



**“Innovating Research, Strengthening Communities”
A Forum on Community-Based Research**

Forum Summary Report

Fall/Winter 2004/5

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Canadian Institutes for Health Research (CIHR)



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Table of Contents

Acknowledgements	1
Preamble	2
Forum Summary	4
Panel Summary	5
Evening Workshop Summaries	8
A) Access to Health Care Working Group.....	8
B) Discrimination and Mental Health Working Group.....	10
C) Housing, Race and Health Working Group.....	12
D) Poverty, Racism and Health Working Group.....	13
Appendix A	
Forum Planning Committee and Volunteers on the Forum Day.....	14
Appendix B	
Panel Speakers.....	15
Appendix C	
Racialised Groups and Health Status – Past and Present Working Group Members.....	16
Appendix D	
Registered Forum Participants.....	18
Appendix E	
Selected Web Resources.....	20
Appendix F	
Copies of PowerPoint Presentations.....	21
Presentation on Racialised Groups and Health Status Initiative	
Working Group Presentations:	
Poverty, Racism and Health	
Discrimination and Mental Health	
Access to Health Care	
Housing, Race and Health Status	

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- The forum planning committee members* who provided their valuable time and energy to the initiative. The creative ideas, essential feedback and support provided at planning meetings were key.
- The wonderful people* who volunteered during the event itself (some of whom also were part of the planning sub-committee). All of the help setting up, running around OISE putting up signs, directing participants to the different rooms...was indispensable.
- The working group members* who facilitated the evening workshops and all those who helped prepare presentations about the activities of their groups.
- Natasha Driver for her great help with carrying out planning tasks, and Robin Alam for assisting with invitation mail-outs.
- The note-takers* for recording the panel discussion and working group workshops. Their notes provided the basis for the panel and workshop summaries in this report.
- The panel speakers* who shared their experiences doing Community-Based Research (CBR) and led a stimulating discussion about the process of CBR.
- Adriana Beemans for moderating the panel discussion and keeping things moving on a tight timeline.
- Soni Dasmohapatra for her sparkling MCing during the first half of the day.
- Ted Richmond for the expertise and enthusiasm he provided in the planning and implementation of the forum.
- The Afghan Women's Catering Group for the delectable dinner they provided.
- Farah Mawani from the Board of Directors of Access Alliance Multicultural Community Health Centre for her inspiring closing remarks.
- Access Alliance staff for their on-going support and ideas.
- All of the people who showed remarkable interest, and who participated in the forum.

* Individuals are listed in the respective Appendices.

Preamble

Racialised groups in Canada experience disproportionate levels of poverty, homelessness and inadequate housing, race-based discrimination, and barriers to health care. Researchers have reported that the most important determinants of health are the effects of socio-economic factors on individuals and populations. However, little research specifically addresses the impact of these determinants on the health status of racialised groups in Canada.

Access Alliance Multicultural Community Health Centre (AAMCHC) and its partners received a one-year research development grant from the Canadian Institutes of Health Research (CIHR) with the objective of developing a long-term program of research to investigate the impact of income, housing, race-based discrimination and access to health care on the health status of racialised groups in Toronto; and increasing the capacity of community organisations, academics and other stakeholders to work collaboratively to develop proposals.

What is particularly exciting about the “Racialised Groups and Health Status” initiative is that the research agenda is in the hands of community organisations. These are working in partnership with academic researchers, government representatives and other stakeholders to develop sound and rigorous research projects that are intended to lead to action and change. They are organised into four working groups each addressing one of the following themes: Race-Based Discrimination and Mental Health; Housing, Race and Health; Access to Health Care for Racialised Groups; and Poverty, Racism and Health. The approach taken is that of community-based research (CBR). CBR aims to have a high degree of relevance to the community and seeks to bring about both understanding and change. Community involvement in the design and implementation of research is a condition for project success rather than an *ad hoc* research component. It ensures that the goals, objectives and methods will be grounded in the realities of racialised communities.

