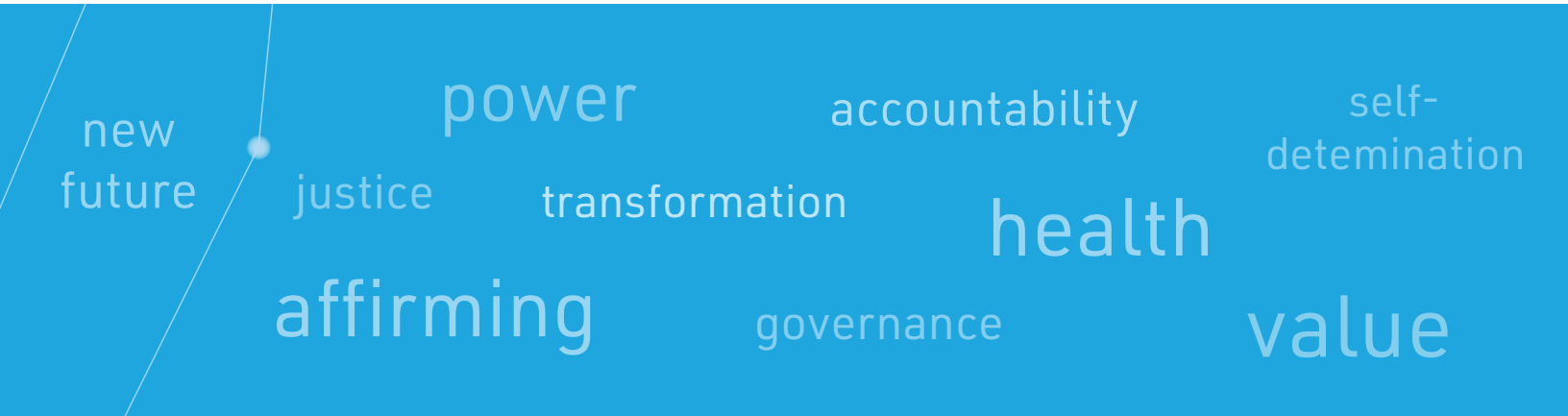
WORKSHOP REPORT

National Collaborating Centre for Determinants of Health
Centre de collaboration nationale des déterminants de la santé

CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada

FUTURE SEARCH:
Action for Disrupting White Supremacy and Racism in Public Health Systems



Workshop hosted by:
Canadian Institutes of Health Research – Institute of Population and Public Health
National Collaborating Centre for Determinants of Health
May 25, 26, 27, 30 & 31, 2022

National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

The National Collaborating Centre for Determinants of Health is hosted by St. Francis Xavier University. We are located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq People. This territory is covered by the "Treaties of Peace and Friendship" which Mi'kmaq and Wolastoqiyik (Maliseet) peoples first signed with the British Crown in 1725. The treaties do not deal with surrender of lands and resources but in fact recognize Mi'kmaq and Wolastoqiyik (Maliseet) title and establish the rules for what is to be an ongoing relationship between nations. These treaties were established at a time when Black people, forcibly brought to Turtle Island through the Trans-Atlantic Slave Trade, were enslaved or fleeing from being enslaved in what is now known as Nova Scotia.

Please cite information contained in the document as follows:

National Collaborating Centre for Determinants of Health & Canadian Institutes of Health Research Institute of Population and Public Health. (2023). *Future Search: Action for Disrupting White Supremacy and Racism in Public Health Systems Workshop Report*. Antigonish, NS: NCCDH, St. Francis Xavier University.

ISBN: 978-1-998022-14-4

Production of this document has been made possible in part through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centre for Determinants of Health.

The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

This document is available electronically at www.nccdh.ca.

La version française est également disponible au www.ccnds.ca sous le titre *Future Search : Agir pour contrer la suprématie blanche et le racisme dans les systèmes de santé publique. Rapport de l'atelier.*

TABLE OF CONTENTS

Acknowledgments

Future Search: Action for Disrupting White Supremacy and Racism in Public Health Systems was hosted by the Canadian Institutes of Health Research – Institute of Population and Public Health and the National Collaborating Centre for Determinants of Health.

The virtual workshop brought together public health researchers, policy-makers and practitioners working on the social and structural determinants of health and health equity across Canada.

We want to thank all those who attended for their active participation and contributions to the workshop focused on creating action to disrupt White[a] supremacy and racism in Canada's or the land known as Canada's public health systems. Thank you to the Steering Committee and planning team for their efforts to design a program intended to focus on dialogue, action and accountability. A particular word of thanks to Sume Ndumbe-Eyoh and Nancy Laliberté for facilitating the Future Search process, as well as to Dr. Claire Betker and Dr. Steven J. Hoffman, who sponsored this crucial work.

STEERING COMMITTEE:

- Rhonda Atwell, African Nova Scotian Services Consultant, Nova Scotia Health
- Ananya Banerjee, Assistant Professor, Faculty of Medicine and Health Science, McGill University
- Corey Bernard, Director, Anti-Racism, Equity, Diversity and Inclusion, Ontario Health
- Claire Betker, Scientific Director, National Collaborating Centre for Determinants of Health
- Shana Calixte, Manager, Mental Health and Addictions, Public Health Sudbury and Districts
- Ariane Klassen, Communications Manager, Canadian Institutes of Health Research – Institute of Population and Public Health
- Rod Knight, Assistant Professor, School of Public Health, University of Montreal
- Nancy Laliberté, Indigenous Health Consultant (project consultant)
- Morgan Lay, Senior Policy Advisor, Canadian Institutes of Health Research – Institute of Population and Public Health
- Sume Ndumbe-Eyoh, Principal, Another World Lab and Assistant Professor, Dalla Lana School of Public Health, University of Toronto (project consultant)
- Stephanie Nixon, Vice-Dean (Health Sciences) and Director, School of Rehabilitation Therapy, Queen's University
- Harlan Pruden, Knowledge Translation Lead, Chee Mamuk Program, BC Centre for Disease Control
- Sana Shahram, Assistant Professor, Faculty of Health and Social Development, School of Nursing, University of British Columbia

TECHNICAL AND ADMINISTRATIVE SUPPORT:

- Ngum Ananga, Consultant, Report writer
- Candy Castellanos, Radiant Consulting
- Shim Pang, National Collaborating Centre for Determinants of Health
- Myrianne Richard, National Collaborating Centre for Determinants of Health
- Nandini Saxena, National Collaborating Centre for Determinants of Health
- Stephanie Simpson, Canadian Institutes of Health Research – Institute of Population and Public Health

WORKSHOP GRAPHICS:

Figures in this report illustrating workshop activities were created in and reproduced here courtesy of Bluescape.

[a] The term *White* is capitalized throughout this report as this explicitly identifies people who are White, or whose ancestors are from Europe, as racialized. To do so helps to disrupt the White supremacist narrative that holds that Whiteness is a neutral standard or norm, and actively engages White people – as having a racial identity – in conversations about race. For further context, please see the post: Recognizing race in language: Why we capitalize "Black" and "White."

Message from the CIHR–IPPH and NCCDH

In May 2022, the Canadian Institutes of Health Research – Institute of Population and Public Health (CIHR–IPPH) and the National Collaborating Centre for Determinants of Health (NCCDH) cohosted the virtual workshop Future Search: Action for Disrupting White Supremacy and Racism in Public Health Systems. This workshop was the result of over a year of collaborations between our two agencies and a joint desire to enable action.

The report that follows documents the activities and discussions that took place online over these 5 days in May. Our hope is that this report, particularly the commitments made in the common ground statements, acts as inspiration and a starting point for participants of the workshop – as well as those who are looking to take their own action – to disrupt White supremacy and racism within Canada's or the land known as Canada's public health systems.

We owe a great deal to the Steering Committee who gave their time, resources, strength and thoughts to guide the cocreation of the design and delivery of this innovative workshop. Every decision was made in collaboration, and we gained so much from your combined wisdom and expertise. Of course, none of this would have been possible without the vision, dedication, passion and perseverance of our two incredible facilitators. This event was their brainchild, and they taught us all the importance of taking time, listening deeply, working differently and establishing common ground. Thank you Sume and Nancy!

One of the small groups of participants created and shared their desired future free of racism and White supremacy in the form of a poem called, "What a wonderful day to breathe, a day where humanity precedes White supremacy." The last verse is shared here:

> Today is the day I breathe with relief
> White supremacy takes a back seat
> Internalized oppression does not exist
> White fragilities confronted, not protected
> "White women tears" no longer used as a weaponry
> Black men and women do not die of police brutality
> I am no longer tone policed for fragile White ears
> Performative allyship are called out to tears
> White saviourism is critiqued till it disappears
> A day where we get to forget what is even White supremacy
> A day where White privilege loses its oppressive currency
> What a wonderful day to breathe
> A day where humanity precedes White supremacy!"

These compelling words help to illustrate that our work is not done. The Future Search workshop and this report mark the beginning of the work we need to do to make our systems and country a better place for all.

Facilitator Reflections

This journey began in early 2021 when the Canadian Institutes of Health Research's Institute of Population and Public Health (CIHR-IPPH) began public dialogue sessions as part of their strategic planning process and reached out to the National Collaborating Centre for Determinants of Health (NCCDH), asking them to collaborate on a session around building anti-racist public health systems. Sume Ndumbe-Eyoh was invited to facilitate the 2-hour consultation session and extended the invitation to Nancy Laliberté as cofacilitator.

Early on, Sume voiced concerns that a 2-hour session would not be enough time to grapple with strategic planning around the major public health problem of racism. Racism is not something that public health systems have contended with in terms of identifying how racism operates in the structures of the systems much less considering how to integrate anti-racism. With the CIHR-IPPH and NCCDH on board, Sume identified the Future Search method as an initial step to bring people together with different forms of knowledge and expertise from the "whole system" in a substantial format to work together to identify common ground and collective work.

Planning began with the Steering Committee for the Future Search: Action for Disrupting White Supremacy and Racism in Public Health Systems workshop a year earlier – almost to the date – of the event held in May 2022. Over that year, we collectively experienced a roller coaster of public health crises with the emergence of the Omicron variant of COVID-19, multiple incidents of racialized violence in health care and policing systems, and ongoing stresses in health care and public health systems and community services where we were hoping to draw our participants from. The Steering Committee meetings became a space of community, solidarity and mutual support.

Disproportionate impacts of the pandemic on racialized peoples were a reality in our planning group as at one point three members of our group – all Black – had to step down temporarily due to multiple pressures with the Omicron variant in their workplaces. This highlighted the importance of who is contributing to decision-making in anti-racism work as we decided to postpone our gathering for a second time due to inadequate representation of our Black colleagues.

Challenges throughout the planning processes highlighted the way in which work to disrupt White supremacy and racism are taken up – or not taken up – in public health as at times we were struggling to find times to come together. We realized this is not always seen as priority work by all actors in the public health systems.

We continuously checked in with the Steering Committee to see if they thought Future Search made sense as a useful, viable process for strategic planning for anti-racism work. We were not so much attached to the process as we were attached to finding a way to move the work to action – we know racism is present in all settler colonial systems and did not need to spend time discussing or further educating on the topic. Advantages of the Future Search method include moving forward and completing tasks to produce common ground statements for action the group agrees on, instead of remaining focused on the past or trying to resolve conflicts. Had we remained stuck in providing anti-racism education or training, which is where many organizations and practitioners feel most comfortable, we would not have moved to action.

The people who came to the Future Search were truly committed to this work. We were very happy with the number of students who participated as they were freethinking and practical and actually initiated change during the course of the meeting. Now the onus is on the participants to figure out how to do the work they agreed is important. We hope motivation is high to continue the work with the level of ownership shown in the development of the actions.

