LOOKING FORWARD

Innovation and creativity in integrative care

2019 ANNUAL REPORT

South Riverdale COMMUNITY HEALTH CENTRE

Ontario's Community Health Centres
Every One Matters.

Board Chair & CEO

Executive Message

As we move past the first wave of the COVID-19 pandemic, the past year feels distant. So much has happened in the15 months since our last annual general meeting. The year has been filled with challenge, loss, achievement and celebration. It has been a year of growth, transition and transformation; it has been a year that challenged our resilience and courage. But, as we look forward to the future, it is important to honour and reflect on the past.

In 2019, we celebrated the nearly two-decade contribution of Lynne Raskin, our previous CEO. An inspiring leader and visionary, she nurtured and grew SRCHC from its grassroots beginning into a significant leader in local, national and international community health centre movements.

Over the past year, SRCHC continued to increase vital services and partnerships to address the needs of people facing barriers, exclusion and discrimination.

This year we have expanded our urban health programs to include not only supervised consumption but safer opioid supply. We have launched a successful community food centre in the Taylor Massey neighbourhood. We have created unique pathways and partnerships for people living with chronic disease. We have expanded the nature of our interdisciplinary teams to include not only people with lived experience but a diverse complement of health care providers. And we continue to show, through both advocacy and action, that “no one is illegal.”

Also, over the past year, we became an anchor partner in the East Toronto Health Partners (our East Toronto Ontario Health Team). We continue to deepen our work with our community health centre network and our other Ontario Health Team (OHT) leadership partners. This work is leading to transformative change and collective impact.

When COVID-19 reached our community in March, we responded. We mobilized to maintain our services to the community, to ensure staff health, safety and wellbeing, to collaborate even more to ensure equitable access. SRCHC never closed its doors to our community. Instead, we scaled up virtual care, expanded transportation and food access services, and partnered with others to offer outreach to communities most vulnerable to COVID and its impacts.

Early in the COVID pandemic, some experts said that this would be "a great equalizer" but nothing could be further from the truth. If anything, COVID has shown us just how deeply racism, colonization and poverty impact the health of communities and just how far we have to go before our values of social justice and equity are realized. Looking to the future, it is clear that community health must be deeply grounded in anti-racist principles and practices that meaningfully address the impacts of colonization and inequality.

Jason Altenberg
Chief Executive Officer

Steven Little
Board Chair

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Year in Review

6 SITES

99 ACCESS POINTS

11,159 UNIQUE CLIENTS SERVED

96,175 INTERACTIONS

12,776 VOLUNTEER HOURS

271 VOLUNTEERS

148 GROUP PROGRAMS

4,698 GROUP SESSIONS

36,107 GROUP ATTENDANCE

COVID-19 Stats

FOOD

19,687 MEALS

571 UNIQUE CLIENTS SERVED

120 PRODUCE BOXES

SUPPORTING **74** FAMILIES

683 REFERRALS TO FOOD GIFT CARD PROGRAM

1,250 UNIQUE CLIENTS SERVED

112 PHONE DRIVE DISTRIBUTION

VIRTUAL/ PHONE

183 SESSIONS

3,259 ATTENDANCE

7,441 INDIVIDUAL VIRTUAL/PHONE APPOINTMENTS

SOCIAL MEDIA

1,725 MENTIONS

132,142,421 ENGAGEMENT

MEDIA

61 ARTICLES

52,376,321 REACH

Maximize Positive Community Impact Through Collective Action

East Toronto Health Partners: Where Health Meets Community

In December 2019, The Hon. Christine Elliott, Ontario's Minister of Health, announced that East Toronto Health Partners (ETHP) had become one of the first 24 Ontario Health Teams. Ontario Health Teams are a new model of care; their goal is to better connect health care (including hospitals, home care and family physicians/primary care) and other care providers in order to create an integrated system across our community.

