STEPS TOWARDS BECOMING AN ANTI-RACIST OT

ANTI-RACIST WORKBOOK & RESOURCE LIST

Manitoba Society of Occupational Therapists

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Land Acknowledgment

Manitoba Society of Occupational Therapists (MSOT) has members that live, play, and serve clients throughout the province of Manitoba, located on the traditional territory of the Anishinaabeg, Inniniwak, Ojibwe Cree, Dakota, Dene, and on the homeland of the Métis Nation. The MSOT office is located on Treaty 1 territory and the homeland of the Métis Nation in Winnipeg. Our work extends throughout Treaty territories 2, 3, 4, and 5. We acknowledge that Winnipeg's water is sourced from Shoal Lake 40 First Nation.

We have been challenged by the Truth and Reconciliation Calls to Action to respect the Treaties made on these territories, to dedicate ourselves to understanding the trauma and harms experienced by Indigenous People in the past and present, and to move forward with Indigenous Peoples in a spirit of reconciliation and collaboration to make Manitoba an inclusive and accessible place for everyone who lives here.

Introduction

Who developed this resource?

This is a continuing education resource developed by Master of Occupational Therapy students in collaboration with MSOT executive officer, Heidi Garcia, and project advisor, Cindy Yamamoto.

This resource was created by:

- Danella Alvaro, who identifies as a White woman and second-generation immigrant.
- Angela Bhatia, who identifies as a Brown woman, and re-settler of South Asian heritage.
- Lorena Dilim, who identifies as a first-generation immigrant of South Asian descent.
- Jade McClure, who identifies as a White re-settler of European descent.
- Kelly Moslenko, who identifies as a White woman and Treaty Land Inhabitant.

What is the purpose of this resource?

The purpose of this resource is to provide an anti-racist educational tool that engages occupational therapists to begin to reflexively consider their positionality related to power and privilege, improve their awareness of racism through a socio-political lens, and to encourage active critical allyship.

How do you use this resource?

For an explanation of the resource and instructions on how to use it, click the link for the presentation of the resource:
https://www.youtube.com/watch?v=tg17lNrFBqc

The workbook consists of eight topics related to racism and anti-racism. For each topic, we have provided general definitions, reflexive questions, and recommended videos or podcasts. Additional readings and community resources can also be found in each section if you would like to learn more about the topic.

Throughout the workbook you will see **bolded resources**: Clicking these will take you to the corresponding link. Additionally, clicking **bolded terms** will take you to Appendix A: Glossary of Terms where you will find more comprehensive definitions.

Please note that podcasts recommended may be found in the following apps:

- Apple Podcasts
- Google Podcasts
- Spotify
- Stitcher
- TuneIn Radio
- YouTube

Please complete this survey before using this resource. Take the time to reflect, answer the questions sincerely, and record your response, at your own pace.

On a scale of 1-5, how confident are you in addressing racism in everyday life?

1 2 3 4 5

On a scale of 1-5, how confident are you in addressing racism in the workplace?

1 2 3 4 5

On a scale of 1-5, how important is it for you to be an anti-racist OT?

1 2 3 4 5

What strategies do you currently use to address racism?

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Social Determinants of Health

Social determinants of health (SDOH) are the broader social, political, and economic contexts that affect health and well-being, such as neighborhood resources, working conditions (Williams & Mohammed, 2008), employment, income and its equitable distribution, food security, housing, early childhood opportunities, education, health services, social exclusion, social safety nets, and social identity (McGibbon & Etowa, 2009).

Race is scientifically debunked but nevertheless continues to be a socially constructed way of categorizing humans based on arbitrary physical differences (e.g., amount of melanin in the skin) (McGibbon & Etowa, 2009). For the purpose of this resource, we refer to non-white racialized groups, including Black, Indigenous, and people of colour, as BIPOC.

Questions to consider:

1. What are common SODH of populations that you see in your area of practice?
2. How do SODH influence health outcomes for non-white racialized people?
3. What are some reasons that health care focuses on reactive rather than preventative determinants of health?

Recommended resource:

- **Clinical Problem Solving: Episode 86: Racial Disparities in COVID – Student Dr. Paul, Dr. Essien & Dr. Manning (60 mins)**

Additional reading:

- McGibbon, E. A., & Etowa, J. B. (2009). Anti-racist health care practice. Canadian Scholars Press.

