

A RESEARCH ROUNDTABLE

THURSDAY OCTOBER 29, 2026
UNIVERSITY OF OTTAWA

Social Sciences Building, Room FSS 4007 Google Maps
University of Ottawa, 120 University Private, Ottawa, K1N 6N5

DETAILED PROGRAM

8:00 AM | Registration opens

9:00 – 9:15 AM | Welcome

JASON MACLEAN, Chair, Canadian Health Coalition
VANESSA GRUBEN, Director, University of Ottawa's Centre for Health Law, Policy and Ethics

9:15 AM – 9:45 AM | OPENING KEYNOTE

JUDE MARY CÉNAT, Interdisciplinary Centre for Black Health, University of Ottawa

9:45 AM – 10:45 AM | ADDRESSING THE RACE-DATA GAP IN HEALTH CARE

Moderator: BASHIR JALLOH, CUPE Local 5430

CAITRIONA FEDERICO, York University

Insurance-Related Disparities in Health care Outcomes for Ambulatory Care Sensitive Conditions Across Three Canadian Provinces

Individuals with ambulatory care sensitive conditions (ACSCs) such as hypertension or diabetes, are likely to be sicker on presentation at health care settings. If these patients are without public health insurance such as those with precarious immigration status, they may face additional barriers to accessing preventive primary care. We analyzed emergency department and hospital admission data from Ontario, Alberta, and British Columbia (2018–2022) using multivariate regression models to assess associations between insurance status and health care outcomes for those with ACSCs. We included interaction terms for province and pandemic period. Among outpatient visits, ACSCs accounted for approximately 2.1–2.6% of visits among uninsured patients compared with 0.8–1.8% among insured patients. Adults had substantially higher proportions of ACSC encounters than children. Among outpatient ACSC visits, insured patients had significantly lower risks of death (RRR = 0.17, 95% CI: 0.13–0.22), leaving before completion of care (RRR = 0.19, 95% CI: 0.18–0.20), and transfer (RRR = 0.52, 95% CI: 0.50–0.53) than uninsured patients. These associations were generally consistent across pandemic periods. Uninsured patients had consistently higher predicted probabilities of severe triage than insured patients in both Ontario (50.1% to 45.2% vs. 41.6% to 40.3%) and Alberta (47.5% to 42.6% vs. 34.3% to 33.0%), with a

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modest decline during the pandemic. Uninsured patients experienced a greater burden of ACSC-related health care utilization and less favourable outcomes than insured patients. These findings suggest persistent inequities in access to effective primary care that were not substantially altered during the COVID-19 pandemic.

MONA-LISA AMAM ODUKOYA, Carleton University

Uncounted, Undiagnosed: How Canada's Race-Data Gap Conceals Diagnostic Inequity in Black Women's Endometriosis Care

Endometriosis diagnosis is delayed by at least five years in Canada, prolonging pain, disrupting education and employment, and postponing access to appropriate treatment. Yet these delays may not be distributed equally. International research reports that Black women have substantially lower recorded odds of receiving an endometriosis diagnosis than White women, while recent Canadian community evidence, namely the national Voices Unheard survey documents widespread dismissal of Black women's health concerns. Despite these warning signs, Canada cannot reliably determine whether Black women wait longer for referrals, specialist assessment, investigation, or diagnosis because race is not consistently collected, linked, and reported across health systems. This research asks: How does Canada's fragmented use of race-based health data limit its ability to identify and address diagnostic inequities affecting Black women with endometriosis? A scoping review will map Canadian and international evidence concerning symptom dismissal, competing diagnoses, referral practices, specialist access, diagnostic investigation, and recorded endometriosis diagnoses. International findings will be used to identify possible mechanisms but will not be presented as proof of Canadian disparities. The review will be combined with a critical policy analysis of Canadian clinical guidelines, race-based data standards, government publications, Black-led community research, and proposed legislation such as Ontario's Bill 115 (the Black Health Equity Act, 2026). These sources will be assessed for measurable equity indicators, implementation requirements, public accountability mechanisms, and community participation in data governance. Rather than inventing a Canada-specific racial diagnostic-delay statistic that existing evidence cannot support, this study examines why such a statistic remains unavailable. It argues that diagnostic inequity is not only a clinical problem involving whose pain is believed and investigated; it is also a data-governance problem involving what institutions choose to measure, analyze, and disclose. The presentation will propose ethical race-based data collection, race-stratified reporting of diagnostic pathways, equity audits, and Black-led reproductive-health research. Its central contention is that the absence of documented disparity does not establish equity. It may instead reveal a health care system that has not built the infrastructure required to see inequity.

