8th Annual Health Equity Summit

AUGUST 7th and 8th, 2019

Conference Proceedings

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A. EXECUTIVE SUMMARY

Introduction

The Health Equity Summit has become a flagship event to discuss issues of health and inequity, focusing on South Asians and other racialized communities. This year's Summit gathered community input from the South Asian and other racialized communities in the Greater Toronto Area (GTA) to help develop a South Asian Health Equity Strategy. CASSA also explored ways to engage the current government in health equity through research and advocacy.

Conference Organization

Due to high demand, the Summit was organized over two days for the very first time. Hosted at the Peel Memorial Centre in Brampton on Wednesday, August 7th, 2019, the first day was full of breakout and plenary sessions. Day two was held at the Ted Rogers School of Management, Ryerson University in Toronto on Thursday, August 8th, 2019. The second day of the Summit held four plenary sessions with a robust set of speakers and engaging dialogue.

CASSA was proud to have hosted 90 attendees on day one and a robust audience of 70 attendees on day two.

Conference Topics

This event featured 35 panelists from across Ontario who led discussions on various areas of health equity, promotion, and healthcare. The full list of speakers and their biographies can be found in the appendix.

DAY ONE

Chronic Health – Heart Health and Cancer

- Dr. Larissa Moniz – Prostate Cancer Canada
- Dr. Milan Gupta – South Asians Networking Supporting Awareness & Research (SANSAR)
- Dr. Russell de Souza – McMaster University

Mental Health & Illness

- Mudassara Anwar – Punjabi Community Health Services (PCHS)
- Dr. Razi Sayeed – William Osler Health System
- Mariyam Lightwala – CAMH South Asian Mental Health Group
- Bareera Sial – CAMH South Asian Mental Health Group

Sexual Health

- Haran Vijayanathan – Alliance for South Asian Aids Prevention (ASAAP)
- Ketussa Sotheeswaran – Abuse Never Becomes Us (ANBU)
- Yoshith Perera – Moyo Health and Community Services

Health Equity Policy

- Dr. Lawrence Loh – Peel Public Health
- Gurwinder Gill – William Osler Health System
- Shermeen Farooqi – Public Health Agency of Canada

Maternal Health

- Sujane Kandasamy - McMaster University

- Dr. Shafi Bhuiyan – Dalla Lana School of Public Health
- Dr. Russell de Souza - McMaster University

Chronic Health – Diabetes and Kidney Health
- Dr. Istvan Mucsi – University Health Network
- Dr. Ananya Banerjee – Dalla Lana School of Public Health
- Avantika Mathur-Balendra – South Asian Diabetes Awareness Program

Social Determinants of Health
- Dr. Ripudaman S. Minhas – St. Michael's Hospital
- Evon Smith – United Way Greater Toronto
- Garima Talwar Kapoor – Maytree

Best Practices in Health Equity
- Liben Gebremikael – Taibu Community Health Centre
- Baldev Mutta – Punjabi Community Health Services (PCHS)
- Marilyn Verghis - William Osler Health System

DAY TWO

Best Practices - Black Health Strategy
- Nakia Lee-Foon – Black Health Alliance
- Dalon P. Taylor – Black Health Alliance
- Tiyondah Fante-Coleman – Black Health Alliance

Best Practices - Indigenous Health Strategy
- Samuel Mukwa Kloetstra – Toronto Indigenous Health Advisory Circle Youth Council
- Tasunke Sugar – Toronto Indigenous Health Advisory Circle Youth Council
- Dr. Raglan Maddox – Well Living House

Health Equity Policy
- Dr. Kofi Hope – Wellesley Institute
- Samiya Abdi – Public Health Ontario

Health Equity Advocacy
- Neshanth Shanmugalingam – South Asian Autism Awareness Centre (SAAAC)
- Sané Dube – Alliance for Healthier Communities

B. DISCUSSION FROM PANELS - DAY ONE

Chronic Health – Heart Health and Cancer

The Heart Health and Cancer panel highlighted issues and gaps faced by South Asians when receiving cardiac and cancer care services. It also explored how culture is incorporated into the care that each service provider delivers.

The guiding questions for this panel were:

1. What are the pressing issues that you see in your work with the South Asian communities?
2. What are the gaps in the existing heart/cancer health care services for the South Asian communities?
3. What strategies should be included for heart health/cancer care of South Asians in the health equity strategy?
4. For service providers: How are you providing culturally sensitive services to your clients?

The first speaker was Larissa Moniz from Prostate Cancer Canada. Larissa highlighted the risk factors of prostate cancer, which included increasing age, family history and genetics, and race and ethnicity. It was emphasized that the prostate-specific antigen (PSA) test, a blood test that measures levels of the PSA protein, is the most effective way to detect prostate cancer early, thus improving survival rates. Data from the UK states that South Asian men have a lower risk of being diagnosed with having prostate cancer when compared to the general populationCanadian data shows that compared to the rest of the population, South Asian women have lower rates of screening and thus have a higher rate of late-stage breast cancer diagnoses.

In hearing from South Asian patients, many expressed that they are not treated with respect or feel unsupported by their primary care physician. A survey created by Prostate Cancer Canada showed that South Asians were less likely to know about prostate cancer and were more likely to underestimate the chances of survival. Prostate Cancer Canada is working to help increase health access and equity in several ways. For instance, they are working with the government of Ontario and British Columbia to get funding for the PSA test, increasing readability and engagement of health education material, and translating resources to different languages.

The second speaker was Dr. Russell de Souza from McMaster University. Dr. de Souza spoke on the high prevalence rates of heart attacks and diabetes among South Asians. This can be partly explained by the South Asian communities' risk factor profile such as poor blood sugar regulation, lower levels of good cholesterol, and higher levels of bad cholesterol. Evidence also suggests that South Asian babies are born smaller with more body fat which is most likely due to in-utero exposure to glucose and high levels of insulin. Therefore, a life-course approach that analyzes people's lives within structural, social, and cultural contexts would be helpful to include within the health equity strategy. The life-course approach would also encourage women who wish to start a family to take actions such as changing exercise and eating habits during

pregnancy. The South Asian Birth Cohort Study (START) sampled mothers and babies from India and Canada. One of their main findings was that pregnant South Asian women were twice as likely to develop Gestational Diabetes Mellitus when compared to Caucasian women, a condition that can lead to Type 2 Diabetes Mellitus in the child.

Dr. de Souza also focused on the numerous gaps faced by South Asian communities when accessing heart health care services. Issues such as this one can be resolved by pairing patients with providers that speak South Asian languages. There are also gaps on the individual level when it comes to improving heart health, such as lack of time and knowledge about healthy food. These gaps can be counteracted with setting clear goals and allocating time to plan meals. Dr. de Souza concludes with suggesting a life-course approach as an optimal choice for the South Asian health equity strategy.

The third speaker was Dr. Milan Gupta from South Asians Network Supporting Awareness & Research (SANSAR). Dr. Gupta spoke about how 60 percent of the world's heart patients are in India. He pointed out that risk scores are underestimated for the South Asian population because reference risk scores were standardized using a white population.

Dr. Gupta also brought up the thirsty gene hypothesis, which states that genes store sugars as fat. It was found that Type 2 Diabetes Mellitus was 30 percent higher in South Asian children.

Mental Health

The mental health panel highlighted issues and gaps South Asians face when accessing mental health care services. The panel also discussed steps to increase awareness of mental health issues.

The guiding questions for this panel were:

1. What are the pressing issues that you see in your work with your community?
2. What are the gaps in the existing mental health care services for the South Asian community?
3. What mental health strategies should be included in the health equity strategy for South Asians?
4. What needs to be done on the community education/awareness side of mental health for South Asians?