In the spirit of CBR, the “Innovating Research, Strengthening Communities Forum” was hosted by the Racialised Groups and Health Status initiative on November 18, 2004 to provide a space to share lessons learned about the process of community-based research; obtain feedback and input on the research proposals; and to build links between people interested in community-based research, particularly around issues pertaining to the health of racialised groups. The forum was made possible through the generous support of CIHR and was held at the Ontario Institute for Studies in Education (OISE) of the University of Toronto. It was organised under the leadership of Mary Roufail, Research Assistant for the project, in collaboration with H el ene Gr egoire, Research & Evaluation Coordinator at AAMCHC, and a planning committee made up of a number of organisations and individuals.

The forum was a rich encounter and it contributed to deepening knowledge on community-university partnerships; discussions were constructive and allowed representatives of community-based organisations, academia and a major funding agency to enter into a meaningful dialogue about the joys and challenges of, and strategies for, working in partnership. Particularly salient among the lessons learned was the value of the *process* in CBR. Panelists emphasized the importance of taking the time to develop trusting relationships, understand where each partner is coming from, negotiate roles and expectations and reach common understandings; of building and utilizing capacities; of implicating ourselves in the research; and of grounding our decisions in an ethical framework.

Through this report, our intention is to provide a synthesis of the forum for those who came out to the event and those who wish they could have been there. As organisers, we certainly left the forum inspired and hope that the energy and ideas generated by the participants will spark new CBR efforts that will hopefully lead to improved policy and programming and, ultimately, to health with dignity for racialised groups.

Forum Summary

The “Innovating Research, Strengthening Communities” forum on community-based research (CBR) was attended by about 130 people representing a variety of sectors and perspectives, which allowed for interesting and dynamic dialogue about the benefits and challenges of CBR.

The day began with a panel discussion featuring key speakers from community organisations, academia, and a funding institution. The panel, a highlight of the event, explored issues that are central to the CBR process, with the speakers using their experiences as examples. (Please see page 5 for more details.) Some key messages that came out of the panel discussion include:

- It takes time to develop meaningful partnerships among various sectors (e.g., community and academia) but it is worth taking this time;
- Community voices and involvement need to be at the forefront;
- The focus needs to be on implementable action and changes – in fact, it can be considered as part of the research itself, not only a distant outcome;
- Funders should understand that non-traditional expenses such as childcare and translation are necessary to allow for community involvement.

The first half of the forum continued with an overview of the Racialised Groups and Health Status project; followed by four brief presentations of each working group’s focus and activities (please see Appendix G for copies of the presentations). As mentioned in the preamble, the project is comprised of four working groups each developing a CBR proposal on one of these areas: discrimination and mental health, poverty, housing, and healthcare access.

Participants had the chance to connect informally during a wonderful dinner provided by the Afghan Women’s Catering Collective (a community-based business). Afterwards, people selected one of four workshops facilitated by each working group of the project. These workshops allowed for further discussion on each working group’s focus area as well as feedback on research ideas. (Please see workshop summaries for more detail on the workshops.) The closing segment provided a review of the event’s presentations and discussions, highlighting some of the main points made during the day.

Prior to the event, mass outreach was conducted, inviting the participation of community-based organisations (particularly those with an ethno-specific focus), funders, and community leaders. This paid off in the tremendous and wide-ranging interest in the forum from a variety of sectors including community health centres, ethno-specific agencies, government (i.e. the City of Toronto), housing groups, health institutions, and funding organisations. Participants included frontline staff and managers, as well as community leaders and residents.

Based on both the evaluation forms and informal feedback from participants, the event was considered to be a great success in bringing a broad range of people together to engage in a dialogue on community-based research. This included many who have not been particularly involved in research before. The forum was likely the first such diverse gathering on CBR in this city, increasing the level of awareness of CBR and of the Racialised Groups and Health Status project. Having generated more interest and feedback into the initiative, the event has led to the involvement of new working group members as well as many potential participants who have signed up for the next phases of the project.

