide better connected care
- Support HSP in building and sustain French services
- Tailor sustainable solutions to community needs

Entité 2 can help integrate French Language Services in the GHHN.

Ontario Health Teams

Aligned with the Connecting Care Act 2019, the Ministry of Health stated in the OHT Guidance document that the public health system should be guided by a commitment to equity and to the promotion of equitable health outcomes and has identified …. that the OHTs must develop specific engagement, consultation, and service delivery strategies for the Francophone population.

Ontario Health Equity Diversity, Inclusion and Anti-Racism Framework (2020)
This framework builds upon our existing legislated commitments and relationships with Indigenous peoples and Francophone communities and recognizes the need for Ontario Health to take an intersectional approach to this work.

City of Hamilton Designation
Hamilton is one of the 26 designated areas across Ontario. Under the *French Language Services Act*, a person has the right to communicate in French with, and to receive available services in French from "any head or central office of a government agency or institution of the Legislature and has the same right in respect of any other office of such agency or institution that is located in or serves an area designated."

Centre de santé communautaire Hamilton Niagara is currently the only Designated Health Service Provider (HSP) in the jurisdiction of the Greater Hamilton Health Network. Designation under the Act is a legal recognition by the Ontario government of an organization's ability and ongoing commitment to provide high-quality services in French.

Several health service providers have been "Identified HSPs" in the GHHN jurisdiction. Some of the obligations and expectations of the identified agencies include seeking designation, increasing capacity, designating positions, developing a FLS plan and ensuring "active offer, etc. However, without an active and ongoing commitment to being an identified HSP, several agencies have not lived up to the expectations and obligations. This list does not necessarily reflect the current capacity to provide services in French and needs to be updated yearly.

II. Francophone Population in Hamilton

The Francophone community in Hamilton is very diverse with a large percentage of the growing population, racialized new immigrants and refugees and people who belong to the Two Spirit and LGBTQIA+ communities.

- In 2016, more than 48,000 people identified that they can speak French in Hamilton.[13]
- According to Stats Canada (2016) Hamilton was home to 11,906 Francophones, a growth of over 40% percent since 2011. This number has continued to grow significantly in the last 5 years.
- The growth of the Francophone community is largely driven by new immigrants, mostly from French speaking countries in Europe, the Caribbean (Haiti) and Africa (Dominican Republic of Congo, Tchad, Burundi, Cameroon, Rwanda, Morocco and Algeria.) 17% of the new immigrants are racialized and includes a vibrant LGBTQIA+ community.[14]
- Hamilton is ranked 6th among urban centres in Canada and 3rd in Ontario outside Quebec for French-speaking immigrants. The Federal government has developed a Francophone Immigrant Strategy (2018-2023). In that strategy Hamilton has been selected as a Welcoming Francophone Community to help French-speaking and bilingual newcomers feel welcomed and integrated in Francophone minority communities outside Quebec. As a result of this identification, the French speaking immigrant population is expected to grow over the next few years.

III. Francophone Health Outcomes and Experiences in the Health System

Research and evidence-based studies are unequivocal: language and culture are essential determinants of health for the minority population and may be the most important determinant of health for this population.[15]

> *"An older adult gets tied to the hospital bed for being agitated. He was simply trying to tell the nurses that he was nauseated."*

In June 2018, the Entité 2 carried out consultations on the needs of Francophone populations in terms of Mental Health and Addiction and Home and Community Care**.**

Mental Health and Addictions:

<u>Priorities identified by the francophone community</u>

[13] Alain Dobi and Sébastien Skrobos, The Francophone Community in Hamilton, March 3, 2021
[14] Ibid.
[15] GHHN Full Application.

- Better dissemination of information: Communication regarding services is scarce and disorganized at best. Francophones are often not equipped with the information to know where they can ask for services.
- Specialized services: French language mental health care that goes beyond the scope of social workers/counsellors.
- Depression, anxiety, dementia and suicidal thoughts: consultation respondents identified mental health services that addressed these specific priorities to be of most importance for the Francophone community in HNHB.

Priorities identified by the stakeholders and frontline workers included:

- Mental health crisis lines: Evidence shows Francophones are resorting to (and sometimes being referred to) a French language crisis line that is not regional. Assuming the provider in question is not aware of HNHB resources, the callers are not getting connected with local programs and services to provide appropriate care.
- More awareness and education: Firstly, to the French speaking population in order to supply them with information regarding where they can access French language services. Secondly for upper management in English predominant workplaces as to why French language service is important, and the added challenges faced by employees working with the Francophone population.
- Better navigation of French language mental health and addiction services: Frontline workers identified the lack of mechanisms in place to access French language services and suggested exploring OTN services, implementation of protocols and further collaboration amongst community agencies and a French language service directory.

Home and Community Care:

Priority needs as identified by the francophone community**:**

- Home visits in French
- Nursing care in French
- Long term care in French (francophone beds)

Priority needs as identified by frontline workers and stakeholder**:**

- Need for less fragmented, better integrated community services available in French all along the continuum. This includes, but is not limited to, initial intake or service request, referrals, navigation support, and personal and home care services.
- Need for linguistically and culturally appropriate home care. According to providers, we must make sure that the front-line workers who come to people's homes can deliver services safely. This includes the capacity to communicate in the client's language and the client's capacity to clearly understand the front-line worker.
- Need to improve distribution of information on services available in French.
- Need for French language services in long-term care homes, applicable to both beds reserved for Francophones, and to friendly visits by volunteers or front-line workers.

IV. Themes from Francophone Consultations (March 10, 2021):

1. Lack of Recognition is the overall theme:

- Lack of recognition of constitutional rights.
- Lack of recognition of the population in Hamilton.
- Lack of recognition of agencies that provide quality FLS.
- Lack of recognition in any deliberate policies in partners organizations.

2. The Francophone population is growing, very diverse with many intersections including new immigrants and refugees, racialized and LGBTQIA+. Refugees have very little trust in the health system.

3. Francophone needs are not prioritized given the numbers of other population groups. However, given the intersection of many Francophones, establishing a robust mechanism to address Francophone needs with the support from the FLHPE will help address francophone needs and the needs of other minority populations.

4. Very little appreciation of the constitutional rights of Francophones and the French Language Services Act obligations in Ontario to build FLS capacity across the health care continuum.

5. Patients and their families struggle to navigate the health care system, especially when accessing FLS. The integration of bilingual health promoters and patient navigators into health care teams is an emerging best practice in servicing minority population.

6. Language Barriers
    - There is no systematic identification of linguistic identify and no "Active offer" of FLS.
    - FLS or interpretation services are often not available. Family, especially children are used to providing translation. This is unethical and immoral.
    - There is no signage in French to direct people.

7. Bilingual staff are not utilized in a deliberate way to meet needs of Francophone patients especially in emergency and home care.

8. Organizations that provide FLS are invisible.
    - HSPs are not aware of the breadth of services of designated organizations (Centre de santé communautaire Hamilton/Niagara) and identified HSPs and therefore do not make referrals.

9. Lack of knowledge about the FLS Act and that Hamilton is a designated community. In most HSPs, FLS is not seen to be a priority resulting in:
    - Most agencies do not seem to have an active FLS plan. All organizations funded by the MOH should at a minimum have mechanisms in place to identify, inform and direct francophone patients to FLS.
    - Lack of knowledge on how HSPs can become Identified or Designated.
    - Very little bilingual communications available, especially in a timely manner

10. There is a sense that funding designated for FLS has been used over the years for other purposes; there is no accountability for this funding.

11. The leadership of the Francophone community needs to be formally embedded in the governance structure of the GHHN.

GHHN Commitments to FLS (in Full Application)

In its full application, GHHN made commitments to FLS in four categories:

1. Engagement of francophone population
    - The GHHN recognizes that the engagement of the Francophone communities needs to be more systematic, and include patient/client, caregiver, advisor, and other stakeholder's voices.
    - The engagement of the local French Language Health Planning Entité2 is at its infancy but will continue throughout the process of establishing and operating the GHHN.

2. Francophone lens
    - A French Language Services (FLS) lens will be embedded in all working groups to ensure that engagement is not done in isolation of FLS planning.
    - Guidance and leadership by the Centre will be invaluable for guiding integrated models of care to address Francophone health and well-being. In addition, the GHHN will seek the guidance of other stakeholders, such as community agencies, the French Language Health Planning Entité2, and patient/client representatives.

3. Data collection and mapping of FLS services
    - In Year 1, the GHHN is committed to quantifying and better understanding the needs of Francophones in our community.
    - By collaborating with the Centre de santé communautaire Hamilton/Niagara and the French Language Health Planning Entité2, the GHHN is committed to mapping existing services through the continuum of care for our Year 1 target populations.

4. Home and Community Care
    - The member organizations of the GHHN have developed a long-term vision for the design and delivery of home and community care that has been established according to the following guiding principles:
        - New models must support and reflect the needs of Francophones.
        - Considering the needs of Indigenous, Francophone and other unique populations will be critical in promoting health equity and access to care for all.
        - Identify, map and plan a future home and community care operating model that leverages all assets in the City, and takes into account the needs of priority populations, including Indigenous, Francophones.
        - The commitment to ask people if they need services in French (active offer) and have a robust external referral mechanism in place (if such services are unavailable in-house) is crucial.

