Strategies to address anti-Black racism in primary care

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The Black Health Alliance is a community-led organization working to improve the health and wellbeing of Black communities in Canada. Using research, community engagement and health promotion, the Black Health Alliance acts as a platform to dismantle systemic barriers.

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Acknowledgement of Traditional Land

We wish to acknowledge this land on which Wellesley Institute operates. For thousands of years, it has been the traditional land of the Huron-Wendat, the Seneca and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

Report

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BLACK HEALTH ALLIANCE

Contents

Introduction

The Canadian healthcare sector has increasingly focused on the presence and impact of anti-Black racism (ABR) on Black populations[1-3]. ABR refers to the unique discrimination, prejudice and stereotypes that Black people face[4]. It is systemic, embedded into the policies and practices of Canadian institutions, including healthcare, justice and education[4]. Consequently, ABR affects healthcare providers' perceptions of Black people and the quality of primary care they provide. Research has shown Black patients report inadequate care, racial discrimination leading to trauma and a lack of support from providers[3,5-7]. Canadian studies have also highlighted that ABR in healthcare institutions can manifest as stereotyping, differential treatment, downplaying a patient's experience of pain, assuming higher pain tolerance, refusal to provide medications and chastising for health behaviours[8].

"Research has shown Black patients report inadequate care, racial discrimination leading to trauma and a lack of support from providers."

ABR's enmeshment in institutions – such as education, justice and social services – creates pervasive barriers to primary care and essential social services like social assistance, food, housing and mental health support. Additionally, evidence has indicated that Black healthcare professionals face differential treatment due to race, increased workplace-related stress and insufficient guidance to navigate these challenges[9-11].

In Ontario, primary care plays a crucial role in serving all populations and acts as the foundation for all types of care[12]. It is positioned as the gateway to the healthcare system and the locale where the social determinants of health, such as housing, education and income, should be central[13]. In addition to providing health prevention, promotion and care, primary care may be a critical point for addressing anti-Black racism. Given the importance of primary care to the health and well-being of the population, ensuring equity in this area is of growing interest to the Province of Ontario[14] and other sector partners. Strengthening primary care for Black populations is a crucial first step to creating a healthcare system that ensures equitable access to care for all residents.

Despite increased attention and commitment to addressing ABR, healthcare providers face challenges in identifying, accessing and integrating best practices to address ABR in frontline services. The limited efforts that exist in Canadian healthcare primarily focus on medical education curricula or modifying prevention or care guidelines[5,15]. These efforts to consolidate evidence on general anti-racist health interventions often do not clearly indicate their relevance for primary care.

The lack of comprehensive information about strategies to address ABR presents a challenge to widespread implementation of anti-racist strategies in primary care in

Ontario. Interventions to mitigate ABR tend to focus on short- or medium-term changes in knowledge, attitudes and behaviours. These types of interventions are not always conducive to making the long-term systemic changes needed to address ABR at all levels.

To address this gap, Wellesley Institute and Black Health Alliance conducted an environmental scan detailing strategies to address anti-Black racism in primary care settings. Each strategy's approach to addressing ABR was categorized by the intended outcome as well as its mechanisms of change, such as knowledge and attitudes (KA), practice (P) and governance (G). This environmental scan can be helpful to identify and apply promising strategies to combat anti-Black racism in primary care and promote equitable healthcare for Black populations.

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Methods

Environmental scans have proven valuable in health service delivery research for evaluating the current state of programs or policies[16]. Their adaptable methods can be refined to best fit the study's approach. In this report, an approach outlined by Shahid and Turin was used, following a step-by-step process for research teams to determine the appropriate components required for a specific environmental scan[16].

Step one identified the need to clearly define the purpose and scope of an environmental scan. This scan aimed to identify strategies to address anti-Black racism in primary care in Ontario.

Step two emphasized the importance of involving relevant stakeholders to determine the necessary standard and dynamic search approaches for the research topic. For this scan, it was noted that the term "strategy" should be broadly defined, as relevant literature has used terms like approaches, plans, frameworks and interventions interchangeably in the context of improving health equity. Additionally, the research team's engagement highlighted the challenge of numerous initiatives addressing anti-Black racism within primary care in Ontario. Although grey literature may be available, it was noted that it may be difficult to collect through traditional methods. Thus, a targeted approach was recommended to gather additional documents.

Engagement of experts provided a theoretical understanding of the mechanisms to target anti-Black racism and address its impact. These shaped the definitions for this scan. They proposed that targeting anti-Black racism occurred through strategies focusing on knowledge and attitudes (KA) to improve awareness and understanding of anti-racism and equity. Addressing the impact of anti-Black racism was understood to involve changes in practice (P) or governance (G). Practice changes included adopting equitable practices to better meet the needs of Black communities. Governance changes focused on modifying structures and processes to ensure inclusive or equity-focused decision making. It was noted that implementing all three mechanisms of change would be essential for enhancing health equity for Black populations in primary care.

Step three detailed the process of clarifying and finalizing the questions that need to be answered. The primary research question in this environmental scan was:

- What strategies exist to address anti-Black racism in primary healthcare?

From the earlier step, secondary research questions were developed:

- What is the extent of evidence supporting the effectiveness of these strategies?
- To what extent do these strategies employ the three mechanisms of change: targeting anti-Black racism through knowledge and attitudes (KA), and addressing the impact of anti-Black racism by implementing changes in practice (P) or governance (G)?

Step four outlined the process to specify what data to collect and from which sources. The following describes the methods used to collect, select and extract the data.

Identifying sources relied on a multi-pronged strategy that included a search of peer-reviewed and grey literature as well as the identification of implemented examples and resources. The search strategy was developed to capture these varying sources. Peer-reviewed literature was identified through a search of the following databases: PubMed, MEDLINE, Cochrane Library, Embase, Web of Science, EBSCOhost, CINAHL, and SocINDEX. Grey literature and implemented examples were drawn from searching Google and Google Scholar. This scan also leveraged information from organizations and professional networks focused on primary care research or provision to gain insight into existing programs and services within Ontario.

Several terms were included in the search strategy to identify relevant sources. These terms encompassed keywords related to the population of interest, such as Black and African descent; anti-Black racism, including racism, discrimination and injustice; the area of interest, like primary care, family medicine and community healthcare; and geographic location, such as Canada, the United States and the United Kingdom.

Records were included if they met the following criteria: explicit mention of Black populations, a focus on primary care, publication between 2010 (after the passing of Ontario's Excellent Care for All Act) and 2024, in English, and focused on populations living in Canada, the U.S. or the U.K. These countries were chosen due to their comparable healthcare systems, cultural contexts for Black populations, and policy and practice relevance. To be included, records also needed to provide explicit strategies for implementation. Sources that were purely conceptual discussions on addressing anti-Black racism in general or not focused on Black populations were excluded.

The team developed a standard data extraction template to organize the information. Articles that met the inclusion criteria were extracted and charted into a table. The table recorded data elements such as the source author, year, geographical location, a description of the strategies and outcomes, and level of focus based on the socioecological model. If the strategies were implemented, the team assessed the specific activities within their health setting or focus area, noted any reported or intended outcomes, and determined whether an evaluative component was included to assess the level of evidence.

Step five of Shahid and Turin's guidance on environmental scans described how to consolidate the gathered information and present it in an accessible format. After extracting the data, the strategies were analyzed at each level of the socioecological model. Their outcomes were grouped into key themes using Braun and Clarke's approach[17]. These key themes, referred to as pillars in this report, represented the intended outcomes of the various strategies. To ensure the scan's utility for action, subthemes were identified

for each pillar to serve as clear, key strategies. These strategies were then assessed for whether they acted through changes in knowledge and attitudes, practices or governance. While implemented strategies were included in the broader analysis, they were also examined in greater detail to assess their evidence on effectiveness.

Results

A total of 33 sources were included in this environmental scan, each providing valuable insights on addressing anti-Black racism in primary care. (Appendix A outlines the results of this search.) Among these sources, 14 examples from the literature were identified as having been implemented. Of these 14, six included an evaluative component to demonstrate their impact.

The types of sources included were peer-reviewed articles[18-28], reports[29-33], guides[34-37], strategies[38-41], toolkits[42,43] and trainings[44,45]. Eighteen sources focused on the U.S.[19,22-31,34-37,40,42,46], 11 sources had Canada as a setting[20,21,32,33,41,44,45,47-50], and four were drawn from work completed in the U.K.[18,38,39,43]. (Appendix B summarizes the key findings from these sources.)

The results of this scan were organized around the three key research questions:

- Existing strategies: A comprehensive list of all strategies identified in this review.
- Evidence on effectiveness: An exploration of the evidence supporting the strategies' abilities to create change.
- Mechanisms of change: An assessment of how these strategies specifically target anti-Black racism or address its impact.

Existing strategies

There were 30 strategies identified across the literature in this scan. They primarily centred on individual, organizational and systemic levels.

The thematic analysis within each level found two main outcomes, again referred to as pillars, at the individual level, with two strategies in Pillar 1 and five strategies in Pillar 2. There were five pillars at the organizational level where Pillar 3 had six strategies, Pillar 4 had three strategies, Pillar 5 had five strategies, Pillar 6 had three strategies, and Pillar 7 had two strategies. There was only one pillar at the systemic level, Pillar 8, which had four strategies. As outlined, each strategy was labelled based on their mechanism of change: knowledge and attitudes (KA), practice (P) and governance (G). (A full outline of these levels, pillars and strategies are outlined in Appendix C: Table C1.)

Strategies were analyzed by three factors	
Level: The level at which they intended to create change.	**Individual** **Organizational** **System**
Outcome: The specific result they were designed to achieve.	**Pillar 1: Equity lens** **Pillar 2: Patient-driven care** **Pillar 3: Organizational readiness** **Pillar 4: Community trust** **Pillar 5. Inclusive workforce** **Pillar 6: Equitable services** **Pillar 7: Monitoring and evaluation** **Pillar 8: Equitable health polices**
Mechanism of change: The pathway by which they achieved their outcome.	**Knowledge and attitudes** **Practices** **Governance**

Pillar 1: Equity lens

The literature emphasized the importance of frontline providers, such as physicians and nurses, applying an equity lens to incorporate the lived experiences of patients into their care. Nine sources mentioned strategies focused on improving equity[22,23,26-28,35,36,44,45]. Two key strategies were identified in this pillar: acknowledge racism[22,23,26,28,35,36,44,45] and personal reflection[23,26,34,35].