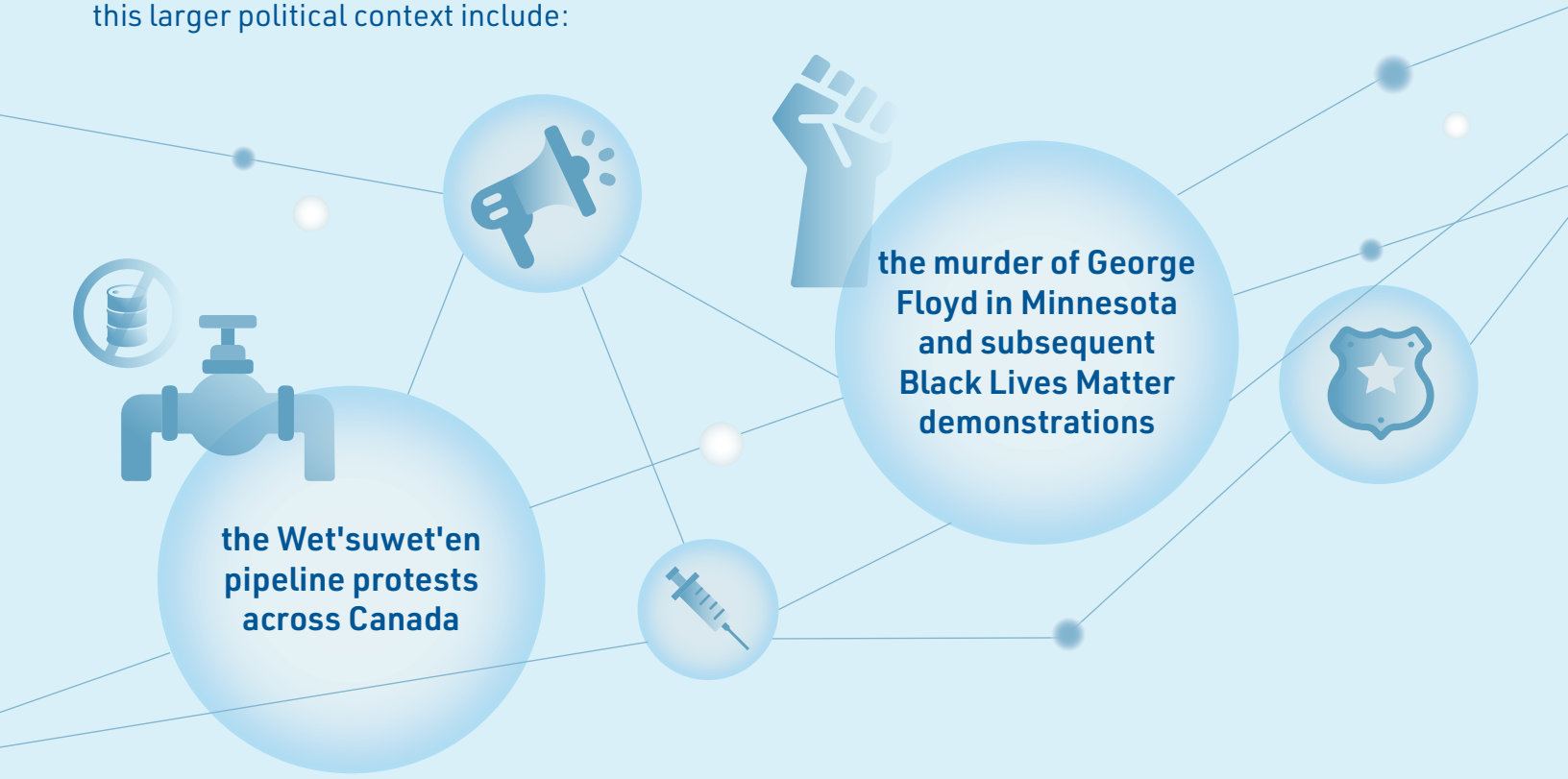
The discussion of the potential for innovating decolonial ways of working together toward the common ground statements began at the May meeting. We are excited by the possibilities of what may flow from this work beyond the initial action groups. The common ground statements have already been presented and utilized in conferences, working groups and public health offices. We remain committed to disrupting White supremacy and anti-racism work as a way of seeking justice for our ancestors and meeting our responsibilities to current and future generations to realize futures free of White supremacy and racism.

Sume Ndumbe-Eyoh
Nancy Laliberté

Our Journey

This infographic presents the process CIHR-IPPH and NCCDH took to identify the need to build anti-racist public health systems, convene a steering committee, action the Future Search workshop, and explore next steps.

The current global political context continues to highlight the urgent need to dismantle racism and White supremacy. Illustrative examples of events reflecting this larger political context include:



Recognition that public health needs to act to address racism

1 Idea

CIHR-IPPH approached NCCDH for help with a session on anti-racist public health systems. NCCDH (Sume Ndumbe-Eyoh) suggests something more substantial and action-based. (April 2021)

2 Facilitation Method

Future Search is selected, faciliatators Sume and Nancy Laliberté identified and trained in this method. (Sept 2021)

3 Governance

NCCDH and CIHR-IPPH establish a joint steering committee. (May 2021- May 2022)

13 Steering committee members

11 Steering committee meetings

Future Search guiding principles: whole system participates; focal issue is put in a historical and global perspective as context for local action; focus on the future and on common ground; people self-manage, and use dialogue as the main tool.

the death of Joyce Echaquan following racist treatment by healthcare providers

the rise in anti-Asian racism with the COVID-19 pandemic

4 Action for Disrupting White Supremacy and Racism in Canada's Public Health Systems workshop

5	15	Approximately 50
Days	Hours	Participants

Affinity groups:
1. public health practitioners
2. data systems, healthcare administrators
3. decision makers, policymakers
4. researchers, educators, funders
5. trainees, students
6. intersectoral community partners

5 tasks:
Task 1: Focus on the Past – Timeline
Task 2: Focus on the Present – Mind Map
Task 3: Focus on the Future
Task 4: Discovering Common Ground
Task 5: Action planning (May 2022)

5 Follow-up event

Session convened with approximately 30 workshop participants to reconnect, share, and talk about next steps. (Sept 2022)

6 Exploration of next steps

Centring dismantling racism and White supremacy as NCCDH & CIHR-IPPH organizational work and continued partnership, conference sessions and webinars.

> "What a wonderful day to breathe, a day where humanity precedes White supremacy."

Excerpt from poem by workshop participants

Executive Summary

The National Collaborating Centre for Determinants of Health and the Canadian Institutes of Health Research – Institute of Population and Public Health jointly convened a 5-day virtual workshop in May 2022 to envision actively anti-racist public health systems and identify concrete actions for disrupting White supremacy.

A broad range of public health actors, including students, researchers, practitioners and decision-makers, took part in this action-oriented strategic planning workshop. The workshop used a Future Search process to bring people together with different forms of knowledge and expertise from the "whole system" to work together to identify common ground and collective action. In the five Future Search workshop sessions, participants:

1. reflected on the past through three timelines of personal, global and public health events that impact this work today;
2. took stock of the present by identifying trends related to White supremacy and racism affecting public health systems as well as current responses and future responses needed;
3. envisioned a future where public health systems are anti-racist and free of White supremacy;
4. developed common ground statements from principles and key features in their desired future; and
5. identified action plans based on the common ground statements and committed to work together to realize them.

The eight common ground statements generated by this Future Search workshop can serve as guidance to others seeking to disrupt White supremacy and racism in public health systems.

1

COMMON GROUND 1

We are committed to living radically and celebrating collectively the Seven Grandfather Teachings to ground our public health work/approach (love, humility, bravery, wisdom, trust, respect, and honesty) in research, education, practice and policy, with joy and compassion.

2

COMMON GROUND 2

We are committed to embracing diverse, anti-oppressive, intersectional and collaborative relationships and ways of knowing (which, while integrating some teachings of Western knowledge, nonetheless reject it as "the ideal standard") in order to support collective change, transformation and well-being.

3

COMMON GROUND 3

We are committed to a research system without racism that is justice-based and honours the wisdom, knowledge, power and healing of community-based participatory action research and policy.

We are committed to enable community to colead/lead the development of the research question and research agenda that matter most to them. We are committed to have community be the principal investigators and academics be the collaborators with appropriate resources identified, advocated for and secured.

We are committed to solutions-oriented intervention and implementation research in communities that has tangible benefits to them and not academics only.

We are committed to ensure that knowledge translation and results are really embedded in the community and that participants are active in the process and outcomes for meaningful change.

4

COMMON GROUND 4

We are committed to (1) iteratively affirming and celebrating the transformative value of difference and diversity; and (2) being deliberate in naming, understanding and addressing the harms caused by White supremacy and its intersections with other historic systems of inequality, which play out simultaneously at institutional (e.g., through norms, policies, laws), interpersonal (e.g., how we treat each other) and internal levels (e.g., internalized superiority and inferiority based on our positions of privilege and oppression, including through bias).

We are further committed to understanding and disrupting the differential impact of White supremacy on, in particular, Black, Indigenous or Black & Indigenous populations.

5

COMMON GROUND 5

We are committed to public health systems and knowledge being informed by all people, not dictated by financial power and corporate interest.

We commit to a future where public infrastructure (e.g., roads, safe water systems) is equitably distributed and supported so that people are able to grow wealth in ways that sustain their health.

We are committed to public health making visible and disarming corporations' excessive power and dominance including abuses/uses of power and their proxies (i.e., NGOs, universities, etc.) by naming, limiting and acting on corporate influence, neoliberal co-opting (i.e., co-opting Black, Indigenous and disability justice movements) and settler colonist agendas that undermine sovereignty and self-determination and that impact health, environment and freedom.

7

COMMON GROUND 7

We commit ourselves to community-based participatory public health to create environments that

- empower individual and collective agency,
- appropriately value expertise (with resources) and
- have governance structures for community control

to shift public health practice, policy and decision-making to be accountable, anti-racist and anti-colonial and deconstruct White supremacist structures.

6

COMMON GROUND 6

We are committed to acknowledging, naming and unlearning the language of White supremacy.

We are committed to taking action to implement anti-colonial practice with the view to reimagine a new future free of anti-Black and anti-Indigenous racism.

We are committed to creating health justice in medical practice, health care and public health.

8

COMMON GROUND 8

In public health, we are members of diverse communities, and we work in solidarity for our collective liberation. We commit to transparency, to stating our values* explicitly as public health practitioners and public health institutions, and to creating concrete accountability mechanisms to align professed values with actual practice, policies, goals and approaches.

* Including anti-racism, anti-White supremacy, relational, solidarity, accountability, transparency, equity, best and wise practices

Introduction

The National Collaborating Centre for Determinants of Health (NCCDH) and the Canadian Institutes of Health Research – Institute of Population and Public Health (CIHR–IPPH) jointly convened this action-oriented strategic planning workshop to envision actively anti-racist public health systems and establish concrete actions for disrupting White supremacy.

The workshop engaged public health practitioners and decision-makers, policy-makers and researchers, trainees and students, intersectoral partners and community organizations with interest, expertise or the ability to influence action on the social and structural determinants of health and health equity.

The workshop was held virtually between May 25 and 31, 2022, using a Future Search process described in more detail below. Throughout the workshop, participants worked in functional affinity groups as well as cross-sectional mixed groups.

They worked through a range of activities: reflecting on the past, taking stock of the present and identifying aspects of their work they were proud of and sorry about. Using these tasks as a foundation, participants then developed a vision of the future and eight common ground statements – statements everyone in attendance could commit to. The Future Search ended with groups meeting to begin developing action plans based on their interests and ability to influence.

The content of the report reflects the workshop activities and discussions as they happened as well as participants' focus and wording. This report is designed to act as a starting point for individuals, organizations and communities to discuss issues presented and build on the common ground statements and initial action steps to become part of a movement to dismantle White supremacy in Canada's public health systems.

What is Future Search?

Future Search[1] is an effective planning method that enables large, diverse groups to:

- agree on a shared vision,
- commit to an implementation plan and
- take responsibility for action.

This process can bridge cultural boundaries because people work entirely from their own experience. There is no management jargon, models, theories, speeches or pressure to act. A Future Search often involves 60 to 100 people who work in small functional affinity groups and in cross-sectional mixed groups. Each person has a chance to speak and listen.

Future Search has four principles not typical of traditional strategic planning:

1. **The whole system participates**
   Bringing together a cross-section of people with authority, resources, expertise, information and need means more diversity and less hierarchy than in a usual planning meeting. It also provides a chance for each person to be heard and to learn other ways of looking at the task.

2. **The focal issue is put in a historical and global perspective.**
   That means thinking globally before acting locally – learning about the "whole elephant" before trying to fix any part. Every person then is able to talk about the same world that includes all perceptions.

3. **The focus is on the future and on common ground.**
   Common ground is the frame of reference, and problems and conflicts are treated as essential information not action items. That means identifying shared values and joint action steps while honouring differences rather than reconciling them.

4. **People self-manage their work and use dialogue, not problem-solving, as the main tool.**
   This means helping each other do the tasks and taking responsibility for our perceptions and actions.

Future Search workshops consist of five sessions: Past, Present, Future, Common Ground and Action. Participants begin with a history of the issue that brought them together and develop timelines. The whole group builds a mind map of current trends affecting their issue, then small affinity groups identify what they are doing now about key trends and what they want to do in the future. Small mixed groups imagine preferred future scenarios.

Participants identify common ground emerging from the work already done including key principles and features of these scenarios. In the final session, everyone focuses on implementation strategy, action plans and accountability.

The Workshop

Future Search was a 5-day virtual workshop to bring together approximately 50 participants, including public health practitioners, decision-makers, researchers, funders, data systems, health care administrators, students and community organizations.

The Workshop

This Future Search workshop was spread over 5 days, with a 3-hour session each day. A weekend was scheduled between the 3rd and 4th days to allow for "soak time." Approximately 50 participants attended the virtual workshop via Zoom and contributed through Bluescape, a web-based workspace for collaboration. The workshop included individual and group activities, with participants joining small functional affinity groups or mixed groups depending on the task. There were six categories of affinity groups: public health practitioners and disciplinary group, public health decision-makers, public health researchers and funders, data systems and health care administrators, students, and community organizations (Figure 1). Given participation numbers, there were two groups of researchers and funders and two groups of students for affinity-group activities.

