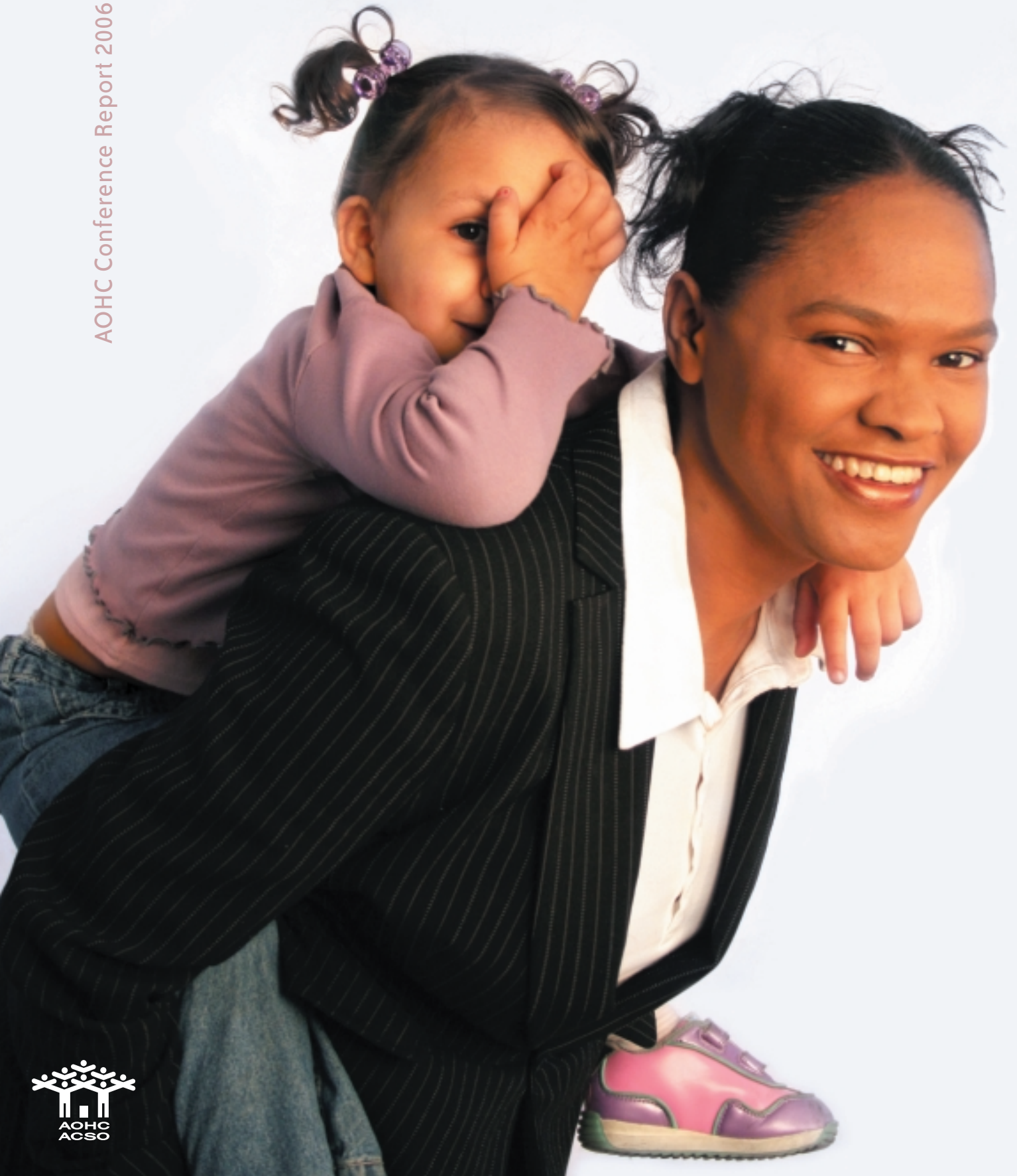


Taking Action

on the Social Determinants of Health

AOHC Conference Report 2006



Our Mission

THE AOHC PROVIDES LEADERSHIP FOR THE PROMOTION OF NON-PROFIT,
COMMUNITY-GOVERNED, MULTIDISCIPLINARY PRIMARY HEALTH CARE.

