Health Reform Observer -
Observatoire des Réformes de Santé

Volume 11 | Issue 1 | Article 6

The Restoration House COVID-19 Vaccination Clinic: Challenging Systemic Racism and Ableism through Community Solidarity and Action

Ameil Joseph, *McMaster University, Hamilton, Ontario, Canada*
Terri Bedminster, *Refuge Newcomer Health, Hamilton, Ontario, Canada*
Kojo Damptey, *Hamilton Centre for Civic Inclusion, Hamilton, Ontario, Canada*
Sarah Jama, *Disability Justice Network of Ontario, Hamilton, Ontario, Canada*
Gessie Stearns, *McMaster University, Hamilton, Ontario, Canada*
Madison Brockbank, *McMaster University, Hamilton, Ontario, Canada*

2 October 2023

Special Issue: COVID-19 Pandemic Policies and Systems Reforms

Guest Editors
Cheryl A. Camillo, *University of Regina*
Peter Berman, *University of British Columbia*
Sara Allin, *University of Toronto*

Recommended Citation: Joseph A, Bedminster T, Damptey K, Jama S, Stearns G, Brockbank M. 2023. The Restoration House COVID-19 Vaccination Clinic: Challenging Systemic Racism and Ableism through Community Solidarity and Action. *Health Reform Observer - Observatoire des Réformes de Santé* 11 (1): Article 6. https://doi.org/10.13162/hro-ors.v11i1.5435.

Abstract

This paper reviews the advocacy efforts, community organizing, establishment, operation, and lessons learned from a project in Hamilton, Ontario to build the first-ever COVID-19 clinic for Black and other racialized people, people with disabilities, and those experiencing barriers to access COVID-19 vaccinations. Community advocates, academics, and health leaders who are from and serve Black and other racialized and marginalized groups in Hamilton responded to the overwhelming impacts of COVID-19 on marginalized Black and other racialized groups in Hamilton through relational solidarities that allowed for community members to lead the advocacy, design, and operation of a clinic to serve those most in need with the knowledge and expertise most capable of such an intervention. Amidst resistance of municipal and provincial officials to act for healthy equity, racist backlash, and problematic organizational and institutional responses to the needs of Black and other racialized community leaders, Restoration House clinic advocates and community leaders responded to the demand by maintaining focus on community through collective solidarities. The Restoration House example offers several contributions to how we think about community and public health advocacy, organizing, and operational interventions through crises and beyond.

Cet article passe en revue la campagne de revendication, les efforts d'organisation communautaire, la mise en place, le fonctionnement et les leçons tirées d'un projet mené à Hamilton, en Ontario, et visant à établir la toute première clinique COVID-19 pour les personnes Noires et racialisées, les personnes handicapées et celles qui rencontrent des obstacles à l'accès aux vaccinations COVID-19. Les défenseurs de la communauté, les universitaires et les dirigeants du secteur de la santé issus et au service des personnes Noires, racialisées ou marginalisées de Hamilton voulaient trouver une réponse adéquate aux effets disproportionnés de la COVID-19 sur les personnes Noires, racialisées ou marginalisées de Hamilton en utilisant les solidarités relationnelles qui ont permis aux membres de la communauté de diriger la revendication, la conception et les activités d'une clinique pour servir les personnes qui en ont le plus besoin avec les connaissances et l'expertise les plus à même de mener une telle intervention. Dans un contexte d'hésitation des autorités municipales et provinciales à agir résolument pour l'équité en santé, de réactions racistes et de réponses organisationnelles et institutionnelles défaillantes aux besoins des leaders de la communauté Noire et d'autres communautés racialisées, les défenseurs de la clinique Restoration House *et les dirigeants communautaires ont répondu à la demande en maintenant l'accent sur la communauté par le biais de solidarités collectives. L'exemple de la* Restoration House *apporte plusieurs contributions à notre réflexion sur la défense des intérêts de la communauté et de la santé publique, l'organisation et les interventions opérationnelles en cas de crise et au-delà.*

Key Messages

- Recent literature has failed to address systemic racism through the COVID-19 pandemic and the ways that local community and grassroots advocacy efforts have developed impactful solidarities to challenge systems of marginalization and exclusion. These stories are important for understanding how transformative change can occur.
- When inequities are not prioritized in responses to crises and health care needs, they are left intact and serve to perpetuate historical and contemporary systems of ongoing exclusion and harm. The identification of inequities is not the same as a response to them.
- The Restoration House project also reveals some examples of the possibilities that exist for solidarities to emerge and to effect change in community work.
- By analyzing literature that documents the negative impacts of structural and relational injustices for marginalized Black and other racialized groups in health care responses such as the COVID-19 pandemic, there are opportunities to develop a deeper appreciation of advocates and community leaders who work across community systems and organizations, thereby building new forms of solidarity for transformational interventions that impact the lives of Black and other racialized groups for the better.

Messages-clés

- *La littérature récente n'a pas abordé le racisme systémique à l'œuvre pendant la pandémie de COVID-19 ni la façon dont les communautés locales et les campagnes de revendication populaires ont développé des solidarités efficaces pour remettre en question les systèmes de marginalisation et d'exclusion. Ces histoires sont importantes pour comprendre comment produire un changement transformateur.*
- *Lorsque les inégalités ne sont pas considérées comme prioritaires dans les réponses aux crises et aux besoins en matière de soins de santé, elles sont laissées intactes et servent à perpétuer les systèmes historiques et contemporains d'exclusion et de préjudice. L'identification des inégalités n'est pas la même chose que la réponse qui leur est apportée.*

- *Le projet de la* Restoration House *démontre également quelques exemples de possibilités d'émergence de solidarités et de changement dans le travail communautaire.*
- *En analysant la littérature sur les conséquences négatives des injustices structurelles et relationnelles pour les personnes Noires, racialisées ou marginalisées dans les pratiques de soins de santé durant la pandémie de COVID-19, il est possible de mieux comprendre le rôle des défenseurs de la communauté et des dirigeants communautaires qui travaillent dans les divers systèmes et organisations, construisant ainsi de nouvelles formes de solidarité pour des interventions transformationnelles qui ont un impact positif sur la vie des personnes Noires et des autres groupes racialisés.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Public health and community health literature analyzing the COVID-19 pandemic has paid inadequate attention to local advocacy efforts, community organizing, and other initiatives that address systemic inequities. This paper focuses on the successes of a project in Hamilton, Ontario, Canada, which built the first-ever COVID-19 clinic for Black and other racialized people, people with disabilities, and those experiencing barriers to access COVID-19 vaccinations, with a focus on these collective organizing and advocacy efforts.