The first speaker was Mudassara Anwar from Punjabi Community Health Services (PCHS). Mudassara began by pointing out the three major causes of mental illness: biological (e.g. genetics), psychological (e.g. trauma), and environment (e.g. social or cultural expectations). The cause of mental illness may be one or a combination of these factors. In the South Asian community, mood disorders, anxiety, and depression are common. In addition, the South Asian community also harbours denial, stigma, misinterpretations, superstitions (e.g. regarding to mental illness such as black magic), and cultural barriers when trying to receive help. To combat these issues, we can:

- Develop anti-stigma
- Focus on intersectionality of health issues (e.g. spiritual, social aspects)
- Utilize cultural media to reach out to people

- Encourage doctors to speak about mental health more
- Connect with religious leaders
- Learn from population focused health strategies

The second presenters were Mariyam Lightwala and Bareera Sial from the CAMH South Asian Mental Health Group. They spoke about the limitation of access to mental health support for South Asian women. Female South Asian youth struggle with suicide, self-harm, anxiety, and depression. This requires interventions that operate at an intersection of gender, ethnicity, culture, and mental health. Mariyam and Bareera provided solutions which focus on culturally relevant prevention, early intervention, and youth engagement.

Mariyam and Bareera also took the opportunity to discuss the Roshni Project that they have created, which consists of 3 phases:

- Phase 1 – Collect information from young South Asian women in the GTA who have a mental health diagnosis and have completed high school.
- Phase 2 – Translate knowledge (i.e. into films)
- Phase 3 – Identify how to help young women with interventions focused on building skills like resilience and coping strategies, psychoeducation on mental health and sexual health, strengthening one's cultural identity, and peer support.

For phase three, they noted that they struggled with identifying networks for peer support. But they emphasized that discussion and support among youth is important since it provides a safe space with people in similar situations.

The third speaker was Dr. Razi Sayeed, the Chief of Psychiatry at William Osler Health System. Dr. Sayeed discussed the issue of family support regarding mental health due to stigma and mental health not being an illness. Even so, South Asian immigrants usually focus on culture and faith-based health interventions. Although this provides some support, it shifts focus away from the mental health aspect of the problem. This issue can only be resolved with societal acceptance.

Sexual Health

The sexual health panel brought a diverse range of voices to discuss the importance of sexual health in the South Asian community. The speakers highlighted the external and internal issues that prevent access to sexual health care.

The guiding questions for this panel were:

1. What are the pressing issues that you see in your work with the South Asian communities?
2. What are the gaps in the existing sexual health care services for the South Asian communities?
3. What strategies should be included for sexual health care of South Asians in the health equity strategy?
4. For service providers: How are you providing culturally sensitive services to your clients?

The first speaker was Yoshith Perera from Moyo Health and Community Services. Yoshith explained that sexual health is often perceived through the goal of reproduction; it is not valued as much as heart or kidney health, which undermines its critical role in the overall well-being of a person. Yoshith further defined sexual health: "Sexual health is defined as a physical, mental, and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, violence, and discrimination" (WHO, 2006). For this reason, Yoshith made a case that we must go beyond disease prevention and develop new perspectives that address the social determinants that result in a lack of access or awareness to sexual health services and education. He further elaborated that in order to do this, there needs to be a social determinant of health approach to supporting clients which requires cultural competency that applies anti-oppressive frameworks with effective monitoring processes.

The second speaker was Ketussa Sotheeswaran, founder of from Abuse Never Becomes Us (ANBU), an organization committed to supporting Tamil survivors of sexual abuse. ANBU believes in providing healing and empowerment through holistic support, resources, and advocacy. Due to the heavy stigma present in the South Asian community around sexual abuse, there is little evidence-based research available, resulting in a paucity in services. ANBU is devoted to filling gaps to further their work through a trauma-informed lens in treatment and resources. Ketussa stressed the importance of strategies to be included for sexual health care of South Asians in the health equity strategy:

- Accessibility based on proximity
- Focusing on intergenerational trauma
- Low-cost medication/services
- Anonymity
- Address barriers for LGBTQ2+ community
- Funding

The third speaker was Haran Vijayanathan from Alliance for South Asian AIDS Prevention (ASAAP). Haran spoke about the Heart to Heart project, which aimed at creating an intergenerational dialogue about sexual health between parents and youth. They engaged 72 unique individuals participated (49 online surveys completed, 23 participants via focus groups, and three key informant interviews of service providers in the areas) including 34 parents and grandparents. This project revealed the grievances and the needs of youth and the reservations of parents and grandparents. The project discovered that 76.1 percent of youth want to discuss sexual health with their parents, and that they do not prefer to do so with religious leaders. Youth generally will opt for online blogs instead of brochures as they do not want others, especially their families, to find out. The Heart to Heart project highlights the significance of having accessible and safe spaces in the South Asian community. Haran presented the 2017 Statistics for sexually transmitted infection (STI) and blood-borne infection (BBI) reports from Toronto Public Health. The existing data revealed that there is a prevalence of STIs in Neighborhood Improvement Areas, which have a high density of low-income and racialized communities.

Health Equity Policy – Brampton

The policy panel explored the implementation of health equity policies and their impact on the achievement of health equity for different communities.

The guiding questions for this panel were:

1. Discussion of policies that have been implemented in health care settings, hospitals, or in government to learn about cultural competencies to create tailored approaches to health care provision.
2. What evaluation has been conducted for these policies for test outputs and outcomes?
3. How can the successful policies be legislated or implemented provincially?

The first speaker was Dr. Lawrence Loh from Peel Public Health. Dr. Loh began with a discussion about the higher risk of diabetes for South Asians. Dr. Loh suggested a population health approach that focuses on upstream efforts to promote health and prevent diseases in the South Asian community. Dr. Loh continued with mentioning the advances we have made in population health. For instance, how population health has shifted from "serving an ethno-culturally diverse population" to promoting "health equity". Health equity was defined as everyone reaching their full health potential no matter their race, ethnicity, gender, and more. Some equity-oriented policies and programs implemented in the Peel region include breastfeeding home-visit pilot program, interpretation services, instructional videos in different languages, impacts on web resources to be inclusive of South Asians, and fact sheets in different languages. Local policy projects have also been implemented, such as partnering with places of worship who can increase opportunities for physical activity and healthy eating.

The second speaker was Gurwinder Gill from William Osler Health System. Gurwinder discussed that in a hospital setting, prevention is overlooked. For social determinants of health, upstream factors are not considered, and we hand off to communities and partners that have the specialized knowledge. When assessing a project, the health inequities tool should be applied. It is difficult to be patient-centred when one does not know how to react or accommodate for cultural and religious practices. Gurwinder suggests that policies should be created to support patients' health equity. Diversity, health equity, and inclusion should be embedded across the board.

The third speaker was Shermeen Farooqi from Public Health Agency of Canada. Shermeen spoke about how commitments addressing health inequities have been echoed to a federal government level. They planned to advance health equity with research. The joint response between the federal, provincial, and territorial government was a collaborative initiative to strengthen knowledge and action on inequalities within Canada through improved data infrastructures. This in turn, will allow us to measure health inequalities to improve them. However, there are a few data limitations such as heterogeneity, data consistency, and granularity.

Maternal Health

The maternal health panel focused on issues in the work of delivering culturally sensitive maternal health care services as well as strategies that can be implemented.

The guiding questions for this panel were:

1. What are the pressing issues that you see in your work with the South Asian communities?
2. What are the gaps in the existing maternal health care services for the South Asian communities?
3. What strategies should be included for maternal health of South Asians in the health equity strategy?
4. For service providers: How are you providing culturally sensitive services to your clients?

