



Black Canadians' Exposure to Everyday Racism: Implications for Health System Access and Health Promotion among Urban Black Communities

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Abstract This study explores the social determinants of Black Canadians' exposure to everyday racism, its relationship to health system access, and implications for health promotion. We used data from the A/C Study survey on HIV transmission and prevention among Black Canadians. We implemented the survey ($N=1360$) in 2018–2019 in Toronto and Ottawa—two large cities that together account for 42% of Canada's Black population—among self-identified Black residents aged 15–64 years, who were born in sub-Saharan Africa or the Caribbean or

had a parent who was born in those regions. Participants reported racist encounters in the preceding 12 months using the Everyday Discrimination Scale. We assessed the socio-demographic correlates of racist experiences and the impact of racism on health system access using multivariable generalised linear models. Sixty percent of participants reported experiencing racism in the preceding 12 months. Based on the adjusted odds ratios, participants were more likely to experience racism if they were older, employed, Canadian-born, had higher levels of

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education, self-identified as LGBTQ+ and reported generally moderate access to basic needs and adequate housing; and less likely to experience racism if they lived in Ottawa, self-identified as female or reported higher levels of social capital. Visiting a healthcare provider or facility, and difficulty accessing healthcare were associated with racist experiences. Racist experiences diminished the likelihood of being tested for HIV. Racist experiences were widespread, especially among those with higher levels of social wellbeing or greater exposure to Canadian institutions. Study participants also associated racist experiences with the healthcare system.

Keywords Black Canadians · Health · Systemic anti-Black racism · Everyday racism

Background

Racism is increasingly acknowledged as a driver of inequitable health outcomes for racialized Canadians

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[1]. Both the United Nations [2] and the Public Health Agency of Canada [3] have drawn attention to the role of systemic anti-Black racism in Black Canadians' disproportionately poor health outcomes. For example, the prevalence of diabetes among Black Canadian adults was 2.1 times the rate among White Canadians by 2015 [2]. In Ontario, Canada's most populous province where more than half of Black Canadians reside, Black people represent about 5% of the province's population but routinely account for one-quarter of new HIV diagnoses [4]. And in Toronto, throughout first 14 months of the COVID-19 epidemic, Black people accounted 14% of COVID-19 cases and 15% of hospitalizations though they make up only 9% of the city's population [5]. Moreover, racialized healthcare users rate racism or ethnic discrimination as central to the challenges experienced in the health care system [6].

In Canada, as elsewhere, systemic or structural racism is a form of racism that is embedded in laws, policies, social practices and institutions [7]. Anti-Black racism is a specific manifestation of racism rooted in European colonialism, slavery and oppression of Black people since the sixteenth century [8]. It is a structure of inequities in power, resources and opportunities that systematically disadvantages people of African descent [9].

At the individual level, however, preconceptions, prejudices and stereotypes concerning Black people are often expressed as everyday racism. Everyday racism involves those practices that permeate everyday life and become 'normalized' in the mainstream even in the context of stated commitments to equity [10]. The practices may often appear to be mindless and habitual, and too minor to address in the moment; however, cumulatively, everyday racism reproduces the social relations of power and oppression, thereby damaging health and wellbeing Black and other racialized Canadians [11, 12]. In short, everyday racism reproduces systemic racism, while systemic racism simultaneously shapes the spaces of everyday racism and is itself also an outcome of cumulative patterns of everyday racism [10].

Though anti-Black racism is not a uniquely urban experience or practice, its effects may be magnified in Canadian cities due to the massive concentration of Black people in urban areas. For example, 94% of Black Canadians live in census metropolitan areas (compared to 71% of the Canada's total population),

and Toronto alone accounts for 37% of Canada's Black population [13]. In general, urban residents may have better access to healthcare than their counterparts in rural or remote areas; even so, in the urban context, structurally disadvantaged population groups may experience poor health outcomes due to diminished access to healthcare and the social determinants of health [14]. This reality appears to have motivated governments in 50 municipalities across the USA to declare racism as a public health crisis [15].

