Good afternoon everyone and thank you for joining us today!

Welcome to COVID 19 and Racialized Communities,

Impacts on Mental Health.

We are delighted to be partnering with the Mental Health Commission of Canada

on this work and on today's event.

Before we begin, we wish to acknowledge the land on which we operate.

For thousands of years,

it has been the traditional land of the Huron-Wendat,

the Chippewa, and the Mississaugas of the Credit.

We are grateful to have the opportunity to work on this land.

Now, some background.

Since the onset of the pandemic,

we have seen differential impacts of COVID-19 on racialized communities.

From high rates of infection and mortality

to higher rates of income and job loss,

racialized people and their communities

have borne the brunt of COVID-19's effects.

And of course, along with this,

COVID has also taken a toll on mental health.

In fact, the Canadian Mental Health Association

found that since the onset of the COVID-19 pandemic,

racialized individuals have been more likely to have trouble

coping with their mental health challenges

when compared to the rest of the population.

And it is with this in mind that Wellesley Institute

and the Mental Health Institute of Canada came together

to investigate the impacts of COVID-19

on the mental health and well-being of racialized adults

in the greater Toronto area.

We wanted to get behind the statistics and hear directly from communities.

The major themes that emerge from that work

is what we'll be unpacking today.

And so, what can you expect?

Well, the first half of the webinar will be short presentations,

and the second half will be an interactive panel discussion

based on your questions.

The presentations will start with the findings of the Wellesley Institute

and the Mental Health Commission of Canada's research,

and that will be followed by views from three organizations

that worked with racialized communities.

And then, it's over to your questions to the panel.

We encourage you to use the question and answer function

at the bottom of your screens if you want to participate by asking a question.

And there are a few other housekeeping notes that we have.

We understand that our research findings

and that the discussions today

may bring about strong emotions for many,

especially Black and racialized individuals,

who may find themselves reflected in our research.

Should you need any support during the webinar or shortly after,

we are providing live support today.

Please look at the resources being shared in the chat.

For French interpretation and if you require subtitles,

please refer to the instructions that are also being shared in the chat.

Though we are sharing things in the chat,

you need to know that the chat function is disabled for this event,

so you will not be able to contact other people or the panelists

directly using the chat.

We would also like you to keep in mind that today's event is being recorded.

The video and the transcript will be accessible

from both the Wellesley Institute

and also the Mental Health Commission of Canada's websites

later in this month.

And lastly,

if you're on social media

and you would like to join the conversation on Twitter,

you can do so by using #MentalHealth.

So, #MentalHealth.

So, let's hear some of these findings.

I would like to first introduce Sarah Sanford

and Mauriene Tolentino,

as they present the findings from their new research for the very first time.

Sarah Sanford is a researcher at Wellesley Institute.

She earned her PhD from the University of Toronto,

where she engaged with critical social theory

to study pandemic preparedness in global health policy.

Since then, she has worked in research and policy development

in various settings,

focusing on a range of topics

including access to prescription medication,

communication across health systems,

and health, safety and regulation in precarious work.

Mauriene Tolentino is a policy and research analyst

at the Mental Health Commission of Canada,

and she is also a community organizer

with a Masters in Public health

from the Dalla Lana School of Public Health,

and a dual specialization in women and gender studies,

and public health policy.

Her work is rooted in antiracist, anticolonial foundations,

with a focus on the role of policies and systems

in addressing health inequities.

I am really glad to hear these presentations,

Sarah and Mauriene.

Thank you, Kwame.

It's great to be here today and to see everybody at the event.

It was clear early on in the pandemic that not everyone was being impacted equally.

Some groups were at greater risk of contracting the virus

and having worse outcomes if they did get sick,

including racialized populations,

low income people,

and front-line or essential workers.

In Toronto there are also clear geographical patterns of inequities.

As this map shows,

some areas had much higher rates of COVID than others,

and these were generally neighbourhoods that had more racialized residents.

As well, early research out of places like the UK and the US

suggested that racialized groups may also be experiencing

poor mental health compared with their White counterparts.

In order to better understand the impact,

the Wellesley Institute and the Mental Health Commission of Canada

designed the study to look at the experiences of racialized people

during the pandemic,

focusing on the mental health pressures that they experienced,

how they coped with these pressures,

and what kinds of support they needed.

The research focused on the experiences of individuals who identiied as South Asian,

Southeast Asian and Black,

because local Public Health Unit data from 2020

showed that these broad groups were experiencing the highest rates of COVID.

Mauriene and I were part of a larger team involved in data collection

which included Lucksini, Kiran and Seong-gee,

who are also co-authors,

and who conducted interviews with people in several languages.

So in total, we conducted over 30 interviews

with people about experiences of mental health and well-being

during the first three waves of the pandemic,

and today Mauriene and I will present on some findings

that provide a brief window into these experiences.

So the findings in our report support previous research

that showed that racialized populations face inequities

both in terms of physical and mental health and well-being,

as well as social and economic security.

The people we spoke with described pressures related to COVID risk,

as well as pressures around the social determinants of health

and how this impacted them.

A key source of stress for some participants

was around job security and income loss during the pandemic.

Some people had lost their jobs,

or had family members who had lost income,

and while emergency income benefit programs like CERB

were important supports in many cases,

others spoke to the fact that these programs

were not always accessible to everyone,

and that they were time-limited.

For those who maintained their employment,

people who worked in front-line essential jobs

described the toll of not always being able to physically distance

or having proper PPE,

and knowing that they were at higher risk of contracting the virus

and possibly transmitting it to vulnerable family members.

On top of that, not everyone had the living space

to maintain physical distancing from their family.

We spoke with a number of people who, in addition to job loss

and income insecurity,

experienced challenges maintaining housing in the middle of the pandemic.

Several people spoke about landlords

who had attempted to evict them from their homes,

and described the mental-health toll that this had had

at a time when they were also experiencing a lot of stress

in other areas of their lives.

People also noted that in addition to the stress of COVID,

incidents of racially motivated violence

that had recently occurred in Canada and the US

had been traumatic for people in their communities.

And while these had been ongoing issues in people's lives,

important social movements like Black Lives Matter and Stop Asian Hate

had increased attention to the effects of racism

and how it plays out in the day-to-day.

People described the stress of seeing the inequitable impacts of COVID

in their communities

and knowing that this was the result of systemic racism

including the inequitable treatment of racialized groups

in the healthcare system.

We spoke with mothers who described the stresses of job loss

and housing conditions in addition to their increased responsibility

educating and caring for their children.

This quote from Nabeela describes her difficulty coping

with the pandemic lockdown restrictions

in the context of all the other intersecting stressors that she faced.

In addition to anxieties around her health due to underlying vulnerabilities,

she'd lost her job and felt a lot of worry

around her family's future financial security.

Because of her health condition,

she decided to educate her child with complex needs at home.

