VOICES UNHEARD:

The Black Women's Institute for Health
Health for ALL Black Women

HEALTHCARE BARRIERS AND THE LIVED EXPERIENCES OF BLACK WOMEN IN CANADA

A Report by The Black Women's Institute for Health November 2025

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"I feel like I'm always being asked to carry more than others, emotionally, physically, and mentally, but when I need support, it's not there."

-Voices Unheard survey participant

Letter from the Executive Director

Kearie Daniel, Founder, Black Women's Institute for Health

There is a moment in every Black woman's life when she realizes that her survival has never been guaranteed. That moment does not come softly. It arrives in an emergency room when no one believes your pain, or in the silence after a mental health referral never comes. It echoes in the stories passed between sisters, mothers, daughters, and aunties — whispered truths about bleeding too long, waiting too long, being dismissed too easily.

I founded the Black Women's Institute for Health because I was tired of hearing those whispers and I could no longer live in a country that refused to listen.

This work began long before the first survey question was drafted. It began in my own body, in the stories of women around me — some who have survived, and some who have not — in the statistics that did not exist because nobody had ever bothered to count us. We were dying quietly. And invisibly.

When I read the 2023 article "The Crisis That Is Killing Black Women" in The Nation magazine, it was like reading a mirror. The piece named what I had been feeling for years. It spoke of misogynoir and the relentless expectation of strength that leaves Black women unprotected, unacknowledged, and untreated. It exposed the rising suicide rates among Black women and girls, not because we are weak, but because systems ignore our pain until we disappear. It was written about America, but it could have been written about Canada. And that is both the tragedy and the wake up call.

I knew then that we needed our own data. We needed our own stories, captured and held in a way that would be irrefutable. So we created *Voices Unheard*: Canada's first-ever national health survey focused on Black women and girls.

Almost two thousand Black women, girls, and gender non-conforming people responded. Not because they were asked nicely, but because they were desperate to be heard. They shared stories of being misdiagnosed, ignored, disrespected, left to suffer, and told they were "too functional" to receive mental health care. They spoke of bleeding out in hospital bathrooms, of being laughed at during postpartum depression, of surviving violence and then being retraumatized by the very systems meant to support them.

This report is our collective testimony. It is also a warning. If systems do not change, if race-based and gender-based data is not collected, if institutions continue to pretend that anti-Black racism is not costing lives, more Black women will die. And more Black girls will grow up believing that their lives do not matter.

But this report is not only about what is wrong. It is about what is possible. In the pages that follow are clear recommendations. They are not suggestions. They are not reforms. They are calls for transformation rooted in justice, equity, and sovereignty. They are roadmaps to safety.

To those in power, in government, in healthcare, in philanthropy, you now have the data. You now have the stories. Neutrality is no longer an option. Every delay is a choice to let harm continue.

To the women who shared their stories, you gave us more than data. You gave us truth, courage, and the blueprint for collective healing. You are not invisible anymore.

To every Black woman, girl, and gender non-conforming person, your voice matters. Your pain is real. Your health should never be negotiable. This is your report. Your evidence. Your proof.

And to every person reading this, the path forward is clear. The only question is whether you will walk it with us.

With love, fire, and an unshakable belief in our right to be well,

Kearie Daniel

Executive Summary

Healthcare is a fundamental right that should serve all people with dignity, respect, and effectiveness. That is not the case in Canada. For Black women, girls, and gender non-conforming people here, accessing quality healthcare too often means navigating systems that neither see nor understand our unique needs. This report examines health comprehensively, encompassing medical conditions, clinical care, but also social determinants of health — the economic and social conditions that influence individual and group differences in health status, including factors like income, education, employment, housing, and experiences of discrimination. When healthcare systems fail to collect the data necessary to identify and address critical disparities across all these dimensions of health, those of us most in need are experiencing a form of institutional invisibility that has real consequences for the quality of our lives and wellbeing.

Despite the Government of Canada's acknowledgement of race and racism as a social determinant of health, Canadian healthcare systems continue to operate without the foundational data necessary to identify, measure, or address health inequities affecting Black communities. This data gap perpetuates a cycle where disparities remain hidden and unaddressed, and ultimately worsen over time.

An intersectional approach to healthcare recognizes that Black women, girls, and gender non-conforming people exist and live within the intersection of multiple identities and systems of oppression. Our healthcare experiences are shaped not just by anti-Black racism or sexism alone, but by the specific ways these forces interact to create distinct challenges requiring specific solutions. This recognition demands a need for a holistic approach to healthcare that considers us within our social, cultural, and economic context rather than treating isolated symptoms or conditions.

To better understand the experiences of Black women, girls, and gender non-conforming people in Canada, Black Women's Institute for Health conducted a groundbreaking, nationwide study. In total, 1,966 individuals shared their stories with us. This report highlights crucial findings from that research and presents compelling evidence for the urgent need to implement systematic race and gender-based data collection in Canadian healthcare systems. It also outlines recommendations for addressing anti-Black racism in healthcare.

The evidence in this report is clear, the need is urgent, and the time for action is now. The health and lives of Black women, girls, and gender non-conforming people depend on it.

Key Themes

Our research revealed that, while most participants could physically access healthcare services, many were not believed or heard when discussing symptoms with providers. Participants identified additional barriers including long wait times, lack of culturally competent providers, fear of discrimination, and financial constraints. These challenges led to distrust in healthcare systems, delayed care, misdiagnoses, and emotional exhaustion from constant self-advocacy.

The report documents six critical areas of healthcare disparities:

1. Medical conditions that disproportionately affect Black women, girls, and gender non-conforming people
2. Black maternal health and medical neglect
3. Severe and unique mental health challenges
4. Exposure to racial violence, abuse, and increased risk for post-traumatic stress disorder
5. Burnout and emotional fatigue through toxic work environments and racial discrimination
6. Black girls' and youth's early experiences with racism and identity

Recommendations

The recommendations in this report are related directly to the research participants’ comments, issues, and concerns. From the federal government and healthcare providers to school staff and employers, everybody has a role to play in dismantling the systems that negatively impact Black women, girls, and gender non-conforming peoples’ health. This report should serve as a guide for how key stakeholders can get involved and take action.

This report provides recommendations for:

- Federal government
- Provincial and territorial governments
- Hospitals, public health units, and healthcare institutions
- Medical, nursing, and hospital regulators and associations
- Employers, labour, and economic policy
- Education, research, and academic institutions
- Cross-sectoral institutions and ministries

Conclusion

The healthcare disparities documented in this report are not abstract statistics. They represent a public health emergency unfolding in real time across Canada. When 25 per cent of Black Canadian women report suicidal ideation compared to 4 per cent of women nationally; when participants in the survey describe bleeding for hours while being told their pain is exaggerated; when early experiences with racism shape the future health outcomes for Black girls and youth — we are witnessing the deadly consequences of healthcare systems that systematically devalue Black women, girls, and gender non-conforming peoples’ lives (Liu, Pollock, Contreras, Tonmyr, & Thompson, 2022).

This report provides irrefutable evidence that Canada's refusal to collect race-based health data is not neutral. It is a choice that enables harm to continue unchecked. Every day that passes without systematic data collection means more Black women, girls, and gender non-conforming people will suffer preventable complications, more will be dismissed when seeking care, and more will die from conditions that could have been identified, treated, and prevented. The nearly 2,000 voices in this study represent thousands more who remain invisible in a system designed to ignore our experiences.

The path forward is clear and achievable. The question is not whether race-based data collection is necessary, but when Canadian healthcare systems will commit to implementing it.

The Black Women's Institute for Health

The Black Women's Institute for Health (BWIH) is a national, Black-led organization that is transforming the conditions that harm Black women, girls, and gender non-conforming people across every social determinant of health in Canada. We use research, advocacy, and community-rooted programs to drive equity and build power. We exist to help make Black women, girls, and gender non-conforming people visible, valued, and well.

BWIH sees health differently. Not only do we focus on the full spectrum of health — including physical, mental, and emotional wellness — but we also examine the social determinants that lead to health inequities. Our unique approach to healthcare analysis enables us to see the bigger picture of how these disparities operate. Only then can we begin to tackle the inequities and systemic neglect that ultimately puts Black women, girls, and gender non-conforming people's lives at risk.

We are a collective of Black women united by shared experiences and a bold vision: to build a future where Black women, girls, and gender non-conforming people are not just surviving, but thriving, and living lives marked by health, safety, sovereignty, and joy. We wish to see a world where our truths are data, our leadership is valued, and our care systems are built for us and by us in order to create better health outcomes for Black women, girls, and gender non-conforming people across Canada.

Acknowledgments

Voices Unheard is the result of collective brilliance. Every insight, every data point, every page is the product of expertise, care, and vision coming together with purpose. This report would not exist without the seamless collaboration of many hands, minds, and hearts.

To those who brought this initiative to life, thank you.
Each of you played a vital role in helping us deliver something historic.

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Endorsements

Voices Unheard: Canada's First National Health Survey of Black Women and Girls is supported by organizations that recognize the critical need for disaggregated data, systemic change, and a health system that reflects the lived realities of Black women and girls in Canada.

We gratefully acknowledge the following organizations for endorsing this work:

Their support reflects a growing movement to centre Black women's health, honour lived experience, and advance equity through action.

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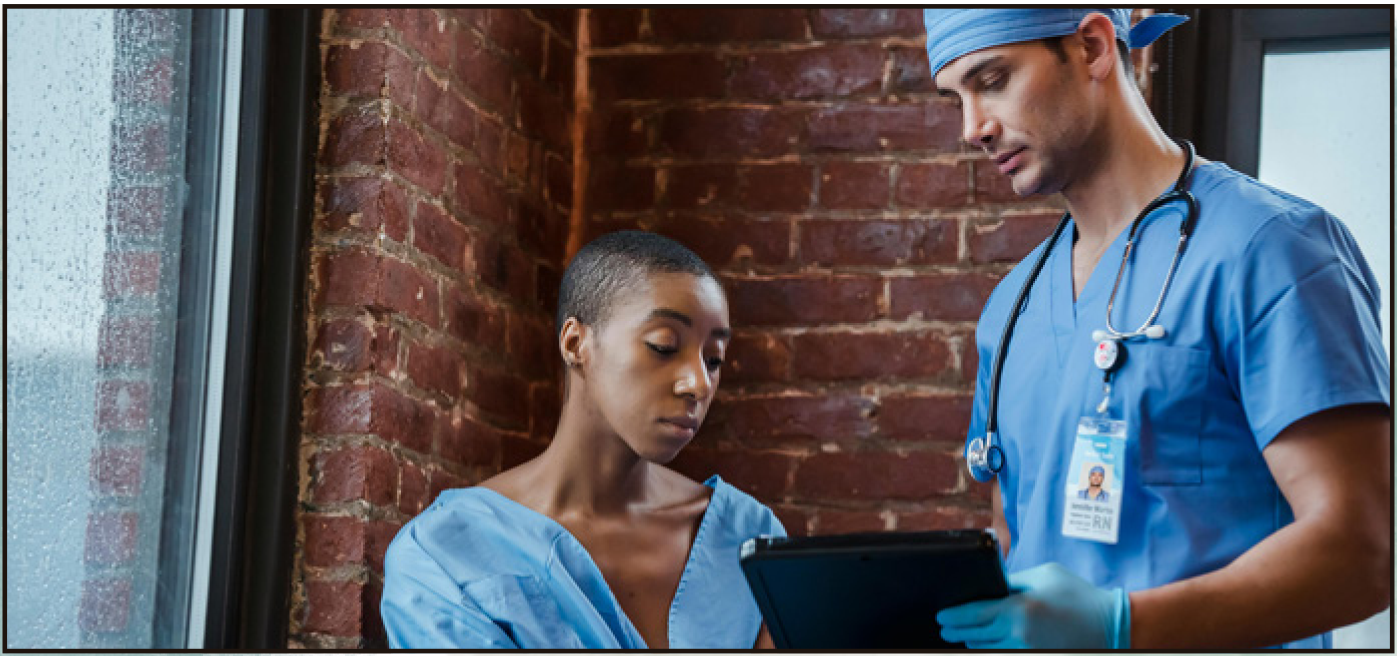
Introduction



A note on language: *This report uses "Black women, girls, and gender non-conforming people" to acknowledge the full spectrum of individuals who participated in this research. For readability, "Black women" is sometimes used as shorthand to refer to this entire group, recognizing that gender non-conforming people and girls face these same systemic barriers in healthcare.*

Canada's universal healthcare system is often celebrated as a source of national pride. Behind this reputation lies a troubling reality: when it comes to the health and wellbeing of Black women, girls, and gender non-conforming people, Canada's healthcare system consistently fails to deliver the dignified care it promises.

Healthcare equity remains an elusive goal for Black women in Canada. Despite mounting evidence of significant health disparities affecting Black communities, Canadian healthcare systems continue to operate without the foundational data necessary to understand, address, or prevent these inequities. This report underscores the urgent case for systematic gender and race-based data collection in healthcare, not as an abstract policy recommendation, but as a matter of life and death for Black Canadian women and girls.

Why Black Women in Canada Need Race-Based Data

Data is the foundation of effective evidence-informed healthcare policy, programming, and service delivery. Without accurate and comprehensive information about how different communities experience health and healthcare, it becomes impossible to develop targeted interventions, allocate resources effectively, or measure progress toward achieving equity (Rizvic, 2020).

Currently, Canadian healthcare systems operate with significant gaps regarding the health experiences of racialized communities. This failure is particularly striking given that the Government of Canada officially acknowledges race as a social determinant of health (Public Health Agency of Canada, 2024). However, this acknowledgement remains largely symbolic. There is very little to no national research or data collection that actually examines how gender and race influence health outcomes in Canadian contexts. As a result, health disparities continue to go unnoticed. The consequences of this absence of data are measured not just in statistics, but in the deteriorating health and premature deaths of Black women, girls, and gender non-conforming people. This research deliberately centres the voices and lived experiences of Black women; these voices have been systematically excluded from healthcare research and policy development for far too long. Decisions about Black communities' health are made without meaningful input from those most affected, resulting in interventions that miss the mark and perpetuate harm. By prioritizing first-person narratives and community-driven insights, this study challenges the traditional power dynamics that have rendered Black experiences invisible in Canadian healthcare discourse.

This report calls specifically for disaggregated data collection. Only through this approach can we demonstrate how Black communities are uniquely impacted by systemic racism and anti-Blackness in healthcare settings. Aggregated data lumps all racialized people together, or fails to collect racial data at all, rendering Black experiences invisible and preventing the development of targeted interventions that could save lives.

Disaggregated data from this survey reveals patterns that would otherwise remain hidden: the higher rates of maternal mortality among Black women, the delayed diagnoses of conditions like lupus and fibroids, the mental health impacts of medical racism, and the barriers to accessing culturally competent care. Without this level of detail, healthcare systems cannot identify problems, let alone solve them.

Disaggregated versus aggregated data: *Disaggregated data breaks down information by specific characteristics like race, gender, or age, revealing differences between groups. Aggregated data combines all groups together into overall averages, which can hide important disparities affecting specific communities.*

An Intersectional Approach to Healthcare

Understanding health disparities requires recognizing that individuals exist at the intersection of multiple identities and systems of oppression. Intersectionality, a framework developed by American scholar Kimberlé Crenshaw, acknowledges that race, gender, class, sexuality, disability status, and other identities combine to create unique experiences that cannot be understood by examining each factor in isolation (Crenshaw, 1989).