The methods by which community advocacy knowledge is shared with respect to systemic racism in health care, public health, and specifically in relation to the COVID-19 pandemic must include interventions that ensure this knowledge is documented to appreciate that grassroots efforts often go unrecognized. Recent literature on issues of racism, vaccine data, infection, and vaccine "hesitancy"[1] rates in the Canadian COVID-19 context from 2019 onward present data analyses that tend to analyze vaccination, infection, and inequity in geographical terms by, for example, "neighbourhood diversity" and "ethnic concentration" of "marginality" (Social Planning and Research Council [SPRC] 2020; Public Health Ontario 2020a, 2020b, 2022; Etowa et al. 2021; Allen 2021; Iveniuk and Leon 2021; Iveniuk and McKenzie 2021; McKenzie 2021). While significantly more evident in organizational and governmental reports and bulletins, these works rarely define or employ the term "racism," appearing to instead favour the often-undefined terms "inequity" or "discrimination" (SPRC 2020; Public Health Ontario 2020a, 2020b, 2022; Iveniuk and Leon 2021; Iveniuk and McKenzie 2021). Conversely, articles that appear to define and discuss race, racism, and histories of health-based discrimination in relation to COVID-19 are rarely accompanied by comprehensive data information to illustrate arguments (Wane 2020; Dryden and Nnorom 2021; Hyndman 2021; Lei and Guo 2021; Machado and Goldenberg 2021). In the absence of race-based data, many of these articles tend toward analysis aimed at exposing the likelihood of racism within the Canadian COVID-19 landscape. Valuable sources examining racism and data collection were most often accessible through local and national news sources and largely excluded from academic literature examining the subject. Local sources made this information more accessible, relevant, specific, and readily situated for discussion and debate in real-time, particularly in exploring concerns related to issues of racism, vaccine data, infection, and vaccine hesitancy rates in the Canadian COVID-19 context (Hristova 2020a, 2020b; Kurek 2020; Frketich 2021; Ghebreslassie 2021; Moro 2021a, 2021b).

Overall, much of the literature addressing racism in COVID-19 infection and vaccine data from Canada relate to low-wage, racialized, or migrant workers, and migrant popula-

[1] We use quotation marks for the purposes of examining discourses attached to the construction of vaccine hesitancy that are specifically presented in an exclusively white, colonial context that frames it as a result of individual choice, ignorance, resistance, preference, etc., rather than a response to historical racism and violence in healthcare that violated the autonomy, agency, dignity, and safety of marginalized persons.

tions and immigration status (SPRC 2020; Côté et al. 2021; Machado and Goldenberg 2021; Berardi et al. 2022; Fabreau et al. 2022; Lee et al. 2022; Lin 2022). What is often missing in these conversations are the ways that local community grassroots advocacy efforts have developed impactful solidarities to challenge systems of marginalization and exclusion. Authors of this paper, some of whom are local health leaders, members of community organizations, and community members committed to transformative change in Hamilton were directly impacted by and involved in the organizing and advocacy efforts presented here. All these stories, in Hamilton and beyond, are important to understanding how transformative change can occur. Careful consideration has been intentionally brought to the fore via advocacy efforts to draw attention to the historical context of racism in healthcare in Canada (Dryden and Nnorom 2021; Nestel 2012; Lei and Guo 2022; Mahabir et al. 2021).

2 HISTORY AND CONTEXT

2.1 Racism in Canada and Hamilton

In recent years, the exacerbation and horror of bigotry and hatred has increased exponentially. We have seen images of hate groups organizing, hate incidents, and incidents of racism in health systems continuing at frightening rates (Das 2021; Lupton 2022; Nerestant 2021; Mahabir et al. 2021). A Statistics Canada report shows that Hamilton has developed a reputation for having the highest levels of police reported hate crimes in Canada for several years, which is continuously supported by emerging data demonstrating the ways in which hate crime rates are extremely high in Canada in comparison to other Canadian cities (Deuling 2019; Moro 2018; Moreau 2021). Much of the reported violence is talked about as racism at an individual level, resulting from personal prejudice, bigotry, or hatred; however, recent attention to systemic racism – both broadly and specifically in the health care context – has helped many Canadians appreciate the unprecedented scope and impact of specific anti-Black, anti-Indigenous, anti-Muslim, anti-Asian, and anti-Semitic forms of racism (Dryden and Nnorom, 2021; Paradies 2016; Williams et al. 2022; Smart 2021).[2]

There is an appreciation in academic and mainstream news sources that racism in Canadian health care is a pervasive issue that is also present in Hamilton, Ontario institutions and practice of health services (Nestel 2012; Wells 2020; Moro 2020; Rankin 2021). It is a topic that has emerged into public media and government (Goldman 2016; Bernard 2018; Timothy 2018; Blake 2018). Mahabir et al. have shown "that racialized health inequities are the result of racism at different levels: interpersonal or structural, intentional or unintentional, and perceived or not perceived" (2021, 9). For instance, a recent study has shown that First Nations patients in Alberta emergency rooms are less likely to be assessed

[2]We refrain from using terms like Islamophobia, Sinophobia, and xenophobia as they direct our attention to the intentions of individuals (i.e., personal bigotry and bias), rather than structural institutions that shape ideas, and are supported by policy, history, and systems. The individualized terms also imply a psychological illness or pathology rather than encouraging us to engage in solidarity around issues of complicity.

as urgent (McLane et al. 2022).

Canada has unique histories of race, racism, racialization, and colonialism that are often unacknowledged in the dominant historical, social, and political contexts of racism in health care. The contexts of racism in Canada include residential schools, reserve systems, the claiming of Indigenous lands within colonial contexts; how Canada's Indian Act inspired South African politicians to come to Canada in the 1940s to learn from our racism, and how to use status cards and the reserve system to uphold and broaden Apartheid; the Chinese Head Tax, the internment of Japanese Canadians, the medical inadmissibility of disabled people, the rejecting of South Asian and Jewish migrants, chattel slavery in Canada, and the erasure of Black settlements are a few historical examples that frame the contemporary realities of injustice and inequity across systems, programs, and services in Canada (Joseph 2015, 2017; Popplewell 2010).

While the legacies of racist ideas are underacknowledged, it is vital to engage the confluence of ways that racist ideas have become divorced from their original projects of colonialism, conquest, and human hierarchy, yet continue to operate in insidious ways that generate inequities in our contemporary age; the necessity of this engagement is often understated. To challenge the impact of structural racism, it must be confronted, as it operates within professions, disciplines, practices, policies, and law. For transformative action to occur, resistance to racial ideas about human capacities, capabilities, threat, burden, need, and risk require critical and informed approaches that engage these complexities via the consideration of the multiplicities of lived experiences of racism. This nuance offers more space for considering accountability, to identify complicities and counternarratives that suggest resiliency is somehow an adequate response to racist systems (Logan et al. 2021; Rumala and Beard 2022; Gullett et al. 2022).

Racism in Hamilton, Ontario, Canada is a widespread concern. Since at least 2018, where it was clearly documented, Hamilton has ranked in the top three in terms of per-capita police reported hate crime from several years; there have been significant hate-based atrocities, including arson attacks on Hindu and Muslim places of worship, racist symbols found on synagogues, and ongoing issues with racial profiling in policing (Bennett, 2015; Taekema, 2016; Beatty, 2016; O'Reilly, 2017).

