Virtual Health Equity Community Forum 2020

Conference Proceedings

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INTRODUCTION

Council of Agencies Serving South Asians (CASSA) aimed to continue the momentum of previous in-person Health Equity Summits by hosting a virtual Health Equity Community Forum in response to the COVID-19 pandemic in Canada. As the environment and realities related to COVID-19 continue to change rapidly, CASSA wanted to provide a platform for community members to hear from experts as the situation develops. We explored available support initiatives, plans for post-crisis, and provided resourceful information on the developing situation. We hoped to take shared responsibility in reducing risks and reinforcing resilience in our communities.

CONFERENCE ORGANIZATION

In lieu of the in-person Health Equity Summit, a virtual Community Forum was organized. The Forum was held using Zoom on Wednesday, July 15th from 4:00pm – 6:00pm.

The Forum was broken down into plenary sessions and a discussion session. Each speaker was given 15 minutes to present on their panel topic. Speakers were given full creative liberty on what they could present as long as they remained within the intersectional framework and addressed COVID-19. The speakers were also given suggested topics in advance meant to guide their presentation. The last 20 minutes of the Forum were dedicated to discussion and questions. The Forum consisted of 40-45 participants.

SPEAKERS

The event featured 5 panelists from across Ontario who led discussions on various areas of health equity, research, promotion, and care. The following is a list of all the speakers with a short biography.

Baldev Mutta – Punjabi Community Health Services (PCHS)

Baldev Mutta has been in the field of social work for the last 45+ years. He is the Founder and Chief Executive Officer of the Punjabi Community Health Services (PCHS). PCHS is a Health Service Provider in the Central West and Mississauga Halton LHIN geographic areas. Baldev has worked for the last 28 years developing an integrated holistic model to address substance abuse, mental health, and family violence in the South Asian community. Baldev has received many community awards for his work on equity, community development, diversity management, and organizational change.

Dr. Nazilla Khanlou – York University

Nazilla Khanlou, RN, PhD is the Women's Health Research Chair in Mental Health in the Faculty of Health at York University and an Associate Professor in its School of Nursing. She is

the Academic Lead of the Lillian Meighen Wright Maternal-Child Health Scholars Program. Professor Khanlou's clinical background is in psychiatric nursing. Her overall program of research is situated in the interdisciplinary field of community-based mental health promotion in general, and mental health promotion among youth and women in multicultural and immigrant-receiving settings in particular. She applies intersectionality-informed frameworks, using diverse research methods, in community-based research. Professor Khanlou is founder of the International Network on Youth Integration (INYI), an international network for knowledge exchange and collaboration on youth. She has published articles, books, and reports on immigrant youth and women, and mental health.

Aamna Ashraf – Centre for Addiction and Mental Health (CAMH)
Aamna Ashraf is the Manager of Health Equity at the Centre for Addiction and Mental Health (CAMH). She is a well-known figure in the field of health equity and is an experienced professional in the areas of program and policy implementation, stakeholder development and partnerships. Aamna holds a master's degree in Education (Counselling Psychology) and has worked in the not for profit sector for over 25 years. As an advocate for health equity, Aamna leads the award-winning Immigrant and Refugee Mental Health Project and serves as one of Ontario's Health Equity Impact Assessment Champions. She previously worked as a Senior Program Advisor in refugee resettlement with the Ministry of Citizenship and Immigration. Before this she was the Director of the Peel Newcomer Strategy Group -Local Immigration Partnership for Peel. Aamna has also worked at United Way Peel and has led service development for diverse populations at Canadian Mental Health Association Toronto. In her current role at CAMH she manages 11 staff whose portfolios include interpretation services, research and evaluation, education and training, and the IRCC funded national immigrant and refugee mental health project.

Dr. Ananya Banerjee – Dalla Lana School of Public Health
Dr. Ananya Tina Banerjee is an Assistant Professor in the Divisions of Social & Behaviour Health Sciences and Epidemiology at the Dalla Lana School of Public Health, University of Toronto. Her public health research on diabetes prevention for South Asian communities exemplifies a commitment to providing a strong foundation in mixed-methods guided by principles of the socio-ecological framework, anti-oppression, intersectionality, community partnerships and cultural safety. Dr. Banerjee launched and offers the first course on "Race, Ethnicity, And Culture and Health" for graduate students at the University of Toronto.