FIGURE 1:
Introducing the workshop task and affinity groups

FOCUS ON THE PAST

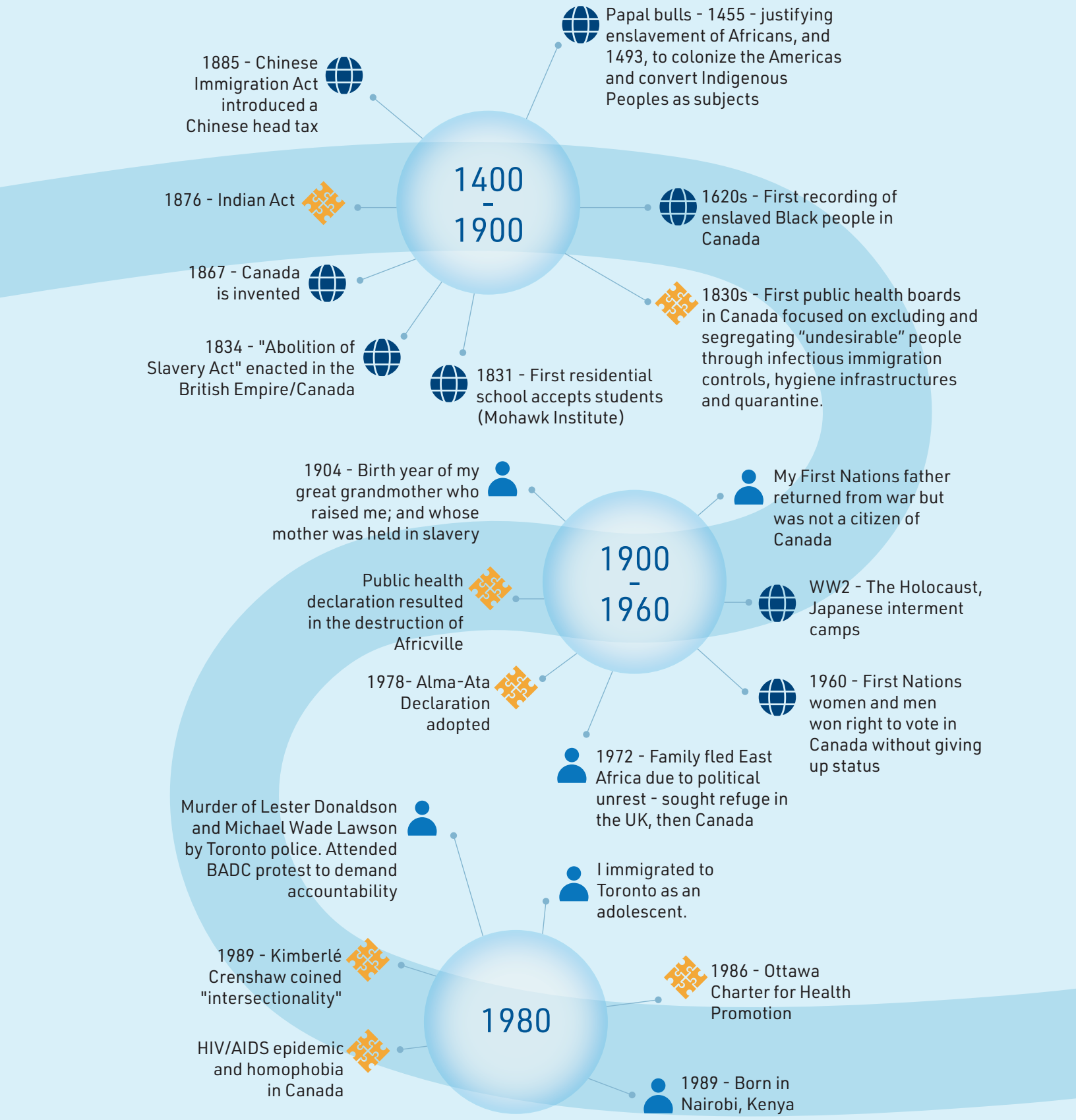
The past is a prelude to the work to be done today. The Future Search process began by examining the past through three timelines of personal, global and public health events that impact this work in the present day.

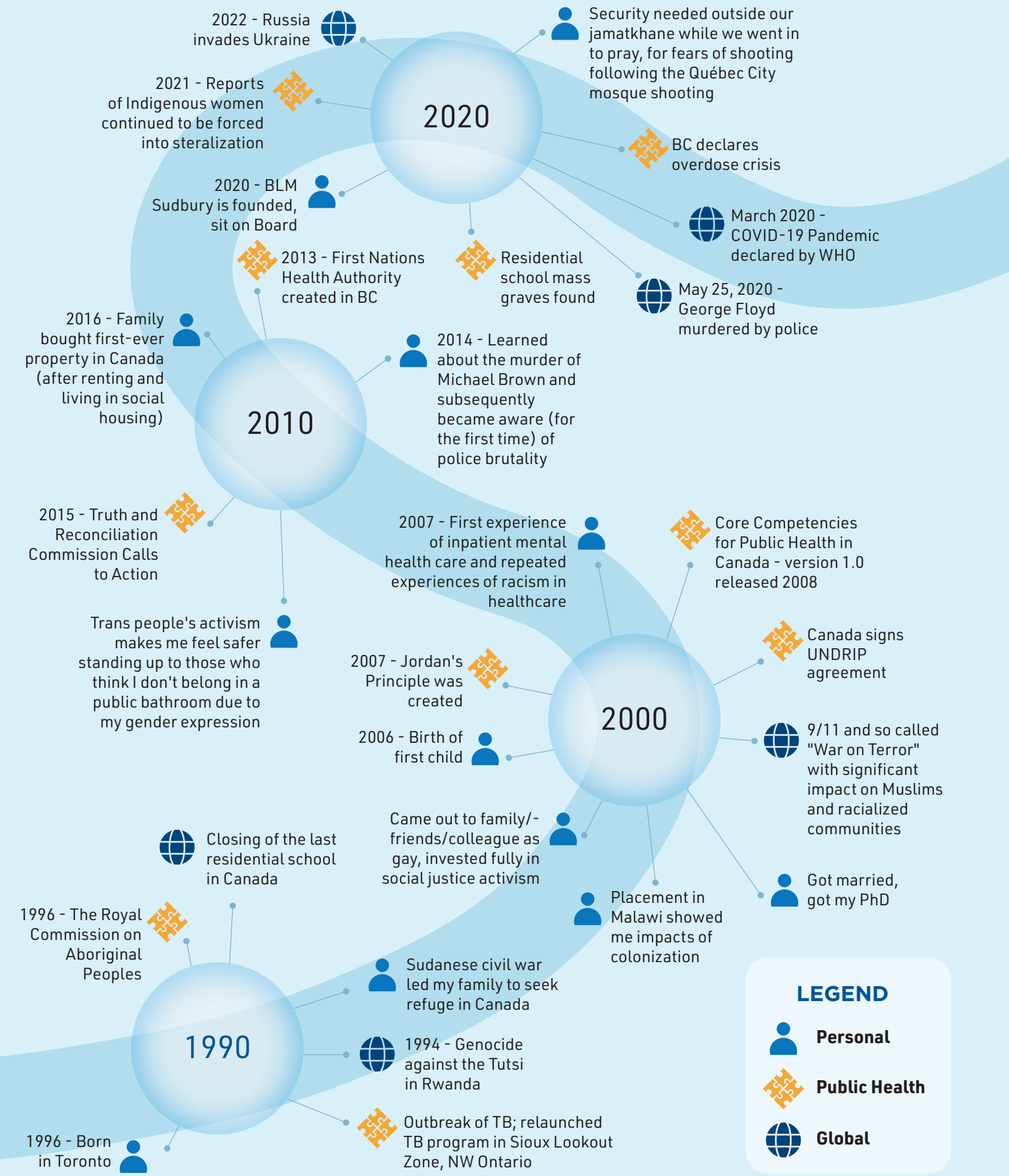
The personal and global event timelines stretched from 1400 to the present day to reflect the historical and multigenerational impacts of colonial processes while the public health timeline ranged from 1980 to present. Participants identified and explored how past events have shaped the present day, their lives, public health and the work of disrupting White supremacy in the realm of public health.

Working in small affinity groups, participants established the framework for a shared story of their past and what it means for the work they would do together over the course of the workshop. The small groups were assigned one of the three timelines to clearly capture the trends.

Our Timeline

This infographic presents a combined view of the personal, global and public health timelines that participants populated with key events. Illustrative examples are shared below.




2020
2022 - Russia invades Ukraine
Security needed outside our jamatkhane while we went in to pray, for fears of shooting following the Québec City mosque shooting
2021 - Reports of Indigenous women continued to be forced into steralization
BC declares overdose crisis
2020 - BLM Sudbury is founded, sit on Board
March 2020 - COVID-19 Pandemic declared by WHO
2013 - First Nations Health Authority created in BC
Residential school mass graves found
May 25, 2020 - George Floyd murdered by police
2010
2016 - Family bought first-ever property in Canada (after renting and living in social housing)
2014 - Learned about the murder of Michael Brown and subsequently became aware (for the first time) of police brutality
2015 - Truth and Reconciliation Commission Calls to Action
Trans people's activism makes me feel safer standing up to those who think I don't belong in a public bathroom due to my gender expression
2000
2007 - First experience of inpatient mental health care and repeated experiences of racism in healthcare
Core Competencies for Public Health in Canada - version 1.0 released 2008
Canada signs UNDRIP agreement
2007 - Jordan's Principle was created
2006 - Birth of first child
9/11 and so called "War on Terror" with significant impact on Muslims and racialized communities
Came out to family/-friends/colleague as gay, invested fully in social justice activism
Got married, got my PhD
Placement in Malawi showed me impacts of colonization
1990
Closing of the last residential school in Canada
1996 - The Royal Commission on Aboriginal Peoples
Sudanese civil war led my family to seek refuge in Canada
1994 - Genocide against the Tutsi in Rwanda
Outbreak of TB; relaunched TB program in Sioux Lookout Zone, NW Ontario
1996 - Born in Toronto
LEGEND
Personal
Public Health
Global

PERSONAL TIMELINES:
key experiences that shaped your life

Telling the story of who is part of this gathering and the implications of that story for the work to be done here.

What emerged from the context of the personal timeline was how personal, global and historical events are intertwined, as demonstrated by the number of historical events that showed up in personal timelines. There were discussions about the shift in understanding the history of colonialism and the role Canada played in the enslavement of Black people, and how the notion of Canada as a safe haven is at odds with the realities and experiences of many Black people. Oftentimes, experiences are hyperlocal and specific, such as Black communities in Nova Scotia and British Columbia who are trying to reclaim institutions and systems that shape the well-being of a community. There was a discussion of our histories before colonization, the movements and migrations resulting from violence and wars, and the complexity of "settler" in this context. It was noted that the pain and trauma associated with events did not show up on the timeline.

There was realization and acknowledgement of individuals' complicity with systems that perpetuate White supremacy, and moments of self-discovery alongside the different experiences of other individuals in the group. Examples of this include some White people learning that police brutality still exists and that many Indigenous, Black and other racialized peoples still experience racism perpetrated by their neighbours and in their communities. This led to a questioning of whether things have actually changed.

Remembering the very different journeys everyone is on encourages caution about the assumptions brought into discussions and actions to disrupt White supremacy, as not all people have the same tools. The complexity of intersectionality (race, gender, sexuality, religion, power, privilege) brings this narrative forward and challenges notions of universal experience often put forward by White-dominant knowledge systems. Racial identities, where people are born and how they are educated impact how they view the socially constructed concept of race.

PUBLIC HEALTH TIMELINE:

critical milestones and events in addressing the disruption of White supremacy and racism in public health systems

Telling the story of the evolution of the need to disrupt White supremacy and racism in public health systems over the years, and the implication of that story for the work to be done here.

The evolution of the public health discourse is toward the understanding of determinants of health and away from individual focus and responsibility. Significant milestones in the timeline of this evolution were the 1948 constitutional charter of the World Health Organization,[2] the 1974 Lalonde report[3] in Canada and the 1986 *Ottawa charter for health promotion*.[4] These documents were pivotal in clarifying the fundamental socioeconomic conditions and resources for health, but they did not underscore the impacts of racism and White supremacy on health. The HIV/AIDS epidemic did finally start to shift the conversation toward the role of social determinants of health and stigma in illness and death. The work of academics like Crenshaw[5] and Holman et al.[6] have highlighted the conversation about intersectionality and the conditions that influence health.

However, this evolution toward a structural focus on determinants of health has not disrupted White supremacy and racism in public health. Over the last decade, social justice movements have influenced the public discourse about health and health equity, such as the Royal Commission on Aboriginal Peoples (1996),[7] the Truth and Reconciliation Commission (2015),[8] the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)[9] and the Black Lives Matter movement (2013).[10] Yet there is still a large gap between theory and practice, and a lack of public understanding of social and structural determinants of health. Powerful systemic change and government action are needed – but, in reality, most of the work is being done at a community level.

Participants were critical of the fact that the public health timeline in this activity only began in 1980. Most work in anti-racism is set up as ahistorical, but to begin this process by nesting it in history is disruptive, helpful and important, and informs the action that needs to be taken. It is important to understand the colonial history of public health and how it creates and re-creates our current policies and structures.

Participants shared that the linear nature of the timeline hegemonizes one system of knowledge and that this system is the dominant approach to public health and is shaped by a Eurocentric world view. This view is insufficient and narrow, although it is framed as "the right approach." There are different ways of thinking about time from Indigenous and Black world views where past, present and future are interconnected. These other forms of knowledge, including holistic and Indigenous knowledges, must be incorporated into the current world view. In looking at the waves of public health, the aspirational fifth wave[11] is framed as making room for and learning from Indigenous ways to be gardeners working in the roots and grounding our work in love, supporting the capacity for health and healing in our relations with self, others, ancestors and the land. It was noted that this is not the public health training that students are currently receiving, which is still situated in the fourth wave.