East Toronto Health Partners consist of:

- Patients, families and caregivers
- Michael Garron Hospital (Toronto East Health Network)
- Providence Healthcare (Unity Health)
- South Riverdale Community Health Centre (on behalf of East Toronto CHCs)
- VHA Home HealthCare (VHA)
- WoodGreen Community Services
- East Toronto Family Practice Network (representing primary care leadership)

In our first year as an Ontario Health Team, we are focused on designing better care for three priority populations:

1. Seniors who have chronic illnesses and their caregivers
2. Youth who need support for mental health and wellness
3. Adults with needs related to substance use and addictions

Raj Sohi has accepted the job of Director of Mental Health and Substance Use, a position created by Michael Garron Hospital and SRCHC to support ETHP's vision of a system without discharges and easier access to integrated (community/hospital) care for those living with mental health and substance use challenges in East Toronto.

During the pandemic, we continue our collaborative planning, using a population health approach to keeping our community healthy. Many exciting and innovative projects have been accelerated during this challenging time, such as:

- Michael Garron Hospital and our CHC partners provided SRCHC with personal protective equipment in the early days of the pandemic so that we could remain operational and provide essential services to our clients and community.
- With our community health centre partners and the infectious disease team at MichaelGarron Hospital, we provided COVID assessments and supported COVID outreach management to shelters and group homes in East Toronto.
- With our ETHP anchored and engaged partners, we are working to develop virtual primary and community care hubs, bringing teams together to support integrated, coordinated care for frail and homebound seniors.

At SRCHC, we are very proud to be working with patients, families, local residents and community partners to co-design the future of local health care. This work is built on a legacy of trust in East Toronto. With our partners, we have a multi-decade track record of delivering "made in East Toronto" solutions together and we look forward to continuing this work over the next year. If you want to find out more about the work of the East Toronto Health Partners, check out their website https://ethp.ca/

COUNTERfit Launches the East Toronto Outreach Project to Meet Needs During COVID-19

The COVID-19 Pandemic hit at the beginning of 2020 and, on March 16, life as we knew it at COUNTERfit changed completely. We adapted all of our service delivery, as did all programs at SRCHC. All group programming was suspended or altered, and every part of the program in which we distribute food and supplies began to restructure.

The East Toronto Outreach Project (ETOP), which began mid-2019, was just getting established. ETOP staff had been doing street outreach along the Danforth, creating routes and finding new service users that COUNTERfit had not previously connected with. ETOP staff were also making connections in Oakridge, connecting during drop-ins at Toronto Community Housing buildings, and playing key roles in helping establish the Oakridge Health and Harm Reduction Hub.

Once the lockdown began, staff and management moved quickly to adapt. We were very lucky to be able to partner with our colleagues at Harmony Hall to shift from foot- and building-based to a driving model. This was even better than foot outreach since we are able to cover more ground in a shorter amount of time. As an added bonus, we've got to know the Harmony Hall team better and have had interesting conversations about health systems.

Food security has always been a struggle for COUNTERfit service users, and COVID has exacerbated this issue. We are very grateful for corporate and community partnerships, as well as food prep by SRCHC staff, that have created meals to distribute. We've distributed approximately 2,340 meals on the van since March.

Moving forward, and eventually out of COVID, we hope to continue our partnership with the Harmony Hall program, to deliver our outreach on the van, and expand the service to new areas and communities.

2,208 encounters

VAN OUTREACH

March-June 2020

4,476 safer sex supplies

1,936 sterile syringes

5,610 used syringes picked up

323 hygiene supplies

1,036 harm reduction kits

5,451
COSS visits

Acute and Integrated Care for Seniors

The Crisis Outreach Service for Seniors (COSS) program offers a variety of services: mobile crisis intervention and counselling; short-term intensive case management; harm reduction and concurrent disorders service; limited primary care and nursing; mental health and addictions assessment, counselling and referrals.

COSS is a partnership between WoodGreen Community Services, Reconnect Community Health Services, LOFT Community Services, Haven Toronto and South Riverdale Community Health Centre. Partnerships also exist for quick access to geriatric psychiatry referrals through Bridgepoint Active Healthcare, and behavioural support through McKenzie Health. South Riverdale CHC is represented on the COSS East team by Carolyn Pitchot, Nurse Practitioner, who provides primary care outreach services to seniors in crisis with mental health and addictions issues; this may include diagnosis and short-term management of dementias.