History of Racism in Canada

Colonialism is a historical and ongoing process of exploitation for economic gain, land, and slave or low-cost labour of other countries and populations, including Indigenous populations, African populations, East Asians, South Asians, Jewish people, Roma, and racialized Muslims (Hage, 2015; Robinson, 2019). An example of **racist** colonial policy in Canada is the Indian Act of 1876 which defined Indian status and was designed to diminish Indigenous rights and sovereignty, steal land, forcibly place children in residential schools, and control where they could live, work and travel (Thobani, 2017; In Plain Sight, 2020). It is widely unacknowledged that Black Canadians were subjected to decades of slavery until 1834 (United Nations Report of the Working Groups of Experts on People of African Descent on its Mission to Canada, Sunga et al., 2017; Anand, 1998). Canadian colonial policy was also historically used to exploit populations of non-white racialized groups in order to advance the wealth of Canada in the late 18th century (Thobani, 2007; Thobani, 2017). Chinese and South Asian labourers worked in treacherous conditions building the railway, and experienced legalized exclusion from voting and owning property (Thobani, 2017). Japanese Canadians were held in detention camps during World War II where they remained for two years after the war ended (Anand, 1998). Occupational therapists can learn how colonial and capitalist ideas continue to constrain occupational choices for BIPOC groups. **See Appendix B for more.**

Questions to consider:

1. Consider some ways in which colonial and racist historical conditions of the past continue in the present.
2. Why might many Canadians believe the history of the past has no impact on the present in Canada?
3. How might medicine and/or occupational therapy have a racist history?

Recommended resources:

- **Anti-Empire Project: Civilizations 26c: Canada pt3 Canadian colonialism: reserves, pass system, residential schools (90 mins)**

- **Antiracism in Medicine Series: Dismantling Race-Based Medicine: Historical and Ethical Perspectives - Edwin Lindo (60 mins)**

Civilizations 26c: Canada pt3 - Canadian colonialism: reserves, pass system,...

Nadir of Canadian colonialism from 1885- By 1885, the Indian Act was in place, most Indigenous people were forced onto reserves, and the nadir of Canadia...

Episode 141: Antiracism in Medicine Series Episode 2 - Dismantling Race-Based...

This is the first episode of a three-part series on understanding and dismantling race-based medicine by unearthing its origin and exposing the paucity of...

Additional reading:

- Colonialism and Its Impacts by The Canadian Research Institute for the Advancement of Women – FemNorthNet

Racism in Healthcare

Despite the common narrative that healthcare workers are healers and heroes (Iwai et. al., 2020; Grenier, 2020), and that many health care workers deny racism exists in their institutions (Palmater, 2021), healthcare institutions continue to perpetuate racism (Paradies et al., 2014).

Questions to consider:

1. Do you believe that racism still exists in healthcare?
2. Have you witnessed racism in your practice setting?
3. What are some barriers to confronting racism in your practice setting?
4. How might you have unintentionally contributed to racism in practice?

Recommended resources:

- **Policy Options Podcast 118 - Systemic Racism in Canadian Healthcare (40 mins)**
- **Medical Racism in Canada (The Silent Parts) by Ubah Ahmed (10 mins)**

Additional readings:

- Enhancing Cultural Humility and Culturally Safer Practices for Indigenous Clients in Occupational Therapy: Professional Development Resource for Occupational Therapists
- Ignored to Death: News Article
- Turpel-Lafond, M. E., & Johnson, H. (2020). In plain sight: Addressing Indigenous-specific racism and discrimination in BC health care. BC Studies, 209, 7-17.

Systemic vs. Interpersonal Racism

Interpersonal racism among healthcare providers exists and is demonstrated through unconscious biases, beliefs, attitudes, and behaviours towards BIPOC patients (Paradies, 2014; Van Ryn et al., 2011), which impacts the quality of care and well-being of BIPOC patients.

Systemic racism is the broader racism that is embedded in practices and policies in institutions, including health care institutions, that controls distribution and access to resources (Paradies, 2015).

Questions to consider:

1. What biases might you have that could influence your beliefs and actions towards racialized clients?
2. Consider a time when you expressed or witnessed interpersonal racism towards others. Why was it easy or challenging to confront? What would you do differently now?
3. What healthcare standards exist in your institution that could unintentionally (or intentionally) be racist?