The historical contexts of racism in Hamilton also emerge from very particular historical trajectories. The Ku Klux Klan was well established in the Hamilton area by the 1930s (Johnson 2019). The histories of Black settlements and slave trading in Hamilton are often omitted in the telling of histories (Carter 2018; Shadd 2010). Hamilton streets and institutions are named after figures like Samuel Hatt and Indigenous leader Joseph Brant who bought and sold Black slaves in Hamilton (Drew 1856). These contexts shape how racism is lived and experienced in Hamilton, the ways it pervades daily life, and is built into our environment, permeating our systems and services, programs, and disciplines. Describing inequities in terms of difference alone can serve to exacerbate ideas of racial difference, human hierarchy, and forms of violence. It can also undermine efforts for racial justice that seek to provide analyses to challenge technologies of difference-making without

clearly articulating the rationale for interventions that support racialized groups.

The current efforts discussed here also learn from, and carry with them, the legacies of advocacy work to draw attention to the social, historical, and political contexts and impacts of systemic racism in health care in Hamilton, in Canada, and beyond. Elias et al. (2021) have called for attention to racism and xenophobia through the COVID-19 pandemic to be contextualized within a broader analyses that appreciate "that an environment of populism, resurgent exclusionary ethno-nationalism, and retreating internationalism has been a key contributor to the flare-up in racism during the COVID-19 pandemic" (784) and "links between racism, nationalism and capitalism" (783).

As Tuyisenge and Goldberg (2021) posit, "unpacking the role of structural racism (the macro-level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities faced by racialised communities) remains crucial for understanding the effects of COVID-19 and pandemic responses among migrants in high-income countries" (650-651). Mensah and Williams (2022) recommend novel approaches to "race-specific" data collection and use to confront the disproportionate ways COVID-19 impacts Black people (123). Additionally, Guo and Guo (2021) have advocated for reforms that include anti-racist education to challenge anti-Asian racism and xenophobia in Canada post-COVID-19. The historical and more contemporary attentions to advocacy and reform to respond to systemic racism in healthcare in Canada continue in this project.

2.2 Thinking beyond superficial ideas on data collection and representation

During the COVID-19 pandemic, there were several reports highlighting racial disproportionalities in relation to COVID-19 infections rates, often without embedded analysis that surface problematic racist histories of blame, portrayals of types of people as threat or burden, and infused with racist ideas of hereditary, cultural, or aptitudinal lack (Hristova 2020b; Kurek 2020; Bellrichard 2020; Ghebreslassie 2021). In October 2020, it was reported that close to 50% of COVID-19 infections in Hamilton were among the racialized population (Hristova 2020b; Hamilton Board of Health 2020). COVID-19 outbreaks in long-term care settings and congregate settings in Hamilton and Ontario at large also highlighted the need to address the ongoing issues with systemic ableism that disproportionately leave disabled people more at risk (Casey 2021). A Statistics Canada report confirms that in 2020 "the COVID-19 mortality rate was significantly higher for racialized populations (31 deaths per 100,000 population) compared to the non-racialized and non-Indigenous population (22 deaths per 100,000 population)," and further, that "Black people had the highest age-standardized COVID-19 mortality rate (49 deaths per 100,000 population), followed by South Asians (31 deaths per 100,000 population), and Chinese (22 deaths per 100,000 population)" (Gupta and Aitken 2022). During the pandemic, and in response to emerging reports, there were calls for more race-based and sociodemographic data collection to get a better sense of the disparities, and for systemic changes to governance systems, account-

ability measures, and the implementation of structures to ensure that data related to race captured racism in ways that informed decision making rather than merely highlighting disparities (Hristova 2020a, 2020c).

Many have written about the problematics of relying on the collection of data on race to convey action where old social relations, inequities, and injustices are not only maintained but, in fact, solidified (Joseph 2020; James, 2020; Walcott, 2020; REDE4BlackLives 2020). As Rinaldo Walcott has articulated,

> There are indeed some truths about calls for race-based data, but there are many half-truths too. Evidence is important and few would dismiss evidence as unnecessary, however race-based data can quite frankly slow down reform. In that context, "doing the research," when a problem is already identified and its solutions known, means that the collection of race-based data does not actually add much to policy making. In fact, in some cases, it can do more harm than good. Race-based data collection, as currently articulated, is a response to a set of political concerns masquerading as if it is the answer (2020, 1).

Llana James has added that

> Personal information, including health data, must be protected whether it is identifiable, de-identified or anonymized. Laws, regulation, policies, and substantive enforceable penalties are the minimum pre-conditions that must be in place before more race-based data is collected and circulated (2020, para. 20).

Ameil Joseph additionally suggests that

> Demands for equity data are always at risk of being reduced to statistics connected to ideas about impartiality or objectivity about race, which undermine our appreciations of race, racism and racialization as socially, historically, and politically constituted. There is also the risk of limiting the understanding of lived experience as mere points of data, perpetuating the risks of being used for quotas or tokenism or to advance racist scientific ideas that falsely equate race with genetic variation (2020, para. 15).

This knowledge shaped local efforts in Hamilton to develop accountable, responsive, and engaged approaches to data collection, analysis and action regarding issues of systemic racism in health care.

3 IMPLEMENTATION AND EVALUATION

3.1 Local advocacy in Hamilton for racial justice in health care

In May 2020, a group of Hamilton-based medical doctors, professors, and community leaders, including some of the authors herein, with experience and interest in equity work

collaboratively wrote, as a group of experts and shareholders in health equity, a letter directly to Hamilton Public Health. They recommended that any collection and analysis of race-based data, including the processes and methods of collection, be developed collaboratively with local leaders and experts who live and do anti-racism work, research, and analysis. They also recommended establishing a community advisory committee to support a responsive, engaged, inclusive, and accountable approach that would improve the quality of analysis and its impact on care in Hamilton. The explanation for these suggestions, including the histories of collecting data on inequities without it resulting in a change to resource distributions, programming, or services was shared with Hamilton Public Health (Hristova 2020c).

The group that wrote the letter expanded in membership, had hours-long meetings with Hamilton Public Health, and developed terms of reference for the proposed advisory group, and successfully sought seed funds to support their work from the McMaster Institute for Health Equity, volunteering their time to do so. The collective made it clear that there is a clear need for Black and racialized people to be involved in how they are identified, how they are described and analyzed, to allow for transparent data collection and analysis. The collective also articulated to Hamilton Public Health that community feedback, insight, and analysis need to be empowered by people in positions of power and authority to effect change. They raised concern about the categories being used to identify people, and issues of data ownership, access, control, and possession. Hamilton Public Health did not respond (Hristova 2020c; Clarke 2020).