Vision

All Ontarians have access to non-profit, community-governed, multidisciplinary primary health care.

Beliefs

We accept the definition of health adopted by the World Health Organization (WHO):

“Health is the extent to which an individual or group is able, on one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacity.”

We believe that:

- Effective primary health care must address the determinants of health, including shelter, education, food, income, a stable eco-system, sustainable resources, social justice, equity and peace. It therefore encompasses primary care, illness prevention, health promotion, health education, community development, social action, building healthy public policy, and creating supportive environments.
- Community governance ensures that the health of a community is enhanced by providing leadership through effective partnerships of individuals and community and the staff of health centres. Community governance allows the skills, expertise, knowledge, and life experience of all partners to be shared to contribute to the health of their community.
- Multidisciplinary teams of health professionals are the most effective and efficient means for providing quality services in an appropriate manner. These multidisciplinary teams include physicians, nurse practitioners, nurses, dietitians, health promoters, counsellors and other staff and volunteers who contribute to the health of the community.

Values

As an association dedicated to its mission and vision, our actions are driven by these key values:

Advocacy – AOHC actively promotes community-governed multidisciplinary primary health care.

Accountability – AOHC is open, transparent and responsible to its members.

Equity – AOHC ensures that each member has the opportunity for equitable participation in the association.

Anti-discrimination (including anti-racism) – AOHC strives to identify and remove systemic barriers to full and equal participation in the association for the staff and volunteers of member centres and the staff of AOHC.

Diversity – AOHC engages the widest possible variety of views, backgrounds and abilities of its members to promote creative and effective programs, policy positions and decision-making.

French Language Services – AOHC values Canada’s francophone heritage and fully supports the efforts of francophone member-centres and emerging groups to protect and improve access to French language health and social services as guaranteed in Ontario’s French Language Services Act.

Collaboration – AOHC’s work is carried out in a spirit of cooperation and shared leadership among members and others who share the association’s vision.

Mentorship – AOHC staff and members support the association’s mission by providing counsel and assistance to other members, groups emerging as potential future members, and others who share the association’s vision.



Community-centred primary health care

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Taking Action

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To learn more about many of the presentations and awards from the AOHC 2006 Conference visit the Conference & AGM section at www.aohc.org

CHCs Medicare's Best Kept Secret

AOHC President, France Gélinas

From Diversity to Equity: Taking Action on the Social Determinants of Health, the AOHC Conference in Kingston this year, reminded us that we have a profound responsibility to address the root causes of illness for our clients, their families and our communities. We shared the many different ways Community Health Centres (CHC) and Aboriginal Health Access Centres (AHACs) address these issues.

We know that if one of us is ill, we are all ill; and that illness is often a symptom of larger malaise. We know that while illness manifests physically and mentally in the individual, it also extends outward into our families, our communities and the world. This means that the role of CHCs is much more than clinical care.

CHCs and AHACs constantly monitor the pulse of the whole community. Then they develop programs that tackle the underlying factors that cause health problems.

CHCs and AHACs encompass clinical primary care, illness prevention, health promotion, health education, community development and social action. They build healthy public policy and create supportive environments. In other words, CHCs address what Sir Michael Marmot calls the “causes of the causes” of poor health. Marmot, the renowned social scientist and chair of the WHO Commission on the Determinants of Health, says that the social determinants of health are the “cause” of many illnesses and diseases.

Through their programs, CHCs address this cause, including racism, heterosexism, ableism and all the oppressive “isms”; as well as the other health determinants, such as shelter, education, food, income, a stable eco-system, sustainable resources, social justice, equity and peace.

Dr. Rinaldo Walcott, the Canada Research Chair in Social Justice and Cultural Studies at University of Toronto, who opened our conference, reminded us that social inclusion and exclusion are the bedrock of the social determinants of health. He said that social injustice and inequity are negative marks on our collective identity and health as Canadians.

“By the time body parts have gone wrong, much larger dynamics are already at play,” he said, describing health as, “a set of complex social and cultural issues that reach far beyond bodies acting out of the ordinary.”