Recommended resources:

- **Structural, Institutional, and Interpersonal Racism: Podcast with Deborah Ejem and Deep Ashana (50 mins)**
- **Warrior Life: Confronting Systemic Racism in Healthcare (90 mins)**
- **Sandy & Nora: Episode 169 – Confronting systemic, institutional racism (50 mins) *contains explicit language**

Additional reading:

- If Joyce Echaquan were white, she would still be alive: News Article

White Supremacy, Power and Privilege

White supremacy is a powerful socio-political system that places white populations as superior to BIPOC populations and as the standard norm for humans (Grenier, 2020; Mills, 1997). It is also embedded in all systems, including visible political systems and the "invisible" aspects of the dominant culture such as what is perceived as generally accepted common sense knowledge (Mills, 1997). Therefore, it is not just confined to far-right white supremacist movements.

Questions to consider:

1. Compare and contrast white supremacy with systemic racism.
2. How does white supremacy inform your beliefs?
3. What is one way to you can begin to dismantle your white supremacist beliefs?

Recommended resources:

- **Sandy & Nora: Episode 196 - Current white supremacy discourse in Canada (46 min) *contains explicit language**

- **White supremacy in academia: White Supremacy and Higher Education | Alexa Joy Potashnik TEDxUniversityofWinnipeg (20 min)**

Additional readings:

- Grenier, M. L. (2020). Cultural competency and the reproduction of White supremacy in occupational therapy education. Health Education Journal, 79(6), 633-644. DOI:10.1177/0017896920902515

- Let's Talk: Whiteness and health equity by National Collaborating Centre for Determinants of Health

Critical Race Theory

Critical Race Theory is a guiding framework that shows how race is socially constructed and used for the purpose of oppressing and exploiting Black, Indigenous, and people of colour (Britannica, n.d.). Further, this framework explains how racism in the legal and judicial system is used to maintain social, economic, and political inequities between white and non-white racialized groups (Britannica, n.d.).

Questions to consider:

1. What are some relative social advantages and disadvantages associated with your social identities (race, ethnicity, gender, age, disability, sexuality, social class)?
2. Consider your positionality from question 1: How does it impact your power in your role as an OT, relative to clients' power and privilege?
3. Reflect on your own understanding of Critical Race Theory and Intersectionality: How does your understanding change after listening to the following podcasts?

Recommended resources:

- **OT Conversations that Matter: The Podcast - Episode 4: Intersecting Identities and Compounding Forms of Discrimination (35 mins)**
- **What does intersectionality mean? (43 mins)**
- **Critical Race Theory in Medicine (29 mins)**

Additional readings:

- A Lesson in Critical Race Theory: Online Magazine Article
- What is Critical Race Theory?
- The Intersectionality Wars

Anti-Racism in Healthcare

Anti-Racism includes actions that aim to disrupt and dismantle any and all forms of racism. It may include actions such as identifying, challenging, and changing power imbalances, racist structures, beliefs, and attitudes (In Plain Sight, 2020).

Questions to consider:

1. What anti-racist strategies do you know about or have participated in?
2. What kinds of policies or healthcare standards exist in your institution that promote anti-racism?
3. While listening to the following podcasts, can you identify new ideas or strategies that may contribute to anti-racism in healthcare?

Recommended resources:

- **The Imperatives of Anti-Racism in Leadership - Dr. Marcia Anderson AHSLP Keynote (120 mins)**
- **OT Conversations that Matter: The Podcast - Episode 10: Socially Accountable Mentorship (30 mins)**
- **OT Conversations that Matter: The Podcast - Episode 7: Social accountability - Engagement with BIPOC populations (40 mins)**

Additional readings:

- AAOTA's guide to addressing the impact of Racial Discrimination, Stigma, and implicit bias on provision of services. AOTA's Guide to Addressing the Impact of Racial Discrimination, Stigma, and Implicit Bias on Provision of Services

Community Resources:

- University of Manitoba Graduate Students' Association

Critical Allyship

Critical Allyship is the action of using one's privilege (or giving up one's privilege) for the purpose of justice for people who have experienced historical and ongoing disadvantages (Nixon, 2019). This may include learning about systemic inequities and actively partnering in solidarity with communities to dismantle inequities at multiple levels (Nixon, 2019). This requires a move away from trying to 'save' historically marginalized people, by acknowledging one's power and privilege, recognizing the strength and knowledge of historically marginalized people, and stepping back to make space for non-white racialized voices in institutions (Nixon, 2019).