An intersectional approach is crucial for healthcare and service delivery because it ensures that interventions address the full range of factors influencing health outcomes. This recognition naturally extends to understanding how social determinants of health, including income, housing, education, employment, and social support networks, intersect with race and gender to create unique health challenges. For Black communities, these determinants are often shaped by historical and ongoing systemic discrimination that affects everything from access to healthy food, to experiences of workplace harassment and mental health challenges.

A truly intersectional and holistic healthcare approach moves beyond treating individual symptoms to address the root causes of health inequities. This means healthcare providers and systems must consider how factors like economic insecurity, experiences of discrimination, intergenerational trauma, and community resilience all influence a person's health status and their ability to access adequate care.

The Consequences of Inaction: Why This Work Cannot Wait

The absence of race-based data collection in Canadian healthcare has profound and measurable consequences. Without this foundational information, we continue to ignore the health disparities affecting Black women, girls, and gender non-conforming people and, as a result, make it impossible to address them effectively. This willful ignorance perpetuates a healthcare system that fails its most vulnerable patients.

Race-based data collection enables targeted health interventions that can address the specific needs and challenges facing Black women, girls and non-confirming peoples. It provides the evidence necessary to hold institutions accountable for disparate outcomes and discriminatory practices. It helps correct the ongoing erasure, invisibility, and colonial legacies that continue to shape healthcare delivery in Canada.

Furthermore, systematic data collection enables healthcare systems to better understand healthcare services and experiences from an intersectional perspective, revealing how multiple forms of discrimination combine to create barriers to care. This understanding is essential for developing comprehensive solutions that address root causes rather than just symptoms.

Most importantly, this is life-saving work. The health disparities documented in this report represent preventable suffering and death.

Every day that passes without systematic data collection is another day that Black women die from conditions that could have been prevented, diagnosed earlier, or treated more effectively. Comprehensive race-based data collection in healthcare is not just recommended; it is essential for creating a healthcare system that truly serves all Canadians. The voices and experiences shared in this report provide both the evidence and the roadmap for transformation.

Methodology

How We Did This Work

When BWIH offered an opportunity for Black women to openly share about their health concerns, we were not surprised that so many people wanted to finally have their voices heard. Once the survey and focus groups were complete, nearly 2,000 Black women, girls and gender non-conforming people shared their experiences and insights with us. Participants were found through a variety of outreach methods, including social media posts, paid ads, and word of mouth. Research was conducted across Canada between October and December 2024. Stories of how Black women are coping with their health conditions and services were captured through online surveys, focus groups, and research workshops.

For BWIH, community-based research was essential because it centred the voices, knowledge, and lived experiences of Black women, girls, and gender non-conforming people. Community-based research empowers Black communities to shape the questions being asked, define what success looks like, and lead the interpretation and application of findings. This approach not only builds trust but also ensures that the research is relevant, culturally responsive, and directly connected to real-world change.

The survey included a combination of closed- and open-ended questions, allowing participants to share both statistical data and narrative responses. Verbatim quotes throughout the report are drawn directly from these submissions, with minimal edits for clarity. Descriptive statistics were used to examine trends and prevalence, while thematic coding was applied to review narrative responses and identify common issues, solutions, and calls to action.

Who Shared their Story

This report relies on data collection from 1,966 participants, which well exceeded the 385 to 1,000 responses required for this research to be viable (Baker, 1982). The research consisted of:

- 1,337 survey respondents
- 15 focus group members
- 207 attendants of the National Townhall for Black Women
- 325 attendants of the Black Women's Mental Health Townhall
- 82 attendants of the Black Girls Townhall

Respondents represented a range of ages, levels of education, and income brackets. With this research, we were able to build a comprehensive profile for Black women in Canada that focuses on their experiences across a range of social determinants of health.

Ethical oversight and informed consent were integral to the project. All participants were informed about the purpose of the survey and consented to the anonymous use of their responses for research, reports, and advocacy purposes.

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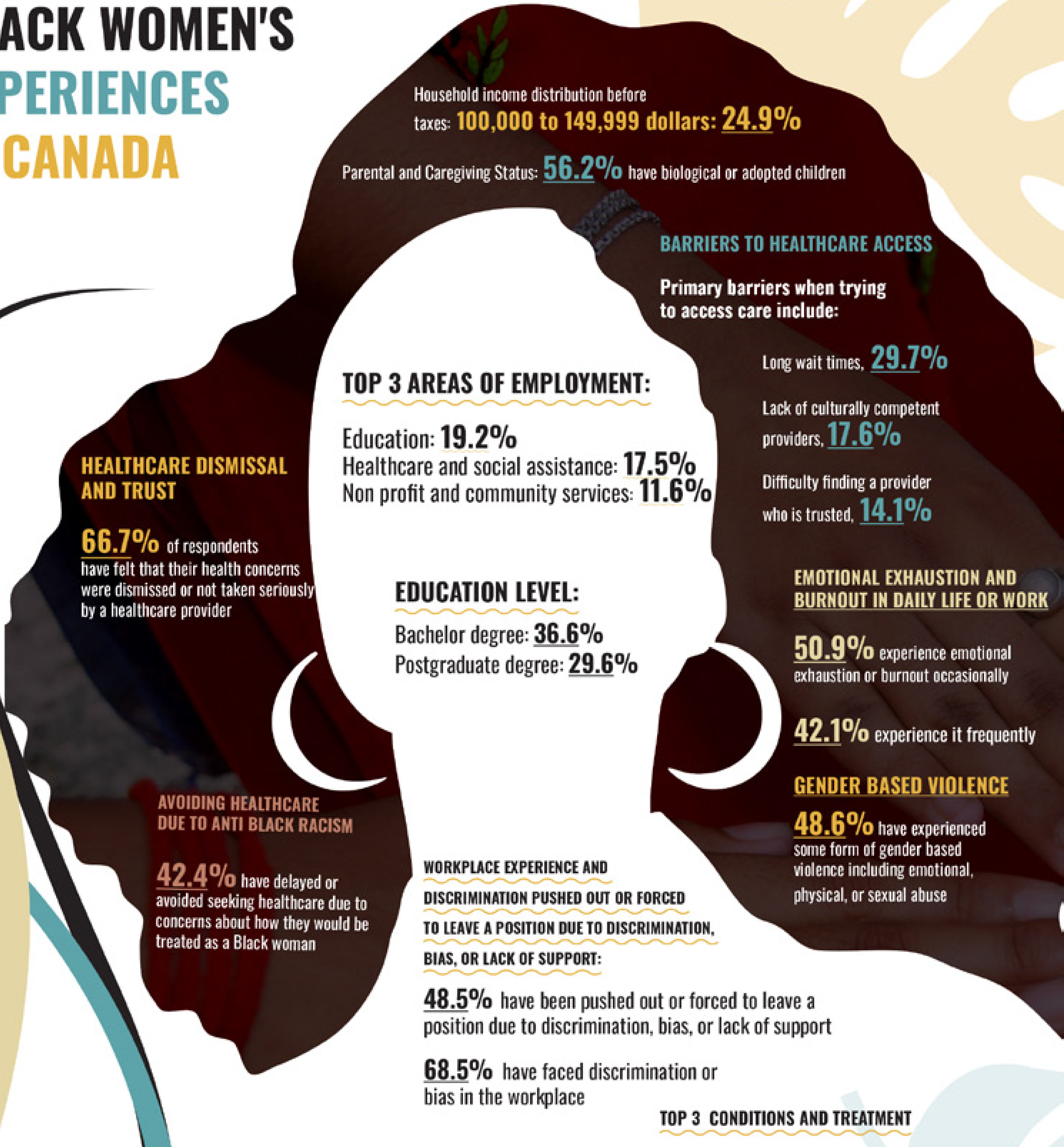
Limitations

A majority of the participants were from Ontario, making up 82.7 per cent of total participants. Participants primarily identified as cisgender women (96.1 per cent), while 53 participants, or 3.9 per cent, identified as non-binary, gender non-conforming, or transgender. Additionally, a majority of survey respondents were highly educated working women, while the focus groups were more inclusive of all socioeconomic statuses.

As one of the largest studies of its kind in Canada, this research offers a glimpse into the experiences of Black women, girls, and gender non-conforming people nationwide, as well as an opportunity for future research.

Scan the QR code to access our digital hub featuring all the data from this research:

PORTRAIT OF A BARRIER: BLACK WOMEN'S EXPERIENCES IN CANADA



Household income distribution before taxes: **100,000 to 149,999 dollars: 24.9%**

Parental and Caregiving Status: **56.2%** have biological or adopted children

TOP 3 AREAS OF EMPLOYMENT:

Education: **19.2%**
Healthcare and social assistance: **17.5%**
Non profit and community services: **11.6%**

EDUCATION LEVEL:

Bachelor degree: **36.6%**
Postgraduate degree: **29.6%**

HEALTHCARE DISMISSAL AND TRUST

66.7% of respondents have felt that their health concerns were dismissed or not taken seriously by a healthcare provider

AVOIDING HEALTHCARE DUE TO ANTI BLACK RACISM

42.4% have delayed or avoided seeking healthcare due to concerns about how they would be treated as a Black woman

BARRIERS TO HEALTHCARE ACCESS

Primary barriers when trying to access care include:

Long wait times, **29.7%**

Lack of culturally competent providers, **17.6%**

Difficulty finding a provider who is trusted, **14.1%**

EMOTIONAL EXHAUSTION AND BURNOUT IN DAILY LIFE OR WORK

50.9% experience emotional exhaustion or burnout occasionally

42.1% experience it frequently

GENDER BASED VIOLENCE

48.6% have experienced some form of gender based violence including emotional, physical, or sexual abuse

WORKPLACE EXPERIENCE AND DISCRIMINATION PUSHED OUT OR FORCED TO LEAVE A POSITION DUE TO DISCRIMINATION, BIAS, OR LACK OF SUPPORT:

48.5% have been pushed out or forced to leave a position due to discrimination, bias, or lack of support

68.5% have faced discrimination or bias in the workplace

PRIMARY HEALTHCARE CONNECTION

84.2% currently have a family doctor or primary healthcare provider Health Insurance Coverage

76.7% have private health insurance

TOP 3 CONDITIONS AND TREATMENT

Mental health conditions, **15.8%**
Hypertension, **14.5%**
Fibroids, **13.5%**
Mental Health and Safety, **27.4%** have struggled with thoughts of self harm

“You stop going [to seek medical assistance] because it becomes exhausting to explain your entire self before anyone even tries to help you.”

-Voices Unheard survey participant

Analysis & Insights

Access to quality healthcare emerged as a foundational issue shaping the health of Black women, girls, and gender non-conforming people in Canada. While most participants could physically reach services, 76.6 per cent reported feeling unheard or disbelieved by providers. This gap between access and quality underscores that health is more than treatment alone — it is tied to dignity, trust, and culturally competent and safe care.

When care is dismissive, it not only undermines immediate health outcomes but also compounds stress and discourages future engagement with the system, showing how systemic bias creates additional barriers and directly shapes overall wellbeing.

Participants identified multiple barriers to quality healthcare access. Nearly three in ten participants (29.7 per cent) cited long wait times as a primary obstacle, while almost one in five (17.6 per cent) pointed to the lack of culturally competent healthcare providers. Other significant barriers included difficulty with finding trustworthy providers, fear of discrimination or bias, limited awareness of available services, and financial constraints.

The need for culturally competent healthcare emerged as a particularly urgent theme throughout participants' responses. Many expressed feeling unseen and unheard in clinical settings, with several stating they would prefer to be treated by Black medical professionals who might better understand their experiences and concerns. Research has shown that patient

CULTURALLY COMPETENT CARE:

Cultural competence refers to the ability of healthcare providers and systems to understand, respect, and respond effectively to the cultural and social needs of patients. It requires awareness of how culture, race, gender, language, and history influence health beliefs, experiences, and behaviours. A culturally competent provider actively seeks to learn from their patients, adapt communication styles, and integrate cultural knowledge into assessment and treatment. It moves beyond tolerance to intentional inclusion, aiming to reduce miscommunication, misdiagnosis, and alienation within clinical settings.

CULTURALLY SAFE CARE:

Cultural safety goes further than competence. It is not defined by the provider but by the patient's experience. Culturally safe care ensures that individuals feel respected, heard, and are free from racism, judgment, or power imbalance when receiving care. It requires self-reflection and accountability from providers and institutions, recognizing that healthcare is not neutral and that systemic oppression shapes patient experiences. Culturally safe care is relational and justice-oriented, with a focus on transforming institutional structures that perpetuate harm.

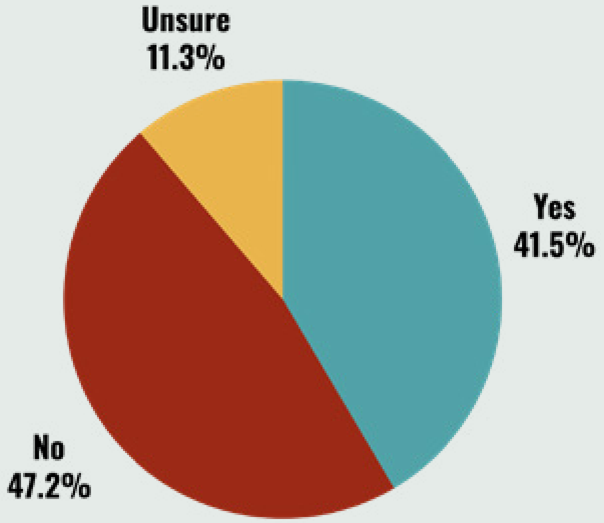
THE RELATIONSHIP BETWEEN THE TWO:

While cultural competence focuses on knowledge and skill development at the provider level, cultural safety demands structural transformation and relational accountability. Competence can exist without safety, but safety cannot exist without competence. For Black women, achieving both means not only having providers who understand their cultural realities but also systems that dismantle anti-Black racism, affirm their humanity, and restore trust.

satisfaction and quality of care are higher when patients and doctors are of the same race (LaVeist & Nuru-Jeter, 2002).

This sense of invisibility and dismissal has real and measurable consequences. Over 42 per cent of respondents reported delaying or avoiding seeking healthcare because of concerns about how they would be treated as Black women, while an additional 11 per cent were unsure (see Figure 1). This hesitation to seek care speaks to a deep and justified mistrust shaped by historical and ongoing experiences of racism in healthcare settings. When Black women anticipate being dismissed, disbelieved, or subjected to bias, they often choose to endure pain, postpone appointments, or disengage from healthcare systems altogether. This not only affects individual health outcomes but perpetuates systemic inequities that deny Black women the full right to care, safety, and dignity within medical institutions., postpone appointments, or disengage from healthcare systems altogether. This not only affects individual health outcomes but perpetuates systemic inequities that deny Black women the full right to care, safety, and dignity within medical institutions.

Figure 1: Delayed/Avoided Seeking Healthcare



Responses from *Voices Unheard* participants on delaying or avoiding healthcare due to concerns about treatment as a Black woman

Have you ever delayed or avoided seeking healthcare due to concerns about how you would be treated as a Black woman?