Panel Summary

The panel discussion, which many considered a highlight of the forum, featured a dynamic discussion among five key speakers representing different sectors – two community organisations, two academic representatives and a funder. They were Angela Robertson, Executive Director, Sistering; Notisha Massaquoi, Program Director, Women’s Health in Women’s Hands; Anver Saloojee, Professor, Politics & Public Administration, Ryerson University; Luin Goldring, Associate Professor, Sociology, York University; and Peter Lévesque, Deputy Director, Knowledge Products and Mobilisation, Social Sciences and Humanities Research Council of Canada (SSHRC). The discussion was moderated by Adriana Beemans of the Toronto Community Housing Corporation, who is a member of the project’s Housing, Race, and Health Working Group.

As the focus of the panel was on the *process* of Community-Based Research (CBR), each speaker drew on an example of a community-based initiative they were part of to explore the development of each project as well as the strengths and challenges of CBR. The audience also had the chance to engage in the dialogue and ask questions, which included how partnerships involving different perspectives are best forged, and best practices for dissemination.

Central points from the panel

A) The process of project and partnership development

- A. Robertson’s project looking at barriers and impacts of homelessness on women’s health (described in the report *Common Occurrence: Impacts of Homelessness on Women’s Health*, 2002), went **beyond involving staff and included voices of women directly affected by homelessness as part of an advisory committee**. They had to convince the funder that a CBR project led by a community organisation would produce valuable and **credible research**. Emphasis was placed on achieving **implementable action for social change**. In fact, the project involved changes during the research process rather than waiting for the project to be completed to implement actions. She also noted that they needed **more time** to ensure that the research was reflective of women’s experiences.
- N. Massaquoi’s project on access to health care by immigrant and refugee women involved negotiations for one year about what the project would focus on and how it would be designed before submitting the research proposal. It was important that the **agency was an equal partner in the development of the project**.
- In his project on the challenges faced by newcomer youth in the school system, A. Saloojee was able to **reach youth through community networks** (agencies, community centres). **Trust and the support of the community** were key.
- L. Goldring spoke about the collaborative development of a research proposal focusing on people without full immigration status (i.e., *Living with Less than Full Status: A Focus on the Labour Market, Social Services and the Family*). The project development also relied on **community organisations** as an entry point. The process was largely about **partnership-building**. It involved two sets of **consultations** (with service-delivery organisations and non-status people) that **yielded important and beneficial changes to the methods and the scope of the proposal**.

- P. Lévesque, who spoke about SSHRC’s Community-University Research Alliance (CURA) program, said that one **key aim** of the initiative is to **foster relationships between community and universities**. Knowledge mobilisation is about increasing the value of research; that is, ensuring the usefulness of research.

B) Strengths of CBR

- Can provide a **space for voices of individuals** who normally do not have their experience validated by the research process;
- Allows the use of a **political framework**, such as an anti-oppression framework;
- Makes **research accessible to community** (normally exclusive);
- When a project is housed within a community organisation, it is possible to **support the participants beyond the research process** (as was the case for the Women’s Health in Women’s Hands project);
- Quality of the product can be improved through collaboration (e.g., leading to a stronger proposal);
- Can **change knowledge, products and people’s skills; increases the value of knowledge** by sharing and implementing it.

C) Challenges of CBR

- Policy-makers and funders wanting **emphasis on the quantitative component of research** even when the project is experience-based;
- Potential conflicts of interest: certain partners not wanting to be associated with some of the action recommendations that come out of a project;
- Having to justify to funders why budget is high in areas of childcare, translation and honoraria; **funders having to better understand the need for expenses that allow for community participation in research**;
- Need for researchers to see **community members as equals**;
- Time it takes to build **trusting relationships** with community (though organisations can help because they know communities best);
- Difficulty in **putting aside preconceived notions** of what the research will tell you.
- **Different timelines/constraints** of academic and community partners (e.g., academics face the pressure to publish: the “**publish or perish**” culture means that people do not spend as much time looking for good research questions);
- Having to rely on in-kind contributions of community groups because of **budget constraints** in the way money can be used;
- Possibility of “fake partnerships, fake questions and fake intents”;
- **Not enough attention given to dissemination.**

D) Key messages identified by panelists

- Be flexible and honest;
- Trust is essential;
- Beware of raising false expectations;
- Need to validate both expertise and experience;
- Realise that research is not neutral; use it to advance the social agenda;
- Make more time because it's worth it;
- Integrate research findings (recommendations and actions) in ongoing work;
- Academics can be advocates and activists and community members can be researchers – everyone brings a lot to the table;
- Responsibility to work ethically;
- CBR is about a conversation; keep the conversation open;
- Choose carefully where to get involved and then get deeply involved.