Dr. Walcott's view on healthy communities and citizenship, which set the tone for the conference, is that authentic community-based health means, “Redefining our very concept of citizenship as more than geography, language and identity.”



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If one of us is ill,
we are all ill

CHCs

Better Care, Healthy Communities

“Citizenship,” he said, “means taking responsibility for our communities and ourselves.”

That is why AHACs work with Aboriginal communities in ways that demonstrate respect, inclusion, accountability and equity.

Our CHCs value Canada’s francophone heritage and support the efforts of centres and emerging groups to protect and improve health and access to quality services in French, as guaranteed in Ontario’s French Language Services Act and Canada Official Languages Act.

CHCs and AHACs challenge oppression and are consistently identifying and removing barriers to full and equal participation of communities, clients, staff and volunteers.

They are changing the ways we provide services by developing cultural competencies in relation to Treaty and Aboriginal rights, French language services, heterosexism, homophobia and racialized and minoritized groups.

They engage the widest possible variety of views, backgrounds and abilities to promote creative and effective programs, policy positions and decision-making.

They carry out this work in a spirit of cooperation and shared leadership among clients and partner organizations who share AOHC values.

This report highlights the ways CHCs and AHACs embed the social determinants of health in all of their work. It illustrates how we address the diverse impacts of language, race, culture, age, sexual orientation, gender identity and other factors on population health.

I thank all who joined us in Kingston and I encourage all to read this report and see why the Globe and Mail has called CHCs “Medicare’s best kept secret”.

Adrianna Tetley
AOHC Executive Director

Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs) are unique and distinct. They are the only primary health care models that place the social determinants of health, community capacity building and local community governance at the core of their programs.

This report from our June 2006 conference shares our experiences and lessons, and shows how a number of Ontario CHCs and AHACs, communities, health care providers and policy makers are changing our health care system for the better.

Highlighting just a sample of the ways it is happening, the report places our experiences and practices right out there where they belong, in the public mind and within the reach of all Ontarians.

You will see how the CHC and AHAC focus on social determinants of health lets us tackle chronic diseases and inequity, breaks down barriers to health and health care and builds healthier communities and environments.

The province’s recent and unprecedented \$75 million funding announcement for CHCs will help us continue to grow by providing 49 more communities with access to primary health care and services under one roof. More doctors, nurses and other health professionals will be able to work together in teams, to provide a seamless array of services.



Dr. Rinaldo Walcott’s view on healthy communities and citizenship set the tone for the conference: “Authentic community-based health means expanding our concept of citizenship to encompass more than geography, language and identity.”

As the Honourable George Smitherman, Ontario Minister of Health and Long-Term Care has said, the investment will help communities to pull together and develop solutions to the issues in their communities. Stressing that one of his government's goals is to stop micro-managing health, Smitherman says: "We want to put real decision-making power where it belongs: in the communities... close to patients... close to real people."

And this is why the AOHC will continue to advocate for the maintenance of local community governance. Locally elected community boards build social capital, according to national and international research. This social capital, in turn, improves health outcomes and reduces health inequities. A growing body of evidence also shows that citizen participation in decision-making leads to more responsive, flexible and wider-ranging programs and services, especially for those who are particularly vulnerable. We also know that participation without capacity building isn't enough. Capacity building, at the very heart of the CHC model, means working together to solve community, organizational and individual challenges.

Read on and see CHCs and AHACs in action. And as Tommy Douglas, the founder of Medicare, said: "Let us not forget that the goal of Medicare must be to keep people well."

CHCs

Better Care, Healthy Communities



PHOTO PROVIDED BY AOHC

AOHC Executive Director Adrianna Tetley (left) and outgoing AOHC President Denise Brooks applaud the commitment of \$75 million in new funding to community health.

CHCs and AHACs directly address the causes of the causes of illness and disease because we are rooted in the social determinants of health; because community capacity building is at the core of our model of care; and, because we are locally governed and directly accountable to our communities.

of note

Dr. Monique Bégin, a former Minister of National Health and Welfare, is bold enough to say that Canadians spend too much on the proximate causes of disease and not enough tackling root causes. In 2005, Canadians spent \$142 billion on the former and too little addressing poverty, inadequate housing, inequality and other social causes of illness and hopelessness.