During the challenge of COVID-19, COSS has continued to provide in-person outreach to clients across the city. The team has experienced a record number of calls via the Toronto Seniors Helpline after being announced as part of the City of Toronto's mental health plan. Wearing personal protective equipment, staff visit client homes across Toronto's east end, Scarborough and North York. Working in partnership with COSS social work and clinical psychiatry resources, the nurse practitioner works to address issues such as chronic disease management, drug reconciliation and prescribing, referral to specialists and hospitals, and the transition to an appropriate primary care provider for continuing care once the client is out of crisis. This collaborative approach to care meets the needs of many seniors who would otherwise fall through the cracks.

Lead System ***Transformation***

2,605 encounters

153 unique clients served

The MATCH Program Turns Two: Setting Our Sights on Dignified, Equitable, Perinatal Care for All

We are proud to say that the Midwifery and Toronto Community Health (MATCH) program will be moving into its third year this fall! MATCH has been providing pregnancy, labour and birth, postpartum, and medication abortion care to people in East Toronto and beyond. The program tries to reach people who typically experience barriers to high-quality healthcare and, over the past two years, it has been able to do just that. About half of its clients are residents of the province without access to OHIP, nearly all of our clients have been BIPOC (Black, Indigenous, people of colour), some of our clients have been people who used drugs, many are under-housed or homeless, and more than half of them live under the poverty line. Being able to provide its clients with thoughtful, wrap-around care keeps the team going every day.

One of the things we are proud of is our commitment to continual reflection on and refinement of our practice in order to better meet the needs of our clients. We learn from our clients on a regular basis and deepen our understanding of what it takes to have good health. Early on we were able to see how issues like food insecurity, access to safe housing, and lack of social connection impacted the lives of our clients. We wanted to be able to address some of these issues meaningfully, beyond what we can typically do in one clinical appointment. We are very proud to say that, earlier this year, a social worker joined our team to support clients with these and other important issues. Now, in addition to four midwives, clients of MATCH can also connect with a social worker when they need to.

The COVID-19 pandemic has forced our team to reimagine how we continue to provide good care to our clients. One thing we noted last year was that many of our clients did not have access to cell phones or basic internet services. Plans were put in place to provide cell phones and SIM cards to our clients in need. The pandemic pushed those plans forward quickly! With the help of the SRCHC Phone Drive, a number of clients now have phones and internet. Some of our clients living in shelters have been affected by the virus and have had to temporarily relocate themselves in order to recover safely. Having access to cell phones while in isolation - to report symptoms, call with concerns, connect with friends - has been important to their recovery. And, because we now see our clients less frequently in-person because of the pandemic, cell phone access has allowed us to provide virtual appointments, which have been most helpful.

Building partnerships with other community organizations and providers has been a cornerstone of our practice at MATCH. For example, many of our clients are connected with doula services for extra support during pregnancy, birth and postpartum. Their doulas have been an extra set of hands, a listening ear, a birth sidekick and some respite when things get hard. For our clients who are parenting for the first time, parenting alone or new to the country, this extra support has been very valuable.

Before the pandemic hit, nearly every one of our clients was connected to programs in the community such as parenting programs, prenatal groups, food and nutrition programs. Staying connected to others is vitally important, particularly in the early days of parenting. As a result of COVID-19, all of these programs have temporarily closed, creating a gap for many people who would otherwise rely on them. Although we have directed our clients to online resources, we have plans to create some programming of our own with others at SRCHC. We are still in the planning stages and getting input from past and present MATCH clients about what they would like to see.

In addition, we are starting a MATCH client advisory group to help guide and refine our work. If you are interested in joining this advisory group or have ideas for groups you would find helpful, please don't hesitate to reach out to us at match@srchc.com.

Local Phone Drive Addresses Digital Inequity

In early April, a client who uses the Moss Park Consumption Treatment Service (CTS) was symptomatic of COVID-19. The individual was sent to St. Michael's Hospital (SMH) Assessment Centre but there was no way for the Centre to call its client with test results because the client had no phone. While the Moss Park CTS service filled in the gap by working with SMH, the experience made it clear to SRCHC leadership and management teams that this kind of experience is the norm and not the exception for our clients.