And as a single parent who'd been cut off from much of her wider social network

due to lockdown restrictions,

she described the significant negative impact

that this had had on her, emotionally.

Nabeela's is one example among the many unique stories that we heard

during our research, but there are also commonalities across our findings.

Many of the individuals in our study had strong social and community networks

and had established effective strategies

to cope with mental health challenges during the pandemic.

But despite this, some did not have access

to the quality of social and economic conditions

that are necessary to maintain good mental health and well-being.

Many people faced barriers in accessing adequate mental health supports.

So, I'm going to hand it over to Mauriene now to speak a bit more about this.

Thank you, Sarah.

As Sarah noted too, many described ways of coping on their own

during this time, and this includes exercising, meditation, journaling.

Many also sought out supports and a sense of community from social groups

or regularly checking in with their loved ones.

Many participants also mentioned a strong need for formal mental health supports.

However, when they sought out these forms of supports,

many of them faced several barriers.

These are barriers already commonly acknowledged,

whether in literature or in the health system

like financial barriers, lack of culturally appropriate services,

language barriers and stigma.

During COVID in particular,

while people mentioned that the move to virtual services

allowed them to seek out health from the comfort of their own homes,

others described this as a barrier for those without strong Internet

or a privacy issue for folks living in multiple people households.

There was also an acute awareness

that racism was not only a significant form of stress,

as explained by Sarah,

but also a barrier to accessing supports in many ways.

And many noted, for example, that simply being aware

of the inequitable treatment in the mental health services,

specifically towards Black and racialized groups,

have deterred people from seeking support in the past.

I will tell the story of another participant, who we will call Kim.

She's a Black Caribbean health care frontliner in her 40s

who mentions that, while she knows that Black people

are affected disproportionately by COVID,

that they are also treated inequitably

compared to white clients in the health system.

And as a health care worker and a Black woman,

she shared with us that she's intimately aware of how these inequities play out

when a Black or racialized person does seek out support.

So during the interview, she posed questions like,

how are their symptoms being addressed?

Will their symptoms be downplayed?

And these questions have been raised

by other participants as well based on their own experiences.

So, for folks like Kim, knowing these direct forms of racism

happens on a regular, day-to-day basis.

She has shared with us as well that she had intentionally sought out

a Black practitioner to support her talk therapy during this time.

This has been very helpful for her.

However, racist encounters in the health system are only one form of barrier

through which racism prevents access for many individuals.

Kim also explained that, while she was able to secure this type of support,

she acknowledged the privilege in having access to an employee assistance program

that pays for this service.

So , it is important to see the intersecting and nuanced ways

in which social, historical and class or economic barriers

all play a role in how people access

or are afforded supports for their overall well-being.

Beyond formalized mental health services,

community organizations have supported the well-being of individuals

during this time in many ways.

And I won't go into the details since we have Aseefa, Liben and Mithi,

who will do it better justice than I can,

but overall what we found was community organizations

recognized the need to go above and beyond their traditional scopes

during the pandemic.

They were quick to respond and knew the what, the where, and the how

in terms of the resources that were needed immediately.

However, they were severely under resourced

and much of the important work that they do is done

from a volunteer or pro bono basis

or has caused tremendous burnout in the sector.

Needless to say, we will end with a reminder

of the gravity of COVID on racialized communities.

Many people have experienced a tremendous amount of loss

and we recognize that this is an experience

that continues to happen as the pandemic continues to develop.

We have seen with this research

and frankly, in our daily lives, that racialized people are resilient.

And many of us hate this term because it is, you know...

We know that it is the environments that sometimes require us

to be resilient and to be resourceful with our health and well-being.

However, continuous grief, loss and everyday social inequities

have lasting impacts on well-being.

So we need a society where racialized communities are not just resilient

but that we are thriving and are emotionally well and healthy.

So, what was so powerful with this project is that the people we interviewed

already know the solutions to addressing their issues of systemic racism

that result to mental health inequities.

So, very quickly, I'll list some of the suggestions posed in the research.

Policies that improve overall living conditions;

better social, economic and health infrastructures that facilitate

equitable access to social determinants of health;

meaningful inclusion of people with experiences of health disparities

in the decision-making peoples of program and health system planning;

increased and sustained funding for community organizations

to continue the important work that they do;

an overall improved access

to mental health services

that are inclusive, culturally appropriate

and accessible for everyone.

So overall, these upstream approaches

need to be taken up across systems,

and everyone has a role to play

to address systemic racism.

And improve not just individual resilience

but collective resilience

across communities.

So, thank you.

I hope this presentation gives folks

a glimpse of the rich information

that's in the report,

which I'm very pleased to share

is now up on the Wellesley website.

But for now, I'll hand it back to Kwame,

who will move us into a panel discussion.

Thanks very much. Fabulous presentation, Sarah and Mauriene.

So many insights.

Before the panel discussion, we're gonna hear community perspectives

from three incredible panelists.

First, we will hear from a Aseefa Sarang.

Aseefa is the Executive Director of Across Boundaries.

Across Boundaries is an ethnoracial mental health centre,

a leader in providing mental health and addictions services

to racialized and Black communities

in Toronto.

For the past 28 years,

these services have been centred

in equitable, holistic, anti-oppressive,

and resisting antiblack racism frameworks

to people who face

multiple barriers to care.

Second, we will hear

from Liben Gebremikael...

Liben Gebremikael.

Liben has over 30 years of experience

in primary care, social services, mental health,

community capacity building

and development.

As the first Executive Director

of TAIBU Community Health Centre,

Liben has led the organization

for the past 13 years.

Today, TAIBU has strong community roots

and has become a recognized agency

that is committed to addressing

the impact of antiblack racism on health

and well-being of Black communities.

And third, we'll hear from Mithi Esguerra.

Mithi has decades of experience in organizing

and advocacy work of migrant work communities.

Mithi currently serves as a Program Coordinator

for the Migrants Resource Centre Canada,

a non-profit service institution for migrant workers

providing services, community education and training

and engaging in community-based research and advocacy.

So lets start with Aseefa Sarang.

Lets all close our eyes for a brief minute

and think back to March 2020, the middle of the month.

What were you doing?

What were you thinking?

What were you planning?

Are you there yet?

I was in a meeting with all of our staff on March 16th,

informing them of our plans for the next two weeks to work remotely,

immediately start a hot food delivery program

and limit, except for emergencies, all in-person contact with our service users.

I was sure we had a solid short-term plan in place.

As the short-term continued to get extended,

I started receiving calls from my staff and managers

that we were not reaching certain service users

because they were inaccessible for various reasons.

Homelessness, transiency or did not have a phone.

Okay, these are critical times.

We bought a few pre-paid phones to support a few service users.

Except the requests continued.