These 4 four commitments can be merged into two overarching recommendations:

1. Develop an GHHN FLS plan that would include engagement, education, data collection and mapping FLS capacity and engagement.
2. Develop a Home and Community Care agency to serve the Francophone population in the GHHN.

v. Starting the Journey

1. **Develop an GHHN FLS plan that would include engagement, education, data collection and mapping FLS capacity and engagement.**

   a. Invite FLHPE to do a presentation at the Sector Council about the francophone population in Hamilton, the role of the Entité and the services provided through designated and identified HSPs (immediate).

   b. Formalize partnership agreement between French Language Health Planning Entité 2 (FLHPE) and GHHN to design and implement an GHHN FLS plan (immediate):
      - *Identify clear FLS objectives, strategies and commitments at all levels (from leadership group to working groups).*

   c. Determine Francophone participation in the different GHHN governance structures (including Executive Committee, Partnership Council, Community tables) (immediate):
      - *Include one representative per structure; nominations to be made by the FLHPE and the designated FLS HSPs in the GHHN.*

   d. Educate all partner organizations' staff (frontline and management) on issues faced by francophone communities in Ontario:
      - *Take free online Cultural Sensitivity training offered by Ontario Health West*
      - *Take free Active Offer training offered by Réseau francophone du mieux-être du nord de l'Ontario (RFMENO)*
      - *Participate in FLS Community of Practice developed by French Language Health planning Entité 2 (FLHPE)*

   e. Recruit an FLS and Equity Health Planner to address (with support from FLHPE) the needs of francophones, minority, and racialized populations at all levels of the GHHN:
      - *With support from the Entity, the FLS and Equity Health Planner will make sure the francophone lens is applied at all levels in the GHHN.*

   f. Start data collection on francophone by establishing a protocol to identify linguistic identity of all clients throughout all partner organizations, and assess francophone population satisfaction
      - *Formalize scope of data collection in GHHN FLS Plan. Data collection findings to help develop FLS metrics and inform GHHN FLS plan*

2. **Develop a Home and Community Care agency to serve the Francophone population in the GHHN.**

   a. Use data collected by FLHPE to further identify needs, gaps and barriers for Francophones (Immediate)
      - Several reports available to GHHN to inform their HCC plan).

   b. Map the francophone patient journey through the Home and Community Care system in Hamilton.
      - *Use report and support from the Entity to identify gaps for francophones and form recommendations and strategies to improve system.*

   c. Establish a strategy and plan to develop HCC model that addresses the needs of the francophone community.

   d. Implement newly designed HCC model that addresses the needs of the francophone

Participants in Francophone Consultation March 10 2021

As the only health service provider that is a designated FLS agency, the consultations included the leaders from the CSC Hamilton Niagara:

- Alain DoBi, Director
- Bonaventure Otshudi, Director
- Joelle Regnier, NP
- Loubna Moric, Program Coordinator
- Rita Ghobrial, Family Physician
- Tara Galitz, Director

Chapter Three
Black Health and the Impact of Anti-Black Racism

This chapter was written under the leadership of Comfort Afari, Chair, Hamilton Black Leaders Forum and Nhlaloenhle (Nala) Ndawana. Comfort and Nala are members of the GHHN EDI ARAO Steering Committee. Also, thanks to all participants in the Black Health consultation.

While the Greater Hamilton Health Network acknowledges the unique historical, treaty rights of Indigenous peoples and the constitutional rights of Francophones, it was silent in acknowledging the impact of anti-black racism on the health inequities of the black communities. In addition to Indigenous health outcomes, the black populations experience the second lowest health outcomes of any other population group in Ontario.

There have been many studies completed with proposed recommendations. These will be reviewed to inform the solutions. A key report is the Special UN Human Rights Council Working Group on African Descendant regarding the deeply imbedded anti-black racism in Canada.

2015-2024 the United Nations has been declared the International Decade for people of African Descent. However, very little has been done to recognize this focus in Hamilton nor give serious attention to issues facing this community. We are well into this decade. It is time for decisive action now to address the health disparities experienced by Black Communities within the Greater Hamilton Health Network.

This Chapter explores the legacy of anti-black racism in Canada, the impact on health outcomes and proposed first steps on our journey to dismantle systemic racism in our health system.

I. Anti-Black Racism

Anti-Black Racism "is a specific form of racism, rooted in the history and experience of enslavement that is targeted against Black people, people of African descent. Myths and stereotypes were created and used to justify slavery and the torture of enslaved African people, including the idea that Black people were biologically different or subhuman, less intelligent, had a greater tolerance for pain and were not to be trusted, among many others."[16]

Anti-Black Racism "is a system of inequities in power, resources, and opportunities that discriminates against people of African descent. Discrimination against Black people is deeply entrenched and normalized in Canadian institutions, policies, and practices and is often invisible to those who do not feel its effects. This form of discrimination has a long history, uniquely rooted in European colonization in Africa and the legacy of the transatlantic slave trade."[17]

Anti-Black Racism "is prejudice, attitudes, beliefs, stereotyping and discrimination that is directed at people of African descent and is rooted in their unique history and experience of enslavement and colonization."[18]

[16] CMAJ 2021 January 11;193:E55-7.doi:10.1503/cmaj.201579
[17] Black Health Equity Working Group (2021) Engagement, Governance, Access, and Protection (EGAP) A Data Governance Framework for Health Data Collected from Black Communities. Blackhealthequity.ca
[18] City of Toronto. Toronto for All campaign https://www.toronto.ca/community-people/get-involved/community/toronto-for-all/anti-black-racism-mental-health/

Anti-Black Racism has resulted in serious health inequities. These disparities between Black people and other groups with respect to medical conditions and risk factors are not explained by biological differences between "races." The field of medicine can no longer deny or overlook the existence of systemic Anti-Black Racism in Canada and how it affects the health of Black people and communities.[19]

II. Anti-Black Racism in Canada

Unknown by the majority of Canadians, Canada has a legacy of slavery and, according to Dr. Afua Cooper, historian, "slave ownership was found at every level of colonial Canadian society, whether English or French." The colony of New France, founded in the early 1600s, was the first major settlement in what is now Canada. Slavery was a common practice in the territory. When New France was conquered by the British in 1759, records revealed that approximately 3,600 enslaved people had lived in the settlement since its beginnings.[20]

> The vast majority of them were Indigenous …but Black enslaved people were also present because of the transatlantic slave trade. Europeans saw enslaved peoples less as human beings and more as property that could be bought and sold. Europeans viewed slavery in racial terms, with Indigenous and African people serving and white people ruling as masters.[21]

Over the years, anti-black racism was systematically engrained in legislation, policies and practices. As recent as August 1911, the Cabinet of Prime Minister Sir Wilfrid Laurier passed an Order in Council with purpose to ban Black persons from entering Canada. It read "the Negro race…is deemed unsuitable to the climate and requirements of Canada."

United Nations Human Rights Council Working Group on African Descendants

In 2017, the Special UN Human Rights Council Working Group on African Descendants stated: "Canadian history informs anti-black racism and racial stereotypes that are so deeply entrenched in their practices that its institutional and systemic forms are either functional normalized or rendered invisible, especially to the dominant group."[22]

The United Nations expressed its deep concern at "the structural racism that lies at the core of many Canadian institutions and the systemic anti-Black racism that continues to have a negative impact on the human rights situation of African Canadians."[23]

The United Nations Working Group of Experts on People of African Descent noted that "across the country, many people of African descent continue to live in poverty and poor health, have low educational attainment and are overrepresented in the criminal justice system" and that systemic anti-Black racism is an upstream factor contributing to these outcomes."[24]

A 2011 study showed that, on average, Black Canadians earn 75.6 cents for every dollar a white person earns, even after controlling for age, education and immigration status.[25] An analysis of Canadian Census

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[19] CMAJ 2021 January 11;193:E55-7.doi:10.1503/cmaj.201579

[20] The Story of Slavery in Canada. Canadian Museum for Human Rights https://humanrights.ca/story/the-story-of-slavery-in-canadian-history

[21] Ibid.

[22] Report of the Working Group of Experts on People of African Descent on its mission to Canada : note / by the Secretariat https://digitallibrary.un.org/record/1304262?ln=en

[23] Ibid.

[24] Ibid.

[25] Ibid.

data from 1996 to 2006 showed that 13.4% of Black people with a graduate degree in Montreal were unemployed, a rate comparable with that of non-Black people who had not completed high school (12%). In response to the UN report, on January 30, 2018 – Justin Trudeau, Prime Minister of Canada, stated that "it's time Canadians acknowledge that racism and unconscious bias against Black people exist in this country."

III. Black Communities in Canada

Blackness in Canada is essentially multi-cultural in and of itself. Making general representations of Black people is extremely problematic. The diversity among Black cultures in Canada calls for putting an end to the idea of Black identify as one essential subject.[26]

This diversity within the Black communities is important to understand because the needs of Black communities will be different depending on key aspects, including culture, religion and traditions. However, while Black people have different multi-cultural identities, the impact of anti-Black racism on lived experience often manifests similar circumstances.

The Black diaspora in Canada and their journey to Canada can be described generally into four types:

Adapted from K. Fenton 2011

Today, Black people comprise 3.5% of Canada's total population and about 43% of Black people in Canada are Canadian born.[27]

In Nova Scotia, there are large, centuries-old communities, including descendants of people who were enslaved in Canada. Although slavery was abolished in what was to become Canada in 1831, it was a foundational institution in the building of the nation.[28]

[26] CMAJ 2021 January 11;193:E55-7.doi:10.1503/cmaj.201579
[27] Ibid.
[28] Ibid.

As per the Black diaspora, the Black communities also represent diverse immigrant communities.

In Ontario, black communities are the third largest racialized population and make up 4.7% of the population. While GTA has 400,000 (8% of GTA population), other communities with larger black communities include Ottawa, Hamilton, Oshawa and Windsor.[29]

According to the 2016 census, Hamilton had a black population 23,700, with 6,800 from the African diaspora. Since 2016, the Black population in Hamilton has significantly grown, primarily due to immigration and refugees from the African Diaspora. However, there is no current data that quantifies the numbers.

IV. Black Mental Health Day Act - Bill 178 March 2020

"This is the day we refuse to be silent about the effects of racism on our mental health."
Government of Ontario

In March 2020, the Province of Ontario passed an important Act to proclaim Black Mental Health Day on the first Monday in March in each year. Below is the preamble to the Act that states clearly, the Province's recognition of Anti-black racism and the impact on health.