CECILIA AMOAKOHENE, York University

Race-Based Data Collection in Health care: The Case of Ontario

There are limited race-based data (RBD) literature in Canada, which raises questions about whether and how RBD is advancing health equity or reproducing harms. This paper examines how Ontario policy discourse about race-based health data collection (RBHDC) compares with organizational practices in the mental health sector, specifically highlighting what potential gaps mean for Black women's mental health outcomes. The methods involved media analysis, literature review, secondary data review, and primary policy analysis of provincial policy and public reports by the Centre for Addictions and Mental Health (CAMH) and Women's College Hospital. Findings show that organizational approaches were positioned within a broader provincial context in which race indicators are inconsistently captured, and policy tools are often framed as recommendations rather than enforceable directives. This analysis underscores how differences persist between Ontario policy discourses and organizational practices. The paper discusses how the province's discourse positions RBHDC as a necessary tool for measuring health inequities, but implementation within organizations remains inconsistent and includes a lack of transparency from the province in its reporting on how data is collected, used, and governed. The paper discusses what is still needed for mental health data governance in Ontario to ensure RBHDC is used, so as to advance health equity for Black women rather than reproduce harm. This paper contributes to Canadian RBD discourse by demonstrating why data collection needs to be paired with clear governance and accountability mechanisms to support health equity for Black women.

HARJYOT KHOSA, Health Applications

Decolonizing the Narrative: Citizen Science, War Economics, and Gendered Health Equity Post-Pandemic

The COVID-19 pandemic exposed deep structural fractures in public health, proving that top-down responses fail racialized, Black, and Indigenous populations. Today, these vulnerabilities are compounded by global war economics, which divert vital resources away from health infrastructure and further fracture equitable health care pathways. This presentation argues that true health equity requires a radical decolonization of health narratives and data governance through localized citizen science, analyzed critically through a gender lens.

Historically, public health tracking has treated marginalized communities as passive data points rather than active knowledge holders. The pandemic taught us that communities must possess direct ownership of disease data. However, recent international donor rollbacks have severely amplified racism-led equity gaps, disproportionately impacting racialized women, gender-diverse individuals, and grassroots health networks who bear the brunt of defunded local care systems. We present a decolonized framework for citizen science that counters these structural barriers by shifting power from volatile colonial institutions back to the community.

By democratizing data generation and health literacy, grassroots networks can bypass institutional gatekeeping and map hyper-local, gender-specific needs. Community rights and resource access must be guaranteed without structural barriers. Ultimately, this session highlights how empowering communities to control their own data and narratives transforms them from vulnerable populations into self-determined leaders capable of resisting the intersecting harms of racism, fiscal austerity, and global conflict.

10:45 AM – 11:00 AM | Break

11:00 AM – 12:00 PM | ANTI-INDIGENOUS RACISM AND HEALTH CARE

Moderator: RITA MORBIA, Inter Pares

REV. DR. KAREN HARRISON, Circle of Survivors for Reproductive Justice

The Legacy of Coerced/Forced Sterilizations of Marginalized Women Workers in North America

We will discuss and illustrate the misogynistic culture in the workplaces of North America which impacted the lives of women workers in health care and other sectors simply because of their gender and reproductive organs and our long fight and advocacy for reproductive justice. We will discuss the coverups, the denials and the stories of women who died because of this form of femicide in health care and its legacy on the families and children. We will present our legislation and our work to protect and educate for women's reproductive health and human rights. We will discuss how the public can advocate and demand the end to coerced/forced sterilizations in North America.