Evidence-informed policies and interventions are required to address systemic anti-Black racism and support health and wellbeing among Black Canadians. The purpose of this current study is to strengthen the evidence base for addressing racism experienced by Black communities in Canada. We used survey data from the A/C Study in Toronto (Canada's largest city) and Ottawa (one of Canada's largest and fastest growing cities). A/C Study was originally developed to explore issues related to HIV among the Black population of those cities; Toronto and Ottawa together accounted for 69% of first-time diagnoses among African, Caribbean and Black people in the province of Ontario in 2019 [4]. We use A/C Study data to explore (a) the socio-demographic factors associated with participants' reported exposure to everyday racism, (b) the association between everyday racism and participants' self-reported health status and health system utilization and (c) the implications of the above for health system access and health promotion.

Methods

Setting and Sample

From November 2018 to December 2019, we implemented the A/C Study survey among first- and second-generation self-identified Black persons residing in Toronto and Ottawa [16]. The research ethics boards at the University of Toronto, Toronto Public Health, the University of Ottawa and Ottawa Public Health approved the study protocol.

People who self-identified as African, Caribbean or Black (Black, for short) were eligible to participate if they were born in the Caribbean or sub-Saharan Africa, or had one parent who was born in these regions; were aged 15–64 years; resided in the

greater Toronto or Ottawa regions; and were capable of communicating in French or English. We recruited participants through posters, flyers and personal contact by peer recruiters and interviewers who attended events and spaces frequented by or catering to the Black population in each city. Some participants completed the questionnaire at the point of recruitment, but many contacted the study coordinator to schedule a survey appointment. The questionnaire was self-administered or interviewer-assisted, in English or French, on a tablet, in the presence of a survey assistant (i.e. participants could not independently access the questionnaire). Participants took about 40 min to complete the questionnaire, and received an honorarium of \$40.

Data

Our recruitment efforts yielded a sample of 1380 self-identified Black individuals, consisting of 828 in Toronto and 552 in Ottawa. We weighted the data to reflect the distributions of Black people based on the 2016 Canadian Census data for age, sex and place of residence [17]. Weights were created using a logistic regression approach by merging Census and survey data, then computing the predicted probability of belonging to the survey group adjusting for age, sex and place of residence. Weights were computed as the reciprocal of the predicted probabilities.

We used the short form of the Everyday Discrimination Scale (EDS) [18] as a vehicle for assessing participants' experiences of racism. Participants recorded any experience of racism in the past year on each of five scenarios of unfair treatment: treated with less courtesy than others, received poorer service than others at restaurants or stores, treated as though they were not smart, treated as though people were afraid of them and being threatened or harassed. We dichotomised participants as reporting (yes) or not reporting (no/don't know/no answer) racism as the cause of at least one episode of unfair treatment. Experiences of racism were spread across the five scenarios, ranging from 59% of participants who attributed their experience of discourteous treatment to racism, to 27% who reported racism as the driver of being threatened or harassed. Our approach (yes/no) prioritizes the incidence of racist experiences (i.e. whether or not participants experienced/reported racist experiences) over the frequency or intensity of those experiences since

more frequent experiences are not inherently more intense than a single experience that is massively destabilizing.

The survey also solicited information about participants' socio-demographic status (Table 1). We assessed each participant's standing on a social capital index which we estimated from their levels of agreement on a 5-point Likert scale to questions about their perceptions of Black communities in their city (willingness to help one another, trustworthiness, opportunities to work together on community problems and the presence of community groups that support the aspirations of Black people) [19]. Finally, we also asked participants to rate their general health on a 5-point Likert scale, and report their use of health services (i.e. yes/no responses about having a family doctor or nurse, and accessing healthcare in the past 12 months [i.e. visiting a healthcare provider, and difficulties accessing healthcare]).

