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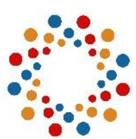
European Society of Medicine

OPEN ACCESS

Published: November 30, 2023

Citation: Dixon S, Batta M, et al., 2023. Using Intersectionality Theory to Explore the Impact of COVID-19 Pandemic on Black Canadian People's Health, Medical Research Archives, [online] 11(11). https://doi.org/10.18103/mra.v11i11.4722

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DOI
https://doi.org/10.18103/mra.v11i11.4722

ISSN: 2375-1924

RESEARCH ARTICLE

Using Intersectionality Theory to Explore the Impact of COVID-19 Pandemic on Black Canadian People's Health

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ABSTRACT

There is a general reluctance to confront the pervasive reality of anti-Black racism that further produces false narratives of inequities in the healthcare system relative to Black communities, especially in Western countries, including Canada. Despite Canada's orientation towards an anti-Black racist agenda that aims to acknowledge the social determinants of health (SDOH) disparities experienced by the Black community during the coronavirus disease 2019 (COVID-19) pandemic, a greater robust discussion is warranted to address this longstanding discourse. In this conceptual paper, we draw upon intersectionality theory to shed light on the social determinants and inequities in health for Black Canadians. Informed by the literature, the authors discuss the historical context of systemic barriers and social injustices Black people face that are uniquely rooted in systems of oppression and anti-Black racism. Additionally, the importance of collecting and analyzing race-based data to prioritize the health concerns of Black people is emphasized. The article also espoused the need for healthcare service providers to advocate for culturally responsive and appropriate interventions like the Africentric model to inform policies, practices, and programs that promote the wellness of Black populations in Canada and beyond. Implications for healthcare service providers are highlighted with emphasis placed on a commitment to cultural humility in the support delivered within this diverse community. The paper concludes with a higher level of consideration to be given to the structural challenges experienced by Black Canadians in the healthcare system as we move towards a collective understanding to better serve this racialized group.

Keywords: Afrocentric Model; Anti-Black Racism; Black Canadians; COVID-19 Pandemic; Intersectionality Theory; Slavery; Social Determinants of Health; Systemic Racism

Introduction

There is an exponential increase in Black population percentages in Western countries such as the United States of America (USA) (13.6%), England and Wales (4.8%) and Canada (3.5%).[1-3] The coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2),[4] impacted racialized communities' health, socio-cultural identity, and economic well-being. Adopted from the World Health Organization's definition, *health* encompasses "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [5(p1)] Although dated, this established description still applies to the modern day lived experiences of Black people whose health was disproportionately impacted during the pandemic in Canada,[6,7] the USA[8,9] and the United Kingdom [UK].[10,11] Particularly in Canada, the Black population is a growing diverse group that has contributed in many ways to the country's growth, diversity and development.[12] Research shows that in 2021, 1.5 million individuals in Canada self-identified as Black, accounting for approximately 4.3% of the nation's total population and representing 16.1% of all racialized groups.[13] For this article, *Black Canadians* include, but are not limited to, individuals with African and/or Caribbean heritage such as immigrants with various backgrounds and experiences.[14] Here, *racialization* is a complex and controversial social process that refers to the designation of particular groups into categories based on their "race", resulting in differential and/or unequal treatment in many sectors of society.[15(p27)] Due to their racial identity, Black individuals in Canada continue to encounter significant disparities in treatment outcomes across various health problems, including chronic illnesses, infectious diseases, as well as mental health and addiction challenges.[16] The COVID-19 pandemic also led to higher infectious cases and deaths of Black Canadians in places with a larger number of individuals like Montreal and Toronto.[17]

According to data collected by the Government of Canada,[18] this global contagion worsened the pre-pandemic deprivation of basic needs for many racialized groups in Canada, thus worsening their overall health outcome.[19] Particularly, this crisis has disproportionately affected Black communities and showed that 'the talk' about anti-racism in Canada does not mean much when a health crisis exposes a significant equity gap in how members of this racial-ethnic group are treated in the healthcare system.[19] As a racialized group, Black Canadians were less protected and more exposed to the COVID-19 virus due to poor access to quality health care, education, employment, housing, and mental health support.[20-23] Once infected, they were more likely to die compared to other racialized groups because of the systemic health inequalities they experienced.[24,25] A current systematic review study examining the health impact of COVID-19 among Black communities in Canada revealed the devastating health impact of the pandemic on mortality,[26,27] morbidity,[28,29] and hospital admission.[30,31] In addition to physical health, the pandemic affected Black individuals' mental wellness, further impairing their psychological functioning and social well-being.[32-34]

