



Commentary

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# Addressing Health Equity Through Peer Equity Navigation (PEN) Program and Community-Based Participatory Research (CBPR)

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## Commentary

In Canada there is widespread recognition that the social determinants of health (SDOH) account for the disproportionate health risks and health inequities experienced within its population. The World Health Organization (WHO) commission on the SDOH, explicitly recognizes racism as contributors to socio-economic position, a key structural determinant of health. People of African descent in the western nations, including Canada, are more prone to pre-existing health conditions, including heart disease, diabetes, lung disease, and high blood pressure. They represent some of the most vulnerable populations in terms of their susceptibility to health risks, receipt of adequate care, and chances of recovery [1]. Social determinants, including structural inequities and discrimination, are known to account for the disproportionate health risks and differential health outcomes experienced in African, Caribbean, and Black (ACB) populations [2-4]. Racism affects people not only at an interpersonal level, but also through the broader structures of society, most notably in the systems of education, justice, media, policing, immigration, and employment, as well as through hate activities and government policies. With respect to COVID-19, excessive cases and deaths have been attributed to disproportionately higher rates of co-morbid conditions (e.g., diabetes, hypertension) in these communities [5], as well as structural factors related to income, employment, food insecurity, and the built environment, such as necessitating risky working conditions outside the home and the use of public transportation [6,7]. Moreover, the same population is overrepresented in jails/prisons [8] where social distancing is impossible. In Canada data is limited, but we know from national surveys that Black Canadians

exceed 50% on economic vulnerabilities arising from the COVID-19 crisis; 61% have seen a decrease in their income, 50% have difficulty meeting their financial obligations, and 47% are unable to pay their mortgage or rent on time [9].

It has been well-documented that ACB communities have experienced multiple and intersecting barriers to the access of appropriate health services; to the extent that Toronto's Board of Health has declared anti-Black racism a public health crisis. These barriers include, systemic anti-Black racism, poor representation in healthcare leadership, lack of research and appropriate decision-making, lack of awareness of available services, lack of culturally appropriate services in relevant languages, and the lack of culturally competent health professionals [10,11]. According to Statistics Canada, the ACB population currently accounts for 3.5% of Canada's total population and 15.6% of its 'visible minority' population [12]. The ACB population has continued to increase and could represent between 5.0% and 5.6% of Canada's total population by 2036 [12]; they are currently the fastest growing racialized population in the Ottawa capital region. However, the ACB population in Canada is not a homogeneous group; in 2016, more than four in 10 ACB people were born in Canada [12], and intersecting identities such as gender, age, religion, etc. shape their experiences and impact their health and well-being. These factors may contribute to the identity crisis first-generation racialized Canadians undergo, as youth have difficulty coming through the Canadian culture for their own ethnic identity, i.e., "white-washed identity", which in turn may contribute to social positioning, inequity, and racism.

Addressing the complex issues of vulnerable populations, such as those experienced by ACB communities, requires a multi-pronged approach and innovation. As Turin et al. noted, top-down approaches, where the researchers and decision-makers offer answers to communities, are more common than community-driven approaches, where community members and researchers work hand-in-hand to identify the problems and co-create solutions [13]. Many scholars have recognized that ACB communities need to be involved in all aspects of health care, such as HIV prevention, treatment, and outreach [14,15]. They identified several strategies that capitalized on existing community institutions and strengths, including working with faith leaders; creating peer-led interventions; promoting economic empowerment and independence; facilitating access to female-controlled prevention methods, such as medical interventions like microbicides and antiretrovirals for post-exposure prophylaxis, and self-protection methods such as the female condom etc. [16].

This commentary proposes the use of the peer-led community mobilization initiative, referred to as peer equity navigators (PENs) program, an innovative intervention used to reach hard-to-reach areas within ACB communities. The use of peers in the community referred as peer equity navigators (PENs) is a key feature of this program. Guided by the intersectionality lens and anchored in the principles of community-based participatory research (CBPR), PENs have been instrumental in community research and knowledge mobilization. The PEN program has been co-created and implemented by the Collaborative Critical Research for Equity and Transformation in Health (CO-CREATH) Lab, at the University of Ottawa, in partnership with Canadians of African Descent Health Organization (CADHO). CADHO is a not-for profit organization created to improve the health and healthcare of Canadians of African Descent (CAD) through transformative community engagement in the Ottawa area. It has been established by volunteers from the ACB community, organizations, academicians, service providers, and decision makers, to contribute to better health outcomes of ACB communities. It also seeks to advance health equity and foster community development with a goal of addressing determinants and barriers to health and health care for Canadians of African descent.