In December 2020, local advocates and leaders organized an event to explore how they might resist the mechanisms and relations that would wield data about race without analyses that highlight what needed to be done about racism (Joseph et al. 2020). In that same month, the Hamilton Vaccine Readiness Network began convening a committee of health and community leaders who worked with Hamilton Public Health to discuss priorities for vaccination. Many community leaders took the opportunity to ask how Hamilton Public Health was addressing the disproportionate rates of infection among racialized groups in Hamilton, suggesting a more nuanced approach to data collection that considered the impacts and experiences of marginalized populations, the need for dedicated outreach, and to prioritize these highly impacted groups for vaccination. Actions to prioritize disproportionately impacted groups were not taken.

Community leaders took action. An open letter was written to the network and to Hamilton Public Health outlining the urgent need to address these disparities with concrete actions. When an adequate response was not seen, they made the letter public, and over 500 Hamiltonians signed their support. The letter highlighted that many had been calling for action since December 2020; it was then April 2021 and nothing had changed. The open letter received widespread media attention, and a growing group of Black and other racialized community members, leaders, and organizations that serve marginalized populations rallied in solidarity to take on the work establishing clinics and services that prioritize those being hit the hardest by COVID-19 (Hristova 2021; Frketich 2021).

3.2 The Restoration House clinic

Black and racialized health leaders, community organizations, and community members began developing plans to address these needs, and Hamilton Public Health agreed to include them in this prioritization. Hamilton Urban Core Community Health Centre, Refuge Newcomer Health, Compass Community Health, Centre de santé communautaire Hamilton Niagara, the Hamilton Centre for Civic Inclusion, and the Disability Justice Network of Ontario agreed to take on the outreach, bookings, and clinic operations for what became the Restoration House clinic (Hamilton vaccination 2021; Rodriguez 2021). De dwa da dehs nye>s Aboriginal Health Centre, the Hamilton Regional Indian Centre and Niwasa set up a clinic for Indigenous people at the Perkins Centre. The Restoration House clinic was established in Hamilton's downtown core, which was accessible and located in a COVID-19 hotspot. When the clinic prioritizing Black and other racialized people for vaccination was announced, torrents of racist and hateful messages were circulated on social media, and the clinic's initiative itself was derided on extremist and white supremacist websites (Moro 2021).

A group of Black and racialized health and community leaders took the call for structural change further by recommending modifications to the composition of the Hamilton Board of Health – they wanted to see its membership comprised of more than city councillors and to have built-in perspectives from community and health leaders, including and especially those who work with Hamilton's most marginalized populations (Rankin 2021).

In the early days of the clinic, patients could schedule appointments through the City of Hamilton online booking system and via telephone. At the same time, the community agencies were doing manual outreach and bookings. Thousands of people registered through the community organizations leading the work, providing a strong argument for a community-based registration process. The collective suggested to Public Health that community-based booking and outreach needed more support. Individual community organizations and community health centres advocated to Public Health for a central booking system and ways to collect data that allowed for them to better understand their work and its impacts. People attempting to register via the City of Hamilton's booking systems reported that their requests for prioritized appointments were met with disrespectful responses.

In May 2021, the prioritization initiative was transferred to primary care (the provincial health care system), and the Restoration House clinic received more support for community-based outreach and bookings. Refuge Newcomer Health led the coordination and management of the community-based clinic. After tireless advocacy through numerous meetings, the City of Hamilton began to rely on the community-led booking system. Community vaccination appointments were scheduled with care to distribute the work and spaces available across community health clinics and centres.

While community leaders, health centres and organizations took on this work, they initially did so without financial recognition or support. As a result of more advocacy,

funding was made available to participating service providers several weeks after the initial approval of the clinic to cover its costs. Funds were made available for community clinics and leaders to apply for the financial resources needed to cover the costs of their labour, programming, and services. Many applications were not fully funded, leaving much of the work without recognition of its significance, or financially supported in a way that acknowledged that work was done. Community leadership advocated for equitable pay for nurses working in the clinic, and action was taken by community leaders running the clinic to ensure fair pay was in practice throughout its operation.

The initiative was managed by Refuge Newcomer Health and partnered with community health centres, community leaders, and organizations who developed plans for mobile clinics at numerous locations across Hamilton, including walk-ins made available at the Barton Street branch of the Hamilton Public Library; disseminated information through in-person and online outreach via social media and in numerous languages; held specialized clinics for people with disabilities; and made it clear to all users that provincial health cards were not necessary. Through this immense hands-on effort, thousands of people in Hamilton have been and are receiving vaccinations. The Restoration House clinic has received emails and messages from individuals and families that shared their gratitude and stories about having such a great experience that they encouraged their family and extended family to also go to the clinic.

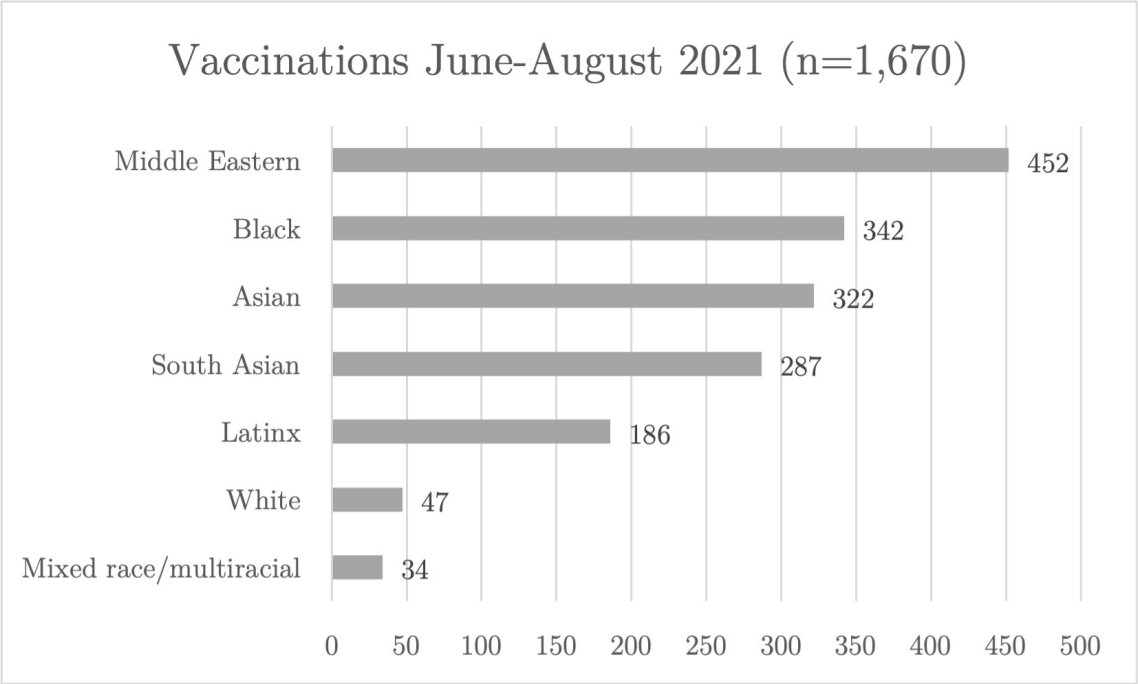
3.3 Impacts: Continued advocacy to focus on need

The solidarities and relationships that began through collectivity and resistance merged through advocacy and stayed focused on need. Community leaders involved in running the Restoration House clinic and outreach clinics made concerted efforts to assess ongoing community needs to develop several specialized clinics adapted to target hard-to-reach population groups disproportionately impacted by COVID-19 in Hamilton within Black and racialized populations. In particular, clinics were established to reach pregnant women, disabled people, newcomers, and people in congregate settings, group homes, local faith-based organizations, and at public parks. Community leaders at the Hamilton Centre for Civic Inclusion, the Disability Justice Network of Ontario, and community health centres did proactive outreach by personally visiting hard-to-reach communities via door-knocking campaigns, communicating with service users at their respective organizations, and through social media. This work was identified as both necessary and important to address long-standing and warranted issues of mistrust with health systems and services for racialized and disabled people.