By the time all the requests were in,

one third of our service users could not be supported

because they did not have a phone,

access to Wi-Fi, a data plan or a combination of the three.

And that is when reality sunk in.

For those of you do not know of Across Boundaries,

we are a mental health centre that came into being 28 years ago

because we know that racialized and Black communities

were not getting the care they needed.

We identified that racism, among other intersecting oppressions,

was a common threat in how people were perceived

and received care from existing organizations of that time.

With a vision and mission of providing equitable holistic care

to only those from racialized communities,

and specifically from an anti-racism, anti-oppressive framework,

we were funded.

So everything that this excellent research has identified today,

that you will read in this report is on point.

We, as Across Boundaries, have lived for these past 28 years

and I can provide real-life examples of each of these points.

However, today I'm going to speak to you about the digital divide

that became apparent to us throughout the pandemic.

One third of our service users equated to aproximately 300 distinct individuals.

For an organization of our size, that is a really high number of people

we would be unable to connect with and support.

If you think about it, as this research

and our collective experience and observations show,

the majority of those that live in poverty, live in homelessness,

live with mental health issues are from racialized communities.

So the fact that one third of our service users

were not going to receive optimum care should not have surprised me.

But I was blindsided.

Pre-pandemic, this didn't surface for us,

because when someone didn't have a phone,

they either came to our office to schedule calls with her their landlord

their doctor, their pharmacist, their lawyer...

Or our staff would go into the community and provide support through their phones.

We were managing this gap without really recognizing the depth of the problem.

This was the invisible divide that we were unaware of.

So how did we handle the situation?

We were able to take advantage of a program that Telus had

and very gratefully received 100 phones with voice and data.

Our founder provided emergency pandemic funding.

The City of Toronto supported us

and of course donations that we were very blessed to receive.

These allowed us to keep purchasing phones as funds became available,

but we had to balance this with other pressing issues,

such as ensuring food security.

We delivered over 10 000 hot meals and groceries,

provided PPE's,

changed the way we provided support,

and the loss of income for so many had to be addressed.

This was a complicated time,

but the digital support certainly rose to the surface.

Our experience with our service users today has shown a wide range of responses,

from them being comfortable with technology

and able to participate in their virtual care,

finding this to be more convenient and accessible,

to having fears about being surveilled if they had to setup an email account

to be registered for a phone;

to not knowing how to use the technology, figuring out how not to go over

their limited data plan and incur exhorbitant bills;

to needing education on exposure to and fears of cyberbullying and scams;

and using the phone responsibly,

i.e. not engaging in gambling, pornography or privacy breaches.

Individuals who were tech-savvy and comfortable with using technology

made an easy transition to primarily digital communication

and reported less isolation and anxiety,

whereas the opposite was true for those who weren't.

We learned that it wasn't just about access to a phone,

the problem was and is bigger than that.

First of all, it's about the different needs

of different segments of the population, whether students, older adults, newcomers.

And the need for each is different.

It is about having a decent sized device that has a decent sized screen.

For students, it's a laptop, a good Internet connection, enough of a data plan

that doesn't get used up because you joined a one-hour virtual group.

It's about connecting to mental health services, yes,

but also connecting to family around the globe,

getting good information, being informed,

feeling supported and less isolated.

So, it is about a digital access, yes,

but also about digital literacy and a digital framework.

Simply put, racialized and other marginalized communities

need support in reducing this divide

that goes beyond just buying a phone with a data plan.

And this need doesn't end with the pandemic,

this is something we have to address moving forward and into the future.

We know we are going to be living in a hybrid world

and we need to ensure that we look forward

and that as we look forward we don't become complicit

in sustaining and exacerbating this particular gap as well.

So where do we go from here and what do we need to do?

I leave you with three thoughts.

First, without elaborating,

we need data to understand the extent and depth of this problem.

Because the lack of access, knowledge and understanding of technology

will impact the participation of racialized communities

in recovery from the pandemic.

Second, a wraparound plan

that really looks at approach at a holistic approach to closing the gap.

Partnerships between the non-profit sector, government

and tech sector to provide alternatives and programs for the community,

not generically, but specifically looking at racialized communities.

Five years from now, let's not look back into the rear-view mirror of life

and say, "If only we had."

Finally, the F word.

Yes, funding.

But funding not as a simple influx of money,

but new and innovative ways of funding so that we create equity.

Let's not divide the $100 envelope

by giving $50 to CAMH and $50 to the community organization.

I'm not picking on CAMH, but it's top of mind.

Or giving $80 to CAMH because of its size,

and $20 to the organization and the community.

We need to help create the infrastructure, capacity and sustainability

within the organizations and the community.

We will have to be unequal in our approach to reduce the inequity.

We can also provide nonmonetary supports.

We can help access to ID personnel,

on-site support for service users to maintain their devices,

provide free equipment, training, and overall digital literacy.

Finally, I want to leave you with one thought.

Racism is not new.

The spotlight on racism and antiblack racism,

anti-indigenous racism,

didn't happen in a vacuum.

We experienced a perfect storm

in the last couple of years with the pandemic,

the murders of George Floyd, Regis Korchinski-Paquet,

the discovery of unmarked graves of Indigenous peoples,

and the antiblack racism movement.

All of this created a space for us to have these conversations.

So let's take this excellent research

and all the tragedies that we have experienced,

and build something truly meaningful for all communities.

Thank you.

Thank you, Aseefa, for that spotlight on the digital divide

and racism, and the need for better data,

more holistic services focused on decreasing racialized inequity

and funding and resources that can drive equity.

I would now like to turn to Liben Gebremikael.

Thank you.

Thank you, Kwame, for the opportunity,

and thank you to my colleague Aseefa

for providing very important context around digital equity.

If I can just follow up, just to make the connections between our presentations,

if I can go back to one of the few points you mentioned last,

around the $50 to CAMH and $50 to community.

I think maybe we should do $40 to CAMH and $60 to community

so we can start some kind of an upstream investment

so that people can be served in the community

and don't need to go to CAMH.

And maybe that should be a future strategy.

We are talking about COVID-19

and the impact it had on mental health

and the well-being of racialized communities

from TAIBU's perspective.

Just as a context, and Aseefa was just mentioning it,

when we talk with the impact of COVID-19 on our communities,

we need to acknowledge a couple of things.

I think the first one is understanding why there is this disproportionate impact

on Black, Indigenous and racialized communities,

even though we know COVID has impacted everybody,

bu disproportionately certain groups of people.

And the reason is that already,

Black, Indigenous and racialized communities

were already having some serious challenges and gaps

in access to care, culturally-appropriate services,

underlying systemic problems and issues that existed generationally.

So, when COVID hit,

it hit communities who were disproportionately impacted already.

I think that is one foundational point that we need to raise.

The other thing that Aseefa also mentioned towards the end

is that COVID was also exacerbated,

particularly for Black and Indigenous communities,

around the events that happened soon after the advent of the pandemic.

