



Council of Agencies Serving South Asians

3rd Annual Health Equity Conference

**“Building an Effective South Asian Health
Strategy in Ontario”**



Conference Report Draft

This document has been prepared by the Council of Agencies Serving South Asians (CASSA)’s Health Equity Steering Committee. CASSA is an umbrella organization of agencies, groups, and individuals that provide services to the South Asian Community. CASSA’s objective is to support and advocate on behalf of these existing as well as emerging South Asian bodies in order to address their diverse and dynamic needs. CASSA’s goal is to empower the South Asian Community. At CASSA we are committed to the elimination of all forms of discrimination from Canadian society.

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November, 2013

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BACKGROUND

The 3rd Annual Health Equity Conference: *Building an Effective South Asian Health Strategy* aimed to share knowledge of health inequities that are prevalent in the South Asian population in Ontario, as well as to facilitate a discussion around best practices to combat health inequities.

The Conference Objectives are as follows:

- To bring together academics, health and social service providers, policy makers and funders to share and exchange knowledge regarding South Asian health care needs with concerns to mental health, chronic diseases, sexual health, and healthcare governance.
- To present research on access to healthcare and health resources within South Asian communities.
- To address health issues affecting South Asian populations based on social determinants of health and through an equity-focused lens.

On the pathway to building an effective South Asian Health Strategy (SAHS), a series of conferences were organized to create a platform for a greater dialogue around what concerns exist with respect to health statuses of South Asians. These conferences gave light to the importance of addressing South Asian health concerns of culturally competent strategies that were relevant to the context of South Asians. The 3rd Annual Health Equity Conference was designed to organize a dialogue around the components and areas of focus for the development of a provincial strategy, including key players and processes that need to be endeavored in order to take the strategy forward. Considering the strategy is in the formative phase, CASSA hopes to take the knowledge generated from conference discussions to be applied in development of building a province-wide SAHS.

This report is intended to inform public health units, health services providers, community agencies, health organizations, community groups, and the South Asian community of South Asian specific health concerns. The report consists of research that can be used to understand the scope of South Asian health outcomes across Ontario's South Asian community.

INTRODUCTION

The South Asian Health Strategy (SAHS) aims to suggest a range of actions to address the dynamic health needs of South Asians across Ontario. The development of the strategy stems from a realization that when it comes to various forms of health encompassing Chronic, Sexual and Mental Health, South Asians are often found to be highly disadvantaged. When exploring reasons for higher rates of poor health among this population, it was evident that social determinants presented complex barriers to acquiring an optimal level of health and well-being for the South Asian population as well as other racialized groups. In Canada, Social Determinants of Health refer to factors such as income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, aboriginal status, gender, race and disability¹. It is evident that upon migration, South Asians as well as other immigrants have limited access to SDOH ultimately increasing the risk of experiencing poor health outcomes, a phenomenon we refer to as the ‘healthy immigrant effect’. Inequalities within the community include higher rates of illness, uneven access to services, and poorer quality of care and health outcomes overall². In addition, a lack of policies that provide equal opportunities for immigrants and prioritizing health concerns of racialized populations at a national level, create an environment in which inequities can be fostered and maintained.

At the heart of ‘inequity’ lies discrimination and exclusion from systems that can promote change or well-being and that perpetuate cycles of poverty. In addition, a lack of culturally-competent services render existing services ineffective when applied to racialized populations, including South Asians. Health inequity being a systemic issue that plays out in all socioecological levels requires multifaceted strategies and the commitment of health professionals, community members, agencies and organizations, educators and policy-makers.

RACIALIZATION AND HEALTH INEQUITIES

The framework for understanding and measuring health equity involves comparison of health for more and less socially advantaged groups³. Health disparities can be understood as health inequities when they are associated with unjust social structures or social determinants of health³. Conversely, health is an essential element for addressing impacts of social inequities. Health inequities are both derived from marginalization and further perpetuate marginalization of

already disadvantaged people. In this report, we present existing evidence related to disproportionate rates of illness, self-reported health and access to care. The evidence includes significantly higher prevalence rates of manageable and preventable chronic conditions, including diabetes and heart disease, as well as evidence of disproportionately poorer health outcomes when compared to non-racialized Ontarians and other groups³.

The term racialized is used to acknowledge “race” as a social construct and a way of describing a group of people. Racialization is the process through which groups come to be designated as different and on that basis subjected to differential and unequal treatment. In the present context, racialized groups include those who may experience differential treatment on the basis of race, ethnicity, language, economics and religion as defined by the Canadian Race Relations Foundation⁴. Racialization impacts health in many complex ways: through limited access to extended health services and insurance due to limited employment and education; through segregation or concentrations of racialized communities in urban residential areas with a lack of amenities or the presence of environmental pollutants; and through the negative psychological and physiological impacts in which experiences of racism may result^{5,3}.

In addition to having impacts on the individual and community level, health inequities have cascading impacts on public policy, programs, research and service delivery such as increased system costs and inefficiencies². There are signs that health equity is becoming a priority at multiple levels of government. At the provincial level, the Government of Ontario has identified strong links between health promotion and poverty reduction in the *Breaking the Cycle: Ontario’s Poverty Reduction Strategy* report (2008)². At the municipal level, Toronto Public Health’s 2010-2014 mission statement has become “*TPH strives to reduce health inequities and improve the health of the whole population*”⁶. This may suggest a climate in which the interplay of race and health can be discussed as it relates to health inequities that have been long apparent across racialized populations.

THE SOUTH ASIAN POPULATION IN ONTARIO

South Asians are the largest visible minority in Canada. The 2006 census data, identified South Asians as one of the fastest growing racialized groups in Ontario¹⁷. Based on the 2011 National Household Survey (NHS), South Asians are the single largest visible minority group,

comprising 29.5% of visible minorities in Ontario, as shown in **Figure 1**. Self-identified South Asians make up 7.6% of Ontario’s total population⁴.