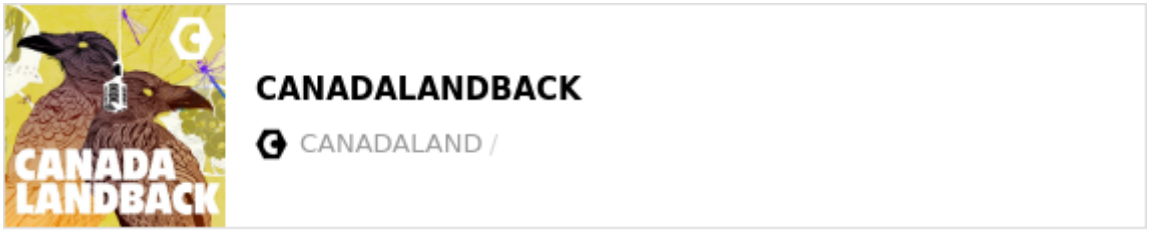
Questions to consider:

1. What is the difference between 'allyship' and 'critical allyship' to you?
2. In what ways might you become a critical ally in your life and/or practice?

Recommended resources:

- **Inclusion Works: 32. Allyship I: What Is Allyship Plus Some Cautions & Caveats for Allies (25 mins)**

- **CanadaLandBack Episode 772: Landback, Then What? (50 mins)**



Additional readings:

- Nixon, S. A. (2019). The coin model of privilege and critical allyship: Implications for health. BMC Public Health, 19(1), 1637–1637.https://doi.org/10.1186/s12889-019-7884-9

Closing

Please complete this survey after using this resource. Take the time to reflect, answer the questions sincerely, and record your response, at your own pace.

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On a scale of 1-5, how important is it for you to be an anti-racist OT?

1 2 3 4 5

What strategies do you currently use to address racism?

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Notes

APPENDIX A
Glossary of Terms

Anti-Racism are actions that aim to disrupt and dismantle any and all forms of racism, including identifying and challenging power imbalances, racist structures, beliefs, and attitudes (In Plain Sight, 2020). Occupational therapists can activate their change agent role toward ongoing anti-racist practice at individual and systemic level racism.

Colonialism is an ongoing system of dominance used to justify genocide and/or for gaining access to, and control over no-cost/low-cost labour, land, and resources (often of or belonging to BIPOC people). Colonialists perpetuate colonialism via exclusionary knowledge, systems, and policies for the economic benefit of the West (In Plain Sight, 2020; Thobani, 2017; Random House, 2010). Colonial ideas are ongoing and continue to manifest in capitalism and the current neoliberal era in which BIPOC groups are globally exploited for low-cost labour (Kelley, 2017, Robinson, 2000). An example of colonial policy in Canada is the Indian Act of 1876, which defined Indian status, was designed to diminish Indigenous rights and sovereignty, control where they could live and work, take away their land, and forcibly place children in residential schools (Thobani, 2017; In Plain Sight, 2020). Occupational therapists can consider how colonial and capitalist ideas constrain occupational choices for BIPOC groups such as lower-income people, refugees, and immigrants.

Cultural Competence is stated to be achieved when one has acquired knowledge about the values, beliefs, and traditions of various cultures, and has the ability to self-reflect upon one's own culture (Agner, 2020). This is the current standard used in healthcare to understand racialized others; however, it is insufficient because it implies an endpoint of knowledge, in which culture is concrete, static and uniformly applied to racialized others, which can inadvertently reinforce stereotypical beliefs (Beagan, 2015). Rather, it’s important to understand that culture is dynamic.

Cultural Humility allows for more meaningful engagement with clients, because there is a focus on learning about the client's unique characteristics, rather than making assumptions based on their race or ethnicity (Agner, 2020). Thus, cultural humility creates room for differences not only between cultures but also within cultures (Agner, 2020), thereby diminishing the stereotyping concerns related to cultural competence. Occupational therapists and other healthcare practitioners should focus on using cultural humility (as opposed to cultural competence) because cultural humility focuses on life-long learning to understand diversity (Agner, 2020). Cultural humility also involves being critically reflexive about one's own biases and assumptions (Agner, 2020). Critical reflexivity prompts one to identify and acknowledge their implicit and explicit biases and prejudices without shameful feelings attached to the process, and allows one to work towards awareness and correction of biases (Agner, 2020). Moreover, cultural humility recognizes and addresses the impact of differing power levels in healthcare interactions (Agner, 2020). A combination of critical reflexivity to identify one's biases and assumptions, journaling, and didactic approaches can be effective strategies for healthcare practitioners to learn how to become culturally humble (Agner, 2020).