DOROTHY (DOT) ANDERSON, Gift Lake Metis Settlement, PAUL COURTOREILLE, Gift Lake Metis Settlement, and NATASHA CAVERLEY, Turtle Island Consulting Services

Provincial Responsibility, Metis Settlement Realities

"Provincial Responsibility, Metis Settlement Realities" explores the health experiences of Metis Settlement members in Alberta, who continue to face significant barriers to equitable care despite being recognized as Aboriginal Peoples under Section 35 of the Constitution Act, 1982. Metis Settlements are the only legislated Metis land base in Canada. Since they are governed through provincial legislation rather than federal systems, Metis Settlement members rely almost entirely on Alberta's health system. This creates a jurisdictional position that confines access to health services, funding and recognition to only Alberta. Grounded in community voices, emerging research and frontline experience, our presentation examines how provincial health reforms may deepen these inequities. Alberta's move toward a more privatized, two-tiered health system, alongside legislation

such as the Compassionate Intervention Act, raises serious concerns about equitable access, cultural safety, self-determination and the ongoing impacts of colonial health systems. For Metis Settlement members, who cannot look beyond provincial responsibility for health services, these changes risk widening existing disparities and further limiting equitable care. By centering the knowledge and lived experiences of Metis Settlement members, this presentation also highlights the need for provincial policies that fully recognize the distinct governance and rights of Metis Settlements, address anti-Indigenous racism within health systems and uphold commitments to equitable, publicly funded care. It calls for community-led approaches that honour Metis Settlement culture, relationships and ways of knowing while responding to the realities of provincially legislated Indigenous communities.

OWEN COBER, Carleton University, and MARC-ANDRÉ GAGNON, Carleton University

Barriers to Accessing Prescription Medication in Ontario First Nations

The primary objective of this research is to identify the barriers that First Nations individuals face when accessing prescription medications in Ontario. Previous research has shown that health care access for First Nations in Canada is neither equal nor equitable, and First Nations face additional barriers to accessing health care compared to non-Indigenous Canadians. This research project, in partnership between Carleton University and the Ontario Native Welfare Administrator's Association, seeks to explore First Nations lived experiences in navigating the pharmaceutical system in Canada. Through a series of 8 semi-structured interviews and 1 focus group, the paper explores barriers related to administration, geography and traditional knowledge, as well as the strategies that communities have developed to address these barriers. The paper will show that many of the barriers in the system constitute an ongoing form of medical racism, and there is a pressing need for greater First Nations control over the health systems they are actively a part of.

12:00 PM – 1:00 PM | Lunch

1:00 PM -2:15 PM | SYSTEMIC RACISM IN HEALTH CARE EXPERIENCED BY MIGRANT WORKERS

Moderator: SUSANA CAXAJ, University of Western Ontario

TANEETA DOMA, Migrant Farmworkers Clinic, VASANTHI VENKATESH, University of Windsor, TANIA CORREA, Toronto Metropolitan University, and CHRIS RAMSAROOP, University of Toronto & Justicia for Migrant Workers

Examining the Intersections of Unfree Labour, Racial Capitalism, Colonial Extraction, and Access to Canada's Health Care System Within the System of Migrant Agricultural Labour

This presentation will examine the intersections of unfree labour, racial capitalism, colonial extraction, and access to Canada's health care system within the system of migrant agricultural labour. There have already been eight deaths of migrant farm workers in Ontario this summer alone. Thousands of racialized workers from the Global South come to Canada every year under a system that ties health care access to their exploitative hazardous farm employment. Examining the role of health care for migrant labourers, the panel will argue that rural health care functions as an extension of industrial agricultural capitalism—one whose central aim is to dispose of those no longer needed for production. Through case studies and firsthand observations, the panel will offer concrete policy recommendations to rethink health care delivery for vulnerable racialized communities within a neo-plantation system. While many observers may view racism as a byproduct rather than a structural feature of Canada's health care system, the presentation will contend that the very idea of who deserves care is fundamentally shaped by the figure of the racialized foreign other—constructed as unworthy of equal access. The presentation will illustrate how this plays out in practice through lived examples of systemic exclusion.