The PEN program is a 12-module training program, accompanied by working with a preceptor in a six-week hands-on practicum in community-based health organizations, such as community health centers. PENs training curriculum is framed within critical health literacy (CHL) and critical racial literacy (CRL) discourses, covering topics such as history of ACB people in Canada, SDOH, health inequities, racism, racial analysis of socio-political context of healthcare, etc. The program is offered in a didactic format where learners engage in a racial equity analysis (REA) reflection-action process. This collaborative and participatory

equity learning process contributes to community capacity, empowerment, practice outcomes, and to long-term improvement in health and health equity [17].

Critical health literacy (CHL) refers to “the degree to which people are able to access, understand, appraise, and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course” [18] that is influenced by underlying socio-ecological factors such as poverty, low health literacy, socio-cultural issues, and lack of political voice [19,20]. CHL is increasingly being used to filter relevant messages from the current sea of information to inform personal behavioral actions and promote health, especially in the current context of COVID-19 and co-morbidities like HIV [21]. To date, the great majority of health literacy interventions have been conducted in clinical settings, and have focussed on task-directed, functional health literacy; relatively few reported interventions have incorporated interactive and critical concepts [22]. A review of a wide range of community-based HIV and health literacy interventions have provided qualitative and quantitative evidence of positive outcomes; primarily changes in knowledge [23,24]. Poor health literacy, in the context of HIV, increases the difficulties related to avoiding HIV infection, by failing to fully understand diagnostic information; having a poorer working knowledge of HIV and its treatment; adhering to antiretroviral therapy (ART); understanding healthcare instructions and directions; and having a greater likelihood of a detectable viral load [25].

In reviewing the limited research, Woods identified major gaps in learning with respect to CHL and HIV interventions aimed at women [26]. The best evidence that was found for interventions that produced high levels of community involvement, at multiple stages, included active participation in evaluation processes, with a focus on issues such as empowerment [25], competence-building, and peer support [27].

Critical racial literacy (CRL) recognizes that racism encompasses individual discrimination as well as institutional and structural factors; it uses pedagogical tools to understand and address the marginalization and social exclusion caused by racism [28]. It also encompasses the processes of understanding, critically interpreting, and effectively acting on racial issues. CRL is important for addressing health equity among racialized communities, especially Black people of African descent, which have received limited attention in the literature. It aims to improve how everyday citizens can understand race and racism and support one another in it. This concept is embedded in a public health commitment to understanding and addressing the marginalization, and social exclusion caused by racism. The goal of CRL is to create an environment of empowerment for communities and individuals, including PENs, and to address the everyday acts of prejudice and

discrimination, while confronting and challenging the systems and structures that perpetuate racism.

A fundamental aspect of CRL is community engagement; it has become increasingly common for community-engagement work to involve peer models [17]. Peers are community members who often share commonalities and perspectives in context, values and norms, proximity, ancestry, experiences, local knowledge, and or background, with the target population [17]. These commonalities serve as a source of information and empathy that provide support for peer modeling; the insider status of the peers often allows them to be perceived as more approachable and fosters credibility and trust within the community and local experts, which is necessary for establishing communication and partnerships [17]. Peer models mainly fall within a human centered design, with processes involving community members, stakeholders, and researchers, or action research (participatory action research (PAR) and CBPR), which focuses on community-academic partner relationships with the principles of participatory practices, co-construction of knowledge, and mutual learning through actions that benefit the target population [17]. Change is more likely to occur, through action research, such as CBPR, since actions are linked to the local context of the community and through the influence, participation, and control of the research process with non-academic researchers; thus, integration of community peers is essential for sustainable change [17]. The peer's expertise does not come from formal academics or professional training in research, but from their range of local knowledge about their community, social connections, and culture; they are valued members of the research team, not only because they increase the study's rigour and reach, but they also create community-academic partnerships through collaborating with the research team, while performing specific project tasks throughout the study [17]. These partnerships encourage community member collaborations that support education, research, and social action [29]. Research and interventions that capitalizes on the strengths of meaningful community engagement focus on collaboration and partnering practices, contributes to empowerment, building community capacity, policy changes, and sustainable improvements in equity in health and healthcare [30].

In conclusion the peer equity navigation (PEN) program involves integrated knowledge mobilization and community-centred approaches to health equity work. The PENs are trained to move beyond knowledge transfer; instead to be 'change-makers' in their communities. The work of PENs is beyond the life of a given project, as the critical awareness and transformation that occur during the critical racial literacy training, facilitates their becoming community health advocates. PENs are also equipped with practical knowledge and skills to help their community, through the successful implementation of knowledge to action, dissemination

strategies, and the identification of trusted sources of information.

## Conflict of Interest

No Conflict of interest.

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