Cultural Safety is the outcome of cultural humility, in which racism and power imbalances in the healthcare system are dismantled, so that patients and clients experience physical, emotional, and spiritual safety when seeking or receiving health care services (In Plain Sight, 2020). This can enhance the therapeutic relationship and outcomes for patients/clients.

Culture is how all humans understand their world - with some common understanding, some individual interpretation, and is dynamic/changing rather than fixed (LaRocque, 2014; McGibbon & Etowa, 2009). However, culture is commonly thought of as belonging to racialized people, while the culture of the dominant (white) population is rarely examined or considered as a culture with shared values and beliefs (LaRocque, 2014; McGibbon & Etowa, 2009). Adding to this issue is that culture is often conflated with ethnicity or country of origin. (McGibbon & Etowa, 2009). Therefore, using the term 'culture' can obscure inequities of power and is sometimes used to avoid discussing race and racism (Grenier, 2020).

Critical Allyship is the action of using one's privilege (or giving up one's privilege) for the purpose of advancing justice for people who have experienced historical and ongoing disadvantages. This could include learning about systemic inequities and actively partnering in solidarity with communities to dismantle systems of inequities at multiple levels (Nixon, 2019). This is a move away from trying to 'save' historically marginalized people, by acknowledging one's positionality, stepping back to make room for racialized voices, and making space in institutions (Nixon, 2019).

Critical Race Theory: Coined by Kimerlé Crenshaw, this theory combines interdisciplinary knowledge and concepts that are important foundations for understanding and addressing ongoing racism (Crenshaw, 1991). Intersectionality is one critical race theoretical concept to help understand the 'synergistic' (not simply additive) experience in which multiple identities (i.e.'race', ethnicity, gender, ethnicity, (dis)ability, sexual orientation, age, socio-economic class) interact to shape a person's relative (and relational) advantage or disadvantage, and other experiences of marginalization, harassment, and vilification (Nixon, 2019; Crenshaw 1991; McGibbon & Etowa, 2009; Disruption of All Forms of Racism Policy, 2020). For example, black women experience heightened synergistic marginalization as a result of the relative disadvantage arising from interlocking systems of oppression as two identities (arising from both racism and sexism) intersect (McGibbon & Etowa, 2009; Beagan & Etowa, 2011). As such occupational deprivation, marginalization, and alienation can be disproportionate for those who experience intersecting marginalized identities.

Interpersonal racism among healthcare providers exists and is demonstrated through beliefs, emotions, and behaviours towards non-white racialized patients (Paradies, 2014). Health care workers' unconscious biases (Van Ryn et al., 2011; Williams, 2018) can impact the quality of care they provide to non-white racialized patients as well as the number of required procedures prescribed (American Psychological Association Presidential Task Force on Preventing Discrimination and Promoting Diversity, 2012; Williams, 2018).

Neoliberalism is a pervasive political economy ideology that posits (despite evidence to the contrary) that the most beneficial economic outcomes in government, business, and institutions arise from privatization, capitalist promoting free markets, austerity policies, and framing of institutions and individuals as responsible for their own success (Harvey, 2007). As such, occupational issues and outcomes are often framed in terms of personal behaviours based on individual choices and lifestyle, rather than social determinants of health (Farias & Laliberte Rudman, 2019).