Acknowledge and address racism. (KA)

It was suggested that physicians should understand and address the realities of anti-Black racism within their practice[23,35,51]. This involved understanding how harm and historical and socioenvironmental contexts related to anti-Black racism affected health and healthcare. In the care setting, it was recommended that providers acknowledge the concerns Black patients may have[23,51]. To address these concerns, physicians were advised to engage in open and honest conversations about the history of slavery, medical mistrust, implicit bias, racism and their impact on care[35,44]. Additionally, adopting anti-racist approaches in care was advised. Suggested strategies included understanding patients' beliefs, culture and lived experiences[35], and learning to recognize racial trauma in patients' communication styles and perceptions[26].

Personal reflection and professional development. (KA)

Brown-Johnson et al.[23] and Herbst[26] noted that reflection was an important first step for clinicians to consider their identities, potential biases and the ways power dynamics

could manifest in clinical practice. To improve practice, it was suggested clinicians address potential biases by leveraging resources such as training (e.g., counter stereotype training)[27,35] and implicit association tests[35]. Understanding anti-racism and anti-racist approaches[27] was also noted as important to improving clinical care. Similarly, the literature noted that cultural humility was necessary for clinicians to identify negative emotions associated with discussions about race, and balance individual care with clinicians' knowledge about communities[26,27].

Resource

- Cultural Sensitivity: The Importance of Cultural Sensitivity in Providing Effective Care for Diverse Populations. White paper that presents strategies for cultural sensitivity in primary care[37].

Pillar 2: Patient-driven care

Patient-driven care was highlighted in 14 sources, emphasizing the need for clinicians to transform their relationships with patients and overall service delivery[19,23,25,27-30,32,34-38,44]. Sources emphasized the need to recognize and prioritize Black patients' needs, perspectives and uniqueness. The strategies included developing individualized care[30,34,35,38], addressing power differences through co-design[19,23,27,28,34,37], practicing inclusive communication[19,23,25,27-29,35], addressing racism in clinical algorithms[35] and acknowledging the social determinants of health[28,32,36,44].

Create individual prevention and care plans. (KA)

Brown and Beesley called for clinicians to recognize their patients as individuals to combat implicit bias about groups[34]. Richards from the Center for Health Care Strategies in the U.S. examined racial equity in trauma-informed care provided by health systems. They noted that identifying adverse childhood experiences could be helpful in understanding a patient's health and social needs[30]. As such, they recommended providers create health prevention and care plans that respond to and acknowledge these experiences. Frederick and Tessema echoed the need for providers to connect with these experiences, as many Black people experience the effects of chronic stress[35].

Address power dynamics with co-design. (P)

The literature highlighted the importance of empowering Black patients to make decisions about their own healthcare based on their interests and concerns[27,28,34,37]. Ordaz et al., Valente et al. and Brown and Beesley asserted that supporting patient autonomy can foster trust with providers, whereby Black patients were shown to prefer clinicians that respected their perspectives[19,28,34]. Specifically, recommendations were for providers to frame interventions by their intended goal, explain recommended guidelines and receive feedback from patients to form the final treatment plan[23,34,37].

Use inclusive communication practices. (P)

Empathetic and high-quality interactions were shown to reduce perceived discrimination and cultivate trust between patients and clinicians. Key strategies included asking open-ended questions about patients' experiences, employing active and reflective listening and using nonverbal cues such as smiling and making eye contact[23,25,29,35]. Ordaz et al. found Black patients especially preferred clinicians who initiated conversations about their family, hobbies and relationships[28]. Garcia et al. further recommended providers in pediatric care prepare for multiple conversations with the entire family unit[27]. They emphasized the importance of always seeking consent and ensuring caregivers have access to various communication methods.

Review racial bias in clinical algorithms. (P)

Frederick and Tessema outline strategies to address anti-racism clinical care to improve health outcomes for Black women[35]. They highlighted that anti-Black ideologies have shaped the development of many clinical measures, particularly those related to pulmonary, renal and cardiovascular outcomes. Consequently, clinicians may mistakenly assume Black patients have lower risk or severity of illness, or higher risk for necessary treatments. They recommend clinicians reflect on and consider the influence of systemic racism in using these clinical algorithms.

Address the social determinants of health. (P)

Three papers highlighted the importance of recognizing social and structural factors that affect experiences of health and well-being for Black communities[28,36,44]. In fact, Ordaz et al. found Black participants valued treatment plans that focused on lifestyle changes and supports[28]. The American Academy of Family Physicians outlined a strategic approach that incorporated individual practices to ensure patients' social needs were recognized and addressed[36].

Resources

- Guidance for providers related to patient and family experiences of racism. Modified Partnership, Empathy, Apology, Respect, Legitimize, Support (PEARLS) framework to support family-centred and culturally responsive care[26].
- Beyond the Surface: A Proactive Guide Series on Screening for Social Determinants of Health. Collection of resources to improve capacity for social determinants of health screenings in primary care settings[36].

Pillar 3: Organizational readiness

Building organizational readiness was a goal for many strategies aiming to address anti-Black racism at the organizational level. Eleven sources provided strategies for building organizational readiness[20,24,30,35,37-39,42,43,45,50]. These strategies included involving leadership and obtaining buy-in[30,38], assessing policies and practices[30,35,39,45], developing an anti-racism strategy[30,38,39,42,50], reallocating funding and resources[24,39], monitoring and evaluation[20,35,42] and developing an inclusive organizational culture[35,37-39,42,43,45]. The research noted that anti-racist interventions in healthcare organizations are most effective when they focus on long-term outcomes and solutions that also address individual and systemic challenges to equitable care[20].

Involve leadership and obtain buy-in. (KA, P)

The literature suggested building organizational readiness by involving leadership early in processes intended to address anti-Black racism[30,38]. Research noted the importance of understanding leadership's understanding of anti-Black racism, promoting racial equity and recognizing the impacts of racism on healthcare access. Leadership's commitment was also important. For example, when implementing an anti-racist strategy, leadership was advised to make public commitments to change. These commitments should acknowledge past and present harms related to racism and discrimination, and recognize their direct impact on mistrust of health systems, organizations and providers[30,38].

Assess policies and practices. (P, G)

Assessing policies and practices was recommended as a necessary step to address anti-Black racism within organizations. Sources recommended reviewing organizational policies for bias and effectiveness of addressing anti-racism, including those related to harassment, violence and hate speech[39,51]. Policies should also focus on hiring and retention of diverse staff[51] (Massaquoi). If such policies did not yet exist, creating them was deemed imperative[30]. This information could assist organizations in identifying existing areas of opportunity for improvement.

Develop an anti-racism strategy. (P, G)

At the organizational level, Berkshire Healthcare in the U.K. recommended organizations develop a robust top-down strategy to achieve racial equity[39]. These strategies should acknowledge the power dynamics inherent to healthcare provision and the vulnerability of patients when accessing care[30]. Organizations were advised to support the development or expansion of a team responsible for overseeing the implementation of the health equity strategy[42]. The team should identify strategic objectives, define key concepts related to health equity, and determine roles, responsibilities, milestones and expectations[42].

Reallocate funding and resources. (P)

Findings indicated that organizations should prioritize funding increases for anti-racist and Black-focused organizational change to align with their commitments to health equity[24]. Funding should be robust and focused on ensuring the anti-racist strategies could be executed effectively[39].

Build readiness for monitoring and evaluation. (P, G)

Research evidence noted that monitoring and evaluation were mandatory for effective anti-racist interventions in healthcare settings, as they were necessary to understand the usefulness of implemented interventions and provide the information needed to make improvements[20]. Suggestions for data collection included patient characteristics such as race, ethnicity and language[20], key primary care performance measures (e.g., HEDIS measures), access and availability of care, quality of care, patient experiences, care utilization and integrations of care[20,42].

When collecting data related to patient outcomes, sources articulated that measures should be sensitive to disparities, address the impact of clinicians' care decisions, evaluate the effectiveness of communication processes, and assess the impact of social and structural causes of health inequities. These measures should be stratified based on patient demographics[42].

Develop an inclusive organizational culture. (KA, P)

Numerous strategies were suggested to build an inclusive organizational culture. A key suggestion involved building relationships with community allies to support the strategy implementation, including community organizations, social enterprises, healthcare providers and diversity, equity and inclusion bodies[51]. Supporting staff education to improve knowledge, attitudes and practices related to equity-focused care was another notable recommendation[37]. Educated staff were mentioned to be better equipped to deliver equitable care.

Monitoring and supporting inclusive representation on organizational boards was emphasized to ensure they reflect the makeup of the communities they serve, fostering trust in decision-making[38]. Furthermore, building organizational trustworthiness by establishing diversity, equity and inclusion advisors was suggested to gather needed guidance on their equity initiatives[35]. Similarly, creating groups such as racial equity caucuses was recommended to provide support for staff and champion anti-racist changes within the organization[35].

Lastly, implementing mechanisms for colleagues and stakeholders to express concerns, share experiences and provide feedback was suggested to improve inclusivity[39].

Resources

- Health Equity Impact Assessment. Tool designed by the Canadian Public Health Association to promote organizational policies and practices that support health equity, drawing on previous work led by the Ontario Ministry of Health and Long-Term Care and Wellesley Institute, among others[52].
- Continuum on Becoming an Anti-Racist Multicultural Organization. Designed as a tool for organizations to assess their location on the spectrum of anti-racist institutions.
- Achieving Health Equity: A Guide for Health Care Organizations. A White paper that presents a framework healthcare organizations can use to improve health equity in the communities they serve.

Pillar 4: Community trust

The role of community trust in addressing anti-Black racism was emphasized in 12 sources[21,33-35,37,38,40-43,47,48]. The literature underscored the need to understand community's needs and deliver appropriate and relevant care for Black communities. This pillar was related to three specific strategies: engaging communities and partners[21,23,33,34,37,38,40,41,43,47,48], practicing community-based participatory research[32,35,38,40] and enabling community governance[34,35,38,40,41].