> Preamble
>
> Anti-Black racism persists in the Province of Ontario and in provincial government systems and services today. It results in inequitable treatment and unequal outcomes for Black Ontarians across all sectors, including the education, justice, employment, housing and child welfare sectors.
>
> Racial inequalities, anti-Black racism, discrimination and the lasting effects of trauma have negative impacts on the mental health and physical well-being of Black Ontarians. The lack of concrete action to address anti-Black racism in public services like healthcare and education, and in the area of housing services, only increases the toll of anti-Black racism on Black Ontarians' mental health, regardless of income, education, or employment status.
>
> By proclaiming the first Monday in March in each year as Black Mental Health Day in Ontario, the provincial government can show Black Ontarians that it recognizes the ongoing impact on mental health that results from staying silent on issues of anti-Black racism in public services. Black Mental Health Day will also raise awareness of the specific mental health needs of Black communities across Ontario.
>
> Currently, there is no coordinated approach or requirement for the collection of race-based healthcare data, despite evidence of racial inequities in health outcomes in Ontario and calls, from the community and health care providers, for the province to collect such data to inform evidence-based policymaking and service provision.
>
> Attempts to respond to the mental health needs of Black Ontarians have often failed to recognize the diversity that exists within Black communities, highlighting the importance of providing culturally appropriate services that respond to this diversity.
>
> Far too often the health needs of Black individuals are left unaddressed by our healthcare system. Black Ontarians are faced with enduring race-based stereotypes that result in the denial of proper medical assessments, increased rates of misdiagnosis, under-treatment and failure to diagnose. The effects of anti-Black racism can result in mental health conditions or aggravate those conditions, including conditions such as depression and anxiety. Mental health issues have been found to increase both risk of physical illness and harm from physical illness that Black communities already experience at higher rates.

[29] Public Health Agency of Canada. (2020). Social determinants and inequities in health for Black Canadians: A snapshot. https://www.canada.ca/content/dam/phac-aspc/documents/ services/health-promotion/population-health/what-determine s-health/social-determinants-inequities-black-canadians-snap shot/health-inequities-black-canadians.pdf

There is a need to deliver mental health services using anti-oppression frameworks that recognize the long-standing and enduring impact of anti-Black racism on Black Ontarians. Taking this important step will lead healthcare professionals to work collectively to ensure that Black Ontarians can access pathways to allow them to live healthy lives.

Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Ministry of Health and Long-Term Care Act
3 Subsection 6 (1) of the *Ministry of Health and Long-Term Care Act* is amended by adding the following paragraph:
2.1 **To ensure that health services in provided in a culturally appropriate manner.**

V. Racism as a Determinant of Health

Race and racism were recognized as a determinant of health in 2005.

In 2020, Dr Gary Newton, President and CEO of Sinai Health System, stated that inequity and racism are disease equivalents in term of their impact on black health outcomes.

Race is a social construct that grew out of European colonization to justify the domination of a "white race" over others. The idea of race has no scientific foundation. The main way that people perceive race is through physical features that provide little to no significant information about an individual's biology or genetics. Racial categories shift over time and from place to place, reflecting societal configurations of power.[30]

Illness does not naturally result from racial differences, because race is an idea with no biological basis. But race still has an impact on health because of racism, a major cause of inequities and social determinant of health.[31]

At a 'Black experiences in health care symposium' in 2020, black health leaders identified lack of access to health care services, gaps in care and inequities in outcomes as key elements in health outcomes.

Impacts of Anti-Black Racism

- 42% of children in care are born to black parents.
- Unemployment rate for Blacks in Ontario is 13% compared to the rate of non-racialized people of 7.5%
- Unemployment rate for Black youths is 28% twice more than the national average.
- The Black community suffers from lower rate of high school graduation while at the same time having a significantly higher drop out rates.
- While the Black population makes 3% of the Canadian population, they account for 10% of federal prison inmates.[32]

Health Inequities

- There is significant over representation of people of African descent in mental health institutions.
- Between 2009 and 2010 HIV diagnosis among Black people in Ontario increased by 20% while at the same time HIV testing in the Black community decreased in 2010.

[30] Black Health Equity Working Group (2021) Engagement, Governance, Access, and Protection (EGAP) A Data Governance Framework for Health Data Collected from Black Communities. Blackhealthequity.ca
[31] Ibid.
[32] TAIBU leadership course, 2019

- Diabetes rates are twice as high in Black communities (8.5%) even when compared to other racialized minorities (i.e., Asian communities at 4.3%)
- Black people have the highest rate of hypertension at 19.8% compared to the white population at 13.7%[33]

A major US study found the following data. Canada does not have comparable data to draw from, but some of the trend lines are assumed to be comparable.

All age adjusted deaths/100,000 (2017)	**All**	**White**	**Black**	**Indigenous**	**Asian Pacific**	**Hispanic**
HIV	1.8	1	**7.2**	1	0.4	1.7
Diabetes Mellitus	21	19.3	**36.8**	34.3	24.7	24.7
Suicide	13.5	**15.2**	6.1	13.5	6.7	6.7
Homicide	6.2	3.5	**21.4**	6.7	1.8	5.3
Breast Cancer Diagnosis		**125.6**	123.3	71.2	94.3	93.6
Breast Cancer Deaths		19.8	**27.6**	12.9	11.8	13.6
% deaths compared to diagnosis		16%	**22%**	18%	13%	15%
Cervical Cancer Diagnosis		7.5	8.6	6.4	6	**9.4**
Cervical Cancer Deaths		2.2	**3.3**	1.7	1.9	2.6
% deaths compared to diagnosis		29%	**38%**	27%	32%	28%
Colon and Rectum Cancer Diagnosis		37.3	**43.2**	30.1	28.8	33.5
Colon and Rectum Cancer Deaths		13.7	**18.6**	11.2	9.9	11
% deaths compared to diagnosis		37%	**43%**	37%	34%	33%
Prostrate Cancer Diagnosis		90.2	**158.3**	49.6	51	78.8
Prostrate Cancer Deaths		17.7	**37.5**	14.2	9	16
% deaths compared to diagnosis		20%	**24%**	29%	18%	20%

Public Health Agency of Canada. (2020). Social determinants and inequities in health for Black Canadians: A snapshot. https://www.canada.ca/content/dam/phac-aspc/documents/ services/health-promotion/population-health/what-determine s-health/social-determinants-inequities-black-canadians-snap shot/health-inequities-black-canadians.pdf

In a Canadian study, it was found that 40% of young women under 21 encountered racism when accessing health care services, including:

- Cultural insensitivity
- Name calling
- Racial Slurs
- Receiving inferior care
- Being over charged for services
- Inappropriate sexual contact[34]

VI. Recommendations to Address Health Inequities:

[33] A Public Health Agency of Canada. (2020). Social determinants and inequities in health for Black Canadians: A snapshot. https://www.canada.ca/content/dam/phac-aspc/documents/ services/health-promotion/population-health/what-determine s-health/social-determinants-inequities-black-canadians-snap shot/health-inequities-black-canadians.pdf

[34] Ibid.

Black experiences in health care symposium, 2020:

The 'Black experiences in health care symposium' in 2020 made the following recommendations:
For Ministry of Health and Ontario Health (included the former LHINs)

1. Mandatory collection of socio demographic and race-based data.
2. Mandatory health equity training
3. Fully funded black health strategy
4. Specific funding for black community mental health services
5. Funding to create culturally safe spaces.

For Hospitals, Community Health Centres and Primary Care providers:

1. Integrate equity into care provision planning.
2. Deploy training around Health equity, cultural safety, and anti-oppression at all levels and within health care organizations.
3. Address racism and discrimination specifically within hospitals.

Collection of Socio Demographic and Race Based Data:

Advocates have long called for the collection and responsible use of race-based data in Ontario's health system. When collected and used in accordance with best practices, race-based data in health can be used to dismantle structural racism:

- by uncovering inequities,
- by developing policy and practice to tackle these inequities,
- by monitoring and evaluating the effectiveness of interventions,
- by holding authorities accountable for improving outcomes, and
- ultimately by eliminating structural racism from systems.[35]

However, the collection of race-based data should never be the end goal. It must be used to create pathways for dismantling structural racism and advancing health equity. Without an explicit focus on dismantling structural racism, the collection and reporting of race-based data can be detrimental to Black communities.[36]

The Black Health Equities Working Group released a report "Engagement, Governance, Access and Protection (EGAP): A Data Governance Framework for Health Data Collection from Black Communities in Ontario" April 2021

The EGAP Framework envisages Black communities gaining control over their collective data. Key to this is the establishment of Community Governance Tables, decision-making bodies on the front lines of building accountability. Community Governance Tables representative of local communities must be developed in various locations across the province. External parties will be required to present plans for community engagement, data collection, data management, data analysis, and data use to the relevant Community Governance Table, which will approve or reject them. Only with approval can the external party proceed with the work. Thus, data stewards and users will be answerable to Black communities through the Community Governance Tables, which can be developed and adapted for different circumstances and organizations.

[35] Black Health Equity Working Group (2021) Engagement, Governance, Access, and Protection (EGAP) A Data Governance Framework for Health Data Collected from Black Communities. Blackhealthequity.ca
[36] Ibid.

This report outlines steps that are required to implement the framework. It is offered as a starting point for anyone involved in the collection, management, analysis, and use of race-based data for health purposes, including governments and related agencies, health system organizations, research institutes, and community-led organizations. It is also intended for Black community members, who are directly affected by the issues, questions, and recommendations for action raised here.

VII. Consultations with the Hamilton Black Health Community Leaders Forum

The Hamilton Black Health Community Leaders Forum represents the African Diaspora and includes members from Cameroon, Ghana, Kenya, Nigeria, Rwanda, South Sudan, Somalia and Zimbabwe.