The painful experience of the murder of George Floyd,

Regis Korchinski-Paquet,

and the few other things that were really very traumatic for communities.

So, that is an added impact that communities were struggling with

as we were trying to understand how this pandemic was impacting our communities.

And then, the impact of COVID itself.

All of this, I think, created a disproportionate burden

on Black, Indigenous and racialized communities,

and that is what we were faced with

as we were trying to support communities on the ground.

How did those things manifest?

I think the first thing that we noticed for us,

in addition to trying to change the way we work and provide services

- whether it was primary care services -

virtually, because people were not able to come in...

Even for our community programs,

to pivot,

to have those programs and activities online for our communities...

And the impact of digital equity was a challenge.

But some of the things we also noticed at the beginning,

particularly we were getting a lot of calls from schools,

where Black students were finding it difficult,

not just because now schools were online

but because of the traumatic experience of George Floyd

and how they were coping with that.

And so, we had to work with schools both the Toronto District School Board

the Durham District School Board,

York Region District School Board,

to go in and provide some kind of a space for students.

And this happened just in May, and so schools were about to close

and there was a lot of concern

of how we were going to support the young people throughout the summer.

So, we developed a program,

but that's one of the first impacts that we have seen.

The second impact that we have seen from our perspective

was the impact on seniors.

Seniors were now further isolated,

they were dealing with grief and losses from family members here in Canada,

abroad, and were not able to really process the grief

and be part of family gatherings

to go through their losses and grief.

And that was very significant.

So, we had to develop programs to support them online,

grief sessions

and individual counselling and support that we have been providing.

Over the years, we've been working very hard with our committee

to get the seniors out

and breaking the isolation for seniors,

and now we were telling them, No, you need to isolate,

go back to where we were,

and that was very challenging for them and confusing.

And then, obviously, the adults,

particularly people with underlying conditions

that were exacerbated by the pandemic.

We haven't seen numbers, but we are expecting

that there will be significant increase around chronic disease prevalence

and acuity, I think,

once we begin to go into recovery mode.

And then mental health in general, as we defined in the community,

and as has been said earlier on,

is not really a physical or just a mental health challenge,

but it's all the social determinants of health

around housing, income, education.

Students were now online,

and parents became the educators,

in addition to all the other barriers they were facing.

What kind of support were they accessing?

The family environment.

All this was a big challenge that communities have gone through.

And as an organization,

we've tried to provide services through the resources that were made available.

I think we also have to knowledge and recognize that there was a lot of work

to get race-based data collection for COVID incidences.

And that helped strategies from the city, Public Health and the province

to allocate resources for racialized communities

and particularly, like I mentioned, the city's COVID-19 equity plan funding

that was made available.

Also the province's high-priority community strategy funding

that was available, and through that,

trying to support people with income support, housing,

digital equity issues, as Aseefa was mentionning earlier,

in providing people with Internet access,

laptops and phones, so they can support...

or address the issues that they were facing.

From the community's perspective, a couple of things...

The other thing I also want to mention is, when we're talking about community roles,

I have to talk about the staff of different community groups

or organizations that have gone through this difficult challenge.

In addition to the COVID impact,

the triggering event of what I mentioned earlier on,

George Floyd and the Black Lives Matter movement,

had also impacted staff - at least I know for our staff

it was a very difficult situation.

We also had to provide the support and the space

for staff to come and address some of the challenges

they were facing emotionally and psychologically.

We also were noticing that the EAP services that were being offered

through our benefit system was not adequate enough,

partly because of the limitation of sessions people could have,

the challenge of finding a representative or a reflective professional

to be able to feel safe to go to

to speak about this very triggering and traumatic event.

So we also had to make support services available for our staff as well

in addition to our communities.

I think if there is any lesson learned through this process...

You know, some of the things that Aseefa has already mentioned:

a strategic kind of fund and resourcing of services

that needs to address the generational disproportionnality around health

and mental health, and other social determinants of health,

will be very critical.

I usually say that COVID is like an x-ray.

It has shown us and demonstrated

how bad this fracture of our bone is,

how many places it has been broken,

and what kind of surgery do we need.

COVID has been an x-ray

to say that there are some very generational disparities that exist,

and this is the extent of those disparities.

Based on that, I think a long-term strategy

to address the underlying conditions and systems change

would be a very important component.

We have also learned that having a very strong community engagement

and relationship with communities

has been and will be very critical.

We believe, as an organization,

that community engagement is not just about informing or involving,

you know, bringing programs to communities,

or asking them to complete a survey and asking them questions.

It also means collaborating with communities

and empowering communities to help us do the work together as partners.

And I will just give one example, just to end.

We have been developing a very extensive community engagement

and involvement of seniors in our communities

through a program called UBUNTU Village project.

And what we have been able to do with the support of our communities

is that the seniors were organized to do and to lead the programs

that they wanted to see in their communities.

And most of the programs were facilitated by themselves.

And when COVID hit and we needed to move into an online process,

they were very active, and with the support that there provided,

they were able to move their programs online,

but most importantly, they were the circle of care and wellness check

for the communities, to kind of keep the communities together.

And today, all of their programs are online, they're as engaged,

and their participation is the same and has not changed at all.

And when COVID hit, the staff here,

we had a list of all the seniors we needed to call to do wellness checks.

We were calling a few people...

The staff had a list of 10 members, and somebody had 15,

and every week we would call and check in, and say,

"Are you OK? Do you need anything? Is everything okay with you?"

And one day I received a call from one of the seniors...

and I thought there was maybe a need from the senior to say,

"Can you help us with this?"

So I was chatting and saying, "How are you doing, is everything okay?"

And the person was saying, "Yeah, everythig is okay."

And I was waiting for this person to say, "By the way, I need this,"

or, "Can you help us with this?"

And the person was just chatting with me, and I said, "How can I help you?"

And they said, "No, no, no, I'm just calling."

You know, UBUNTU circle has organized a list of people

that we want to do wellness checks on.

And we also have included the staff of TAIBU,

because this is a very difficult time for you as well,

and so we are calling to do wellness checks,

and I want to check in with you and see if you're doing okay.

That was very touching for me,

but in my reflection I said,

If we are able to really get the community to be empowered enough,

and they have the right resources,

they know how best to address the supports that they need,

or addressing their challenges.

And so, one thing that we have learned is that true community engagement

and empowerment of communities will be very important to address,

and to keep us supportive within our communities.

And right now, I think there is also the conversation around recovery.

And in our circles we are very mindful when we say "recovery",

what that should mean for our communities.

Recovery is going to be different

for the people who have been disproportionately impacted by COVID

and other systemic issues and barriers generationally.

And so, we also are very mindful that these kinds of conversations

need to continue.