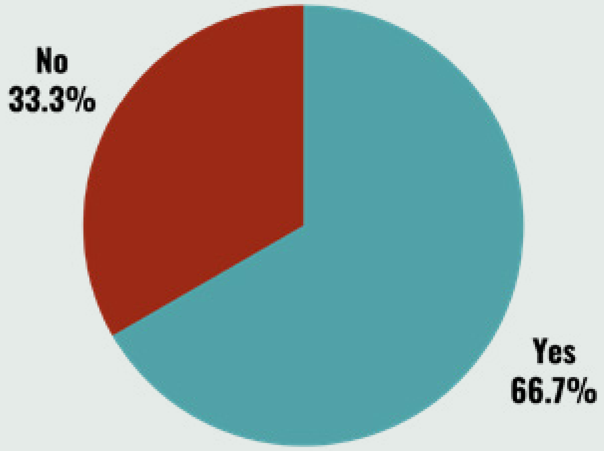
Yes: **n=485**

No: **n=528**

Unsure: **n=131**

The data further underscores the profound impact of medical dismissal on Black women's health experiences. Two-thirds of respondents (66.7%) reported feeling that their health concerns were dismissed or not taken seriously by a healthcare provider. These experiences are not isolated incidents but part of a systemic pattern of disbelief, minimization, and stereotyping that has long shaped how Black women are treated within medical spaces. Participants described being told their pain was exaggerated, their symptoms were "normal," or their concerns were rooted in anxiety rather than legitimate medical need. Such experiences mirror broader research documenting how racial bias and gendered assumptions lead to misdiagnosis, under-treatment, and neglect, particularly in pain management, reproductive care, and mental health.

Figure 2: Felt Like Health Concerns Were Dismissed



Responses from *Voices Unheard* participants on the dismissal of health concerns from healthcare providers

Have you ever felt your health concerns were dismissed or not taken seriously by a healthcare provider?

Yes: **n=766**

No: **n=382**

This widespread sense of dismissal reinforces why so many Black women delay or avoid seeking healthcare altogether. When the very systems meant to care for them become sites of harm and humiliation, self-protection often takes the form of disengagement. The result is a dangerous feedback loop: medical mistrust drives avoidance which can worsen health outcomes, while providers interpret delayed care as noncompliance rather than a rational response to discrimination. Breaking this cycle requires an intentional commitment to cultural competency, anti-racist training, and accountability within healthcare systems to ensure Black women's voices are heard, believed, and acted upon with respect and care.

This desire reflects not simply personal preference but a direct response to the systemic dismissal and disbelief they have encountered in healthcare settings. When healthcare providers lack cultural competency, they often fail to recognize how racism, discrimination, and historical trauma impact Black women's health, leading to inadequate care and further erosion of trust. Over time, the result of these systemic issues leads to worse health outcomes and ongoing inequities in care for Black communities, but especially for Black women, girls, and gender non-conforming people.

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The survey revealed significant health impacts that emerged from not having adequate access to supportive healthcare. We have parcelled them out into six themes:

1. Medical Conditions
2. Reproductive Health
3. Mental Health and Wellbeing
4. Violence and PTSD
5. Burnout and Emotional Fatigue
6. Black Girlhood and Identity

Each of these themes shows how systemic barriers in healthcare create significant challenges for Black women's health, underscoring the urgent need for more equitable and responsive healthcare services.

Medical Conditions

Black women face disproportionately higher rates of certain chronic illnesses and medical conditions compared to other groups of women (Salami et al., 2024). These health disparities reflect complex interactions between genetic predisposition, environmental and social factors, systemic barriers, and historical inequities in healthcare access and quality.

Our survey findings confirm these patterns among participants. A significant portion of Black women reported being diagnosed with chronic conditions, with hypertension and uterine fibroids each affecting approximately 22 per cent of respondents (see Figure 3). These rates align with broader epidemiological data and underscore the urgent need for race-based data collection in Canadian healthcare systems.

“The only reason that I am still alive is because I VERY assertively advocated for myself. My life-threatening symptoms have always been dismissed and downgraded, but I've persisted until I found a diagnosis for many of my illnesses, which I presented to the various medical professionals, and convinced them to treat me.”

-Voices Unheard survey participant

Hypertension: A Silent Killer

Hypertension, commonly known as high blood pressure, is a condition where blood consistently flows through arteries at higher than normal pressure, often without noticeable symptoms until serious complications develop. This "silent killer" significantly increases the risk of heart disease, stroke, and kidney problems.

> *“The cause of my hypertension is stress, primarily around finances. It has become increasingly difficult to improve my financial situation, so it's increasingly difficult to manage my stress.”*

For many respondents managing hypertension, their high blood pressure is linked to pressures surrounding work and finances. While hypertension affects more than one in five Canadian adults, the burden is not equally distributed (Veenstra, 2012). A 2010 study found an age-adjusted prevalence of hypertension of 17.1 per cent for white Canadians compared to 23.9 per cent for Black Canadians (Liu et al., 2010). Another analysis by Heart & Stroke demonstrates similar findings: Black women are particularly at risk for hypertension and related conditions such as preeclampsia, often tied to the compounding effects of racism, economic inequity, and anti-Black racism itself (Heart & Stroke Foundation, n.d.). These are factors that are frequently overlooked in medical consultations.

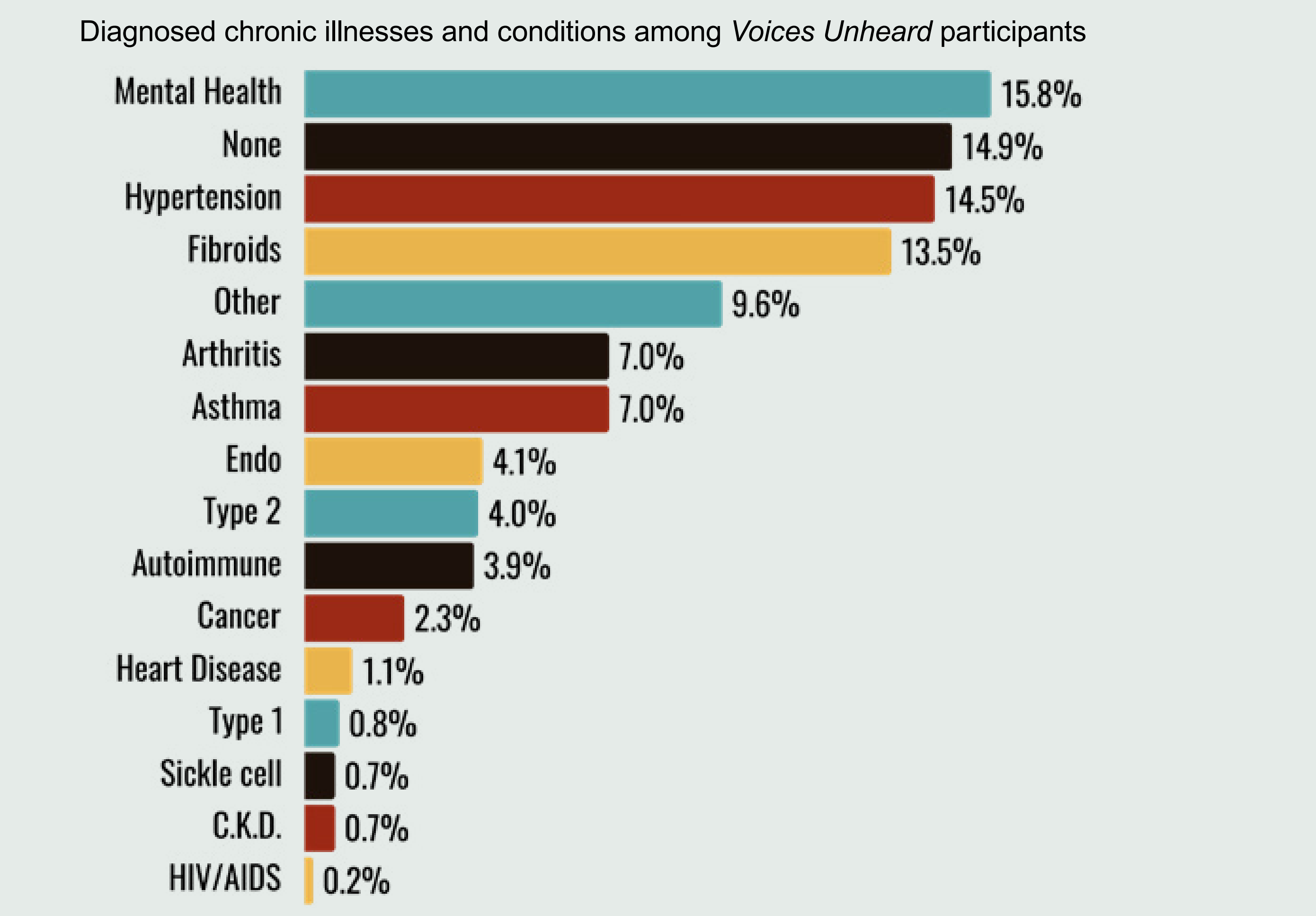
These studies clearly display the urgent need for race-based data collection and the information it can provide us. However, despite the high rates of hypertension among Black women, there remains a profound lack of interventions or research focused on prevention and treatment within Black communities. This mismatch between the high need and low response exposes a serious gap in Canada’s public health landscape. The absence of disaggregated race-based data and targeted public health approaches means that hypertension continues to be treated as an individual issue rather than a systemic one.

For Black women, whose hypertension is often linked to chronic stress, racism, and socio-economic pressures, this lack of tailored intervention deepens inequities and contributes to delayed diagnosis, inadequate management, and preventable complications. Addressing this gap requires investment in Black-led health research, policy reform, and community-rooted programs that recognize hypertension not only as a medical condition but also as a reflection of broader structural harms.

Uterine Fibroids: Dismissed and Downplayed

Uterine fibroids are noncancerous growths that develop in or around the uterus. While they can be asymptomatic, they often cause heavy menstrual bleeding, pelvic pain, frequent urination, and complications during pregnancy. Fibroids are more common, more severe, and more likely to lead to complications in Black women than in white women (Stewart, 2001). Despite this,

Figure 3: Diagnosed with a Chronic Illness or Condition


Diagnosed chronic illnesses and conditions among *Voices Unheard* participants

Black women often struggle for years to receive a proper diagnosis, let alone treatment.

Several participants highlighted how finances were a large barrier to receiving treatment. They said that often, insurance providers would not cover the medication needed to manage fibroids, resulting in patients covering the cost themselves. Over time, paying out of pocket becomes unsustainable.

Participants offered a stark reminder of the ongoing inequities that Black women face when seeking care for gynecological conditions. Although 282 respondents noted they are diagnosed with fibroids and receiving treatment for it, the journey to receiving the diagnosis and treatment was far from easy.

> *"My fibroids were dismissed for years. I kept being told it was just heavy periods. By the time they took me seriously, I needed surgery."*

One respondent shared: “For years, I was told my fibroids condition was not severe by Canadians specialists.” She suffered from severe menstrual bleeding, low energy levels, and anemia. She spent the next eight years advocating for herself and getting magnetic resonance imaging (MRIs) and ultrasounds, which all appeared negative. Finally, during one of her surgeries, she was diagnosed with fibroids. This is only one of many similar stories reflected in the research. It is clear that Black women in Canada continue to struggle with receiving a fibroids diagnosis, causing years of unnecessary harm and pain.

Lupus: Fighting for Recognition

Lupus is a chronic autoimmune disease where the body's immune system attacks its own tissues and organs, causing inflammation that can affect the skin, joints, kidneys, heart, lungs, and brain. Symptoms can range from joint pain and fatigue to life-threatening organ damage. Symptoms can range from joint pain and fatigue to life-threatening organ damage.

Lupus disproportionately affects Black women, girls, and gender non-conforming people. Research shows that Black women are two to three times more likely than white women to develop lupus and tend to experience more severe symptoms and complications (Lupus Foundation of America, n.d.). In Canada, this heightened vulnerability is compounded by systemic racism, a lack of data to support an efficient diagnosis, and a healthcare system that frequently dismisses or minimizes Black women's pain.

Participants shared experiences of being ignored, misdiagnosed, or told to simply lose weight despite clear medical histories. One respondent recounted, “I was told to lose weight and come back in a year. They didn’t even look at my chart or history. I have lupus.” These experiences echo broader findings from medical literature and underline a harsh reality: Black women are forced to fight for recognition and care in a system that too often erases their suffering.

The stories that participants shared reveal a troubling pattern where Black women's symptoms are dismissed, their pain is minimized, and their health concerns are attributed to lifestyle factors rather than underlying medical conditions. This medical gaslighting means that conditions like hypertension, uterine fibroids, and lupus are often diagnosed years later than they should be, leading to more severe complications and poorer outcomes. These disparities across multiple conditions also demonstrate why systematic race-based data collection is essential. Without tracking how medical conditions affect different racial groups, healthcare systems cannot adequately prepare for, prevent, or treat the conditions that disproportionately impact Black women.

Action is needed to help prevent this from continuing to happen. There is a clear urgency for targeted, culturally competent care approaches

> *“I was complaining about my illness for years and it took them a very, very long time — over 10 years — to figure out that I had lupus."*

“First pregnancy, bled out at the Humber River Hospital at triage. [The] baby came out in the bathroom as I was not considered urgent.”

-Voices Unheard survey participant

that recognize and address the unique health challenges facing Black women in Canada. Healthcare providers must be equipped with the knowledge to recognize conditions that commonly affect Black women and take their symptoms seriously from the first point of contact.

Reproductive Health

For many Black Canadian women, their experiences with reproductive health are shaped by a long history of medical neglect, coercion, and systemic racism.

> *“I couldn’t walk down the hallway after a C-section, and they told me I was neglecting my child. They contacted Children’s Aid.”*

This report confirms that contemporary healthcare systems often fail to provide safe, respectful, and culturally competent maternal care to Black women and Black parents who have given birth, leading to harmful health outcomes and trauma for both parent and child.

A Legacy of Harm

Understanding contemporary anti-Black racism in reproductive healthcare requires examining its historical roots in the dehumanization and exploitation of Black women’s bodies. The medical profession's treatment of Black women today cannot be separated from centuries of institutionalized practices that viewed Black people around the world as suitable subjects for experimentation. These historical foundations created enduring myths about Black women's bodies, specifically around pain tolerance, sexual behaviour, and reproductive capacity.

Anti-Black racism in reproductive care dates back to slavery-era pseudoscience. In the United States, 19th century physician J. Marion Sims, often referred to as the “father of gynecology,” subjected enslaved people to painful and intrusive gynecological experimentation without consent. Sims is known to not have used anesthesia on test subjects, believing that Black women could endure pain more than white women.

The Black Maternal Health Crisis

These historical legacies are not relics of the past. The legacy of slavery-era experimentation echoes today in the stories of participants who described being dismissed, denied pain relief, or coerced into medical procedures without full consent. These contemporary manifestations of reproductive harm reveal that anti-Black racism in healthcare has evolved rather than disappeared, continuing to undermine Black women’s bodily

> *“I was talking to myself when it came to telling the doctor or nurse that I was in pain. They told me that I am making it up and it's not that bad.”*

autonomy, safety, and trust in medical institutions (Williams et al., 2024).