Themes from Consultation:

1. Health system has marginalized, traumatized and re-traumatized Black communities.

2. Constant Anti-Black racism in the form of micro aggressions and systemic racism makes us sick.

   Examples of Micro aggressions
   - Body language from health care providers is dismissive.
   - Health care providers do not take our health seriously.
   - In emergency it is assumed that we are on drugs; symptoms not treated seriously.
   - Without trust, we do not speak.
   - Treated poorly.
   - Immediately written off.
   - Health Care providers think less about black people.

   > *"I need to get ready each day. I walk out the door to prepare myself to be belittled, looked down upon, judged before I speak, seen as less intelligent. Just the looks demoralize me every day."*
   >
   > *A professional black leader*

3. Mental Health Services:
   - Must be culturally and linguistically appropriate.
     - Some of our elders believe in witchcraft; this is cultural and should not be treated as a mental health issue or psychotic. Often elders are prescribed drugs as a result.

4. Long-term Care and Home Care
   - Most LTC facilities are not culturally or linguistically appropriate; need culturally specific LTC facilities
   - Many communities prefer to keep elders in their home as much as possible but need more culturally and linguistically appropriate services.

5. Primary Care
   - Many physicians do not listen nor do they understand black specific health issues
   - Interpretation services are not available; using family members, especially children as interpreters is potentially harmful.
   - A patient is often seen as evasive (i.e., in sexual health describe the body part instead of naming it) often resulting in being dismissed and misdiagnosed.

6. History of mistrust

- Black communities have been subject to experimentation. This results in issues such as vaccine hesitancy.
    - Important to see white people take vaccine so they can trust that the Black communities are not an experiment for a new drug.

7. Leadership
    - No black leadership at decision making tables; the higher in authority, the whiter the leadership.
    - Need to change who is at table.
    - Need to see themselves in the health care system from students to physicians to frontline workers to leaders.

8. Appropriation of Ideas:
    - When black leaders come up with ideas that the health system supports, the ideas are often appropriated, and the community is no longer involved.
        - i.e., Cultural Ambassadors for Covid. "Public health moved the idea forward without the role of the community in implementation. The community was not recognized in the process." – focus group participant.

9. Lack of trust in the process:
    - Have attended many consultations re EDI – with no follow up – reactive not proactive.
    - This time are they willing to listen? Will our voices get watered down? How will we know if they take us seriously?

10. Governance in GHHN:
    - Being a lone voice is very hard. Very isolating.
    - If system is not ready to hear and act – then it is very frustrating and exhausting to carry weight of community as lone voice.
    - Need more than one person – cannot be the token.
    - System will only change if we demand it to change - need to be more aggressive or will not be heard.

VIII. GHHN Commitments to Anti-Black Racism and Improving Black Health Outcomes (Proposed Statement)

- GHHN acknowledges that anti-black racism and racial stereotypes persist in the health care system and are so deeply entrenched in the practices that its institutional and systemic forms are either functionally normalized or rendered invisible, especially to the dominant group.
- GHHN acknowledges that racial inequalities, anti-Black racism, discrimination and the lasting effects of trauma have negative impacts on the mental health and physical well-being of Black communities.
- GHHN is committed to meaningful sustained change to dismantle systemic racism across the continuum of the health system.
- GHHN's work to address anti-black racism is rooted in a commitment of "nothing about us without us".

In recognition of these commitments, the Greater Hamilton Health Network is committed to:

- Developing a culturally safe and linguistically appropriate, trauma and violence informed, coordinated,

seamless health care system.

- Beginning the journey of building trust, by listening to the voices of Black communities, patients and health care professionals who have been grappling with anti-Black racism for generations, and by engaging with the many communities that have made recommendations for meaningful change to address the problem.
- Embedding the principle of "nothing about us without us" in each of the initiatives under the authority of the GHHN
- Beginning the journey to educate all leaders, staff and partners on systemic racism, anti-oppression, decolonization practices, implicit bias and cultural safety within our health care institutions.
- Committing to the collection of socio demographic and race-based data.

IX. Starting the Journey

1. Include racially diverse leaders in all levels of the GHHN including the Executive Council, working groups and staff teams. Engage with the Hamilton Black Health Leaders Forum and more diverse black voices that represent those of Caribbean descent, second generation Black Canadians, 2SLGBTQIA+ Blacks and more.

2. Develop a strategy to collect disaggregated socio demographic and race-based data across the partners and in GHHN initiatives that include standardized data. Use the EGAD principles as outlined in "Engagement, Governance, Access and Protection (EGAP): A Data Governance Framework for Health Data Collection from Black Communities in Ontario" including the development of community governance table to oversee the use of the data.

3. While the health system is still fragmented, develop a system of cultural ambassadors to help people navigate the system. These positions should be anchored in the community and help people navigate across the entire continuum of care.

4. Develop a strategy to enhance culturally appropriate and accessible mental health and HIV services for the Black communities, anchored in Black focused organizations.

5. Develop interpretation services that meets the linguistic needs of new immigrants and refugees and does not rely on children or friends.

6. Once the mandate has been clarified for Home care – develop a culturally and linguistically appropriate home care delivery system that meets the needs of diverse communities to keep their families at home.

X. Resources

Black Experiences in Health Care: Symposium Report, March 2017

Black Health Equity Working Group (2021) Engagement, Governance, Access and Protection (EGAP): A Data Governance Framework for Health Data Collection from Black Communities in Ontario. Blackhealthequity.ca

Public Health Agency of Canada. (2020). Social determinants and inequities in health for Black Canadians: A snapshot. https://www.canada.ca/content/dam/phac-aspc/documents/ services/health-promotion/population-health/what-determine s-health/social-determinants-inequities-black-canadians-snap shot/health-inequities-black-canadians.pdf

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Black Health Consultation Participants: April 8, 2021

Ike Agbassi, President Nigerian Community
Comfort Afari, President of Ghanaian Community
Kosita Musabye, Leader of Rwanda Community
Gabsia G Nyomykam, Leader of Cameroonian Community
Gatwor Lock, Leader of South Sudanese Community
Henry Onwuka, Vice President Nigerian Community
Ronnic Sanyaolu, Leader Nigerian Community
Peter Galluak, Leader South Sudanese Community
Asha Dirir, Somali Community
Mandy Jubani Zimbabwean Community
Jean-Jacques Somwe, President Congolese Community
Mohamad Siyad, Leader Somali Community
Donald Ngalla, President Cameroon Community
Priscilla Ankama, Leader Ghanaian Community
Yvette Asselstine, Leader Ghanaian Community

Facilitated by:
Comfort Afari, Chair of the Hamilton Black Health Leaders
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Supported by:
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Chapter Four
Immigrants and Refugees

This Chapter was co-authored with Nora Melara-Lopez, Social Worker, Compass Community Health and Nhlaloenhle 'Nala' Ndawana (She/Her), Executive Director (Interim) (co facilitator), Hamilton Urban Core Community Health Centre. Nora and Nala are members of the GHHN EDI ARAO Steering committee and co-facilitated the Immigrant and Refugee session. Thanks also to the participants who joined the session and reviewed this chapter.

There is a vibrant and growing Immigrants and refugee population in Hamilton. These communities are highly diverse and have significant intersections with racialized communities, and LGBTQIA+ communities. There is also a significant racialized Francophone populations as Hamilton has been designated as a Francophone settlement community.

This Chapter explores the issues impacting immigrants and refugees within our health care system and the impact on health outcomes. It also identifies proposed first steps on the journey to dismantle systemic racism and discrimination in our health system as it impacts immigrants and refugees.

Given the many intersections with the racialized communities, many of the themes from this consultation are similar to the themes from the Black Health consultations and from the Francophone consultations. It should be noted that racialized individuals from families that are second or third generation or even longer from when they immigrated, continue to feel the impact of racism and discrimination, indicating that racism is the deeper root cause for poor health outcomes.

I. Demographic Shifts in Hamilton

Key Findings from "Demographic Shifts", Social Planning and Research Council, Hamilton (2016):

- Racialized: The two largest racialized groups in Hamilton are South Asian with just over 22,000 residents, and Black with just over 20,000 residents. The next largest groups, with about 10,000 residents each, are Chinese and Arab. The Chinese and Southeast Asian visible minority groups had the slowest growth between 2006 and 2016. Conversely, Filipino and Arab were the fastest growing visible minority groups in that time period.
- Age: More than four in ten of Hamilton's seniors arrived to Canada as immigrants, but the immigration rate drops to 26% among adults under age 65, and 7% among Hamilton's children. The most common age of arrival to Canada for Hamilton's immigrants is in or near their 30s, but recently Hamilton has seen a big jump in the number of immigrants arriving at age 45 or later.
- Languages: Top non-English languages spoken at home include Italian, Spanish, Arabic, Polish and Serbian.
- Refugees: The influx of Syrian refugees in 2016, to communities across Canada, including Hamilton slowed down the decline in new immigrants locally. Over 500 Syrian children arrived in Hamilton in 2016 alone. In more recent years, refugees have arrived from Colombia, Mexico and Sudan.
- Housing: Accessing subsidized housing is a real challenge with a wait time longer than 10 years. High market rent prices force people to live in over-housed conditions and using most of their income to pay rent. If in need of medications not covered by OW or ODSP, they often do not fill prescriptions.

- Migrant workers face more challenges accessing health care – work schedule and distance to health care facilities; employers reluctant to allow workers during working hours to access health care.

Healthy Immigrant Effect

Research on a broad sample of immigrants has shown that when immigrants arrive to Canada they are generally in better health than their Canadian born counterparts.[1] Even refugees, overall, have lower mortality rates than do Canadian citizens.[37] This is known as the 'healthy immigrant effect'.[38] It should be noted that the majority of Canadian research on the healthy immigrant effect has been on adults and not on children and youth.