Dr. Sanjay Ruparelia – Ryerson University
Dr. Sanjay Ruparelia is an Associate Professor in the Department of Politics and Public Administration at Ryerson University, and holds the Jarislowsky Democracy Chair, made possible by a generous donation from the Jarislowsky Foundation. In addition to a PhD in

Politics from the University of Cambridge, Dr. Ruparelia holds a Bachelor of Arts (Honours-Political Science) from McGill University and a Master of Philosophy (Sociology and Politics of Development) from the University of Cambridge. Prior to joining the Department of Politics and Public Administration at Ryerson University, Dr. Ruparelia was an Associate Professor of Politics at the New School for Social Research. Prior to the New School, he was the Assistant Director of the South Asia Institute, a lecturer at Columbia University, and served as a consultant to the United Nations. Dr. Ruparelia's research addresses the politics of democracy, equality and development in the postcolonial world, as well as the role of parties, movements and institutions in politics.

DISCUSSION FROM PANELS

The overarching theme of the forum was **Equitable Access to Care for All: COVID-19 Emergency and Health Care Response.** Speakers were asked to remain within an intersectional framework when addressing the pandemic. To ensure a strong narrative and use of consistent topics, the following topics were suggested:

- Canada's COVID-19 emergency and health care response.
- Specific intersecting identities that make people vulnerable to health inequities.
- Frontline health-care workers and communities who have been hit hard by prevention measures.
- Disparities in reported cases – identities within the larger community that have gone unnoticed.
- Approaches communities can take to advocate for health equity in times of crisis and emergencies.
- Available federal and community support initiatives.
- Planning for post-crisis.

The first speaker was Baldev Mutta from Punjabi Community Health Services (PCHS). He addressed Marginalized Communities and the COVID-19 Crisis. Baldev brought up the challenges newcomers faced prior to the COVID-19 pandemic. The challenges mentioned included the issues revolving around the Healthy Immigrant Effect, higher rates of diabetes and low cancer screening rates among South Asian communities, and specific illnesses other minority groups face. He pointed out that no efforts have been made by the government to address these issues. Additionally, he mentioned that mental health issues have skyrocketed during the COVID-19 pandemic, and virtual counselling has been implemented as a response to the crisis. However, the problem with virtual counselling is that of access to technology and privacy. Women have experienced a high rate of abuse because they have not been able to talk about family issues. In addition, resources for mental health are underfunded within the G7 nations, specifically for the York and Peel region. The presence of systemic racism in healthcare is evident from the existence of predominantly euro centric models of services and the

ground-level agencies that fail to collect data on the populations they serve. As a result, international students, homeless people, racialized and indigenous communities, seniors, newcomers, and LGBTQ communities continue to be among the high-risk populations.

The second speaker was Dr. Nazilla Khanlou from York University. Dr. Khanlou presented on the COVID-19 pandemic guidelines for mental health support of racialized women at risk of gender-based violence. Dr. Khanlou's current research study is community- and intersectionality-based. The study evaluates immigration status, youth cultural identities, and women gender-based violence (GBV). GBV is violence inflicted on individuals based on their gender expression, identity, or perceived gender. Worldwide, GBV affects 30-60% of women, impacting their mental, physical, and sexual health. Dr. Khanlou stated that the COVID-19 pandemic has worsened the problem. As a result, the objective of the study is to understand the social determinants of mental health among racialized women and girls exposed to GBV during the COVID-19 pandemic. Preliminary findings found that racialized communities bear a disproportionate burden of stress, illness, and health inequities. There have been alarming rates of COVID-19 infections and death amongst the Black, Latino, and Asian populations. There has also been an increased risk of racial and sexual harassment of targeted, sexualized attacks against women of East Asian ancestry. Preliminary findings suggest that national, local, and provincial agencies in Canada as well as international organizations need to apply an intersectional approach to recovery in an attempt to understand the mediating pathways.

The third speaker was Aamna Ashraf from Centre of Addiction and Mental Health (CAMH). Aamna provided an overview of the Response of the Immigrant and Refugee Mental Health Projects to COVID-19. The Immigrant and Refugee Mental Health Project offers online training, tools, and resources to settlement, social, and healthcare service professionals. In response to COVID-19, the project has been focusing on providing interpreting services, virtual mental health services, and COVID-19 resources to support immigrant and refugee populations remotely.