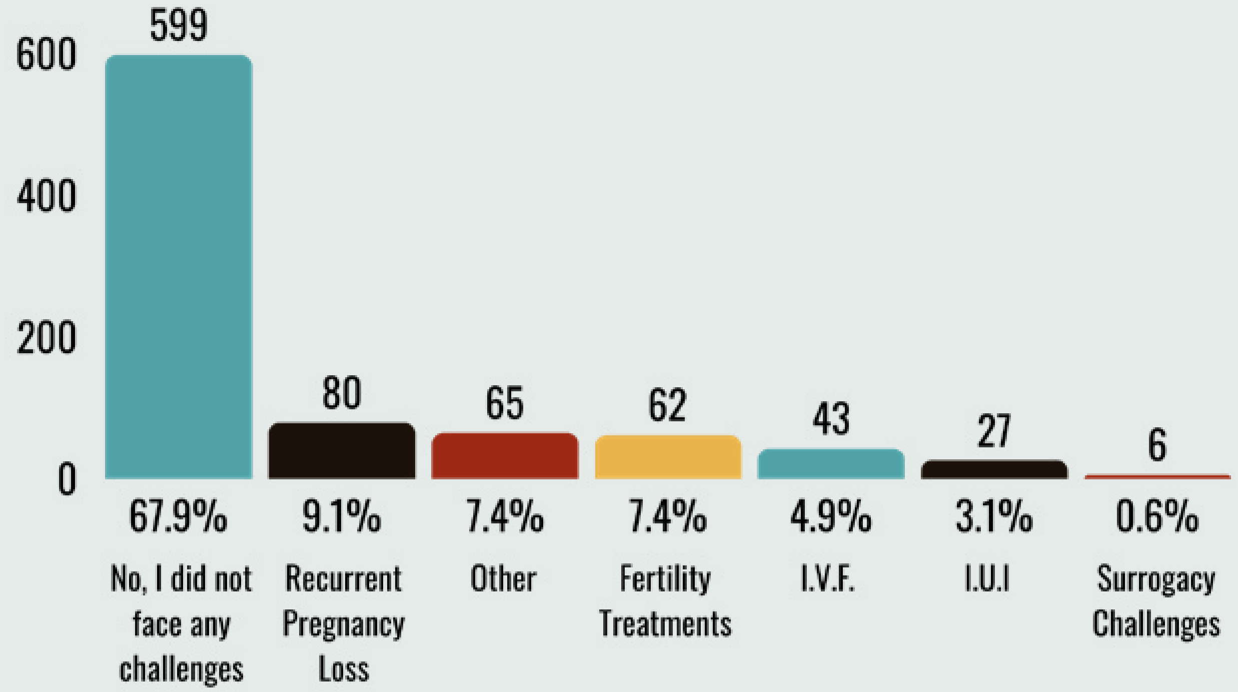
> *I recall a psychiatrist laughing off my concerns after I gave birth to my son and was experiencing post-partum depression.*

Pregnancy and childbirth are when mothers and parents are supposed to feel safe and supported. Unfortunately, this is not the reality for Black women in Canada. Over 28 per cent of participants expressed dissatisfaction with how their pregnancy-related health issues were managed. Many reported feeling scared, traumatized, and neglected. Others shared experiences of being ignored in moments of extreme vulnerability, subjected to unnecessary interventions, and blamed for complications that stemmed from systemic failures, not personal choices (see Figures 4 and 5).

Broader data proves that there are large gaps in the quality of maternal care between Black and white women. Research published in the Canadian Medical Association Journal in 2022 confirms what many Black mothers already know from lived experience: they are more likely to receive substandard obstetrical care, including inadequate pain management, diagnostic delays and errors, and dismissive treatment from healthcare providers (Dayo, Christy, & Habte, 2023).

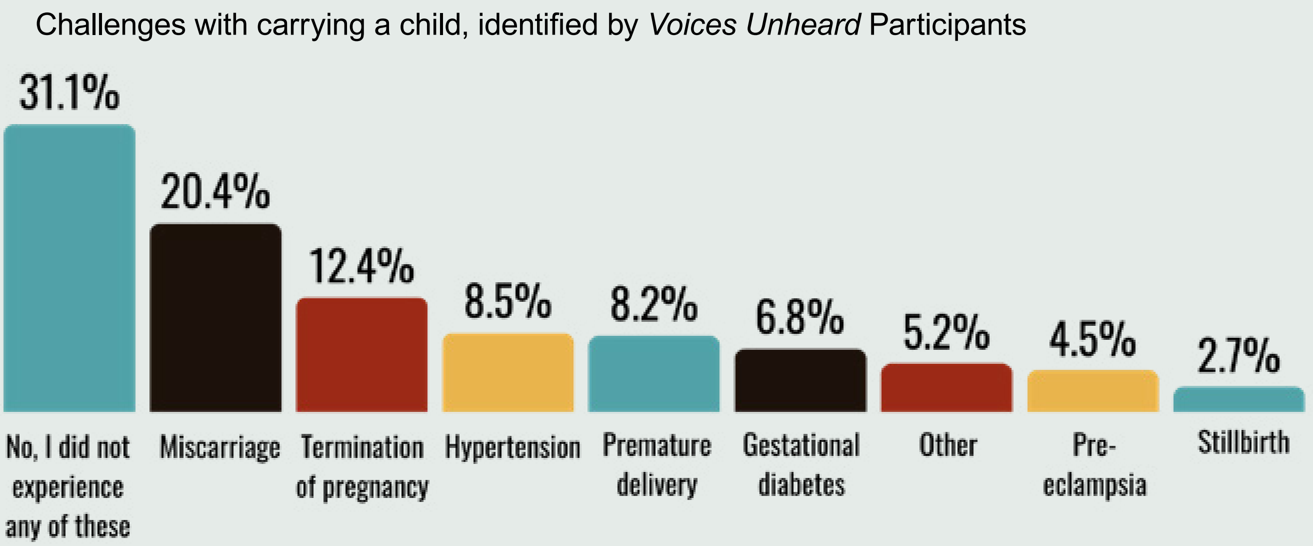
Figure 4: Challenges with Conception

Challenges with conception among *Voices Unheard* Participants



Canada's lack of race-based data makes it challenging to address these inequities. The stories told by participants of this research are only a few of many nationwide that clearly demonstrate the consequences of inaction. Not only can race-based data collection improve the health outcomes of mothers and infants, but it can also save lives.

Figure 5: Challenges with Conception



"I was diagnosed with depression but told I was 'too functional' for services. What does that even mean?"

-Voices Unheard survey participant

Mental Health and Wellbeing

Mental health challenges among Black women in Canada reflect the compounding effects of anti-Black racism, cultural expectations, and systemic barriers. The scope of this crisis becomes starkly apparent when examining suicidal ideation rates: while Statistics Canada reports that 4 per cent of women nationally experience suicidal thoughts, our research found that 27.4 per cent of Black women have contemplated self-harm, more than six times the national average, as depicted in Figure 6 (Liu, Pollock, Contreras, Tonmyr, & Thompson, 2022). This means one in four Black women in Canada have had thoughts of ending their lives, which is a stunning figure that health professionals should be mitigating against.

Black women face unique challenges rooted in their intersectional identities, constantly navigating systems that were not designed for them while simultaneously confronting institutions that have historically ostracized, pathologized, and undermined their wellbeing. These systems perpetuate harm through both active discrimination and willful neglect, creating environments where Black women must advocate for their own humanity while managing the psychological toll of existing within structures built to exclude them. This pressure can have devastating effects and often lead to depression, as depicted in Figure 7.

Supporting research from the University of Ottawa reveals that Black Canadians exhibit significantly higher rates of severe depressive symptoms,

Figure 6: Thoughts of Self Harm

Responses from *Voices Unheard* study participants on thoughts of self harm

Have you ever struggled with thoughts of self-harm?

Yes: **n=321** No: **n=852**

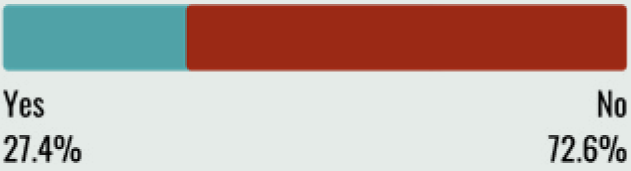


Figure 7: Feeling Down, Depressed or Hopeless

Frequency of feeling down, depressed, or hopeless among *Voices Unheard* study participants

In the past year, how often have you felt down, depressed or hopeless?

Rarely: **n=222** Sometimes: **n=455**
Often: **n=354** Never: **n=68**
Always: **n=66** Prefer not to say: **n=8**

with particularly elevated rates among women, employed individuals, those born in Canada, and nearly everyone who has experienced high levels of racial discrimination (Cénat et al., 2021).

To get a holistic understanding of these racial disparities requires examining not only the external systems that harm Black women, but also the internal pressures and cultural expectations that prevent them from seeking help or expressing vulnerability. One of the most pervasive and damaging of these pressures is the expectation that Black women must always demonstrate strength and resilience, regardless of the personal cost.

Toxic Resilience: The Burden of the "Strong Black Woman" Stereotype

Societal expectations that Black women will "soldier through" regardless of their treatment has created the harmful stereotype of the "Strong Black Woman." This stereotype portrays Black women as naturally resilient and self-sacrificing. While some may view this as empowering, this stereotype silences vulnerability, discourages help-seeking, and contributes to chronic stress, anxiety, and depression (Godbolt, Opara, & Amutah-Onukagha, 2022). This stereotype is literally killing Black women physically, mentally, and emotionally.

Many survey respondents expressed how the pressure to appear strong has led to delayed care and isolation. They reported pushing through exhaustion and the pain of poor mental health rather than risk being seen as weak. This cultural narrative shaped the path of their mental health journeys and created significant barriers to accessing the care they crucially need. The consequences of untreated mental health problems can be devastating, including increased risk of suicide (Gould et al., 2025). When Black women are expected to endure suffering silently, they are denied the support and intervention that could save their lives.

Cultural Stigma and Barriers to Care

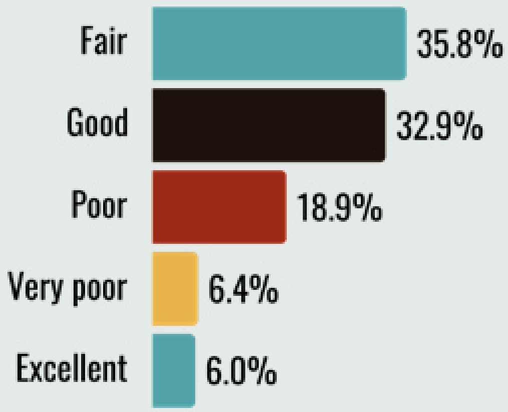
Cultural stigma around mental health creates additional barriers for Black women seeking support. In many Black communities, mental health challenges have long been considered taboo, making it especially difficult to start conversations about mental health or seek professional help (Mental Health Commission of Canada, 2021; Waldron et al., 2023). These internalized and community-based stigmas can leave Black women suffering in silence instead of reaching out for the support they desperately need.

Luckily, things are starting to change. As proven by the participants in this study, more and more Black women are seeking help. What prevents Black women from receiving care is not the stigma, but the barriers they face. Everything from affordability and lack of culturally competent mental health providers to appearing as too high functioning creates multiple layers of obstacles that Black women must face when seeking mental health care.

> *"There's a belief that Black women are strong, so I've been afraid to say when I'm not okay. I had to hit rock bottom before I finally asked for help."*

The intersection of historical oppression, ongoing anti-Black racism, and systemic exclusion from quality healthcare creates a perfect storm that continues to disadvantage Black women's mental health outcomes. Understanding these patterns through race-based data collection is essential for developing targeted interventions that can address both the immediate mental health crisis and the underlying long-term systemic factors that perpetuate it.

Figure 8: Feeling Down, Depressed or Hopeless



Self-reported mental health status in the past year among *Voices Unheard* participants

How would you describe your overall mental health in the past year?

Excellent: **n=70** Good: **n=386** Fair: **n=420** Poor: **n=222** Very poor: **n=75**

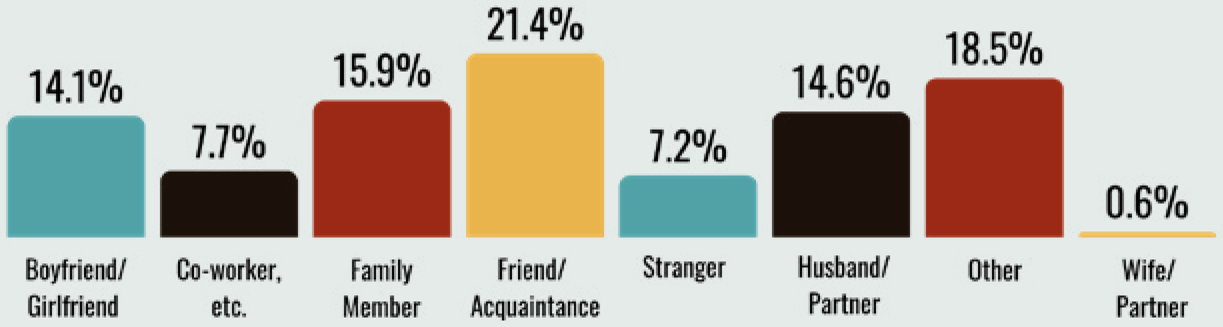
"I sought help after one instance of [a] gender-based violence offence and it was dismissed at work because I was told my dress was lifted up and looked under because the coworker is from a different era."

-Voices Unheard survey participant

Figure 9: Perpetrator of Violence

Who was the perpetrator of the violence?

Boyfriend/Girlfriend: n=198 Co-worker, etc.: n=108 Family member: n=300
Friend/Acuaintance: n=300 Stranger: n=101 Husband/Partner(male): n=204
Other: n=259 Wife/Partner (femlae): n=8



Violence, Abuse, and PTSD

Violence and abuse against women is a pervasive public health crisis that extends far beyond physical harm. Violence against women creates lasting mental, emotional, and psychological wounds that can persist long after the occurrence ends, leading to post-traumatic stress disorder (PTSD). For Black women who are adversely affected by violence, the impact is often amplified and finding a pathway to healing can be more difficult to access due to the intersection of discriminatory and systemic barriers.

The Scope of Violence in Black Women's Lives

Our research revealed that nearly 50 per cent of those surveyed reported experiencing violence and abuse, either from an intimate partner, family member, or friend (see Figure 9). This alarming statistic reflects broader patterns of gender-based violence while highlighting the particular vulnerabilities that Black women face within their personal relationships and family systems.

The violence experienced by participants encompasses one or more forms of abuse (see Figure 10): 37 per cent of participants reported experiencing emotional abuse, 29.8 per cent experienced sexual violence, 22.1 per cent faced physical violence, and 11.1% per cent endured financial abuse. Each of these carry their own set of consequences and trauma responses. Understanding the full scope of how these violent acts affect the wellbeing of Black women is crucial for healthcare professionals to provide effective treatment.

The Mental Health Impact of Violence

The psychological consequences of experiencing violence are severe and well-documented. Women who experience violence are three to five times more likely to develop depression, substance abuse disorders, PTSD, or experience suicidal ideation compared to women who have not experienced violence (Conroy, 2021).

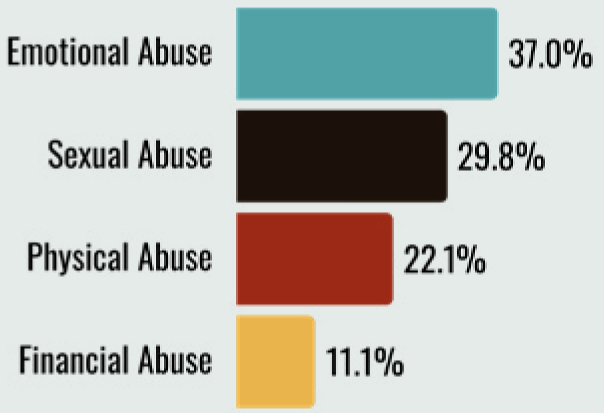
Emotional and psychological symptoms following violence include profound isolation, overwhelming anxiety, chronic insomnia, depression, and suicidal thoughts. These symptoms can persist for months or years after the violence ends, particularly when survivors lack access to appropriate trauma-informed care. The development of PTSD is common among survivors, manifesting as intrusive memories, nightmares, hypervigilance, and avoidance of triggers that remind them of the traumatic experiences.