Statistical Methods

We summarized participants' socio-demographic characteristics using descriptive statistics for categorical and continuous variables, and categorised participants according to whether they reported experiencing racism in the past 12 months. We evaluated the factors associated with experiences of racism using multivariable generalised linear models, adjusting for age, city, employment, sex, sexual orientation (homosexual, bisexual, questioning and other sexualities operationalized as 'LGBTQ+'), place of birth (born in Canada or elsewhere), level of education, ability to meet basic needs, housing situation and social capital index. Previous research suggested that reported experiences of racial discrimination varied with these and similar measures of socio-demographic status [20, 21]. In the current analysis, age categories were entered into the models as an ordinal score, and, in the multivariable models, covariates were entered as a block [22].

We also explored the impact of racial discrimination on self-assessed general health, having a family doctor or nurse, visits to healthcare providers in the past 12 months, difficulties in accessing healthcare and ever taking an HIV test. Getting tested for HIV is the first step in the care or engagement cascade that promises to end HIV transmission as a public health crisis. In the context of Black people's grossly

disproportionate burden of HIV in Canada, racism may complicate their access or adherence to the cascade. For the analysis of health status and healthcare access, the main predictor was experience of racial discrimination in the past 12 months (yes, no). All models were adjusted for the covariates mentioned above.

We assessed model fit using Akaike's information criterion (AIC). We assessed multicollinearity using the variance inflation factor (VIF), which resulted in 'gender' being excluded due to its $VIF > 25$. Variables with a $VIF > 10$ but ≤ 25 were examined to assess their impact on the models. All analyses incorporated the sampling weights and included cluster robust standard errors (by city). We report crude odds ratios (OR), adjusted odds ratios (aOR), 95% confidence intervals (CI), p values and the proportion of missing data for each variable. Data were analysed using Stata/IC version 16.0.

Results

Participant Characteristics

Table 1 shows that the majority of participants identified as female (63.4%), heterosexual (85.8%), 20–39 years old (56.8%) and residing in Toronto (61.9%). Education levels were relatively high, with over half (55.7%) reporting that they had achieved at least some university education. Fewer than a quarter (22.3%) of participants were born in Canada. Close to half (46.4%) reported that they were not employed, while about one-third (34.6%) reported being in full-time employment. Less than a quarter reported having no difficulty meeting basic needs (22.8%), and the majority reported their housing situation as either very (30.2%) or fairly (39.2%) adequate. Three-quarters of the participants reported having ever been tested for HIV (74.6%), and the majority self-reported that they were HIV-negative (91.9%).

Sixty percent of participants reported experiencing racism in the past 12 months. Over a quarter (28.4%) of participants who reported experiencing racism were Canadian-born, compared to just 12% of those who reported no direct experience of racism in the past 12 months. Slightly more than one-third of people who reported personal experiences of racism were unemployed or not working, and 60% of those who

Table 1 Sociodemographic characteristics of participants who reported experiencing racial discrimination in the 12 months preceding the study