Emergency measures brought on to prevent the spread of COVID-19 meant that community, health, and social services began transitioning to virtual platforms accessible only by phone and/or web. For the majority of our marginalized clients who experience income, housing and food insecurity, the transition to virtual service became another barrier. As a result, the "social prescription" of cell phones became part of our work to address the digital health equity gap.

An equity-focused digital health approach implies that a person has access to:

1. Hardware (phone, computer, tablet, etc.)
2. A viable connection (internet access through data or minutes for a phone)
3. Skills to access and use the technology.

SRCHC's electronic medical record (EMR) identifies 500 people without hardware. Accounting for those clients who use services provided by the urban health team (and are not accounted for in the EMR), 1,500 individuals were in need of phones with viable connection. The experience of the Moss Park CTS client led to a conversation with Sarah Sharpe, CEO of QoC Health, and this was the start of the initiative. Within two weeks, we issued a public "call to action" to help us secure 1,500 devices (phones and tablets), chargers and funds for the purchase of SIM cards and data plans to activate the phones and tablets.

As of June 2020, we have given 112 phones to clients of various SRCHC programs (urban health, social service, midwifery, newcomers and families, seniors, and chronic disease services). The privilege of being able to stay in one's home, have food to eat, and have access to information at the tip of one's finger is one experience that feels familiar for many with means. However, for many of the the clients we serve, access to shelter that enables physical distance, food, showers, and communication tools are lacking. Through this drive, we are doing what we can to address the digital equity gap, recognizing that this barely scratches the surface of their ongoing needs but is an important contribution nonetheless.

Ensuring Access to Quality Healthcare for Uninsured Ontario Residents During COVID19

Through the allocation of necessary resources and ongoing advocacy, SRCHC has demonstrated an unwavering commitment to accessible healthcare for Ontario residents who have precarious immigration status and who do not have access to OHIP. SRCHC continues to work closely with community partners and allies to provide access to programs and services that reflect the unique needs of the uninsured community.

A frontline social worker at SRCHC serves as co-chair of the Health Network for Uninsured Clients, and works to improve access to healthcare for uninsured people with precarious immigration status. A collaboration of over 40 health and community service organizations, the network focuses on capacity building, research and policy solutions around the needs of uninsured communities. During the COVID-19 pandemic, these needs have been amplified.

On March 20, 2020, in response to COVID-19, the Ontario Ministry of Health directed all hospitals to provide medically-necessary care to uninsured patients, without charge. While the directive was sent to all Ontario hospitals, implementation was not consistent across hospitals, resulting in misinformation, hospital bills and confusion for patients. Many reports were received about clients facing barriers to care. The network and its allies (such as Alliance for Healthier Communities, the Association of Ontario Midwives, OHIP for All, No-one is Illegal and community legal clinics) began to work on addressing these barriers.

The network developed multiple strategies to improve hospital access, including knowledge exchange and translation, partnership-building and direct patient support. In partnership with Toronto South Local Immigration Partnership, it developed a plain language guide (www.wellesleyinstitute.com/uninsured) in over ten languages. These resources were widely distributed and resulted in many requests for help from both patients and service providers across the city. The urgent demands for support inspired the development of the network's "Rapid Response Team" (RRT), hosted by co-chairs of the network and staff from Centre Talks at St. Michael's Hospital, SRCHC, Flemingdon CHC, and Queen West/Parkdale CHC. The RRT meets on a regular, virtual basis to assess emerging issues and advocate for client needs.

The network's co-chairs have also reached out to Toronto hospital leadership about barriers to care which have been reported. This resulted in the review and revision of policies and practices, and the refund to several patients who were charged in error for service. With support from Centre Talks at St. Michael's Hospital, the network also hosted a webinar that helped increase capacity and give frontline workers the necessary tools and information to advocate for uninsured clients.

Although there have been several successes, the fight is far from over. SRCHC continues to advocate for the new directives even in the post-COVID era. The new guidelines have been instrumental in saving lives while hospitals continue to get paid for their services. The network and its allies, with support from SRCHC, will continue the fight for accessible healthcare for all. After all, healthcare should be a human right and not a privilege!