WORLD TIMELINE:

global events that have shaped the world

Telling the story about how the world has changed in the past decades, and the implications of that story for the work to be done here.

Participants assigned the world timeline began by noting that, although the group in this workshop appeared to be diverse, it was important to remember that there are voices not present or represented in this workshop and, because of that, the outcome is subjective and limited. Also important to remember is that, although there is some commonality of experiences, each participant's experience of racism is essentially unique.

Racism has a long history, and what is most recent stands out. Those who write histories hold their own world views, and their timelines do not tell of the strengths and stories of Indigenous Peoples and Black peoples but rather the oppression and devaluing of them. They tell the history according to other cultures and ways of being, based on viewing time as linear, part of a specific world view.

In the 600 years of this timeline, many harms were done by White communities, and now White communities are looking to Black and Indigenous communities for the remedies. Also noted is that the law has been used for endless gatekeeping and for controlling access to water, freedom, immigration, care, education, etc.

Participants asked: "How are we continuing conversations when it comes to anti-Indigenous racism and anti-Black racism? And how can we ensure that we are not ignoring the existence of anti-Black racism in these conversations?"

Making the connections across all timelines

What are the connections across all three timelines, and what are the implications of this for the work to be done here?

Despite the many differences in the group, it was recognized that there is common ground in how everyone got here and in the work they do. Solidarity is important, yet the colonial state continues to deploy tactics of divide and conquer in racialized communities, such as marginalizing different groups differently. This is a purposeful undermining of the ability of racialized groups to work together.

Though bound by shared histories and experiences, it is necessary to recognize everyone's unique histories and contributions to this work and to remember that even within our own communities some come from places of privilege, something that is not always adequately reflected on.

Personal, global and public health timelines all intersect, and personal events are tied to what happens globally. Personal timelines have been shaped by conflict, colonialism and war. It is worth noting that much more was recorded on the personal timeline than the public health and global ones.

There is a continuous theme of government-imposed policies and discriminatory actions against certain groups, and the major events of racist violence are either linked to actions by the state or by state apparatus. Around 2020, all three timelines were dense with particularly traumatic events. These include the murder of George Floyd; the police shooting deaths of Chantel Moore, a member of the Tla-o-qui-aht First Nation in British Columbia, and Breonna Taylor, both occurring in their homes; the preventable death of Joyce Echaquan following racist treatment at a Quebec hospital; and the discoveries of unmarked graves of Indigenous children at Tk'emlúps te Secwépemc First Nation and numerous former residential schools across the country. This convergence represented a tipping point where there was an ability to mobilize and move forward with anti-racism work.

Reflections from the larger group

Further discussion in the larger group at the end of the day generated a conversation about the fifth wave of public health,[11] in which public health practitioners are gardeners instead of experts, where complexity is acknowledged and rebalancing occurs. It is also where movement is made from being deficit-based to asset-based, from objectivity (measurement) to subjectivity (lived experience, inner growth) and collectivity (hope, wellness, belonging, meaning, purpose). This movement impels the creation of a future consciousness for the present and a design process where we try things out, learn and share from the experiences – tempering data with lived/living experience to support growth. The fifth wave is aspirational for much of the Western world while Indigenous world views naturally embed and uphold these core values as a way of working and being. The fifth wave can be looked to as a model of how to work in a better way within public health.

In this current time, there is a "snapback of White supremacy" in response to the movements addressing the anti-Indigenous, anti-Black and anti-Asian racism that clustered in 2020. The snapback phenomenon described by participants refers to pushing people and thoughts off the table and re-centring power back to the status quo. How can what is being done in this current snapback moment be centred in public awareness? If the right people are not at the table, the issues will not come up, hence the importance of equity, diversity and inclusion (EDI) work.

There need to be more spaces to have honest conversations about the system – is this workshop itself the work?

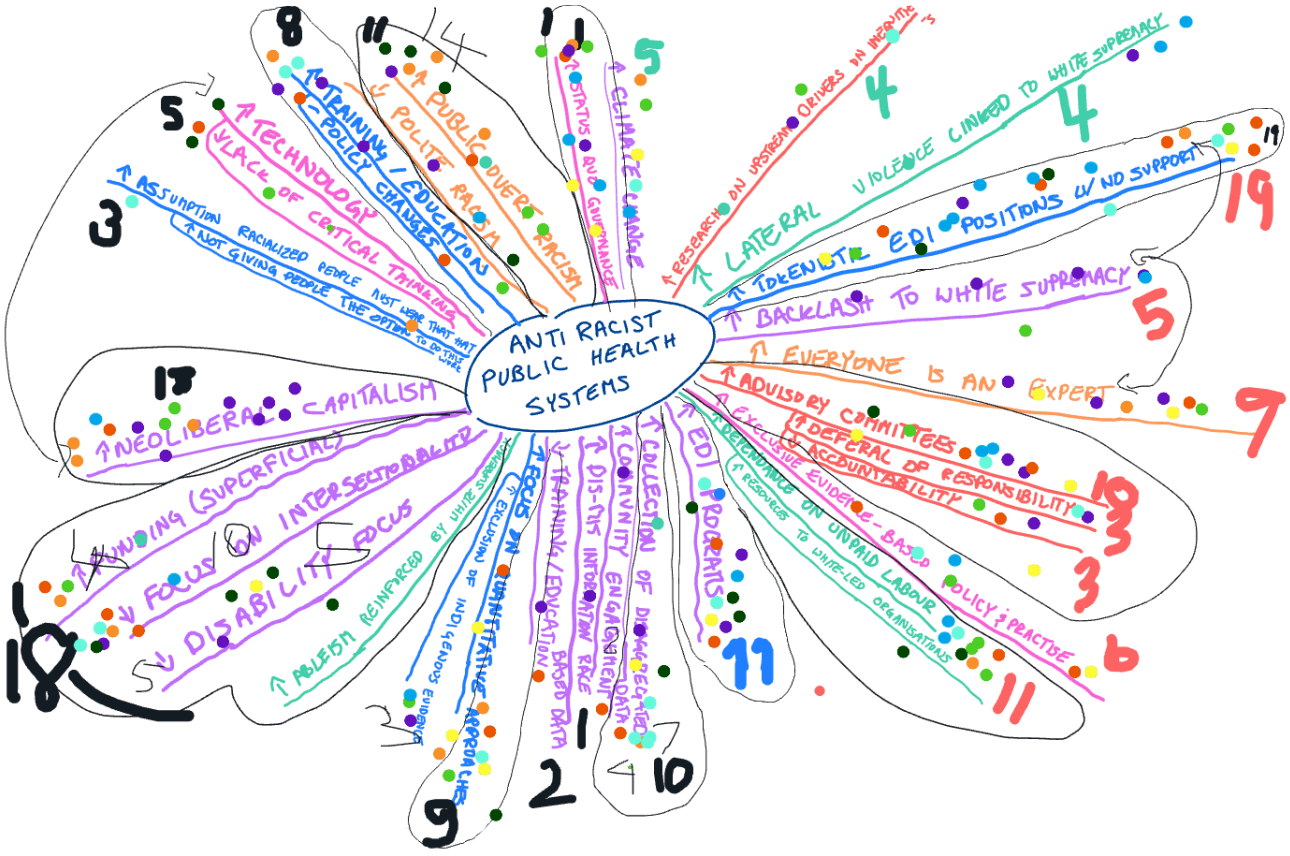
FOCUS ON THE PRESENT

Switching to the present began with a large-group task to create a mind map of key trends affecting our public health systems today.

Identifying these social, economic, technical, environmental and political trends and conditions related to White supremacy and racism enabled participants to create a global context for dialogue that included everybody's perceptions of the key issues.

The broad range of key trends that emerged from this discussion are described below. After the group finished, each participant distributed six dots on the mind map branches they wanted others to pay attention to (Figure 2). This was not priority-setting but a focusing device to flag trends participants considered central to the task.

FIGURE 2:
Mind map of key trends affecting our public health systems



Trends affecting our public health systems

- **Increase in climate change:** The continued trends toward a warmer climate and climate change increase stress on the public health system, intensifying the need to respond to local and global environmental disasters and challenges.

- **Increase in neoliberal capitalism:** Neoliberal capitalism is an ideology and a policy model that leads to a free market economic structure in health care and a divestment from public resources.

- **Increase in backlash to White supremacy:** Organizations are hiring based on race without paying attention to the level of position and skill set needed to do the job. Failing to create a supportive workplace environment can lead to the burnout of racialized people in the workplace and a lot of harm and violence. This tokenistic lens pats White people on the back because they've done "due diligence" to race and results in further inequity.

- **Increase in equity, diversity and inclusion (EDI) programs:** EDI is in danger of becoming a nondescript catch-all, a meaningless phrase without concrete actions or meaningful community control. These programs cater to White fragility and White leadership. They are sometimes winning out over anti-racist approaches and initiatives (which go beyond lip service and statements to actually put into motion structural change) and enabling the status quo. Related to this trend is the emergence of tokenistic EDI positions without the support needed to do the work.

- **Increase in focus on quantitative approaches:** In this era of big data, primacy is given to quantitative data as the driver of truth and evidence. This is accompanied by the exclusion of Indigenous evidence and the discounting of qualitative data. This mainstream trend is on the rise in academia and research, as is seen in funding priorities. Even in policy-making, weight is given to what can be measured in numbers and to providing statistical evidence before something is fleshed out as a problem. This creates perverse outcomes and makes it difficult to capture the existence of institutional racism and unequal dynamics or distribution of power. The ready availability of hard "actionable" data categorized around groups of individuals can lead to a focus on individual-level interventions and does not address the structural factors or impel wider systemic change. There is an epistemic injustice in not being heard until quantified and "legitimized" under narrow norms of what is seen as evidence.

- **Increase in misinformation and disinformation around the lack of disaggregated race-based/equity data:** There is a demand for data and yet a lack of expertise in data collection and analysis. There are datasets available that are being underutilized, and yet those doing anti-racism work do not have enough information about what data is available and what the data gap is. People who are engaged in the critical use of data have not been actively working on anti-racism and do not have enough accountability or expertise. Although some institutions are beginning to collect disaggregated data, there is a disconnect with biomedical research that affects public health and a lack of readiness to do the work of looking at the hard metrics of racism.

- **Increase in "everyone being an expert":** The competition between critical and non-critical scholarship shows up in funding. Researchers and professionals lacking critical perspectives on racism are being funded in public health and research whereas those with critical anti-racist perspectives and decolonizing approaches are not. This is also reflected in how EDI programs are winning over anti-racist approaches and initiatives in funding, minimizing the fact that people are "experts in their lived experiences" and, as such, people with lived experience need to be valued as true experts.

- **Increase in "superficial funding" given to specific groups experiencing inequities:** The way that funding is being directed is connected to neoliberalism, and decisions about who gets funding are made from a standpoint of capitalism and patriarchy. There are new pots of money to help with anti-racism, but most of the money is given to organizations led by men in capitalist positions whose governing boards are not representative of the community (i.e., Indigenous, Black and People of Colour [IBPOC] populations). In the funding, there is often no recognition of intersectionality. In the Black community, for example, there is no space for discussion around intersections with disability, gender-based violence, 2SLGBTQI+, etc.

- **Increase in lateral violence linked to White supremacy:** This increase in lateral violence within communities is a direct result of an increase in White supremacist structures that are class-based and cause groups on the same plane to engage in harmful behaviour. An example of this is when someone in the Black community who has not been doing this work receives funding whereas those who have been doing anti-racism work for years do not have the basics to support their work. This is a new trend but, again, linked to neoliberal capitalism.

- **Increase in representation among advisory committees with no change in their decision-making power:** There is a strong trend of creating IBPOC advisory committees or increasing IBPOC representation when equity issues are identified. Rather than looking critically at decision-making roles within the organization and applying anti-racist principles to address the issues, a committee is formed that is usually made up of volunteers who lack decision-making power. This represents a lack of accountability from institutions.

- **Increase in training and education around anti-racism with no accompanying structural or policy changes at a systemic or institutional level:** There is increased focus on and interest in anti-racism training and education in organizations and institutions. However, this is not accompanied by changes in the structures, policies, processes and decision-making power within those organizations and institutions.

- **Increase in reliance on unpaid labour:** There is an increased demand on racialized people to do equity work on specific projects in health authorities or hospitals without the compensation that acknowledges additional work in contracts, consultancies or workshops. A lot of this work ends up being done as unpaid work, and the unpaid work along with existing work responsibilities and the emotional labour often lead to burnout. The expertise, work and lived experience of these people are not valued from the beginning, and then at the end of these projects a large chunk of time is required. On the other hand, there is an increase in the flow of resources to White-led organizations.

- **Increase in the assumption that racialized people must wear "that hat":** Racialized people are actively being pushed into roles of anti-racism work that they did not choose. The expectation is that racialized people must already have this expertise and be able to support the organization in anti-racism work without being given the option to do this work or not. There is an accompanying deskilling of racialized people and their operational expertise in public health by forcing them into doing anti-racism work rather than the work they are trained to do.