Despite their initial relatively good health, the health of immigrants often starts to decline sometime after their arrival to Canada. For example, research has found that those who had been living in Canada for 10 years or less had fewer chronic illnesses and less chance of disability than immigrants who had been living in Canada for longer and Canadian born citizens.[39]

II. Themes from the Immigrant and Refugee Communities Consultation

Over 17 people participated in the consultations; mostly middle level staff who work directly with the immigrant and refugee communities in Hamilton.

1. Immigrants and refugees are part of society, but they are often segregated.

2. Need to acknowledge and name that "racism makes us sick"; it's the worst type of 'cancer'.
    - Racist bias, policies and people are at the root.
    - Stress from racism and discrimination leads to physical and mental health challenges.
    - There is a serious negative impact of daily and constant micro-aggressions as soon as a person walks out the door of their own homes.

3. Call for all organizations to do work in AR/AO.
    - Develop AR/AO policies.
    - Do staff development that is AR/AO and trauma and violence informed.
    - Measure patient experience as it relates to feeling safe(r) as it relates to their experience with micro aggressions.
    - Hiring practices – health care providers who are reflective of Hamilton's diversity.

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[37] Beiser, M. The Health of Immigrants and Refugees in Canada. Canadian Journal of Public Health. 2005. 96 (2), S30-S44.

[38] Caring for Kids New to Canada. Adaptation and Acculturation. 2013. http://www.kidsnewtocanada.ca/culture/adaptation#resilience

[39] Newbold, K.B., Danforth, J. Health status and Canada's immigrant populations. Soc Sci Med. 2003. 57, 1981-95.

4. Leadership
    - Need diversity at the higher levels of management.
    - Frontline workers and middle management are more diverse, but they are not in the position to make changes.
    - Need to mentor middle managers for leadership positions (allowance for diverse perspectives and ways of knowing, communicating, being and leading, or outside of the box leadership).

5. Primary Care
    - Patients do not receive information in a manner that they understand it; often feel dismissed.
    - Challenges: timely appointments and language barriers.
    - LGBTQIA+ individuals have to decide between a provider who speaks their language or who is gender affirming.
    - Seeking culturally appropriate trans care is a significant challenge.
    - People may be diagnosed with HIV through the refugee process but have no idea how to access services.

6. Structural Health System Challenges:
    - Often coordinated health is based on the needs/requests of those who were born in Canada. The coordinated health process was designed for people with these health, wellness and access needs.
    - Newcomers have very different unique needs depending on where they were born and the context (i.e., socio-economic-political) of such as place, how long they have lived here, their type of employment, etc. For example, someone experiencing the health impacts from PTSD who was born in Canada will be different than the services required for someone who has PTSD due to political war and/or from migration.

7. Individual Impacts:
    - Newcomers are arriving from diverse places, where there is different health and mental health care approaches and understandings. For example, some are not as familiar and comfortable with Western medicine (medications etc.) and approaches.
    - Perspectives on health vary across the globe, so issues may not be as, or more, prevalent or cause for concern. One such example is that outside of the West the Body Mass Index Scale (BMI) is not relied upon to the degree it is here. Health is the overall wellbeing of an individual and it is not tied to weight.

8. Lack of information re the system or patient right:
    - This is important for new immigrants and refugees given that they do not trust the system based on experiences in their home countries.

9. Interpretation
    - Children and minors are frequently being used as interpreters to inform parents of often life changing conditions including cancer diagnosis. Another example provided was that children are being asked to explain the trauma that their parents experienced, to their provider. This experience can be retraumatizing for the child and parent. Participants expressed concern that using children as interpreters can be dangerous and is unacceptable.

10. Services required:
    - Violence against women
    - Trauma informed practice
    - Harm reduction
    - Citizenship services and knowledge
    - Culturally and linguistically appropriate LGBTQIA+ services
    - Culturally and linguistically appropriate mental health and addiction services.

11. Need system navigators and patient advocates.
    - System navigators should be anchored in the community to assist people across the continuum of care.
    - They should not be anchored in each organization.

Feedback on GHHN Congregate Setting Initiative:

1. Shelters & Residential Care Facilities:
    - Need front line workers who are culturally competent and speak multiple languages.
    - Not enough supply for women and families.
    - Shelters are usually male and female; and do not accommodate LGBTQIA+.

2. LTC & Retirement Homes:
    - PSWs and RNAs are often diverse and from racialized communities; many speak many languages but there is little attempt to match language and culture with residents.
    - Elder family members are often supported by family as best they can because they cannot receive physician nor mental health support in their languages or in a manner that supports their culture in LTC or Retirement homes.
    - Need to provide culturally and linguistically appropriate home and community care so that elder family members can remain at home.
    - Advocate for culturally specific congregate setting i.e. Black and Asian specific homes.

Feedback on Governance:

- Immigrants and refugee leaders should be at the table.
- Change starts from the top and from within – need to face racism from executive down to front-line.
- Develop mentorship opportunities for emerging leaders.
- Stay with discomfort.
- Avoid tokenism, especially when including people with different races or who speak different languages.
- Give credit and compensate.
- Sit with communities and talk to them.
- There is a difference between people speaking and being heard.
- Policies need to be in place to dismantle the structure of racism in order to have meaningful change.

Build Capacity from Within:

- Need to build capacity within the immigrant and refugee community.
- Leaders from Immigrant and refugee communities should participate and empower themselves and demand to be at appropriate tables; speak with a united voice.
- Need resilience and not to give up.

IV Starting the Journey

1. Include immigrant and refugee leaders in all levels of the GHHN including the Executive Council, sector council, community collaborative council, working groups and staff teams. Develop mentorship opportunities for emerging leaders.
2. Move beyond representation, hire someone who has migrated at the executive level—provide power and resources thus allowing them to guide the process and provide direction, including at the working group level.
3. Develop a strategy to collect disaggregated socio demographic and race-based data across the partners and in GHHN initiatives that include standardized data.
4. Assess the capacity of interpretation and translation in GHHN initiatives and encourage collaboration among partners to enhance appropriate interpretation services. Ensure materials are available in the languages of the participants in any GHHN initiative.
5. Design a system that is based on the experiences of immigrants and refugees. Increase ease of services in terms of access and cost- including parking and time off from work. Not everyone has a job, benefits or works 9-5. Have service providers that speak a range of languages so that interpreters are not always needed.
6. In GHHN initiatives, and while the health system is still fragmented, develop a system of cultural ambassadors/system navigators to help people navigate the system. These positions should be anchored in the community and help people navigate across the entire continuum of care.

Longer Term:

7. Develop a coordinated and collaborative interpretation services across the continuum of care that meets the linguistic needs of new immigrants and refugees and does not rely on children or friends.
8. Develop a strategy to enhance culturally and linguistically appropriate and accessible mental health and HIV services for the immigrant and refugee communities anchored in community-based organizations.
9. Once the mandate has been clarified for home care – develop a culturally and linguistically appropriate home care delivery system that meets the needs of diverse communities to keep their families at home.
10. Support the advocacy for a Black Health focused Community Health Centre.

List of Participants: Immigrant and Refugee Focus group discussion – April 13, 2021
Nora Melara-Lopez, Social Worker, Compass Community Health (co facilitator)

Nhlaloenhle 'Nala' Ndawana, Executive Director (Interim), Hamilton Urban Core Community Health Centre (co facilitator)
Maria Antelo, Board Member of the Emergency Support Committee for Refugees (ESCR) & Community Development Worker at Hamilton Community Legal Services
Aayah Amir, Pathways to Education Coach, Compass CH
Tareq Al-Ajak, Pathways to Education, Compass CH
Eddy Aranguen, Regional MSM Health Promotion and Risk Reduction Worker -The AIDS Network
Liliana Figueredo, Co-Founder of Multicultural Wellness Fair
Bonaventure Otshudi, Francophone CH
Scott Jones, Executive Director Micah House (Shelter for Refugee Claimants)
Tibor Lukacs, Refugee Counsellor, Hamilton Urban Core CH
Sana Minhas, SW student McMaster
Noura Afifi, 2S-LGBTQIA+IA+ Newcomer Youth Support Worker Speqtrum Hamilton and the YWCA Hamilton
Rana Aldibs, YWCA Supervisor of Health & Wellness Programs
Sandra Ezepue, Manager, Community Health Programs, Hamilton Urban Core CHC
Tethreem Zafar, Manager, Immigrant and Settlement Services, YWCA
Zayed Tora. Imam, Muslim Association of Hamilton
Mona Aziz-Hanna, Board member of the ESCR
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Dr Mirna Carranza, School of Social Work, McMaster University

Chapter Five
Two Spirit and LGBTQIA+

This chapter was co-authored with four members of the GHHN EDI ARAO steering Committee including Clare Freeman, Lisa Jeffs, Tim McClemont and Kyle Weitz. The four members of the Two Spirit and LGBTQIA+ communities met regularly to conduct a community consultation with over 107 respondents to a survey and thirty participants in a focus session.

Note: The terminology in this report follows that of "Mapping The Void" and serves as an imperfect representation of Hamilton's diverse queer community.

Hamilton's Two Spirit and LGBTQIA+ communities are visible, highly engaged and diverse. Folks within these communities represent the intersectionality of many communities across Hamilton, including but not limited to, BIPOC communities, immigrant and refugees and Francophone communities.

The voices and experiences of Hamilton's Two Spirit and LGBTQIA+ communities were not engaged or acknowledged as a community that face barriers or poor health outcomes in the GHHN full application. In fact there is no mention of the communities anywhere in the work done thus far in the GHHN. The Two Spirit and LGBTQIA+ communities view the omission of their communities as a further example of the systemic exclusion and barriers that exist and lead to poor health outcomes in their communities.

In developing this chapter's recommendations, four members of the EDI committee who identify as queer, gay and trans developed a process to ensure the voices, experiences and recommendations from Hamilton's Two Spirit and LGBTQIA+ communities were engaged.