Between April and November 2021, more than 5,940 vaccinations prioritizing Black, racialized, and disabled people reached through advocacy and community solidarity were given. Where race was identified (Table 1), the clinic provided vaccinations to persons who identified as Black (342), Middle Eastern (452), South Asian (287), Asian (322), Latinx

(186), White (47), and mixed race/multiracial (34)[3] between June and August 2021.

Table 1: Vaccinations where race was self-identified, June-August 2021

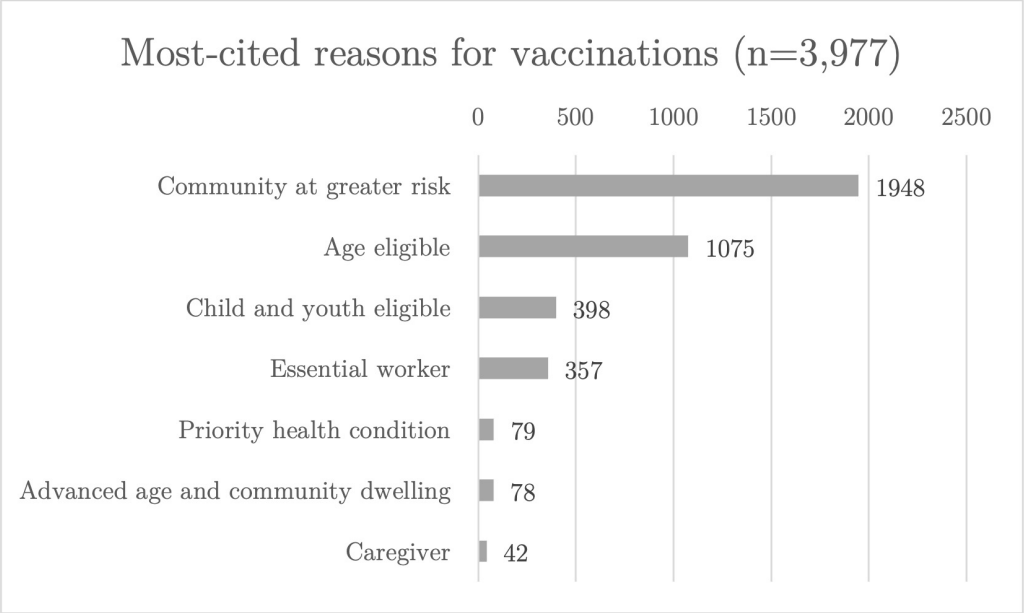


Across data collected between April and November 2021, the most-cited reason for accessing the clinic was self-identification within a community deemed at greater risk for contracting COVID-19 (Table 2). Age-eligible populations were also well represented in the data, including age-eligible individuals (based on provincial roll-out prioritization and vaccine eligibility, such as those 65+, then those 50+, children and youth (those aged 12-17 until vaccines were deemed safe for those under 12, then including those 12 and under).

Postal codes beginning with L8R, L8L, L8M, and L9C were identified as COVID-19 hotspots due to high infection rates. Postal code data is relevant for this study as neighbourhoods identified as COVID-19 hotspots are highly populated and tend to have significant representation of low-income racialized residents (See Appendix 1). Postal code data indicated that the clinic was able to reach residents across Hamilton while connecting specifically to COVID-19.

[3]It is important to note that within these self-identifications, many service users often clarified this marker further by naming specific regions, languages, and nationalities (e.g., Iranian or Farsi). The data demonstrated a wide range of self-identifiers across racial identifications.

Table 2: Most-cited reasons for vaccinations distributed, April and November 2021



4 CONCLUSION

4.1 Challenging systemic racism and ableism through community solidarity and action

To achieve health equity, the stories of advocacy, solidarity building, organizing, and mobilization of community members and leaders who belong to racialized and disabled populations need to be told and documented. The example of the Restoration House clinic offers ways to think about health equity work that respectfully engages with the complex realities of the struggle for justice. While data collection is part of the story, thinking beyond the collection itself to the ethics and relations of health knowledge, who the data is collected about, how is it collected, for whom is it collected, how is it made impactful, how it is protected, and how we ensure accountability to the knowledge generated are all important considerations in health equity work. Respecting the need for impacted and affected community members and leaders to be directly involved, listened to, and supported for their knowledge must go beyond ways of thinking about representation in terms of proportionalities. It is crucial that there is space for community members to critique, review, and evaluate who gets to speak, and who is heard, what gets to be said, and how voices are able to effect change.

When inequities in the responses to crises and health care needs are not prioritized, we leave them intact and are thus complicit with both historical and contemporary systems

of ongoing exclusion and harm: the mere identification of inequities is not the same as a response to them. Struggles to address them through the prioritizing of communities and populations that can and should be recognized is a kind of labour that comes with a greater risk of dismissal, omission, erasure, and in some cases, direct hateful attack. These experiences reproduce the historical harms of knowledge erasure that in turn reproduce the harmful phenomenon of requiring marginalized community members and leaders to reprove the existence of inequities, demand action, experience denial, all while having to endure the violence of these encounters. These processes, contexts, and analytical linkages must be considered as a confluence to achieve better outcomes.

This work has generated key lessons that, when synthesized, may be invaluable for others who might take on similar initiatives. The acknowledgment, respect for, and response to community leaders and members from racialized groups who have and continue to work with those disproportionately impacted by systemic racism must not be allowed to be omitted or approached as an afterthought in work that is about what and who they have direct, nuanced, and lived experience. Further, stories of challenging systemic racism within advocacy and reform efforts (like the one outlined in this paper) must be shared, as they may help to reveal what did not work well. To establish a vaccine readiness network that homogenizes attention to health equities, especially when it leaves the work of attending to communities most affected by systemic racism and disproportionate harms to the racialized groups most impacted, (while simultaneously having affected advocates do the work) amidst exploitative conditions, relies upon the relations and conditions of systemic racism that so many of these matters of inequity advance from. Additionally, the ways we attend to matters of racism and data collection cannot begin from the presumption that issues of appropriation, erasure, and omission have been confronted and challenged. Data collection must acknowledge the process of engagement with those most impacted by it as a form of knowledge in and of itself.