- **Increase in focus on technology:** The discourse on technology in public health emerges from universities and industry, and the emphasis is on partnerships with industry. This trend reinforces structural racism since Indigenous, Black and other racialized peoples are not in control of industry due to the history and continuing impact of colonialism and enslavement. The claim of technology is to be atheoretical, objective and evidence-based, but this actually represents a lack of critical thinking that is related to White supremacy, dominance and, again, neoliberalism.

- **An increase in mainstream evidence-based policy and practice:** There is a lack of political will to mandate grassroots involvement in policy-making and no evaluation mechanism in place to ensure that research funding and programs (even those including some "EDI") are relevant to those who are experiencing marginalization. This raises the question of who is considered to be an "expert" and gets the funding. Is it those who have actually been doing the work?

- **Increase of status quo governance:** In public health, there is a dearth of leaders from Indigenous, Black and other racialized communities who – despite the recognition that this must change – continue to be excluded from decision-making and positions of leadership.

- **Increase in the collection of disaggregated data:** Interest in data on race and other social determinants of health is a huge trend, and there is increased willingness and interest in collecting disaggregated data based on race or other elements of social identity and equity (e.g., immigration experience, sexual orientation, gender identity). For example, the Public Health Agency of Canada, Canadian Institute for Health Information and Statistics Canada are engaging in more data collection on race since the summer of 2020. Previously, they had stated it was not feasible.

- **Increase in the recognition of racism as a social determinant of health:** There is an increasing recognition of racism as a social determinant of health that underlies all others, and an increasing expectation that Indigenous, Black and other racialized communities will be involved in the collection, analysis, reporting and sense-making of data. An example of this trend is the collection of data and identification of differential impacts in Manitoba during the COVID-19 epidemic. Manitoba Health's report on COVID-19 race, ethnicity, Indigeneity (REI) analysis, wave three[12] pointed out how "reliance on age-based vaccination restrictions likely contributed to the 10+ year differences in the mean ages of hospitalizations between White and IBPOC Peoples."(p24)

- **Increase in the need for academic research:** A problem at the intersection of public health and academia is a lack of readiness or willingness to focus on the upstream drivers of racial inequity. Change is not going to happen based on data from individuals. The real source of inequalities is structural racism working hand in hand with White supremacy.

- **Decrease in polite or "coded" racism in Canada:** The angel complex is a term that was coined by the Colour Code podcast in 2016.[13] It is the idea that, in comparison with the United States, Canada does not have as severe a problem of racism. In fact, racism has become even more overt in Canada and is now public and licensed. An example is the view of Natasha Bakht[14] that Canadian laws are in essence legalizing Islamophobia by upholding bans and actions against public servants wearing religious symbols such as niqabs.

- **Increase in ableism reinforced by White supremacist structures:** Black people are experiencing increased ableism, encouraged and maintained by White supremacist structures. It is disability injustice.

- **Decrease in focus on intersectionality and disability:** There is a lack of focus on the intersection of race and disability. In White-dominant organizations, there is a focus on intersectionality to the exclusion of race. Also, in Black-led organizations, there is a focus on gender and race but not disability. The disability movement is in general based on White experiences and is exclusionary. Racism and anti-Black racism are experienced within accommodation and accessibility processes and resources, and there is not a coherent intersectional approach to race and disability.

How trends affect actions

Once the mind map activity was complete, participants worked in affinity groups to identify the trends of greatest concern to them and how these trends connect to each other. Finding the relationships among trends pivots sense-making to a systemic approach, and this in turn leads to more powerful planning than dealing with individual trends or problem-solving. The groups next explored what they were currently doing in response to these trends and, most importantly, what actions they could take in the future to address them. Trends and responses are presented below by affinity group.

DATA SYSTEMS AND HEALTH CARE ADMINISTRATORS

TRENDS OF CONCERN	CURRENT RESPONSES	FUTURE RESPONSES NEEDED
» Collection of disaggregated race-based data. » Increased focus on quantitative data and decreased focus on qualitative data. » Disinformation and misinformation on race and equity data. » The role of corporate influence on data systems and privatization. » Decrease in consenting to research in violation of convention. » Implications for data systems (how do our data systems collect information?).	» Ongoing advocacy for fairness and justice. » Emphasis on the importance of both quantitative and qualitative approaches to data science. » A framework for the collection of disaggregated data founded in relationships, needing to know from a place of care, and accompanied by processes that aim to reduce systemic racism and oppression is described in the 2020 report *Disaggregated demographic data collection in British Columbia: The grandmother perspective.*[15] » Ensuring that race and equity data is embedded into national strategy for data collection, including policies for how to use and protect the data. » Recognizing the lack of support and expertise for meaningful data collection and analysis. » Recognizing that data is being used in harmful ways and there is a lack of resources to work with it in a way that minimizes harm. The lack of protective oversight is most worrisome. Many data pathways are set up as private–public partnerships, with a massive decrease in consent.	» Break down silos to create more space for conversations about this. » Implement legislation to protect race/equity data from misuse and abuse by the very folks who request it. » Whistleblower protection. » The end of "data governance," and a move to data justice. » Stop the spreading of disinformation. » Don't drive Canada into a "data apartheid system" as exists in the United States by, for example, requesting facial identifiers for health care. » Uplift qualitative data and analysis and mixed methods as being as equally valuable and important as quantitative data. » Increase engagement in designing data systems. » Ensure robust guidance as to how the data is collected and used.

COMMUNITY ORGANIZATIONS

TRENDS OF CONCERN	CURRENT RESPONSES	FUTURE RESPONSES NEEDED
» Trends around ableism, disability and intersectionality. » Increase in advisory committees with no change in their decision-making power. » Tokenization of EDI positions with no support. » Increase in training and education in anti-racism with no accompanying structural or policy changes at a systemic or institutional level. » The connection between these themes is that they are all rooted in White supremacy, and that systems are organized to extract knowledge, not resource knowledge. People with lived experiences are being leveraged to access funding that goes to large organizations, not to supporting those with the lived experience.	» Pushing back to make sure those with lived experience of racism are being centred and resourced in creation of their own advisories. » Hyperlocal strategies for community engagement being done with trusted folks, figuring out ways to resource and support local communities. » Mobilizing groups that are already doing the work and that are trusted. » Holding systems accountable.	» Change how people in positions of power engage. » Move to hyperlocal, trusted community-based action. » Hold folks accountable and identify whose responsibility it is to do that. This responsibility needs to be named and addressed. » Build accountability to define change and measure ongoing success. » As they envision the future, think about how to resource the time needed to reorganize these things.

PUBLIC HEALTH PRACTITIONERS AND DISCIPLINARY GROUP

This group focused mainly on trends of concern.

TRENDS OF CONCERN
» All the trends are centred in an epistemology of public health based on a White model of historical development, one that disregards the fact that populations around the world have taken care of their people for centuries. » The collection of race and equity data within our public health institutions has historically ignored workforce data showing the diverse communities that exist within these institutions already. This lack of recognition has resulted in a gap of perception that perpetuates "othering" within public health. » The increase in advisory committees without the power to act gives organizations something they can point to as "action," which gives the "experts" permission to do what they want to do rather than make room for people with lived experience to be the experts. » As for the increasing prevalence of tokenistic EDI initiatives, talking about health equity gives those of us in public health permission not to use the harsher language of racism, call people out or make them uncomfortable. This means that the actual harm done is not being acknowledged.

PUBLIC HEALTH DECISION-MAKERS

TRENDS OF CONCERN	CURRENT RESPONSES	FUTURE RESPONSES NEEDED
» An important trend not previously mentioned explicitly during the mind-mapping is the naming of White supremacy and the naming of racism. » Trends around governance and evidence need to be leveraged to ensure that the initial trend of naming or calling out racism and White supremacy ultimately results in meaningful transformation and anti-racist actions.	» Leaning into this trend of naming and attempting to respond and react, for example, like the recently released report on Indigenous-specific racism in health care across the Champlain Region[16] that measured, recorded and reported evidence of racism and proposed policies for more representative workforces. » Exploration of different types of evidence and disaggregated data. » Exercising caution to ensure they don't slide back down the well-greased path towards upholding racism and White supremacy by tokenizing practices.	» Develop new tools and mechanisms to hold White people accountable to Indigenous, Black and other racialized peoples, and also to themselves. » Maximize the legislative tools that are trending up right now and make sure to use the teeth that are in them. Examples of these are British Columbia's action plan[17] to implement the United Nations Declaration on the Rights of Indigenous People (UNDRIP), the Government of Canada's adoption of UNDRIP into federal law,[18] and the Anti-Racism Data Act[19] (also in B.C.) to support the collection of intersectional demographic data while protecting that data from being misused.

PUBLIC HEALTH RESEARCHERS AND FUNDERS (GROUP ONE)

As this affinity group convened, they paused to acknowledge the news of a police shooting in Scarborough, Ontario that had just occurred. The group wove their reactions to this event into the conversation they had and focused on trends of concern (presented below).

TRENDS OF CONCERN
» The news about the shooting reinforced how the important discussions taking place about racism are often occurring in academic spaces in a very conceptual and theoretical way. There is rarely any discussion about the impact an event like this has on the bodies of Indigenous, Black and other racialized peoples, and how important trauma-informed approaches are for those experiencing racism on a day-to-day basis, as well as for the people who are doing this work. » The oversight of Blackness in academic spaces, notions about professionalism and how little time has been devoted to thinking about how Whiteness continues to oppress people from Indigenous, Black and other racialized communities in these spaces. There is an expectation that the ways in which racism and White supremacy are spoken about won't make people feel uncomfortable, and, when it does, it is seen as angry or dismissive behaviour. The continuing harms done to Indigenous, Black and other racialized peoples who work on these committees or in shared workspaces in academia cannot be ignored. How often is harm caused by those who are in turn being oppressed? When the system is challenged, there's a price to pay. And that price often affects positions and careers, as well as health and well-being. » Advisory committees where Indigenous, Black and other racialized peoples are not valued for their expertise and for the knowledge they bring. They are put into situations where they do not have decision-making power, and the committees cannot do anything to fundamentally change or impact policies that are affecting them.

PUBLIC HEALTH RESEARCHERS AND FUNDERS (GROUP TWO)

TRENDS OF CONCERN	CURRENT RESPONSES	FUTURE RESPONSES NEEDED
» Lack of focus on upstream drivers and a tendency to focus only on downstream impacts, for example, the impacts of the pandemic. » How funding and the focus on EDI programs take away from a community – for example, a predominantly White team with a token Indigenous, Black or other racialized individual and no value placed on relations or building trust or community expertise. » How the granting agencies elevate "productivity," which is oftentimes at odds with community-based research. » The decreased focus on intersectionality, specifically in research: how that relates to overt racism and how it manifests itself in health care. » The absence of research on racism as a social determinant of health in the Canadian context, something that is also observable in the funding ecosystem.	Examples of individual and collective actions (guerilla tactics) that disrupt the status quo and compel the system to change: » Indigenous research chairs, when required to do an individual midterm report, disrupted the rules by coming together to do a collective report, thereby decolonizing the work. » Community intervention where a CIHR-funded researcher came from outside the community and did not know the local context. The community held them accountable, pushed back hard and asked questions about, for example, compensation that was determined to be inadequate. This resulted in the researcher going back and reframing the research by asking the community what they wanted, and doing what was necessary to meet the community needs. » In a tokenistic EDI circle that was using terms of reference that did not matter much, a small but significant disruption was made by the group demanding to see the budget.	» No more statements or strategic plans – insist on seeing the budgets. » Explore what alternative community-based funding models exist that meet community needs. » Change what the tokenistic EDI committees are called and adjust their terms of reference. » Commitment to race-disaggregated data analysis.

STUDENTS (TWO GROUPS)

TRENDS OF CONCERN	CURRENT RESPONSES	FUTURE RESPONSES NEEDED
» Increase of corporatism and neo-liberalist capitalism: Who gets the money and where does it come from? Who is it directed to and who is being prioritized? » Increase in focus on quantitative data. What does this mean, and what's needed in terms of a paradigm shift so that other data sources are seen as relevant to making decisions about change? Often qualitative data is not perceived to be as effective as quantitative data, and work may not be accepted if only qualitative data is offered. » Lack of diversity in curriculums that is not conducive to learning about these issues, and how that puts the onus on the students to learn all this on their own. Going against the system takes a lot of time, and trying to create shifts is actually quite risky at times, especially for students and young professionals who are just beginning to take on roles in the industry. » Increased reliance on unpaid labour, especially for racialized students trying to excel who are being pushed into "voluntary" positions. » Increased superficial funding (or funding directed to specific areas). » Increase in tokenistic EDI positions with no real institutional support. » Decreased focus on intersectionality. » These trends appear woven together by a shift within this work that lacks a critical lens, leading to dependency on unpaid labor and the unfair allocation of financial support. In terms of the tokenization of EDI work or advisory boards and committees, these are put into place without appropriate financial backing. If they can come to conclusions about how to improve or move forward, roadblocks are put in place that result in a lack of meaningful action by the boards or the organizations that appoint EDI boards and committees, and so the effort doesn't lead to any real change.	» Naming these trends, talking about them and acknowledging them is a good first step. » Ensuring that the work and research of students are based on and reflective of right (better) practices. » There is a sense of powerlessness in being able to change things because of the limited roles students have within research and academia, and the lack of decision-making power they have. » It is important for students to attend conferences like this and be able to enact change and limit the perpetuation of the same harms when they join the workforce.	» Create allyships within educational institutions with professors and supervisors. » Reconsider the roles of the CIHR and Public Health Agency of Canada in monitoring: What and how can these large organizations change to better embed equity rather than simply promote it? » Make sure that all are aware and understand the social location they come from, and what it means to support one another. » Continue to voice concerns about the need for change within these institutions. » Advocate for best practices when possible, and do it also for those who are unable to get this type of education. » As new workers and researchers, push to elevate the bar to include different perspectives for those who come after so that it becomes the norm. » Push for anti-racist and anti-oppression approaches within academia so that all students are learning this. » Have the courage to speak up and call out injustice.