There has been a lot of learning, both from the community side,

from the service providers' side, from government and funders,

and I think we need to keep the pressure on

to make sure that, as we move into a recovery situation,

that these particular disparities and disproportionalities

are taken into consideration,

and a longer recovery process is put in place,

whether it is to remove some of the barriers that exist,

to ensure that there are culturally-appropriate

and community-based services in the community that are better accessed.

And as much as we need all the specialized services

such as the CAMH and the hospital services,

most of the work, I think,

is better supported when it is done within communities.

And so, that kind of collaboration will also be very important.

I'll stop there and I'll see if there will be any other questions

for our conversation afterward.

Thank you for the opportunity.

Thank you, Liben, that was fabulous.

Now, I'd like to introduce Mithi.

Thank you, Kwame,

and the organizers of this event today.

And also to the previous panelists, Aseefa and Liben.

As was mentioned in my introduction,

our organization, the Migrants Resource Centre Canada,

or MRCC, works with GIB services,

primarily to migrant workers.

So, our client base are temporary workers

who are engaged in precarious work.

We also serve workers who, for one reason or another,

have become undocumented.

A lot of times it's workers who have been victims or labour trafficking,

who have fallen prey to recruitment agencies

that have unethical practices

and have taken advantage of them.

And so, a lot of the challenges

that the communities we serve have faced during COVID

are similar to what has been mentioned in the report.

But as migrant workers, I think the added dimension is that

when we talk about concerns about employment and job security,

for migrant workers, employment is very much connected to immigration status.

And this is a big stressor for migrant workers,

and it was a very big stressor during the pandemic,

because not having a job means they will lose their status

as temporary foreign workers here,

and will be at risk of having to go home to their countries,

where there is not much opportunities for livelihood.

What I would like to share is our experience

in how we have provided support

to these populations during the pandemic.

MRCC has its roots in community organizations,

particularly in Filipino migrants organizations.

And even though we are relatively new,

we do have these established partnerships already,

from those years of being involved in the migrant justice community.

So during the pandemic,

we found ourselves pivoting to emergency support

and adjusting our services in the context of the pandemic.

And the approach that we have taken is based on the principle of mutual aid,

providing culturally-specific services,

community-based and collaborative services.

So, as such, we relied heavily on community partnerships.

At the onset of the pandemic,

Migrante and other organizations in its network initiated CAPIC BC,

a mutual aid project to provide support to those affected by the pandemic.

So in the network, it wasn't just migrant workers organizations,

but also student organizations and youth organizations.

So, how it was initiated is that there were a callout.

On one hand, who needs assistance? What kind of assistance do you need?

And on the other hand, are you able to help

and what kind of help will you be able to share?

So, you know, migrant workers and community members

volunteered their time

to call community members requesting assistance.

So it started with general check ins, "How are you doing?

Do you have work right now?

How is your family?

How are you doing physically and mentally?"

And so, from these general check ups, there were follow-up phone calls,

and then we started gathering the material resources that were needed

by the people who requested help.

In this effort, we partnered with FoodShare,

who was able to provide boxes of fresh produce for community members.

As MRCC had the physical space,

we offered our offices as a central hub for operations.

It was the central delivery site for the donations

that were distributed to the people needing assistance.

So, community members donated material goods:

food, baby supplies, clothing.

The students from Filipino university associations

offered tutoring or help with finding tutoring support

for the children of community members.

We also were able to undertake COVID-specific projects.

So, through these, we also were able to continue giving material assistance.

So we gave away kits with information,

but also PPE and some food supplies.

But not just for the purpose of providing immediate relief,

but also meeting community members and establishing relationships with them.

In this effort, we were able to partner with local stores.

So, we had a couple of Filipino take-out places who allowed us to conduct outreach

outside their stores, and also be our liaison to the community.

So, if we were to arrange a scheduled outreach with them,

days before that they would tell the customers coming into their store.

They would say, " Hey, MRCC is coming here on Friday,

they're gonna have free materials and free assistance for people,

so come here if you need it."

And they also offered their stores to be drop-off locations where,

outside of scheduled outreach hours,

we could drop off these care kits,

and community members could pick them up.

We also adjusted our education and training program

so that we were able to give workshops that gave information to people

on how to navigate the new realities of COVID.

So, what changes have there been to the Employment Standards Act

to accommodate the new conditions during the pandemic?

What special policies in relation to immigration

have been set up for migrant workers?

And we had resource persons from community agencies

who had expertise on the matter,

but we also had migrant workers themselves

talking and sharing their lived experiences.

For example, we had a migrant worker talking about her challenges

with mental health during the pandemic and how she managed them.

We also had another worker talking about housing challenges

that her family had experienced.

And so, for some of these projects,

apart from CAPIC BC, which is the mutual aid project,

initially we did have some resources and some funding

for the subsequent projects,

but largely we still relied on a volunteer base and partnerships

to make them successful

and to be able to reach a larger population.

Even our research project,

it wasn't just a data gathering activity.

We had a research project in partnership with York University

on Filipina care workers during COVID-19.

And the way it was done was through talk story groups.

Basically, they were focus groups

but it was more about sharing.

And for the participants, they treated it like a support group

where they could vent out their fears, their anxieties during the pandemic...

And they found so much support in these groups

that they wanted to keep in touch with other respondents in their group

even after the research project was done.

And of course, our casework continued

because migrant workers continued to experience issues in their workplaces,

challenges with maintaining their immigration status...

You know, they came to us asking for assistance, referrals,

and so that continued and even increased during this time.

Our key observation is that for racialized and working communities,

mental health is very much determined by their economic and social situations.

So, the responses that are needed are not necessarily clinical.

Rather, what needs to be addressed are the social determinants

of their mental health.

The second learning is that there's preference for community support

rather than formal institutionalized support.

This has to do with culture, first of all.

For the Filipino community in particular,

there is the sense of being able to rely on your community

as the primary source of support.

But also, there's the issue of accessibility.

So in terms of mental health, when we do see the need

for clinical support,

it is difficult to find affordable and culturally appropriate services.

We find a lot of Filipino counsellors and therapists,

but they have their private practice.

Third learning is, in addition to the alleviation of stress

through immediate assistance,

what helps workers a lot in this stressful time

is the sense of empowerment

knowing that they themselves can be part of efforts for change.

And that they can be part of advocacy, they can speak up for themselves.

For example, the mutual aid network, those who received help from that,

they were interested,

they were very interested in joining Migrante,

the migrant workers organization,

because aside from having a support group,

they felt that they have a voice in it.

And even the care workers research participants,

they wanted to be part of the advocacy.

They were asking, "How can we propagate the policy brief

that came out of this research project?"

There were ideas about doing a petition

so that they could ask more supports for care workers.

So, that's been our experience,

and in terms of what we think is needed to address all of these challenges

that have been identified,

as an organization working with migrant workers,

our advocacy is very much focused on labour and immigration issues.