The Restoration House clinic also shows that possibilities exist for solidarities to emerge and effect change in community work. While the disproportionate impact of COVID-19 on Black, racialized, low-income, and disabled people was eventually recognized as a priority, this appreciation must go beyond single, project-based interventions. Listening must include careful attention to the social, historical, and contemporary contexts of systemic inequity in order to be able to think, communicate broadly, educate, and inform others beyond analyses that can be taken up or reduced to reproductions of oversimplified ideas of human hierarchy, deservedness, separation (that rationalize inequities), or sameness (that ignore inequities). When we begin by respecting the contexts of exclusion, we can undermine the confluence of historical forces that shape these encounters and truncate the impacts of challenges to them. By respecting complexity, we can value the complex knowledge that comes from lived experience. By listening to analyses that speak to the negative impacts of structural and relational injustice, there might be more opportunities to cast our gaze in the direction of those who work across systems, building new forms of solidarity for transformational interventions that impact lives for the better.

5 REFERENCES

Allen UD. 2021. Reducing the impact of COVID-19 on Black communities in Canada: building confidence and decreasing vaccine hesitancy. RSC COVID-19 series publication 83. *The Royal Society of Canada.* https://rsc-src.ca/en/voices/reducing-impact-covid-19-black-communities-in-canada-building-confidence-and-decreasing.

Beatty D. 2016. Arson at Hamilton mosque was planned as a hate crime say police. *CBC News.* https://www.cbc.ca/news/canada/hamilton/arson-at-hamilton-mosque-was-planned-as-a-hate-crime-say-police-1.3772262.

Bellrichard C. 2020. Investigation finds widespread racism and discrimination against Indigenous peoples in BC health-care system. *CBC News.* https://www.cbc.ca/news/indigenous/bc-health-care-racism-report-1.5820306.

Bennett K. 2015. Carding in Hamilton: 5 things we learned. *CBC News.* https://www.cbc.ca/news/canada/hamilton/headlines/carding-in-hamilton-5-things-we-learned-1.3166501.

Bernard WT. 2018. Racism is a health crisis: Senator Bernard. *Senate of Canada, Parl 42-1.* https://sencanada.ca/en/sencaplus/opinion/racism-is-a-health-crisis-senator-bernard/.

Berardi C, Lee ES, Wechtler H, Paolucci F. 2022. A vicious cycle of health (in)equity: migrant inclusion in light of COVID-19. *Health Policy and Technology,* 11(2). https://doi.org/10.1016/j.hlpt.2022.100606.

Blake E. 2018. People 'dying unnecessarily' because of racial bias in Canada's health care system, researcher says. *CBC News.* https://www.cbc.ca/news/canada/north/health-care-racial-bias-north-1.4731483.

Brownell C. 2018. Canada's 10 worst cities for hate crime. *Maclean's.* https://macleans.ca/news/canada/top-10-cities-for-hate-crime/.

Carter A. 2018. The untold story of how Hamilton's black community was built. *CBC News.* https://www.cbc.ca/news/canada/hamilton/black-history-1.4543788.

Casey L. 2021. Covid-19 outbreaks declared in 40 Ontario long-term care homes in span of one day. *CTV News.* https://toronto.ctvnews.ca/covid-19-outbreaks-declared-in-40-ontario-long-term-care-homes-in-span-of-one-day-1.5724541.

Clarke K. 2020. Hamilton will start tracking race-based data as group calls for formation of Advisory Committee. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/05/25/hamilton-will-start-tracking-race-based-data-as-group-calls-for-formation-of-advisory-committee.html.

Côté D, Durant S, MacEachen E, Majowicz S, Meyer S, Huynh AT, Laberge M, Dubé J. 2021. A rapid scoping review of COVID-19 and vulnerable workers: intersecting occupational and public health issues. *American Journal of Industrial Medicine* 64(7): 551-566. https://doi.org/10.1002/ajim.23256.

Das A. 2021. Hate crimes "sharply increased" during the COVID-19 pandemic in Canada. *Urban Alliance.* https://www.urbanalliance.ca/hate_crimes_sharply_increased.

Deuling M. 2019. Hamilton has the highest rate of hate crimes in Canada: report. *CBC News*. https://www.cbc.ca/news/canada/hamilton/hate-crime-statistics-canada-hamilton-1.5221663.

Drew B. 1856. *A north-side view of slavery: the refugee: or, the narratives of fugitive slaves in Canada.* Cleveland: JP Jewett and Company.

Dryden O, Nnorom O. 2021. Time to dismantle systemic anti-Black racism in medicine in Canada. *CMAJ* 193(2), E55-E57. https://doi.org/10.1503/cmaj.201579.

Elias A, Ben J, Mansouri F, Paradies Y. 2021. Racism and nationalism during and beyond the COVID-19 pandemic. *Ethnic and Racial Studies* 44(5): 783-793. https://psycnet.apa.org/doi/10.1080/01419870.2020.1851382.

Etowa J, Hyman I, Dabone C, Mbagwu I, Ghose B, Sano Y, Osman M, Mohamoud H. 2021. Strengthening the collection and use of disaggregated data to understand and monitor the risk and burden of COVID-19 among racialized populations. *Canadian Studies in Population* 48(2): 201-216. https://doi.org/10.1007/s42650-021-00050-2.

Fabreau GE, Holdbrook L, Peters CE, Ronksley PE, Attaran A, McBrien K, Pottie K. 2022. Vaccines alone will not prevent COVID-19 outbreaks among migrant workers–the example of meat processing plants. *Clinical Microbiology and Infection* 28(6): 773–778. https://doi.org/10.1016/j.cmi.2022.02.004.

Frketich J. 2021. 'Nothing happened': Vaccines took too long to get to Hamilton's racialized communities. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2021/04/26/hamilton-covid-vaccines-latest-news.html.

Ghebreslassie M. 2021. Canada's South Asian community facing a higher risk of COVID-19. *CBC News.* https://www.cbc.ca/player/play/1820137539990.

Goldman B. 2016. 'It's the hardest conversation we can have': confronting racism in health care. *White Coat, Black Art* (CBC podcast). https://www.cbc.ca/radio/whitecoat/i-am-a-white-settler-why-that-matters-in-health-care-1.4545454/it-s-the-hardest-conversation-we-can-have-confronting-racism-in-health-care-1.4545477.

Gullett HL, Brown GL, Collins D, Halko M, Gotler RS, Stange KC, Hovmand, PS. 2022. Using community-based system dynamics to address structural racism in community health improvement. *Journal of Public Health Management and Practice* 28(4): S130-S137. https://doi.org/10.1097/phh.0000000000001492.

Guo S, Guo Y. 2021. Combating anti-Asian racism and xenophobia in Canada: toward pandemic anti-racism education in post-COVID-19. *Beijing International Review of Education* 3(2) 187-211. http://dx.doi.org/10.1163/25902539-03020004.