During the height of the pandemic, results indicated that Black Canadians had lower COVID-19 immunization rates (56.4%) compared to non-racialized groups (77.7%).[35] Vaccine hesitancy among Black communities was due to barriers to vaccine uptake such as inadequate public health response, lack of prioritization of Black people during vaccine rollout, lack of culturally relevant vaccine clinics and mistrust in the medical system.[4,36,37] Based on this awareness, an important step is necessary to improve the underlying health inequities faced by racialized populations. In this article, Crenshaw's[38] intersectionality theory is utilized as a unique lens to understand how decision-making and behaviour around institutional structures of power (e.g., healthcare system) shape such social determinants of health (SDOH) factors as race. A more in-depth analysis of SDOH is undertaken later in the paper. As a racialized group, the invalidation and underrepresentation of Black people's lived experiences in the Canadian healthcare system during the pandemic justify why this topical issue must be explored. This theoretical paper, therefore, starts with the historical context of anti-Black racism in Canada's healthcare system; the brutality of slavery is also underscored in this discussion. Attention is then given to the intersectionality theoretical framework, which recognizes the overlapping systems of power that inherently influence and shape the multifaceted of Black Canadians' health.[39-41] Next, the fundamental processes surrounding SDOH concerning Black Canadians are presented. Increased advocacy for race-based data during COVID-19 to address the health disparities in care for Black Canadians is reported on, along with limitations of race-based data collection. This is followed by a discussion on Black Canadians' health and policymaking strategies. Next, the authors focus on relevant implications for healthcare service providers to consider when supporting Black Canadians. The paper concludes with a clear take-home for us to work toward equitable healthcare for racialized groups like Black Canadians, whilst dismantling systemic racism in policymaking.

Historical Context of Anti-Black Racism in Canada's Healthcare System

There is a persistent history of oppression, racism, and discrimination against Black communities ingrained in Canada's healthcare system.[42] The racial power dynamics from slavery and colonization perpetuate this systemic health disparity issue.[35] Termed the *Holocaust of Enslavement*, or the *Black Holocaust* by prominent Black scholars,[43(p269),44(p178)] *slavery* describes the ongoing effects of atrocities inflicted upon African people, particularly by Europeans. This inhumane treatment continues today through imperialism, colonialism, and other forms of oppression.[45,46] In recent years, racism has been increasingly recognized as one of the root causes of inequitable health outcomes for people of African descent.[47] Black Canadian communities and their allies have long advocated for increased recognition of the health and social impacts of anti-Black racism in Canada. *Anti-Black racism* is a system of inequities in power, resources, and discrimination targeted at Black individuals.[48] These forms of social injustices are entrenched in European colonization and the legacy of the transatlantic slave trade. In 1834, slavery was officially abolished in Canada after the ratification of the Slavery Abolition Act that outlawed chattel slavery of Black people across most of the British Empire.[49] Despite being legally free, people of African descent are still not equal because slavery was a foundational institution in the building of Canada.[49]

Black Canadians continue to experience significant racial segregation, discrimination, prejudice, and inequality in the healthcare system, resulting from the curse of slavery.[49] The intergenerational trauma caused by this inhumane treatment of Black people has contributed to their degrading health and wellness today.[50] Originated in 2005 by renowned African American researcher Joy DeGruy,[51] the enduring impact of multigenerational trauma and injustices experienced by people of African descent is called *Post Traumatic Slave Syndrome (PTSS)*. These continued forms of discrimination and oppression have led not only to psychological problems like low self-esteem, persistent feelings of anger, and internalized racist beliefs[52] but also health-related concerns such as heart disease, hypertension, and stroke.[53] The systems and structures that allowed for the institution's legalization and administration of slavery and colonialism have not been fully dismantled. This form of institutional injustice has accounted for the intersected inequalities in racial, social, political and health outcomes for Black Canadians