Variable, <i>n</i> (%)	Reported experiencing racism		Total (<i>N</i> = 1380)
	Yes (<i>N</i> = 828)	No (<i>N</i> = 552)	
<i>Age (years)</i> ^a			
15–19	76 (9.3)	81 (15.5)	157 (11.7)
20–29	285 (34.7)	141 (26.9)	426 (31.7)
30–39	212 (25.8)	126 (24.0)	338 (25.1)
40–49	159 (19.4)	127 (24.2)	286 (21.3)
50–59	71 (8.6)	37 (7.1)	108 (8.0)
60–64	18 (2.2)	12 (2.3)	30 (2.2)
<i>City</i> ^a			
Toronto	548 (66.2)	306 (55.4)	854 (61.9)
Ottawa	280 (33.8)	246 (44.6)	526 (38.1)
<i>Employment</i> ^a			
Not employed [‡]	308 (37.2)	333 (60.3)	641 (46.4)
Employed part time	185 (22.3)	77 (13.9)	262 (19.0)
Employed full time	335 (40.5)	142 (25.7)	477 (34.6)
<i>Sex</i> ^a			
Male	305 (37.1)	186 (35.6)	491 (36.5)
Female	518 (62.9)	335 (64.2)	853 (63.4)
Intersex	0 (0.0)	1 (0.2)	1 (0.1)
<i>Sexual orientation</i> ^b			
Heterosexual	657 (82.7)	427 (90.9)	1084 (85.8)
Homosexual	45 (5.7)	14 (3.0)	59 (4.7)
Bisexual	62 (7.8)	25 (5.3)	87 (6.9)
Questioning	13 (1.6)	1 (0.2)	14 (1.1)
Other	17 (2.1)	3 (0.6)	20 (1.6)
<i>Born in Canada (yes)</i> ^a	232 (28.4)	66 (12.7)	298 (22.3)
<i>Education</i> ^{a†}			
University	488 (59.8)	251 (49.1)	739 (55.7)
College	154 (18.9)	95 (18.6)	249 (18.8)
High school	160 (19.6)	149 (29.2)	309 (23.3)
Less than high school	14 (1.7)	16 (3.1)	30 (2.3)
<i>Meeting basic needs</i> ^b			
Not at all difficult	191 (23.1)	124 (22.5)	315 (22.8)
A little difficult	266 (32.1)	128 (23.2)	394 (28.6)
Fairly difficult	184 (22.2)	109 (19.7)	293 (21.2)
Very difficult	154 (18.6)	100 (18.1)	254 (18.4)
<i>Housing situation</i> ^b			
Not adequate	132 (16.4)	98 (21.6)	230 (18.3)
Barely adequate	110 (13.6)	46 (10.2)	156 (12.4)
Fairly adequate	326 (40.4)	167 (36.9)	493 (39.2)
Very adequate	238 (29.5)	142 (31.3)	380 (30.2)
<i>Social Capital Index (mean, SD)</i> ^b	3.15 (0.72)	3.34 (0.70)	3.22 (0.72)
<i>Relationship status</i> [*]			
Single	431 (52.0)	266 (48.2)	697 (50.5)
Partner (live apart)	91 (11.0)	25 (4.5)	116 (8.4)
Partner (live together)	52 (6.3)	15 (2.7)	67 (4.8)

Table 1 (continued)

Variable, <i>n</i> (%)	Reported experiencing racism		Total (<i>N</i> = 1380)
	Yes (<i>N</i> = 828)	No (<i>N</i> = 552)	
Married	190 (22.9)	178 (32.2)	368 (26.7)
Separated/divorced	59 (7.1)	23 (4.2)	82 (5.9)
Widowed	12 (1.4)	7 (1.3)	19 (1.4)
Ever tested for HIV (yes) ^b	582 (72.1)	368 (78.8)	950 (74.6)
Self-reported HIV status ^{a#}			
HIV-positive	39 (6.9)	36 (10.1)	75 (8.1)
HIV-negative	524 (93.1)	322 (89.9)	846 (91.9)

HIV human immunodeficiency virus, SD standard deviation

^aMissing data < 5%, based on total N

^bMissing data 5–10%, based on total N

* Not mutually exclusive

[†] Includes some university for 'University', some college for 'College' and some high school for 'High school'

[‡] Includes participants who indicated that they were unemployed or otherwise not working (i.e. students, people with disabilities, and people who were prohibited from working because of their residency status)

[#] For those that responded 'yes' to 'Ever tested for HIV'

reported a personal experience of racism had at least some university education.

Factors Associated with Experiencing Racism

The direction, magnitude and statistical significance of the odds ratios (ORs) were similar for both the unadjusted and adjusted models, except for the associations based on city, female sex and social capital index (Table 2). Based on the adjusted model (Table 2), increasing age, part-time and full-time employment, LGBTQ+ identity, being born in Canada, higher levels of education, little or fair amount of difficulty in meeting basic needs and barely or very adequate housing were associated with experiencing racism. In comparison, living in Ottawa, female sex and increased social capital were associated with lower odds of experiencing racism.