Physical Health Consequences

The impact of violence extends well beyond mental health, creating lasting physical health problems that survivors must navigate alongside their emotional healing. Survivors frequently experience sleep disorders that compound other health issues, chronic pain conditions that may have no clear medical explanation, and significant changes in appetite that can lead to nutritional deficiencies or eating disorders.

These physical symptoms often perplex healthcare providers who may not recognize them as trauma responses, leading to misdiagnosis or inadequate treatment. The interconnection between trauma and physical health underscores the need for healthcare providers to screen for violence and understand trauma's impact on Black women's bodies.

Figure 10: Types of Violence Experienced



Types of violence identified by *Voices Unheard* participants

If yes, what type(s) of violence did you experince?

Emotional: **n=438** Sexual: **n=353**
Physical: **n=262** Finanical: **n=132**

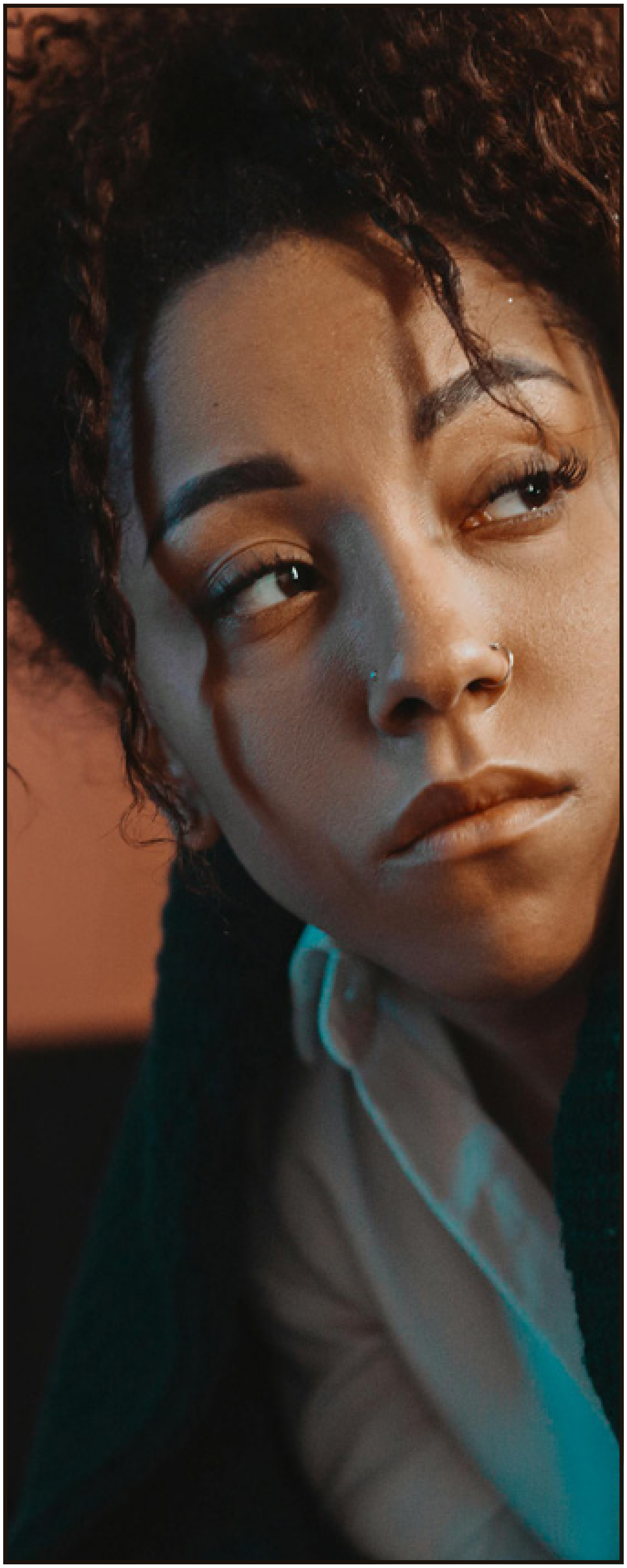
Amplified Risk for Black Women

For Black women, the risk of experiencing violence and its lasting consequences can be amplified by intersecting factors including disability, poverty, and immigrant status (Duhaney, 2022). These intersecting identities create multiple layers of vulnerability while simultaneously limiting access to support services and quality healthcare.

Racism within both the Canadian justice system and Canadian healthcare system can prevent Black women from seeking help or receiving appropriate care when they do reach out. Economic barriers may also trap women in violent situations, while immigration status for newcomers can create additional fears about seeking formal support. Black women with disabilities face increased vulnerability to violence while having fewer resources available for escape and recovery.

The combination of these factors means that Black women survivors often face longer recovery periods, more severe symptoms, and greater challenges accessing trauma-informed care. This reality underscores the critical importance of collecting race-based data to understand how violence differently impacts various communities and to develop targeted interventions that address the unique barriers Black women face.

Healthcare providers supporting Black women in Canada must be equipped to recognize the signs of violence-related trauma, understand its lasting impacts, and provide culturally competent, trauma-informed care that acknowledges the particular challenges facing Black women survivors.



“Whenever I bring up racism, I’m told to keep it professional. But the racism is unprofessional.”

-Voices Unheard survey participant

Burnout and Emotional Fatigue

The workplace experiences of Black women are marked by persistent stressors that extend far beyond typical job-related pressures. Systemic racism, discrimination, and exclusion in professional environments create chronic stress that significantly impacts both mental and physical health. For Black women, navigating workplace discrimination while simultaneously managing other life stressors creates a perfect storm for burnout and emotional fatigue (see Figure 11).

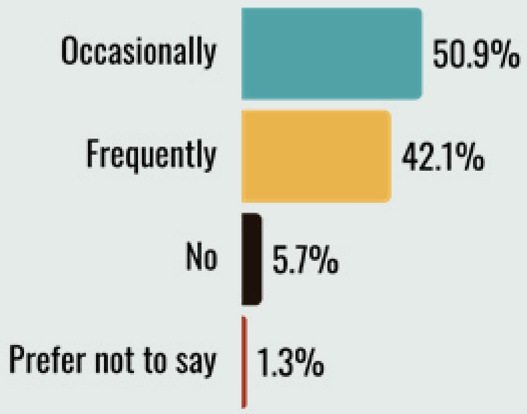
Employment Discrimination and Health Consequences

Many participants reported experiencing employment discrimination that directly contributed to their health problems. Lost opportunities, hostile work environments, and the constant stress of proving their competence in spaces where they face skepticism and bias create chronic psychological strain and can lead to feeling pushed or forced out of their positions (see Figure 12). In Canada, studies have shown that racialized women are underrepresented in senior leadership roles and face significant wage gaps compared to white colleagues (Canadian Women's Foundation, 2022; Block, Galabuzi, & Tranjan, 2019). A little more than 700 survey respondents shared they had left a job or switched careers due to a lack of advancement opportunities.

When employment opportunities are systematically taken away or when Black women are subjected to persistent workplace harassment, the resulting stress manifests in both immediate and long-term health consequences.

Stress and discrimination do not end when the workday is over. Participants described carrying the weight of these experiences when they get home, and that those stressors impact their sleep, relationships, and overall well-being. The constant hypervigilance required to navigate discriminatory workplaces creates a state of chronic stress that the body simply cannot sustain without consequence (Fante-Coleman, Plowman, Chira, Booker, & Gabbidon, 2025).

Figure 11: Feelings of Emotional Exhaustion/Burnout

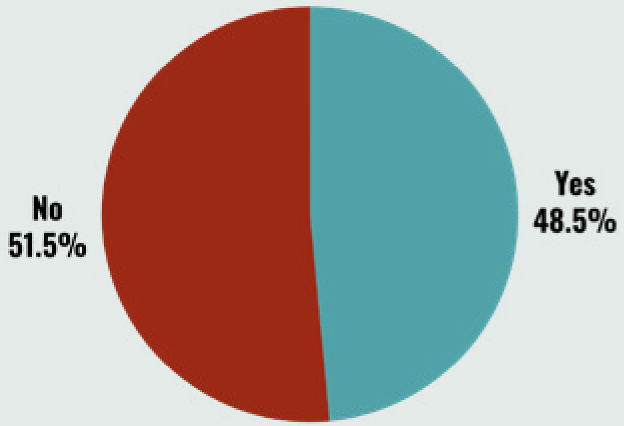


Self-reported frequency of experiences with feelings of burnout and emotional exhaustion among *Voices Unheard* participants

Have you ever experinced feelings of emotional exhaustion or burnout in your daily life or work?

Occasionally: **n=597** Frequently: **n=494**
No: **n=67** Prefer not to say: **n=15**

Figure 12: Felt Pushed Out/Forced to Leave a Position



Self-reported experiences with feeling pushed out from a job as identified among *Voices Unheard* participants

Have you ever felt "pushed out" of a job or forced to leave a position due to discrimination, bais, or lack of support?

Yes: **n=576** No: **n=612**

Blocked Pathways and Systemic Exclusion

Black women in Canada often share that their dreams of career advancement are blocked by a lack of professional development opportunities, which become sources of stress and demoralization. Anti-Black racism in professional settings manifests as being overlooked for leadership roles, excluded from important meetings or projects, and having contributions minimized or attributed to others.

These experiences of systemic exclusion create what many survey participants described as emotional fatigue: the exhaustion that comes from constantly fighting for recognition, respect, and basic professional opportunities. The psychological toll of repeatedly encountering barriers while watching less qualified colleagues advance creates a unique form of workplace trauma that impacts every aspect of a person's life.

Black Women in Healthcare: A Critical Crisis

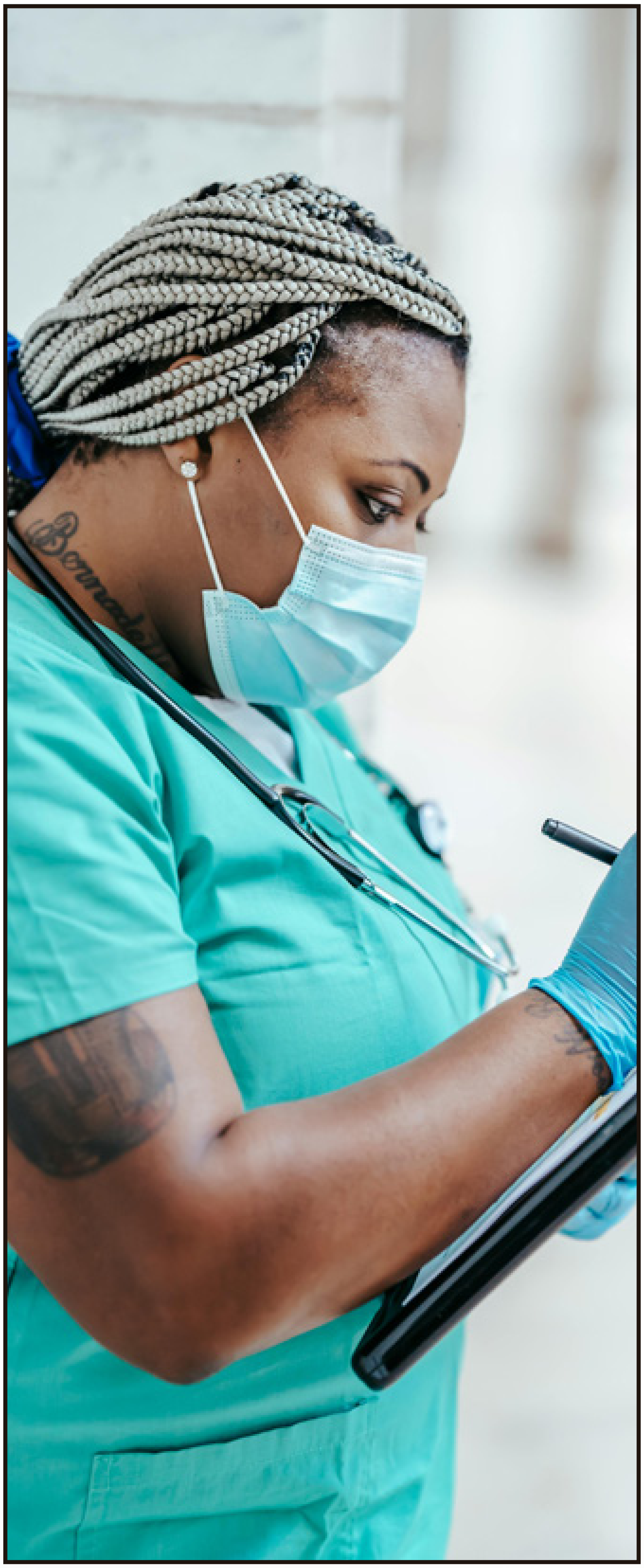
One in three Black women in Canada work in healthcare (Houle, 2020). Knowing that healthcare is one of the largest sectors employing Black women, it was crucial to take a deeper look at the experiences of Black women within the sector, specifically focused on healthcare workers in the Greater Toronto Area. That's why, in addition to this report, BWIH created a sub-report titled Black Women In Healthcare Leadership: Barriers And Pathways In The Greater Toronto Area, to further focus on what female healthcare workers had to say.

Black female healthcare workers shared particularly concerning experiences that highlight the urgent need for systemic change within healthcare institutions. Despite working in a field dedicated to healing and caring for others, these healthcare professionals reported overwhelming feelings of burnout, persistent racism from colleagues and patients, blocked pathways to advancement, and systemic neglect of their professional development and well-being.

The experiences shared by Black healthcare workers revealed a troubling pattern: many expressed a strong desire to leave the field entirely due to the toxic work environments they endure. While any worker leaving their job is making an individual decision, the impact of even one skilled Black worker in the field also represents a significant loss to the broader healthcare system. Black healthcare workers bring the expertise and valued cultural competency needed to serve diverse patient populations.

Black healthcare workers described feeling isolated, unsupported, and constantly having to prove their competence, in contrast to their white colleagues whose abilities were assumed. They reported experiencing racism from both patients who questioned their qualifications and colleagues who excluded them from decision-making processes. The irony of being healers within a system that creates profound emotional distress and moral injury is a sad reality for many healthcare workers.

Understanding the workplace experiences of Black women through comprehensive data collection is essential for developing interventions that address not just individual burnout, but the systemic factors that create these overwhelming professional challenges.



“Some of the books and information used is not considerate of Black excellence and achievements, but rather views Black people in a derogatory manner. There aren’t many Black people in the classes here, so you do feel isolated when topics like this are discussed and there isn’t proper representation.”

-Voices Unheard survey participant

Black Girlhood and Identity

Black girls and youth face a distinct set of challenges that differ significantly from those experienced by adult Black women and gender non-conforming people. The intersection of racism, sexism, and ageism creates unique vulnerabilities during critical developmental years when identity formation, peer relationships, and academic achievement are foundational to future well-being. Understanding these early experiences is crucial, as they often set the stage for the health challenges that Black women face throughout their lives.