Reflections from the larger group

Following the discussions in affinity groups, participants reflected on what was shared by all groups. There was a recognition of the tension between holding White people accountable to disrupt White supremacy and the disconnect in their understanding of what this work entails.

There was a deep and enthusiastic appreciation of the students: their knowledge, their clarity around what needs to happen and their openness. Participants resolved to continue to invite youth perspectives and hardwire them into this work. Students felt it was refreshing to be in the larger group and experience having similar priorities. It demonstrated to them the importance of collective action.

There was also a recognition of how much expertise students and community organizations hold, and an understanding that it is necessary to mobilize power and shift resources to where that expertise already is. It is clear that the capacity is there, and it needs to be supported in sustainable and accountable ways.

Prouds and sorries

Before moving to focus on the future, participants divided into affinity groups to reflect in a deeply personal way on what they felt proud and sorry about in relation to their work in disrupting White supremacy and racism in public health systems. The purpose of this activity was to acknowledge and bring forward the emotive nature of this work.

The groups considered, discussed and reported back (see Table 1) on the following questions:

- What is it that we hold in ourselves about the work we do?
- What are we proud of and what do we regret and wish that we had done differently?

TABLE 1: WHAT AFFINITY GROUPS ARE PROUD OF OR SORRY ABOUT IN THEIR WORK TO DISRUPT WHITE SUPREMACY AND RACISM IN PUBLIC HEALTH SYSTEMS

PROUDS	SORRIES
STUDENTS (TWO GROUPS)	
» Being more intentional about what we have been studying, looking more deeply into racism as a social determinant of health and, for some, specifically Indigenous health » Expanding beyond our education, which is often very biomedical or concerned with basic sciences » Building relationships and community, and learning from one another in those spaces » Speaking out on behalf of other classmates » The continuous process or learning and unlearning » Changing how we function within academia – e.g., changing the focus of our research and letting anti-racist pedagogies direct the research » Public actions – e.g., writing open letters condemning racism and standing up against the backlash and hate generated by it, remaining reflexive and aware of one's social location within this work » Doing community work toward prison reform » Having the courage to name Whiteness and discuss it with people, thus bringing forward awareness	» Being ignorant about non-mainstream intersectionality – e.g., ableism » Not advocating for communities but, as students, focusing more on research and academia within a capitalist construct – looking out for our individual interests » Tokenizing others or ourselves » Lack of care in our conversations » Not making more time to understand and study the robust history of resistance, the many important thinkers and theoretical backgrounds; it is hard to make the time to build that foundation » The ways we have been complicit – e.g., when we are tired, when it feels hard to stand up because the risk is high, when it feels like it may impact our future in academia; or not questioning earlier in our journeys

PROUDS	SORRIES
PUBLIC HEALTH RESEARCHERS & FUNDERS (TWO GROUPS)	
» As our work emerges, we become more and more aware of our complicity within a system that needs to change » Accessing funding and opportunities to do anti-oppressive work including with students, and working within research ethics boards and organizations like the International Public Policy Association » Finding ways to do anti-racism and anti-colonial work » Being disruptive in meetings, and challenging and making structural changes to disrupt White supremacy » Mobilizing our own bravery to push back » Countering misinformation from people that we work with or service providers » Creating a workshop to make the real history of Indigenous peoples more widely known » Building structural supports so that people experiencing barriers in social determinants can move into leadership positions » Being part of national networks that advance conversations about how our research and science perpetuate racism » Helping people unpack the complex histories of Black peoples in Canada, and not oversimplifying their roles around being settlers or not	» Still fitting into a system where we want to be successful – e.g., writing grants in a way that are not as explicitly anti-racist as they should be » Being part of a research ethics board that is caught up in rules and recognition about what is expected, and complying with a system that is upholding racism » Anti-racism work that is being done is resulting in benefits for oneself that are unjust » Still centring Whiteness in ways that need to be peeled back, and falling back to colonial processes » Being complicit with some of the mainstream racist and White supremacist ideas about different populations » Being complicit with mainstream practices » Not going far enough if you are working in an area where you have the potential to have an influence on equity
PUBLIC HEALTH DECISION-MAKERS	
» Hiring people from Indigenous, Black and other racialized communities to be in leadership roles and influential positions » Not getting stuck in the discomfort – shame is not a productive place to be » Holding ourselves and our organizations to account to do better and to do it in different ways, including in the community or publicly	» We have taken our privilege for granted, the blind spots we have, not having done the critical work to be aware » Not being deliberate in putting enough energy into mentoring and developing people from equity-deserving groups to enable them to be more involved in decision-making and changing systems » Not being aware of how the rules hurt people » Not being aware enough to ask who is missing from the table
PUBLIC HEALTH PRACTITIONERS & DISCIPLINARY GROUP	
» Finding ways to bring the language of anti-racism into our work, using anti-racist language in our health unit or having justice included in health equity statements » Finding new ways to call out behaviours that are not okay and reminding people that just because you go out and engage with your community does not mean you are doing health equity work » Proud of walking a fine line between being an activist in our community and supporting anti-racism work in our communities while being a public health professional	» When we have not been enough of a disruptor or as influential or strategic as we would have wished to be, and when what we have done has not resulted in change » Contributing to any burden of this work on racialized staff, or putting pressure to do this work on our racialized peers who may not be in a position to push back and be vocal due to fears of repercussions » Not knowing how to address the various forms and experiences of racism

PROUDS	SORRIES
COMMUNITY ORGANIZATIONS	
» Proud of the Black communities coming together in Toronto to challenge racism at the intersection of COVID-19 » Acknowledging the stakes with colleagues and talking about it, doing reflexive work advocating for the inclusion of Indigenous peoples repeatedly, and continuing to talk about racism and Whiteness » Proud of the younger generation for having more awareness, and knowing that we are headed in the right direction » Proud of who we are, embracing social locations by being proud of all our identities, being courageous enough to name some of the advantages of our dominant culture, having the courage to accept reality and move from where we are and accept the call to this conference	» Not centring the most marginalized in Black communities in our own analyses and into work that we do as organizations » We have not been able to hire more Indigenous, Black and other racialized peoples in leadership » We have participated in tokenism in our organizations, particularly in relation to hiring Indigenous peoples » Centring Whiteness and not paying attention to anti-Black racism when we are working with Indigenous-specific racism » Not having taken the time to unlearn what we believe in terms of race and the history of White people » To have internalized neoliberal racist values and to have to unlearn all these values » Not considering the context of colonialism and racism, the assumptions of history and the impact that our assumptions of history have been perpetuating
DATA SYSTEMS & HEALTH CARE ADMINISTRATORS	
» Proud of the people who have come before us who have been continuing to push institutions to recognize the importance of Black health » Recognizing opportunities when they presented themselves (e.g., Social Sciences and Humanities Research Council funding that came out on race, gender and data) and using those opportunities to advance work around a community » Being able to have a seat at the table when discussing data strategies and centring those conversations around disaggregated data; Indigenous, Black and other racialized groups and their data; racism; the impacts of racism in relation to that data; and the importance of how that data is being used » Listening and learning » Leveraging decision-making power within our organizations » Staying true to our roots of community-based research, advocacy and mixed methods of bringing this forward » Shaping conversations as well about AI [artificial intelligence] data science and health research funding to really focus on inequities, as well as racism and colonialism	» We may not be doing enough – e.g., to promote qualitative and mixed methods approaches » Not finding better ways to incorporate community engagement in the data science sphere » Not integrating both quantitative and qualitative data in data systems » Not changing the culture in how we engage members of the public

Reflections from the larger group

It was noted how much easier it was to find faults and highlight what we want to do better than speak about what we are proud of having done. Talking about what we are sorry about is a way to develop accountability for oneself but also to encourage critical reflection. Being sorry can help us understand what strategic intentional work might look like and how our efforts might be more productive than they have been to date.

FOCUS ON THE FUTURE

The purpose of this part of the workshop was to envision a future we could believe in and, most importantly, work toward.

Participants were asked to imagine that the date is May 31, 2032. We are 10 years into the future and our dreams of the future of public health in Canada are now reality. We imagined the future into being!

To help with visioning, participants considered these guiding questions:

- What does an anti-racist public health system free of White supremacy look like?
- What systems are in place, what barriers have been removed?
- What policies now exist, what relationships have been formed?
- What do you want to see in a decolonial, non-racist, White supremacy-free public health system?

Seven cross-sectional mixed groups took on the challenge of coming up with a vision for the future based on the following attributes:

- It is feasible (possible to implement).
- It is desirable (benefitting nature and people).
- It is motivating (we are all ready, willing and able to work to make it happen).

After discussing and creating future scenarios, each group acted out their desired future to the full group. In acting out the future as if it were happening right now, people could tap into their deepest aspirations.

Excerpts and synopses of these desired future scenarios appear below.

1

GROUP 1

This group presented a skit featuring a trip to the hospital with a Black mom and her child who was ill and in pain to show what it would be like to access the health care system in 2032. When they arrive at the hospital, and the child is coughing up blood, they are greeted with compassion and concern. Their (both mother's and child's) pain and worry are taken seriously, and the patient's nonbinary gender is kindly and respectfully acknowledged. The child expresses wanting to grow up and be like the doctor, who is a Black woman. In fact, this aspiration is entirely possible since, in 2032, more than 30% of the graduates from medical school are Black.

Tests are scheduled, mother and child are referred to a patient navigator and community health worker who is sympathetic and helpful, connecting them with resources and even offering food.

The dreams that prompted this presentation of a desired future include fair funding, cultural safety, representation, access, continuity of care and data for action.

2

GROUP 2

This group chose an image by Lisa Boivin, called Sharing Bioethics[20], that represents their desired future of a team situated within nature and the world. There is a place for medical/Western knowledge with intersections of traditional and other types of knowledge. In this desired future, the culture has shifted to one where humility and being part of a team is experienced by all, and we celebrate diverse epistemologies, perspectives, medicines and world views. There is not a choice to be anti-racist but only to work in solidarity, and loving right relations are the reality. There are very clearly articulated mechanisms of accountability, and we demonstrate our trustworthiness to one another. We are collaborators with our patients and see our patients as part of a relationship, and the same is true with one another as practitioners. Good health care is a space of love, giving, generosity and care. There is an absence of those power structures that acted as barriers to Indigenous, Black and other racialized peoples – they were disrupted by allowing those individuals to lead us in the right direction.

3

GROUP 3

This group acted out a news interview to celebrate what had been accomplished in the public health system in the last 10 years. When asked what the most important roadblock had been to overcome, the answer was to find a way to work within the capitalist system through reimagining a new way of doing things. The redesign of the public health system was inspired by abolitionists and moved beyond policing and the exclusion of Black and Indigenous peoples, and sex workers. The work was done to redistribute power and create supportive environments for everyone. The most important collaborations were those where Indigenous peoples and Black people committed to work together and talk about colonization, anti-Indigenous racism and anti-Black racism. Another important piece was around supporting communities so that they could help each other heal and become self-sufficient and self-determining, while at the same time having reciprocal accountability mechanisms in place to make sure that there was no alleviation of public responsibility. There was much learning from mistakes that were made previously, and now there is a fostering of communities through working with healers and traditional Knowledge Keepers and, of course, supporting Black and Indigenous health care professionals. It is a beautiful public health system today.

4

GROUP 4

This group created and presented a poem entitled "What a wonderful day to breathe, a day where humanity precedes White supremacy." The themes are feeling safe, free and open; being able to thrive without oppression; and respecting Blackness, Indigenousness and Brownness. There are Indigenous, Black and other racialized peoples in leadership roles; a sense of belonging; and an awareness that we no longer need to advocate for family and friends. We are living in a world with cultural humility, love and compassion. There has been a change in society, and there is access to clean water, food and housing for everyone. Justice is rehabilitative, and the makeup of the workforce truly reflects the population. White supremacy is now completely dismantled, and there has been a massive shift in our values so that we actually care about future generations. "What a wonderful day to breathe."

To read the full poem, please see page 50.

5

GROUP 5

This group created and shared a poem entitled "A Pedagogy of Hope," reflecting the words that arose during the group's discussion around desired future scenarios from the four rooms of change: contentment, denial, confusion, renewal. These words and phrases include:

- "Looking up" – Equity. Hope. Contentment.
- "Looking down" – Pessimism. Distrust. Denial. Can we work together? Break down silos! Work across sectors.
- "Looking everywhere" – Fatigue. Confusion. Everybody wants a revolution, but first we want a nap.
- "Looking Ahead" – Values. Integrity. Reparations. Renewal. Critical thinking supported and fostered.