Gupta S, Aitken N. 2022. COVID-19 mortality among racialized populations in Canada and its association with income. *Statistics Canada.* https://www150.statcan.gc.ca/n1/pub/45-28-0001/2022001/article/00010-eng.htm?utm_source=rddt&utm_medium=smo&utm_campaign=statcan-all-content-22-23.

Hamilton Board of Health. 2020. Social determinants of COVID-19. Office of the Medical Officer of Health, Public Health Services, Hamilton. https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=242579.

Hamilton vaccination program to prioritize black and other racialized populations ages 18+ in hot spots. (2021). *CHCH News.* https://www.chch.com/hamilton-vaccination-program-to-prioritizes-black-other-racialized-populations-ages-18-in-hot-spots/.

Hristova B. 2020a. City to consider tracking race-based COVID-19 data after calls from experts. *CBC News.* https://www.cbc.ca/news/canada/hamilton/gender-race-income-data-coronavirus-1.5554966.

Hristova B. 2020b. People of colour make up roughly 50% of Hamilton's COVID-19 cases: report. *CBC News.* https://www.cbc.ca/news/canada/hamilton/hamilton-covid-19-report-people-of-colour-1.5763043.

Hristova B. 2020c. BIPOC committee say it feels 'erased' after efforts to work with Hamilton public health. *CBC News.* https://www.cbc.ca/news/canada/hamilton/bipoc-committee-public-health-1.5772731.

Hristova B. 2021. 'No excuse': Hamilton vaccine group member wants BIPOC community prioritized. *CBC News.* https://www.cbc.ca/news/canada/hamilton/hamilton-bipoc-vaccine-priority-1.5989119.

Hyndman J. 2021. Vaccine geopolitics during COVID-19: how pandemics thicken borders, exacerbate violence, and deepen existing fault lines. In *COVID-19 and similar futures*, edited by Andrews GJ, Crooks VA, Pearce JR, Messina JP, 193-198. New York: Springer International Publishing. https://www.springerprofessional.de/en/vaccine-geopolitics-during-covid-19-how-pandemics-thicken-border/19275754.

Iveniuk J, Leon S. 2021. An uneven recovery: measuring COVID-19 vaccine equity in Ontario. Wellesley Institute. https://www.wellesleyinstitute.com/publications/covid-19-vaccine-equity/.

Iveniuk J, McKenzie K. 2021. Monitoring progress: race and vaccine equity. Wellesley Institute. https://www.wellesleyinstitute.com/publications/monitoring-progress-race-and-vaccine-equity/.

James L. 2020. Race-based COVID-19 data may be used to discriminate against racialized communities. *The Conversation.* https://theconversation.com/race-based-covid-19-data-may-be-used-to-discriminate-against-racialized-communities-138372.

Johnson S. 2019. A cross-burning on Hamilton mountain. Gatherings Partnership. https://gatheringspartnership.com/museum-gallery-blog/2019/4/5/a-kkk-cross-burning-in-hamilton.

Joseph A. 2020. Equity data as an ethical necessity: understanding the viral confluence of injustice through COVID-19. *Canadian Dimension.* https://canadiandimension.com/articles/view/equity-data-as-an-ethical-necessity-understanding-the-viral-confluence-of-injustice-through-covid-19.

Joseph AJ. 2015. *Deportation and the confluence of violence within forensic mental health and immigration systems.* Basingstoke: Palgrave-Macmillan.

Joseph AJ. 2017. Making civility: historical racial exclusion theories within Canadian democracy. In *Civil society engagement: achieving better in Canada,* edited by Daenzer PM, 17-30. New York: Routledge.

Joseph AJ, James L, Damptey K, Downey B. 2020. Data colonialism and plantation logics in social services and public health. Data & Sovereignty: Resisting Colonial Logics for Racial Justice panel and discussion. McMaster Institute for Health Equity, the Lewis and Ruth Sherman Centre for Digital Scholarship, and the McMaster Indigenous Research Institute, McMaster University. https://www.macvideo.ca/media/Data+%26+Sovereignty/1_2gxgha0l.

Kurek D. 2020. Racialized people make up 79% of COVID-19 cases in Toronto, city says. *Toronto.com*. https://www.toronto.com/news/racialized-people-make-up-79-per-cent-of-covid-19-cases-in-toronto-city-says/article_5a85c064-338a-5e12-b881-886af6252c87.html?.

Lee RS, Collins K, Perez-Brumer A. 2022. COVID-19 violence and the structural determinants of death: Canada's seasonal agricultural worker programme. *Global Public Health* 17(5), 784-793. https://doi.org/10.1080/17441692.2022.2053735.

Lei L, Guo S. 2022. Beyond multiculturalism: revisioning a model of pandemic anti-racism education in post-Covid-19 Canada. *International Journal of Anthropology and Ethnology* 6(1). https://doi.org/10.1186/s41257-021-00060-7.

Lin S. 2022. COVID-19 pandemic and im/migrants' elevated health concerns in Canada: vaccine hesitancy, anticipated stigma, and risk perception of accessing care. *Journal of Immigrant and Minority Health* 24(4): 896-908. https://doi.org/10.1007/s10903-022-01337-5.

Logan RG, Daley EM, Vamos CA, Louis-Jacques A, Marhefka SL. 2021. "When is health care actually going to be care?": the lived experience of family planning care among young Black women. *Qualitative Health Research* 31(6): 1169-1182. https://doi.org/10.1177/1049732321993094.

Lupton A. 2022. As June 6 anniversary approaches, hate crimes and incidents continue to climb. *CBC News*. https://www.cbc.ca/news/canada/london/as-june-6-anniversary-approaches-hate-crimes-and-incidents-continue-to-climb-1.6457903.

Machado S, Goldenberg S. 2021. Sharpening our public health lens: advancing im/migrant health equity during COVID-19 and beyond. *International Journal for Equity in Health* 20(1). https://doi.org/10.1186/s12939-021-01399-1.

Mahabir DF, O'Campo P, Lofters A, Shankardass K, Salmon C, Muntaner C. 2021. Experiences of everyday racism in Toronto's health care system: a concept mapping study. *Int J Equity Health* 20(74). https://doi.org/10.1186/s12939-021-01410-9.

Mensah J, Williams CJ. 2022. Socio-structural injustice, racism, and the COVID-19 pandemic: A precarious entanglement among Black immigrants in Canada. *Studies in Social Justice* 16(1), 123-142. https://doi.org/10.26522/ssj.v16i1.2690.

McKenzie K. 2021. Socio-demographic data collection and equity in COVID-19 in Toronto. *EClinicalMedicine* 34: 100812. https://doi.org/10.1016/j.eclinm.2021.100812.

McLane P, Barnabe C, Mackey L, Bill L, Rittenbach K, Holroyd BR, Bird A, Healy B, Janvier K, Louis E, Rosychuk RJ. 2022. First Nations status and emergency department triage scores in Alberta: a retrospective cohort study. *CMAJ* 194(2): E37-E45.

https://doi.org/10.1503/cmaj.210779.