Questions from audience/participants

Question #1: Request for advice on partnerships

Responses:

- Address issues from the beginning: expectations (of project and of partnership), definitions, methods, needs, who gets what at the end;
- Establish protocol for issues that may arise in process;
- Discuss philosophical approaches and understanding of issues at stake in research;

Question #2: How should projects be evaluated?

Response:

- Need for ongoing evaluation process to be built into research process (parallel to the research agenda). Do not wait until the end of the project.

Question #3: What are best practices for disseminating research?

Response:

- Produce reports aimed at various levels of policy-making. The final report is only midway point of dissemination process.

Question #4: How can common research objectives be developed among different perspectives?

Responses:

- Negotiate a common research question as the focus; be open to using mixed methods (i.e., qualitative and quantitative)
- Find partners who are really committed to the project.

Evening Workshop Summaries

A) Access to Health Care Working Group

This workshop focused on getting feedback from participants on their experiences with the health care system. They were asked to identify both good and bad experiences and discussed these in detail.

Highlights of good experiences:

- Access to doctor in own language
- Education/health prevention programs
- No charge to visit doctor
- Non-status individuals get discount at some hospitals
- Community Health Centres (CHCs) offer range of services

Highlights of bad experiences:

- Lack of information on services available or misinformation
- Waiting times for specialists
- Inaccessibility of oral health services (dental care not covered universally/by OHIP)
- Long waiting list at CHCs
- Attitudes of health care professionals
- Difficulty accessing hospital for non-status people
- MD (Medical Doctor) incompetence – lack of recourse on part of patient
- Hard to transfer care to different MD (risk not having a GP – General Practitioner)
- Language barriers
- Inappropriate diagnosis/testing
- De-listing of services covered by OHIP (eye care, physiotherapy)

All of the experiences listed were grouped into three themes:

- Service Provision
- Systems and Structures
- Information and Awareness

Participants broke out into smaller groups to further discuss these themes. The main points for each sub-group are below.

Service Provision - This theme was discussed by two sub-groups:

Service Provision #1:

- Need for more MD accountability to patients
- More professional development for health practitioners
- Need for external review bodies for hospitals
- Perception that people from ethnoracial communities do not complain when bad service has occurred
- Need for more community input into planning at systemic level
- Need for increased cultural competency of health care practitioners
- Language barriers between health care practitioners and patients

- Different values and traditions between practitioners and patients
- Need for patients to feel valued by practitioners (e.g., patients should not feel rushed)
- Patients should have information on different health services (e.g., prenatal services)

Service Provision #2

- Everybody is affected by service provision issues, especially newcomers and the elderly.
- People are losing faith in health care and do not want to go to any health service.
- There are different avenues to complain about bad services (e.g., multicultural media, TV, radio, flyers).
- It is also important to acknowledge and promote the good services.
- Need evaluation of experiences in service provision.
- Possible allies in providing information on health services, client rights, and different health care providers: settlement organisations, LINC (Language Instruction for Newcomers to Canada).
- Many people are using the internet, so they can get web-based information. They can also provide feedback on services through a website with a questionnaire. Another information and feedback mechanism would be a hotline in different languages.
- Provide flyers in multiple languages on available services.

Information and Awareness

There was a concern that newcomers find out too late about existing programs and services.

Suggested research questions were:

- What are some successful models (in Canada or elsewhere) for informing newcomers, immigrants and refugees about health care services and rights to services?
- What are the most effective means for agencies to communicate with refugees and immigrants?
- How do we communicate messages about health in ways that are both culturally appropriate and appropriate to a given generation?
- How many doctors are practicing within their own community? For those who are not, why not?
- How to create culturally appropriate health messages/education (rather than just direct translation/interpretation)?