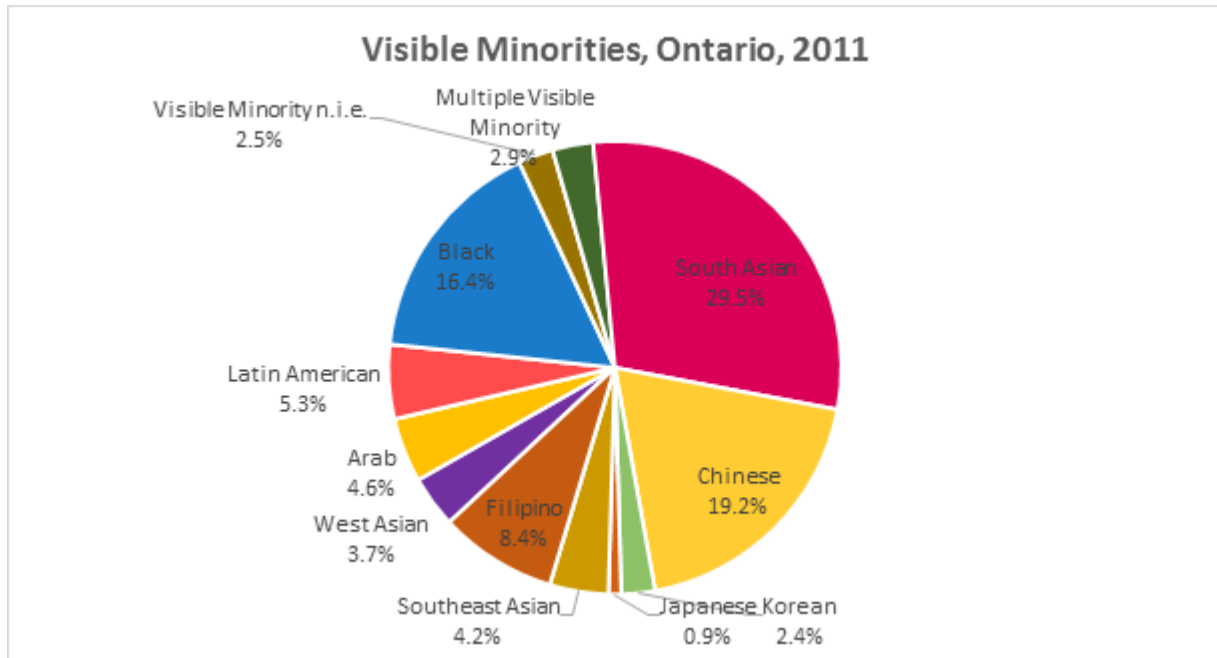


Figure 1. Visible Minorities in Ontario, 2011. Source: National Household Survey 2011 data⁸

In discussing health equity, social planning, and policy, it is important to consider the relationship between population and geography.

The top 5 Central Metropolitan Areas (CMA) with higher proportion of visible minorities are Toronto, Ottawa, Kitchener, Windsor, and Hamilton. These CMAs fall under the census divisions that make up the Greater Toronto and Hamilton Area (GTHA) shown in **Figure 2** in addition to the CMAs of census divisions of Ottawa, Waterloo, and Essex.



Figure 2. Census Divisions of GTHA⁹

Across these census divisions, self-identified South Asian visible minority population was found to be the highest in the Peel Census division, composing 28% of the total population

in Peel as shown in **Figure 3** and **Table 1**. Similarly Toronto and York also had higher percentages of South Asians with 12 % and 10% respectively⁸.

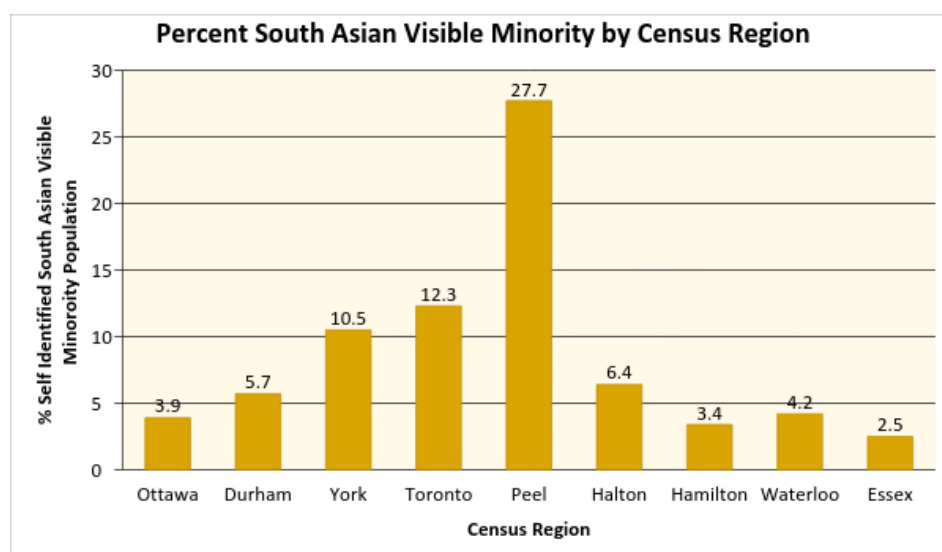


Figure 3. South Asian Visible Minority by Region. *Data Source: Statistics Canada, NHS 2011 data*⁸

Data from the 2011 NHS survey shows that immigrants from Select South Asian countries: India, Pakistan, Sri Lanka, Bangladesh immigrate mostly to the census divisions of York, Toronto, and Peel shown in **Figure 4**. Immigrants from India are highest among these countries across all the census divisions. Immigrants from Pakistan are highest in Peel. Immigrants from Sri Lanka and Bangladesh are highest in Toronto. From the 2011 NHS survey, Toronto had the highest Bengali, Gujarati, Tamil speakers. Peel had the highest Hindi, Panjabi, Urdu, speakers.