Impact of Racism on Use of Health Services

Based on the adjusted models (Table 3), experience of racism was not associated with participant's general health rating or whether they had a family doctor or nurse. Participants who reported experiencing racism had greater odds of visiting a healthcare provider

or facility, and difficulty accessing healthcare in the past 12 months. Participants who reported experiencing racism were less likely to have been tested for HIV.

Discussion

Below, we summarize and discuss the results according to the overall experiences of racism among the sample, the socio-demographic correlates of reported experiences of racism in the multivariable model (Table 2) and the relationship between racist experiences and health (Table 3).

Overall Experiences of Racism

Six of every 10 participants reported experiencing racist behaviours or comments in the past year. This high incidence is consistent with Black people's previously reported experience of racism, and the prominence of racism in their lives. For example, in a previous survey of 845 Black Canadians aged 15–40 years old, 40% of respondents reported experiencing racism in the week before the survey [20]. In another survey of racism in Canada, 42% of Black respondents

Table 2 Logistic regression results for factors associated with experiencing racial discrimination

Variable	Bivariate		Multivariable	
	OR (95% CI)	<i>P</i>	aOR (95% CI)	<i>P</i>
<i>Age</i>	1.19 (1.11–1.28)	<0.001	1.01 (1.01–1.01)	<0.001
<i>City</i>				
Toronto	1 (ref)		1 (ref)	
Ottawa	1.24 (1.24–1.24)	<0.001	0.76 (0.72–0.80)	<0.001
<i>Employment</i>				
Not employed ^a	1 (ref)		1 (ref)	
Part time	2.90 (1.70–4.94)	<0.001	2.15 (1.65–2.82)	<0.001
Full time	2.71 (1.65–4.44)	<0.001	2.18 (1.63–2.93)	<0.001
<i>Sex</i>				
Male	1 (ref)		1 (ref)	
Female	1.68 (1.36–2.07)	<0.001	0.93 (0.92–0.94)	<0.001
<i>Sexual orientation</i>				
Heterosexual	1 (ref)		1 (ref)	
LGBTBQ+	3.10 (2.81–3.42)	<0.001	1.78 (1.34–2.36)	<0.001
<i>Born in Canada</i>				
No	1 (ref)		1 (ref)	
Yes	3.71 (3.02–4.54)	<0.001	2.52 (2.24–2.85)	<0.001
<i>Education</i>				
Less than high school	1 (ref)		1 (ref)	
High school	1.16 (0.96–1.40)	0.134	1.97 (1.92–2.02)	<0.001
College	2.00 (1.45–2.76)	<0.001	2.37 (2.17–2.60)	<0.001
University	2.13 (1.65–2.74)	<0.001	3.02 (2.96–3.08)	<0.001
<i>Meeting basic needs</i>				
Not at all difficult	1 (ref)		1 (ref)	
A little difficult	2.42 (1.69–3.46)	<0.001	1.80 (1.08–3.01)	0.025
Fairly difficult	1.93 (1.49–2.50)	<0.001	1.59 (1.05–2.41)	0.029
Very difficult	1.64 (1.39–1.94)	<0.001	1.58 (0.99–2.53)	0.057
<i>Housing situation</i>				
Not adequate	1 (ref)		1 (ref)	
Barely adequate	2.66 (2.25–3.13)	<0.001	1.74 (1.56–1.94)	<0.001
Fairly adequate	2.17 (1.70–2.77)	<0.001	1.14 (1.00–1.31)	0.052
Very adequate	1.68 (1.41–2.00)	<0.001	1.09 (1.01–1.18)	0.019
<i>Social Capital Index</i>	1.19 (1.11–1.27)	<0.001	0.67 (0.58–0.76)	<0.001

aOR adjusted odds ratio, CI confidence interval, OR odds ratio, *P* *p* value, Ref reference category

^aIncludes participants who indicated they were unemployed or otherwise not working (i.e. students, people with disabilities, and people who were prohibited from working because of their residency status)

reported that Black people are ‘often’ treated unfairly because of ‘race’, and an equivalent proportion (41%) indicated that Black people ‘sometimes’ experience unfair treatment for the same reason [23]. Moreover, in the same survey, 70% of Black respondents reported that people close to them are affected by racism ‘to a great extent’ or ‘somewhat’.