STACEY GOMEZ, Centre for Migrant Workers Rights Nova Scotia

Essential Yet Excluded: Systemic Racism Faced by Migrant Workers in Nova Scotia's Health Care System

Migrant workers are essential to Canada's economy, particularly in sectors such as agriculture, yet they continue to experience significant barriers to equitable health care access. Most arrive through the Temporary Foreign Worker Program (TFWP), which a United Nations Special Rapporteur has described as a "breeding ground for contemporary forms of slavery." This presentation draws on findings from a forthcoming community-based report on systemic racism experienced by migrant workers in Nova Scotia's health care system. The presentation highlights how policy gaps, employer control over migrant workers' lives, reliance on inadequate private health insurance, and discriminatory treatment within the health care system create barriers to equitable access to health care. Findings are based on a review of the literature on systemic racism in health care and the design of the TFWP, as well as focus groups with approximately 30 migrant workers in Nova Scotia. The presentation concludes by discussing policy reforms to address health care inequities, including permanent residency upon arrival and immediate access to public health care coverage for all migrant workers.

LISA HALPERN, Carleton University

Structural Racism in Alberta's Long-Term Care Sector Work: Cross-Comparative Research with Workers

Canada's long-term care (LTC) sector relies heavily on racialized and immigrant workers, disproportionately concentrated in lower paid, lower status roles. While a range of scholarship looks at structural racism shaping health care workers' experiences, less is known about how particular care settings can generate distinct forms of racialized insecurity for workers. Drawing on research with the Alberta Union of Provincial Employees (AUPE) that integrates survey data from unionized workers (N = 7,826) with interviews from 36 LTC staff, we present an 'embedded case study' that documents structural racism in the sector. We start by identifying factors and features making it harder for workers to mitigate racism and xenophobia in LTC, as compared to other settings where they work. From there, to further illustrate the conditions shaping workers' struggles, we present cross-comparisons, looking across sectors and positions of work. As we illustrate, racialized workers are disproportionately concentrated in the lower-paid health care sector, while non-racialized workers are more prevalent in government services and education. In LTC, Black and Filipino workers are overrepresented in lower paid, lower status and less secure positions, as compared to non-racialized staff. While focused on Alberta, our analysis has implications for other jurisdictions, inviting reflection on how organizational settings drive race/ethnic inequalities. This research strengthens the evidence base for organizing to improve equity and working conditions in LTC.

2:15 PM-3:15 PM | PRECARIOUS MIGRANTS AND HEALTH CARE EXCLUSIONS

Moderator: ANIL NAIDOO, NUPGE

Y.Y. CHEN, University of Ottawa

Medicare Exclusion and the Children of Uninsured Migrants

While it is well known that some foreign nationals are excluded from Canada's Medicare system, the conventional assumption is that Canadian citizens enjoy universal health coverage as long as they can demonstrate residency in a province or territory. In reality, however, some Canadian citizens are effectively excluded from the promise of universal health care from birth. This presentation examines the Medicare eligibility of children born in Canada to migrant parents who themselves lack provincial or territorial health insurance coverage due to their immigration status. Drawing on findings from a legal mapping study, this presentation provides an overview of how parental immigration status can create significant barriers to health coverage for citizen children. In some jurisdictions, these children are excluded from Medicare altogether through residency rules that effectively treat them as non-residents despite their birth and presence in Canada. In others, their families must navigate additional administrative requirements that are difficult for some to satisfy. Elsewhere, ambiguities in the law create uncertainty regarding their Medicare entitlement. By

revealing these disparities, the presentation sheds light on an overlooked consequence of Canada's exclusionary immigration and health care policies. It illustrates how the non-belonging imposed on certain largely racialized migrants can be transmitted across generations, creating a form of second-class citizenship in access to Canada's Medicare system.