Table 1. The South Asian Visible Minority Population *Data Source: Statistics Canada, NHS 2011*

	Total Population	Total Visible Minority	SA Visible Minority	% SA Total Population	% Visible Minority
Ottawa	867090	205155	33805	3.9	16.5
Durham	601605	124250	34090	5.7	27.4
York	1024225	442840	107955	10.5	24.4
Toronto	2576025	1264395	317095	12.3	25.1
Peel	1289015	732805	356430	27.7	48.6
Halton	495440	89850	31860	6.4	35.5
Hamilton	509635	79970	17240	3.4	21.6
Waterloo	499615	77085	21170	4.2	27.5
Essex	381350	57795	9665	2.5	16.7

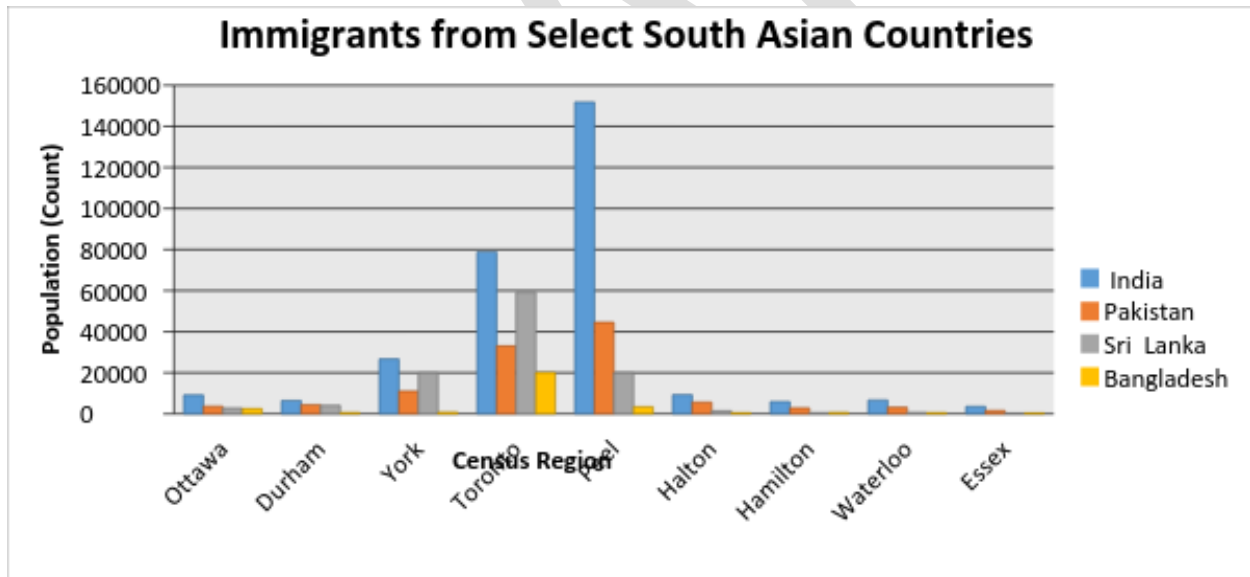


Figure 4. Immigration from Select South Asian countries to CMAs. *Data Source: Statistics Canada, NHS 2011 data⁸*

The City of Toronto identified Indo-Aryan home languages, including Urdu, Gujarati, Bengali, Panjabi (Punjabi), Hindi and other languages collectively compose 4% of the total population of Toronto¹⁰. The number of people who speak Bengali regularly at home has increased by 22%

since 2006 and is considered a growing home language¹⁰. Of the top -15 non-English home languages in Toronto, four are South Asian languages: Tamil, Urdu, Gujarati, and Bengali.

Table 2. City of Toronto Top 15 Home Languages (Excluding English and Multiple languages). Taken from *City of Toronto*

	Persons	% of Toronto	Rank in 2006	Change since 2006
1. Cantonese	67,210	2.8	2	-11%
2. Other Chinese dialects*	64,075	2.7	1	-24%
3. Mandarin	50,430	2.1	6	+32%
4. Tamil	48,680	2.0	3	-4%
5. Spanish	45,330	1.9	5	+3%
6. Tagalog	37,195	1.5	8	+10%
7. Italian	35,025	1.5	4	-21%
8. Portuguese	34,580	1.4	7	-9%
9. Persian (Farsi)	30,595	1.3	11	+11%
10. Russian	26,935	1.1	10	-4%
11. Urdu	26,590	1.1	9	-14%
12. Korean	23,380	1.0	12	-2%
13. Gujarati	19,255	0.8	13	-13%
14. Bengali	17,820	0.7	19	+22%
15. Vietnamese	17,680	0.7	14	-16%

* "Other Chinese dialects" include Hakka, Fukien, Shanghainese, Taiwanese, dialects not otherwise specified, as well as responses of "Chinese" that do not specify a dialect.

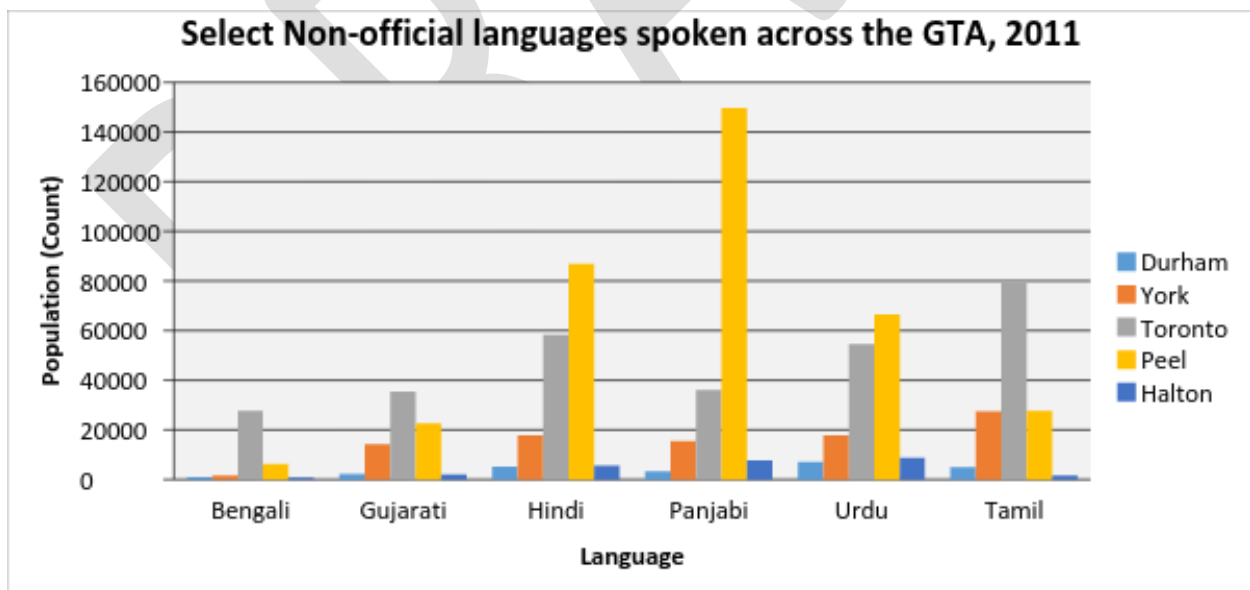


Figure 5. Select Languages Spoken at Home across the GTA. Data Source: Statistics Canada, NHS 2011