So, for workers whose work conditions

and employment is a very big thing,

the protection of their rights in the workplace is crucial,

and what is needed is proactive monitoring enforcement

to ensure that migrant workers' rights are protected in their workplaces.

And for immigration, there also needs to be protection of migrant workers' rights.

And in terms of resources,

in our experience, we would like trust from funders

that the organizations on the ground know what we're doing,

and we know the needs of our communities.

So, that's it,

and I will leave all my other thoughts for the question and answer.

Thank you.

Perfect. Thank you very much, Mithi.

Perhaps we can get all of the panelists back.

We have about 25 minutes

and I can see the already we have got 22 questions coming through.

So, unless we speak incredibly quickly,

I don't think we're getting through all of these questions.

So, question one.

Has there been an increase in racialized care providers

who can offer racialized and marginalized communities support

since the start of the pandemic?

Has there actually been an increasing in capacity,

you know, of any of the...

Aseefa, I can see you unmuted there.

Oh, you didn't even finish the question yet, sorry.

No, I finished the question.

Has there been an increase in capacity to deal with the increase in demand?

No, actually not.

In fact, one of the things that we found out

through our centralized provider at this point

is that there has actually been an 175% increase

in people waiting with urgent needs for supports.

But for Black and racialized clients,

there has been a 274% increase in people waiting for supports

from March 31st, 2020, to February 2022.

So, there is a great increase, there's a large waiting list

and not enough supports.

Wow, so in general there's been a 70% increase,

but it's 170% increase for racialized populations waiting for care?

274% increase.

274%, yeah.

OK.

All right, so...

Question two is: studies have shown that if there's disproportionate effects

of the pandemic on racialized communities,

and they've all made recommendations on how to address various issues.

But there seems to be a gap between these research recommendations

and actually what policy initiatives do.

So, why aren't we seeing noticeable efforts and initiatives

to help bridge the gap between what we know needs to happen

and what is being done?

Liben?

Yes, I think it's a very interesting question.

And it baffles the mind, why this is not happening.

I think it's because...

Number one, I think now's the time that maybe those changes are becoming possible,

because we have some data to help us demonstrate

...demonstrate the need and know what needs to be done.

Two, as I was mentioning earlier,

the impact of COVID is very deep-seated, systemic issues,

and it requires changes at the higher levels,

where it is usually slower to bring about change than it is in communities.

In communities, we always are very quick to respond to needs

because the need is there.

I think there is this ongoing advocacy, engagement, awareness raising

that we need to do with government, with policymakers and with funders.

We have also seen some shift around funding.

But because it is very deep-seated, it's generational and systemic,

I don't think we will see these results pretty soon.

I think it will take us a few more years

until we begin to see some of those changes.

I see there has been some positive movement towards change.

There is a lot of work to be carried out.

And the other thing also is...

sometimes it is very overwhelming because it is not just in health.

It is in every institution and system,

and actually in the the living environment of our communities.

And so, maybe there is change in an educational or school environment,

but what about the other complex connections that need to happen?

So I think will take us a longer time.

I'm very hopeful that we have started that journey,

that's why I was saying these are the times

we really need to advocate for sustained effort, to just, like...

For example, to say we've reached 80% vaccination, we're good, let's go?

No, we need to stay with it because we are still seeing people

coming for their first dose a year after vaccination rollout.

So, this has to be a persevered, sustained effort on a longer strategy.

OK.

And Mithi, we...

You know, I think Liben just started talking about

the social determinants of health,

and one of the issues, as I said in the question I asked,

is why is there such a gap between what the research says

and what the policies say, and what the actual policies do?

Why aren't we making the fundamental change that we need

to decrease the stress on people?

I think it has a lot to do with policymakers trying to...

or, you know, finding the balance between government priorities.

And I say that in relation to migrant workers, for example.

Migrant workers...

There is definitely a need for migrant workers

in order to keep Canada's economy going,

but on the other hand, how do policymakers see...

How do they view migrant workers?

Is it just that they are here to benefit Canada?

Or do we see them as human beings contributing,

or that can contribute more,

not just through their labour but to the social fabric of Canada?

I think it depends on how they are viewed.

And if there viewed as truly valuable,

the policies that are needed

to make life easier for them

and to alleviate the stressors that they have to face in their lives here

will be addressed.

But that is not the case right now.

OK, so one of the things I heard was...

And one thing we've heard before is at the start of the pandemic,

everybody was saying, "We're all in this together."

And you are saying that we have to change our thinkings

to really think that we're all in this together

if we're going to meet the needs of migrant workers.

So, one of the things that happened that I thought was really interesting

is just how quickly both Across Boundaries and also TAIBU pivoted and changed.

They were so nimble in changing

to try and meet the needs of your population groups.

But you know, now I'm really interested in...

And this is a question from Steve Loree.

What happened to the in-person services during the pandemic?

Are these resuming with the lifting of restrictions,

or are hybrid models emerging?

And what is working?

So, there is a pivot.

Is there a pivot back?

What is actually happening? Aseefa?

I think it's so easy for us to pivot because it's client first, right?

We are there because of our service users.

So one we know that there's a particular need,

we pull out all the stops to make sure it happens.

When we did the food support program, from day one,

we had to tell our staff that you are no longer going to be calling

or meeting with the service users.

You're going to be delivering food.

That's not in jour job description, you're unionized, but it doesn't matter.

That is what our clients need.

So I think keeping that centre in the forefront

helps us to be really nimble and be able to pivot.

In terms of moving forward,

I think that the organizations that work with people

never really stopped working with people.

Our doors were open throughout the pandemic, we didn't stop our services.

We modified them so that we didn't have everybody

just coming in without an appointment,

and we had staff who still went out and saw people in the community,

but again with permission from the managers and whatnot.

We put safeguards in place, but we never stop serving.

And so, going forward, I think that yes, will have a hybrid.

All our clients are literally begging us to know when they will be back in person,

and we will definitely be doing that, but it will be a choice.

People who want to join by Zoom or some other web application

will be able to do that,

and those who want to be here in person will be able to do that as well.

And the thing about that dynamism...

moving over to you, Liben, is, you know,

one of the things that you were saying was the need for staff support as well,

because change and change and change during the pandemic,

it can lead to burnout.

Definitely. I think even without change.

I think the intensity of the work has changed

because of what staff are working with their clients.

That has changed completely.

Also because many of our staff are from the community themselves,

so they're also impacted in their individual lives.

So it's multi impacted, but at the same time,

they have to deliver, they have to stay strong

when they're meeting with clients.

But they need space to go and address their own challenges

that they are facing, whether it's personal, family or community.

So it is quite difficult.

But as we know, many of the people who are in this field and doing this work

are doing it because of the passion that they have to serve their community.