The process used by the Two Spirit and LGBTQIA+ members of the GHHN EDI Steering Committee were as follows:

1. Reviewed of the "Mapping The Void" (2019) research findings and recommendations.
2. Met and prepared a survey based on the "Mapping the Void" findings.
3. Issued a community survey; and analyzed and summarized the 107 responses.
4. Hosted a community meeting to discuss the survey findings and recommendations.

The chapter concludes with recommendations on beginning the journey for inclusion of the Two Spirit and LGBTQIA+ communities.

I. Two Spirit and LGBTQIA+ Legislation and Health Impacts

Historically across Canada and the world, the Two Spirit and LGBTQIA+ communities have faced levels of systemic, institutional, legal, health discrimination and oppression. Since the late 60's many systemic and cultural changes to reduce discrimination and oppression have occurred across Canada. However, it must be stated that most of those changes have been as a result of long advocacy by the Two Spirit and LGBTQIA+ communities through Supreme Court challenges. In fact, health care was often used to promote social norms of discrimination and was responsible for practices that caused physical and mental health harm towards the community; including but not limited to forced mental institutionalization, lobotomizing, sterilizing, denying access to trans surgery and supports and forcing gender assignment.

In addition, supporting research made false claims about Two Spirit and LGBTQIA+ communities, did not

adequately resource the early HIV pandemic and fed misinformation about the gay community especially as it came to parenting or the ability to be with children. Lesbian health has often been invisible and thus their health care needs are not always adequately addressed. Poor treatment within institutional care or congregate settings in the past and current practices within these settings have caused fear within the seriously ill, aging or palliative patients in accessing care.

Consistent research into the lives and experiences of Two Spirit and LGBTQIA+ communities find risk factors to poor health comes that stem from lack of access and support in health services: including the continuation of discrimination when accessing care. Additionally, it must be recognized that currently several faith lead organizations actively deny health care to Two Spirit and LGBTQIA+ communities and/or advocate for conversion therapy.

In reviewing health risk research, the communities experience higher rates of disability, violence, substance use, depression, anxiety, some cancers and are at greater risk of suicide. When accessing health services, research finds physicians, nurses and allied health professionals are poorly trained in supporting the health needs; including but not limited to a significant gap in sexual and identity health. Studies have consistently shown that Two Spirit and LGBTQIA+ people continue to face health disparities when compared to people who are cisgender and heterosexual as a result of experiences of transphobia, homophobia and heterosexism.[40]

"MAPPING THE VOID"[41]

"Mapping the Void" aimed to capture the full range of Two Spirit and LGBTQIA+ experiences, especially those of traditionally marginalized populations. The purpose of the study was to describe the lived experiences and to determine what services, spaces and institutional changes were needed. At the time of the study, there was no permanent, public social space for Two-Spirit and LGBTQIA+ community members, and very few services designed to assist them in Hamilton. The report built on previous studies completed in 2006-07 and is the most comprehensive project on Hamilton's community to date.

Key themes from the study include:

- Many people reported feelings of discomfort with individual health care practitioners and face forms of discrimination when accessing health care.
- Many people delay access to health care due to fear of discrimination and lack of trans-and LGB-competent health care available.
- Health Care providers' knowledge is limited about Two Spirit and LGBTQIA+ communities.
- There is a high need for mental health services among Two Spirit and LGBTQIA+ people in Hamilton.
- Sexual health is a concern for everyone in the community.
- There is a strong need for trans and gender affirming care to be available in Hamilton[42]

II. Survey Findings and Consultation with Community 2021

As part of the consultations for a Health Equity Action Plan for Greater Hamilton Health Network, members of the GHHN EDI/AR Steering Committee issued a further survey built on the health findings in the "Mapping the Void" report and three questions not covered by the Mapping the Void study. 107 community members

[40] Mapping The Void, 2017
[41] Ibid. Page 18
[42] Ibid. Page 51.

responded to the survey. Unfortunately, demographic data was not collected so there is no way to know which community voices were heard or missed.

After the survey findings were collated, the committee invited members of the Two Spirit and LGBTQIA+ communities to review findings and make recommendations. Thirty community members attended the virtual meeting.

Key findings:

- Transphobia and homophobia exist within all levels of health care delivery and it causes harm and barriers to better health within the Two Spirit and LGBTQIA+ communities.
- Two Spirit and LGBTQIA+ communities experience discrimination and barriers when accessing health services across the spectrum and across the life span.
- Health Services lack the competency to fully affirm and support the Two Spirit and LGBTQIA+ community.
- Health care practitioners are not trained to adequately support Two Spirit and LGBTQIA+ community.
- Health care services do not have visible representation of the community in personnel or in any branding or communication.
- Primary care providers are not consistently offering legal right to care for trans members. Some primary care physicians continue to refer out.
- Members of the community want access to Two Spirit and LGBTQIA+ therapist and health care providers.
- Mental health services neglect the needs of Two Spirit and LGBTQIA+
- Sexual Health Services for Two Spirit and LGBTQIA+ needs improvement.
- Members of the Two Spirit and LGBTQIA+ communities fear being out in all congregate settings and when community health services are in their home due to fear of discrimination and fear of violence/hate. It was identified that the more precarious the housing the more the fear i.e., RCF and shelters.
- Members of the Two Spirit and LGBTQIA+ communities fear end of life care and lack access to good advance care planning and health care directive supports.
- The financial burden of gender affirming care is a barrier to better health.
- There is a lack of health care transitional support for youth to adult services.
- More harm reduction and safe injection sites are needed that address the needs of the Two Spirit and LGBTQIA+ communities.
- HIV and SDI testing needs to be more accessible and inclusive.
- Due to discrimination against Two Spirit and LGBTQIA+ communities, personal risk to hate crime and personal violence exist.
- Two Spirit and LGBTQIA+ are invisible within the shelter and homeless strategies and face additional barriers.

III. Starting the Journey

GHHN Leadership

Year 1:

- Acknowledge the community in all the work of the GHHN.
- Adopt an EDI intersectional Anti-racism and Anti-Oppression culture in all aspects of Governance and work at operational or community level.

- Include Two Spirit and LGBTQIA+ leaders in all levels of the GHHN including the Executive Council, Partnership Council and staff teams.
- Conduct a three-day education and strategy for GHHN and Board on building inclusive Two Spirit and LGBTQIA+ and gender affirming health care within the GHHN-to be led by communities
- Include visible representation and consultation with Two Spirit and LGBTQIA+ communities in all GHHN priorities through different networks and advisors; including working with the Hamilton Trans Health Coalition to support the implementation of a trans health training strategy for primary care.
- Ensure all branding and communication incorporates the above framework.
- Work to establish a network of Two Spirit and LGBTQIA+ serving agencies-like the AIDS Network, Trans Health Network in the efforts of establishing a Health and Community Hub for Two Spirit and LGBTQIA+ communities.

Year 2

- Have a developed Two Spirit and LGBTQIA+ community engagement strategy that will employ multiple ways to gain the voices of the communities.
- Establish quality improvement metrics and ways to audit programs and services.
- Explore ways to improve gender affirming competency across health and social services.
- Work with GHHN Partners to begin the journey to educate all leaders, staff and partners on homophobia, transphobia, hetero-sexism, systemic oppressions, implicit bias and discrimination within and across our health care system.

Year 4:

- Integrate a Health equity intersectional Anti-racism and Anti-Oppression culture in all aspects of governance and work at operational or community level.
- Invest funding into Two Spirit and LGBTQIA+ communities-shared health and community centre.

Health Care Providers

Year 1:

- Leadership within organizations adopt auditing and strategies to train staff and create an inclusive organizational culture. The approach recognizes that all approaches will ensure an understanding of how gender, age, racial ethnicity, linguistic, abilities and social location will create additional barriers and thus all strategies must address all barriers.
- Review and revise all client forms and records to ensure visibility of Two Spirit and LGBTQIA+
- Access to harm reduction and safe injection sites that are gender affirming.
- Access to Two Spirit and LGBTQIA+ sexual health.
- Build a collaborative to address discrimination and build a strategy for congregate care settings, including Residential care facilities, Long Term Care, Shelters, Youth homes, Retirement homes, and hospices.
- Ensure all health care and community providers across the region of the GHHN develops a strategy to build competencies to deliver barrier free care to the Two Spirit and LGBTQIA+ communities across the life span. This includes ensuring all health care providers:
    - Know the legal and health care rights for gender affirming care.
    - Ensure all forms include the visibility of Two Spirit and LGBTQIA+
    - Ensure all communication (verbal, printed, social media and personnel) include affirming visibility of community.

Year 2:

- Commit to mandatory, comprehensive, ongoing training at all levels of the organizations across the health system. Accredited training (approved by community and organization) and CME credits made available for physicians.
- Develop transitional care plans for youth moving into health care.
- Ensure Two Spirit and LGBTQIA+ staff are safe to be out within workplace by including gender identify, expression and sexual orientation into HR policies and by hiring from within the community. This will allow clients to feel safe.
- Ensure frontline and organizational communication is gender affirming; including, but not limited to, asking for and respecting pronouns and names.
- Ensure no primary care physician or service will misinform or refer a client due to lack of competency or knowledge by providing training on gender affirming care, ensuring the Rainbow Health guidelines are in every primary care office and by supporting a network of support with physicians familiar with transitioning patients.
- Develop harm reduction, safe injection and better access to Sexual Health services designated to the Two Spirit and LGBTQIA+ needs or community.
- Develop a community collaborative partnership that will fund and support the social, housing and health care needs of the Two Spirit and LGBTQIA+ communities.
- Develop Two Spirit and LGBTQIA+ peer mental health supports and access to Two Spirit and LGBTQIA+ mental health experts/visible members.