Intersectionality Theory and Black Canadians' Health

Throughout the COVID-19 pandemic, the false assumption was made in mainstream discourse that this deadly virus was impacting everyone equally in Canada. However, this narrative was refuted with growing evidence that this global crisis brought the intersections of race, socio-cultural injustice and inequity to the forefront of public health.[28,29,54] The health catastrophe proved that as a multicultural country, we might all have been in the same storm but not in the same boat; some people were in super-yachts, while others had just one oar.[55] This analogy clearly depicted health disparity for racialized groups during the pandemic. It also provided a compelling explanation of why, concerning the disproportionate risks of ongoing exposures to COVID-19, this theoretical paper is well-placed to discuss Black Canadians' experience of poor health outcomes in the public healthcare system.[53,56] With this insight, intersectionality theory is fitting to evaluate the relationship between Black Canadian people's health and anti-racism because these individuals continue to experience the matrix of intersectional oppression.[40] *Intersectionality* raises concerns about the complex dynamics of inequality and discrimination in political and institutional spheres that produce hindrances for racialized groups.[57-61] The intersectionality between race and gender became more pronounced during the pandemic with racialized groups, like Black women, being overrepresented in the healthcare field as "essential workers"[62(p1)] in the healthcare field. As frontline health workers, they were coping amidst the dual pandemics of COVID-19 and racism that made them more at risk of contracting this deadly virus.[63] This racialized group was also earning substantially less than their White coworkers with household incomes of less than $50,000.[63] This pay gap further reinforced systemic issues of economic discrimination regarding the inequities between income, gender, and race.

In addition, racialized women aged 25-54 were twice that of their same-age male peers working part-time and in precarious jobs like food services, retail, nurse aides and home support workers.[64] More so, data collected by the Labour Force Survey earlier in the pandemic reported that although employment increased quicker for women (+ 3.4 %) than men (+1.5%), South Asian (20%) and Black women (18.6%) experienced the highest unemployment gap in the labour market.[21,65] Evidence also suggested that Black Canadian women were disproportionately affected by poverty because of their race, gender, language, health, age, income, education, and other socio-

cultural dimensions of health.[66,67] Additionally, Canadian research completed by Toronto Public Health during the peak of the pandemic found that rates of COVID-19 were higher in the lowest-income areas of neighbourhoods predominantly comprised of diverse racialized communities like Black individuals.[68] The results of this report suggested a strong link between overcrowded living conditions and the spread of this infectious disease, partly because when people tested positive or were exposed to COVID-19, they could not self-isolate.[68] The intersected issues outlined in this section reflect some of the inequitable health outcomes experienced by Black Canadians, which are expanded on below.

Social Determinants of Health Among Black Canadians

Consequently, the racist ideologies established during slavery (discussed above) continue to influence Black Canadians' SDOH in various institutional sectors including the healthcare system. Drawing from Solar and Irwin's[69] work, we conceptualize the *SDOH framework* as conditions that shape the environment in which people are born, grow, work, live and age. These health conditions help individuals to thrive, contribute and feel supported in their communities.[70] Previously, race/racism was not considered as one of Health Canada's 11 determinants of health factors for many immigrants like people of African descent; these factors included income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviours, access to health services, biology and genetic endowment, gender, and culture.[71] With the growing understanding that Black people's health is a public health issue in Canada, race/racism was included as one of the main determinants of health in recent years.[70,72-74] We argue that for Black Canadians, insidious encounters of stigma, discrimination, racism and historical trauma are important SDOH that have invisible systemic effects.

Subsequently, the authors assert that the initial exclusion of race/racism from the main determinants of health factors could be related to Canada's misguided notion of multiculturalism. Introduced in 1971, Trudeau's policy of multiculturalism positioned within a bilingual framework emphasized the acceptance of all cultures and their equal accessibility to services including healthcare.[75,76] However, the nation's international reputation as a multicultural mosaic presents a unique perspective for critique. Henry and Tator[77] claimed that this myth of multiculturalism preserves the ideology that Canada is colour-blind, a belief that simultaneously negates the need for racial inclusivity and perpetuates the false notion that racism no longer exists. This view contradicts research that shows the harmful impact of anti-Black racism and structural inequities on the health outcomes of Black Canadians pre-COVID-19 and during the height of the pandemic.[78,79]

Although people of African descent were severely affected during this outbreak, there appears to be unclear disaggregated mortality data of COVID-19 exposure and death concerning race, gender and income.[37] Moreover, Canadian research indicated that a comprehensive portrait of Black Canadians' health does not exist due to substantial data gaps in the literature.[6] Hence, there is a growing demand for race-based data to be collected by members of the Black community using an intersectionality framework to address longstanding concerns like anti-Black racism, equity and accountability in the healthcare system.[80,81] The issues surrounding race-based data were intensified nationally and internationally during the pandemic, requiring adequate attention in this article.