So, you know, pivoting and adjusting

is the nature of community organizations.

The same thing that Aseefa was saying, we never stopped.

We just changed the way we did things.

I think moving forward...

I see for example, for primary care,

some of the virtual care, I think, will be of ongoing benefit

because now people can access their doctors or providers online,

and it may reduce the barriers around transportation,

or they will have quicker access if they wanted to.

But there are people for whom, especially culturally,

being in presence of another is significant.

It's healing by itself when you're in the presence of somebody else.

So, we are also paying attention to that

and making sure that for those who want to continue with online services...

That's more for primary care.

For our community programs, as Aseefa said,

everybody wants to come back.

They are really stressed out from not being together

with their community members.

And so, we are following guidelines

to make sure that that is going to be a staged approach.

Excellent.

Oh, sorry, Aseefa?

Can I just quickly add something to what Liben was saying

around staff support?

Right at the beginning, one of the things we noticed was,

at Across Boundaries, all our staff were racialized,

and our board is racialized.

So, the impact on our staff was very noticeable

in terms of what was going on.

At the beginning, we got a facilitator to speak to all of our staff,

just around their feelings, their emotions.

EAP wasn't going to cut it, we needed to bring in somebody externally.

And we quickly realized that the staff from our Black community

had different needs and different requirements

in terms of their well-being and care.

So we needed to pull them apart,

and did a caucus with Black only staff with a Black facilitator.

So, I think throughout the pandemic, and even now,

we continue to have to keep an eye on their well-being

along with our service users.

Isn't it interesting that you're paying for EAP,

but when you need it,

EAP doesn't meet the needs of racialized staff?

No, they don't.

Though we are in Canada, right?

OK, so the next question...

Question four: were the needs of refugee clients different during COVID-19?

Anybody can jump in that.

Yes, I can jump in.

We do serve quite a lot.

Particularly for us, many of the newcomers and refugee population

are francophone communities, and that has been a significant challenge.

I mean, Kwame, you know very well the kinds of challenges

that newcomers and refugees face when coming into a new country.

The pre and post migration impact is significant.

There is added pre trauma, I think, that they may have.

The adjustment here, the impact that COVID had.

And even with the kind of usual practical challenges

that they would face around integration, employment, housing.

Now, it's exacerbated.

And even their immigration process.

We know how immigration processes have been impacted by COVID,

whether people were able to get correspondences,

information, decisions in a timely fashion...

And the longer they stay in not knowing and being in this very challenging time

adds to the impact that it has on their mental health

and social well-being as well.

And so, we've seen that that is a huge challenge.

And then, referring them to appropriate services

with the language barrier also becomes another challenge.

So they have been impacted,

and they also have their own peculiar challenges

that they have been facing, you know, based on where they're coming from,

the trauma that they have experienced,

but also adjusting into an environment where there was no connection.

Everybody is isolated, there's no movement,

there's no going to places, there's no accessing services.

So, that has been a challenge that we have seen.

Aseefa and Mithi, did you want to jump in, or should we move on to the next question?

Looks like we're moving on to the next question.

I think both the research and all of the people in the research,

as well as all of the presentations...

You have talked about the social determinants of health

in one way or another,

and the importance of these social determinants of health.

And there is a question that's come up that says:

"COVID has highlighted food insecurity as an issue...

but funding to respond has been temporary.

What are the strategies to deal with this issue going forward?"

How do we deal with it going forward?

I wondered whether Mithi, you wanted to start with this one,

and then we'll go around to Aseefa?

Yeah, um...

I know that it is definitely something that our communities have struggled with

these past couple of years,

and it has to do with the fact that many have lost their jobs,

but also the prices of food have gone up

and there is great disparity in that the prices of commodities continue to go up...

at a very fast pace,

but wages are not necessarily increasing at the same pace.

And for many low income communities, for migrant workers,

they are earning minimum wage, or if not minimum,

they are at the lower range.

And so, that is something that for us,

the issue food security is not something that is separate

from all other issues of economic security.

And so, part of our advocacy is also to continue to...

the improvement of labour law,

including laws around minimum wage

and providing meaningful work

for racialized and working-class populations.

Thank you. And Aseefa, you guys started doing food insecurity work.

No, we didn't start, we pivoted to enhance it.

For Across Boundaries, as I said, over the last 28 years,

food security has always been a focus of our work.

We've had an in-house breakfast, lunch and dinner program from day one.

Drop In has been a really requested program.

On any given day, we would have 40 to 50 people coming in,

not only for the social connection but also for the food.

And the reason we were able to pivot so quickly to the food support

was because we knew how great a need that was,

and so having people not have access to healthy, reasonably good food

was not going to be an option during the pandemic.

So I would say that, moving forward,

yes, the funding is one kind that we receive,

but in all good conscience,

there is no way we are going to be able to stop providing

any additional food support going forward.

Whether it means taking from Peter to pay Paul,

whether it means we have to reduce some of the other programs

to ensure that this continues, we will be continuing it.

So, I think that one of the things that came out in the research

but also subsequently in these presentations has been about...

And I think Liben, you were talking...

I think Aseefa was talking about the need for better data,

and you were also talking about the fact that data was available at the city level

allowed for the development...

well, for people to advocate for a more equitable pandemic strategy.

And so, one of the questions here is,

"How can researchers work better with racialized communities

to reduce barriers for better race-based data?"

Going to you first, Liben.

Oh, okay, I was waiting for Aseefa.

We'll wait for Aseefa, yeah.

No, I mean, we have been saying, and it has been known

that race-based data is going to be the driver for any...

I mean, to know where we are, and to see where we can go

and monitor whether we have arrived

or reached any kind of change or improvement.

And so, I think, as I say,

one of the things that the pandemic has brought about

is this greater awareness conversation,

and some acknowledgement from the decision-makers and policymakers,

and institutions,

that race-based data is going to be very important.

We have been referring...

As we all know, data existed in the States or the UK.

That has been our gauging and measuring...

for us as we try to advocate for things.

But now creating a system where...

You know, now most public agencies like the police and others

are required by law to start collecting race-based data.

Health is the one that is not there yet,

and we need to continue to advocate for that to take place.

And once we see the numbers...

And as somebody has said in the past,

I remember them saying that not having race-based data

is like hiding the crime that we are trying to solve.

So, if we don't know how the impact has been,

we will not be able to think about solutions.

So it's going to be the driver, we have a good start.

I know at least in some circles, this is now being considered.

A lot of other agencies have also started doing that on their own,

even though there is no legislation or requirement.

So that is going to be very important.

And one point is,

as Angela Robertson, one of our Black health leaders always says,

"We can collect the data and we can analyse it,

but if there is no action, or if it's not used for accountability purposes,

it's not going to be enough.

And she always refers to the United States,

who have been collecting race-based data for a very long time,

and they have very good data.