The Roots and Lasting Impact of Childhood Racism

Many of the health problems that Black women experience as adults have their roots in childhood and adolescent experiences with anti-Black racism. Black girls are exposed to discriminatory treatment and harmful stereotypes from an early age, creating chronic stress during crucial developmental periods. This early exposure to racism creates lasting psychological impacts that can influence everything from self-love and academic performance to having healthy relationships.

According to a 2022 study on racism in Canada, racialized girls who experience ongoing racism often report distress, sleep problems, reduced self-esteem, a pervasive sense of unsafety, suppressed anger, and maladaptive coping mechanisms including eating disorders. These early stress responses establish patterns of poor mental and physical health that persist into adulthood (Williams, Khanna Roy, MacIntyre, & Faber, 2022).

These challenges do not simply disappear with age. They create lasting patterns that influence adult health outcomes. Early experiences with discrimination, stress, and identity struggles establish coping mechanisms, relationship patterns, and health behaviours that can persist throughout life. Comprehensive race-based data collection is essential for developing interventions that can interrupt negative health trajectories and end cycles of trauma.

School as an Unsafe Space

For many Black girls, schools become sites of discrimination and harm rather than safe spaces to learn and grow. Participants, who were aged 15 and up, shared experiences of not feeling safe in educational environments where they faced disciplinary disparities, lower expectations from teachers, and exclusion from academic and social opportunities.

> *“We’re punished for things our non-Black classmates are praised for.”*

Black girls are disproportionately suspended and expelled from schools, often for behaviours that are treated more leniently when exhibited by their white peers. These early experiences with racism and punishment can create educational disruptions that have lasting impacts on academic achievement and future opportunities. The stress of navigating discriminatory school environments contributes to the mental health challenges that persist into adulthood.

The connection between educational outcomes and health is well-established: lower educational attainment is directly linked to poorer health outcomes throughout life (Public Health Agency of Canada, 2022). When Black girls are systematically excluded from educational opportunities, they are not only denied academic advancement but also the foundation for a healthy and successful life.

Navigating Stereotypes and Body Image

During the impressionable teenage years, Black girls in Canada face tremendous pressure from conflicting messages and harmful stereotypes that attempt to define who they should be. Both traditional and social media demonstrate an increased interest in representation and diversity. However, Eurocentric beauty standards still dominate. Black girls also face the fetishization of their bodies, making it challenging to navigate identity formation while being pulled between harmful racial stereotypes and accusations of betraying their racial identity.

This constant policing of authenticity, combined with body image pressures, creates profound identity confusion and chronic stress during crucial developmental years. Black girls must learn to define themselves in opposition to both racist stereotypes and conflicting community expectations, often without adequate support or guidance. The psychological burden of these mixed messages and attempts to label them as something they are not contribute to stress, loss of authentic identity, and lasting mental health challenges that can continue into adulthood.

Navigating Relationships and Misogynoir

Black girls in Canada face the unique challenge of misogynoir — a term that refers to the specific form of discrimination faced by Black women and girls that combines both anti-Black racism and sexism, creating unique forms of prejudice and marginalization. They often face adultification, where they are perceived as older, more mature, and less innocent than their white peers. In romantic and peer relationships, Black girls encounter harmful stereotypes about their sexuality, aggression, and desirability that can profoundly impact their self-worth and relationship patterns.

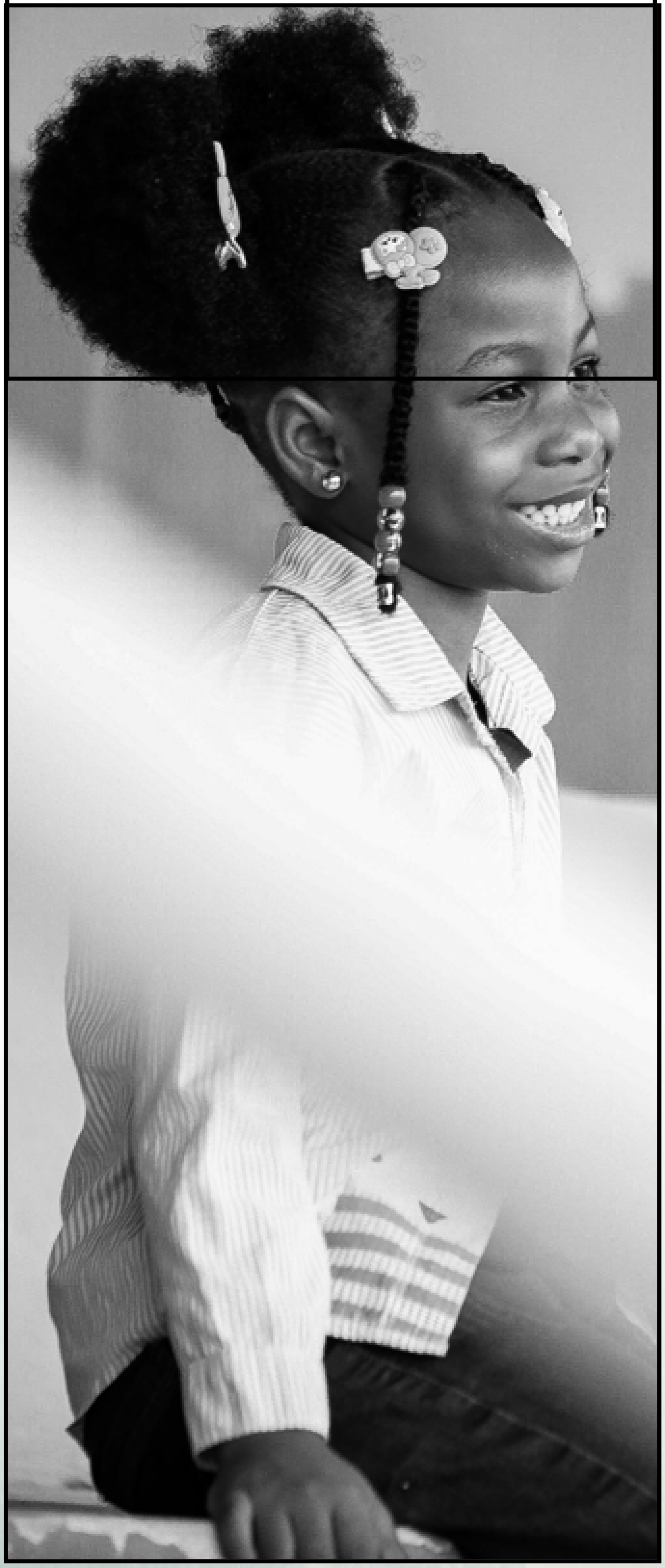
In the survey, Black girls shared that romantic relationships, particularly interracial ones, can be a source of cultural scrutiny and judgment. Many described a lack of safe, judgment-free spaces where they can openly talk about dating without

> *We’re constantly told what not to wear, how not to act, what not to say. It’s like we can’t win.”*

facing assumptions or criticism. Some felt they had to hide their romantic interests or censor their feelings to avoid backlash from peers or community members.

While all teenagers struggle with their journey into adulthood, Black girls have the added pressure of learning to handle racism as well. Addressing these gaps requires more than increasing capacity. It demands culturally responsive, anti-racist educators and policies, and a reimagining of wellness that centres the needs and realities of Black girls.

By recognizing and addressing the unique challenges of Black girlhood, healthcare systems and communities can work to prevent many of the health disparities that Black women face as adults. The experiences of Black girls and youth represent both the origins of many adult health challenges and an opportunity for early intervention that could transform lifelong health outcomes for Black women, girls, and gender non-conforming people in Canada.



Recommendations

These recommendations are not calls for reform — they are demands for transformation. They are rooted in the testimonies of Black women, girls, and gender non-conforming people who have spoken through the survey and qualitative narratives. These recommendations are designed to reimagine, restructure, and reclaim systems that were never meant to protect Black life. They are grounded in the principles of anti-Black racism, equity, disability justice, reproductive justice, and sovereignty.

Foundational Recommendations

1. **Define Black health as holistic**, inclusive of physical, mental, emotional, cultural, economic, and spiritual well-being, informed by lived experience, and grounded in Black feminist thought, disability justice, and Africentric knowledge systems.

2. **Adopt a Black health equity lens** across all levels of government, institutional policies, and legislation. This lens must include mental health sovereignty, reproductive justice, and the realities of sole-support parenting in the Black community.

3. **Enshrine Black data sovereignty** in legislation, protecting the rights of Black communities to collect, govern, and interpret their own data.

4. **Recognize and fund Black community based organizations** as essential health infrastructure.

5. **Ensure the inclusion of people with lived and living experience**, especially those from the disability community and those engaged with the child welfare system, in every decision-making table.

Implementation Principles

All recommendations must be implemented using the following guiding principles:

- **Self-Determination:** Black communities must have the authority to lead, shape, and govern the policies that impact their lives.
- **Cultural Reclamation:** All programs must be rooted in the cultural, spiritual, and ancestral knowledge of Black communities.
- **Nothing About Us Without Us:** Lived and living experience, including disability and sole-support parenthood, must be centred in all processes.
- **Disability Justice:** Disability must be viewed through a racial justice lens, not solely medicalized or individualized.
- **Intersectionality in Action:** Intersectionality should not be viewed as a theory, but a practical, structural commitment in every system.
- **Sustainability:** Funding must be long-term, renewable, and not pilot-based.
- **Transparency and Accountability:** Public, measurable, and enforceable accountability must be built into every response.

These recommendations are not a list of suggestions. They are a political and moral imperative. They reflect a vision of sovereignty, dignity, and accountability where Black communities are no longer asking for systems to care for them, but are building systems that centre their care, power, and healing. The time for incrementalism has passed. The time for revolutionary, community-led transformation is now.

Federal Government

1. Establish a **national Black health equity strategy** that is developed, led, and governed by Black communities, with Health Canada and the Public Health Agency of Canada as infrastructure and funding partners only.
2. Create a **permanent, independent Black health secretariat** governed by a council of Black health leaders, researchers, community advocates, and people with lived experience, with full structural independence and enforcement power.
3. Allocate a **minimum of $30 million annually**, secured through multi-year federal commitments, to support the strategy, with a five-year operational plan developed through a national Black health summit.
4. Enact a **Black health equity act**, co-drafted with Black communities, that legally recognizes the right to equitable, culturally grounded care and mandates institutional compliance, including a national Black Health Equity Inspectorate.
5. Establish a **national Black health knowledge hub**, governed by Black academic and community institutions, funded at $15 million annually, responsible for research, policy monitoring, data transparency, and education.
6. Enshrine in federal legislation the **requirement for disaggregated race-based data collection**, Black data sovereignty agreements, and transparency in reporting.
7. Launch a **federal-provincial-territorial**

Black health equity roadmap, with SMART goals, enforced public reporting, and clear consequences for non-compliance.

8. Advance **mental health parity and equity** in the Canada Health Act.

9. Amend the **Canada Health Act** to enshrine **mental health parity**, ensuring that mental health care is treated with the same urgency, funding, and accountability as physical health care. This includes establishing clear national standards that guarantee equitable access to culturally responsive and community-based mental health services for Black women and other marginalized populations. Specifically:

  a. Include mental health services in provincial health insurance plans. Mandate that provincial and territorial health insurance cover culturally responsive and trauma-informed mental health services delivered by qualified providers, including therapists, social workers, and community- based practitioners.

  b. Fund Black-led and culturally grounded mental health programs. Provide sustained federal transfers to support organizations delivering care tailored to the needs of Black women and girls.

  c. Embed accountability within federal health funding. Tie federal health transfers to measurable equity outcomes in mental health access, utilization, and quality for racialized communities.

  d. Recognize mental health as a matter of health sovereignty, not privilege. Enact federal policy that affirms mental health as a human right and an essential component of holistic well-being.

17. Create a **permanent, dedicated funding stream for Black health research** within the Canadian Institutes of Health Research (CIHR) and Tri-Council agencies, ensuring sustained investment in research led by and for Black communities, including:

  a. Permanent funding for Black undergraduate and graduate students pursuing studies in health, social sciences, and medical research, with priority given to projects that address anti-Black racism, health inequities, and culturally safe care.

  b. Dedicated research chairs, postdoctoral fellowships, and grants to advance Black health scholarship, knowledge mobilization, and data collection.

  c. Funding for Black-led community organizations engaged in participatory and applied health research

  d. Long-term operational funding for Black health institutes and networks to sustain infrastructure, evaluation, and innovation.

Provincial and Territorial Governments

18. Legislate **provincial Black health equity acts**. Each province and territory must pass a **Black Health Equity Act** that codifies the right of Black residents to equitable, culturally safe, and anti-racist healthcare. These Acts must:

  a. Mandate the creation of Provincial Black Health Equity Plans tied to public funding.

  b. Require annual racial equity audits of all publicly funded health institutions.

c. Establish enforceable legal accountability for institutions that fail to meet benchmarks.

d. Empower independent enforcement bodies with powers to investigate and sanction.

19. Mandate hospital-level Black health equity requirements. Ministries of Health must:

a. Require all hospitals and public health units to develop and implement Black health equity implementation plans as a condition of funding.

b. Mandate the creation of Black-led Patient Advocacy and Protection Units in every hospital (or regional equivalents).

c. Tie executive performance and funding to race equity outcomes.

d. Require race-based data collection and public reporting across all care environments.

20. Establish and fund provincial Black health equity councils. Each province must create a Black Health Equity Council, governed by Black-led organizations, clinicians, researchers, and community advocates. These Councils must:

a. Hold institutional and government bodies accountable to equity goals.

b. Review budgets, policies, and legislation through an anti-Black racism lens.

c. Be granted formal oversight authority and be embedded into Ministry structures.

21. Include mental health services in provincial health insurance plans. Provinces must:

a. Fully cover culturally responsive mental health services under public insurance (e.g., OHIP)

b. Fund Black-led mental health providers and wellness programs.

c. Train and certify providers in racial trauma and anti-Black racism.

d. Recognize mental health care as a matter of health sovereignty, not privilege.

22. Establish regional Black-led advocacy and protection units. Where hospital-embedded units are not feasible due to geography, provinces must fund regional Black-led Patient Advocacy and Protection Units. These must:

a. Be mobile, legally empowered, and accessible virtually and in person.

b. Report to the Ministry of Health with independent oversight.

c. Cover multiple institutions in underserved areas and ensure continuity of care and justice.

23. Create provincial inspectorates for anti-Black racism in healthcare. Provinces must establish Black Health Equity Inspectorates with:

a. Powers to investigate and intervene in institutions exhibiting racial harm.

b. Mandate to monitor compliance with health equity legislation and institutional plans.

c. Ability to impose funding consequences for non-compliance and issue public findings.

24. Fund Black-led health workforce pipelines. Provinces must co-create pathways into health professions for Black youth and workers, including:

a. Tuition-free training programs for Black students in clinical and allied health fields.

b. Paid placements, internships, and mentorships across the health system.

c. Supports for workplace navigation, leadership advancement, and retention.

d. A province-wide Black health talent database to support equitable recruitment.

18. Embed anti-Black racism protections in health sector labour agreements. Provinces must work with unions, post-secondary institutions, and regulatory bodies to:

a. Mandate anti-Black racism protections in collective agreements.

b. Embed race equity in hiring, retention, and promotion practices.

c. Protect Black staff from retaliation when reporting harm.

d. Embed racism as a reportable category in workplace violence protocols.