Lead engagement and partnerships with Black communities. (P, G)

Working closely with communities was described to help primary care providers in delivering integrated and diverse services. Organizations were advised to undergo anti-racist education prior to engagement and describe a clear purpose in engaging with communities[48]. Strategies to enable effective community engagement included locating services close to communities, increasing availability of home visits, and hosting community sessions in non-healthcare-related facilities[37,43]. Naar et al. explained how these perspectives could inform the development and prioritization of necessary anti-racist interventions and policies[40].

Employ community-based participatory research (CBPR). (P, G)

CBPR was positioned as a method to enhance health service delivery and become a trusted resource to communities[35]. The National Health Services in the U.K. emphasized the need for using CBPR approaches for not only academic research, but specifically the improvement and evaluation of services[38]. The transformative health justice conceptual framework by Naar et al. served as an example of strategic integration of CBPR in a primary care clinic's development of anti-racist interventions[40].

Establish community governance. (G)

The literature underscored the value of community governance to empower communities to make decisions on service design and delivery, organizational governance, funding, workforce strategies and data management. Their leadership was demonstrated to ensure services were culturally sensitive and meaningfully responded to their needs[34,38]. These bodies were commonly described as advisory committees or boards with powers ranging from providing feedback, interpreting data or providing approvals for community-related activities[34,35,40,41].

Resources

- A Toolkit to Advance Racial Health Equity in Primary Care Improvement. Toolkit to improve racial equity in primary healthcare through nine key drivers with tailored strategies and case study examples[42].
- Transformative Health Justice Conceptual Framework. Created for the development of anti-racist interventions in primary care settings. It was informed by community-based participatory research methods and systems science methods[40].
- Engaging People with Lived Experience Toolkit. Developed to collate strategies and best practices when incorporating community members into healthcare development[42].

Pillar 5: Inclusive workforce

A total of 10 sources highlighted the importance of implementing inclusive workforce practices to improve Black representation in healthcare settings[21,24,25,28,34,35,38,39,46,48]. There were five key strategies that could be used to develop an inclusive workforce: prioritize workplace diversity and hiring[35,48], employ targeted recruitment of health professionals[28,34], create equitable policies for hiring, retention, promotion, and compensation[38,39,43,46], provide social support for staff[39,46], and implement anti-racist education and training for staff and leadership[24,25,34,35,48].

Prioritize workplace diversity and hiring. (P)

Organizations were encouraged to hire Black staff, including healthcare providers and leadership, that were representative of their patients[35,48].

Employ targeted recruitment of Black physicians. (P)

The literature noted that patient outcomes improved when providers resembled their patients. Therefore, it was recommended that organizations hire healthcare staff with similar cultural backgrounds and languages spoken[34]. Some participants preferred Black physicians whenever available to receive culturally appropriate care, such as culturally tailored diet changes[28].

Create equitable policies for hiring, retention, promotion and compensation. (P, KA, G)
Creating interventions focused on attracting and retaining Black talent in healthcare settings at the recruitment, selection and retention phases was described as imperative to addressing anti-Black racism[46]. The success of these changes depended on obtaining leadership buy-in at the organization, monitoring progress along indicators, and commitment to organizational culture change. It was suggested that organizations monitor the effectiveness of these interventions by tracking progress and race-based disparities in compensation and promotion against specific equity targets and indicators[38,39].

Organizations were also advised to implement workforce training and education initiatives and develop schemes and medical school placements to promote the recruitment and retention of local staff in under-resourced areas. These would promote community building and involve financial or training incentives, especially to less experienced individuals[43].

Provide social support for staff. (P)
The literature emphasized the need for empathy to create an anti-racist organizational culture, specifically for racialized staff's stressful and sometimes traumatic workplace and personal experiences. To improve Black staff's sense of belonging and access to opportunities, it was advised to foster a workplace culture that did not tolerate racism and had mentoring programs for emerging Black clinicians[39,46].

Implement anti-racist internal education and training for staff and leadership. (KA)
Several sources emphasized the need for organizations to understand and respond to the lived experiences and challenges faced by Black healthcare staff[25,34,35,48]. Without adequate awareness of how health disparities form, healthcare providers and leadership risked perpetuating harm. Organizations were recommended to implement education and training programs for staff and leadership focused on implicit bias, discrimination, systemic racism, and the causal relationship between these factors and health disparities.

Resources

- Recommendations Organizations Can Use to Improve Black Representation of Physicians. Table of recommendations created for organizations and clinicians to address diversity, inclusion and equity for Black physicians in the healthcare system[46].
- An Evidence-Based Guide to Hiring and Retaining Black Academic Faculty. A guide to best inclusion and diversity best practices from residency directors in emergency medicine[46].

Pillar 6: Equitable services

Nine papers underscored the need for equitable services to address the impact of anti-Black racism, calling for healthcare strategies that directly respond to the specific needs of Black communities[19,21,23,28,33,43,47-49]. Recommended strategies included assessing barriers to services[19,23,48,49], improving coordination of care[19,28,29], and developing culturally specific services and health promotion[21,29,33,47,48].

Identify barriers to health services. (P)

The literature underscored the importance of assessing specific barriers to generate appropriate recommendations. For instance, Brown-Johnson et al. found that short clinical appointments limited time for active listening, impairing Black patients' trust[23]. Another study by Canie et al. discovered that Black communities wanted a position dedicated solely to their health and well-being48. Lastly, Valente et al. reported that clinics using rotating residents were rated lower by Black patients, emphasizing the need for continuous, individual relationships with providers[19].

Improve coordination of care. (P, G)

The literature highlighted the importance of improving coordination of care among Black patients. Valente et al. found that better information sharing and coordination between primary care providers and specialists increased trust with Black patients[19]. Similarly, Ordaz et al. noted that Black patients valued efficient orders for necessary tests and prescriptions, contrasting with their previous experiences of fragmented care[28]. Lin et al. discussed the effectiveness of care pathways, case management, community health workers and patient navigators in providing consistent, high-quality care and improve health outcomes for targeted populations[29].

Create culturally specific health services and promotion strategies. (P)

Creating culturally specific health services and promotion strategies was deemed crucial for making healthcare accessible. Canie et al. found that Black patients felt more comfortable accessing healthcare through Black-focused services[48]. As well, Nnorom et al., noted that organizations should adapt service pathways to ensure more effective patient care through collaboration with non-clinical staff. As an example, Lin et al. highlighted that community health workers who were culturally and linguistically aligned with patients were shown to have better impact[29]. Moreover, targeted outreach strategies, such as telephone, mail or in-person reminders, were shown to be most effective in cancer prevention contexts[29].

Pillar 7: Monitoring and evaluation

At the organizational level, 10 sources identified monitoring and evaluation as essential aspects of working towards addressing the impacts of anti-Black racism in primary care[21,27,32-34,37,43,47,49,50]. Strategies focused on collecting and using qualitative and quantitative race-based health data[21,27,33,34,37,43,47,49,50], and race-based clinical algorithms[34,50].

Collect and use qualitative and quantitative race-based data. (P)

The literature emphasized that after an intervention was created, it was essential to collect and evaluate both quantitative and qualitative race-based data to determine its effectiveness[37]. Local primary care providers were encouraged to collect patient sociodemographic information and integrate it into care and the evaluation of clinical practices. This involved implementing inclusive risk calculation algorithms, using IT resources, maintaining up-to-date patient registers, assigning data collection responsibilities to specific staff members, and training on data collection tools and data sharing policies. Institutions used disaggregated performance data by racial and ethnic identifiers to examine potential disparities[43] and monitor the impact of quality improvement initiatives[27]. For instance, one healthcare setting assessed barriers for screening services by auditing provider performance using electronic medical records for priority populations[21].

The literature also highlighted that monitoring and evaluation efforts were integral to improving clinical outcomes and reducing health disparities, similar to preventive or chronic care, and should be incentivized[34]. Evaluation metrics needed to align closely with the intervention's outcomes. A new approach to healthcare focused on patient-centred goals and true value-based care was suggested to close healthcare disparities. In theory, value-based care models should reward practices that produce better health outcomes for all patients, but many of these programs have inadequate indicators of success.

Analyze racial bias in clinical algorithms. (KA, P)

It was recommended that clinics analyze the underlying assumptions of race-based algorithms and calculators before using them to inform clinical decision-making[34]. It was highlighted that many race-based clinical recommendations were not founded on physiological differences but rather were crude proxies for social differences or evolutionary variation based on regional ancestry. The use of these tools haphazardly could perpetuate health disparities by mistakenly guiding clinicians to offer certain treatment options to one patient, but not another.

The authors of a 2019 editorial published in JAMA proposed the following standard: using race to guide clinical care was justified only if "the use confers substantial benefit; the benefit cannot be achieved through other feasible approaches; patients who reject race categorization are accommodated fairly; and the use of race is transparent[34]."

Pillar 8: Equitable health policies

The literature emphasized the need for an equitable system, where policymakers act to improve the healthcare system and better serve Black patients. Ten sources suggested key strategies for equity-centred health policy[18,29-31,42,43,45,46,49,50], which included funding[43], workforce diversity[29,45,46], health equity policymaking[29,31,43], and standards for anti-racist initiatives[18,49,50].

Change funding priorities. (G)

Gkiouleka et al. suggested that primary care policymakers should fund policy-level interventions that account for need differences for marginalized populations[43]. For example, funding for increased services based on data that analyzes socioeconomic status, race and patient waiting lists. The California Healthcare Foundation noted that governments should increase funding to family care practices and community health centres to incentivize service delivery to priority neighbourhoods and populations[42].

Prioritize workforce diversity. (G)

Sources also identified the need for policy interventions that ensure the healthcare workforce is diverse. Suggestions included improving the education pipeline for healthcare professionals, addressing economic barriers to education for diverse healthcare professionals, improving the climate of health education, and increasing the accountability of health systems and health profession schools, governments and stakeholders[29]. Massaquoi et al. suggested partnerships with diverse professional organizations to promote a culturally diverse workforce[45], while Williams et al. encouraged leveraging Black physician mentoring programs, diverse hiring committees and targeted recruitment to ensure workforce diversity[46].