The fourth speaker was Dr. Ananya Banerjee from Dalla Lana School of Public Health. Dr. Banerjee reflected on what it means to be "South Asian" during the COVID-19 era. Dr. Banerjee presented on the many factors that overlap with the South Asian identity and knowing how they work together as they fight for equity before, during, and after the pandemic. South Asians have often been combined into a single South Asian category, which masks the heterogeneity of the community. Therefore, as public health units begin to collect race-based data, disaggregated data needs to be advocated for to ensure high equality monitoring of South Asian health and health disparities in COVID-19. She stated that many communities of the South Asian diaspora will fall through the cracks if their only option is to check the South Asian box on medical forms. Dr. Banerjee then proceeded to present the findings from early research, explaining that Black and

South Asian communities were more likely to be affected by COVID than white people. The Bangladeshi community in particular had the highest rates of COVID in New York and the United Kingdom. With the Bangladeshi population in New York being predominately Muslim, there has been a rise in Islamophobia, which has been amplified by social media outlets. This can also be seen in Toronto. The South Asian community is being targeted and it has created a lot of stigma and misinformation. Dr. Banerjee concluded by stating that prevention efforts to COVID-19 need to take into account historical impacts to South Asian communities and the need to collect data that reflects these disparities.

The final speaker was Dr. Sanjay Ruparelia from Ryerson University. Dr. Ruparelia briefly addressed how the pandemic has exposed and deepened socioeconomic and health inequalities not only in Canada, but in societies throughout the world, and that planning for post-crisis requires far greater preparedness by governments in terms of data collection, testing and tracing, and a new social contract. Dr. Ruparelia began with presenting the responses other countries have taken against the pandemic. Singapore had handled the pandemic well during the earlier stages; however, since then there has been a massive rise in the number of COVID cases amongst workers. In India, the government had only given a six-hour notice prior to initiating a lockdown and the migrant communities were immediately affected as they lost their work and place of residence. In comparison, Canada has done relatively well. Canada is placed in the upper-middle spectrum in terms of handling the pandemic, but is not doing as well as South Korea and Taiwan. Canada did however, lack in preparedness for the pandemic. There had been a lot of predictions that this would happen, but none of the commissions or recommendations were taken into consideration. Coordination between provinces and the centre were not as quick and efficient as one would hope. The level and accessibility of testing has been inadequate and contact tracing has also been ineffective. Going forward, recommendations made by the public need to be taken seriously, data based on ethnicity and race needs to be collected, and testing/tracing needs to be ramped up.

DISCUSSION FROM COMMUNITY FEEDBACK AND INPUT SESSION

During the Community Feedback and Input Session, participants were given the chance to ask questions to the panelists and make additional comments. Following the session, participants were asked to fill out a survey. The main objective of this session was to facilitate conversations with members of the community about barriers to accessing health care and to present solutions to the issues put forward.

The questions and comments brought up by the participants during the session were:

1. Who is collecting the data? Are there any preliminary data on the impact on South Asian communities in Canada in terms of cases, deaths, employment? Before data collection begins, are there any community-based ways of collecting and highlighting this data?

2. For those who have lost loved ones during this time, are there bereavement counselling available? Are there any tailored bereavement counselling for different cultures, communities, and languages?
3. How does health equity dismantle systemic racist organizations, organizational structures, and barriers?
4. How do we ensure there is equity in funding during the recovery, new and smaller South Asian organizations are appropriately supported? And any new funding does not simply reinforce existing organizations and power structures within the sector?
5. With the South Asian community being overrepresented in the IT sector, many South Asians that work in tech are benefitting from additional work/income during this pandemic. How do we bridge economic class divides within the community between those benefiting and those suffering from the pandemic?
6. While South Asians are overrepresented in the IT sector, women are losing their jobs (or quitting) due to added household work and childcare responsibilities, thus "decreased" productivity. A nuance to take into consideration: where there may be additional work/income for some, many are losing income and having to go down to single income households. The economic classes have gotten more clouded since the pandemic hit.
7. South Asians are overrepresented in particular types of healthcare professions. Any insight into this South Asian/health-profession/COVID-19 dynamic?
8. For international students who have been stuck here without the complete knowledge of their health coverage, is there any data on the effects of the pandemic on the health of international students from South Asia (or other regions)?

For question one, CASSA's Executive Director Samya Hasan had mentioned that CASSA has been working in collaboration with Colour of Poverty - Colour of Change Steering Committee on a series of conversations with Ministry of Health and that there has been a rollout of data collection in the public health units in Ontario as they are collecting some race-based data. Colour of Poverty will be working with the Ministry of Health on how to collect data, how it will be used by government officials, and what kind of questions will be asked. Baldev mentioned that Statistics Canada is also collecting some race-related data.