DR. PARISA REZAIFAR, University of Ottawa

Refugees' Access to Health care in Canada and the U.S.: Perspectives of Refugees, Sponsors and Providers

Background: Asylum-seekers and refugees in Canada and the United States face complex health challenges and significant barriers to care. Recent cuts to Canada's Interim Federal Health Program (IFHP), including a 30% co-pay and a 10-session annual cap on mental health counselling, further limit access, reflecting challenges seen in the U.S., where essential health coverage is largely unavailable. The IFHP cuts risks deepening health inequities and systemic racism for equity-denied populations. Methods: In this qualitative study, we interviewed 31 refugees (only in Canada), 53 sponsors, and 49 providers in Canada and the U.S. Findings: Participants reported serious health concerns among refugees, including post-traumatic stress disorder, compromised mental health due to racism, chronic pain, diabetes and reproductive health needs, many of which were unmet. Even before the cuts, the complexity of providing care under IFHP contributed to limited access and cost-related health disparities. Canadian participants emphasized the urgent need to revitalize primary care, improve mental health services, and address broader social determinants such as housing and employment. Sponsors played a vital role in helping privately sponsored refugees navigate complex systems. Systemic changes, such as the regular use of professional interpreters and health navigators, were recommended. Conclusion: Our findings are a cautionary tale on the expected impacts of limiting access and compounding inequities in Canada. Our participants illustrated the complexity of health care access for vulnerable populations. It reinforces the need for policies that attend to racism and enhance health equity rather than limit access to care, especially in mental health.

LUTFUNNESSA TANIA, Madhu Verma Migrant Justice Centre, and TRACY GLYNN, Canadian Health Coalition & Madhu Verma Migrant Justice Centre

Free and Universal? Disparities in Health Care Access for Migrant Workers and International Students in Canada

Migrant workers and international students have varying access to public health are depending on where they live. Migrant workers who hold work permits of under one year often do not qualify for Medicare. Employers of migrant workers in Canada are required to provide private health insurance to their workers if the worker is not eligible for Medicare. Private health insurance plans are inferior to Medicare as they usually do not cover up front the costs of health care services like Medicare does and many walk-in clinics, labs, and pharmacies do not directly bill private insurance companies. Not all international students in Canada have access to public health care. In provinces and territories where international students are not covered under public health care plans, students must arrange private health insurance coverage for themselves. The barriers to accessing health care differ by province and territory but mostly relate to waiting periods and the costs of private health insurance. The presentation will discuss reports published by the Madhu Verma Migrant Justice Centre and the Canadian Health Coalition on the barriers migrant workers and international students face when attempting to access public health care in Canada. The reports conclude with key policy recommendations for more equitable access to health care for migrant workers and international students in Canada, including the provision of Medicare for migrant workers and international students on their arrival in Canada and for the entire duration of their stay in Canada.

3:15 PM – 3:30 PM | Break

3:30 PM – 3:40 PM | DR. BOLU OGUNYEMI, President, Canadian Medical Association

3:40 PM – 5:00 PM | WORKER-DRIVEN, ANTI-RACIST SOLUTIONS

Moderator: Tyler Levitan, Canadian Federation of Nurses Unions

FATEMA RASHED, University of Toronto (OISE)

Resistance from Nurses Supporting Asylum-Seekers and Refugees (ASR) in Health Care Spaces in Ontario

Discrimination and racism within Canadian health care contribute to significant health disparities among asylum-seekers and refugees (ASR) (Mahabir et al., 2021). As a visible Muslim, granddaughter of refugees, and registered nurse working with ASR, I explore the intersection between colonialism in health care, racism, health disparities, and nurse-led advocacy efforts to drive positive change which directly benefit ASR. The impact of racism is especially harmful for ASR given their pre- and post-migratory trauma (Ziersch et al., 2020). While the nursing profession has faced criticism for its historical role in perpetuating colonial harms against racialized populations, racialized nurses in Canada such as Jean Cuthland Goodwill, and Ruth Bailey led to way in advancing health equity, and inclusivity (Brown et al., 2022; Flynn, 2008; Goodwill, 1989; Kimani, 2023; Molloy, 2020; Stake-Doucet, Wilson et al., 2022). Existing research highlights barriers to care for ASR from the perspective of physicians, specialists, and allied health professionals, there is a notable gap addressing institutional racism, medical neocolonialism, nursing advocacy (Desmyth et al., 2021; Pollock et al., 2012; Rousseau et al., 2017; Ziersch et al., 2020). Preliminary findings indicate the absence of organizational policies for interpreter services, inflexible patient lateness policies, doctors refusing care to patients without OHIP, and insufficient support coupled with negative attitudes from health care workers toward ASR. This study employs generic qualitative research (GQI), critical race theory (CRT), and decolonial principles to ask, "how does medical neocolonialism and institutional racism operate in nurses' interactions with ASR and how do they resist these dynamics and advocate for these patients? In answering that, the study engages nurses in semi-structured interviews to examine their perceptions of medical neocolonialism and institutional racism in health care, and how they resist these practices when advocating for ASR.