Table 3. Select Languages Spoken at Home across the GTA. *Data Source: Statistics Canada, NHS 2011*

Region	Bengali	Gujarati	Hindi	Panjabi	Urdu	Tamil	Total Population
Durham	1080	2230	5125	3230	7005	4890	601605
York	1520	14250	17865	15525	17715	27435	1024225
Toronto	27760	35355	58315	35975	54485	79330	2576025
Peel	6210	22525	86910	149755	66425	27705	1289015
Halton	835	2090	5690	7680	8735	1545	495440

HEALTH RESEARCH AND RACIALIZATION

When conducting health research, it is important to recognize the diversity embedded within the term South Asian and differences among various communities that are identified as South Asians. There may be significant differences in health status and outcomes between and within different South Asian communities in Ontario. Consequently, it is important for data to be disaggregated beyond the category “South Asian”. The census data includes information for South Asian communities as a whole, doing so obscures the group’s incredible diversity while enabling a strategic discourse on social inequities. Differences in migration patterns or histories may lead to different health outcomes; while some South Asian communities are shaped by experiences of conflict and the refugee system, others may be disproportionately exposed to occupational health hazards because of an overrepresentation in certain employment sectors. Furthermore, because race is a social construct opposed to a biological, there is no standard or consistent way to operationalize ethnicity or race in research. Existing and current research reflects the way original data compilers or interpreters understand race².

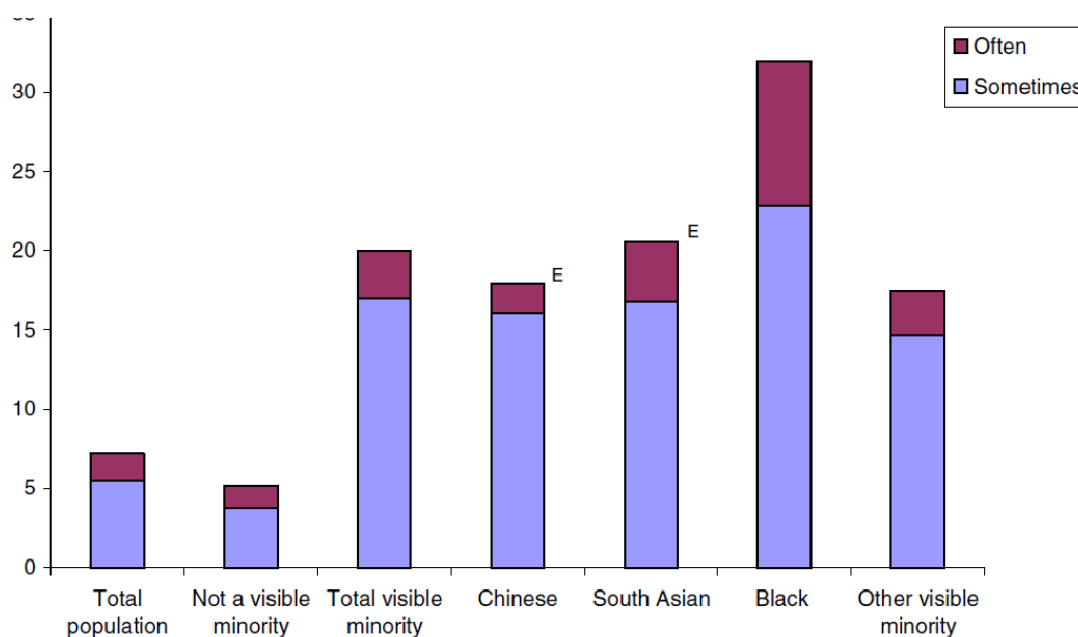
SOUTH ASIAN HEALTH IN ONTARIO: Health Inequities and Race

Researchers have documented a “healthy immigrant effect” where the health of Canadian immigrants upon immigration is substantially better compared to the Canadian born population¹⁰.

^{12, 13}. After settlement in Canada however, studies show that this better immigrant health rapidly declines due to lifestyle changes such as patterns of physical activity, and dietary habits¹¹. For South Asian immigrants in Ontario, the healthy immigrant effect and the decline in health after settlement illustrates perturbations in health that affect South Asians both individually and as a community. It should also be noted that not all South Asians in Ontario are immigrants, and this adds to the complex heterogeneity of the South Asian community.

According to the 2002 Ethnic Diversity Survey, Canada, 21% of South Asians reported experiencing discrimination often or sometimes **Figure 6**¹⁴.

Percentage reporting discrimination or unfair treatment 'sometimes' or often in the past five years, by visible minority status, 2002.



^E use with caution

Note: Refers to Canada's non-Aboriginal population aged 15 and older reporting discrimination or unfair treatment in Canada because of ethno-cultural characteristics.

Source: Statistics Canada, Ethnic Diversity Survey, 2002.

An emerging body of health research has found that members of racialized groups experience poorer health outcomes compared to members of non-racialized groups¹⁵. These poorer outcomes include higher infant mortality rates, higher rates of poor self-rated health, cardiovascular disease and diabetes¹⁵. Racial discrimination and other stressors, socioeconomic

status, access to Health Care, and health behaviour are factors that can explain the pathways between Racism and Health outcomes⁷.

Figure 7.