19. Build provincial Black health data infrastructure and ownership protocols:

a. Require all health institutions to collect, store, and publish race-disaggregated data.

b. Partner with Black communities to define ethical usage and data ownership.

c. Ensure that data drives funding decisions and structural reform.

d. Publicly report Black health indicators in ministry dashboards.

20. Fund Black healing and wellness hubs across the continuum of care. Each province must fund Black healing hubs rooted in:

a. Clinical care, doula and birthwork, peer, and elder support.

b. Legal navigation, food justice, community wellness, and storytelling.

c. Services for Black youth, single mothers, 2SLGBTQIA+ folks, newcomers, and elders.

d. Governance by Black organizations, not mainstream health agencies.

21. Enforce race equity standards in public health units and agencies:

a. Require every public health unit to have an Anti-Black Racism Action Plan.

b. Employ dedicated Black Health Equity Officers.

c. Track racial disparities in vaccination, screening, and health promotion access.

d. Make racial equity a required domain in public health performance reviews.

22. Create reparative justice and redress pathways for harm:

a. Create formal systems for survivors of anti-Black racism in healthcare to access justice.

b. Include financial compensation, public acknowledgement, and systemic reforms.

c. Guarantee survivor-led processes rooted in dignity, truth-telling, and accountability.

d. Monitor institutional participation and publish compliance reviews.

– Hospitals, Public Health Units, and Healthcare Institutions –

23. Mandate institution-wide Black health equity implementation plans. Every hospital, public health unit, and healthcare institution must develop and publicly implement a Black Health Equity Implementation Plan. These plans must include:

a. Measurable outcomes and timelines.

b. Third-party audits by Black-led evaluation teams.

c. Co-governance with Black community stakeholders.

d. Equity benchmarks tied to executive compensation and institutional funding.

24. Establish Black-led patient advocacy and protection units (institutional and regional models). Every hospital must provide access to a Black-Led Patient Advocacy and Protection Unit with the authority to intervene in cases of racial harm or discrimination against Black patients or staff.

a. In urban centres with significant Black populations, these units must be embedded directly in hospitals.

b. In regions with fewer Black residents, Regional Black Advocacy Units must be established, funded by the Ministry of Health, and available for rapid response, virtual support, and in-person advocacy across clusters of institutions.

c. Units must report directly to hospital CEOs and submit quarterly reports to the Provincial Ministry of Health.

d. These reports must include case trends, compliance issues, and institutional recommendations and feed into a province-wide Black Health Equity dashboard.

e. Units must be legally protected from retaliation and must have authority to escalate unresolved cases to external oversight bodies, including a Black Health Equity Inspectorate.

25. Create safe, survivor-centred reporting pathways for anti-Black harm. Hospitals must develop and maintain accessible, multilingual, culturally safe systems for patients and staff to report racial harm. These pathways must:

a. Include anonymous options, third-party support, and legal resources.

b. Guarantee trauma-informed responses and protect against institutional retaliation.

c. Require time-bound resolution processes with public accountability for outcomes.

26. Implement mandatory anti-Black racism education and certification. All healthcare institutions must implement rigorous, mandatory anti-Black racism and cultural safety education:

a. Training must be designed and delivered by Black-led organizations.

b. Completion must be required for hiring, professional advancement, and licensure renewal.

c. Leadership must undergo intensive modules on institutional racism, accountability, and power dynamics.

27. Mandate racial equity audits and public reporting on patient outcomes. Hospitals must collect, audit, and publicly report race-disaggregated data on health outcomes, access to care, diagnostic patterns, pain management, and discharge decisions.

   a. All existing algorithms and protocols must be reviewed and corrected for racial bias (e.g., eGFR, pain scales, VBAC risk scores).

   b. Data must be used to set performance benchmarks and corrective action plans.

28. Protect and advance Black health workers. Every hospital must develop a formal, fully funded Black Staff Equity Program, including:

   a. Career advancement pipelines into executive, clinical, and research leadership.

   b. Whistleblower protections and third-party reporting systems for Black staff experiencing harm.

   c. Pay transparency and audits to ensure salary parity.

   d. Dedicated mentorship, training, and wellness supports.

29. Establish onsite Black healing and wellness hubs. Hospitals must fund and co-develop dedicated spaces that centre Black wellness through clinical care, holistic healing, mental health support, peer programming, and community education. These hubs must be open to both Black patients and Black health workers and be co-designed with Black practitioners and communities.

30. Create death and harm review panels for Black patients. Every hospital must establish or participate in an independent Black Patient Death and Harm Review Panel. These panels must be triggered automatically in cases of death, serious harm, or negligence involving Black patients.

   a. The panels must have full investigatory access.

   b. Their findings must be publicly reported.

   c. Hospitals must implement binding recommendations within six months.

31. Require Black-specific Patient and Family Advisory Councils (PFACs). Every hospital must create and fund a dedicated Black PFAC. These councils must:

   a. Be co-led by Black patients, caregivers, and health advocates.

   b. Have decision-making authority over relevant policy areas.

   c. Be involved in the review of race-based outcome data and institutional practices.

   d. Be compensated for their time, insight, and labour.

32. Introduce hospital-level Black health equity report cards. Institutions must annually publish a Black Health Equity Report Card, co-developed with Black community members and reviewed by the Provincial Ministry of Health.

   a. These report cards must measure outcomes, access, staff experience, and institutional reforms.

   b. They must be made accessible to the public and reviewed in executive performance processes.

33. Fund radical curriculum reform in health professional education. All teaching hospitals and academic health centres must work with Black-led education and community organizations to revise curriculum and training for medical and allied health professionals, including:

   a. Case-based learning rooted in Black lived experience.

b. Decolonized and culturally grounded approaches to anatomy, diagnostics, and care.

c. Simulation training that reflects systemic harm and healing justice.

34. Embed equity into hospital accreditation and ministry oversight. Ministries of Health must make Black Health Equity Implementation a condition for:

a. Hospital accreditation.

b. Renewal of leadership appointments.

c. Funding allocation.

35. Access to capital expansion projects.

— Medical, Nursing, and Hospital Regulatory Associations —

All health regulatory bodies and licensing councils across Canada — including the College of Physicians and Surgeons, College of Family Physicians, provincial nursing colleges, and allied health regulatory bodies — must formally **recognize anti-Black racism as both a public health emergency and a professional harm standard.**

To achieve this, regulatory bodies must:

36. Declare anti-Black racism to be a public health emergency and an explicit form of professional misconduct.

37. Embed racism-related harm as a reportable and sanctionable offence within codes of ethics, professional standards, and practice guidelines.

38. Create a distinct complaint category within professional discipline processes addressing racial discrimination, bias-based neglect, and racial trauma.

39. Mandate self-assessment, reflection, and remediation for members where findings of racial harm are substantiated.

40. Publicly report aggregate data on complaints and disciplinary actions related to racism to promote transparency and accountability.

41. Develop and enforce a national Black health competency framework. Working in partnership with Black health leaders and Black-led organizations, associations must co-create a national Black health competency framework, covering:

a. Licensing exams and board certification criteria for all regulated health professions.

b. Continuing medical and professional education requirements.

c. Curriculum and practicum guidelines for academic institutions.

d. Specialized training on the intersection of anti-Black racism, diagnostic bias, and systemic neglect.

This framework must be mandatory and built into accreditation, re-certification, and advancement pathways.

42. Audit and reform all clinical guidelines and practice standards through an anti-Black racism lens:

a. Conduct full-scale reviews of diagnostic tools, treatment algorithms, and clinical guidelines to remove racially biased practices (e.g., race corrections in kidney function tests, pain scale assessments).

b. Collaborate with Black-led research institutions to create revised, race-conscious standards of care.

c. Publish findings and changes in peer-reviewed journals, and distribute updated tools system-wide.

43. Establish Black physician, nurse, and allied health protection units within regulatory colleges:

a. Create internal protection units to investigate harm against Black health professionals within hospitals, training programs, and clinical settings.

b. Provide legal, psychological, and career protection to Black members facing retaliation or racial violence.

c. Mandate that Black professionals are not required to "prove" racism without systemic support and oversight.

d. Issue public reports on institutional complicity in the harm or career stagnation of Black health workers.

44. Fund Black-led leadership, education, and innovation pipelines:

a. Allocate a dedicated portion of annual revenue to fund Black student and practitioner fellowships, leadership pipelines, and innovation labs.

b. Establish partnerships with Black-led health education initiatives and student networks to increase representation and reduce attrition.

c. Guarantee tuition assistance, mentorship, and leadership access points across the career trajectory — from pre-med to medical boards and executive positions.

45. Publicly report on racial disparities in the profession. All associations and regulatory colleges must collect and publish disaggregated data on:

a. Recruitment, admission, and graduation rates for Black students.

b. Hiring, promotion, and compensation of Black health workers.

c. Disciplinary action patterns, including who is more likely to face investigation or lose licensure.

d. Leadership demographics within hospitals, health systems, and academic institutions.

e. This data must be linked to equity benchmarks and included in annual reports and public accountability scorecards.

46. Embed mandatory anti-Black racism training into licensure and renewal. Licensure for physicians, nurses, midwives, and all regulated health professionals must be contingent upon:

a. Completion of accredited training on anti-Black racism, medical neglect, historical harm, and healing justice.

b. Demonstrated application of Black health competency standards in care provision.

c. Periodic renewal requirements that assess retention, implementation, and accountability in clinical practice.

47. Develop a Black health justice code of practice. Each association must co-create a Black Health Justice Code of Practice with Black health leaders that:

  - **a.** Outlines the ethical responsibilities of healthcare professionals when caring for Black patients.
  - **b.** Includes trauma-informed care, cultural humility, and racial harm reduction as core tenets.
  - **c.** Can be enforced and integrated into education, hiring, and performance evaluations.

48. Collaborate on national surveillance and legal remedies for medical racism. Associations must collaborate with Health Canada, provincial Ministries of Health, and Black health secretariats to:

  - **a.** Create a national surveillance system for tracking medical racism.
  - **b.** Develop legal pathways for Black patients and professionals to seek justice for harm.
  - **c.** Participate in truth and reconciliation initiatives that document and repair medical apartheid in Canada.

Mental Health and Community Healing

This list centres Black mental health sovereignty, community-defined care, and structural repair, rejecting models of care that individualize trauma while failing to dismantle the systems that cause it.

49. Establish Black mental health sovereignty as a foundational right. Governments at all levels must recognize Black mental health sovereignty — the right of Black communities to define, govern, and deliver their own mental health supports — as a principle of health equity which must:

  - **a.** Reject deficit-based models that pathologize Black grief, rage, or survival.
  - **b.** Treat mental health access not as charity, but as a form of reparative justice.
  - **c.** Centre lived and living experience, ancestral knowledge, and trauma-informed peer wisdom in all mental health program development.

50. Create and fund Black-led mental health ecosystems. Governments must allocate sustained, long-term funding to develop Black-led mental health ecosystems across the country, including:

  - **a.** Peer support circles, narrative therapy, and intergenerational healing spaces.
  - **b.** Afro-spiritual wellness practitioners, art therapists, somatic therapists, herbalists, and elder-led counsel.
  - **c.** In-community models rooted in cultural safety and liberation psychology.
  - **d.** Funding must flow directly to Black-led organizations with autonomy in service design, staffing, and evaluation.

51. Establish a national Black mental health registry and practitioner council. Create a publicly funded, Black-governed registry of Black mental health providers, accessible across Canada, that includes:

  - **a.** Therapists, clinical social workers, traditional healers, birth workers, and grief counsellors.
  - **b.** Regional filters, virtual service options, and sliding-scale availability.
  - **c.** Verification systems and community ratings, rooted in cultural resonance and safety.

This registry must be overseen by a National Black Mental Health Provider Council, composed of practitioners, peer support leaders, and researchers.

52. Launch a national healing justice initiative. Develop a Healing Justice Fund to support Black communities in designing, leading, and evaluating their own mental health practices, including:

- **a.** Core funding for Black-led healing collectives.
- **b.** Space to practice non-clinical, community-rooted care models.
- **c.** Seed grants for innovation in grief rituals, somatic justice, and intergenerational trauma recovery.
- **d.** A commitment to redefine what counts as “evidence” to include ancestral, oral, and lived expertise.

53. Mandate mental health equity and psychological safety in workplaces. All federally and provincially regulated workplaces must:

- **a.** Implement trauma-informed mental health policies that address racial harm, microaggressions, and burnout.
- **b.** Guarantee accommodations for Black workers facing race-based trauma.
- **c.** Require racial trauma awareness training for human resources professionals and management.
- **d.** Include mental health equity audits in all employment standards reviews.

54. Fully fund Black-led maternal mental health and health programs. Fund maternal mental health programs led by Black birth workers, doulas, peer mentors, and therapists. These programs must be:

- **a.** Grounded in reproductive justice.
- **b.** Community-based and culturally centred.
- **c.** Designed to support Black mothers and Black parents who have given birth from conception to postpartum, including loss, birth trauma, and identity grief.
- **d.** Evaluated by participants themselves using holistic and relational wellness indicators.

55. Embed Black mental health services in primary care and community spaces by:

- **a.** Embedding Black therapists and wellness workers in schools, libraries, shelters, and neighbourhood hubs.
- **b.** Co-locating services with food banks, community kitchens, arts spaces, and spiritual centres.
- **c.** Using outreach, not intake, as the standard of care — meeting people where they are.
- **d.** Mental health care for Black communities must not be isolated in hospitals or behind clinical walls.

56. Remove barriers to licensing for Black internationally trained mental health and health professionals. Establish clear, expedited, and affordable pathways for Black internationally trained practitioners to be licensed in Canada, including:

- **a.** Recognition of credentials from African and Caribbean institutions.
- **b.** Funding for bridging programs and practicum

placements.

c. Culturally relevant licensing exams.

d. Support to join and lead professional colleges.

57. Legislate coverage of mental health under provincial health insurance plans. Mental health care must be legislated as essential and covered under public insurance (e.g., OHIP, MSP).

a. Coverage must include both clinical and culturally defined mental health services.

b. Services must be accessible without diagnosis or referral.

c. Black-led clinics and wellness hubs must be able to bill directly and equitably.

d. This shift must frame mental health not as a discretionary benefit but as a constitutional right to wellness.

58. Create accountability and healing frameworks for mental health harm. Fund national and provincial public inquiries into the systemic mental health harms experienced by Black communities in Canada, including:

a. Institutionalization, misdiagnosis, overmedication, and forced treatment.

b. Loss of family due to biased child apprehension linked to mental health labels.

c. Lack of access to care in crises resulting in police involvement, violence, or death.

d. Intersections of racism, poverty, and incarceration.

These inquiries must lead to formal apologies, reparations, and a permanent oversight structure for mental health equity.

Employers, Labour, and Economic Policy

59. Mandate anti-Black racism workplace protection legislation. Federal and provincial governments must legislate anti-Black workplace safety standards that recognize anti-Black racism as a workplace hazard and psychological injury. These protections must:

a. Be embedded in occupational health and safety laws.

b. Require employers to prevent, respond to, and repair race-based harm.

c. Recognize race-based trauma as a form of workplace violence.

d. Protect employees from retaliation when reporting racism, bullying, exclusion, or tokenism.