The first speaker was Sujane Kandasamy from McMaster University. Sujane focused on Gestational Diabetes Mellitus (GDM) within a South Asian context. GDM and related risk factors consist of upstream conditions such as type 2 diabetes. Investing time, money, and resources into tackling these problems can minimize the prevalence of chronic disease. GDM is seen as a transient condition and follows 6 steps:

1) Many foods contain sugar
2) The digestive system transforms these foods into glucose
3) The pancreas creates insulin which is responsible for breaking down sugars that the body uses as energy
4) All pregnant women have a harder time breaking down these sugars
5) Pregnancy hormones also make it harder for the body to use insulin
6) This causes blood sugar to increase above the normal level and leads to the woman being diagnosed with GDM

GDM not only has consequences on the mother, such as an increased likelihood of having a caesarean delivery and increased blood pressure, but also influences the child such as a higher birth weight and higher body fat. Compared to other ethnic groups, South Asian women who move to higher income countries have a higher prevalence of obesity, type 2 diabetes and GDM. Additionally, Sujane discussed the South Asian Birth Cohort Study (START), a study used to determine the maternal factors associated with GDM and the impact of GDM on newborn characteristics, such as birth weight. The key findings from this study were that the incidence of GDM in South Asian women was 36 percent or one in every three women. This is much higher than the general population, where the incidence is usually 5 to 10 percent. To prevent the occurrence of GDM, the focus should be on active living with an emphasis on maintaining a healthy pre-pregnancy weight and high-quality diet prior to having children.

The second speaker was Dr. Shafi Bhuiyan from Dalla Lana School of Public Health. Dr. Bhuiyan focused on the Maternal and Child Health Handbook, a booklet containing information on safe pregnancy, delivery, child health, and health education. The handbook supports healthy pregnancies and reduces birth risk, as well as increases quality of child-care. One aspect of the handbook includes guidelines on what to eat and what to avoid eating. This handbook is given to patients by the midwives or gynecologists. The handbook is used in many East Asian countries but has not yet been piloted in Canada.

The third speaker was Dr. Russell de Souza from McMaster University. Dr. de Souza discussed the higher prevalence of heart attacks and diabetes among South Asians, like the presentation given during the Heart Health and Cancer panel. Additionally, Dr. de Souza outlined some tips

including breastfeeding for mothers, not drinking, decreasing sugar intake, promoting a better diet, and having less screen time when older.

Chronic Health – Diabetes and Kidney Health

The diabetes and kidney health panel gave insight to the issues and barriers faced by South Asian individuals as well as the delivery of culturally competent care.

The guiding questions for this panel were:

1. What are the pressing issues that you see in your work with the South Asian communities?
2. What are the gaps in the existing kidney/diabetes health care services for the South Asian communities?
3. What strategies should be included for kidney/diabetes health of South Asians in the health equity strategy?
4. For service providers: How are you providing culturally sensitive services to your clients?

The first speaker was Dr. Istvan Mucsi from the University Health Network. Dr. Mucsi spoke about barriers to accessing transplantation services and how it relates to ethno-cultural groups, specifically the South Asian Canadian population. To understand these barriers, Dr. Mucsi works with the South Asian community as well as the Black, East Asian and Chinese communities. One of the goals is to improve education about transplants, both for patients who have kidney disease and for professionals who are working with these patients. As for strategies that are implemented to improve kidney rates and culturally sensitive services, Dr. Mucsi suggested that ethno-sensitive and culturally competent services are not being provided to any communities. Kidney disease is more prevalent and progresses faster in certain populations in Canada, including the South Asian community. Chronic kidney disease (CKD) is most frequently caused by diabetes, which is also very common in the South Asian community when compared to the Caucasian population. Individuals are at an even higher risk if they have a family history of CKD. The best treatment for onset of kidney disease is kidney transplantation, specifically living donor kidney transplant (LDKT). LDKT provides a longer life expectancy and fewer complications from the transplant surgery and immunosuppressive medications. There is a difference between various ethnic groups primarily because of the different distribution of blood types and the willingness or readiness to donate a kidney. In general, South Asian people are less likely to donate a kidney. As a result, the chance to receive a LDKT in Ontario is 50 percent reduced for both South Asian and Black patients when compared to Caucasians. Dr. Mucsi suggests that there should be more focus on the culture of medicine. When dialysis patients were asked about whether anyone had donated or offered a donation to them, it was found that compared to Caucasians, both African Canadians and South Asians were less likely to have received this offer, partly due to less willingness to communicate about the illness. Due to this inequality in access, Dr. Mucsi is currently working on a project that focuses on South Asian and Black populations to provide culturally competent care and education for patients from these communities. Many people are involved, including physicians, community leaders, religious leaders, and more.

The second speaker was Avantika Mathur-Balendra from Dalla Lana School of Public Health as well as the Research Coordinator for the South Asian Adolescent Diabetes Awareness Program (SAADAP). Avantika discussed diabetes in the context of social determinants of health and why we need to start shifting the discourse on diabetes and the South Asian community to better understand the cause. Apart from behavioural factors such as lack of exercise or inadequate diet, Avantika suggested that we need to start looking at more structural issues that are relevant to the South Asian community. Bringing attention to this area of research is crucial to understand why South Asians are at a higher risk for diabetes. Diabetes is an epidemic in this community. However, there is very little conversation that takes place to inform the public that risk factors for South Asian are more than their behavioural practices, genetics, and culture. There are many factors that determine diabetes. It is complex and intersectional. There is a plethora of social and behavioural factors, and family history is not the only component to blame.

Avantika recommends changing the language in which we talk about diabetes by highlighting more social determinants of health. Migration is one of the key determinants that places South Asians at a higher risk of diabetes. Many immigrants come as refugees, live with trauma experienced back home, and more. The built environment in which they live in can have a significant effect; for instance, environmental factors such as the number of recreation centres or health care services available. Additionally, many South Asians are employed in precarious work without health benefits and may not be able to afford treatment. Even within South Asia itself, there are differences in risks depending on which region one's ancestors are from. It was found that those from Sri Lanka had the highest risk for diabetes within the South Asian diaspora. Avantika proposed that based on their intersectional identities, we should try to understand why specific communities of the South Asian diaspora are at a higher risk for diabetes. We should also be evaluating it from a theory perspective, such as the theory of intersectionality.

The third speaker was Dr. Ananya Banerjee from Dalla Lana School of Public Health. Dr. Banerjee also spoke about the diabetes epidemic in South Asians. Migration and geographical region were again emphasized as one of the key determinants of diabetes in the South Asian diaspora. It was found that immigrants from Sri Lanka had the highest risk. Dr. Banerjee emphasized that we must understand the relationship between diabetes, immigrants, and refugees through an intersectionality lens. This suggests that there are many systems of oppression including race, ethnicity, gender, and religion. Individuals are affected by several conditions and factors. Overall, there is a difference in the prevalence of diabetes among immigrants of different regions within South Asia. This should be recognized so that it may aid with the delivery of care for specific populations.

Social Determinants of Health

The social determinants of health panel discussed the different factors that affect health outcomes of South Asians and how to incorporate these factors into the health equity strategy.

The guiding questions for this panel were:

1. Discussion of social, economic, and cultural factors that play a role in the health outcome of South Asian and other racialized communities. This can include issues of housing, employment, education, isolation, racism, etc.

2. How should the South Asian health equity strategy consider social determinants of health in a policy framework?

The first speaker was Dr. Ripudaman S. Minhas from St. Michael's Hospital. Dr. Minhas reviewed the following: concepts of social determinants of health in the context of children and young families, the concept of Early Childhood Development (ECD), Adverse Childhood Experiences (ACEs), and highlighted the opportunities to mitigate these barriers with changes in individual or institutional practices. ACEs is a study that evaluates the effects of experienced abuse (i.e., verbal, physical, sexual), neglect (i.e., physical, emotional), and household dysfunction on a child's future. Some foreseeable effects include a higher chance of risk outcomes in terms of behaviour, physical, and mental health. ACEs stresses the importance of early interventions, and states that interventions aimed at the poorest children can have an enormous investment value.

Dr. Minhas also goes through the intergenerational poverty cycle: development disadvantage, educational disadvantage, employment disadvantage, and parenting disadvantage (with intervention implemented in this section).