Moreau G. 2021. Police-reported crime statistics in Canada, 2020. Report No. 85-002-X. Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2021001/article/00013-eng.pdf?st=wnaqK9Mw.

Moro T. 2018. Hamilton has highest rate of police-reported hate crimes in Canada. *The Toronto Star.* https://www.thestar.com/ths/news/hamilton-region/2018/04/27/hamilton-has-highest-rate-of-police-reported-hate-crimes-in-canada.html.

Moro T. 2020. Black patient recalls struggle to be taken seriously at Hamilton General Hospital. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/06/26/black-patient-recalls-struggle-to-be-taken-seriously-at-hamilton-general-hospital.html.

Moro T. 2021a. Racist backlash to Hamilton's effort to vaccinate Black and racialized residents condemned. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2021/04/29/racist-backlash-to-hamiltons-effort-to-vaccinate-black-and-racialized-residents-condemned.html.

Moro T. 2021b. COVID-19: mixed messages on vaccines for racialized Hamilton residents. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2021/04/29/covid-19-mixed-messages-on-vaccines-for-racialized-hamilton-residents.html.

Nerestant A. 2021. Racism, prejudice contributed to Joyce Echaquan's death in hospital, Quebec coroner's inquiry concludes *CBC News.* https://www.cbc.ca/news/canada/montreal/joyce-echaquan-systemic-racism-quebec-government-1.6196038.

Nestel S. 2012. Colour coded health care: the impact of race and racism on Canadians' health. Wellesley Institute. https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf.

O'Reilly N. 2017. Hamilton ranks second highest for hate crimes in Canada – again. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2017/06/14/hamilton-ranks-second-highest-for-hate-crimes-in-canada-again.html.

Paradies Y. 2016. Colonisation, racism and Indigenous health. *Journal of Population Research* 33(1): 83-96. https://doi.org/10.1007/s12546-016-9159-y.

Popplewell B. 2010. A history of missteps. *The Toronto Star.* https://www.thestar.com/news/investigations/2010/10/30/a_history_of_missteps.html.

Public Health Ontario. 2020. Addressing health inequities within the COVID-19 public health response. Report. https://www.publichealthontario.ca/-/media/Documents/nCoV/he/2020/12/covid-19-environmental-scan-addressing-health-inequities.pdf?sc_lang=en.

Public Health Ontario. 2022a. COVID-19 vaccination coverage in Ontario by neighbourhood diversity and material deprivation: December 14, 2020 to February 21, 2022. Bulletin. https://www.publichealthontario.ca/-/media/Documents/nCoV/epi/covid-19-immunization-diversity-deprivation-epi-summary.pdf?sc_lang=en.

Public Health Ontario. 2022b. COVID-19 in Ontario – a focus on neighbourhood diversity: January 15, 2020 to December 13, 2021. Report. https://www.publichealthontario.ca

/-/media/Documents/nCoV/epi/2020/06/covid-19-epi-diversity.pdf?sc_lang=en.

Rankin C. 2021. Hamilton's board of health needs more diversity, local doctors and advocates say. *CBC News.* https://www.cbc.ca/news/canada/hamilton/board-health-hamilton-restructuring-1.5958843.

REDE4BlackLives. 2020. Data, algorithms, and automation as "weapons of math destruction." YouTube. https://www.youtube.com/watch?v=bjtOWURDYao&t=32s.

Rodriguez J. 2021. Good public health policy: the success of vaccine clinics for Black, racialized Canadians. *CTV News.* https://www.ctvnews.ca/health/coronavirus/good-public-health-policy-the-success-of-vaccine-clinics-for-black-racialized-canadians-1.5416822.

Rumala BB, Beard KV. 2022. Resilience will not erase structural racism. *American Journal of Nursing* 122(2): 11. https://doi.org/10.1097/01.naj.0000820488.63539.36.

Shadd A. 2010. *The journey from tollgate to parkway: African Canadians in Hamilton.* Hamilton: Dundurn Press.

Smart K. 2021. Time to recognize and address antisemitism in medicine and beyond. *Canadian Medical Association.* https://www.cma.ca/news-releases-and-statements/time-recognize-and-address-antisemitism-medicine-and-beyond.

SPRC (Social Planning and Research Council of Hamilton). 2020. Hamilton's social landscape bulletin: COVID-19 in Hamilton. https://www.sprc.hamilton.on.ca/wp-content/uploads/2020/08/SPRC-Hamilton-Social-Landscape-COVID-full-series-August-2020.pdf.

Taekema D. 2016. Black city councillor says Hamilton police 'carded' him. *The Toronto Star.* https://www.thestar.com/news/crime/2016/04/27/black-city-councillor-says-hamilton-police-carded-him.html.

Timothy RK. 2018. How racism impacts your health. Opinion: Health impacts related to racism interrupt narratives of the 'disadvantaged,' the 'poor,' the 'lazy' and the 'needy.' *Maclean's.* https://www.macleans.ca/society/how-racism-impacts-your-health/.

Tuyisenge G, Goldenberg SM. 2021. COVID-19, structural racism, and migrant health in Canada. *The Lancet* 397(10275): 650-652. https://doi.org/10.1016/s0140-6736(21)00215-4.

Walcott R. 2020. Data or politics? Why the answer still remains political. The Royal Society of Canada. https://rsc-src.ca/en/covid-19/impact-covid-19-in-racialized-communities/data-or-politics-why-answer-still-remains.

Wane NN. 2020. COVID-19: the pandemic and histories of inequities unveiled impact on Black communities. The Royal Society of Canada. https://rsc-src.ca/en/covid-19/covid-19-pandemic-histories-inequities-unveiled-impact-black-communities.

Wells J. 2020. Joyce Echaquan's death sparks Hamilton task force targeting racism in health care. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/10/16/joyce-echaquans-death-sparks-hamilton-task-force-targeting-racism-in-health-care.html.

Williams MT, Khanna Roy A, MacIntyre M-P, Faber S. 2022. The traumatizing impact of

racism in Canadians of colour. *Current Trauma Reports* 8(2): 17-34. https://doi.org/10.1007/s40719-022-00225-5.

6 APPENDIX 1

Vaccine distribution across postal codes, September-November 2021

Postal code	Clients
L8L	129
L9C	36
L8H	30
L8R	25
L8N	20
L9A	12
L8W	11
L8P	10
L8V	7
L8M	7
L0R	6
M9W	6
L8T	6
L8S	3
L3M	2
L7S	2
L8G	2
L2A	2
L6V	2
L9H	2
P0H	2
P1H	2
N0B	2
L6L	1
L7M	1
L4N	1
L2N	1
L2P	1
L5B	1
L7L	1
L9B	1
L9G	1
L0P	1
N0A	1
N3W	1

Postal code	**Clients**
N4S	1
M1J	1
M4A	1
M4C	1
M4Y	1
K9H	1
Total	**345**