307
uninsured clients served

Screening Out the "Silent Disease"

In 2013, researchers reviewed data from the Greater Toronto Area and found a lack of annual eye examinations for a considerable number of people with diabetes. A "silent disease," diabetic retinopathy is the leading cause of blindness in working-age people in Canada. Lack of awareness, cost of examination and difficulty accessing services, especially for marginalized and low-income families, led to the birth of SRCHC's tele-ophthalmology project in 2013.

Starting from scratch, a great deal of effort was put into program development. The ability of the project to identify vulnerable patients met with positive feedback and the project became the Diabetes Eye Screening Program (DESP). Over four years, DESP expanded to other communities across Toronto, increasing to 16 sites. DESP has traveled hundreds of kilometers every month, from Victoria Park in Scarborough to LAMP in Etobicoke, from Anishnawbe Health Toronto in downtown Toronto to Unison at Finch and Bathurst.

One of the goals of DESP is to increase awareness and inform the public about the importance of eye screening. Our team approached community papers publishing in English, Arabic, Korean and Farsi languages and placed ads. An article introducing the program appeared in The Mirror, a community newspaper. Promotion of the program gained momentum after a team member spoke about it on CBC's Metro Morning, and CTV news also reported on its importance. Several presentations to clients and healthcare providers provided another way DESP has shown its value to the healthcare system.

The number of individuals screened has increased considerably, from 399 (2018/19) to 673 (2019/20). Two academic articles and ongoing reviews have proven the effectiveness of the program, both in cost efficiency and in access to the urban populations that most need eye screening. This journey shows how community health centres can connect and improve the lives of vulnerable people to prevent debilitative chronic conditions. We are proud to be a candidate for the 2020 Diabetes Canada Award as we continue to raise awareness for the longterm wellbeing of our clients and community.

706
encounters

691
unique clients served

Promoting Healthier Communities: What Can One Person Do?

Staying healthy may depend on having a steady income, housing, nutritious food and options for getting around the city. When it comes to making health-promoting changes in our community, people might ask, "What can one person do?" With a long history of collective action and working in partnership with community members and other groups, SRCHC continues to make a difference.

Our efforts on behalf of safer cycling and better air quality are examples, and our partnerships strengthen community voices. For example, we continue to work with The Eastview Neighbourhood Community Centre to offer a "Rescue Bike" bike repair in the Blake Boultbee neighbourhood. We work with Ward 14 Bikes to improve cycling conditions. As cycling rates continue to grow in Toronto, it's a health-supporting trend we actively promote.

This summer, we joined a successful campaign for "shared streets" and "open streets" which provides safer cycling and walking choices. Especially now, people are looking for "physically distant" travel options along major transit lines like Danforth Ave. For those persons living in apartments, public space and parks are even more important. Streets are important public spaces and, when redesigned for health, they can become a valuable asset.

New research shows that the Covid-19 pandemic is connected to climate change and climate change causes more extreme weather, such as lengthy heat waves. This is another health-related reason to reduce automobile use in the city and to support non-polluting options for travel.

This summer, we joined campaigns to fight incineration of garbage and we helped neighbours understand the impact of the proposed Ontario Line commuter rail (previously designed to be underground). We are also supporting the phase out of gas-fired electricity plants which would reduce greenhouse gasses and slow climate change.

Life "after Covid" will be different. We hope that some of the changes we are working toward (greener transportation, more public space, guaranteed minimum income, affordable supportive housing, democratic decision-making) will remain after Covid-19. Join us in our efforts. Together we are stronger!

To get involved, please contact Paul Young at pyoung@srchc.com or 416-461-1925 ext. 241.

Healthy Community Grant

The Healthy Community Grant provides an opportunity for the Indigenous drug and substance using community to gather and engage in a cultural dialogue by providing a space for the discussions around the current accessibility to primary care and harm reduction services that are relevant to the community. There is a focus on developing service models specifically for the Indigenous drug and substance user community. Special purpose funding will cover refreshments, transportation and honoraria for participants and knowledge keepers. Due to COVID-19 programming has been delayed and community members are planning for next steps.