MARCUS ZACHARIA, Ottawa Newcomer Health Centre

Performing Welcome, Producing Exclusion: What Newcomer Health Navigation Reveals About Racism and Health Equity

Drawing on more than ten years of experience as a multicultural health navigator and interpreter with the Ottawa Newcomer Health Centre, as well as previous work with newcomers and refugees in the United States, this contribution examines everyday mechanisms of racism that are often overlooked in health equity and EDI conversations. While racism in health care is often discussed through explicit discrimination, disparities, or provider bias, newcomer patients frequently encounter subtler but deeply consequential forms of exclusion: paternalistic "niceness," administrative labelling as "complex" or "non-compliant," lack of interpretation at first contact, front-desk gatekeeping, and poor institutional knowledge of community resources beyond English and French.

This presentation argues that health systems often perform welcome while denying newcomer patients full dignity, agency, and credibility. It situates frontline navigation experience alongside research on language barriers, migrant health inequities, race-based data collection, and systemic racism in Canadian health care. The contribution calls on researchers to treat interpretation, navigation, community-resource literacy, and administrative workflows as core components of health equity infrastructure. It also asks how anti-racism research can better include the knowledge of navigators, interpreters, community workers, and newcomer patients themselves.

LENNIE DOLINSKI and LOU BLACK, Hospital Employees Union

De-colonizing Collective Agreements: Learnings in the Early Stages

Indigenous specific racism remains pervasive throughout BC's health care system. The personal impact of this on HEU's Indigenous members is great—it impacts mental and emotional health, erodes self-esteem, and can cause irreparable harm to individuals. The landmark 2020 independent review, In Plain Sight, documents the experience of Indigenous health care workers and patients clearly. Over half of Indigenous workers surveyed had experienced Indigenous specific racism in their workplace. Those who were targets of this racism reported negative personal outcomes including limiting their careers. Yet one of the most effective solutions to addressing Indigenous specific racism toward patients, residents and staff in health care seems to be to hire more Indigenous staff and make sure they are in leadership positions. The great majority of respondents to the 'In Plain Sight' survey, felt that increasing the numbers of Indigenous health care staff was the number one way to combat Indigenous specific racism in health care settings. The HEU has bargained collective agreement entitlements as one means to repair the harms of colonization. The Union, with the direction of its Indigenous members has achieved language to make health care workplaces safer and more appealing to Indigenous workers. This work is new for the Union and demands deep learning and shifting to work in right relations with Indigenous peoples. The presenters will share experience, and barriers and progress arising in this work.

DARDIA GARCELLE JOSEPH and FERNANDO BELTON, Clinique juridique de Saint-Michel (St. Michel Legal Clinic)