Racist encounters may also be much more widespread among Black Canadians and represent a greater threat to their wellbeing than among other racialized groups: in 2020, 70% of Black Canadians reported experiencing racism regularly or from time to time, versus about 50% of people from other racialized groups [24]; by 2017, 35% of participants in

Table 3 Logistic regression results for the impact of racial discrimination on selected outcomes

Variable	Multivariable ^a	
	OR (95% CI)	<i>P</i>
<i>1. General health rating^b</i>		
Experienced discrimination based on race (yes)	1.02 (0.99–1.05)	0.232
<i>2. Have a family doctor or nurse</i>		
Experienced discrimination based on race (yes)	1.12 (0.94–1.32)	0.198
<i>3. Visited a healthcare provider/facility in past 12 months</i>		
Experienced discrimination based on race (yes)	1.81 (1.63–2.02)	<0.001
<i>4. Difficulty accessing healthcare in past 12 months</i>		
Experienced discrimination based on race (yes)	1.25 (1.23–1.27)	<0.001
<i>5. Ever tested for HIV</i>		
Experienced discrimination based on race (yes)	0.58 (0.56–0.61)	<0.001

CI confidence interval, *OR* odds ratio, *P p* value

^aAdjusted for experienced racism (shown), age, city, employment, sex, sexual orientation, born in Canada, education, meeting basic needs, housing situation and social capital index

^bLinear model

the Black Experience Project identified racism is the ‘greatest’ challenge facing the Black communities, ahead of all other challenges [25].

Social Determinants of Racist Experiences

The multivariable model in Table 2 shows that A/C Study participants who were older, employed, Canadian-born, with higher levels of education and adequately housed were more likely to report that they had experienced racism. Those who identified as LGBTQ+ were also more likely to report that they had experienced racism. The results were mixed with respect to participants’ ability to meet their basic needs; nonetheless, participants who reported a small degree of difficulty meeting their basic needs were more likely to report racist experiences. In contrast, women and Ottawa residents were less likely to report experiencing racism.

Experiences of racism were widespread among study participants, but participants were more likely to experience or report racism as their socio-economic or social class status improves, and as they claim better access to the social determinants of health. In other words, Black people do not escape everyday racism, or are not protected from racism, by achieving higher class or social status, through social mobility or by improved access to the social determinants of health. This finding is consistent with

results from previous research [20, 21, 26–28]. It suggests that anti-Black racism is deeply entrenched in Canadian society and may be more commonly experienced when Black people are making gains in social mobility. Two related factors are worth consideration. First, as their social and class mobility unfolds, Black people become more exposed to (or involved in) mainstream institutional life, which in turn may increase their exposure to racism. Second, as Black people compete for access to the social goods that distinguish social mobility, racism may emerge more openly as others seek a competitive advantage or try to maintain their dominance [21].

Some observers may interpret the finding about education (greater likelihood of experiencing or reporting racism as education level increases) to suggest that ‘educated’ Black people are more pre-occupied with racism precisely because of their education. This kind of interpretation is problematic for several reasons. For example, all classes of participants experienced racism even though the likelihood of reporting or experiencing racism increased with education. Moreover, in the African diaspora, Black people’s struggle for justice has been a popular struggle from slavery until today. Education promises upward social mobility; however, among those with more formal education, continued exposure to racism may destabilize their expectation of social mobility commensurate with their education.

Consistent with previous research [20], Canadian-born participants were more likely than those who were born abroad to report experiencing racism. Canadian-born participants may have greater exposure to Canadian institutions than those who were born abroad, which may increase their exposure to inter-personal forms of racism. In other words, foreign-born Black Canadians may ascribe unfair treatment to their status as newcomers or immigrants rather than to racism, while Canadian-born Black people may be more conscious of racism through their lifelong exposure to Canadian institutions (beginning with the education system). Black people who were born and educated in Canada may experience blocked mobility and inequitable labour market opportunities as an outcome of racism, whereas those who immigrated to Canada may attribute their settlement difficulties and diminished circumstances to their status as immigrants [29, 30].