Engage in health equity policymaking. (G)

It was suggested that policymakers should prioritize policies that focus on long-term solutions to health inequalities, addressing intersectional health inequities, the integration of services, and the engagement of healthcare providers. Policies should focus on using a population health management approach[43]. The United States Preventative Task Force noted there were four types of interventions that can intervene on health inequities[29]. These interventions were those focused on healthcare delivery (e.g., how, when and where healthcare is organized and delivered), implementation strategies (e.g., changes in healthcare organizations, healthcare professionals and the use of health services), financial arrangements (e.g., how funds are used and collected, insurance coverage) and governance (e.g., changes in rules and processes focused on authority, accountability, participation and coherence). Collecting standardized race-based data across health systems was also noted as important to ensure quality of care across a jurisdiction[31].

Establish standards for anti-racist initiatives. (P, G)

It was recommended that medical governing bodies such as the Canadian Medical Association and College of Family Physicians of Canada lead anti-racist initiatives. This can include legislation that mandates the collection of sociodemographic data including data on race to investigate health disparities for Black populations[18].

Resources

- Checklist for Medicaid Decision-Makers. Brief designed to assist state purchasers and payers to develop a funding strategy focused on health equity[42].
- A Toolkit to Advance Racial Health Equity in Primary Care Improvement. Toolkit with resources that address barriers to primary care at the systems-level.

Evidence on effectiveness of interventions

This environmental scan identified 33 sources that contributed to the development of 30 strategies across eight thematic pillars. The strategies varied in their genesis. Some were recommendations based on expert or community advice, while others demonstrated practical application in clinical settings. The goal of this scan was also to examine the extent of evidence supporting the effectiveness of these strategies, providing context on how they achieve their intended goals.

Among the 33 sources, 14 provided evidence of actual implementation of their strategies. These included nine examples from Canada[21,32,33,41,44,45,47,49,50], three from the U.S.[25,30,31] and two from the U.K.[38,39]. Five of the nine Canadian examples were identified by the targeted grey literature approach[32,33,47,49,50], as suggested through the expert engagements. The types of sources included two peer-reviewed articles[21,25], two reports[30,31], two program evaluations[32,33], two strategies[38,39], two trainings[44,45], two media articles[41,47], one conference poster[50] and one project planning document[49]. Of the 14 identified implemented examples, only six also had data generated from monitoring efforts or evaluations[21,25,32,33,39,47].

The examples covered multiple pillars and strategies identified in this scan. The highest concentration of implemented examples were in Pillar 4: Cultivating community trust[21,32,33,38,41,47] and Pillar 7: Monitoring and evaluating performance, with four of six implemented examples having monitored or evaluated components[21,32,33,47,49,50]. Pillar 6: Delivering equitable services had three of four implemented examples having monitored or evaluated components[21,32,47,49].

At a more granular level, specific strategies with the greatest references to implemented and monitored or evaluated examples were:

- collect and use qualitative and quantitative race-based data[21,32,33,47,50],
- create culturally specific health services and promotion strategies[21,33,47], and

- lead engagement and partnership with Black communities[21,33,38,39,41].

This scan also comprehensively assessed implemented and evaluated examples across the eight pillars. Appendix C: Table C2 summarizes the activities, related pillars and strategies, outcomes and description of evaluations or monitoring efforts, if any, for these 14 implemented examples.

Pillar 1: Equity lens, Pillar 2: Patient-driven care, Pillar 3: Organizational readiness

The anti-racist trainings proposed by Massaquoi[51] and Black Health Collaborative[44] were not formally evaluated. Anecdotal evidence from physicians' reviews supported the former training, indicating the online module improved their knowledge and attitudes towards ABR, as well as the experiences of Black staff members. There was minimal rigorous evaluation evidence to support Pillar 1, namely anti-racist strategies aiming to apply an equity lens in primary care settings.

Pillar 2 featured implemented examples of interventions that addressed knowledge and attitudes and practices in primary care settings. Tajeu employed an anti-racist educational intervention delivered online to healthcare staff working in primary care settings[25]. To investigate the effectiveness of this intervention, Tajeu et al. administered standardized survey instruments pre- and post-online intervention. These standardized surveys inquired about implicit and explicit bias, empathy, understanding of the social determinants of health and perceived discrimination. Ultimately, this online anti-racist intervention decreased implicit bias among non-physician or registered nursing healthcare staff.

A similarly robust mixed methods evaluation was performed on the two-year social prescribing pilot project by Bishop-Earle et al.[32]. This evaluation disseminated pre- and post-intervention surveys and focus groups to measure changes in self-reported health outcomes. Improvements included self-confidence, increased socialization, ability to manage one's health, client well-being, and decreased stress, anxiety and clinician visits. Though few, the existing evaluative evidence supporting the effectiveness of anti-racist strategies that focus on patient-driven care was quite strong.

The Black Health Education Collaborative presented an accredited Black Health Primer, online module to facilitate the unlearning of ABR among healthcare professionals, improving their understanding of the social determinants of health and making transformative change to the Canadian healthcare system[44]. The National Health Services in the U.K. (NHS) created a strategic framework to guide organizations through the process of creating and implementing anti-racist interventions in healthcare settings[38]. Though no formal evaluation of the framework was conducted, the authors indicated plans to refine their theory of change for future evaluation and monitoring. Additionally, the NHS recommended adopting a participatory approach to learning and the evaluation of services.

In a brief, Richards and the Center for Health Care Strategies provided recommendations for incorporating racial equity into trauma-informed care and recognizing racism as trauma[30]. Though none of these recommendations were evaluated, one of the authors' recommendations underscore the importance of monitoring data to hold parties accountable and track progress. NHS Berkshire outlined a comprehensive equity, diversity and inclusion (EDI) improvement plan with clearly defined success metrics that were used as benchmarks to measure their progress toward addressing prejudice and discrimination among its staff[39].

Pillar 4: Community trust, Pillar 5: Inclusive workforce, Pillar 6: Equitable services, Pillar 8: Equitable health policies

Vesnavar described an implementation research study aimed at improving screening and addressing health disparities among Black people who give birth in Ontario[49]. There were plans to conduct evaluations that assess the feasibility and acceptability of the program.

Bero reported on the Black Health Vaccine initiative, which aimed to improve vaccination rates among Black people in Ontario[47]. Although no formal evaluation of this initiative took place, monitoring data regarding the number of doses administered was tracked, demonstrating promising attendance at vaccination events. Hull et al. detailed an initiative to facilitate the safe collection and use of race data for multi-marker screening to enhance the accuracy of prenatal screening[50]. The University of Toronto's Department of Family and Community Medicine (DFCM) implemented a new Black Health Advisory Table to advise the department on strategies for supporting Black students and faculty members. These two initiatives have not been evaluated.

In their report on primary care, Rittenhouse et al. provided recommendations for improving health equity at the individual, organizational and systems levels[31]. Though these recommendations were not evaluated, the authors highlighted evaluation data from examples of effective implemented policies and programs.

Nnorom et al. implemented a multi-component health promotion intervention to increase breast, colorectal and cervical cancer screening rates among immigrants at a community health centre in Ontario[21]. The study drastically improved cancer screening rates by leveraging insights from audits of providers done through electronic medical records (EMR), health promotion activities, and a patient-callback program. To assess the effectiveness of this intervention, a retrospective analysis of annual screening rates from 2011-2018 was performed. The success of the program was largely attributed to its Afrocentric nature and commitment to quality improvement.

Rittenhouse et al. highlighted implemented examples of equitable health policymaking[31]. Although there was no evidence of evaluations of proposed changes at the state- or system-level for the recommendations, many individual programs listed as practice examples were evaluated and determined to be effective. For example, Equity and Quality at Independent Practices in LA County (EQuIP-LA) assessed the programs and services of independent primary care practices that primarily served people of colour[53].

Mechanisms of change

This scan aimed to evaluate the extent to which implemented strategies employ three mechanisms of change to combat anti-Black racism: targeting anti-Black racism through improving knowledge and attitudes (KA), addressing its impact by implementing changes in practice (P) and making governance adjustments (G).

Of the 30 strategies, practice changes were the most frequently occurring mechanisms of change, appearing in 23 instances. Among these, 17 strategies showcased examples of implementation. The most common strategies for creating changes in practice were:

- Pillar 4: Engaging and partnering with Black communities[21,33,38,41,47]
- Pillar 7: Collecting and using qualitative and quantitative race-based data[21,32,33,47,49,50]
- Pillar 6: Creating culturally specific health services and health promotion[21,33,47]
- Pillar 3: Developing an inclusive organizational culture[39,45]
- Pillar 2: Addressing the social determinants of health for patient-driven care[32,44]

These pillars mainly operated at the organizational level, with only one pillar excluded. Organizations were advised to prioritize building a culture of change. Specifically, these pillars emphasized the importance of empowering Black communities to lead health system changes, establishing data-driven accountability for evidence-based decision-making, and creating tailored interventions to improve the quality and accessibility of primary care for Black communities. At the individual level, it became evident that addressing the needs of Black communities required a broader social determinants of health approach, where providers actively inquired and responded to their clients' diverse needs.

Twelve strategies led to changes in governance, with nine of them providing examples of implementation. The most used strategies were:

- Pillar 4: Leading engagements and partnerships with Black communities[21,33-35,37,38,40,41,43,47,48]
- Pillar 5: Creating equitable policies for hiring, retention, promotion and compensation[21,33,39]
- Pillar 3: Developing an anti-racism strategy[30,38,50]

- Pillar 3: Assessing policies and practices[39,45]
- Pillar 4: Employing community-based participatory research[32,38]

Of the three pillars at the organizational level, each contributed uniquely to these strategies. Pillar 4 highlighted the ongoing significance of community engagement and partnerships in fostering trust to address the impact of anti-Black racism. Meanwhile, Pillar 3 emphasized the necessity of a strategic and documented institutional effort to implement practice and policy instruments aimed at dismantling systemic barriers affecting Black communities. Complementing these, Pillar 5 focused on enhancing the representation of Black communities within the workforce.