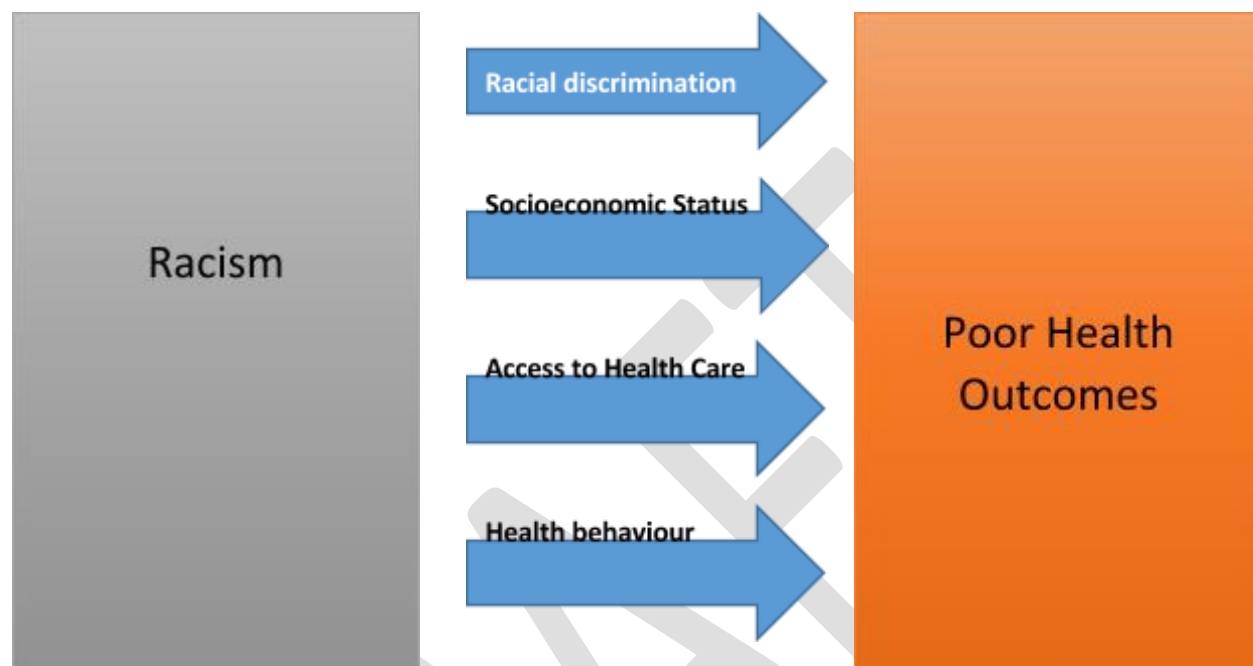


Figure 7. Pathways between Racism and Poorer Health Outcomes. Pathways are where health inequities exist and poor health outcomes demonstrate health disparities. Note- these pathways can intersect, resulting in a stronger effect on health outcomes.

It is now widely recognized by public health researchers that race and ethnicity is an important social determinant in individual health¹⁶. There is evidence that day to day racism and discrimination has negative consequences on health¹⁷.

Furthermore, it is important to look at the intersectionality of inequalities, such as the joint effects of poor socioeconomic status and race. Ornstein's 2000 statistical report on Ethnoracial Inequality in Toronto illustrated an inherent racialization of poverty in the city¹⁸.

Health Inequities also arise when access to health care is restricted. Barriers to health care come in many forms such as geographic access to services and care, cultural and language barriers, and cost (i.e. limited access to extended health service and insurance due to citizenship status/employment/education).

Compared to non-racialized and other ethnic groups in Ontario, South Asians have disproportionately poor health outcomes². Health disparities include higher rates of illness,

uneven access to services, poorer quality of care and poorer health outcomes for South Asians in Ontario². South Asian Canadians have been identified by researchers as having a three times greater risk for diabetes mellitus and a greater risk for death from cardiovascular disease compared to the general population¹³.

SOUTH ASIAN HEALTH IN ONTARIO: A geographic dimension

There is emerging evidence showing that neighbourhoods can influence the health of its members¹⁹. The neighbourhood is home to healthy resources like groceries, parks, recreation centres, and healthcare centres¹⁹. When these resources are distributed unevenly across neighbourhoods, it also speaks to the concentrations of varying levels of affluence and poverty¹⁹. Neighbourhoods can also be characterized by crime and unemployment rates which can be a collective stressor for health¹⁹.

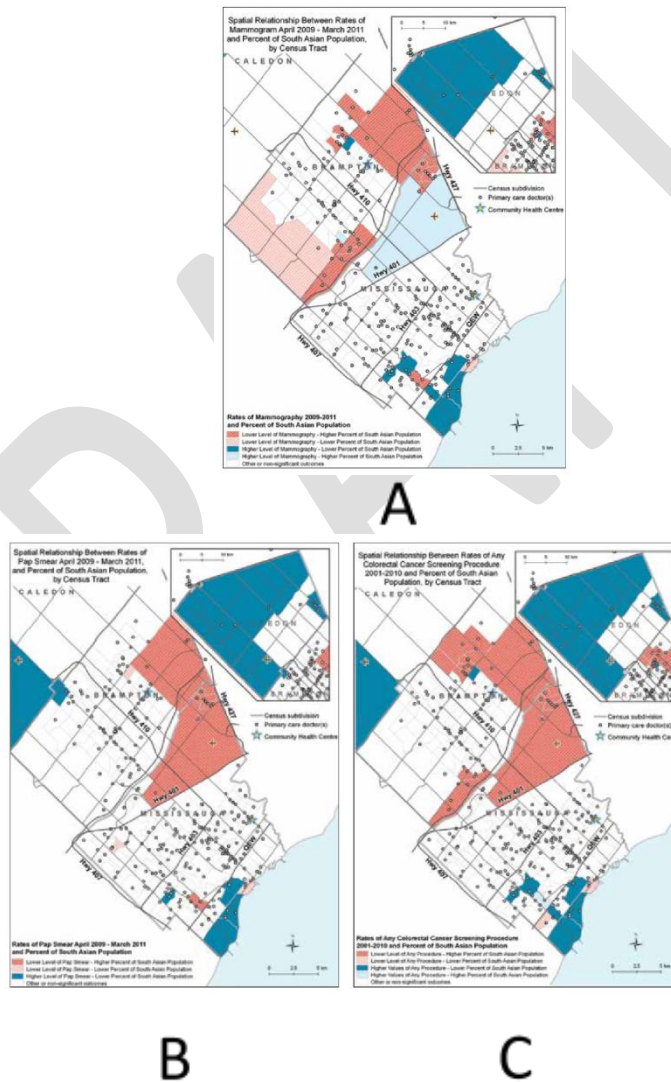
The prevalence of illness and quality health care of South Asians in Ontario have shown to have a geographic dimension. For instance, the higher rates of diabetes in Toronto are also identified as the regions with highest populations of South Asians **Figure 8**²⁰. Thus accessibility and availability to health services/resources, and important built neighbourhood features such as walkability must be questioned in a geographic context and assessed as a potential barrier and health inequity.