Our findings are also in line with previous research that found women are less likely than men to report experiences of inter-personal or everyday racism, though one Canadian study [20] found that women reported more daily and major discrimination than men. Women's apparently lesser likelihood of reporting racism has triggered debate [27]. At face value, men may experience racism more than women or may be more willing to report that they have experienced racism. However, it is possible that scales designed to assess inter-personal racism (like the EDS) may emphasise issues that men experience more than women. Therefore, men's reputedly greater experiences with racist policing may be reflected in other experiences of unfair treatment on the respective scales. Also, Black women's exposure to discrimination may be associated with their intersectional identities and the attendant intersectional prejudices and oppressions (gender, sexism, racism, etc.), rather than only or primarily through racism.

Participants who identified as LGBTQ+ were more likely to report experiencing racism. Systemic racism disadvantages Black LGBTQ+ communities in the same way that it disadvantages Black communities in general [31, 32]. However, the system-wide experiences of Black LGBTQ+ people may be compounded by racist behaviours and interactions in majority-white LGBTQ networks [33]. For example, 61% of Black LGBTQ+ people in the UK reported discrimination because of their 'ethnicity'

[34]. Similarly, in the USA, racialized LGBTQ+ people were significantly more likely than their white counterparts to report experiencing 'racially biased' micro-aggressions [35].

Participants who reported having access to a high level of social capital were less likely to report that they had experienced racism. That is, people who had stronger or more secure ties to Black communities in their city were less inclined to report (or endure) experiences of racism. The networks and relationships that constitute social capital may enhance people's resourcefulness to deal with or resist racism. This suggests that social capital may be a protective asset in the context of inter-personal racism, which substantiates its beneficial role that has emerged in previous research [36, 37]. However, there is some uncertainty about whether or how social capital benefits marginalized communities [38, 39].

Health Outcomes, Use of the Health System, and Experiences of Racism

In Table 3, the reported presence or absence of racist encounters did not influence how participants rated their health, which has also emerged in previous Canadian research [40]. However, it is possible that self-report instruments may fail to pick up sub-clinical changes in health that individuals are not aware of [41]. Therefore, the impact of racism on self-reported health may only emerge beyond the relatively short time frame specified in those instruments (e.g. the last 6 or 12 months).

Table 3 also shows that participants who reported experiencing racism in the past year were more likely to have visited a healthcare practitioner/facility and experienced more difficulty accessing healthcare, but were less likely to have been ever tested for HIV. Once again, racism was associated with increased exposure to (or involvement in) mainstream institutional life in Canada. Also, racism was associated with participants' apparently diminished adherence to care [42–44]. The data in Table 4 illustrate these findings and implications. One of every five participants reported difficulty accessing healthcare and, of those, one-quarter attributed their difficulty directly to racism while approximately 30% and 10% cited other specific reasons that are plausibly associated with racism. Though further research is warranted, our results suggest that Black people understand the healthcare

Table 4 Factors related to discrimination and racism as reasons for difficulty with accessing healthcare

Difficulty accessing healthcare in past 12 months (yes)	234 (21.8%) ^a
Reasons*:	
Provider was insensitive or racist	56 (23.9%)
Provider was trying to give as little services as possible	67 (28.6)
Judged on appearance, ancestry, or accent	25 (10.7)

^aNumber and % of participants who indicated they had difficulty accessing healthcare

* number and % of the 234 participants who had difficulty accessing healthcare

system as a source of racism. As such, the healthcare system may be contributing to poor health outcomes for Black Canadians.