Knowledge and attitude changes were the least common, appearing in seven strategies in total with six demonstrating examples of implementation. The most cited implemented strategies to target anti-Black racism through knowledge and attitudes were:

- Pillar 1: Acknowledge racism[39,44,45]
- Pillar 5: Creating equitable policies for hiring, retention, promotion and compensation[21,33,39]
- Pillar 3: Developing an inclusive organization culture[39,45]
- Pillar 5: Implementing anti-racist education and training[25]
- Pillar 7: Analyze racial bias in clinical algorithms[50]

The strong emphasis on individual acknowledgement of racism highlighted the need for providers to understand the historical and socioenvironmental contexts driving anti-Black racism in health and healthcare. At the organizational level, strategies from Pillars 3, 5 and 7 collectively advocated for increased presence of Black voices and greater attention given to issues faced by Black communities. Evidence also underscored the need to address biases within an institution's workforce and the algorithmic tools used for clinical purposes.

Discussion

The purpose of this environmental scan was to identify strategies to address anti-Black racism in primary healthcare. We aimed to answer a primary research question: 1) What strategies exist to address anti-Black racism in primary healthcare? There were two secondary research questions: 2) What is the extent of evidence supporting the effectiveness of these strategies? And 3) To what extent do these strategies employ the three mechanisms of change: targeting anti-Black racism through knowledge and attitudes (KA), and addressing the impact of anti-Black racism by implementing changes in practice (P) or governance (G)?

This scan was conducted due to a lack of knowledge about effective ways to address anti-Black racism in primary care. There is a shortage of synthesized information that includes specific examples of best examples in this sector. This environmental scan aimed to address this gap by summarizing and providing examples of existing strategies to address anti-Black racism in Canada, the U.S. and the U.K. It also intended fill the gap on programming and services between data available from online sources and academic databases and data from a targeted approach.

This scan searched eight databases for published articles. It identified grey literature through Google Search and a targeted approach to identify strategies specific to Ontario. The review identified 33 sources that contained 30 strategies across eight outcomes, or pillars, to address anti-Black racism in primary care. Of these sources, 14 were implemented. Strategies were also categorized by their mechanism of action as indicated by the third research question.

This scan identified that addressing anti-Black racism in primary care required a multi-level approach, addressing various facets of how racism has been encoded into primary care. To achieve this, the scan identified eight key outcomes, or pillars. Each pillar represented an end goal, with individual strategies designed to achieve these outcomes through tangible actions. The eight pillars are: 1) An equity lens, 2) Patient-driven care, 3) Organizational readiness, 4) Community trust, 5) Inclusive workforce, 6) Delivering equitable services, 7) Monitoring and evaluation, and 8) Equitable health policies.

This report differentiated between strategies that addressed ABR and those that focused on its impact. This broader scope allowed for a richer understanding of improving primary care experience and outcomes for Black communities. Most results focused on the impact of ABR.

While individual strategies can impact ABR in primary care, many sources indicated that long-term and sustainable changes must be actioned from a systems-focused approach. This would be able to address the complex ways ABR has been encoded into healthcare.

This means changes should be made at the individual, organizational and system levels in the health sector[42].

Evidence on effectiveness of interventions

There were 14 examples of implemented interventions. Of those, five were evaluated, and monitoring data was collected for one intervention. Despite the lack of formal evaluations and routine monitoring data collection, the effectiveness of nearly all implemented interventions was supported by anecdotal evidence, including positive client and practitioner feedback as well as promising monitoring data.

A closer analysis of Appendix C: Table C2 revealed considerable evaluative evidence for implemented interventions aligning with Pillar 4: Community trust, and Pillar 7: Monitoring and evaluation. Substantial monitoring data support the effectiveness of interventions centred on Pillars 4, 6 and 7. However, the analysis also revealed a significant lack of evaluation and monitoring evidence to support the effectiveness of interventions focused on Pillars 2, 3, and 8. None of the reviewed implemented interventions reported evaluation or monitoring data for those targeting Pillar 8: Equitable health policies.

These findings aligned with scoping review by Hassen et al. results that identified few articles on health policy anti-racism interventions, and noted very few multi-level, long-term interventions in outpatient healthcare settings had been formally evaluate20. To demonstrate effectiveness, make improvements and proactively identify issues, high-quality evaluations and diligent monitoring should be integral components of anti-racist interventions in primary care settings. Many community-based organizations lack the expertise and resources to evaluate and monitor their initiatives, resulting in insufficient evidence to support the long-term effectiveness of many interventions.

Reflecting on this literature, it appeared that increased resources should be allocated by government decision makers in Ontario. These resources would enable the evaluation of the long-term effectiveness of systemic-level interventions such as health equity policies. This suggests that future grants for anti-racist interventions could benefit from dedicated funding for monitoring and evaluation costs. Additionally, providing organizations with suggestions for hiring internal or external evaluators, methods, indicators, and educational resources on evaluation may be beneficial. Strengthening organizational monitoring and evaluation infrastructure could better equip individual practitioners with the tools, organizational buy-in and experience required to evaluate their practices and patient outcomes.

Mechanisms of change

This environmental scan also sought to explore the most common mechanism of change in strategies targeting anti-Black racism, focusing on whether they aim to change knowledge and attitudes (KA), address its impact through changes in practice (P) or governance (G). Most of the strategies – 23 out of 30 identified from the literature – focused on changes in practice. This trend remained consistent whether considering all strategies, or only those that were implemented or had an evaluative or monitoring component. Specifically, three key strategies emerged from Pillars 4, 6 and 7 at the organizational level: engaging and partnering with Black communities, collecting and using qualitative and quantitative race-based data and creating culturally specific health services and health promotion strategies.

These findings may not necessarily suggest these are the most important strategies, as other strategies may have been equally important to build and enable capacity for organizational change. Rather, these three strategies could be understood as the primary drivers for implementing, measuring and reporting change. This has important implications for strategic planning.

Furthermore, these three strategies align with the current priorities of policy, health and community leaders, who have emphasized stronger engagement and partnership, use of data, and culturally specific services. Greater emphasis could be placed on identifying specific models of engagement and partnership for Black communities, understanding best practices to use data to drive change in health systems, and determining ways to deliver services responding to the diverse cultural, social and systemic contexts among Black communities in Ontario.

Successful initiatives led by TAIBU Community Health Centre, Alliance for Healthier Communities, Black Health Vaccine Initiative, and Black, African and Caribbean Community Health and Wellness Collaborative shared these three strategies. An important next step would be to engage with partners such as these to explore the significance of other strategies, such as reallocating funding, involving leadership, and obtaining buy-in, to fully implement these three key strategies.

Importance to the sector

These findings are significant because policymakers and the health sector have increasingly recognized the need to address ABR within primary care settings. Addressing ABR ensures all residents, including Black residents, can access timely, adequate and equitable primary care services. These are necessary for a successful public healthcare system and improved health and well-being for all residents.

"Addressing ABR ensures all residents, including Black residents, can access timely, adequate and equitable primary care services."

At the provincial level, these priorities are reflected in the government's commitment to champion the Black Health Plan, a strategy intended to address "long-standing systemic health inequities" in Black communities[54]. Ontario's commitment to the Black Health Plan underscores the need for this review. Furthermore, the province has demonstrated a commitment to improving primary care. The province announced its Primary Care Action Plan in January 2025[55]. This plan focuses on improved health outcomes, increased efficiency and a focus on health equity. The appointment of Dr. Jane Philpott as Chair of the Primary Care Action Team further emphasizes the province's dedication to ensuring every resident has access to primary care[56].

This review determined there is a need for an integrated, systems-wide approach to addressing anti-Black racism in primary care. This should be complemented by a focus on measurable targets and partnerships in sectors focusing on health and well-being, such as the social determinants of health. In Ontario, Black-focused community health centres and social service organizations have contributed to this work and would benefit from longer-term funding to ensure sustainability.

Many impactful efforts have been overlooked due to a lack of evaluation or measurement. To address this, the initial search was supplemented with targeted search for literature on provincial initiatives. There should be caution against overlooking the work of sector partners due to a lack of publication and evaluation. Instead, there should be a concerted effort to understand the activities related to addressing ABR in primary healthcare and supporting efforts that align with this review's recommended outcomes. This includes providing support for organizations to evaluate their activities to demonstrate effectiveness, which could have wide-reaching impacts for identifying programs and services that make a meaningful impact on the health and well-being of Black Ontarians.

This scan's results indicated that most strategies focused on collecting quantitative and qualitative race-based data to demonstrate effectiveness. Many strategies focused on organizational-level actions rather than a systems-wide focus. Identifying effective strategies within Ontario that can be leveraged throughout the province may positively

impact the province's ability to deliver quality care and ensure an integrated systems approach.

Limitations

The results of this environmental scan must be interpreted with caution due to several limitations. Firstly, the structure of the health system may limit the capacity of organizations addressing anti-Black racism to document, implement, evaluate and monitor their initiatives. This creates gaps in the literature, potentially missing important efforts and leading to varying significance or critical gaps in strategies. This scan included a targeted approach for grey literature data collection by engaging with partners such as the Black Health Plan, identifying most Ontario-based examples. However, there should be better support for these groups to enhance their resources, prioritization and capacity to capture their efforts comprehensively.

Moreover, the focus on implemented strategies may undervalue important strategies that have yet to be addressed by the health sector but are crucial for targeting anti-Black racism or mitigating its impact. This limitation has two main impacts. Firstly, strategies like community governance and reviewing race-based clinical algorithms, which have garnered significant attention, were not evaluated due to their lack of implementation. Secondly, critical strategies, such obtaining leadership buy-in and reallocating funding, are necessary, but challenging to quantify. Focused engagement with relevant actors could refine significant strategies and explain the relationship between reported strategies and those serving as important precursors.

Lastly, while the flexible methodology of this environmental scan allowed for richer and more contextualized research, the lack of a universal definition or methodology for environmental scans creates challenges for making comparisons with other studies. Although the data is more contextualized to Ontario, potential biases in data selection and analysis may exist due to the less rigorous method. To ensure transparency, this scan utilized a commonly cited methodology by Shahid and Turin and provided a clear breakdown of methodological decisions. Engagement with relevant stakeholders was also prioritized to maintain the scan's timeliness and usefulness for Ontario.

Conclusion

The literature reviewed in this environmental scan outlined numerous strategies and resources for combatting anti-Black racism in primary healthcare settings at the individual, organizational and systems levels. Collectively, it appears that successful anti-racist strategies aim to influence knowledge and attitudes, governance, and clinical practices in relation to primary care.