Advocacy for Race-Based Data During the COVID-19 Pandemic

When we revisit the health outcomes related to the COVID-19 disaster, it is evident that race played a critical role in how treatments were delivered, and the accessibility of resources provided across various cultural spheres. Constituting one of the largest global public health crises in history, this worldwide health emergency created greater awareness and advocacy efforts from diverse groups to compile national and international race-based data. For instance, Canadian hospitals failed to collect race-based data on Black populations, which generated limited primary research on this group and further inhibited publication efforts and new knowledge production.[82] Given this reality, advocates in Canada from racialized communities increasingly accentuated the need for disaggregated race-based data in healthcare to address the widespread inequalities in the country's public healthcare system.[81] This form of advocacy was based on the fundamental disparities in health equalities observed by racially oppressive groups like Black Canadians. For many of these individuals, access to affordable housing has been a pressing public health issue before and during the pandemic.[18,83]

Black communities across the diaspora also faced similar socio-cultural health challenges during this global outbreak. That being the case, it is valuable

to comment on race-based data in other geo-political contexts to analyze similar health outcomes of COVID-19. Comparable to Canada, race and ethnicity were recognized as risk markers in the USA, alongside such SDOH factors as socioeconomic status (SES), occupation, and access to health services.[84] In the USA, Centers for Disease Control and Prevention's (CDC's)[84] race-based data gathered during the pandemic unearthed notable discrepancies between reported cases (1.1x), hospitalizations (2.3x), and deaths (1.7x) among Black Americans compared to their White counterparts. Additional research generated in the USA showed that compared with non-Hispanic White patients, Black Americans had 2.7 times the odds of hospitalization after controlling for sociodemographic and clinical factors and income.[85] Expanding beyond the North American context, race-based data accumulated in the UK confirmed that Black individuals in Britain were four times more likely to die from COVID-19 than White persons.[86,87] Similarly to the North American context, race-based data accumulated in the UK indicated that the intersectionality effects of poverty and overcrowded housing among racialized groups like Black individuals were largely to blame for higher COVID-19 infection rates.[88] As well, a rapid systematic review by Jidong et al.[11] that examined the impact of COVID-19 on the mental health of Black communities in the UK raised concerns that African and Caribbean communities across the country were worse hit by the COVID-19 pandemic. This revelation was attributed to high levels of social inequalities, unequal opportunities, poor housing, and poverty which were prevalent among these ethno-cultural groups.

Conversely, European countries neglected to consider the benefits of race-based data due to a "colour-blind" approach.[89] In a systemic review study, Pan et al.[90] examined whether ethnicity data was reported in COVID-19 patient cases in May 2020, during the epidemic's peak. The results showed that several European countries, including France, Germany, Italy, Spain, Brazil, Turkey, and Russia, failed to report ethnic group data despite having the highest incidences of COVID-19 cases. Consequently, France's aversion to collecting data on race and ethnicity hindered the country's ability to identify and protect vulnerable populations like Black individuals during the pandemic.[91] Likewise, failure to acquire race-based data in Germany has made it difficult for the country to accurately determine how much more likely Black people were susceptible to die from this severe respiratory illness because of SDOH concerns like racial discrimination.[92] These generated trends from the race-based data, indicated a higher impact of COVID-19 among racialized communities within high-income countries (HICs), including Canada, the USA, and the UK. Such increased awareness challenges healthcare providers, policymakers, and other stakeholders to address social determinants and maternal mental health disparities among people of African and Caribbean origin in these HICs.[6,93]