The Role of Community-based Legal Activism in the Fight Against Medical Racism

Medical racism constitutes a violation of the right to health and the right to equality. Although the literature increasingly documents manifestations of systemic racism in health care, one question remains: how can this knowledge be translated into tangible changes for the communities affected? This presentation offers a reflection on the role of community-based legal activism in the fight against medical racism. Drawing on the Academic Guide to Medical Racism developed by the Saint-Michel Legal Clinic, we will present an approach that combines research, legal outreach, community education and support for people experiencing discrimination. The guide documents the sociological, intersectional and legal dimensions of medical racism, whilst highlighting existing remedies and the limitations of current mechanisms for protecting rights. The innovative aspect of this approach, however, lies in its purpose. Rather than viewing research as a product intended primarily for the academic world, we transform it into a tool for community engagement. The knowledge generated is used to develop training programs, conferences, workshops and public outreach resources that enable communities to better understand their rights, recognize situations of discrimination and empower themselves to take action. At the same time, this approach helps to train future legal professionals and build lasting bridges between the legal, health and community sectors. This presentation argues that access to justice is an essential component of health equity. Eliminating medical racism requires not only institutional reforms, but also interdisciplinary mobilization in which the legal, community and health sectors work together to ensure fundamental rights are upheld and to promote genuinely anti-racist care.

HANIF KARIM, BC Nurses' Union

Union Education that Empowers IENs: Anti-Racism as Collective Healing

Care activism encompasses the collective and everyday practices through which migrant care workers navigate institutional hierarchies, and collectively advocate for safer, more equitable workplaces (Tungohan 2023). This presentation explores care activism in the form of union-led education that centers the needs and perspectives of Internationally Educated Nurses (IENs). IENs, a majority of whom are racialized and from the Global South, exist on the margins of movements for labour justice and the health care system in Canada. They are framed as a solution to Canada's nursing staffing crisis and bring critical knowledge and skills to Canada's nursing workforce. Yet, at

the level of worksites, in Canadian health care systems defined by systemic racism and colonialism, many IENs feel disenfranchised and treated as disposable, burdensome and unfit workers. The BC Nurses' Union's Communicating Essential Skills (CES) Course is a form of union-led education that empowers IENs. Participants learn to: 1) Map how power hierarchies, defined by racism and colonialism, sabotage channels of communication in Canadian health care to endanger the safety of nurses and patients, and 2) how to practice anti-racist tactics of communication to disrupt racism at work. In the fragmented licensing and registration process that IENs must navigate to practice in Canada, education serves as a gatekeeper and is a major site for racism and discrimination. Employing participatory models of theatre, and storytelling, the CES curriculum, offers IENs education that is anti-racist and rooted in the collective healing and joy. Feedback from workshop participants highlights the solidarity, healing, and care that comes from sharing the weight of their stories, vulnerabilities, and dreams together.

5:00 PM | **CLOSING REMARKS**

For more information, contact Tracy at **tglynn@healthcoalition.ca**.

Organized by the Canadian Health Coalition and the University of Ottawa's Centre for Health Law, Policy and Ethics.

BIOGRAPHIES

Convenors



Y.Y. BRANDON CHEN (SJD, MSW, JD) is an Associate Professor in the Common Law Section of the University of Ottawa's Faculty of Law, where he holds the Dean's Research Professorship in Migrant Health Equity. A lawyer and social worker by training, his research examines legal, policy, and ethical issues at the intersection of health systems and international migration, principally through the lenses of constitutional and international human rights law. His work has addressed such subjects as migrants' right to health, public health-related border regulation, and cross-border health care. In 2025, he represented the Canadian Health Coalition and the Madhu Verma Migrant Justice Centre in their joint intervention before the Supreme Court of Canada in Quebec (AG) v Kanyinda. He is currently co-counsel for the Canadian Health Coalition and several other organizations intervening jointly in Toussaint v Canada (AG).

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ANNE LAGACÉ DOWSON is the Communications Director of the Canadian Health Coalition. She is an award-winning interviewer and commentator, former CBC radio host, reporter and researcher. Anne worked for 25 years for CBC, Radio-Canada and BellMedia. She has an MA in History from Carleton and is fluently bilingual.

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TRACY GLYNN is the National Director of Projects and Operations of the Canadian Health Coalition. She holds a regular teaching appointment at St. Thomas University. She is a founder of Reproductive Justice New Brunswick and the Madhu Verma Migrant Justice Centre where she engages on migrant health care activism.

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VANESSA GRUBEN is the Director of the Centre for Health Law, Policy and Ethics, and Associate Professor in the Faculty of Law at the University of Ottawa. A recognized expert in health law and reproductive justice, her scholarship spans assisted reproduction, organ donation, harm reduction, and healthcare regulation.