To maximize impact and sustain change over time, effective anti-racist strategies involved mandatory components that took place at multiple levels, specifically the individual, organizational or system level. Without widespread implementation of anti-racist interventions, the lack of Black physicians and the inequitable health outcomes and quality of care Black populations experience will be exacerbated. Primary care practitioners and organizational leaders can advocate for medical governing bodies to mandate anti-racist practice and hiring standards. Moreover, they can also disseminate this work to colleagues and apply the pertinent recommendations in their own practices. Future work should evaluate the effectiveness and implementation process of interventions that address anti-Black racism in diverse primary care settings.

"Without widespread implementation of anti-racist interventions, the lack of Black physicians and the inequitable health outcomes and quality of care Black populations experience will be exacerbated."

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51. Unity Health Toronto. (2024, 2024/02/09/T19:26:38+00:00). Unity Health launches a module for staff to address anti-Black racism. https://unityhealth.to/2024/02/anti-black-racism-learning-module/
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53. California Quality Collaborative. (2023). *Equity and Quality at Independent Practices in LA County*. https://www.calquality.org/initiative/equity-quality-improvement-los-angeles/
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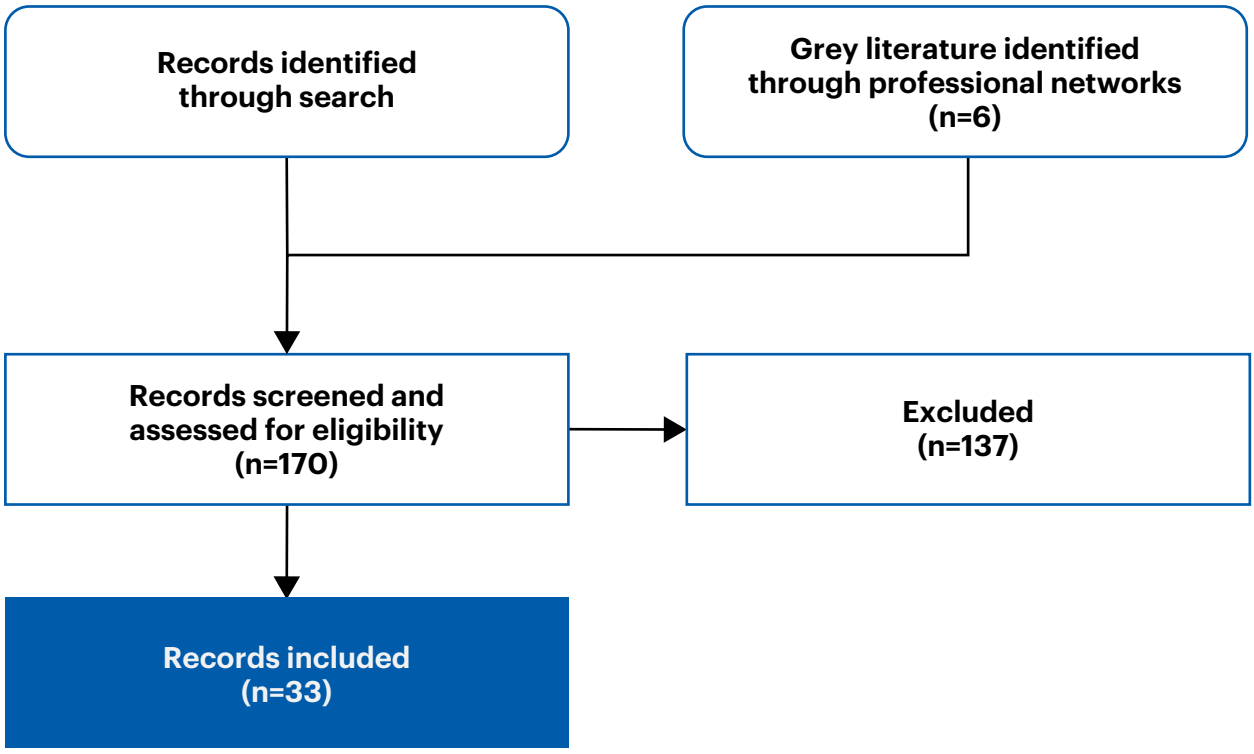
56. Government of Ontario. (2024). *Province Appoints Dr. Jane Philpott as Chair of New Primary Care Action Team*. https://news.ontario.ca/en/release/1005209/province appoints-dr-jane-philpott-as-chair-of-new-primary-care-action-team

Appendix A. Results flow diagram



Appendix B. Summary of results

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
18	Priest, N., Esmail, A., Kline, R., Rao, M., Coghill, Y., & Williams, D. R. (2015). Promoting equality for ethnic minority NHS staff – What works? BMJ, 351, h3297. https://doi.org/10.1136/bmj.h3297	A review of the evidence regarding the effectiveness of diversity initiatives and recommendations for how to meet the NHS workforce equality standard.	U.K.	(Org); (Sys)	
19	Valente, J., Johnson, N., Edu, U., & Karliner, L. S. (2020). Importance of Communication and Relationships: Addressing Disparities in Hospitalizations for African-American Patients in Academic Primary Care. Journal of General Internal Medicine, 35(1), 228–236. https://doi.org/10.1007/s11606-019-05392-x	This study explored primary care-based strategies to prevent 30-day readmission of Black patients to hospitals.	U.S.	(Ind); (Org)	
20	Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review. International Journal of Environmental Research and Public Health, 18(6), Article 6. https://doi.org/10.3390/ijerph18062993	Scoping review consisting of peer-reviewed and grey literature, that identifies anti-racist interventions in outpatient settings.	Canada	(Ind); (Org); (Sys)	
21	Nnorom, O., Sappong-Kumankumah, A., Olaiya, O. R., Burnett, M., Akor, N., Shi, N., Wright, P., Gebreyesus, A., Gebremikael, L., & Lofters, A. (2021). Afrocentric screening	This study aimed to improve cancer screening rates in a primary care setting for Black and immigrant communities.	Canada	(Org)	(Imp); (M/E)

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
	program for breast, colorectal, and cervical cancer among immigrant patients in Ontario. Canadian Family Physician Medecin De Famille Canadien, 67(11), 843–849. https://doi.org/10.46747/cfp.6711843				
22	Rodríguez, J. E., Campbell, K. M., & Washington, J. C. (2021). Dismantling Anti-Black Racism in Medicine. American Academy of Family Physicians. https://www.aafp.org/pubs/afp/issues/2021/1200/p555.html	This paper lists individual actions physicians can do to dismantle anti-Black racism.	U.S.	(Ind)	
23	Brown-Johnson, C., Cox, J., Shankar, M., Baratta, J., De Leon, G., Garcia, R., Hollis, T., Verano, M., Henderson, K., Upchurch, M., Safaeinili, N., Shaw, J. G., Fortuna, R. J., Beverly, C., Walsh, M., Somerville, C. S., Haverfield, M., Israni, S. T., Verghese, A., & Zulman, D. M. (2022). The Presence 5 for Racial Justice Framework for anti-racist communication with Black patients. Health Services Research, 57(Suppl 2), 263–278. https://doi.org/10.1111/1475-6773.14015	This initiative developed a framework to highlight anti-racist communication practices between clinicians and Black patients.	U.S.	(Ind)	

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
24	Konuthula, D., De Abril Cameron, F., Jonassaint, N., Ufomata, E., Torres, O., Essien, U. R., Hamm, M. E., Merlin, J., & Ragavan, M. I. (2022). Perspectives on Anti-Black Racism and Mitigation Strategies Among Faculty Experts at Academic Medical Centers. JAMA Network Open, 5(4), e228534. https://doi.org/10.1001/jamanetworkopen.2022.8534	This qualitative study interviewed Black medical experts to understand their experiences of anti-Black racism and obtain recommendations for interventions that can effectively mitigate anti-Black racism in academic medical institutions.	U.S.	(Org)	
25	Tajeu, G. S., Juarez, L., Williams, J. H., Halanych, J., Stepanikova, I., Agne, A. A., Stone, J., & Cherrington, A. L. (2022). Development of a Multicomponent Intervention to Decrease Racial Bias Among Healthcare Staff. Journal of General Internal Medicine, 37(8), 1970–1979. https://doi.org/10.1007/s11606-022-07464-x	This study developed and evaluated an online racial bias intervention to address bias and improve empathy in patient interactions. Results demonstrated decreased pro-White bias.	U.S.	(Org)	(Imp); (M/E)
26	Herbst, R., Corley, A. M. S., & McTate, E. (2023). Clinical Framework for Dismantling Antiblack Racism in the Clinic Room. Clinical Pediatrics, 62(10), 1129–1136. https://doi.org/10.1177/00099228231156009	This article aimed to educate providers on historical contexts to anti-Black racism in healthcare and provide strategies to address racism.	U.S.	(Ind)	

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
27	Garcia, R. S., Hollis, T., Baratta, J., King, Z., Faulks, M., Ricketts, M., Brown-Johnson, C., Shankar, M., Guerin, A., Wong, H.-N., Zulman, D. M., & Floyd, B. D. (2024). Building Trust and Partnership with Black Pediatric Patients and their Caregivers. Academic Pediatrics, 24(2), 216–227. https://doi.org/10.1016/j.acap.2023.08.016	This scoping review examined communication practices improving care for Black pediatric patients.	U.S.	(Ind)	
28	Ordaz, O. H., Croff, R. L., Robinson, L. D., Shea, S. A., & Bowles, N. P. (2024). Belonging, endurance, and resistance: Black placemaking theory in primary care. Social Science & Medicine (1982), 342, 116509. https://doi.org/10.1016/j.socscimed.2023.116509	This study explored the barriers Black Americans face in receiving quality primary care and generated recommendations based on the findings.	U.S.	(Ind); (Org)	
29	Lin, J. S., Ho man, L., Bean, S. I., O'Connor, E. A., Martin, A. M., Iacocca, M. O., Bacon, O. P., & Davies, M. C. (2021). Addressing Racism in Preventive Services: Methods Report to Support the US Preventive Services Task Force. JAMA, 326(23), 2412. https://doi.org/10.1001/jama.2021.17579	Report designed to provide healthcare decision-makers with evidence to make well-informed decisions and improve the quality of healthcare services.	U.S.	(Ind); (Org)	