Despite the benefits of amassing race-based data, valid criticisms are noteworthy. First, collecting race-based data does not mean such information will be equitably shared locally, nationally, and internationally across various socio-cultural and geo-political settings. For example, concerns surrounding communities and service providers' access to the data have been an area of contention for many individuals from racialized communities due to ethical risks and potential harm.[94] This line of argument stems from the lack of data-privacy systems within public health infrastructure in Canada.[95] More so, race-based data is often hindered by quality, comprehensiveness, and lack of comparability across other data sources.[6] In some cases, data from racialized communities like Black Canadians has been cumulated primarily by outsiders with limited and/or no input from members of that group; hence, the reliability of such information tends to be skewed and not reflect the lived realities and worldviews of members from this community.[96] Appraising these limitations denotes that a more balanced approach and intersectionality lens are needed cross-culturally to identify gaps in the accrual of race-based data. This collective effort, we believe, will help create an inclusive healthcare system that actively supports the development of policies to address systemic discrimination and anti-Black racism.

Black Canadians' Health and Policymaking

Canada's reputation as a multicultural nation with equal access to healthcare has been rightly questioned due to the country's failure to develop an inclusive anti-racism healthcare policy. The country's failure to establish such a policy perpetuates health disparities and creates discrimination in decision-making and health outcomes amongst numerous Black Canadians before and during the pandemic.[88,97] To provide an anti-racist policy, racialized voices need to be included to generate meaningful change in the Canadian healthcare system. Accordingly, we offer several steps to be taken that could support a truly anti-racist policy. First, we need to implement provincially regulated policies that address the

historical challenges of intergenerational trauma that have othered racialized communities like Black Canadians.[49] This form of otherization has caused inequitable health treatments, significant financial and economic impacts, greater occupational exposure, and poorer health outcomes of COVID-19 for people of African descent.[88,98] We, therefore, propose that healthcare providers serving Black individuals should be mindful of the impact that trauma and other systemic factors have on their daily health functioning.

Second, to fully capture and understand the impact of race on the healthcare experiences of Black Canadians, a nationwide anti-racism data legislation policy that requires Canadian health agencies to collect race-based data must be introduced. The introduction of such legislation would be able to accumulate disaggregated data to identify the gaps in Canadian healthcare policies; in turn, the insights gathered from this evidence would assist with delivering equitable services and programs to racialized populations.[18,81] Specific standards must be developed for the collection process to ensure racial information is reliable and comprehensive. Such measures would include consultation with members of the Black community and the assurance that they are fairly represented in all decision-making processes.

Lastly, we recommend an anti-Black racism policy that considers the systemic and psycho-social impacts of slavery and colonization of Black Canadians.[99] This acknowledgement will allow for developing culturally responsive and appropriate interventions, such as the Africentric model to better care for Black Canadians. Credited to USA Black scholars,[100,101] the *Africentric model* is culturally grounded in African-centred ways of doing, knowing, being and living. This African worldview encompasses the intersectionality of cultural dimensions such as race, gender, ethnicity, social class, ability status and sexual orientation. In this view, it acknowledges Black people's cultural and spiritual resiliency. This model provides healthcare service practitioners with a strong cultural foundation to co-create healing for people of African heritage. In this co-creating process of healing, Black people are better positioned to solve pressing health problems that diminish their human potential and preclude positive social change.[78]

Using the Africentric Model Intervention with Black Canadians

Arguably, anti-racism interventions like the Africentric model must be implemented using a multilevel approach that incorporates support from all levels of government, institutions, stakeholders, policymakers, businesses, schools, healthcare, social services, community agencies and individuals. It is noteworthy for all parties in question to understand that working with Black Canadians is not a 'one-size-fits-all approach' to policymaking in the healthcare system.[102] Rather, it requires a collective effort at the micro, meso, and macro social levels regarding the intersectionality of the SDOH. Recognizing these multifactorial issues will help healthcare professionals determine culturally appropriate assessment and intervention tools to interrogate race as a social system in the Canadian healthcare sector.