B) Discrimination and Mental Health Working Group

This workshop began with an outline of the evening's objectives: to discuss people's experiences with mental health services and how issues of racism may impede an individuals' ability to participate in society. It was stressed that the working group wants community participation in looking at these issues, especially from people affected by the mental health system. One of the points made in the introduction was that this field is dominated by the medical profession - it does not give space for issues of racism and how these issues impact health and mental well-being. Overall, the workshop focussed on exploring opportunities and barriers for good mental health as it relates to racialised groups.

Facilitators presented two questions to consider:

- 1) What opportunities and barriers exist for good mental health *within racialised groups*?
- 2) What opportunities and barriers exist for good mental *health service provision to racialised groups*?

Highlights from responses for *opportunities* for good mental health within racialised groups:

- Education and research of racialisation and health
- Public awareness campaigns
- Services that currently exist
- Community and gatherings that bring the community together

Highlights from responses for *barriers* to good mental health within racialised groups:

- Delayed access to services
- Lack of services
- Government won't fund culturally different services and treatments
- Lack of employment services, housing services, etc.
- Stigma in the neighbourhood
- Lack of encouragement and support at the family level
- Non-recognition of foreign education/skills; barriers to foreign-trained professionals

Highlights from responses for *opportunities* for good service provision to racialised groups:

- Enough people have acknowledged that the system needs to change
- Resources exist in some instances (the problem is how to get them to people and make the connections)
- Days like these present opportunities to make linkages and discover what people are doing

Highlights from responses for *barriers* for good service provision to racialised groups:

- Long waiting lists
- Services are only centrally located, not accessible to everyone
- Lack of professionals of colour
- Lack of understanding of issues of clients of colour
- Varied definition of what constitutes mental health in the West vs. other areas
- There is an abundance of assumptions in the system; just because you have a client of colour doesn't mean they are more comfortable with providers of the same or a similar background

- Absence of inclusion of the lived experiences of the consumer survivor
- Cultural sensitivity is a euphemism for politically correct – nothing has changed, the system is the same. We are afraid to name it as racism.
- Individual workers are taking anti-racism training, but it is not an institutional initiative – if upper management is not open to change, it won't happen.
- We don't have anything to make institutions more accountable to being anti-racist, inclusive or anti-oppressive, etc.

Highlights from discussion on opportunities for moving forward:

- Sharing information about who is doing what, organising conferences on best-practices, engaging in dialogue.
- We must listen to the voices of people who are using the services.
- We could have resources/course materials for mental health professionals integrated into the current training.
- We must involve policy makers, politicians and consumer voices in making change.
- We should include policy makers other than those who work with mental health issues – other areas influence mental health, such as housing, etc.. We must be inter-sectoral.
- If there was a structure in place that would enable consumers and workers to lodge complaints in an anonymous manner, this information could be used as data and be used to advocate on issues.
- Having a really comprehensive anti-racism, anti-oppression framework to support the work.

C) Housing, Race and Health Working Group

This workshop began with an overview of the project and working group, emphasizing the group's desire to involve the community, for example by inviting community members to raise new questions for further research. As the focus group participants were interested in discussing the **concept of racialisation**, they shared their personal interpretations, which were varied. This discussion included the following observations:

- The concept of 'racialisation' has come out of the experience of individuals who have been ignored in society because of their 'difference'. It is an 'attitude problem.' It is how racialised individuals experience authority and power.
- The term 'racialised' may exclude populations and groups that are significantly disadvantaged, but not by their race.
- 'Racialised' is not a neutral term. It is political and it relates to power.
- Race plays into other variables such as class and underscores them.
- The term 'racialised' denotes the use of power in preventing others from attaining any power.
- Being 'racialised' constitutes a cycle of disempowerment.
- There is a distinction between 'racialised' and 'ethno-specific'.
- 'Racialisation' is in effect when you consider the 'hows' and 'whys' of who gets out of poverty.