Dr. Minhas concludes with proposing 10 strategies that can be used to guide organizations to enhance the capacity of equity-oriented services. The strategies include:

1. Making an explicit commitment to equity
2. Developing supportive structures, policies, and processes
3. Revising use of time (i.e., flexible working hours).
4. Attending to power differentials
5. Tailoring care, programs, and services to context
6. Actively countering oppression
7. Promoting community and patient participatory engagement
8. Tailoring care, programs, and services to histories
9. Enhancing access to social determinants of health
10. Optimizing use of place and space

The second speaker was Evon Smith from United Way Greater Toronto. He spoke about FOCUS Toronto, which is a collaboration between the City of Toronto, Toronto Police, and United Way. The advantages of FOCUS Toronto include better relationships between members, identification and tackling of systemic issues, as well as the existence of a platform for strategic conversations. FOCUS Toronto works to identify risk factors followed by a collaborative approach to address the concerns. On a weekly basis, 15-20 support agencies meet where they determine acutely imminent risks to support individuals and families in need. The steps include identify, assess, and plan. Mental health was found to be the highest risk factor.

The third speaker was Garima Talwar Kapoor from Maytree. Garima discussed economic and social rights as tools to advance thinking on social determinants of health. Economic and social rights are human rights and they impact one's ability to live in dignity and participate fully in society. Although Canada's Charter of Rights and Freedoms has been critical in advancing civil and political rights, there has been little progress as of late on economic and social rights. To make progress, direct engagement on social policy is required. There is a need to enable a deeper articulation of the inherent dignities that we believe everyone in Canada should be afforded. This depends on the policy decisions made by governments. To realize economic and social rights,

they must be recognized in legislation and there must be accountability, where one can identify whether their rights have been infringed upon and thereafter work to fix the problem. The federal government presented a National Housing Strategy that states that everyone has a right to safe, affordable, and adequate housing. Some future work can include cultivating a culture of rights by looking at data on who is included, not included, and by expanding the provincial and municipal jurisdictions.

Best Practices in Health Equity

The best practices in health equity panel highlighted programs in health care with a culturally competent lens and the challenges associated with them.

The guiding questions for this panel were:

1. Discussion of projects/programs that have been implemented in health care settings, hospitals, or in government to create tailored approaches to health care provision using cultural competency.
2. What evaluation has been conducted for these programs/practices for test outputs and outcomes?
3. What are some gaps, risks, challenges and/or additional resources required to replicate or implement this practice for the South Asian communities?

The first speaker was Liben Gebremikael from TAIBU Community Health Centre. TAIBU provides primary healthcare services and health promotion programs to the black, Indigenous, and francophone communities in Scarborough. TAIBU focuses on specific chronic conditions such as diabetes, mental health, and sickle cell. Speaking in terms of equity, Liben says that we not only need to remove barriers that prevent access to services, but also build tools to ensure racialized communities do not get trapped in inequity. For example, the black population is disproportionately impacted by social determinants of health, such as child welfare and mental health institutions. Moreover, breast cancer has a higher death rate for black women and there are higher rates of prostate cancer in black men. To ensure best equity practices, we need adequate resources and services that are language appropriate and culturally safe, as well as encourage engagement and participation within the community. What is TAIBU doing? Liben stated that to have access to adequate resources, it is not always about financial means. It is also about leadership capacity and organizational capacity. To ensure culturally safe services, TAIBU has built trust with the Indigenous community. For engagement and participation, TAIBU starts with the people and not the program – to determine what is needed and how it needs to be delivered. TAIBU has also advocated for improvements in education attainment, and they aim to reduce suspension and expulsion rates in Black communities. Looking ahead towards a system change, TAIBU wants to engage young people in education, employment, and training.

The second speaker was Baldev Mutta from Punjabi Community Health Services (PCHS). Baldev discussed how Canada does not want to address racism and that cultural sensitivity and health equity is brought up to cover up racism. No one is collecting data and even with the existing data, nothing substantial is being done. For example, existing data found high right rates of heart disease, that women are twice as likely to have depression, and that members of the LGBTQ community have higher rates of mental health and addiction. But what is being done to

address these issues? We also do not talk about the distribution of power and race and racism with allocation of funding. Baldev also suggests making services family-based and involve entire families. For example, with counselling, the family should get involved and make connections with the person suffering from mental health issues. This integrates their culture and has more effective results for the patient.

The third speaker was Marilyn Verghis from William Osler Health System. Marilyn discussed about Osler's Model. Their focus is not only on the patients who are sick today, but also those that are at risk of acquiring an acute illness tomorrow. Social determinants impact both patients. Health outcomes and revisits are all impacted by social determinants of health. William Osler wants to individualize and make it unique to get personal support. Better health outcomes mean innovative cross-sectoral community partnerships such as the one with the PolyCultural Immigrant and Community Services and with the Post-Discharge Support program. William Osler conducts a reassurance check within 48 hours of discharge, especially with seniors, so that they can determine whether the patient is in a safe environment. They have also embedded health equity at the system level using the Health Equity Impact Assessment tool. This is a decision support tool to look at the gaps of equity in groups. They want to see an uptake of services and outcomes for clients.

DAY TWO

Best Practices – Black Health Strategy

The best practices – Black health strategy panel highlighted how the Black Health Strategy was developed and helpful tips for the South Asian Health Strategy.

The guiding questions for this panel were:

1. Highlight some of the process involved in developing the Black health strategy – i.e. choosing areas of focus, community input, government involvement, policy analysis
2. Are there other domestic or international examples of Indigenous Health Equity that we can learn from?
3. What are some lessons learned that we could consider for the South Asian health strategy?

The first speaker was Nakia Lee-Foon from Black Health Alliance. Nakia works with an intersectional, anti-oppressive and anti-black racism lens. This is a lens that does not undermine the racism struggles faced by other races, but highlights the unique systemic racism, history of slavery and colonization of the black community. Some partnerships and community research include Toronto Public Health and Pathways to Care. Nakia discussed the need and importance for a Black Canadian health strategy because Black Canadians are an invisible minority in health care research in Canada. They do not have services available to them and face a high level of health disparities. For example, a high percentage of those diagnosed with HIV are black. The Black Health Strategy originated from many places: community and stakeholder input, literature reviews, and other health strategies such as the Toronto Indigenous Health Strategy. For the South Asian Health Strategy, Nakia suggests putting community and stakeholder input at the forefront. Additionally, we should use an intersectional lens in data collection and analysis, as

well as policy review and how the policy addresses the needs of the community. It was also suggested to embed anti-racism into the South Asian Health Strategy, acknowledge what it is since it looks different in different communities.

The second speaker was Dalon Taylor from Black Health Alliance. Dalon spoke about how the Black Health Strategy aims to eradicate the impact of anti-black racism and racialized poverty while also building a sense of community and connectedness. The strategy supports and improves health outcomes like mental health. Plans need to be practical, actionable, and inclusive of all parts of an individual's identity. It is a comprehensive approach. Some other considerations include a need to be measurable, a need to know when to continue or change course, and a need to be tangible. Dalon stressed the need to have cultural competency training and safety training for professions. Many individuals are misdiagnosed and traumatized in the health care system. We should also have a public policy and engagement policy. Dalon suggested starting with a plan that is manageable because we still need room to grow and include people that will be represented.

The third speaker was Tiyondah Fante-Coleman from Black Health Alliance. Tiyondah discussed how mental health is reaching a crisis level in the black community. Some youth are not getting mental health care unless they are interacting with the justice system. Black youth face significant barriers to mental health care such as having to wait twice as long compared to white youth, anti-black racism, financial issues, geographical issues, and stigma. Other issues include physiological effects of police brutality and lack of acceptance in the community. The Pathways to Care project is a collaboration between Black Health Alliance, TAIBU Community Health Centre, Centre for Addiction and Mental Health, East Metro Youth Services, and Wellesley Institute. This project is community-led and aims to remove barriers and improve access to mental health for black youth and families by making interventions at policy, sector, and population levels. It builds off established programs such as the Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY) and the Black Enhanced Youth Outreach Worker Program. This project is not only academic, but also takes grey literature into account. Pathways to Care conducts community-based research to better understand needs and define and improve the pathways to care for black youth to deliver culturally safe mental health services. It focuses on anti-black racism, empowers black youth, and focuses specifically on culturally relevant services. The Black Health Strategy incorporated community input in the form of a community health assessment, strategy development, and the Black Health Alliance forum.