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
30	Richards, D. & Center for Health Care Strategies. (2021). Incorporating Racial Equity into Trauma-Informed Care. Center for Health Care Strategies. https://www.chcs.org/media/Brief-Incorporating-Racial Equity-into-Trauma-Informed-Care.pdf	Brief outlining considerations for health systems and provider practices looking to integrate a focus on racial equity to enhance trauma-informed care.	U.S.	(Ind); (Org)	(Imp)
31	Rittenhouse, D. R., O'Malley, A. S., Wesley, D. B., Manchanda, R., Ament, A., & Genevro, J. (2023). Primary Care's Essential Role Advancing Health Equity. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2023/03/PrimaryCaresEssential RoleAdvancingHealthEquity.pdf	Report focused on summarizing evidence related to primary care's impact on health equity.	U.S.	(Sys)	(Imp)
32	Bishop-Earle, Denise, et al. *Black-Focused Social Prescribing (BFSP) Model Participatory Evaluation*. Transform Practice, 1 June 2024.	A report on a social prescribing model to address needs related to the social determinants of health for Black populations.	Canada	(Ind); (Org)	(Imp); (M/E)
33	Black, African and Caribbean Community Health and Wellness Collaborative (BAC CHWC). *A Case Study: Black, African, Caribbean Community Collaboration*. Region of Peel.	Report on the BAC Community Health and Wellness Collaborative to support COVID-19 vaccination and its evolution to address overall health and well-being in BAC communities in Peel.	Canada	(Org)	(Imp); (M/E)

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
34	Brown, J., & Beesley, R. (2023). It's Time: Six Steps to Creating an Anti-Racist Clinic. Family Practice Management, 30(4), 23–26. http://localhost:4503/content/brand/aafp/pubs/fpm/issues/2023/0700/antiracist-clinic.html	Guide designed to support family physicians on their journey to practice anti-racism.	U.S.	(Ind); (Org)	
35	Frederick, L & Tessema, H. (2023). Anti-racist clinical care: Improving Health Outcomes For Black Women. Black Women's Learning Institute. https://bwli.org/wp-content/uploads/2023/03/Final-White-Paper-Antiracist-Clinical-Care.pdf	Guide intended to equip providers with information on how to provide anti-racist clinical care for Black women.	U.S.	(Ind); (Org)	
36	American Academy of Family Physicians. (2024). Beyond the Surface: A Proactive Guide Series on Screening for Social Determinants of Health. American Academy of Family Physicians. https://www.aafp.org/dam/AAFP/documents/patient_care/health_equity/Takeda-social-needs.pdf	Guide developed to provide primary care physicians with useful strategies and tools to effectively screen for social determinants of health in their practice.	U.S.	(Ind)	

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
37	Johnson, Christen, Hugue, Brittany, & Thompson, Darian. (2024). The Anti-Racist Family Physician: A Guide to Making a Difference. American Academy of Family Physicians. https://www.aafp.org/dam/AAFP/documents/patient_care/health_equity/Takeda-antiracism%20guide.pdf	Guide developed to support family physicians to develop their anti-racist practice.	U.S.	(Ind)	
38	National Health Service. (2023). A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist approach. National Health Service. https://www.transformationpartners.nhs.uk/londonpartnership/wp-content/uploads/sites/2/2023/08/20230726_Strategic-framework-to-tackling-ethnic-health-inequalities-through-an-Anti-racist-approach.pdf	A strategic framework intended to guide local action to address racial health inequities at all levels of health and care organizations.	U.K.	(Org)	(Imp)
39	Berkshire Healthcare NHS Foundation Trust. (2024). Unity Against Racism. Berkshire Healthcare NHS Foundation Trust. https://www.berkshirehealthcare.nhs.uk/about-us/equality-diversity-and-inclusion/unity-against-racism/	Anti-racism strategy focused on improving outcomes within the National Health Service.	U.K.	(Org); (Sys)	(Imp); (M/E)

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
40	Naar, S., Pettus, C., Anderson, N., Pooler-Burgess, M., Ralston, P., Flynn, H., Combs, T., Baquet, C., Schatschneider, C., & Luke, D. (2024). Study protocol for transforming health equity research in integrated primary care: Antiracism as a disruptive innovation. PLOS ONE, 19(6), e0306185. https://doi.org/10.1371/journal.pone.0306185	Study protocol that explores the development of an anti-racist intervention integrating community-based participatory research and systems science.	U.S.	(Ind); (Org)	
41	University of Toronto Department of Family and Community Medicine. (2024). Building momentum for change: DFCM's Black Health Advisory Table. https://dfcm.utoronto.ca/news/building-momentum-change-dfcms-black-health-advisory-table	University of Toronto established a Black Health Advisory Table that will inform inclusive curriculum development and advise faculty on key topics including Black data governance, mentorship, patient care and recruitment.	Canada	(Org)	(Imp)
42	Manchanda, R., Do, R., & Miles, Nasaura. (2022). A Toolkit to Advance Racial Health Equity in Primary Care Improvement. California Improvement Network and Healthforce Center at UCSF. https://www.chcf.org/wp-content/uploads/2022/07/ToolkitRacialEquityPrimaryCareImprovement.pdf	Toolkit designed to help those who provide, pay for or support primary care to translate their commitment to racial health equity.	U.S.	(Ind); (Org); (Fra)	

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
43	Gkiouleka, Anna, Jackson, Ben, Ford, John, Mitchell, Caroline, Pearce, Helen, Ariss, Steven, Reynolds, Josephine, & Coster, Jeanne. (n.d.). Building equitable primary care: A toolkit for practitioners and decision makers. University of Cambridge. Retrieved October 4, 2024, from https://www.qmul.ac.uk/ceg/media/ceg/documents/Final_HealthInequalities Report_Cambridge_Reduced.pdf	Toolkit that highlights two studies that describe what equitable primary care looks like and provides practical steps to help local decision-makers address inequalities in health and healthcare.	U.K.	(Ind); (Org); (Sys)	
44	Black Health Collaborative. (2024). Black Health Primer. https://www.bhec.ca/bhp	Training designed for physicians to gain knowledge in and promote dialogue on anti-Black racism and Black health by learning to identify anti-Black racism in healthcare and its effects on health.	Canada	(Ind)	(Imp)
45	Massaquoi, N. (2024, February 9). Introduction to Anti-Black Racism. https://unityhealth.to/2024/02/anti-black-racism-learning-module/	Training implemented at all Toronto Academic Health Science Network hospitals as a component of human resources orientation to address anti-Black racism.	Canada	(Ind); (Org); (Fra)	(Imp)

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
46	Williams, M. S., Myers, A. K., Finuf, K. D., Patel, V. H., Marrast, L. M., Pekmezaris, R., & Martinez, J. (2023). Black Physicians' Experiences with Anti-Black Racism in Healthcare Systems Explored Through An Attraction-Selection-Attrition Lens. Journal of Business and Psychology, 38(1), 75–88. https://doi.org/10.1007/s10869-022-09825-z	This paper presents an organizational framework that includes recommendations to address anti-Black racism that Black physicians face at different stages of the hiring process.	U.S.	(Org); (Sys)	
47	Bero, Tayo. 'Vaccinating Black Toronto'. The Local, 11 May 2021, https://thelocal.to/vaccinating-black-toronto/.	Article on the Black Health Vaccine Initiative to increase COVID-19 vaccination rates among Toronto's Black community through pop-up clinics and culturally sensitive information sessions.	Canada	(Org)	(Imp); (M/E)
48	Canie J, Tobah S, Sanchez AM, Wathen CN. Research with Black Communities to Inform Co-Development of a Framework for Anti-Racist Health and Community Programming. Can J Nurs Res. 2024 May 15;08445621241254883.	This study worked to prioritize areas for anti-Black racism interventions in health services and explored relationship-building with African, Caribbean and Black communities in London, Ontario.	Canada	(Org)	

#	Citation	Description	Location	Strategy level Individual (Ind) Organizational (Org) Systemic (Sys)	Evidence Implemented (I) Monitored/ Evaluated (M/E)
49	Vesnaver, Elisabeth. *Implementation Research to Support Equitable Implementation of First Trimester Preeclampsia Screening Program*. Prenatal Screening Ontario, 20 Jan. 2025.	This research project by Prenatal Screening Ontario (PSO) will aim to implement a first trimester preeclampsia screening program, focusing on Black women and birthing people in Ontario.	Canada	(Org)	(Imp)
50	Hull, Danna, et al. *Considerations for the Collection and Use of Race in Multiple Marker Screening and the BORN Information System*. Better Outcomes Registry & Network (BORN) Ontario and Prenatal Screening Ontario (PSO).	This report discussed BORN and PSO's assessment of the collection and use of race-based data in Multiple Marker Screening (MMS) for Black communities.	Canada	(Org); (Sys)	(Imp)

Appendix C. Tables of findings

Table C1: Strategies by pillar and socioecological level of focus with number of unique citations

Level	Pillar (Outcomes)	Key strategies	Unique citations
Individual	Pillar 1: Equity lens	Acknowledge and address racism	7
		Personal reflection and professional development	4
	Pillar 2: Patient-driven care	Create individual prevention and care plans	4
		Address power dynamics with co-design	7
		Use inclusive communication practices	7
		Review racial bias in clinical algorithms	1
		Address the social determinants of health	4
Organizational	Pillar 3: Organizational readiness	Involve leadership and obtain buy-in	2
		Assess policies and practices	4
		Develop an anti-racism strategy	3
		Reallocate funding and resources	2
		Build readiness for monitoring and evaluation	3
		Develop an inclusive organizational culture	7
	Pillar 4: Community trust	Lead engagement and partnerships with Black communities	11
		Employ community-based participatory research	4
		Establish community governance	5
	Pillar 5: Inclusive workforce	Prioritize workplace diversity and hiring	2
		Employ targeted recruitment of Black physicians	2
		Create equitable policies for hiring, retention, promotion and compensation	4
		Provide social support for staff	2
		Implement anti-racist education and training for staff and leadership	5
	Pillar 6: Equitable services	Identify barriers to health services	4
		Improve coordination of care	3
		Create culturally specific health services and promotion strategies	5
	Pillar 7: Monitoring & evaluation	Collect and use qualitative and quantitative race-based data	10
		Analyze racial bias in clinical algorithms	2
Systemic	Pillar 8: Equitable health policies	Change funding priorities	2
		Prioritize workforce diversity	3
		Engage in health equity policymaking	2
		Establish standards for anti-racist initiatives	3