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HAYLEE KEYES is the National Director of Development and Community Engagement at the Canadian Health Coalition, championing public health care through strategic fundraising initiatives and digital advocacy.

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JASON MACLEAN was elected NUPGE Secretary-Treasurer at the National Union's Triennial Convention in June 2022. In this role, he oversees NUPGE's finances, focusing on transparency, accountability, and the implementation of modern operational and technological best practices. Jason also serves on the National Executive Board, where he helps guide the National Union to advance the best interests of all members. In 2023, he co-chaired NUPGE's first-ever antiracism conference, bringing together diverse voices from the National Union's Components to foster better understanding and drive positive change for all members. He spearheaded the establishment of the new Indigenous Issues Committee to advance the National Union's equity and reconciliation efforts. Jason serves

on several boards, including the boards of the Black Class Action Secretariat and the Canadian Centre for Policy Alternatives, and he is a member of the Coalition of Black Trade Unionists. Before his current role at the National Union, he led the Nova Scotia Government and General Employees Union (NSGEU/NUPGE) as President, first elected in 2016 and re-elected in 2019. As NSGEU President, he introduced an annual diversity summit to support tangible improvements for all members in the province.

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STEVEN STAPLES is National Director of Policy and Advocacy of the Canadian Health Coalition. He is an accomplished policy advocacy, strategist, communicator and author, with 30 years of experience in non-profit, labour, and research organizations. He holds a Bachelor of Education and a Master of Leadership and Community Engagement.

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Moderators



SUSANA CAXAJ is an Associate Professor of Nursing at Western University. She is also a Principal Investigator on Migrants' Intersecting Experiences with Housing in Agriculture Project.

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BASHIR JALLOH is based in Regina, Saskatchewan, and serves as President of CUPE Healthcare Workers in Saskatchewan. He has a professional background in nuclear medicine and public health. He studied Nuclear Medicine at the University of Toronto and earned a Master of Public Health from the University of Saskatchewan.

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TYLER LEVITAN works as a Policy and Research Specialist with the Canadian Federation of Nurses Unions (CFNU). He has worked in a variety of research, government relations and communications roles since graduating from the Institute of Political Economy at Carleton University.

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RITA MORBIA (she/her) has worked with Inter Pares for over 20 years on a range of issues related to women's rights, feminist movement-building, and sexual and reproductive health. For several years, she has been engaged specifically with activists in the Philippines and Sudan on bodily autonomy and women's political participation respectively. She serves as Co-Treasurer of the Canadian Health Coalition.

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ANIL NAIDOO is a National Representative at the National Union of Public and General Employees (NUPGE). Previously, he coordinated the Blue Planet Project with the Council of Canadians, advocating for global water rights.

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Presenters



CECILIA AMOAKOHENE, M.A. is a second-year PhD student at York University in the Health Policy and Equity stream of the Graduate Program in Health. She has over a decade of experience working in health promotion and mental health with a focus on youth and young adult populations. Her current research areas include mental health care access and outcomes for Black Canadian populations, race-based data collection within the health care sector, and the impacts of structural racism on knowledge translation in health care.

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DOROTHY (DOT ANDERSON) is a member of Gift Lake Metis Settlement.

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FERNANDO BELTON is the executive director of Clinique juridique de Saint-Michel (St. Michel Legal Clinic). He is the Supervising Attorney for the Racial Profiling Division.

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S. MEGAN BERTHOLD, PHD., LCSW, is a Professor at the University of Connecticut's School of Social Work. Her research and clinical practice are focused on refugee and asylum-seeking survivors of torture and other traumas. She is co-director of the Forced Migration Hub, serves on the U.S. National Consortium of Torture Treatment Programs' (NCTTP) Executive Committee, and chairs the NCTTP Study. She has testified extensively as an expert witness in U.S. Immigration Court and was the 2009 NASW Social Worker of the Year. She was a Fulbright Canada Distinguished Chair in Public Affairs in North America: Society, Policy, Media, Carleton University, 2024-2025.



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