Best Practices – Indigenous Health Strategy

The best practices – Indigenous health strategy panel highlighted how the Indigenous Health Strategy was developed along with helpful tips for the South Asian Health Strategy.

The guiding questions for this panel were:

1. Highlighting some of the process involved in developing an Indigenous Health Strategy - i.e. choosing areas of focus, community input, government involvement, policy analysis
2. Are there other domestic or international examples of Indigenous Health Equity that we can learn from?

3. What are some lessons learned that we could consider for the South Asian health strategy?

The Indigenous health panel consisted of Samuel Kloetsra from Toronto Indigenous Health Advisory Circle, Tasunke Sugar from Toronto Indigenous Health Advisory Circle, and Dr. Raglan Maddox from Well Living House. They contextualized the lived experiences of Indigenous populations in Toronto to the colonial occupation of Turtle Island. Samuel Kloetstra began by drawing out the dearth of information available through Statistics Canada, which only accounts for 19,265 Indigenous folks living in Toronto while the Health counts show an estimate of 39,000 to 65,000 Indigenous people in the city. Moreover, 90 percent are living below the poverty line while Statistics Canada survey only indicates 26 percent. Samuel highlights that this is not due to nomadic practices but a transient community, as Indigenous folks are living between the city and their community. Tasunke emphasized that there are many more Indigenous people in the GTA than it says on the stats reports, so the Youth Council developed a map which located different agencies supporting Indigenous youth. This map assists in finding Indigenous communities and doing consultations with them to inquire about their needs and to add more data to the app that helps their work grow.

The speakers also criticized the regressive notion that Indigenous health needs can only be addressed in the hospital since Indigenous culture has emphasized community health for centuries. Biologically, colonialism has impacted Indigenous people greatly by preventing them from applying Indigenous practices. Additionally, Indigenous health issues are a direct result of systemic issues created by Canadian settler colonialism. Hence, Dr. Maddox adds that being Indigenous is inherently political and that your identity has political ramifications; therefore, fighting bureaucratic boundaries and pushing for change is the only way to move forward.

Samuel emphasized the need for young people to be active but recognized the bureaucratic restrictions that prevent them from doing so. However, the advisory circle is the foundation for health equity work, but the youth council is invested in guerilla advocacy, where their work is not limited by funding and is more centered around young indigenous health.

Samuel also suggested that the Advisory Circle should create a living document; it will be key in ensuring that work progresses. He argued against having a document that lives on a shelf. He stated that it is important for a policy to be tangible and moldable according to the needs of the community instead of being firm and rigid.

Dr. Maddox added that putting our community voice forward is key – especially since colonialism has silenced Indigenous people for centuries and they have faced an imminent threat of being pushed into reserves, sterilized, and abused. Inspite of this, the Indian act continues till this day. = We must keep re-centering our community's needs as we are still living the trauma of our histories. The task of building trust is an important one; however, the first step should be to determine how to consolidate the knowledge that will then enable us to build the trust.

Dr. Maddox concluded by highlighting the importance of community organization as everyone is time and resource-poor; however, we need to create safe spaces as the city does not consist of limitless places.

Health Equity Policy – Toronto

The policy panel focused on exploring the different policies that have been implemented and how successful they have been at incorporating culture.

The guiding questions for this panel were:

1. Discussion of policies that have been implemented in health care settings, hospitals, or in government to learn about cultural competencies to create tailored approaches to health care provision.
2. What evaluation has been conducted for these policies for test outputs and outcomes?
3. How can the successful policies be legislated or implemented provincially?

The first speaker was Dr. Kofi Hope from Wellesley Institute. Dr. Hope highlighted a few issues such as culturally specific interventions, stigma around mental health, linguistic barriers, and feeling unsafe when speaking to doctors. There is a need for culturally specific support. Racialized communities lack services they need, and organizations do not put money into this. For example, there are a few old age homes for long-term senior care for Italian, Spanish, and Chinese people, but not even one for South Asian or Caribbean people. They too need old age homes that suit their cultural needs. In addition, ethno-aggregate data needs to be collected to ensure that resources are deployed in the right way. There is also a need for race-based data which is important for health and for those facing barriers. This data is crucial to create policies. Dr. Hope stressed that we need culturally specific interventions and programs.

The second speaker was Samiya Abdi from Public Health Ontario. Samiya spoke about the importance of taking a health equity approach. Harm of policy and emphasizing gaps between the rich and poor has always been the focus. Another thing we need is economic change which needs to be beneficial for everyone and not disproportionate to certain groups. We need to evaluate all policies with a health equity approach/perspective. For example, being inclusive of other religious holidays and places of prayer. Many do not know about a lot of programs available for lower income people such as the TTC fare pass program. We need to find ways to communicate certain policies and programs to racialized communities.

Health Equity Advocacy

The advocacy panel discusses the challenges and successes when advocating for health care as well as recommendations to the health sector.

The guiding questions:

1. What are some existing challenges your organization is facing in advocating for health care?
2. What has worked (or had some degree of success) in persuading the three levels of government?
3. What are your recommendations to the health sector to work with the provincial government on health equity?

The first speaker was Sané Dube from Alliance for Healthier Communities. Their mandate is health equity through comprehensive primary health care. Alliance for Healthier Communities serves the people first before their organization/members' survival. Sané discussed how they leverage their power and networks and are willing to meet government needs using government language. It is important to know which lines to not cross and the organization is respected for

their approach. They have built personal relationships with Ontario Public Service staff in the long-term as well as political staff immediately post-election. They take a partnership role on issues that influence the determinants of health, including allying and supporting.

The second speaker was Neshanth Shanmugalingam from South Asian Autism Awareness Centre (SAAAC). SAAAC's mission is to make autism care equitable for all Canadian and to aid and empower marginalized communities who live with autism. They have many advocacy and awareness building initiatives and many programs such as speech-language therapy. Many families are low-income immigrants, including South Asians, East Asians, and Middle Eastern. Some challenges they face are stigma, financial gaps, and knowledge gaps for caregivers when it comes to service and treatment.SAAAC has been able to advocate for programming focused on caregiver empowerment and more inclusion of diverse voices in policy creation impacting families with autism. SAAAC recommends being engaged in key issues happening in the sector, developing evaluation capacity to provide evidence-based data, and mobilizing diverse voices.

C. DISCUSSION FROM COMMUNITY FEEDBACK

Community Feedback and Input on Health Equity Strategy for South Asian Communities

The community feedback and input session took place on Day two of the Summit at Ted Rogers School of Management, Ryerson University. This session consisted of five different table discussions with a facilitator and a notetaker at each table. The main objective of these discussions was to collect information about culturally sensitive health services and barriers to accessing health care, and to present solutions to these issues by having direct conversations with members of the community.
The questions asked during this session were:

1. How has your/your clients' experience been with accessing culturally sensitive/safe and/or linguistically appropriate health services?
2. Do you/your clients' feel more comfortable visiting your local community agencies for health care needs or mainstream health facilities?
3. Who do you feel is more equipped to provide health care delivery to your community?
4. What kind of barriers have you/your clients' experienced with trying to access health care services in this province?
5. What solutions do you propose to improve service delivery to racialized communities which would lead to positive health outcomes and wellbeing?

For question 1, many participants pointed out language as a barrier. Many tools are only available in English which is a disadvantage for marginalized people. Additionally, many patients are not aware of the fact that hospitals are obliged to provide a translator. As for services, often clients need to fit into the service rather than the service fitting the cultural needs of the clients. Other issues when accessing culturally sensitive health services includes long wait lists, misuse of current tools that are not culturally specific, and lack of cultural sensitivity in service provision. There is also stigma with South Asian communities and putting senior/family members who are patients into homes or care facilities. One participant mentioned helpful solutions that they implement to tackle some of these issues. These include ensuring someone at

the front desk can speak a language that is predominant in the area, asking clients what language they speak, and having an open discussion about spirituality to make sure they can imbed interventions that the client can appreciate.