Consequently, the uptake of mental healthcare is low for the Black population in HICs, due to systemic racism and lack of access to culturally appropriate care.[93,103] Here, *systemic racism* represents structural or institutionalized racism that is entrenched in legislation, policies, and practices of society; it privileges preferential treatment toward the dominant White group who is deemed as superior while oppressing and disadvantaging racial populations classified as inferior.[4,104] In the quest for an African-centred approach to healthcare, Jidong et al.[93] conducted the first randomized controlled feasibility research trial in the UK. This study examined Learning Through Play plus Culturally adapted Cognitive Behaviour Therapy (LTP+CaCBT) for treating maternal depression in British mothers of African and Caribbean origin. Findings showed that LTP+CaCBT was culturally relevant, appropriate and acceptable with reduced levels of maternal depression and anxiety. These outcomes attest to the need for more African-centred and culturally relevant research that sheds light on the SDOH disparities within racialized communities. The knowledge translation generated from this research will ensure better treatment outcomes and policies that are socially informed and patient-centred for Black people.

Implications for Healthcare Providers Working with Black Canadians

As previously noted, the COVID-19 pandemic disproportionally impacted Black people and placed them at an increased risk of the virus due to anti-Black racism and SDOH.[31,86] Despite this fact, the current healthcare policies and interventions used by government agencies and decision-makers fail to reflect the multicultural nature of the Canadian population.[19] On that account, healthcare providers working with Black Canadians

are urged to adopt anti-Black racist policies that advocate for institutional change. This form of systemic shift would, in turn, promote inclusivity, diversity, equity, decoloniality, and a sense of belonging for racial and ethnic differences. It will further facilitate effective ways to prevent and mitigate racially inequitable outcomes and power imbalances for racialized groups like Black Canadians. This means that healthcare professionals should strive to understand the intersected identities of Black individuals. The authors postulate that this increased competency is crucial to providing effective services and conducting culturally appropriate assessments adapted to their needs.

Essentially, Black people's experiences of health and their interactions within the Canadian healthcare system are quite complex and multi-factorial. Taking an ethical stance, healthcare providers are urged to practise cultural humility in their work with racialized communities. The term *cultural humility* was coined in 1998 by African-American physicians Drs. Melanie Tervalon and Jann Murray-Garcia, to address health disparities and institutional inequities in medicine.[105] Now used cross/disciplinary in education, social work, psychology, and counselling, this concept emphasizes a "lifelong commitment to self-evaluation and self-critiques" through education and empathy with defined groups like people of African descent.[105(p117)] From this perspective, healthcare professionals should co-construct knowledge with Black people through open dialogue, non-judgement, and compassionate curiosity whilst recognizing their subjective realities, unique cultural experiences, beliefs, and worldviews.[106] Undoubtedly, utilizing culturally appropriate tools (e.g., the Africentric model) to examine and understand the health and well-being of Black Canadians would aid healthcare professionals in their practice. Embracing these tools, policymakers would be able to design and implement effective services to improve the health conditions of Black Canadians.

Conclusion

Moving forward, it is crucial that we prioritize the healthcare needs and mental wellness of Black Canadians, which embodies their socio-cultural emotional, and spiritual dimensions.[78] The inequitable health outcomes Black people experienced during the widespread of COVID-19 strongly reinforce Canada's need to take immediate action to alleviate their exacerbated SDOH. Systemic racism is widely recognized to have negative consequences on the health outcomes of Black Canadians, and as such was a key stand-alone determinant of health and well-being pre-, during and post-pandemic era[78,79,88,97]. Additionally, the categories of intersectionality including discrimination, poverty, housing, gender, and social inequities continue to serve as systemic barriers for Black individuals in the healthcare system. Thus, understanding the differential impact of COVID-19 based on the above diverse intersectionality categories is vital as we seek to tackle institutional racism. Collectively, we can accomplish this societal task by identifying and removing barriers in delivering healthcare, employment, education, and culturally informed research practices in the Black community.

With the understanding that policies influence people's social locations, and access to power and resources, we as a society must create racially based methods to operationalize intersectionality in policy as we advance in our care and support for Black Canadians. In this vein, health agencies must follow a standard approach to collect reliable race-based data to recognize the poorer health outcomes among Blacks communities. We reason that gathering and analyzing race-based data in Canada should adhere to culturally responsive data collection, management, reporting standards and ethical practices.[18] To this end, we are all encouraged to acknowledge the diverse problems of the Black communities and determine what public health action measures should be taken to better protect, serve, support, and heal them.

Conflicts of interest statement: The authors have no conflicts of interest to declare.

Funding statement: This work was supported by the Open Access Publication Fund, Research and Innovation Services, University of Lethbridge.

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