Step by step, inch by inch, with each flickering flame added, the fire grows.

6

GROUP 6

This group shared the five waves of public health.[11] Inspired by the promise of the fifth wave, it is recognized that there is a world view problem, which opens a world view solution. This is not about tweaks but about manifesting radical change. Solutions follow these principles:

- The remedies must match the harms. For example, harms caused by residential schools in terms of cultural genocide require a response grounded in the restoration of Indigenous cultures. There is the concept of culture as prevention, care and treatment for the remedy of that harm.
- Not waiting for the future but living it in our own practice right now. So, thinking about concepts of transforming Whiteness, radical love, redistribution of power, resources, money and taking accountable action.
- The waves are not just temporal. The waves are also the metaphor for being in collective action together and what it might feel like. How it can feel swirling in and a little out of control, as well as energizing and exhilarating and fun when done well. But also, sometimes, it feels like you're drowning. "Grab your noodles, we are in this together."

7

GROUP 7

The group reported a good news story for their representation of a desired future, "What the public health system has been able to accomplish in the last 10 years":

- Succeeded in disrupting White supremacy!
- Epistemic health is being taught in textbooks and in practice.

This has been done by focusing on the fifth wave[11] and rebalancing mindsets from anti- to pro- and from dominion and independence to greater interdependence and cooperation. We have been able to rebalance models from a mechanistic understanding of the world and of ourselves as mechanics who diagnose to organic metaphors where we understand ourselves as gardeners, enabling the growth of what nourishes human life and spirit.

Some of the advancements: The Truth and Reconciliation Commission has acknowledged that 94 calls of Truth and Reconciliation have been achieved; the rates of turnover in community agencies have decreased due to equitable resources, support and decreased burnout; and, across the country, the public health budget has now allowed for prevention to take focus over care. This is supporting upstream programming and has yielded better social programs and support for families to provide and take care of their children.

COMMON GROUND AND ACTION PLANNING

The ultimate purpose of the Future Search workshop was action-oriented strategic planning. Continuing the process of moving toward an action plan, it was clear that common ground was emerging already from the work done, and the principles and key features that form the base of a shared vision of the future were becoming clearer. The next phase of the work was to codify these principles and key features into statements of common ground.

In small mixed groups, participants were asked to consider the following questions:

- What do you think we all want?
- What do you think we can all agree on?

Each group prepared a list of the elements that reflected what they believe everyone wants. These were presented to the larger group and organized into themes. Then the group embarked upon the work of seeking consensus: Does this statement truly reflect what everyone wants and believes?

This long and collaborative process of seeking consensus and common ground was the heart of the work done together in this workshop. It was not always easy, and not everyone participated. Some language was contested, and time had to be taken so that participants could reflect and then negotiate how things were phrased and what would be included in their statements.

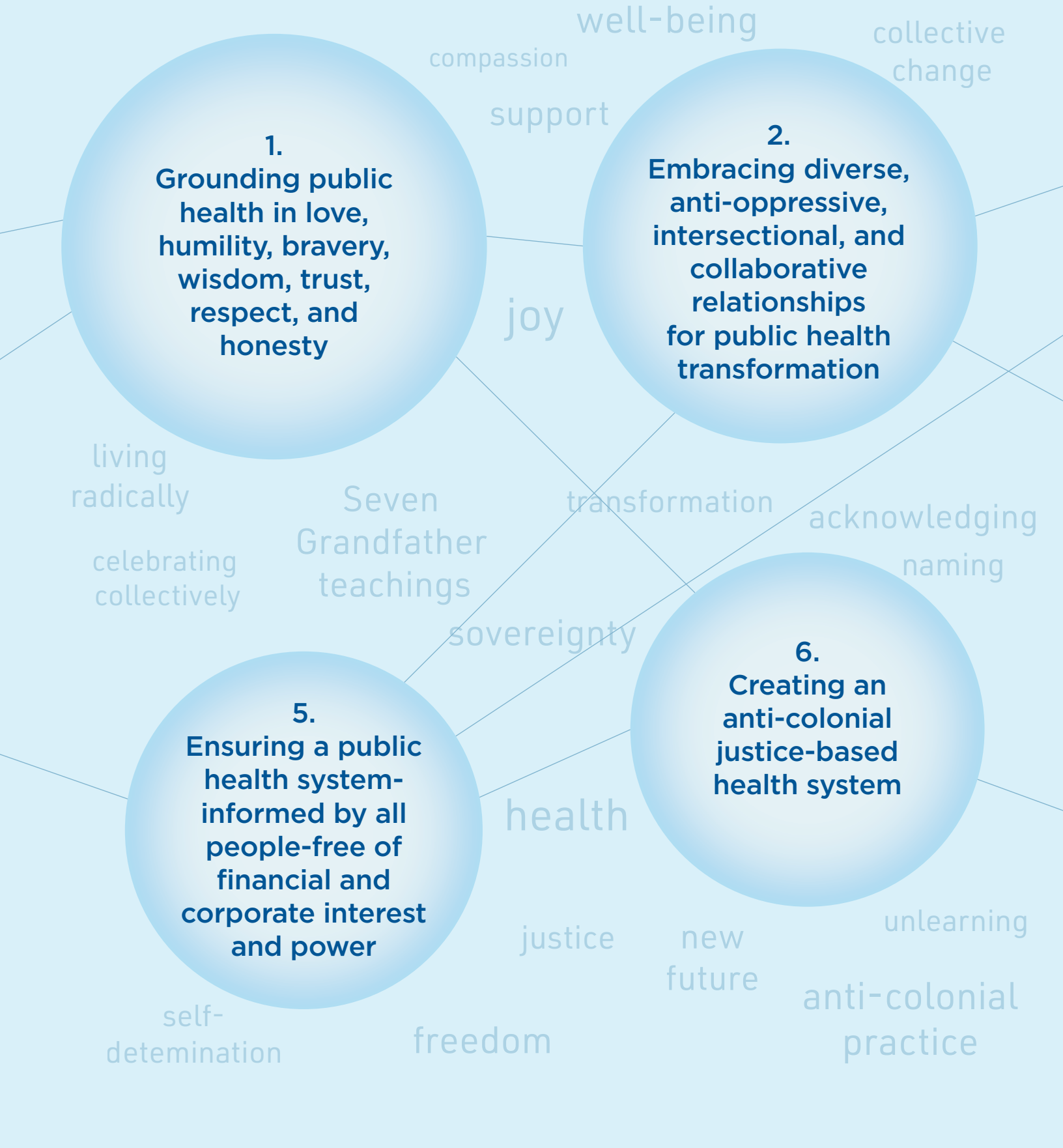
In the end, eight statements of common ground were created. The common ground statements form the basis for action planning, and so the final task of this workshop was to translate all the work done into actionable steps. Self-selected groups discussed and identified:

- What steps are you ready, willing and able to take that will work toward your common ground agenda?
- When and where will you next meet, and who will organize this?

It should be noted that actionable steps were not developed for two of the common ground statements, and only two of the groups actually identified when they would meet next or designated someone to organize the next meeting.

Our Common Ground

The following Common Ground Statements generated by Future Search workshop participants can serve as guidance to others seeking to disrupt White supremacy and racism in public health systems.




wisdom
meaningful change
celebrating
community leadership
value
affirming
disrupting
3. Enabling community leadership within public health research
4. Naming and undoing the harms caused by White supremacy and its intersections with other historic systems of inequality
healing
knowledge
power
solutions-oriented
community-based
diversity
understanding
resources
transparency
collective agency
anti-White supremacy
7. Empowering community control and collective agency in public health
anti-racist
8. Working in solidarity for collective liberation and developing accountability mechanisms that align values with practice
governance
accountability

Below you will find each complete common ground statement and its accompanying actionable steps.

1

COMMON GROUND 1

Statement

We are committed to living radically and celebrating collectively the Seven Grandfather Teachings to ground our public health work/approach (love, humility, bravery, wisdom, trust, respect, and honesty) in research, education, practice and policy, with joy and compassion.

ACTION STEPS

Values-oriented, short term and ongoing:

- Develop and promote widely available cultural safety awareness and understanding of the Seven Grandfather Teachings, and how that can ground our work in public health.
- The values and principles are critical to advancing all work in policy, education and research.

Relation-oriented, short term and ongoing:

- Encourage and support individual grounding in one's own cultural and ancestral identity, particularly in relation to colonial histories.
- Foster new pathways that build trusting, harmonious and equitable relationships by honouring Indigenous rights, ways of knowing, languages, world views, spirituality and relationality, and relationships to the land.

Education, integrating the teachings into education by:

- Developing program/course philosophy statements grounded in the seven teachings.
- Developing curriculum-mapping across programs to identify the philosophical and critical pedagogical approaches that model/embody and align with seven teachings.

Research, integrating the teachings into research by:

- Ensuring that grant proposals are being evaluated based on the seven teachings.
- Building research capacity to ensure that the seven teachings are integrated into proposal writing, mentorship and supervision, and publications.

Practice, integrating the teachings into public health by:

- Changes in workplace policy and culture to support the seven teachings, allowing time and safe space for reflexivity, relationship-building, personal learning and growth.
- Delivering mandatory and ongoing culturally safe training and capacity-building for embodying/working with the seven teachings.
- Creating leadership development training and goals that align with the seven teachings, to build workforce capacity.

Policy-making, integrating the teachings into policy-making by:

- Meaningfully involving and equitably compensating Indigenous Knowledge Keepers and Elders in core policy decision-making in public health.
- Transforming policy-making processes to be participatory and grounded in the seven teachings.
- Including the seven teachings in policy development and implementation, and in evaluation processes, mechanisms and criteria.

2

COMMON GROUND 2
Statement

We are committed to embracing diverse, anti-oppressive, intersectional and collaborative relationships and ways of knowing (which, while integrating some teachings of Western knowledge, nonetheless reject it as "the ideal standard") in order to support collective change, transformation and well-being.

Note: No participants developed an action plan for this common ground statement.

3

COMMON GROUND 3
Statement

We are committed to a research system without racism that is justice-based and honours the wisdom, knowledge, power and healing of community-based participatory action research and policy.

We are committed to enable community to colead/lead the development of the research question and research agenda that matter most to them. We are committed to have community be the principal investigators and academics be the collaborators with appropriate resources identified, advocated for and secured.

We are committed to solutions-oriented intervention and implementation research in communities that has tangible benefits to them and not academics only.

We are committed to ensure that knowledge translation and results are really embedded in the community and that participants are active in the process and outcomes for meaningful change.

ACTION STEPS

Advocate to funding agencies about the specificities of anti-racist and anti-colonial research approaches

- Integrate meaningful community-based research programming.
- Measure success by engaging each member in the process and having a logic model.
- Dedicate a portion of the funding to the community.
- Paying everyone needs to be in the budget; relying on unpaid labour is not acceptable.

Be clear about terms of engagement with community and who is at the table within research projects

- Value the time of community members.
- Again, to emphasize, paying everyone needs to be in the budget, and relying on unpaid labour is not acceptable.

Launch funding opportunities for community-based programming

- Inform community members about the benefits of research.
- Build trust and relationships – a priority.

Change assessment and evaluation criteria of community-based projects

- Peer review process.
- Simplify research requirements that are barriers for community researchers.

4

COMMON GROUND 4
Statement

We are committed to (1) iteratively affirming and celebrating the transformative value of difference and diversity; and (2) being deliberate in naming, understanding and addressing the harms caused by White supremacy and its intersections with other historic systems of inequality, which play out simultaneously at institutional (e.g., through norms, policies, laws), interpersonal (e.g., how we treat each other) and internal levels (e.g., internalized superiority and inferiority based on our positions of privilege and oppression, including through bias).

We are further committed to understanding and disrupting the differential impact of White supremacy on, in particular, Black, Indigenous, or Black & Indigenous populations.

ACTION STEPS

Amplify efforts for structural change

- Iteratively affirm and celebrate the transformative value of difference and diversity.
- Create an action network of students and young professionals to advocate for diversity. Short term: national network of anti-racist public health student/faculty network. Long term: student diversification and faculty recruiting.

Contribute to existing good work

- Cross-institutional project in collaboration with the Black Health Education Collaborative to implement their work in reviewing public health education curriculum.

Leverage our individual positions

- Our group members pledge to use our diverse spheres of influence and expertise to uplift and contribute to actions being conceived by other groups where there is synergy.
- Advocate the centring of public health students in positions of influence and decision-making as part of the transformative change in public health broadly; this disrupts the power hierarchy, models redistribution of power and builds collective power.

Name this as a topic needing attention

- Address the issue of unpaid (and inadequately paid) internships, placements and practicums within public health programs.

5

COMMON GROUND 5
Statement

We are committed to public health systems and knowledge being informed by all people, not dictated by financial power and corporate interest.

We commit to a future where public infrastructure (e.g., roads, safe water systems) is equitably distributed and supported so that people are able to grow wealth in ways that sustain their health.