According to the “Making it Happen Together: Increasing cancer screening rates for South Asians in Peel”, a report based on findings from the Peel Cancer Screening Study, South Asians are vulnerable to under screening for certain cancers²¹. While cancer screening tests are offered at no cost through Ontario’s healthcare system, evidence shows inequalities for immigrants, certain sub groups and low-income people in Ontario²². The study examined the region of Peel, with a population of 1.3 million and the highest concentration of South Asians in Ontario. Peel had screening rates slightly lower than other Ontario regions²². The study identified geographic “high risk” areas that were characterized with relatively low screening rates and relatively large South Asian population shown **Figure 9**²¹. These high risk areas have also been identified for as suited for initiating interventions. South Asians in Peel are more likely to live in areas with lower rates of screening²¹. Screening for breast, cervical and colorectal cancer are known to reduce morbidity and mortality from these cancers. Peel community members

including residents and representatives of community health groups all agreed on the top-rated barriers for cancer screening:

- Limited knowledge among residents
- Ethno-cultural discordance
- Health education programs

Figure 9. Screening Rates in geographical regions²¹



CONFERENCE ORGANIZATION

As with previous years, the 3rd Annual Health Equity Conference by CASSA took place at the Centre for Addiction and Mental Health (CAMH) on November 17th, 2014, from 9:00am-5:00pm. In partnership with CAMH, CASSA staff and a team of 10 volunteers worked collaboratively in planning for the conference prior to and on the day of the event. During the planning process CASSA's Health Equity Intern worked closely with the Health Equity Steering Committee to generate a list of presenters and attendees. The conference target audience consisted of health professionals, researchers, community workers, policy-makers and community-based organizations directly providing services to South Asian and other Immigrant populations. Speakers were selected based on their expertise and contribution to the field of health equity. Our Speakers brought with them their diverse wealth of knowledge concerning addressing health challenges and health service delivery among the South Asian population. Speaker were organized based their expertise by areas of conference focus.

CONFERENCE COMPONENTS

The conference was organized in two parts. Part A (morning sessions) consisted of a knowledge sharing component with four concurrent information sessions in the areas of sexual health, chronic health, mental health and healthcare governance. Part B (evening sessions) consisted of breakout sessions exploring areas of practice including Training, Policy and Research, Outreach and Communication, Funding and Resources. The Conference Agenda is as follows:

PART A PRESENTATIONS

Mental Health Panel:

Punjabi Community Health Services
The Centre for Addiction & Mental Health
Farah Ahmad from York University

Sexual Health Panel:

Vijaya Chikermane from ASAAP
Radha Bhardwaj from Aids Committee of York Region
Nadia Junaid from Planned Parenthood

Chronic Disease Panel:

Gurpreet Grewal from Trillium Health Partners

Firdaus Ali from Heart & Stroke Foundation

Health Care Governance Panel:

Ruby Lam from Toronto Public Health

Dr. Eileen De Villa, Associate Medical Officer of Health in the Peel Region

Alejandra Bravo from Maytree Foundation

PART B BREAKOUT SESSIONS

Training- Facilitated by Jasmin Lobo

Policy and Research- Facilitated by Gayathri Naganathan & Tanzina Islam

Outreach and Communication- Facilitated by Mythri Vijendran & Urooj Shahzadi

Funding and Resources- Facilitated by Neethan Shan

DISCUSSION FROM BREAKOUT SESSIONS

The Breakout Sessions focused on topics that encompass areas of practice that merit more attention on the road to building a South Asian Health Strategy (SAHS). The session topics included Training, Policy & Research, Funding & Resources, and Outreach & Communication. Four questions were asked by facilitators in no orderly manner to guide the discussion. The following questions were considered with respect to each Breakout Session category:

- 1) What are key challenges?
- 2) What are key strategies & solutions?
- 3) How do we achieve desired solutions?
- 4) Who are the key players in this initiative?

The discussion below presents the dialogue that took place between session attendees surrounding each area of focus. Data was recorded by note-taking and translated with consent. Due to the wide range of topics that were presented in the breakout session, we have including information we found most relevant to consider when building a South Asian Health Strategy.

Policy & Research

When discussing the topic of Policy & Research, participants raised concerns of lack of availability of disaggregated data in the context of South Asian health in Ontario. As evidenced in the 2006 and 2011 census data, data specific to the South Asian population is not distinguished in the reports. Rather, South Asians are included under the umbrella term of ‘minority groups’. There is an overall lack of general South Asian health related data as well as data on diverse South Asian groups. It is important to highlight that although South Asians are grouped together, there is much diversity in language, belief systems, cultural practices and health behaviours. It is important to find a balance in data collection between desegregating and homogenizing data across the South population. Due to a lack of availability of South Asian specific health data, it is problematic to identify the major health concerns evident across the South Asian population. This in turn provides challenges to identify potential strategies and the effectiveness of strategies to target health concerns. It was also recognized that funding comes from generating evidence which is written concisely in grant applications. Without high quality evidence in the form of data, agencies may face rejection from funders and may be at risk of reducing quality of their services or their service reach. There needs to be greater accountability by agencies, non-governmental and governmental agencies in obtaining funding geared towards collecting South Asian health data. Although, community-based organizations have gathered small scale data from the South Asian populations they serve, that data is too trivial in statistical power to be generalized across the wider South Asian population, therefore we must work collaboratively to collect provincial health data across the South Asian population. Other than collecting population-based data, data concerning the quality of health service provision from the perspective of service recipients and service providers is key to ensuring effectiveness of current programs and services. Identifying gaps in service provision can give light to continual learning from knowledge and service improvement.

In general, there is enthusiasm in the wider social context in policy change through research, however the professional sector is lacking in this aspect. This may be due to the limitation (in terms of funding and resources) to carry out research. Knowledge translation was identified by the group as a key step to learning and professional development, ultimately leading to service improvement in terms of relevance and applicability in the South Asian context. However, the process of Knowledge Translation and the Knowledge Uptake should be

culturally appropriate and user friendly for adequate knowledge uptake. In addition, this knowledge should be shared with key stakeholders and should be translated at a policy level in order to make strategy building a part of a provincial agenda. Stakeholders should attempt to make a greater connection with the South Asian population to establish strong partnerships with the South Asian community to better address community needs.