But nothing has changed as it relates to the health and well-being

of the Black communities there.

We can do better by not just capturing, collecting and analysing data,

but using that as a way of accountability and also action.

Yeah, so the Black Health Equity Working Group's position

is that the United States collects data, and they have lots of data.

The UK collects data, and analyses data,

and they have lots of data and lots of data analysis.

And that hasn't changed anything.

So you have to collect the data, you have to analyse the data,

then you have to use the data in a community-engaged way to find solutions.

And that's what we need.

It's not more data.

It's data that's collected, analysed and used.

And I think that brings us to the last couple of questions.

Oh, sorry, Aseefa, did you want to jump in there?

I was simply going to add that the analysis part is really critical,

and to ensure that when researchers are actually looking at the data,

to please ensure that you have the community members

from that community as part of the analysis work.

Because it is so easy for data to be whatever you want it to be,

and you want to make sure that it reflects us

and represents us the way it's meant to.

Yeah, and it's that model of the EGAP data governance model of engagement,

governance accessibility and protections around data sovereignty

for racialized populations,

that is getting a lot of support at the moment.

We have got only a few minutes left,

so I wanted to do a couple of questions that are more like summing up questions.

So the first is,

"What are the key policy issues that need to be addressed

to shift support to more community and away from institutional institutions?"

So this is something that came up in both, I think, Aseefa and also Liben's talks,

talking about having a proper share of funding and resources.

So, what are the key policy issues that we need in order to make that happen?

So, that's one question.

Now I'm gonna ask another question,

and you can choose which one you want to answer.

And the other one is,

"What kind of organizations or social actors

do you think will be critical to bring about the change

in the mental health dynamics that we are dealing with today?"

Okay? So, let's start with Mithi.

I think, since we are talking about mental health in racialized communities,

in relation to our work at MRCC,

I think something that's worth looking at is,

what are the immigration policies that are existing right now?

Canada is taking migrant workers doing temporary work

from the global South.

And these are workers,

racialized workers, when they come here.

So, these trends in migration also have an impact

on how migrants settle into Canada, how they function here,

and how communities as a whole, how racialized communities as a whole,

are impacted by policies.

So that is something, I think, that's definitely important to look at.

Key actors, I think there's a lot of talk about racialized communities,

marginalized communities,

being severely impacted by COVID and mental health issues.

But at MRCC we operate from the principle

that the community members themselves

are the most instrumental in moving forward with any kind of change.

So we always emphasize the importance of community organizing,

and our role as a service agency

is to help build the capacity of communities

to advocate for themselves.

We are not here to do it for them,

we're not here to speak for them,

but rather we are here to support them.

Liben... Oh, Aseefa?

Sure.

I was just going to say that I think the question

about who are the key actors or organizations

is the wrong question in this day and age.

I think it's about all of this.

We all need to be able to do this work to make real change happen.

We can't pass the puck anymore.

Communities and organizations have continuously advocated

over years and years,

and I think we need to now turn the gaze away from us

to the larger world.

I think Canada is "woke" now.

We have a lot of organizations that are creating antiracism frameworks.

We've got Ontario Health,

we've got Addictions and Mental Health Ontario,

and individual organizations that are begin to do this work.

I think it's really hard for me to know that over the years,

when I've sat at a table and I'm the only one who's saying,

"but antiracism" or "racism," and it's fallen on deaf ears.

Right? Like, there is a silence.

Now to sit at a table and know that somebody else is going to stick to it,

it's really empowering, and I hope that that will continue.

I think change is happening,

whether its policy or action, or implementation or funding.

And we will have to continue to push that.

Liben, Mithi, myself, you, Kwame...

All of us, we all have to continue to keep this momentum going.

But the work needs to be shared.

Wonderful, thank you.

And Liben, last word. We are running out of time.

I will just add to what Aseefa just said,

but maybe have a slight kind of angle

and say that I think we all have to participate, definitely.

And, you know, Paul Bailey, executive director of Black Health Alliance,

says, "Nobody is going to come and rescue us."

So we have that commitment that we should have from communities.

But I think the empowerment of grassroot community organizations,

or very close to communities, is going to be very important.

And a network of collaborators who are really focused on racialized,

Indigenous, Black, immigrants kind of groups.

We need to come together as collaborators to create this voice and momentum,

I think it's going to be important.

Because the system is not going to do it for us.

We have to go and knock on the door and influence.

And you are right, Aseefa, there is opening here now,

thare are spaces where we can bring this,

but I think there is some organization among ourselves,

there is the uplifting and building capacity

for the grassroot community organizations

that have been working with no resources at all,

and then bringing about the change to those service providers,

institutions, policy makers.

So there is a comprehensive and combined effort moving in one direction.

Liben, I'm not abdicating...

I was just saying, I'm not abdicating responsibility from our end,

but I'm expecting and raising the bar for additional supports.

I agree with you.

Perfect, listen, we are out of time, we're nearing the end of this event,

but I want to keep you just for one second.

Before we go, I would like to call your attention to a brief survey

that will appear on your screen when we conclude,

and we would really appreciate it if you took the time to answer a few questions

so that we can use your thoughts to improve future events.

We've had wonderful presentations of the research,

but also from community organizations,

and it seems clear from what people have said

that the social determinants exacerbated...

That Covid exacerbated existing inequities in health,

making things worse.

That means we had a health system in the first place,

and a social system, that was inequitable.

And inequities are avoidable differences between populations.

So we had avoidable differences that were pre-existing,

and then we had a pandemic response which made things worse.

And so, when we are looking to the future,

we have to look at better-sustained support to communities,

action on the social determinants of health,

better data collection, analysis and use, with authentic community engagement,

and we need to look at how we fund and sustain funding of communities.

All of these are things we have to think about.

And much more has been discussed by the panel,

and I'm really looking forward to probably watching again

to see all of the depth, because it was really rich presentations.

I would like to appreciate all of the people

who took time to put forward questions.

I would really love to thank the panelists,

because I think it's been a wonderful conversation.

But I want to also thank Mauriene, and Nina and Michael,

who were some of the organizers of today's event.

I would really like to thank our sign language interpreters,

especially given how quickly we all speak, for managing to keep up with us.

But I would also like to thank those people who worked behind the scenes

to ensure we had French translation, English text,

and mental health supports in place.

This is a major undertaking, with 14 people working behind the scenes

to ensure that we have equitable access and support available,

and I would really like to thank all of you for your work

and support for this webinar.

And of course, I would like to thank the 517 people who came on today

to listen to this great group of people.

I would really like to thank you,

not just for your attendance,

but for your attention and thoughtful questions,

because it's when we work together and we start thinking things trough together

in this way that we start to make progress.

So I would like to thank everybody, the researchers, the community presenters,

and all of the background staff for making this such a wonderful webinar.

Stay safe, everybody.