For question 2, some participants stated religious institutions are often a main channel to conduct outreach for minority populations. However, the services that are offered at the religious institute, despite being open for everyone, are only utilized by people regularly attending that institute. Clients are reluctant to use culturally appropriate services/facilities due to concerns regarding competency (for example, thinking white doctors know better), cultural stigma, privacy, and fear of judgement. On the other hand, some South Asians do not trust professional judgement of someone who is "white" versus someone who is South Asian. Ideally, community agencies would be the go-to, but community agencies are not always prominent as they should be. They need to be able to scale up somehow, either on their own or with the help of large structures, such as government facilities. For cases of domestic violence, most people do not want to visit anyone, whether that be a local community agency or a mainstream agency. A large part of this is because the diagnostic criteria for abuse is tailored specifically towards Caucasians. Individuals need to accept that they are going through it before they can seek help. Additionally, there needs to be increased awareness around what domestic abuse really is and what can be done about it. Many are not willing to perceive it as a legal issue; rather, they believe it to be a household matter. Lastly, it is important for clients to have the option to choose. If they go to a place in the community which is not right for them, they should be able to choose from other available options.

For question 3, participants stated that the person must be qualified. They want community-based services. For example, some Muslim women refuse to go to mainstream shelters and only go to a Muslim one, which often lacks training and resources. Some will also go to a mosque, a religious leader, or to a community member to seek services. But not all leaders are well informed and may lack training in the area. In addition, cultural competency for mainstream hospitals should be possible as they have the resources. Often, clients will receive poor services due to a lack of cultural competency. However, culturally sensitive training is not always effective, implemented or updated. Culturally sensitive training often homogenizes people and experiences within/between a certain culture(s). Listening to clients/patients without judgement and creating a safe space for them is the most crucial thing. Right now, the burden falls on the marginalized demographic to speak up about their needs; however, this burden ought to fall on the system. Additionally, minorities are most likely to go to their family doctor. Many people see nurses more often, who are the ones spending more time with their patients and are thus more comfortable and closer to them. One participant stated that this all depends on social determinants of health since health care needs vary from person to person of different classes and cultural backgrounds.

For question 4, many stated that there is a lack of services, such as specialist services, and services for autism, which shows a lack of equity. There is also a lack of knowledge of trans and queer, such as asking for pronouns, and having that on paperwork. There is the barrier of waitlists and not receiving services in a timely manner. Other barriers include lack of trust, linguistic barriers, denial, funding, and ease of access to specialist support – which usually means travelling to downtown Toronto and is not always possible. In addition, there is a lack of

an appropriate lens through which services are shaped to highlight the presence of systemic racism. South Asians blindly trust mainstream services (i.e. white-Canadian doctors and hospitals) due to their own settler-colonial history with Europeans. There are a few services tailored to immigrants. New immigrants and long-term immigrants do not know about the services available to them. The first step should be to raise more awareness about these services.

For question 5, several solutions were proposed. Some participants stated that if people do not have the lived experience, we need to find innovative ways to learn of that perspective. We need intersectionality in the work that we do, practising it in a non-judgemental way. There are two streams of action to be taken simultaneously: improving community-based services and improving mainstream services by collaborating with community services. Additionally, we need to let the community build based upon their needs and have more community engagements to determine their needs and barriers. It is also important that patients go to doctors who are familiar with their culture and background to ensure what they say is not lost in translation. We need to encourage communities and educate them. The medical institutions need to prepare medical students better. The new generation needs to be encouraged to do jobs outside of the generic options; doctor, lawyer, and accountant – maybe explore different careers in careers class in high school and in post-secondary education. This is because we need more racialized people in different occupations to help our own people. A lot of clients have also expressed issues with transit, some need rides from family. Some participants tried to provide support with this issue by opening late hours and on Saturdays. Sometimes they come themselves to workplaces and organizations so that clients can get referrals from doctors and come straight to them within the same building. Some clients have very little time during the day, so it helps to see them for 10 minutes within the same building and being able to catch their next meeting. Most agencies work nine to five, just like everyone else's work time, so that is a huge barrier for health care services. Taking services to them is very helpful. In general, South Asians tend to go to the doctor at a late stage during their illness. South Asian women tend to put their health in the back burner and prioritize their families first. Women in general are an afterthought. Racialized women and their health need to be a priority. We need more research, more community health centres in different areas including mobile clinics, pushing for funding for research, and educating staff about services. The duration for a doctor's appointment is very short, and there are long wait times to receive this appointment in the first place. This must be changed. The participants felt that there should be a collaboration between different agencies, and services should not be duplicated, so that they can complement other health services instead. Multiple agencies need to communicate with each other, so that the clients can have multiple needs met. There needs to be more willingness to share capacity to help clients and the referral system between agencies needs to be more seamless.

D. APPENDIX

Speaker Biographies

Dr. Ananya Banerjee – Dalla Lana School of Public Health
Dr. Ananya Tina Banerjee is Assistant Professor in the division of Social & Behaviour Health Sciences and Epidemiology at the Dalla Lana School of Public Health, University of Toronto. Dr. Banerjee also is the Program Director for the MPH –Health Promotion program. Dr. Banerjee holds leadership positions in original theoretical and applied research with a focus on diabetes prevention for South Asian communities funded by the SSHRC and the Lawson Foundation. Dr. Banerjee public health research exemplifies a commitment to providing a strong foundation in quantitative and qualitative methods guided by the principles of the socio-ecological framework and cultural safety. Dr. Banerjee launched and offers the first course on "Race, Ethnicity, And Culture and Health" for graduate students.

Avantika Mathur-Balendra – South Asian Diabetes Awareness Program
Avantika is a Research Coordinator at the Dalla Lana School of Public Health, focusing on community-driven projects in the South Asian community. Avantika is currently involved with the South Asian Adolescent Diabetes Awareness Program and the Sri Lankan Migrants and Diabetes Study. Avantika graduated from the University of Waterloo with a BSc. in Health Studies and McMaster University with an MSc. in Global Health specializing in Global Health Management. Avantika is passionate about grassroots community development work, and health promotion and disease prevention initiatives. Avantika also has a strong interest in health research, specifically examining high-risk ethnic groups and their susceptibility to chronic diseases including heart disease and type 2 diabetes.

Baldev Mutta – Punjabi Community Health Services (PCHS)
Baldev Mutta has been in the field of social work for over 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 29 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.

Bareera Sial – CAMH South Asian Mental Health Group
Bareera holds an Honours BSc in Biology & Psychology from Wilfrid Laurier University. During her studies, Bareera often engaged student leadership in dialogue about inclusive spaces for racialized students on campus. Bareera is interested in using her skills and lived experience to create culturally competent mental health supports for young South Asian women.

Dalon P. Taylor – Black Health Alliance
Dalon P. Taylor is a social work professional and researcher, whose teaching, academic and community work, draws from critical social work, critical race theory, anti-black racism, and anti-oppressive practice. Dalon's research focuses on social identity negotiation, race and racism, skilled migration and immigration, health inequities and the health and well-being of marginalized communities, with teaching experience at George Brown College, York University,

and the University of Windsor's MSW for professionals' program. Dalon's publications include contributions in peer-reviewed journals and opinion pieces in the media. Dalon has a strong record of presentations in the community and academic conferences, local and international, with upcoming conference presentations at both Princeton and Harvard university, respectively.

Evon Smith – United Way Greater Toronto
Evon Smith is a driven community change agent who has a collaborative approach to problem solving and bringing cross-sectoral initiatives together. He has over 15 years' experience working with some of the city's most vulnerable populations and communities. Today, Evon's most recent body of work is serving to help transform lives and communities through his current position as the Manager for FOCUS Toronto at United Way Greater Toronto. Evon works as one of the strategy's lead partners alongside the City of Toronto and the Toronto Police Service to tackle issues of imminent risk.