If data is to be collected, understanding the South Asian context is very important. Some members of the group felt that Caucasians generally exhibit more health seeking behaviours compared to South Asians and are likely to participate in research projects. In comparison, South Asians are more reluctant as they have difficulty understanding how participating in research could benefit them. This may be reflective of a lack of trust towards researchers and research in general as research may not always lead to action. In addition, an outsider stepping in to their communities to conduct research may not be well received by the community, as feelings of being perceived as study subjects may exist. Working collaboratively to target all of the South Asian population and its diverse groups would require researchers to work collaboratively with community-based/grassroots organizations. To counter this challenge, grassroots organizations could be trained to carry out research themselves as trust-building with the community is likely to have already been established. Due to this trust, frontline workers from such agencies have more access to information in comparison to researchers. In addition, providing incentives and tokens for transport may reduce certain factors that may act as a barrier to participation. Researchers would also have to adopt innovative approaches to targeting South Asian populations through media outlets and communication tools that is widely used and accepted by South Asian communities. Researchers must adopt community-based principles and approaches in conducting research as well integrating cultural competency in interview and survey guides (such as adopting qualitative methods such as story telling).

Outreach & Communications

Effective outreach and communication is key to recruitment and knowledge sharing in the context of South Asian Health. However, as with other approaches, the socially determining barriers that South Asians often experience provide challenges for organizations and service providers to reach out and communicate at a meaningful level. For instance, ‘income’ is a determinant that often limits or allows access to other determinants such as transportation,

shelter, food etc. To attain an equitable flow of income, immigrant populations often work odd job with unfavorable schedules that limit their participation in leisure and community activities. Being isolated from engaging with their community at community settings presents barriers to accessing knowledge, information, resources and services. Organizations as well as service providers must therefore work harder to find meaningful approaches to conduct outreach and communicate effectively that can allow them to overcome limitations presented by the influence of the Social Determinants of Health (SDOH). To do this, they must find communication tools and outlets that is widely utilized and accepted across the South Population. For instance, outreaching for a seniors health program may reach a wider target if advertised through a local South Asian newspaper as a communication tool. This may be due to evidence that suggests that seniors and perhaps South Asians in general are more likely read local South Asian-based newspapers than mainstream newspaper.

To identify useful tools, there should be research around effective outreach methods and communication tools that are well suited for the South Asian population. A settings-based approach could be adopted for outreach and communication where South Asians normally gather. For instance, faith-based settings and faith-based leaders could be approached to carry out knowledge through outreach and communication methods. In addition, the language, terminology and message composition should be diverse to target diverse cultural groups. Learning from the community about what they prefer is likely to be the best approach as identified by the session group. Communication needs to be applied in a simplistic form with simple literacy for all groups to understand. Community-based agencies have a large role to play in sharing expertise and mentoring other service providers to adopt culturally competent approaches in outreach and communication. Outreach and communication must also work in long-term frameworks to firstly facilitate a dialogue around sensitive health concerns in order to reduce stigma and then promote behaviour change. However, to expand outreach and utilize a range of communication tools, funding is a necessary resource which is often limited at community health level.

In general, the group felt that having limited funding reduces the capacity for community-based organizations to be creative when reach out to South Asian populations. It was suggested that community-based organization should make continuous efforts to seek out funding

opportunities by funding agencies or work collaboratively with existing provincial agencies to improve outreach and communication. At the same time, it is also important for funders to respect the need for tailored strategies for diverse populations and appreciate the work carried out by ethno specific agencies. In practice, we need to take a bottom-up approach however funding and policy change must come from top-down systems. When discussing solutions, a strong need to bring together grassroots organizations (who often lack funding) and mainstream organization (with more access to funding) to work collaboratively in better outreaching to communities was expressed. However, a change in perspective amongst political leaders in policy level structures is needed in prioritizing the health concerns of marginalized populations.

Training

In their discussion, the group generally referred to training of front line service providers from South Asian community health centres and from mainstream hospital or clinical service providers. In addition, challenges to training community members as peer support and front line workers were also discussed.

When serving marginalized populations such as South Asians, front line workers face numerous challenges because of the complex array of issues South Asians face that influence their health. Many poor health behaviours are a result of life circumstances and limit the capacity of individuals to attain an optimal quality of life. Factors that influence health are even more complex when dealing with high at-risk populations such as refugees. Refugees often migrate from countries of conflict suffering from social, emotional and economic loss in hopes to find a better way of life abroad. However, upon migration they soon come to realize the range of inequities that exacerbate their poor health outcomes due to a lack of opportunity and fair treatment. When attempting to provide meaningful services to such individuals and families, service providers often lack training to provide meaningful care. Within the community-based settings, service providers often lack the resources to provide specialize care due to limited staffing and funding. Many of these health centres also feel disconnected from governmentally funded agencies that would provide resources, proper training and funding to enhance in capacity to address the needs of South Asian communities. Often times, when health services are provided by mainstream hospitals and clinics, health professionals may lack in cultural sensitivity in properly managing cases. The groups expressed that community-based health centres can play a

major role in training mainstream organizations and health professionals to work from an equity-focused lens by improving in cultural competency.

In order to provide effective services, on-going training and learning is essential from health professionals and front-line service providers. However, community health centres are unable to provide out-of-pocket access to training as a result of limited funding. In addition, conducting research to adapt evidence-based approaches in to training is lacking because of limited staffing and funding. Service providers at large express that they are aware of culturally-competent services and do not need training in this regard, however when though they may know what best practices are, they do not have the capacity to implement and integrate those practices into the centres they practice out of.

Funding & Resources

When discussion funding and resources, majority of group members expressed concerns about program sustainability within their organizations due to cutbacks in funding. It was also acknowledged that mainstream organizations are increasingly receiving funding to carry out South Asian focused initiatives while ethno-specific agencies continue to face challenges due to limited funding. When funding is provided by mainstream organization, there is a lack of understanding of the cultural diversity that is apparent in the South Asian population. This is problematic as community-based agencies often adopt a wide range of strategies to implement services that require tailoring for numerous South Asian sub-groups. Overall, diversity is not reflected in grant applications nor in the funding received. In addition, a lack of desegregated data evidencing diversity and the need for tailoring strategies based on South Asian diversity presents challenges for a compelling argument for greater funding. Although there is funding towards clinical services, there is an overall lack of funding geared towards carrying out outreach activities including services that allow accessibility such as the provision of translation services. Providing accessibility services is often considered a luxury when limited funding hampers program sustainability. Certain health concerns relevant to mental health and sexual health are often found to be sensitive topics in the South Asian population. To target behavior change in such areas requires much ground work to increase awareness and change perspectives prior to program implementation. The process of creating platforms for change is tedious but yet it is difficult to measure, which makes it difficult to be funded for carrying out such initiatives.