Occupational injustice, in the context of non-white racialized and other marginalized identities, are the barriers that prevent choice and autonomy in occupations, meaning in occupations, and occupational balance (Townsend & Wilcock, 2004). Health care workers should be cognizant of occupational justice and how they interfere with participation and engagement in occupations that are important for health and well-being (Townsend & Wilcock, 2004; Whalley Hammell, 2017). Occupational injustice can be manifest through the following forms which may operate independently or in tandem:

- **Occupational marginalization:** Discrimination, based on the dominant groups' norms and standards, that results in marginalized people having fewer, precarious, or less valued opportunities and less power to participate in decision-making (Hocking, 2017; Townsend & Wilcock, 2004).
- **Occupational deprivation**: Structural barriers which chronically prevent meaningful occupations for health and well-being (Hocking, 2017).
- **Occupational apartheid**: The systematic, systematic, deliberate, organized manner of segregating groups of marginalized people to deny them access to occupations, for the benefit/entitlement of the dominant group (Hocking, 2017).
- **Occupational alienation**: Structural barriers constrict occupational choices so that the choices remaining are meaningless because they do not fit the individual's potential or aspirations (Townsend & Wilcock, 2004). Sometimes this results in negative occupations (Hocking, 2017).
- **Occupational imbalance** (Hocking, 2017): The occupational patterns in groups of marginalized people, who are over or under-occupied due to structures that enforce excessive work (i.e. via labour market, or caregiving for dependents), idleness, or lack of opportunity to engage in a variety of occupations for health and well being (Hocking, 2017).

Race is scientifically debunked but nevertheless continues to be a socially constructed way of categorizing humans based on arbitrary physical differences, such as the amount of melanin in the skin (McGibbon & Etowa, 2009). Yet 'race' is an important concept because it is a descriptive system of difference used to justify ongoing discrimination and "hierarchies of humanity" that have consequences in non-white racialized people's lives (Disruption of All Forms of Racism Policy, 2020; Anand, 1998; McGibbon & Etowa, 2009). Further, groups of people may be designated a 'race' even if they do not necessarily share physical characteristics, but may share social characteristics such as religion; for example, Jewish people and Muslims have also been targets of racial hate propaganda (Anand, 1998).

Racial trauma is the psychological, emotional, and physiological effects of racism and racial discrimination experienced by non-white racialized people (Carter, 2020). This is widely unacknowledged in mental health discourse; however, there is a significant body of literature addressing assessments and interventions that healthcare and resource workers can refer to (Carter, 2020).

Racism consists of attitudes and beliefs towards those who are ideologically deemed inferior 'races', regardless of contact or experience with them (Anand, 1998). Racism is not a natural part of humanity, but a colonial-era tool for justifying slavery, genocide, land theft from non-white racialized people around the globe (Thobani, 2017) and the unequal distribution of resources and opportunities (Carter, 2020). It was actively tied to the economic development of the West and is systemically embedded in white supremacist legal and social institutions in the present through practices, policies, behaviours and domination of knowledge systems (Bannerji, 1995; Disruption of All Forms of Racism Policy, 2020; Mills, 1997; Thobani, 2017). Different forms of racism may operate independently or in tandem; including (but not limited to) everyday racism, interpersonal racism, and systemic racism (Disruption of All Forms of Racism Policy, 2020). For example, in Canada, pervasive racist ideology, such as framing Indigenous people as inferior, was used for the 'legalized' and tolerated dispossession of Indigenous people from their land for the economic benefit of colonizers (Thobani, 2017). Racist ideology is not isolated: they are "repetitive, historic, and ritualized occurrences" that have gained the "widespread social tolerance" in dominant society, culture, in the media, and in institutions in order to maintain colonial powers in the present (Thobani, 2017). Racism affects everyday occupations for non-white racialized people (Beagan & Etowa, 2011).

Social determinants of health (SDOH) encompass the broader social, political, and economic contexts that affect health and well-being, outside of solely physical or medical diagnosis (McGibbon & Etowa, 2009). Essentially, SDOH grasp health in a holistic way. There are many generally accepted social determinants of health (SDOH) including: neighbourhood, and working conditions (Williams & Mohammed, 2008), employment, income, and its equitable distribution, food security, housing, early childhood opportunities, education, health services, social exclusion, social safety nets, social identity (McGibbon & Etowa, 2009). Social identities are demographic identifiers that impact social relationships and power, such as gender, 'race', ethnicity, sexual orientation, (dis)ability, social class, and age (McGibbon & Etowa, 2009). In addition, McGibbon & Etowa (2009) incorporate culture and spirituality as SDOH. Evidence shows that biological, genetics, and lifestyle account for fewer health outcomes in comparison to the SDOH, particularly intersecting SDOH (McGibbon & Etowa, 2009). The biological and genetic component of 'race' is not a SDOH in itself; however, racism is a SDOH because structural factors place groups at a relative advantage or disadvantage (McGibbon & Etowa, 2009; Nixon, 2019). The unequal distribution of health-promoting social determinants is responsible for up to one-third of premature deaths; thus, this is a paramount reason for justice-based approaches that target structural issues versus the dominant biomedical approaches (Schroeder, 2007; Baillard et al., 2020).