Taking Action on the Social Determinants of Health

French Language Services in Ontario

Even before implementation of Regulation 17 of the Education Act in 1912, social, cultural and policy-related factors had worked against the health and welfare of Ontario's Francophone minority populations.

Executive Director of the Centre de santé communautaire de Sudbury and incoming AOHC President, France Gélinas, says that for more than three generations, minority Franco-phones in Ontario have been subjected to patterns of oppression.

They have higher self-reported rates of certain chronic conditions, including asthma, bronchitis, and emphysema. They have higher than average rates of smoking and use of emergency services and significantly less frequent use of dental services. As well, sources like the Canadian Community Health Survey and census data shows that Ontario Francophones have lower levels of

literacy, education and income than the Canadian average.

This is not news to centres like the Montfort Hospital in Ottawa, Ontario's five Francophone CHCs and a handful of bilingual CHCs that have witnessed the impact of historical discrimination on health and community development on a daily basis.

An ongoing challenge is that the Ontario health system does not adequately collect and analyze data according to language group. Gélinas says that while Franco-phones still face significant challenges, the positive impact of French language health services and the right to education in the French language is beginning to reverse some of the historic inequities and injustices of the past.

"AOHC values our francophone heritage and supports the efforts

The Five Principles for Provision of Quality French Language Primary Health Care

Quality French language primary health care is the integrated application of five equally important principles:

- multidisciplinary/interdisciplinary salaried providers
- critical mass of French-speaking providers
- well-networked and connected in Francophone and broader communities
- French language community-governed
- French language community-driven

of centres and emerging groups to improve health and access to French language health and social services, as guaranteed in Ontario's French Language Services Act," says Gélinas.

"In taking root, we are challenging oppression and removing barriers to full and equal participation."

Francophones in Ontario have higher than average rates of smoking and higher self-reported rates of certain chronic conditions, including asthma, bronchitis, and emphysema.



Taking Action on the Social Determinants of Health

GLBTTQ: Gay, Lesbian, Bisexual, Transsexual, Two-Spirited and Questioning

Ernie Gibbs is a Mental Health Worker for GLBTTQ Youth at the Ottawa-based Centretown Community Health Centre. In his groundbreaking presentation to the AOHC conference, Gibbs demonstrated how the cumulative impact of GLBTTQ oppression has created the troubling realities for the health of GLBTTQ communities. Higher than average rates of suicide,



#ISTOCKPHOTO.COM/ARRAD_BENEDEK

Legalization of same-sex marriage, gradually dispelling pervasive myths, and increasing the cultural competence of health services to support individuals and families are key to the cultural competency work being pioneered in Ottawa with GLBTTQ communities.

depression and other mental health issues are the order of the day. Substance abuse, addictions and continued high rates of sexually transmitted infection such as HIV and hepatitis C are not uncommon.

Homophobia, biphobia and transphobia are pathologies of oppression and are unhappily part of the social fabric. Ottawa's Centretown CHC challenges oppressive pathologies that create stereotyping, type-casting, and discrimination – major determinants of health among GLBTTQ individuals and groups.

Though the challenges are significant, the Centretown CHC is making some important policy strides, Gibbs said. Being culturally competent creates appropriate behaviours, attitudes, policies and practices that enable community health and resource centres to provide the needed health services.

