National and European Policy

The challenge is to push back the puch back

Not all are in the position to be treated equally within the system

Need to redefine the norm - Consider the other - Evidence based action points

Public health is about people, therefore voices are essential

Can only advocate if EVERYONE can realise fundamental right to health

Barriers and biases in data collection and indicators

Goal: Europe in which health equity is the norm

Direct/national legislation and sanctions → foundations for rights

Recognition of different forms of racism, structural racism and an intersectional approach

Racism causes trauma → impacting mental health

Mainstreaming as a step forward to therefore make better use of existing measures

Increasing diversity of European going hand in hand with increasing barriers (administrative, language, workforce racism)

Joint EU and Member state cooperation is needed

Equality data key for evidence based understanding

Knowledge gap

To address health disparities data must be collected to inform decision making and action

Including in dialogue civil society and health care professionals

Transcultural skills developed and taught (specifically health care professionals)

Without specific focus on people of African desent there is little reason for governments to act accordingly

Education as key leading to awareness, community and understanding of history

Three challenges
1. Everyday racism (physical aggression and victim blaming)
2 institutional (structurally ingrained and not immediately recognisable)
3.Polarisation/political racism (online and in streets)

Lack of inclusion in knowledge broader and intersectional biomedically relevant →

Knowledge Inclusion

Break down idea of white man as the standard. Society has changed and we cannot go with the flow

Mental Health

Top down and bottom up approach is needed

Holding hands with people as a method of change

Double/triple/ quadruple marginalisation

Racism is a spectrum and effects people in different manners

System built on ableism, sexism and racism

Community organising for healthcare from a holistic perspective (therapist with x language and culturally competent)

Breaking isolation and trusting those you work with (trusting communities and not manipulating trust)

Integration process needs to look at mental health, without this people are left with open wounds

Refugees need a level of dignity and must be on agenda of all projects

Only people in mental health can participate in development, but people in mental ill-health need to first receive treatment

Women isolated, alone, do not speak the language, poor public transport (i.e. access to healthcare)

Gathering information can than discover failures to improve practices

Listening to women

Grassroots, personal story, narrative giving a voice and enabling community from grassroots to policy

Little data on migrant women experiences in care

Access to councillors that have a similar experience and are able to provide the care that all need and deserve

Bias in Systems

Excessive effort is required to convince policy makers

Contemporary medical knowledge has post colonial paradox

Guidelines/ technology are all dependent on white man as "imagined patient"

Assumptions made by tax offices with non-Dutch sounding last names

Alternative and complentary medicine not reimbursed

Research is needed on long term effects of racism and discrimination on health

Research for both health care professionals and patients

Inclusion of transcultural care in the basic scheme

A recognition of missing knowledge by policy makers is key

Lack of responsibility from system to those impacted by discrimination

Racial Bias in Healthcare

In implementation (diversity) things do not always have the outcome we want

UNESCO statement on race ending many conversations and they have been left at the table since

We often fall back to cultural stereotypes get frequently when doing diversity

Direction is more important than speed

Idea of US and Europe as knowledge authorities BUT other places have this research! - **Look to the rest of the world**

Who decides what is science and what is not science

How do we approach racism to not follow white logic and not participate in epistemic injustice

Health starts before the moment you enter a clinic - breakfast, clean air, socio-economic status

We need to know both our history and how race impacts health today

Collecting data in an ethical way enables us to highlight health inequities

What needs to be tackled is the silence on racism, political and historical components

Not talk about race but skin colour diversity or biomarkers behind the medical issue

Biology in terms of population difference not race

Instead of race conscious medicine, think anti-racist medicine

Systemic nature of the problem

Doctors failing to recognise conditions due to medical education

Under representation in medical research and studies

Input from the Audience During the Sessions

Anti-discrimination law not covering the scope of anti-discrimination in health

In Germany no set president and no concrete laws for people who face discrimination from health professionals → Means via bureau, college for human rights and ombudsman but with limited resources

→ Can go to a designated person, at the hospital but they are not for individuals, but for the system

How to ensure in the future people are not excluded?

Challenge and have the debate

Publicity Media Ideas

Get best practices from around the world (Canada, New Zealand)

Look at public sector equality data (UK) - put into place when ALL policy is made

Language of Policy

How to insert personal experiences into policy documents and give lived experiences weight

Lived experiences being heard is KEY

Co-designing policy with multiple stakeholders to more easily identify gaps and solutions

Gender unclassified and different cities interpret in different manners.

Components not making it to the policy output - a skewed approach to questions

Bringing community into the formation of the bill itself!

Trauma Healing Initiatives Impact on Community

Authorities creating more trauma vs pushing for healing

Collective solutions from the community - need to find a safe space for all to talk

Challenges in Promoting Evidence-based Care Advocacy with a Human Rights Lens

Advocacy is about the individual

Policy has to be for the people

People receiving care should be involved with designing it

Decision making must always belong to the individual receiving the care

Dealing with Executive Powers Ignoring Blind Spots

Not necessarily blind BUT silenced

Triangle of denial

Lack of legal infrastructure

Policy Recommendations

Alternative data sources - not only using Anglo-Saxon sources → Research from Latin America - specifically Columbia and Argentina

Need to start addressing politically uncomfortable topics → All European countries have signed normatively binding treaties

Inclusion in Leadership and Medical Administration

A lack of representation makes bringing the conversation is difficult - medicine is elitist

Education not honoured → not allowed to practice medicine

Education

Not built into the schools and the systems in public health

Knowledge not promoted or instilled in young professionals

Need for intrinsic motivation to see issues of diversity and inclusion within education

Social sciences - racism & social determinants of health should be considered

Doctors not feeling comfortable with diagnosis across different skin colours

Developing diverse teaching materials for medical schools

Lack of Infrastructure

Scientific

People are there but how do they connect to do work

Networks to be formed where policymakers are invited

International networks to move money to community driven research (US as an example)

Trauma Reseach

Many studies done on white population but not applied to people of color

Gap Analysis- What is Missing

Increase Diversity and Inclusion in clinical trials

In Europe there are no regulations in place → Regulations to support internal and external governing agencies asking for inclusion

Something to address with pharmaceutical researchers or other researchers?

Diversity in this topic is not just including but enabling a seat at the research table

Different standards on race - but diversity must be included from the start - voluntary act of inclusion

Language - how quick meaning changes (Lexicon)

racialise - showing concept of others

Making white people the standard- i.e.. we must perceive how words take on different meaning in other contexts

What words to use in medical schools and education?

What can someone as a white man do? How can they do better?

Conflict of word "race"- or "persons with migration background" → For example in Germany there is no definition

Link Windrush and Mental Health

compensation connected with legalities not the mental health aspect

Links:https://www.bbc.com/news/uk-65926622

https://www.ucl.ac.uk/news/2022/apr/windrush-scandal-victims-speak-about-mental-health-and-trauma

Infrastructure

Needs to be made compulsory to ensure action

Sensitised Health Work Force

Race concious Medicine

Race concious health workforce

Sidelining of African Researchers

Sidelineing

Valuing of research

Not having a standardised system

Specialised mental health care

Shortage of care in general BUT even worse when looking for someone who is culturally competent

Life cycle (Elderly People)

Data Privacy

Need for Research

Collecting data is key

Need to be able to compare systems

Lots about Conciousness BUT not what do do about the current powers

What to do on anti discrimination action plans → Strengthening binding nature

Recurring themes

Infrastructure
Health Professionals
Research