Garima Talwar Kapoor – Maytree
Garima is the Director of Policy and Research with Maytree, a charitable foundation that works to advance systemic solutions to poverty through a human rights approach. Prior to joining Maytree, Garima spent several years with the Ontario Public Service in various roles. She focused on understanding how changes in the labour market and economy impact population health and our social fabric and helped develop policy initiatives that could help strengthen the income security system. Garima is driven by a passion to understand how civil society organizations, governments and private industry can work together to strengthen communities. Garima holds a Master of Public Health from the University of Toronto, and a Bachelor of Public Affairs and Policy Management from Carleton University.

Gurwinder Gill – William Osler Health System
Gurwinder Gill is the Director of Health Equity & Inclusion and Lead for Global Health Program at William Osler Health System. Gurwinder is an author, trainer, and keynote speaker. Gurwinder is a member of the World Health Organization's Health Promoting Hospitals' International Task Force for Culturally Competent Hospitals. Gurwinder was a member of the City of Brampton's Inclusion/Equity Committee. Gurwinder is a recipient of 'The Woman Worth Watching' award and 'The Pink Attitude - Game-Changer' award. Gurwinder led Osler's journey to successfully receive Canada's Best Diversity Employers award seven years in a row.

Haran Vijayanathan – Alliance for South Asian AIDS Prevention (ASAAP)
Haran Vijayanathan founded the first 2SLGBTQ+ organization in York Region called My House: Rainbow Resources of York Region, a space for individuals from the community to gather socially and recreationally while accessing supports. Haran is the Executive Director of the Alliance for South Asian AIDS Prevention (ASAAP) and through his leadership, brought to light the systemic injustices that occurred when eight men went missing and were found murdered, resulting in the call for an Independent External Review of Missing Persons and is a Community Advisory Group member. Haran was the first Tamil man to be the Grand Marshal of Toronto Pride 2018.

Dr. Istvan Mucsi – University Health Network
Istvan Mucsi, MD, PhD is a clinician investigator, transplant nephrologist at the Multi-Organ Transplant Program and Division of Nephrology at the University Health Network in Toronto. Dr. Mucsi is an Associate Professor of Medicine at University of Toronto. Dr. Mucsi received his medical degree and his certification in internal medicine in Budapest, Hungary and completed nephrology training at the University of Toronto. In Toronto, Dr. Mucsi worked as a general nephrologist but later moved to Montreal to work as a transplant nephrologist at McGill University.

Ketussa Sotheeswaran – Abuse Never Becomes Us (ANBU)
Ketussa Sotheeswaran is a proud Queer Canadian Tamil woman who enjoys traveling the world and learning about different communities as much as she loves to eat different cuisines. She was born in Sri Lanka during escalating war, which led her parents to escape to Canada. While studying Political Science, Women's Studies and Religious Studies at the University of Waterloo, she was the first Tamil women to coordinate its Women's Centre for a few years. Getting involved through feminist organizations in university, she realized a lack of representation for marginalized communities and has worked in this area ever since.

Dr. Kofi Hope – Wellesley Institute
Dr. Kofi Hope is a change maker. He is a Rhodes Scholar and has a Doctorate in Politics from Oxford University. Currently, Dr. Hope is Senior Policy Advisor at the Wellesley Institute and a strategic consultant to the Vice President HR/Equity at the University of Toronto. Dr. Hope is an emeritus Bousfield Visiting Scholar for the University of Toronto's School of Urban Planning. In 2017, Dr. Hope was the winner of the Jane Jacobs Prize and in 2018 he was named as A Rising Star by Toronto Life in their Power List. Dr. Hope is the founder and former Executive Director of the CEE Centre for Young Black Professionals. In 2005 Dr. Hope founded the Black Youth Coalition Against Violence, which became a leading voice for advocating for real solutions to gun violence in Toronto and led to him being named one of the Top 10 People to Watch in Toronto in 2006 by the Toronto Star.

Dr. Larissa Moniz – Prostate Cancer Canada
Larissa Moniz joined Prostate Cancer Canada in 2017. She has a notable track record of working in cancer research for over 15 years, both in Canada and the UK. After finishing her PhD at the University of Toronto, Larissa moved to England where she continued her research into the molecular mechanisms of cancer and then worked in evaluation and knowledge translation at Macmillan Cancer Support and Prostate Cancer UK. In her current role at Prostate Cancer Canada, Larissa is focused on moving data and evidence into practice through health education, awareness, and advocacy.

Dr. Lawrence Loh – Peel Public Health
Dr. Lawrence Loh is Associate Medical Officer of Health at the Region of Peel – Public Health and Adjunct Professor at the Dalla Lana School of Public Health. Dr. Loh completed his undergraduate science and medical training at Western University and a residency in public health and preventive medicine at the University of Toronto, which included a Master of Public Health at the Johns Hopkins University. At the Region of Peel, he oversees the health equity and health protection portfolios as well as the department's digital strategy.

Liben Gebremikael – TAIBU Community Health Centre
Liben Gebremikael is the first Executive Director of TAIBU Community Health Centre and the first black male Executive Director of a community health centre in the province. Originally from Ethiopia, Liben has over 25 years of experience in the primary care, social services, mental health sector, and community capacity building and development field. Liben has worked as a social worker, child and family therapist, project coordinator, and therapeutic group facilitator with various primary care and non-for-profit organizations working with racialized and marginalized populations in the United Kingdom and in Canada.

Marilyn Verghis – William Osler Health System
Marilyn Verghis is an Equity, Diversity, Inclusion (EDI) professional working as a Health Equity & Inclusion Specialist at the William Osler Health System. Marilyn's work involves building and leveraging strategic partnerships with many community organizations, government agencies, places of worship and other groups that serve Osler's local communities to support the needs of diverse patients in achieving equitable health outcomes.

Mariyam Lightwala – CAMH South Asian Mental Health Group
Mariyam Lightwala is currently a consultant on The Roshni Project. She began with the project during her Masters of Global Health at McMaster University in May 2017 as a research assistant and quickly realized that she wanted to be more involved with mental health research, particularly with racialized groups and youth. Her personal experiences during undergrad and her knowledge of mental health through her masters is what drew her to research and advocacy work in this field. Currently Mariyam also works at a non-profit in Toronto called CivicAction and is involved with a Muslim Youth Helpline in the GTA called Naseeha.

Dr. Milan Gupta – South Asians Network Supporting Awareness & Research (SANSAR)
Dr. Milan Gupta is a cardiologist certified by the Royal College of Physicians and Surgeons of Canada in both internal medicine and adult cardiology. Dr. Gupta received his MD from the University of Toronto, where he then completed his residency in internal medicine and a fellowship in cardiology. He runs a busy clinical practice in Brampton, ON (www.oslercardiology.com). He is an Associate Clinical Professor of Medicine at McMaster University in Hamilton, ON, and an Assistant Professor of Medicine at the University of Toronto. He is also the medical director of Brampton Research Associates and has participated in over 100 large research trials as an investigator, or steering committee member.

Mudassara Anwar – Punjabi Community Health Services (PCHS)
Mudassara Anwar has a master's degree in Social Work and is a registered Social Worker. Currently, Mudassara works with Punjabi Community Health Services (PCHS) as a Supervisor of the Mental Health & Geriatrics Program. Mudassara has fifteen years of experience working with social service sector and serving vulnerable and marginalized population. Mudassara works with people having mental health issues due to various factors including, immigration, poverty, and lack of access to employment and housing. Mudassara works with clients and communities to address trauma and mental health issues and to further link families to health, community, and social service resources.

Nakia Lee-Foon – Black Health Alliance
Nakia Lee-Foon Nakia is a Ph.D. candidate in the Social and Behavioural Health Sciences division of the Dalla Lana School of Public Health at the University of Toronto. Nakia's award-winning research explores the sexual health literacy of young, self-identified African, Caribbean, and Black gay, bisexual, queer, non-hetero+ youth in Toronto, Ontario. Nakia completed her Master of Health Sciences with specialization in Community Health from the University of Ontario Institute of Technology. Her Master's thesis explored the state of Black-Canadian parent-youth sexual health communication in Toronto.