SPECIAL PURPOSE FUND	
Healthy Community Program Grant: **Indigenous Harm Reduction Network**	$1,490

FINANCIAL HIGHLIGHTS

Operating Revenue & Expenses

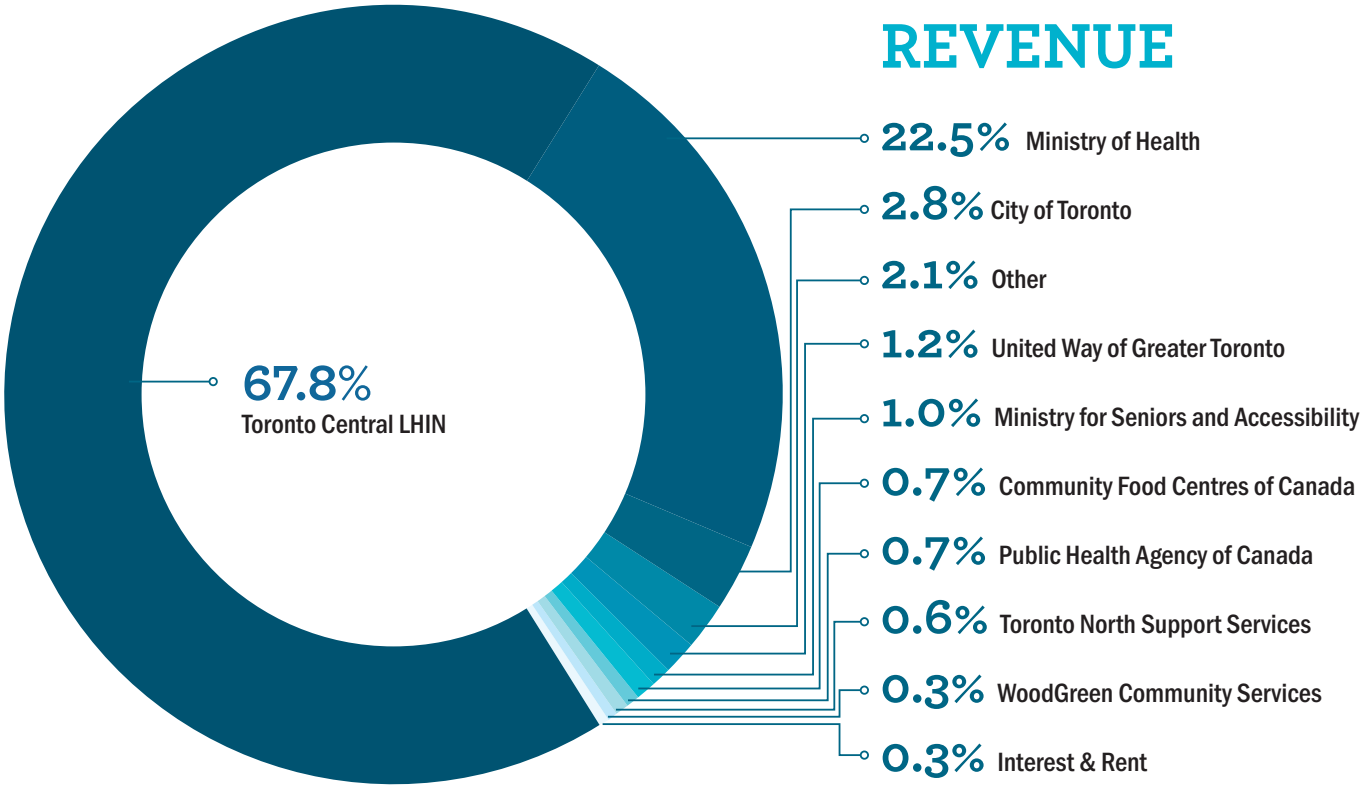
Year ended March 31, 2020

	2019-2020		2018-2019
REVENUE	**$15,216,356**		**$14,020,694**
Toronto Central LHIN	$10,309,303	**67.8%**	$9,816,407
Ministry of Health	3,430,430	**22.5%**	2,478,006
City of Toronto	432,428	**2.8%**	566,609
United Way of Greater Toronto	184,579	**1.2%**	184,579
Ministry for Seniors and Accessibility	148,154	**1.0%**	156,180
Community Food Centres of Canada	113,280	**0.7%**	-
Public Health Agency of Canada	101,332	**0.7%**	-
Toronto North Support Services	89,653	**0.6%**	86,228
WoodGreen Community Services	43,542	**0.3%**	176,474
Interest & Rent	39,423	**0.3%**	38,710
Other	324,232	**2.1%**	517,501