Year 3:

- Implement an integrated community and health care collaborative that is defined by the Two Spirit and LGBTQIA+ communities to collaborate across the life span with health, community services and home services to ensure safe care. This will require additional funding.
- Develop integrated care pathways for congregate care and end of life/palliative services.
- Collaborate with home care providers to train staff and develop strategies to deliver visible open care for Two Spirit and LGBTQIA+ communities.
- Ensure competent sexual health delivery anywhere across the health system including within primary care.
- Reduce costs for trans health.
- Ensure Trans inclusive and gender affirming care is available within all health care providers including acute and primary care.

Chapter Six
People Who Use Drugs

This chapter was co-authored with Tim McClemont (The AIDS Network), Monika Abdelmaseh (Hamilton Urban Core) and Nhlaloenhle Ndawana (Hamilton Urban Core). Tim and Nala are members of the GHHN EDI ARAO Steering Committee. A special thanks to Tara Johnson (Health Promotion Specialist, Hamilton Public Health) and Candice Bremmer (Registered Social Worker, Concurrent Disorders Capacity Building Team, St. Joseph's Healthcare Hamilton) for adding their voices and expertise. And finally, much appreciation to the participants of the May 7, 2021 focus session.

According to an article in the Hamilton Spectator, Hamilton is "ground zero" for the Opioid crisis in Ontario, and people who use drugs are often one of the most marginalized, stigmatized and discriminated population groups. Despite this, the Greater Hamilton Health Network, in their response to equity pressures in their full application was silent on acknowledging the opioid crisis in Hamilton or the unique needs of People Who Use Drugs (PWUD). The voices and experiences of the PWUD were not engaged or acknowledged as a community that face barriers or poor health outcomes.

Silence about the opioid crisis is an example of the marginalization of this population and the systemic exclusion that leads to poor health outcomes. GHHN must provide leadership in calling on all levels of government to declare the Opioid crisis an emergency.

During the consultation, examples of good work were identified that need to be amplified and scaled up, especially the expansion of harm reduction policies in all organizations. There are also many developed good training resources available.

The chapter ends with recommendations for the GHHN to begin the journey in addressing the issues for PWUD, including incorporating harm reduction in all its initiatives.

I. OPIOID Crisis

Between 2005 and 2019, Hamilton had a higher rate of opioid-related deaths when compared to the provincial average.

- In 2019, Hamilton's death rate was 75% higher than the provincial rate.
- As May 25, 2021, 378 people in Hamilton died from Covid-19. During a similar period (March 2020 to April 2021) 206 people in Hamilton have died from opioid use.[43]
- In first 15 weeks of COVID pandemic, 40 people lost their lives in opioid-related deaths; compared to 15 in the previous weeks before pandemic.[44]
- In Hamilton the death rate from opioid use climbed during the first wave to 6.8 per 100,000 compared to 3.1 prior to COVID. The provincial death rate in 2020 was 2,271, a 50% increase from 2019.[45]

[43] Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, Centre on Drug Policy Evaluation. Preliminary Patterns in Circumstances Surrounding Opiod-Related Deaths in Ontario during the COVID-19 Pandemic. November 2020. https://odprn.ca/wp-content/uploads/2020/11/Opioid-Death-Report_FINAL-2020NOV09.pdf

[44] Hamilton Spectator. Nov 10 2020.

[45] Ibid.

Yet the response to this crisis at all levels of decision making has been woefully inadequate.

The Ontario Drug Policy Research Network, the Office of the Chief Coroner for Ontario, Public Health Ontario and the Centre on Drug Policy Evaluation released a report in November 2020 on how opioid related deaths climbed across Ontario as measures to control the Covid-19 pandemic set in. They found that the COVID-19 pandemic emerged in the midst of the ongoing epidemic of opioid-related deaths in Canada. Public health restrictions introduced in Ontario to reduce the spread of COVID-19 resulted in reduced service levels for health and social services that provide care to people who use drugs. Despite the intention to reduce the impact of COVID-19, there was also concern that these measures would lead to unintended harms.

The ODPRN, the Office of the Chief Coroner for Ontario/Ontario Forensic Pathology Service (OCC/OFPS) and Public Health Ontario (PHO) developed a new report describing patterns surrounding opioid-related deaths that occurred in Ontario during the COVID-19 pandemic up to the end of December 2020. This report updates the data provided in the preliminary report released in November 2020 describing patterns that occurred during the first three months of the pandemic. The study determined that two important factors contributed to this increase in deaths: the COVID-19 public health measures themselves and the more toxic supply of street drugs. The study also found the highest clusters in neighbourhoods with the highest material deprivations but also a significant trend in neighbourhoods with a higher ethno-cultural diversity.

In response to the increased opioid crisis across Canada, there is an increasing call on the federal government to decriminalize the possession of small amounts of drugs. This does not mean legalizing drugs. Drugs would remain illegal. It means removing the stigma of criminal activity and shifts the possession of small amounts for personal use in the realm of public health instead of the criminal code in order to increase practices of safe drug use without the fear of being criminally charged. According to the Hamilton Spectator, among many others, the City of Vancouver and the Canadian Association of Policy Chiefs has called for decriminalization of small amounts of drugs.

II. Harm Reduction Interventions for PWUD (Draft Hospital Policy)

Candice Brimner, RSW, Dr. Robin Lennox, Dr Tim O'Shea and Dr Leslie Martin, from the Inpatient Addiction Medicine Services in Hamilton co-authored a paper entitled "Hospital policy as a harm reduction intervention for PWUD". The policy will be published shortly in the International Journal of Drug Policy.

This proposed policy addresses six areas that could improve hospital experience with PWUD including:

- Use of non-prescribed substances in hospital.
- Distribution of sterile drug use equipment and naloxone.
- Use of hospital restrictions to access off site or outside privileges.
- Use of security services and search of personal belongings.
- Supporting inpatient addiction medicine consultation services.
- Engaging PWUD in policy development and implementation.

This proposed hospital policy could be adapted to the GHHN work in the congregate settings.

III. Themes for Consultation with Agencies and Peers who work with People Who Use Drugs (PWUD) (May 7, 2021)

1. People who use drugs are marginalized, stigmatized and discriminated resulting in lack of trust with the health care system.

- Experience stigma as soon as they enter the institution; from reception to nurses to all staff
- Lack of empathy; lots of judgement

2. Health Care system is failing PWUD.
    - Failures in primary care and mental health system means people end up in emergency departments or emergency shelters.
    - Primary care providers do not take on PWUD as patients.
    - There is an inadequate pain management strategy for PWUDs.

3. Experiences with the health system
    - Medical condition is dismissed with implication that the person is drug seeking. "If I go with a broken arm, they treat me as if I am drug seeking."
    - Hospitals discharge PWUD with no regards to where they will go; even if they have need for serious physical care; discharge to emergency shelters is not a plan.
    - Security searches at hospitals throw out substances that PWUD need to cope daily.
    - There is a lack of access to harm reduction and to opioid replacement therapies while in hospitals and other institutions.

4. Substance abuse should be treated as a medical issue not a criminal issue. Medical model is based on prohibitive model, abstinence and assumption of 'drugs seeking'.

5. PWUD who are white and privileged have different access issues than people who are street involved or from the BIPOC communities.

6. Need for system navigators and peer workers.
    - People do not know where to go or how to navigate the system.

7. Professionals determine pathway without input from patient.
    - What is happening to you today, no judgment.
    - Be in the moment when they need and are ready to accept service.
    - Need to listen before drawing a plan.
    - Need a shift to be a partner or serving the person that they are treating.

8. Nothing about us without us
    - Our voices need to be at the tables where we will be heard.
    - Go to where people are at and where there is trust.
    - Need to compensate as appropriate.

9. Education system has not changed in the last 10-15 years.
    - Physician and nursing training should require addictions medicine to be core; and not a specialty.

10. Need for comprehensive training in AR/AO and trauma and violence informed care for all current staff and leaders.

11. Need more harm reduction, peer outreach initiatives and consumption treatment services.

- Stop the pilots; already good proven models; need to scale up and made permanent

12. Successful models:
    - Shelter Health Network: Meets people where they are at.
    - Wesley: integrates harm reduction in residential facility.
    - Hamilton Public Health – Harm Reduction Program.

IV. Starting the Journey

1. Join with the Hamilton Drug Strategy to declare the opioid crisis an emergency.
2. GHHN must provide leadership in calling on all levels of government to declare the opioid crisis an emergency.
3. Within GHHN congregate care priorities:
    - Develop integrated pathways for care for people who live in the prioritized congregate settings; align with Hamilton Drug Strategy (HDS): Treatment Pillar.
    - Integrate harm reduction approaches in all prioritized congregate settings; align with HDS: Harm Reduction Pillar.
    - Review the "Hospital policy as a harm reduction intervention for PWUD", referenced above, for the six policy changes that could be adapted to congregate settings.
    - Include organizations who work with PWUD, peer workers and people with lived experience in the working groups for each priority.
4. As part of membership of the GHHN sector and community collaborative councils in GHHN, require organizations to begin to develop harm reduction strategies within their organizations.
5. In the emerging engagement strategy for patients, clients, families, caregivers and people with lived experience, ensure the voices of PWUD are included. Include peer workers at all levels of engagement.
6. Review available training resources with organizations who work with PWUD and determine a collaborative strategy to implement in the congregate settings. Consider mandatory, standardized training similar to the model used with the City of Toronto via the Toronto Hostels Training Centre.
7. Ensure GHHN initiatives are aligned with the Hamilton Drug Strategy by
    - Including a GHHN presence on the HDS Steering Committee,
    - Engaging in multi-sectoral collaboration with HDS stakeholders,
    - Leading, supporting, and participating with HDS stakeholders in health equity related initiatives (such as, health equity analysis, advocacy, policy development, and advancing healthy public policies) that decrease health inequities.
    - Align GHHN initiatives with the HDS Treatment and Harm Reduction Pillars

V. Resources

Hamilton Drug Strategy (HDS), 2019 Report

Hamilton Opioid Information System:

- Hamilton Public Health Services is collaborating with Hamilton Paramedic Services, Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, and community partners to provide timely opioid-related information to the public.