Systemic racism is the broader racism that is embedded in practices and policies in institutions, such in health care institutions, which constrains access to resources through discrimination towards non-white racialized people (Paradies, 2015). It remains in the healthcare system because racist acts and practices are not named. Racist acts are often viewed as "isolated" events and based on "individual ignorance" which can obscure systemic and social tolerance to racism (Thobani, 2017).

White privilege is the "invisible" advantage belonging to the dominant white population (Mills, 1997; Nixon, 2019). For those who experience relative privilege, it can be challenging to recognize their own privilege and the relative disadvantage of people who experience marginalization because of the myth of meritocracy (Nixon, 2019). That is, those who are often in positions of power, including health care practitioners, attribute their success to individual merit rather than societal, historical, and political mechanisms that privilege those that look like them across the life course (Nixon, 2019). Nonetheless, there is complicity in unearned privilege because the systems that are designed to oppress can continue to perpetuate injustice when systemic privilege is not acknowledged (Nixon, 2019).

White supremacy is a powerful socio-political system that valorizes the dominant white population in the West, and informs all systems, including the visible political systems and the "invisible" aspects of the dominant culture (Mills, 1997). It is sometimes referred to as 'whiteness' or a culture of 'whiteness' that upholds white forms of knowledge and systems.

APPENDIX B
Historical Context of Ongoing Racism

Historical context is imperative in understanding how ongoing racism affects health, which is conceptualized as being affected by broad and intersecting social determinants of health (SDOH). While we speak of anti-racism as an act of dismantling racism towards all non-white racialized groups, the differences in colonial history and timing may produce differential disadvantages for different groups. The political grouping of Black, Indigenous, and people of colour (BIPOC) together to address common colonial and capitalist exploitation may also inadvertently obscure these differences. Thus, the differences are important to acknowledge so as to not further obscure historical processes affecting experiences of systemic and overt racism in the present.

With regards to Indigenous people, Canada introduced the Indian Act in 1876 in order to define Indian status and diminish Indigenous rights and sovereignty. It was used to control where they could live, work, and travel while simultaneously stripping them of their own land and governing body (Thobani, 2017). They were then forcibly removed from their homes and placed in residential schools. Within these schools, Indigenous children were deprived of their cultural and traditional beliefs while being subjected to physical, emotional, mental, and sexual abuse (In Plain Sight, 2020; Anand, 1998). Inequities within Canadian health care stemmed from two ideologies that would become legal policy, that Indigenous people should be served through a separate health system, and second, that Indigenous people could be treated less as patients, and more as research objects for the purpose of experimentation (In Plain Sight, 2020).

It is widely unacknowledged that Black Canadians were subjected to decades of slavery until 1834 - a practice that lasted longer in Canada than it did in the United States (United Nations Report of the Working Groups of Experts on People of African Descent on its Mission to Canada, Sunga et al., 2017; Anand, 1998). Despite Black Canadians' contributions, such as defending Canadian borders in the war of 1812, policies in Canada remained decidedly exclusionary and anti-black (Sunga et al., 2017). Once slavery was abolished, racism and hatred towards Black Canadians ensued and was reinforced by the government-mandated segregation of schools until 1965, and the relocation of entire black communities, such as Africville in Nova Scotia, in order to procure the desired land upon which they resided (UN Report, 2017; Anand, 1998).

The colonial policy was also historically used to exploit populations of non-white racialized groups that were used to advance the wealth of Canada in the late 18th century (Thobani, 2007; Thobani, 2017). Chinese labourers, and later South Asian workers, were recruited to work in treacherous conditions building the railway where they were paid significantly less than white workers (Thobani, 2017). In an effort to keep Canada white, they experienced legalized exclusion from voting, purchasing property, and occupations of their choice (Thobani, 2017). Furthermore, Japanese Canadians were held in detention camps during World War II where they remained for two years after the war ended (Anand, 1998). During this time their land, houses, vehicles, and businesses were confiscated and sold, and their civil rights were denied (Thobani 2007; Thobani, 2017; Anand, 1998).

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