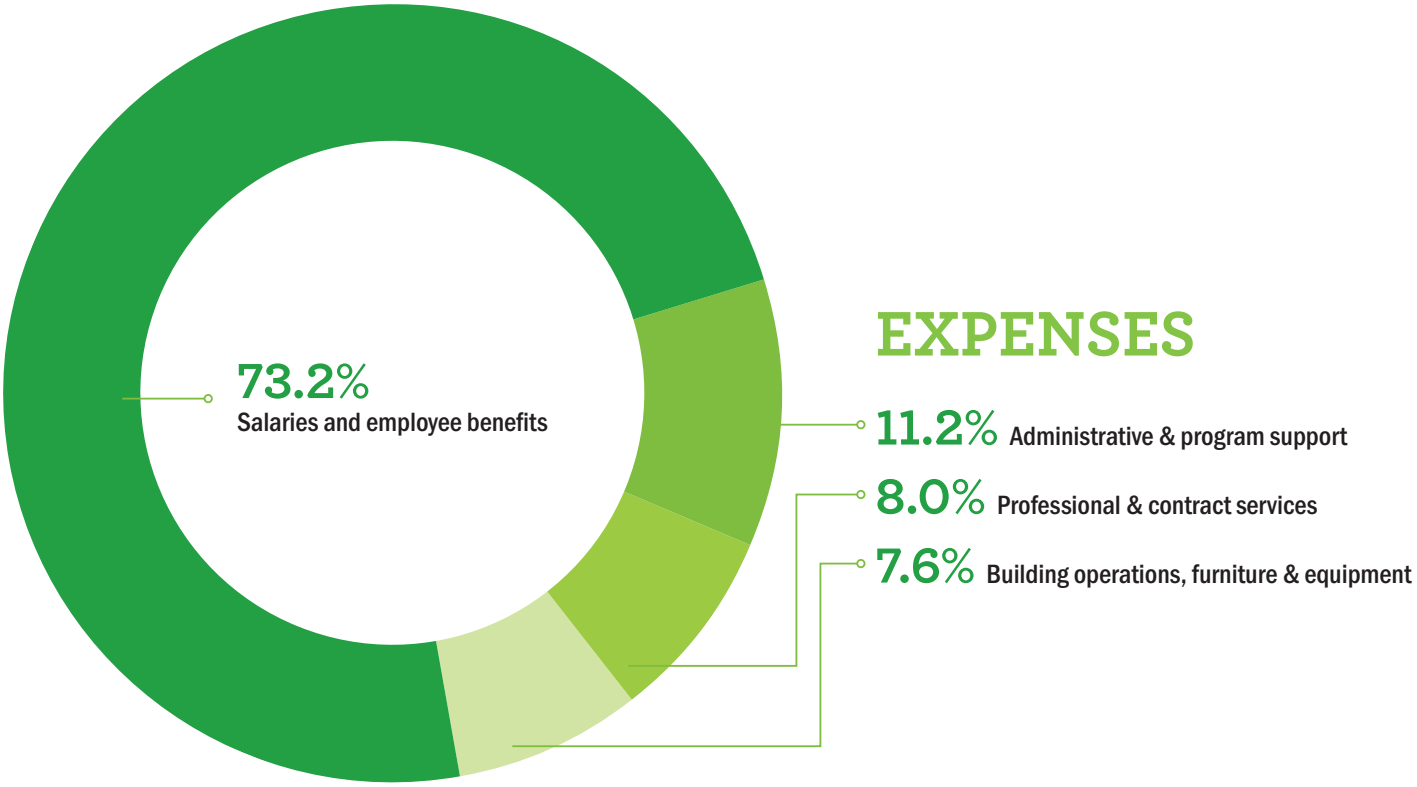
EXPENSES	**$15,216,356**		**$14,020,694**
Salaries and employee benefits	$11,138,782	**73.2%**	$10,447,382
Administrative & program support	1,704,487	**11.2%**	1,263,769
Professional & contract services	1,212,943	**8.0%**	1,392,886
Building operations, furniture & equipment	1,160,144	**7.6%**	916,657