Neshanth Shanmugalingam – South Asian Autism Awareness Centre (SAAAC)
Neshanth Shanmugalingam has been with the SAAAC Autism Centre for 9 years. His current position with the organization is the Director of Mental Health Services. His main roles include overseeing the parent mental health program, mobile developmental outreach clinic and helping families advocate for their rights. Over the years Neshanth has worked with many marginalized communities within the autism community, and this has inspired him to seek equality and ensuring accessibility amongst this population. Through his work, he strives to defeat ignorance, embrace differences, and conquer stigmas.

Dr. Raglan Maddox – Well Living House
Dr. Raglan Maddox's (Modewa Clan, Papua New Guinea) program of research focuses on developing population based Indigenous health information systems using community driven processes. This research has been generating primary data platforms to identify critical gaps in understanding Indigenous health, including mental, emotional, spiritual, and physical health and wellbeing. Dr. Maddox works with Indigenous communities and health service providers to obtain information to better understand, inform and evaluate health service programs and policies. Dr. Maddox's program of research has included a strong focus on commercial tobacco use, exploring tobacco related morbidity and mortality, and having strengths-based conversations about respectful relationships and preventing domestic violence.

Dr. Razi Sayeed – Chief of Psychiatry, William Osler Health System
Dr. M. Razi Sayeed is a Physician with special interest in the treatment and research of mental illness with somatic therapies. He works at William Osler Health Systems as a psychosomatic medicine consultant and Geriatric psychiatrist. Dr Sayeed has teaching affiliations with Memorial University and McMaster University. He is a visiting faculty at Dow University of Health Sciences Pakistan.

Dr. Ripudaman S. Minhas – St. Michael's Hospital
Dr. Ripudaman Minhas is a Developmental Paediatrician with the Inner-City Health Program at St Michael's Hospital and an Assistant Professor in the Department of Pediatrics, University of Toronto. Dr. Minhas research interests are in the development, behaviour, disability, and rehabilitation of children in urban settings and in newcomer immigrant and refugee families. Dr. Minhas is currently working to develop interventions to support the developmental potential of children in the unique context of their social determinants of health. This is particularly through using Community-Based Participatory Research principles to guide the design and implementation of family-based interventions and the evolution of health systems.

Dr. Russell de Souza – McMaster University
Dr. de Souza is a registered dietitian and nutrition epidemiologist. His current research advances methodology for systematic reviews and meta-analysis and clinical trials in the field of nutrition, with an interest in the contribution of dietary patterns and macronutrients (specifically fructose, saturated and trans fats) to cardiovascular disease risk throughout the lifespan. He is a co-investigator on the INMD-funded Birth Cohort Alliance, which seeks to explore associations among maternal nutrition, infant feeding patterns, and epigenetic determinants of maternal and child health; and the Alliance for Health Hearts and Minds cohort examining neighborhood-level factors that contribute to cardiovascular risk.

Samiya Abdi – Public Health Ontario
Samiya Abdi is a Senior Program Specialist with Public Health Ontario. Samiya holds a master's degree in public health and a Postgraduate diploma in Social Innovation & Systems Thinking. Samiya has over 14 years' experience in strategic planning, program development, management and evaluation working within the non-profit, corporate and government sectors. Samiya's practice is grounded in challenging multiple and intersecting forms of oppression; understanding marginalization in knowledge production, research and practice; and building equitable systems.

Samuel Mukwa Kloetstra – Toronto Indigenous Health Advisory Circle Youth Council
Sam Mukwa Kloetstra is an Anishinaabe youth from Mattagami First Nation. Sam is an advocate for Indigenous youth, nation-building, and community wellbeing. He has been an advisor to Ontario Minister of Education and has sat on the Ontario Premier's Council for Youth Opportunities. Sam continues to work in influencing change in health and education policy. He is a vocal advisor on the Toronto Indigenous Health Advisory Circle and the Toronto Drug Strategy Panel and has worked with the City of Toronto and the Toronto Local Health Integration Network. He is currently living in Toronto where he has taken an active role in the urban Indigenous community with the Toronto Indigenous Youth Collective.

Sané Dube – Alliance for Healthier Communities
Sané Dube holds a degree in Public Health. She's worked in community-based programs in Zimbabwe, ESwatini and Canada. She's currently the Policy and Government and Relations Lead at the Alliance for Healthier Communities, Ontario's voice for community governed health care. Her work advances health equity in Ontario. Sané is based in Toronto.

Dr. Shafi Bhuiyan – Dalla Lana School of Public Health
Dr. Shafi Bhuiyan MBBS, MPH, MBA, PhD is an adjunct professor, distinguished visiting scholar in the Faculty of Community Services and co-founder and program lead of the Internationally Trained Medical Doctors (ITMDs) Post-Graduate Bridge Training Program, the Chang School of Continuing Education, Ryerson University. He also Assistant Professor, Clinical Public Health and Socio Behavioural Health Sciences Division of the Dalla Lana School of Public Health, University of Toronto. Dr. Bhuiyan currently Chair of the Board of Directors of the Canadian Coalition for Global Health Research (CCGHR).

Shermeen Farooqi – Public Health Agency of Canada
Shermeen Farooqi is an Analyst at the Public Health Agency of Canada. Shermeen is currently a Knowledge Mobilization Lead for the Pan-Canadian Health Inequalities Reporting Initiative. For the past 5 years, Shermeen has supported many national files, including mental health promotion, healthy living, dementia and concussions. As a public health practitioner, Shermeen is committed to working alongside others to advance the health of vulnerable populations across Canada through research, evaluation and data analysis. Shermeen holds a Master of Public Health from the University of Toronto, as well as an Honours Bachelor of Science from McMaster University.

Sujane Kandasamy – McMaster University
Sujane Kandasamy is a PhD Candidate and CIHR Vanier Scholar in the Department of Health Research Methods, Evidence & Impact at McMaster University. Under the mentorship of Dr. Sonia Anand, Sujane is using mixed methods to study the early-life risk factors of cardiovascular disease, gestational diabetes, and Knowledge Translation efforts tailored for South Asian women and their primary healthcare providers. Sujane also holds a BSc (physiology), BA (anthropology) and MSc (Epidemiology).

Tasunke Sugar – Toronto Indigenous Health Advisory Circle Youth Council
Tasunke Sugar is an Indigenous youth and father from Pine Ridge Reservation, South Dakota. Tasunke is a Social Worker and has worked within the Indigenous Community of Toronto for over 5 years in different capacities. Tasunke's personal and professional life revolves around the well-being of his community. Tasunke sits on numerous councils as an advisor and is currently working on a protect for youth with the Toronto Indigenous Youth Collective.

Tiyondah Fante-Coleman – Black Health Alliance
Tiyondah Fante-Coleman works as a researcher with the Pathways to Care project. Conducted with numerous community partners including the Black Health Alliance, Pathways to Care is focused on improving access to mental healthcare for Black children, youth and their families. Tiyondah recently completed her MA in Community Psychology (2019) and her B.Sc. in Health Sciences (2016) at Wilfrid Laurier University. Passionate about social justice and health equity, her research interests explore access to health care, mental health, and the behavioural and cultural influences of sexuality, particularly among racialized and minority populations. To learn more about Pathways to Care, please visit www.PathwaystoCare.ca

Yoshith Perera – Moyo Health and Community Services
As a Public Health professional with a variety of experiences supporting health communications, primary healthcare delivery and community health promotion programs, Yoshith looks forward to working with communities to support health equity gains. Yoshith's strategy for success is to value creativity, communication and collaboration while appreciating diverse perspectives, ideas and opinions. Building on the needs and wants of the communities we serve, Yoshith looks forward to collaborating with agencies, networks and community champions to develop knowledge and mobilize sustainable program delivery.