60. Create racial trauma leave with legal protection. All employment legislation must include paid racial trauma leave as a protected category. This leave must:

a. Be recognized under provincial and federal labour codes.

b. Not require medical documentation for access.

c. Cover healing from personal, collective, or workplace racial trauma.

d. Be available to contract, gig, and part-time workers in both public and private sectors.

61. Require public pay transparency and wage justice measures. All federally and provincially funded employers must:

a. Conduct and publish disaggregated race and gender wage gap audits.

b. Set timelines and strategies to close pay gaps.

c. Be held financially accountable for failure to meet pay equity targets.

d. Include pay transparency requirements in procurement and vendor contracts.

62. Embed mandatory racial equity audits into workplace standards. Workplace equity audits must become mandatory and recurring across all sectors, including:

a. Public institutions, Crown corporations, and large-scale private employers.

b. Hiring, retention, promotion, and leadership demographics.

c. Job quality indicators, including precarity, benefits access, and burnout levels.

d. Audits must be conducted by independent, Black-led firms and tied to executive performance evaluations and government contracts.

63. Legislate protections for Black workers across labour codes and collective agreements. Governments must:

a. Amend labour codes to recognize systemic racism and cumulative harm.

b. Embed protections against race-based discrimination, tokenism, and exploitation.

c. Mandate inclusion of anti-Black racism clauses in collective agreements.

d. Ensure unions are held accountable to represent Black workers equitably in grievances and promotions.

64. Create a national Black economic and employment justice fund. Federal and provincial governments must establish a Black Economic and Employment Justice Fund to:

a. Resource Black-led employment centres, entrepreneurship initiatives, and job readiness programs.

b. Support Black women, 2SLGBTQIA+ workers, disabled workers, and survivors of workplace trauma.

c. Prioritize flexible funding for community-led innovation in income generation, financial healing, and workplace repair.

d. Include infrastructure and capital access support for Black cooperatives and social enterprises.

65. Establish community-based employment and economic healing hubs. Black-led organizations must be funded to create healing and employment hubs that provide:

a. Legal supports, mental health services, and job retraining for workers pushed out of toxic workplaces.

b. Access to childcare, transportation, and basic income bridging for those re-entering work.

c. Financial literacy, cooperative economics, and entrepreneurship mentorship rooted in Africentric principles.

d. Accountability structures for employers with histories of racial harm.

66. Mandate employer participation in anti-racism training and accountability structures. All employers receiving public funds or contracts must:

a. Participate in mandatory anti-Black racism training developed and delivered by Black-led organizations.

b. Develop internal race equity committees with decision-making power.

c. Publish annual reports on anti-racism progress, tied to funding renewals or tax incentives.

d. Create leadership pathways and succession planning specifically for Black employees.

67. Protect Black gig, migrant, and precarious workers. Governments must extend labour protections to the most vulnerable Black workers and must:

a. Ensure access to benefits, paid sick leave, mental health supports, and labour protections.

b. Create regularization pathways and protection from deportation for migrant workers reporting abuse.

c. Fund Black-led advocacy and legal navigation hubs for these communities.

68. Establish provincial and federal Black worker ombudsperson offices. Independent Black Worker Ombudsperson Offices must be created to:

a. Investigate systemic racism in hiring, retention, and workplace practices.

b. Enforce compliance with labour protections and equity standards.

c. Provide public reporting, employer scorecards, and redress mechanisms.

d. Centre lived experience, cultural safety, and economic dignity in all enforcement work.

Education, Research, and Academic Institutions

69. Establish federally funded Black research institutes with full Black governance. The Government of Canada must create and sustain a national network of Black Research Institutes in partnership with post-secondary institutions, which must:

a. Be governed entirely by Black scholars, researchers, clinicians, community leaders, and elders.

b. Focus on health equity, intergenerational trauma, reproductive justice, disability, economic justice, and environmental racism.

c. Hold independent research mandates and power to influence public policy.

d. Receive long-term base funding with full autonomy in research direction, staffing, and dissemination.

The presence of a university or hospital partner must not override Black governance or restrict critical inquiry.

70. Mandate Black Health Research Ethics Boards (BH-REB) for all federally funded research involving Black communities. All research involving Black people, funded by federal dollars, must be subject to BH-REB approval, including:

a. Biomedical, clinical, social, educational, and public health research.

b. Oversight by a Black-led ethics board composed of community members, researchers, disability justice advocates, and trauma-informed experts.

c. A requirement for researchers to demonstrate cultural safety, consent beyond the individual (e.g., community consent), and post-study accountability.

d. Failure to comply must result in immediate funding suspension and public disclosure.

71. Enforce Black data sovereignty and community ownership of research. Every research institution receiving federal or provincial funds must:

a. Establish and honour Black Data Sovereignty Agreements for research conducted with Black communities.

b. Recognize Black communities as co-owners of all data collected, with authority over its use, publication, and storage.

c. Provide communities with access to raw data, summaries, and evaluation tools.

d. Require a clear plan for knowledge return to participants, beyond academic publication.

72. Fund Africentric curriculum development across all levels of health education. Federal and provincial governments must fund Black-led organizations, educators, and scholars to:

a. Develop and deliver Africentric health curriculum in secondary, post-secondary, and professional education.

b. Embed Black feminist frameworks, critical race theory, reproductive justice, disability justice, and Indigenous-Black relationality.

c. Ensure content development includes students, educators, elders, and survivors.

d. Mandate inclusion of this content in health licensing pathways and continuing education programs.

73. Restructure health research funding distribution with transparency and justice. Tri-council and other public funding bodies must:

a. Conduct and publish annual audits of funding awarded to Black principal investigators, research assistants, and community-based projects.

b. Include disaggregated data by race, gender, and disability at every stage of funding, from submission to peer review.

c. Require diverse peer review panels that include Black scholars, community members, and youth.

d. Reallocate funding away from institutions that consistently exclude Black researchers or tokenize Black community involvement.

74. Embed community governance in all health research governance structures. Post-secondary institutions and research networks must restructure to include:

a. Community Governance Tables with binding decision-making power over Black health research.

b. Protocols to prevent extractive research and academic voyeurism.

c. Shared leadership roles for grassroots organizations, youth, and elders in shaping research priorities.

d. Enforcement mechanisms for institutions that fail to operationalize equity beyond rhetoric.

75. Create reparative fellowships and career advancement programs for Black scholars. Publicly funded institutions must establish fellowships, chairs, and advancement programs specifically for Black scholars whose work has been underfunded or suppressed due to systemic anti-Blackness, including:

a. Tenure-track positions for Black community-based researchers and health practitioners.

b. Salary parity reviews and retroactive compensation processes.

c. Discretionary funds for healing sabbaticals, research retreats, or community-embedded fellowships.

76. End predatory publishing and peer review exclusion of Black researchers. Academic journals and funding bodies must be held to account for the consistent exclusion of Black researchers, including:Legal supports, mental health services, and job retraining for workers pushed out of toxic workplaces.

a. Banning racially biased gatekeeping practices in peer reviews.

b. Funding the creation of open-access, Black-led journals and publishing houses.

c. Requiring training for editorial boards on anti-Black racism and trauma-informed academic practice

Anti-Black Racism and Education: Protecting Black Girls, Students, and Staff

77. Enact provincial and federal legislation to protect Black students from racial harm in education. All provinces must pass legislation that formally recognizes anti-Black racism as a form of educational violence, including:

a. Clear definitions of racial harassment, exclusion, neglect, and disproportionate discipline.

b. Legal obligations for all school boards and private institutions to prevent and respond to harm.

c. Enforceable accountability for teachers, principals, trustees, and school boards.

d. Mandatory public reporting of racial incidents, suspensions, streaming, and expulsions, disaggregated by race and gender.

e. Independent complaint processes led by Black bodies with restorative justice pathways.

78. Create Black student protection units at the school board level. Establish Black Student Protection Units across all school boards, especially those receiving federal or provincial equity funds. These units must:

a. Operate independently from existing board equity teams.

b. Include legal advocates, peer navigators, and trauma-informed counsellors.

c. Provide real-time support to Black students and caregivers reporting harm.

d. Be governed by local Black families, youth, educators, and elders.

79. Ban anti-Black streaming and remove police from schools. Immediate elimination of all tracking, streaming, or academic streaming practices that disproportionately push Black students into non-academic or low-expectation pathways.

a. Mandate decolonized, Africentric, and disability-justice-informed pedagogy.

b. Remove all forms of police presence, including School Resource Officers (SROs), from schools.

c. Redirect policing funds to community-based safety models and wellness supports inside schools.

80. Establish Black youth-led accountability councils for every school board. Each school board must fund and support an independent Black Youth Council to monitor, review, and make recommendations on equity policies. Councils must:

a. Hold decision-making power to veto policies that perpetuate harm.

b. Receive stipends and mentorship.

c. Be resourced to collect testimonies, survey student experiences, and publish community reports.

d. Sit at board tables and participate in director hiring and evaluation processes.

81. Mandate mental health supports designed by and for Black students. Every school board must partner with Black-led organizations to deliver in-school mental health programming designed specifically for Black youth, including:

a. Access to therapists, peer supporters, and cultural practitioners.

b. Curriculum on healing justice, emotional literacy, and navigating racial trauma.

c. Consent-driven, confidential access pathways not mediated by teachers or administrators.

d. Training for school staff on how to avoid retraumatizing youth seeking help.

82. Legislate workplace safety standards for Black educators and staff. Black educators, early childhood educators, and support workers must be protected by education-specific anti-racism workplace laws, including:

a. The right to report anti-Black racism without fear of retaliation.

b. Access to trauma-informed leave, legal support, and cultural healing services.

c. Inclusion in all staff equity planning and school improvement committees.

d. Promotion and retention strategies that centre Black leadership and pay equity.

83. Resource Africentric alternative education models and schools. The government must fund Black-led alternative schools and learning centres rooted in Africentric and Black feminist pedagogy. This funding must support:

a. Land-based learning, intergenerational mentorship, and community governance.

b. Formal partnerships with public school systems to offer dual credit and re-entry pathways.

c. Supports for expelled, pushed out, or suspended students to re-enter school without stigma.

d. Inclusion of disabled, queer, and neurodivergent Black learners in all programming design.

84. Make Africentric curriculum mandatory and co-governed by community. Curriculum at all grade levels must include mandatory Africentric content that honours Black Canadian histories, global diasporic contributions, and contemporary issues, which must:

a. Be co-created with Black educators, youth, historians, artists, and parents.

b. Include critical race theory, gender justice, and resistance histories.

c. Be regularly evaluated for impact and authenticity by Black education councils.

Cross-Sectoral and Structural Justice

Black health does not begin in a hospital bed. It begins with freedom. With clean air. With safe housing, fair pay, healing schools, unpoliced communities, and the ability to raise our children without fear.

To improve health outcomes for Black communities, every sector must be held responsible for the conditions that produce or undermine Black wellness. These are not social supports. These are matters of survival. Governments must act decisively to embed health equity into every ministry, every policy, every budget, and every measure of success.

85. Enshrine Black health equity benchmarks across all ministries and sectors. Legislate mandatory Black health equity targets across all government ministries — including education, housing, transportation, justice, and child welfare. These targets must be measurable, enforced through public accountability frameworks, and tied to funding allocations. Require disaggregated race and gender data collection, publish annual progress reports, and implement consequences for non-compliance.

86. Establish inter-ministerial Black health equity accountability tables. Form permanent inter-ministerial tables across federal, provincial, and territorial governments with representation from Health, Labour, Education, Children's Services, Housing, and Justice sectors. These tables must co-govern with Black-led oversight bodies and be mandated to coordinate equity-focused strategies. Require shared budgeting, joint reporting, and enforceable commitments to remove silos and deliver measurable impact.

87. Fund Black-governed, community-rooted health innovations without intermediaries. Create direct funding pathways to Black-led health organizations, healing networks, and cultural practitioners. End the practice of funnelling resources through white-led institutions that replicate anti-Blackness. Fund long-term, relationship-based models that prioritize trust, community wisdom, and culturally rooted approaches. Remove colonial compliance tools from evaluation frameworks and let Black communities define success on their own terms.

88. Implement reparative investment models for Black health infrastructure. Recognize land, space, and capital access as a form of health equity. Provide land grants, long-term leases, and infrastructure capital to Black-led health and wellness spaces. Fund clinics, birth centres, counselling hubs, and traditional healing centres — not as pilot projects but as permanent institutions. Build in operating and sustainability funding to ensure generational impact.

89. Establish a national council for Black health and wellness with legislative authority. Create a federally mandated, Black-led National Council for Black Health and Wellness composed of youth, elders, researchers, birth workers, healers, artists, and people with lived experience. This Council must have legislative authority to shape, monitor, and publicly assess federal and provincial policies that impact Black communities. Provide a secure $25 million annual operating budget and direct access to federal ministers and agency leads.

The Council must act as both conscience and catalyst, holding systems accountable to the people they were built to serve.

90. Legislate an expanded, Black-centred definition of health as a social determinant. Amend all health, education, housing, and social service legislation to enshrine a Black-centred definition of health that includes:

a. Mental and emotional wellbeing.

b. Reproductive justice.

c. Economic and housing security.

d. Environmental safety.

e. Freedom from criminalization.

f. Cultural and spiritual connection.

This definition must guide policy design, funding decisions, accreditation, and health service delivery across all jurisdictions. Health must be recognized not only as the absence of illness but as the presence of justice, safety, dignity, and joy for Black people.

Conclusion

This report exists because of the extraordinary courage of the Black women, girls, and gender non-conforming people who chose to share their most personal healthcare experiences. To the 1,966 respondents who took time to document their struggles, who relived painful moments, and who trusted that their stories could spark meaningful change: thank you. Your willingness to have this conversation has created a foundation for transformation that extends far beyond these pages.

The urgency of this work cannot be overstated. Every day that Canadian healthcare systems operate without race-based data collection, Black women will continue to face dismissal, misdiagnosis, and inadequate care. The patterns documented in this report represent preventable suffering that systematic data collection could help address.

The healthcare disparities affecting Black communities are not inevitable. They are the predictable result of systems that refuse to acknowledge how race shapes health outcomes. When healthcare institutions fail to collect race-based data, they choose to remain oblivious to disparities that could otherwise be identified, measured, and addressed through targeted interventions.

This work builds upon the tireless advocacy of Canadian organizations and individuals who have been fighting for healthcare equity for Black communities. The Network for the Advancement of Black Communities and the Black Health Alliance have been leading critical efforts to centre Black health in discussions. Individual scholars and advocates, including Professor Josephine Etowa, Dr. Chika Stacy Oriuwa, Jenelle Ambrose Dash, and Dr. Bukola Salami, continue to shine a light on the urgent need to dismantle the systemic racism that Black people face in healthcare. We are grateful for all they have done and continue to do to amplify awareness of healthcare gaps for Black women.

The evidence presented in this report should serve as both a wake-up call and a practical guide for anyone committed to advocating for systematic race and gender-based data collection in healthcare. Healthcare administrators, policymakers, researchers, community advocates, and concerned citizens now have answers to questions they may have had about what Black women, girls, and gender non-conforming people in Canada need for their care.

The path forward is clear: healthcare institutions must begin collecting disaggregated race and gender-based data immediately. They must train providers in cultural competency and anti-racist practices. They must create accountability mechanisms that track and address disparities.

Black women are making their voices heard. Through this report, they are saying: the time for incremental change has passed. The evidence for systematic race-based data collection in healthcare is overwhelming and urgent. The only question remaining is whether Canadian healthcare systems will rise to meet this moment.

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