For question two, Aamna had mentioned that current bereavement counselling and resources available at CAMH require cultural adaptation. Dr. Khanlou mentioned that a colleague of hers is currently working on culturally sensitive bereavement resources and would share them once made available.

For question three, Aamna shared the same sentiments as Baldev that training is not the only answer to structural dismantling. There needs to be a lot of work done before even considering

training. The question now is – how do we move forward from thinking that no other effort is required once training is received?

For question four, Baldev took the lead. Baldev expressed that one of the weaknesses that the South Asian community has is that we have been able to lobby to put our needs forward and as a result, we have been viewed as a perfect community who does not need any help or who does not need to have their needs met. However, it is now time for other South Asian organizations to come together to lobby and support each other to ensure equitable outcomes for our communities.

For question five, Dr. Ananya expressed that an economic divide is given under such circumstances and that the IT sector has a lot of racialized workers, which adds to the complexity. However, in order to bridge the economic class divides, we must lobby and ask what does health equity look in the South Asian community? The South Asian community is so vast, yet we are not working together as a community. We need to synergize.

For statement six, Dr. Khanlou shared that women shoulder an additional burden during the pandemic as they are caring for their children and elderly relatives as caregivers while working. The work-life balance has been impacted for women in all sorts of professions. Clearly, the benefits are gendered, and very class based. Individuals with more precarious jobs, with less rights, and with less permanence in their positions are worse let off than individuals who have secured jobs, are tenured, and have the option to work from home. Individuals who are privileged to begin with will be better off. Dr. Ruparelia made additional comments and claimed that there cannot be an economic recovery without addressing child-care. Without accessible child-care, it will be hard to return to work.

For question seven and eight, Samya tackled both questions with one answer. Samya mentioned that currently there is a lack of race-based COVID-related data in all communities in Canada. Once the data is collected and released, we will have a better understanding of the impact of the crisis on different fields, professions, and different segments of the South Asian population.

Following the discussion, a survey was provided. The survey consisted of three open-ended questions and two closed-ended questions. The questions asked in the survey were:

1. We know that racialized communities have been disproportionately negatively impacted by COVID-19, what structural and systems level changes are required to ensure racialized communities are protected from this in the future.
2. What health care delivery practices and programs changes are required in the COVID-19 recovery phase to advance health equity for racialized communities?
3. What is your level of satisfaction for this event?

4. Are you likely to participate in one of our events in the future?
5. How can we improve for our next event?

Question one was an open-ended question and several changes were proposed. Responders expressed that structural change needs to come from the higher-ups in the hospitals and the governments; a recognition that their teams are not diverse and thus have an intentional blind spot for immigrant, Indigenous, and racialized communities. Hospitals need to make an added effort to change their boards and decision-makers to represent the community that they serve. Structural level changes also need to include policy revisions, equitable funding devoted to South Asian organizations and low-income populations, awareness of available support resources in marginalized communities, better communications with diverse linguistic and cultural communities, as well as disaggregated race-based data collection. The collection of data has to be led and supported by communities affected to ensure data use is not weaponized to negatively impact marginalized communities.

Question two was an open-ended question and several changes were proposed. Responders suggested that multilingual health care practices, resources, and outreach efforts need to be implemented. Different communities need the ability to form their own organizations that are supported by government funding and technical expertise like mainstream culturally based organizations. With that being said, cultural competency needs to be accounted when providing solutions. Responders also suggested that collecting race-based data would be useful if programs and policies attempted to target the affected communities. For example, targeting elderly citizens and children to ensure optimal care.

Question three was a Likert scale in which responders specified their level of agreement with the given statement in five points: (1) Very dissatisfied; (2) Dissatisfied; (3) Neither satisfied nor dissatisfied; (4) Satisfied; (5) Very satisfied. 75% of the responders responded as (5) Very satisfied while 25% responded as (4) Satisfied with the event.

Question four was a dichotomous question with two possible answers: Yes or No. 93.8% of the responders responded with Yes to participating in future similar events.

Question five was an open-ended question. Many responders shared that the event was very informative but required more engagement from the participants and time to discuss future steps. Responders also expressed that presenters seemed to have focused on promoting their own work and that they should have worked to make more genuine connections to difficult issues.