In an extensive conversation on the **impact of poverty, racialisation and marginalisation on housing**, a number of consequences were highlighted, such as:

- cramped quarters
- renting as opposed to owning
- loss of community and isolation

Participants also identified **indicators of good housing** such as:

- a sense of 'home', comfortable, safe/secure, security of tenure, control
- good community, schools, stores, transportation, safety, health care, parks
- maintenance, public and private space, mechanics, temperature control
- well maintained structure, access to good employment, recreation, good education
- food security, safe environment, access to affordable/free health care

Lastly, the workshop participants identified **themes that are of interest and could be further explored**: ghettoisation; protective factors of ethno-specific neighbourhoods.

D) Poverty, Racism and Health Working Group

This discussion began with a recap of the themes explored during the panel, highlighting ideas about Community-Based Research (CBR), such as the need for CBR to lead towards improving the lives of participants, and the importance of the partnership development process (i.e., the need for it not to be rushed.)

A key point made during the workshop is that **the idea of poverty is relative**. There is no uniform definition of what we mean by the term “poverty” and many groups don’t wish to identify as such. The general consensus was that the term “poverty” itself was not socially inclusive and that another concept, which would empower communities was needed.

After engaging in an open discussion about issues related to the research process, the workshop participants and facilitators decided to **focus the research project that this working group is developing, on unemployment and underemployment, as entry points into the question of income/poverty, race and health.**

Main points from the session include:

- How key issues would be determined over the course of research is a question to consider. Concern was expressed about how a central research question could be framed in such a way as to benefit groups most.
- There is tension between what kind of research would attract government support vs. research that would assist oppressed communities – sometimes they are not the same.
- We need to take care to include communities not traditionally part of research.
- The dual purpose of the research is 1) to produce knowledge that will be relevant to inform action and change (possibly at the policy level); and 2) the project should be useful to the people who are directly concerned/involved. The project should not only be about studying people’s personal experiences but also about exposing the system (e.g., revealing lack of government accountability, as well as hiring processes and discrimination built into practices of different employers in Toronto.)
- In order to help define the community, it should be grounded in a geographical area.
- One participant suggested that perhaps the term “poverty” should be replaced with “social exclusion” or “low income.”
- There is a lack of race-based statistics. (Statistics are not streamed into categories defined by ethno-racial identity.)
- Variables such as access to employment, among others, need to be looked at taking into consideration: family size, number of years in Canada, poor housing and other variables related to a given “poor” area, to provide a more complex picture.

APPENDIX A

Forum Planning Committee and Volunteers on the Forum Day*

Forum Planning Committee

Stephanie Austin – Access Alliance MCHC (volunteer)
Adriana Beemans – Toronto Community Housing Corporation
Kim Chow - Access Alliance MCHC
Soni Dasmohapatra- Council of Agencies Serving South Asians (CASSA)
Natasha Driver – Access Alliance MCHC (volunteer)
Karima Hashmani - South Asian Women Centre (SAWC)
Ted Richmond – Laidlaw Foundation
Albert Viera – CASSA

People who helped on the day

Stephanie Austin
Adriana Beemans (panel moderator)
Nasir Butt
Kim Chow
Soni Dasmohapatra (MC)
Natasha Driver
Karima Hashmani
Nadya Martin
Farah Mawani (closing remarks)
Ayshia Musleh
Sukanya Shankar
Julie Young
Albert Viera

Note-takers

Mandy Hickman
Stephanie Jay
Nadya Martin
Galen Trull
Julie Young

* The lists are organised alphabetically based on last names.

APPENDIX B

Panel Speakers*

- Luin Goldring, Associate Professor, Sociology, York University
- Peter Lévesque, Deputy Director, Knowledge Products and Mobilisation, Social Sciences and Humanities Research Council of Canada (SSHRC)
- Notisha Massaquoi, Program Director, Women's Health in Women's Hands
- Angela Robertson, Executive Director, Sistering
- Anver Saloojee, Professor, Politics & Public Administration, Ryerson University

*The list is organised alphabetically based on last names.