Trauma- And Violence-Informed Care Toolkit, developed by Centre for Sexuality and Canadian Public Health Association, 2020

- Trauma- and violence-informed care (TVIC) is a framework that helps individuals and organizations provide safe and inclusive sexual health, substance use and STBBI-related services. TVIC reduces service barriers and promotes strategies and changes in organizations to result in more caring, compassionate, person-centred and non-judgmental care.

DDCAT/DDCMHT Standardized Toolkit (American Assessment)

- Measures seven dimensions of an organization's capacity to work with dual diagnosis (concurrent disorders.
    - Program Structure
    - Program Milieu
    - Clinical Practice: Assessment
    - Clinical Practice: Treatment
    - Continuity of Care
    - Staffing
    - Training
- To be used as a pre and post measure and assist with determining more targeted training needs. Provides specific recommendations as to how an organization can increase their capacity and see better outcomes.
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3655772/

Anti-Stigma Training

- Mental Health Commission of Ontario, Opening Minds Report, 2014
- The purpose of the research was to explicate the process for designing and delivering successful anti- stigma programs for healthcare providers. This included identifying critical components related to program design (i.e., content ingredients necessary for stigma reduction), critical components related to program delivery and other key ingredients, strategies, practices or processes integral to a program's success.
- https://www.mentalhealthcommission.ca/sites/default/files/qualitative_model_report_feb_2015_0.pdf, pgs 4-5

St. Joseph's Healthcare Hamilton, Concurrent Disorders Capacity Building team (partners with the inpatient addiction medicine service)

- Multi-disciplinary team who provides education and consultations throughout emergency, psychiatric emergency, medicine and mental health.
- Could be used to support training need.
- www.cdcapacitybuilding.com

Toronto Hostels Training Centre (THTC)

- City of Toronto requires all staff who work in congregate settings to complete the THTC training certificate.
- Provides practical, affordable, standardized training. Workshops include substance use, concurrent disorders, psychotropic medications etc. Executive Director: Ruth Gilson
- Provides more targeted training to suit specific needs of organizations via in-service training.
- https://thtcentre.com/

Operational Practices (e.g., auditing assessments, monitoring practices and evaluation tools):

- Trauma and violence-informed approaches to policy and practice – Public Health Agency of Canada
- Trauma- and violence-informed care: A tool for health and social service organizations and providers Source: Equip Health Care - Research to Equip Primary Health Care for Equity (University of British Columbia, University of Victoria, University of Northern British Columbia, Western University)
- Trauma-informed Practice Guide Source: BC Centre of Excellence in Women's Health
- Trauma-informed: A resource for service organizations and providers to deliver services that are trauma-informed Source: Klinic Community Health Centre

<u>Peer Support Resources:</u>

- Best Practice in Peer Support, 2017 Final Report Source: Addictions and Mental Health Ontario
- Guidelines for the Practice and Training of Peer Support Source: Mental Health Commission of Canada
- PEER POSITIVE TOOLBOOK: Preparing Organizations to Better Engage People with Lived Experience Through Equitable Processes – Source: CAM
- TEN: ENGAGING PEOPLE WITH LIVED/LIVING EXPERIENCE (2019) – Source: Tamarack Institute, Health Canada Ontario Harm Reduction Network
- South Riverdale Peer Training Certificate

Ontario Harm Reduction Distribution Program (OHRDP)

Health Equity Guideline (2018) Source: Ontario Ministry of Health and Long-Term Care

Chapter Seven
Rural Health

This chapter was developed with the support of the community support organizations in rural GHHN. A special note of thanks to Clare Freeman who ensured that rural voices were included in the consultations.

According to the 2016 census, rural communities consist of 29% of the population of the City of Hamilton and, therefore, are an important part of the Greater Hamilton Health Network attributed population. They have unique challenges related to their health outcomes.

The rural communities in GHHN include Flamborough, Ancaster, Glanbrook and Stoney Creek and to a lesser degree, Dundas.

Despite one in three residents living in rural communities, their unique challenges and barriers to health are often overlooked when developing health and social services. This chapter provides an overview of the unique challenges and recommendations to begin the journey to include rural voices and perspectives in the planning for GHHN.

I. Rural Health Outcomes

According to a research review completed by the College of Family Physician of Canada, in general, rural Canadians are older, poorer, and sicker than their urban counterparts.[46] Canadians living in rural communities have long had challenges obtaining equitable access to health care services.

- Local services are often limited, with fewer physicians and other health care professionals living and working in rural communities. They constitute 18% of the Canadian population but are served by only 8% of the physicians practicing in Canada.[47][48]
- Geographic, environmental, and organizational factors result in challenges accessing care outside of the community. Lack of public transportation is a key barrier to accessing health care services.
- Increased urbanization and centralization of medical services have further stressed this situation.

II. Greater Hamilton Health Network Rural Populations

According to the 2016 census, 29% of the residents in the City of Hamilton live in the rural communities of Ancaster, Flamborough, Glanbrook and Stoney Creek.

Within this populations, there were 53,665 residents older than 55 in Ancaster, Flamborough and Glanbrook and Stoney Creek compared to 97,250 residents in Hamilton. Glanbrook saw an increase of 69% between 2006-2016.

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[46] Bosco C, Oandasan I. Review of Family Medicine within Rural and Remote Canada: Education, Practice and Policy. Mississauga, ON: College of Family Physicians of Canada; 2016.
[47] Wilson CR, Rourke J, Oandasan IF, et al. Progress made on access to rural health care in Canada. Can Fam Physician. 2020.
[48] College of Family Physicians in Canada. Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. The Rural Road Map for Action – Directions. Mississauga. 2017. www.cfpc.ca/arfm.%0Ahttp://www.cfpc.ca/uploadedFiles/Directories/Committees_List/Rural Road Map Directions ENG.pdf

Number of residents by older age groups, city of Hamilton communities, 2016 Census							
	Ancaster	Dundas	Flamborough	Glanbrook	Hamilton	Stoney Creek	City of Hamilton
55-64 years	5,780	3,745	6,160	3,220	44,595	9,810	73,310
65-74 years	3,710	3,120	4,040	2,935	29,005	6,755	49,565
75-84 years	1,830	1,730	1,590	1,595	16,850	3,305	26,900
85+ years	700	660	585	480	6,800	1,170	10,395
Total 55 years and older	12,020	9,255	12,375	8,230	97,250	21,040	160,170
% of total population in 2016	30%	38%	29%	28%	29%	30%	30%
% growth from 2006-2016	39%	20%	35%	69%	14%	33%	22%

III. Themes from Consultation: May 7, 2021

1. The voices of rural community and agencies are missing from consultations and planning.

2. Shifting demographics:
    - Seniors are the fastest growing demographic.
    - Followed by families, largely Asian, Filipino and Chinese moving into developing neighbourhoods; some multi-generational families living in one home.
    - No affordable housing for single young people or seniors; therefore, they migrate to the city.

3. Lack of services:
    - Lack of public transportation and reliable internet are significant barriers to accessing health care services.
    - New communities do not have sufficient health and community services infrastructure.
    - Food deserts in rural communities; stigma with going to local food banks.
    - Lack of services for women facing violence.
    - Agencies do not deliver services to rural communities stating that it is out of their catchment area.
    - Limited to no primary care in some rural communities. There is a primary care clinic in Waterdown and Carlise; people may have physicians in urban centres but are not accessible due to lack of transportation.
    - Palliative care is increasingly only available virtually.

4. Home and Community Care
    - Community support services for seniors are supported by a large cadre of volunteers.
    - Need for more locally hired PSWs. Travel is an issue between clients.
    - When locally developed community recommendations were developed and provided to the LHIN/CCAC, they were not used.

5. Paramedics are playing a key role in home visits and palliative care.

6. Youth are particularly isolated:
    - No access to public transit, lack of digital access and lack of public transit.
    - Increase in risk for drugs and alcohol.
    - Parents commute and work long hours.
    - If need access to mental health services or are a member of the LGBTQIA+ community often need to go to larger centres to protect privacy.

7. Need to have a better understanding of the Community Support Services available in rural communities.
    - There is capacity in small community agencies but there is an assumption by larger organizations that the community support agencies do not have skills or capacities.
    - Larger institutions come into community and duplicate or take over existing community services without fully understanding the communities. This also puts current programs in jeopardy.
    - Community support services have strong information and referral tool, but it is not fully used by larger agencies.
    - Community Support services are significantly underfunded.

IV. Beginning the Journey

1. Include rural voices in all tables that impact rural health. Involve community support agencies in all decision-making tables, including strategic, leadership tables and working groups

2. Get to know rural communities in GHHN:
    - Engage rural communities regarding their health needs. This has never been done.
    - Learn about the services and capacity of community support agencies in the area.

3. Collaborate with rural community agencies. Community service agencies are the frontline to connecting with rural residents. If consultation/surveys etc are to be undertaken ensure funds and resources are available to include and support CS in helping to facilitate those efforts.

4. CSS agencies want to work alongside and partner. If urban organizations/institutions have rural mandates a shift should take place to ensure rural organizations have the capacity to fulfil these efforts. Urban organizations and institutions should be supporting/sharing/collaborating with local agencies to facilitate that work.

5. Integrate rural issues into the priorities of the GHHN, not as an afterthought.

6. In consultation with the Community Support organizations, develop a primary care strategy for rural community including the need for:
    - More home visits.
    - Local primary care services: There are many orphan patients or people have a physician in an urban centre, but they are not accessible due to distance and transportation issues.
    - Lack of reliable internet and computers makes virtual care difficult.

List of Participants: Rural health group discussion – April 21, 2021
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