



Health professionals join together to bring timely COVID-19 information to South Asian communities and advocate for equitable systems

The South Asian community, which represents 30% of the overall population in Ontario, represented 45% of COVID-19 cases in October 2020. This overrepresentation was the direct result of structures and systems that perpetuate inequities in groups that have been marginalized. To address inequities the South Asian community was facing, a team of approximately 30 volunteer health and public health professionals joined together to educate, advocate, and remove barriers. The impacts of their efforts would later spread beyond the Peel Region and across Canada.

At the beginning of the pandemic, collecting sociodemographic data was not a priority in understanding the spread of COVID-19. It took considerable advocacy from several organizations to highlight that racialized communities were being hit hard. Timely measurement and data were necessary to understand the true picture of what was happening on the ground and to respond accordingly. Once data collection began, we discovered that the South Asian community was vastly overrepresented in the COVID-19 data.

About 2 years ago, media started weaving together a story that Diwali, a prominent religious holiday in the South Asian community, was causing a spike in cases of COVID 19 for Ontario. These stories shifted the blame to the individual South Asian communities and took attention away from the structural and social determinants that were the true upstream causes of the high case numbers. Despite a popular narrative, let me tell you, our community was not having Diwali parties — our community was sick, our community was working, our community was on the front-lines.

This Equity in Action story is distilled from an interview with Sabina Vohra-Miller, co-founder of the South Asian Health Network. The interview took place in June 2022, and its details should be considered within the context of that time period.

Many individuals in the South Asian community work front-line jobs in manufacturing, transportation and warehouses. Very often, this community lives in multigenerational houses creating conditions where COVID-19 spreads exponentially. The structural inequities such as precarious employment, unsuitable housing and lack of access to health care were resulting in an inequitable burden of COVID-19.

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Pulling together to overcome inequities in our community

Frustrated at the media blaming individuals and Diwali celebrations for rising cases, I joined with some colleagues to write an op-ed that was published in the *Toronto Star* newspaper about the structural determinants of COVID-19 in South Asian communities. This got the attention of many South Asian health professionals. We came together to ask: what can we do to mitigate the inequities our community faces? We all had passion and commitment to ensure our community thrived during this difficult time.

From this passion, the South Asian Health Network was formed. Our diverse team of approximately 30 members, all volunteers, began to address some of the inequities. The members of the Network were from the community and felt a shared responsibility to help. We were able to do so much on a volunteer basis because of the fire within our Network members.

Despite the commitment of our community members, I think the fact that the onus is put on our own community to fix the issues that were not caused by us, but rather by structural inequities, is problematic and unjust. We do it because we

have that responsibility and concern for our community's well-being, but the responsibility cannot fall fully on the community to address structural determinants outside of their control.

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Creating a culture of education and safety around COVID-19 and vaccinations

To ensure our community was poised to make informed choices, the Network converted information about COVID-19 into materials that were easy for the South Asian community to understand. Materials were then translated into multiple South Asian languages, usually by Network members themselves, in order to maintain the nuances and level of language needed. Direct translations of English commonly lose the context and meaning and, subsequently, fail to inspire many communities to act.





Craig Miller @craigmillr · 2021-05-07 ***

This is @SabiVM. She spent the entire day cold-calling businesses in Toronto's at-risk Rexdale area to let them know about a local popup clinic and encourage them to get their employees vaccinated. #mywifeismyhero



We hosted virtual vaccine education town halls for various communities. Each Zoom meeting focused on a different topic; some were general while others were targeted for elderly, youth or pregnant individuals. The Network partnered with media organizations, and the town hall meetings were broadcasted across Canada on South Asian television channels such as OMNI Punjabi and Y Media. We also thought about our transportation workers who were on the road and who were not able to attend a Zoom meeting or watch TV. We had one of our members go on Punjabi radio to answer questions and raise awareness. Because we embedded equity and accessibility into every action of the Network, we were able to reach a much wider audience than had we limited ourselves to Zoom.

We started with the intention to educate and spread awareness of vaccinations, but we very quickly approached

the barrier of accessibility. The Network was hearing from the community that they wanted to be vaccinated but didn't know how to get it or where to go. In response, we pivoted to advocacy for prioritization of our community in vaccination campaigns. We were able to get local pop-up vaccination centres, sponsored by Toronto Public Health, medical officers of health and various hospitals. These centres were targeted to South Asian front-line workers, and we spread the news through various local businesses.

At many points throughout our response, we felt the toll of this work, especially since every single member of the Network had another job and was serving the Network on a volunteer basis. Then we would get an email saying, "Guess what, after your education session, our vaccination rate went from 50% to 90%," and that would give us the fire to keep going because we felt the impact of our efforts.

Harnessing the power of relationships to reach our community

At the beginning, we were concerned that we wouldn't be able to do everything we wanted on a volunteer basis, with a \$0 budget. However, we began to recognize the power of community. People banded together with a common cause, even people from outside the South Asian community. There was a "let's pitch in and do this together" mentality that went a long way. As the foundation of our work was promoting equity, we also successfully expanded our education model to the Black and Latin communities in our area. This demonstrates that, if communities band together, there is strength and resilience.

Our Network partnered with temples, cultural centres and health centres to reach our community. In doing so, we were able to build trust within the community as well as create targeted, hyperlocal and very focused strategies to break down barriers. We also reached out to several different South Asian student groups across universities and colleges to collaborate on information sharing, in hopes that they

would then transfer knowledge to their families, especially elderly parents. It was not just us doing the work but rather all the relationships and connections that we had cultivated and extended throughout the pandemic. Our hope is that we will continue to leverage these relationships and this community focus throughout recovery. As we wind down our work related to education and vaccination, we hope to pivot and use this model to address common chronic health conditions within our community.

Our work is an example for communities across Canada. Speaking broadly, our job as health professionals is not done until every single community has an equitable experience of health, and the resources put into each community are sufficient to support them to get there.

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LESSONS LEARNED:

- 1** Collecting sociodemographic data including race-based data can demonstrate existing inequities. This is critical for understanding how structures and systems produce unjust differences in health outcomes and informing efforts to address existing barriers.
- 2** Successful public health education is culturally safe, nuanced and sensitive to different community contexts. Effective materials are developed with specific communities.
- 3** Strength and power exist in community, relationships and collective advocacy. Cohesive action, for example amongst health professionals united by a shared passion, will achieve public health priorities more effectively than siloed efforts.

RELATED RESOURCES

Toronto Star op-ed: ['It's not Diwali, it's precarious employment and less health care resources.'](#) South Asian medical experts on Brampton's rising COVID-19 cases

Twitter thread: [How we organized the vaccination townhalls](#)

KEYWORDS

COVID-19, Communicate, Community engagement, Cultural competency, Racism/Racialization, Stigma/Discrimination, Structural Determinants

To learn more about the initiative described in this story, contact the National Collaborating Centre for Determinants of Health at nccdh@stfx.ca.

Do you have an idea for an Equity in Action story? If you have heard of other health equity-promoting COVID-19 pandemic response initiatives in Canada that we should share, please let us know.