Implications and Conclusion

Our research suggests that racist experiences are widespread among first- and second-generation Black Canadians in Toronto and Ottawa and, by extension, among urban Black Canadians more generally. In A/C Study, racist experiences are increasingly likely as Black Canadians increasingly secure their wellbeing through social mobility and better access to the social determinants of health. This process also entails greater or more widespread exposure to Canadian institutions, which may then precipitate greater exposure to everyday racism. On the other hand, social capital (or stronger ties to their local Black communities) appears to be a protective asset against routine experiences of racism. Black people who identify as LGBTQ+ also have a greater likelihood of experiencing racism, perhaps due to the effect of racism in the broader society layered with racism within majority white LGBTQ+ communities. Study participants also associated racist experiences with the healthcare system, which suggests that the system itself may be contributing to health inequities.

One notable limitation of the study is that the instrument we used to assess everyday experiences of racism may not have been sensitive to the gendered dimensions of those experiences. The study is also limited to first- and second-generation Black Canadians in two large cities; however, the results may be applicable beyond Ottawa and Toronto for several reasons: first, as outlined previously, Canada's Black population is concentrated in urban areas; second, for Canada as a whole, the Black population consists mainly of first- and second-generation persons—56% of Canada's Black population is foreign-born,

and a further 35% had at least one foreign-born parent); third, over 90% of foreign-born Black Canadians were born in Africa or the Caribbean [13]. Nonetheless, the results may underestimate exposure to racism among long-standing Black communities dating from the seventeenth or eighteenth centuries (e.g. in Nova Scotia, and in southwest Ontario abutting the US border).

On the whole, the study contributes substantively to strengthening the knowledge base about racism and health in at least three ways. First, we have demonstrated that everyday racism is pervasive and reproduces on a daily basis the structural violence that is associated with systemic anti-Black racism. Second, we note that social mobility or greater access to the social determinants of health may not protect Black Canadians from anti-Black racism, though strong ties to local Black communities may mitigate the effects of exposure to racism. Third, we have shown that Black Canadians experience racism in the healthcare system.

Our research has broad implications for health promotion practice and health system policy. First, in an environment where racism impacts health and wellbeing, health promotion initiatives and health policies that are neutral or blind to racism will reproduce inequities in health and wellbeing. Instead, evidence-informed health promotion and health policy must be designed to curtail (or at least mitigate in the short run) the structural disadvantages that undermine health and wellbeing. Second, access to ethically collected and curated disaggregated ethno-racial data is essential for designing program or policy interventions, and monitoring outcomes. Moreover, Black stakeholders must be supported to exercise stewardship for race data and leadership to develop policy that addresses the health and wellbeing of Black Canadians. Third, and finally, serious thought should be given to who makes decisions about policy, and how those decisions are made. Despite their advocacy and

activism, Black stakeholders still play a very marginal role in decisions about health policy and practice, which may account for the continued role of structural and everyday racism in diminishing the life chances of Black Canadians. We support a more radical approach to decision-making whereby Black stakeholders exercise leadership in decisions by local, provincial and federal health authorities that affect Black Canadians' health and wellbeing. On the whole, our results endorse the action steps that have been proposed for addressing racism in the medical profession [8], which can be adapted to strengthen health promotion and health system access among Black Canadians.

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Author Contribution Winston Husbands, Wangari Tharao, Josephine Etowa, Lawrence Mbuagbaw and Shamara Baidoo-bonso conceived the A/C Study project; all co-authors collaborated on implementation. Muna Aden coordinated the study implementation; all authors collaboratively designed this paper. Daeria Lawson and Lawrence Mbuagbaw performed the data analysis; Winston Husbands, Lawrence Mbuagbaw, Daeria Lawson, Josephine Etowa, Egbe Etowa and Shamara Baidoo-bonso led the writing of the manuscript. Sanni Yaya, Muna Aden, Wangari Tharao and LaRon E. Nelson provided materials and critical feedback on all drafts.

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Data Availability Women's Health in Women's Hands Community Health Centre (Wangari Tharao).

Declarations

Ethics Approval A/C Study protocols were approved by the research ethics boards (REB) at the University of Toronto, Toronto Public Health, the University of Ottawa and Ottawa Public Health.

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