These summarized statements have been extracted from the South Riverdale Community Health Centre's audited financial statements for the year ended March 31, 2020. A copy of the complete financial statements prepared by Management and audited by Deloitte LLP, Chartered Professional Accountants is available to any member of the public upon request.

REVENUE



EXPENSES



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Ontario
MINISTRY OF HEALTH

TORONTO

United Way
Greater Toronto

Ontario
MINISTRY FOR SENIORS AND ACCESSIBILITY

Public Health Agency of Canada

community food centres
CANADA good food is just the beginning

A BIG THANK YOU

to all of the companies and individuals that donated to clients and staff during the first wave of the COVID-19 Pandemic.

Devices

Bruce Telecom · QoC Health Patient Centered Innovation · ROGERS · TELUS · UNITED JEWISH PEOPLE'S ORDER

Cloth Masks

CATHY PARSONS · DEBORAH LIVINGSTON-LOWE · KIT HOLLINGWORTH · MICHAEL GARRON HOSPITAL · SARA COWAN · TORONTO BEACHES LIONS CLUB

Food for Clients / Staff

ASCARI · AVLING BREWERY · Domino's · flow alkaline spring water · GOOD FOOD ACCESS FUND · HILLSONG CHURCH · INTEGRICON Property Restoration and Construction Group Inc. · MAPLE LEAF · MLSE · ResQ · SECOND HARVEST FOOD RESCUE · Tim Hortons · VICTOR DRIES

Personal Hygiene Supplies & Toys

JUSTINA KLEIN · LOCAL COMMUNITY DONATION DRIVES · UNITED JEWISH PEOPLE'S ORDER

Personal Protective Equipment

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THANK YOU

to our volunteers who have contributed a total of

12,776 HOURS

to SRCHC.

Every year, we are honoured to have the time, talent and compassion of hundreds of volunteers. In many different ways, they assist us in improving the lives of people who face barriers to physical, mental, spiritual and social well-being.

Our volunteers serve in a number of capacities. The board of directors provides governance and policy oversight. Our seniors program volunteers are instrumental in helping to deliver quality recreational, educational and meal programs. Peer volunteers support programs through the delivery of educational workshops, trainings and outreach activities.

We hope our volunteers can continue to help us build on our strengths and be responsive to the needs and opportunities within our communities.

YOUR SUPPORT MAKES A DIFFERENCE!

We now accept credit card or debit donations online at www.canadahelps.org

Then follow these steps:

- Search "South Riverdale Community Health Centre."
- Select "Give in honour or memory of someone special."
- Next, either write the person's name and save, or choose "Continue with my donation."

If you have questions or wish to donate in person, please contact
Rose Shang, *Manager of Finance*, at 416-461-1925, ext. 221 or rshang@srchc.com.

CanadaHelps.org

EMPOWERED, HEALTHY, AND THRIVING COMMUNITIES WHERE EVERYONE BELONGS.

South Riverdale COMMUNITY HEALTH CENTRE

955 Queen Street East · Toronto, Ontario · M4M 3P3
1245 Danforth Avenue · Toronto, Ontario · M4J 5B5
2 Gower Street · East York, Ontario · M4B 1E2
2A The Market Place · East York, Ontario · M4C 5M1
134 Sherbourne Street · Toronto, Ontario · M5A 1S4
720 Bathurst Street · Toronto, Ontario· M5S 2R4

416.461.1925
srchc@srchc.com
srchc.ca

@ SRiverdaleCHC
South Riverdale Community Health Centre
@southriverdalechc