We are committed to public health making visible and disarming corporations' excessive power and dominance including abuses/uses of power and their proxies (i.e., NGOs, universities, etc.) by naming, limiting and acting on corporate influence, neoliberal co-opting (i.e., co-opting Black, Indigenous and disability justice movements) and settler colonist agendas that undermine sovereignty and self-determination and that impact health, environment and freedom.

Note: No participants developed an action plan for this common ground statement.

6

COMMON GROUND 6
Statement

We are committed to acknowledging, naming and unlearning the language of White supremacy. We are committed to taking action to implement anti-colonial practice with the view to reimagine a new future free of anti-Black and anti-Indigenous racism. We are committed to creating health justice in medical practice, health care and public health.

ACTION STEPS

We are committed to acknowledging, naming and unlearning the language of White supremacy

- Assert the right to speak.
- Stop using passive and soft language.
- Have a conversation with independent or political parties about a bill or amendment.
- Educate the workforce on anti-colonialism and anti-oppression.
- Long term: legislation!
- Maintain affordable access to public health education.
- Enable supports and fast-tracking for new arrivals.
- Enshrine public health care as opposed to private health care.

We are committed to taking action to implement anti-colonial practice

- Shift research to research for action not knowledge.
- De-centre researchers from research practice (removing the focus from the researcher to the participant to ensure a more collaborative process).
- Demand an equitable reportioning of the data infrastructure, budget and power.
- Long term: money; safeguards to anti-colonial, anti-oppressive efforts.
- Remove enforcement aspect of Public Health Act.

We are committed to creating health justice in medical practice, health care and public health

- Advance standard of care for racialized populations.
- Institute differential prioritizing for populations more adversely affected by COVID-19.
- Representation of Indigenous, Black and other racialized peoples across all levels of decision-making.
- Long term: enshrine rights of people receiving health care in regard to data privacy.

7

COMMON GROUND 7

Statement

We commit ourselves to community-based participatory public health to create environments that

- empower individual and collective agency,
- appropriately value expertise (with resources) and
- have governance structures for community control

to shift public health practice, policy and decision-making to be accountable, anti-racist and anti-colonial and deconstruct White supremacist structures.

ACTION STEPS

We need governance structures

- Policy regarding nothing about us without us.
- Policy regarding compensation for community members involved in engagement and collaboration.
- Start with collecting examples of good/wise practice.

Draft a call-to-action document to communicate and collaborate

- Identify White supremacist nature of public health.
- Create an ongoing process to hear the stories.
- Create relationships with community leaders.

Create opportunity for individuals who interact with the public health system to give feedback on racism

In 3 years, institutions would report back on their participatory public health actions

Propose that this event happen again in a year to check in on progress

8

COMMON GROUND 8

Statement

In public health, we are members of diverse communities, and we work in solidarity for our collective liberation. We commit to transparency, to stating our values* explicitly as public health practitioners and public health institutions, and to creating concrete accountability mechanisms to align professed values with actual practice, policies, goals and approaches.

*Including anti-racism, anti-White supremacy, relational, solidarity, accountability, transparency, equity, best and wise practices

ACTION STEPS

Organizational level

- Develop toolkit and performance measures for social accountability.
- Evaluate this.

Individual level

- Develop a community of practice.
- Examine organizational statements.
- Incorporate social accountability funds in the Canadian Centre for Policy Alternatives' alternative federal budget for 2022.

Closing

The Future Search workshop closed with remarks from Claire Betker of the NCCDH and Jennifer Gunning from the CIHR-IPPH, and a promise to meet again in September 2022. Participants were encouraged to follow up on action plans in the meantime.

Over the course of these 5 days, participants contributed generously to the work at hand. They were creative, authentic and not afraid to be vulnerable, and they brought unique and diverse perspectives to the table. Voices were heard from different sectors of public health: from students to decision-makers, funders to public health practitioners, data analysts to community organizations. Their varied perspectives created a nuanced picture of the trends in public health in Canada at this moment and, with their clear and bright visions, a hopeful image of the future of public health in Canada.

The overarching objective of this workshop was action planning, and most participants left the session with a clear idea of the work they will have to do in order to bring that future vision to life.

Group Four Poem

What a wonderful day to breathe, a day where humanity precedes White supremacy.

It is May 31st, 2032 – what a wonderful day

I feel safe, open, free to speak without filters, understood in education, academic,
healthcare, and in Canadian society
I look at my room, a PhD certificate hanging on the wall, reminding me that I graduated
from my university without any discriminatory fall
Reminds me of how I walked wearing my saree and bindi on my graduation
Without being gazed as crazy, exotic, or negative narration
Knowledge and the change that we bring to the world that mattered
Without oppression and it's all evil entities unflattered
Reminds me of my decolonized and anti-racist university respecting Blackness,
Indigenousness, and Browness with all its shades
Giving space for Black kids to thrive and succeed on all days
What a wonderful day to breathe
A day where humanity precedes White supremacy!

I walk outside my neighbourhood
I feel a sense of belonging to the broader community, beyond only "my people"
My action is not the representation of my whole community
so many people who look like me, so great to see this state of unity
Not dreading judgment in everything I say
Being able to speak without filters and fear
A search for truth regardless of its harshness
Freedom to speak the truth, power only available in its sparseness
A truth beyond Whiteness and its power
What a wonderful day to breathe
A day where humanity precedes White supremacy!

I go to my office
I see many POC in leadership roles, representing the people they serve
The same goes to organizations and systems around me and the community they oblige
All ways of knowing appreciated
All forms of healing celebrated
No evidence of the "othering"
No one treated less valuable or alternative
White centring has ended
Christmas and Easter off is now over
I don't have to work on days that are important to me and my community,
People can pick their own days such as Dashain, Eid, or Hanukkah
I no longer have to worry about conforming to White beauty standards that influence
if I will or will not be promoted at my job
My hiring and advancement does not depend on how "threatening" I could become
to the status quo of racism
I can be my own amazing self in my own shade of skin
What a wonderful day to breathe
A day where humanity precedes White supremacy!

I go to my doctor
I feel relieved that my skin colour does not determine my deservingness to health care
My accent does not dictate my intelligence or worth to indulge in my wellness repair
I no longer feel the need to advocate for my family and my friends for health care
Power to those who are affected to decide on what they need or do not need
People of colour are no longer murdered in healthcare by White supremacy
Public health is no longer run by nauseating Whitenesss
Power is distributed to people of diverse values, backgrounds, gender etc.
Collaboration and innovation from this mix well received
Truth and Reconciliation Commission calls to action have been achieved
What a wonderful day to breathe
A day where humanity precedes White supremacy!

I think of the world that I now have discovered
Cultural humility, love and compassion for each other
Existence of shared intellectual empathy
Reestablishment of already lost humanity
I am no longer asked where I am "really from"
Which made think as if I am some unwanted "germ"
A changed society
Everyone has easy access to clean water, food and housing, is what I see
No more band aids or quick fixes
Values to long-term, sustainable solutions with all its premises
We are moving toward upstream and preventative solutions
Moving away from prison systems towards rehabilitative justice inclusion
A shift in values to care about future generations
Not just ourselves and our one small communities
The workforce and leadership are reflective of the population
Increased diversity at all levels without tokenism or persuasion
Love for all, and everyone
What a wonderful day to breathe
A day where humanity precedes White supremacy!

Today is the day I breathe with relief
White supremacy takes a back seat
Internalized oppression does not exist
White fragilities confronted, not protected
"White women tears" no longer used as a weaponry
Black men and women do not die of police brutality
I am no longer tone policed for fragile White ears
Performative allyship are called out to tears
White saviorism is critiqued till it disappears
A day where we get to forget what is even White supremacy
A day where White privilege loses its oppressive currency
What a wonderful day to breath
A day where humanity precedes White supremacy!

References

1. Future Search Network. What is Future Search? [Internet]. Wynnewood (PA): Future Search Network; [cited 2023 Jan 27]. [about 2 screens]. Available from: https://futuresearch.net/about/whatis.
2. World Health Organization. Constitution of the World Health Organization [Internet]. Geneva (Switzerland): WHO; [cited 2023 Jan 27]. 18 p. Available from: http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1
3. Lalonde M. A new perspective on the health of Canadians [Internet]. Ottawa (ON): Minister of Supply and Services Canada; 1974 [cited 2023 Jan 27]. Available from: http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf
4. World Health Organization; Health and Welfare Canada; Canadian Public Health Association. Ottawa charter for health promotion [Internet]. Geneva (Switzerland): WHO; 1986 [cited 2023 Jan 27]. 5 p. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion/charter.pdf
5. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Rev. 1991 Jul;43(6):1241–99. doi: 10.2307/1229039.
6. Holman D, Salway S, Bell A, Beach B, Adebajo A, Ali N, et al. Can intersectionality help with understanding and tackling health inequalities? Perspectives of professional stakeholders. Health Res Policy Syst. 2021;19:Article 97 [15 p.]. doi: 10.1186/s12961-021-00742-w.
7. Library and Archives Canada. Royal Commission on Aboriginal Peoples [Internet]. Ottawa (ON): LAC; [modified 2021 Jan 19; cited 2023 Jan 27]. [about 4 screens]. Available from: https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/introduction.aspx
8. Crown-Indigenous Relations and Northern Affairs Canada. Truth and Reconciliation Commission of Canada [Internet]. Ottawa (ON): CIRNAC; [modified 2022 Sep 29; cited 2023 Jan 27]. [about 5 screens]. Available from: https://www.rcaanc-cirnac.gc.ca/eng/1450124405592/1529106060525
9. National Inquiry into Missing and Murdered Indigenous Women and Girls [Internet]. [place unknown]: The National Inquiry; [cited 2023 Jan 27]. Available from: https://www.mmiwg-ffada.ca.
10. Black Lives Matter [Internet]. [place unknown]: BLM; [cited 2023 Jan 27]. Available from: https://blacklivesmatter.com/.
11. Hanlon P, Carlisle S, Hannah M, Reilly D, Lyon A. Making the case for a 'fifth wave' in public health. Public Health. 2011 Jan;125(1):30–6. doi: 10.1016/j.puhe.2010.09.004.
12. Manitoba Health. COVID-19 novel coronavirus: race, ethnicity, Indigeneity (REI) analysis, wave three [Internet]. Winnipeg (MB): Manitoba Health; 2021 Jul 5 [cited 2023 Jan 27]. 25 p. Available from: https://www.gov.mb.ca/health/publichealth/surveillance/docs/rei_analysis_w3.pdf

13. Balkissoon D, Sung H, Hashim M, Maroon A, Balkissoon I, Balkissoon T. The angel complex. Colour code [audio on the Internet]. Toronto (ON): Globe and Mail; 2016 Sep 27 [cited 2023 Jan 27]. Podcast: 29 min. Available from: https://colour-code.simplecast.com/episodes/the-angel-complex-OCHf83xC
14. Raymer E. Ottawa law prof wins award for book on niqab-wearing women in Canada [Internet]. Toronto (ON): Canadian Lawyer; 2021 Nov 2 [cited 2023 Jan 27]. [about 10 screens]. Available from: https://www.canadianlawyermag.com/news/general/ottawa-law-prof-wins-award-for-book-on-niqab-wearing-women-in-canada/361339
15. British Columbia's Office of the Human Rights Commissioner. Disaggregated demographic data collection in British Columbia: the grandmother perspective [Internet]. Vancouver (BC): BCOHRC; 2020 Sep [cited 2023 Jan 27]. 102 p. Available from: https://bchumanrights.ca/wp-content/uploads/BCOHRC_Sept2020_Disaggregated-Data-Report_FINAL.pdf
16. Wabano Centre for Aboriginal Health; Ottawa Aboriginal Coalition. Indigenous-specific racism & discrimination in health care across the Champlain Region: full report [Internet]. Ottawa (ON): Wabano Centre; 2022 [cited 2023 Jan 27]. 111 p. Available from: https://wabano.com/wp-content/uploads/2022/05/ShareYourStory-FullReport-EN.pdf
17. Government of British Columbia. Declaration on the Rights of Indigenous Peoples Act action plan: 2022-2027 [Internet]. Victoria (BC): Ministry of Indigenous Relations and Reconciliation; 2022 [cited 2023 Jan 27]. 32 p. Available from: https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/indigenous-relations-reconciliation/declaration_act_action_plan.pdf
18. United Nations Declaration on the Rights of Indigenous Peoples Act, SC 2021, c 14. Available from: https://laws-lois.justice.gc.ca/eng/acts/U-2.2/index.html
19. Government of British Columbia. Anti-Racism Data Act: about the legislation [Internet]. Victoria (BC): govTogetherBC; [cited 2023 Jan 27]. [about 2 screens]. Available from: https://engage.gov.bc.ca/antiracism/data-act.
20. Crawford A. Dene and Western medicine meet in image-based storytelling. CMAJ. 2018 Sep 10;190(36):E1085–6. doi: 10.1503/cmaj.180384.

National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH
St. Francis Xavier University
Antigonish, NS B2G 2W5
tel: (902) 867-5406
nccdh@stfx.ca
www.nccdh.ca

CANADIAN INSTITUTES OF HEALTH RESEARCH
160 Elgin Street
9th Floor Ottawa ON K1A 0W9
tel: (613) 941-2672
info@cihr-irsc.gc.ca
www.cihr-irsc.gc.ca