Strong advocacy is required on behalf of the South Asian community to achieve greater funding in reducing health inequities. More collaboration is needed when applying for funding and when managing resources in this regard. For collaboration to occur, joint leadership is required. For instance, Executive Directors of South Asian Agencies can work towards clarifying funding expectations with funders and advocating for more funding geared towards addressing health concerns of the South Asian population. To support the acquiring of funds must work hand in hand towards generating evidence through research to retrieve strong health data from the South Asian population. For funders to meaningfully understand the challenges South Asian agencies face in delivering meaningful services to the South Asian population, they must first value the work ethno-specific agencies do despite financial drawbacks. On the pathway to building an effective South Asian health strategy, South Asian agencies need to consider working in partnership with government and non-government bodies such as the Ministry of Health, Toronto Public Health, Local Health Integrated Networks and various hospital networks.

Executive Directors Round Table

Several months after the 3rd Annual Health Equity Conference, CASSA organized a ‘Health Equity Executive Directors Round Table’ to build on the body of suggestions and categorize some action steps to consider prior to the development of the SAHS. These steps concern what South Asian agencies do to improve the state of health of South Asians.

The discussion consisting of Executive Directors from several South Asian agencies was coded into themes and organized in several focus areas:

Funding

- Create a clear funding plan to gather resources for the SAHS.
- Advocate for appropriate funding and resource allocation from a critical anti-racist lens.
- Identify champions in the government level (political influence) for support.
- Strengthen research and data collection to strengthen funding rationale.

Collaborative Work

- Work towards a political, collective and united voice to approach mainstream organizations.

- Identify sustainable approaches to mobilizing and uniting the community such as collectively administer integrative programs.
- Share key knowledge with government level officials for them to support the strategy.

Develop a Health Strategy

- Establish strategic partnerships with health care practitioners that practice within the context of South Asian and immigrant health from South Asian background.
- Focus on the intersectionality of health issues.
- Learn from population focused health strategies (i.e. Aboriginal Healing & Wellness Strategy).
- Let's not reinvent the wheel! Let's learn from existing strategies.
- Develop a strategy rooted in community consultation and needs.

Research

- Perform meta-analysis on existing health research to create evidentiary support organize, plan, advocate and present the evidence from research.
- Create an agenda for province-wide South Asian health status data collection.
- Conduct asset-mapping along with needs assessment.

Awareness Campaign

- Creating a plan to map trends and movements of immigration status and health coverage (e.g. Non-status women, health and disability, immigration).
- Promote inner-community collaboration particularly between second generation youth and first generation adults. Work towards better approaches to empower young adults to take initiative and address stigmas within our community.
- Prioritize support for groups of people with disabilities, seniors, and LGBTQ communities and initiatives that support women's rights.
- Address widespread rejection of western medicine within the community. Work towards a pathway to bridge Western and Traditional health and wellness practices.

The roundtable provided a range of suggestions that will potentially be integrated in the development of the strategy. CASSA would like to thank all South Executive Directors who participated in the roundtable.

RECOMMENDATIONS

Across the Health care system, there is a strong need for a network of ongoing and active relationships between community agencies, primary care physicians, testing facilities, hospitals, health organization, grassroots groups and community residents²². To increase screening rates, the Peel cancer study recommends logistical supports like shorter wait times for appointments; interpretation services; transportation help (e.g. bus fare); and access during hours that do not interfere with employment/other responsibilities²². The study also recommends more female health providers. Community-based outreach materials in South Asian languages were found to be very effective in improving knowledge, beliefs and clinical breast examination (CBE) rates among South Asian women²³. Similarly, dietary education tools were found to be more effective when provided in South Asian languages and when oriented towards appropriate diets²⁴. Educational materials need to be well translated, and could be more effective if endorsed by credible community sources and are distributed through media outlets accessed by South Asian residents²². Resources should outline details of screening and testing, risk factors for illnesses and encourage utilization of the health care system for preventative measures opposed to solely treatment.

From Breakout Session discussion, it was evident that South Asian-based organizations and community health centres widely serving the South Asian populations experience drawbacks in the services they provide due to limited funding and cuts. This has created a resource poor organizational environment in which service quality and sustainability is often compromised, reducing the potential impact of existing services. As discussed in the breakout sessions discussion, funding often limits training and learning, outreach and communications as well as policy and research geared towards improving health outcomes of the South Asian population.

The findings in this report demonstrate that there is an increased need for culturally competency training, and the representation of health providers and technicians from South Asian cultures and who speak South Asian language²². There is an overall need for a Task Force to work collaboratively and advocate for funding at a provincial level. This Task Force can also work towards promoting diversity in leadership in the healthcare sector. The Task Force should be accountable to strategize a plan to develop a mandate for the strategy and to find resources and agree on processes to carry the strategy forward.

The Task Force's Mandate in regards to Building an Effective South Asian Health Strategy can include the following components:

- **Areas of Focus**
- **Action Plan**
- **Key Players**
- **Timelines**
- **Provincial Data Collection**
- **Apply For Provincial Funding**
- **Create A Policy Mandate**
- **Create An Advisory Groups**

Furthermore, South Asian socio-demographic data collection is necessary to determine the extent of health and illness in South Asian communities. Research should be geared towards understanding the availability and accessibility to services, barriers to seeking services and the best practices to providing services for South Asians. Service providers must develop, implement and evaluate health programs from an equity-focused framework. In addition, agencies should strive to be culturally competent and build community capacity to reduce barriers. Challenge cultural perspectives and behaviours that impede health and human rights.

As discussed earlier, South Asians are the largest minority group in Ontario, a population exceeding in prevalence of diabetes, heart diseases and certain cancers. Many of these poor health outcomes can be prevented with interventions that target behavior change as well as a change in the social political structures that contribute to poor health. Considering the impact of social determinants on the health of South Asian as well as other immigrants could be a starting point to addressing root causes of poor health. In addition, culturally competent service planning and provision could potentially increase the effectiveness of services ultimately resulting in improved health outcomes. However, in order create an environment where culturally-competence training can be provided, mainstream organization as well as funders need to recognize the importance of diversity and inclusion in the healthcare sector. This change in perspective and priority can potentially save the government from potential loss in financial resources due to effective utilization of funds and health and well-being of diverse citizens.

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