Table C2: Overview of implemented examples

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
Development of a Multicomponent Intervention to Decrease Racial Bias Among Healthcare Staff[25]	This study developed and evaluated an online racial bias intervention to address bias and improve empathy in patient interactions.	Pillar 2 • Use inclusive communication practices. (P) Pillar 5 • Implement anti-racist internal education and training for staff and leadership. (KA)	To decrease implicit and explicit bias among healthcare workers in primary care clinics. Results demonstrated decreased pro-White bias post-intervention.	Yes. (Quantitative (pre-and post-test) and Qualitative (interviews))
Afrocentric screening program for breast, colorectal, and cervical cancer among immigrant patients in Ontario[21]	This study aimed to improve cancer screening rates in a primary care setting for Black and immigrant communities through effective community interventions. The study reported on a culturally appropriate, multi-pronged quality improvement intervention that consisted of auditing providers' cancer screening practices using EMR, health promotion activities, and a patient-callback program drastically improved cancer screening rates at a Black-serving community health centre.	Pillar 4 • Lead engagement and partnerships with Black communities. (P, G) Pillar 6 • Create culturally specific health services and promotion strategies. (P) Pillar 7 • Collect and use qualitative and quantitative race-based data. (P)	To increase breast, colorectal and cervical cancer screening among Black patients at TAIBU Community Health Centre. Screenings increased 55, 49 and 11% respectively. Success of the program was attributed to its multi-faceted approach that involved cultural sensitivity education initiatives, administrative support and media awareness campaigns.	Yes. (Quality Improvement Model (Retrospective Analysis))

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
Introduction to Anti-Black Racism[45]	Training implemented at all Toronto Academic Health Science Network Hospitals as a component of human resources orientation to address anti-Black racism.	Pillar 1 • Acknowledge racism. (KA, P) Pillar 3 • Assess policies and practices. (P) • Develop an inclusive organizational culture. (KA, P) Pillar 8 • Prioritize workforce diversity. (G)	The modules were designed to support health service providers and their learners, staff, and physicians in their anti-Black racism learning journey.	No.
A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist Approach[38]	A strategic framework intended to guide local action to address racial health inequities at all levels of health and care organizations.	Pillar 2 • Create individual prevention and care plans. (P) Pillar 3 • Involving leadership and obtaining buy-in. (KA, P) • Develop an inclusive organizational culture. (KA, P) Pillar 4 • Employ community-based participatory research. (P, G) • Establish community governance. (G) Pillar 5 • Create equitable hiring, retention, promotion, and compensation policies. (P, KA, G)	The framework was developed to guide local action at all levels of health and care organizations in Greater London.	No. (Highlights various initiatives)

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
Black Health Primer[44]	Training designed for physicians to gain knowledge in and promote dialogue on anti-Black racism and Black health by learning to identify anti-Black racism in healthcare and its effects on health.	Pillar 1 • Acknowledge racism. (KA, P) Pillar 2 • Address the social determinants of health. (P) Pillar 5 • Implement anti-racist internal education and training for staff and leadership. (KA)	The Black Health Primer focuses on the "unlearning" of anti-Black racism among healthcare professionals. With a focus on guidance towards anti-racist practices and solutions to address health inequities.	No.
Unity Against Racism[39]	Anti-racism strategy focused on improving outcomes within the National Health Service.	Pillar 3 • Assess policies and practices. (P) • Develop an anti-racism strategy. (P, G) • Reallocate funding and resources. (P) • Develop an inclusive organizational culture. (KA, P)	The EDI improvement plan leveraged six targeted actions to address prejudice and discrimination through "behaviour, policy, practices and culture" within the NHS. Some metrics reported included a 2.8% reduction in staff reporting discrimination from managers.	Yes. (Quality Improvement Metrics, Quantitative)
Building momentum for change: DFCM's Black Health Advisory Table[41]	The purpose of the table is to provide strategies to improve the health of Black communities by supporting Black faculty and learners at the Department of Family	Pillar 4 • Establish community governance. (G)	To advise the Department of Family and Community Medicine on topics related to Black data governance, Black patient care, community	No.

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
	and Community Medicine at the University of Toronto.		partnerships, recruitment, mentorship and curriculum development.	
Incorporating Racial Equity into Trauma-Informed Care[30]	Brief outlining considerations for health systems and provider practices looking to integrate a focus on racial equity to enhance trauma-informed care.	Pillar 2 • Create individual prevention and care plans. (P) Pillar 3 • Involve leadership and obtain buy-in. (KA, P) • Assess policies and practices. (P) • Develop an anti-racism strategy. (P, G) • Reallocate funding and resources. (P) • Develop an inclusive organizational culture. (KA, P) Pillar 8 • Engage in health equity policymaking. (G)	Drawing from the experience of two organizations: 11th Street Health Center and Bread for the City in Philadelphia, PA, the report outlined six suggestions for focusing on racial equity to improve trauma-informed care and promote racial justice.	No. However, the organization was profiled in a report (Dubay et al., 2018) on early adopters of trauma-informed care (Qualitative)
Primary Care's Essential Role Advancing Health Equity[31]	Report focused on summarizing evidence related to primary care's impact on health equity.	Pillar 8 • Engage in health equity policymaking. (G)	The report is a comprehensive review of strategies to strengthen primary care and health equity in California. The report's overall goal was	No. However, individual cases were highlighted and some of those examples used evaluation data.

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
			to provide suggestions to improve healthcare delivery in a coordinated fashion top-down from the state-level.	For example, Equity and Quality at Independent Practices in LA County (EQuIP-LA) is a collaborative led by the California Quality Collaborative (CQC) which provides data-led insights to healthcare organizations to develop health equity-focused quality improvement interventions.[53]
Black-Focused Social Prescribing (BFSP) Model led by Alliance for Healthier Communities[32]	A social prescribing model intended to assist people who identify as African, Caribbean or Black to improve their health and well-being using Afro-centric values. The program assessed clients based on needs related to the social determinants of health (e.g.,	Pillar 2 • Address the social determinants of health. (P) Pillar 4 • Employ community-based participatory research. (P, G) Pillar 7 • Collect and use qualitative and quantitative race-based data. (P)	To improve the health and well-being of African, Caribbean and Black people through social prescribing to address health-related needs. Evaluation reported 60% of respondents accessed food supports through the program, while 30%	Yes. Qualitative Participatory Evaluation

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
	food, security, housing, social connection).		accessed Black-focused services.	
Considerations for the Collection and Use of Race in Multiple Marker Screening and the BORN Information System[50]	The strategy for the collection and use of race in Multiple Marker Screening (MMS) for Black communities focuses on enhancing prenatal screening accuracy and safety. It involves using race-specific adjustments to improve screening precision, reviewing the necessity of these adjustments, and ensuring safe data collection. The program focused on linking clients to additional programs and services beyond solely biomedical care based on their needs. Services included access for food supports, gift cards, mental health supports and community connections.	Pillar 3 • Developing an anti-racism strategy. (P, G) Pillar 7 • Collect and use qualitative and quantitative race-based data. (P) • Analyze racial bias in clinical algorithms. Pillar 8 • Establish standards for anti-racist initiatives.	To ensure the safe collection and use of race data in Multiple Marker Screening (MMS) for Black communities, the strategy aims to improve screening accuracy specifically for Black individuals and develop a Safe Use of Race Data Policy. It also seeks to engage with Black communities to balance the benefits and risks of using race in MMS, conduct research on the effects of social determinants of health on serum marker levels and MMS accuracy, and promote transparency and understanding of race as a social construct and its implications in prenatal screening.	No.

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
Implementation research to support equitable implementation of first trimester preeclampsia screening program[49]	This research project by Prenatal Screening Ontario (PSO) will aim to implement a first trimester preeclampsia screening program, focusing on Black women and birthing people in Ontario. The goal is to develop tailored supports to improve health outcomes and reduce the impact of preeclampsia on Black communities.	Pillar 6 • Identify barriers to health services. (P) Pillar 7 • Collect and use qualitative and quantitative race-based data. (P) Pillar 8 • Establish standards for anti-racist initiatives. (P, G)	To improve screening rates, acceptance of preventative treatments, and address barriers through surveys and community studies.	No. However, this is a future project with evaluations of feasibility and acceptability planned.
Black Health Vaccine Initiative[47]	The Black Health Vaccine Initiative, a collaboration between the Black Physicians Association of Ontario (BPAO) and local community organizations, aimed to address COVID-19's disproportionate impact on Black communities in Toronto by setting up pop-up clinics in accessible locations and providing culturally sensitive information sessions.	Pillar 4 • Lead engagement and partnerships with Black communities. (P, G) Pillar 6 • Create culturally specific health services and promotion strategies. (P) Pillar 7 • Collect and use qualitative and quantitative race-based data. (P)	To improve vaccination rates and health equity among Black communities. Evaluation reported that the pop-up clinics achieved 2,231 doses over a weekend, with later clinics vaccinating about 250 people per day.	No. However, quantitative monitoring data was collected. Tracked number of doses and clinic attendance.

Name	Description	Related strategies and pillars	(Intended) Outcome	Monitoring and evaluation
The BAC Community Health and Wellness Collaborative[33]	The BAC Community Health and Wellness Collaborative (BAC CHWC) was formed in 2021 to support COVID-19 vaccination and now focuses on overall health and well-being in BAC communities in Peel. They hosted pop-up and smaller clinics familiar to Black communities, engaged community health ambassadors, collaborated with the BPAO among others, conducted townhalls, webinars and community conversations with faith leaders, and hosted wellness fairs.	Pillar 4 • Lead engagement and partnerships with Black communities. (P, G) Pillar 6 • Create culturally specific health services and promotion strategies. (P) Pillar 7 • Collect and use qualitative and quantitative race-based data. (P)	To improve vaccination rates and health outcomes. Evaluation reported 18 community clinics with 44 clinic days delivering more than 16,000 COVID-19 vaccinations as well as hundreds of RSV and influenza vaccinations. Wellness fairs had average of 200-400 attendees.	Yes. Quantitative.

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