APPENDIX C

Racialised Groups and Health Status Past and Present Working Group Members*

Access to Health Care Working Group

Huda Abbas, Multicultural Inter-Agency Group of Peel (MIAG)
Marisa Creatore, Centre for Research on Inner City Health, St. Michael's Hospital
Cynthia Damba, Toronto District Health Council
Guilherme Dantas, Scarborough Hospital
Natasha Driver, volunteer
Elsa Galan, MIAG
Ilene Hyman, Centre for Research in Women's Health, Sunnybrook & Women's College
Health Sciences Centre
Lama Jamjoum, Institute for Health Research, York University
Axelle Janczur, Access Alliance Multicultural Community Health Centre (AAMCHC)
Nazilla Khanlou, Faculty of Nursing, University of Toronto (CERIS)
Alan Li, Regent Park Community Health Centre
Doug Manual, Institute for Clinical Evaluative Sciences
Lorraine Purdon, South East Toronto Project
Mandana Vahabi, Toronto District Health Council
Julie Young, volunteer

Discrimination and Mental Health Working Group

Stephanie Austin, Post-Doctoral Researcher, University of Toronto
Farah Mawani, Board Member, Access Alliance Multicultural Community Health Centre
Martha Ocampo, Across Boundaries
Chris Rahim, Women's Counselling Referral and Education Centre
June Y. Yee, Ryerson University

Housing, Racialisation and Health Working Group

Adriana Beemans, Toronto Community Housing Corporation
Erika Khandor, formerly of Lawrence Heights Community Health Centre
Mwarigha, M.S., Toronto Community Housing Corporation
Robert Murdie, York University
Sherry Phillips, formerly of Lawrence Heights Community Health Centre
Jim Dunn, Centre for Research on Inner City Health, St. Michael's Hospital (supporting member)

* The list was organised by alphabetical order based on last names.

* Each working group has been coordinated by Hélène Grégoire (Research & Evaluation Coordinator) with the assistance of Mary Roufail (Research Assistant) both from Access Alliance Multicultural Community Health Centre.

APPENDIX B (Continued)

Racialised Groups and Health Status Past and Present Working Group Members*

Poverty, Racism and Health Status Working Group

Nasir Butt, volunteer

Soni Dasmohapatra, Council of Agencies Serving South Asians

Karima Hashmani, formerly of South Asian Women's Centre

Dianne Patychuk, Toronto Public Health

Dennis Raphael, York University

Laurel Rothman, Family Services Association

Sukanya Shankar, volunteer

Miryam Zeballos, St. Christopher House

* The list was organised by alphabetical order based on last names.

* Each working group has been coordinated by H el ene Gr egoire (Research & Evaluation Coordinator) with the assistance of Mary Roufail (Research Assistant) both from Access Alliance Multicultural Community Health Centre.

APPENDIX D

Registered Forum Participants

Organisations*

This list includes community-based agencies, health centres, research as well as health institutions, government offices, and funders who were represented by staff members.

Please note that in a number of cases, more than one representative/staff member of an organisation attended. Working Group members' organisations are not recorded here (as these are listed separately in Appendix C) unless additional agency representatives registered.

Abrigo Centre
Across Boundaries
African Canadian Social Development Council
AIDS Committee of York Region
Ani-Sa'a: The Association of Sudanese Women in Research and Development
Ayuda Hispana – Spanish Services
Black Secretariat
Canadian Cancer Society, Ontario Division
Canadian Heritage Department-Multiculturalism Program
Canadian Mental Health Association
Central Neighbourhood House
Centre for Addiction and Mental Health
Centre for Urban Health Initiatives (CUHI)
CERIS (Joint Centre for Excellence in Research on Immigration and Settlement)
Chetwynd Community Development Program
Chinese Canadian National Council Toronto Chapter
City of Toronto – Chief Administrator's Office, Diversity Management and Community Engagement, Strategic and Corporate Policy/Healthy City Office, CAO
Community Social Planning Council of Toronto
East Scarborough Storefront
Ethnoracial Coalition: Access to Addiction Services
Family Services Association
Fort York Food Bank, A Multi-Service Agency
Four Villages Community Health Centre
Interim Place (Transitional Support Worker Program)
Jane/Finch Community and Family Centre
Laidlaw Foundation
Lawrence Heights Community Health Centre
Midaynta Association of Somali Service Agencies
Mount Sinai Hospital
Mujer
My Canada Integration and Settlement Services
Peel Health, Chronic Disease and Injury Prevention Division
Regent Park Community Health Centre
Rexdale Community Health Centre

Scadding Court
Somali Family and Child Skills Development Services
South East Toronto Project (SETO)
St. Christopher House
St. Michael's Hospital
St. Stephen's Community House
Street Health Community Nursing Foundation
Toronto Community Housing Corporation
Toronto Public Health
Toronto Social Services
United Way of Greater Toronto
Wellesley Central Health Corporation
Women's Counselling Referral and Education Centre
Working women Community Centre
World Vision Reception Centre

** While every effort has been made to include everyone in this list, we recognize that unintentional oversights are possible (especially in the case of participants who did not pre-register). If your organisation was not listed, we sincerely apologize.*

Community Members

Aside from the organisational representatives listed above, **we are happy to report that a number of community members (approximately 17) also participated. They included** community leaders, volunteers, a service user (from Across Boundaries), an independent consultant, several tenant representatives from Toronto Community Housing Corporation, Riverdale Housing Action Group and Hydro Block Tenants Association, and people who were not affiliated with a particular organization.

Since we did not ask for the permission to publish their names, we are respecting the possibility that they might not want their name printed.

APPENDIX E

Selected Web Resources

On Community-Based Research:

"Community-based research projects are those that are driven by community needs and involve community and academic collaborations and place highest priority on action outcomes."

(Wellesley Central Health Corporation, <http://www.wellesleycentral.com>)

- ❖ The Loka Institute: <http://www.loka.org/>
- ❖ PARnet: www.parnet.org
- ❖ Ontario AIDS Network: <http://www.ontarioaidsnetwork.on.ca>
- ❖ Detroit Community-Academic Urban Research Center:
<http://www.sph.umich.edu/urc/>
- ❖ Action Learning Action Research and Process Management Association:
<http://www.alarpm.org.au>
- ❖ *Living Knowledge*: International Journal of Community Based Research:
<http://www.scienceshops.org/>

On Social Determinants of Health:

- ❖ International Society of Urban Health (ISUH): <http://www.isuh.org/resources.html>
- ❖ Population Health, Health Canada: <http://www.hc-sc.gc.ca/hppb/phdd/whatsnew.html>
- ❖ Centre for Social Justice: <http://www.socialjustice.org/subsites/conference/english.htm>
- ❖ SDOH-Listserv: <http://quartz.atkinson.yorku.ca/QuickPlace/draphael/Main.nsf/>

On Immigration Research:

- ❖ Centre of Excellence for Research on Immigration and Settlement (CERIS):
http://ceris.metropolis.net/frameset_e.html

On Racialisation:

- ❖ Salojee, Anver. 2003. *Social Inclusion, Anti-racism and democratic citizenship*:
<http://www.laidlawfdn.org/files/children/saloojee.pdf>
- ❖ National Antiracism Council: <http://www.antiracism.netfirms.com/>
- ❖ Canadian Race Relations Foundation: <http://www.crr.ca/EN/>
- ❖ City of Toronto. 2002. Report for the Community Consultations on the Plan of Action for the Elimination of Racism and Discrimination:
http://www.toronto.ca/diversity/pdf/plan_report_plain_text.pdf
- ❖ Alternative Planning Group. 2003. Social Inclusion and the City: Considerations for Social Planning: <http://www.cassa.on.ca/BmFINAL%20Social%20Inclusion--%20Apr.22.031.pdf>

APPENDIX F

Copies of PowerPoint Presentations

- **Presentation on Racialised Groups and Health Status Initiative**
- **Working Group Presentations:**
 - Poverty, Racism and Health
 - Discrimination and Mental Health
 - Access to Health Care
 - Housing, Race and Health Status