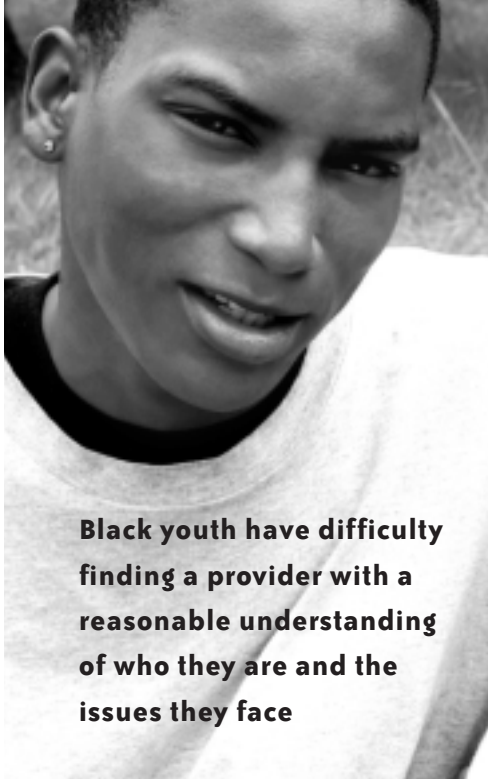
In developing cultural competence, Centretown has created safe, welcoming, and suitable support for gay, lesbian, bisexual, transgendered, two-spirited and questioning community members and their families.

The Ottawa-based project is now expanding to provide education and training of other health and resource centre staff by linking the core cultural competencies to organizational values. Centretown's GLBTTQ Cultural Competence Self-Assessment Tool addresses all levels of organizational operations, from governance to volunteers, assisting centres in determining what steps, if any, may be needed to work effectively and respectfully with GLBTTQ communities and individuals.

Q&A

Q. What is GLBTTQ?

A. GLBTTQ stands for Gay, Lesbian, Bisexual, Transsexual, Two-Spirited and Questioning. It is an acronym for a widely accepted identity framework that is an attempt to capture the spectrum of sexual orientations and gender identities that currently co-exist with exclusive heterosexuality in our communities. →



Black youth have difficulty finding a provider with a reasonable understanding of who they are and the issues they face

Beyond political correctness

Floydeen Charles-Fridal of the Toronto-based Black Health Alliance (BHA) placed the issue of cultural competency – and the need for culturally competent health services for racialized and marginalized populations in Ontario – front and centre at the conference.

Referring to the BHA’s successful campaign for a new community health centre in the east-Toronto community of Malvern, Charles-Fridal said that race, ethnicity and culture are major social determinants of health and access to health care in black, Caribbean, and African diaspora communities.

Challenging colleagues to move beyond “political correctness,” she cited a 2005 BHA research study that examined usage of health care services by black youth in Scarborough, Ontario.

“Black youth have difficulty, not only in finding services where physicians, nurses and other providers look and sound like them, but finding a provider with a reasonable understanding of who they are and the issues they face,” she said.

What’s needed is a set of cultural behaviours and attitudes that enable professionals to work in cross-cultural situations. What’s needed are positive, helping relationships with clients and improvements in the quality and up-take of services.

Applied appropriately, culturally competent practices address socio-cultural dynamics at two levels.

On the surface it means matching interventions and materials to observable characteristics of a target population. For example, services have a better chance of being received if audio-visual materials include people, places, language, music, food and clothing that are familiar to, and preferred by, the target populations.

Going deeper, cultural competency really means addressing socio-demographic, racial, and ethnic population differences, taking into account the interplay of cultural, environmental and historical factors that influence individual and group behaviours.

Relevant services and interventions must always be attuned to, and guided by, the deeper issues.

Culturally competent health care for racialized and marginalized communities must acknowledge the gaping demographic hole in Ontario’s health care system regarding black, Caribbean, and African diaspora communities. →

Q&A



Q. What’s the difference between Gay, Lesbian, Bisexual, Transsexual and Two-spirited?

A. The words Gay, Lesbian and Bisexual refer to issues of sexual orientation. They refer to the emotional, physical, romantic, sexual and/or spiritual attraction, desire or affection of one person for another.

Transsexual and ‘Two-spirited’ identity (in the Aboriginal tradition) refer to gender identity and a person’s sense of being male or female, neither, or both.

Q. What does “questioning,” mean?

A. The term Questioning communicates an individual’s sense of uncertainty or exploration of their sexual orientation, gender identity or both. Questioning affirms an individual’s right to explore the terrain of sexual and gender self-identification, free from judgment and discrimination.

Beyond political correctness



Charles-Fridal also stressed the need for services that are geared to priority health concerns, including elevated cardiovascular risk, the racial predominance of sickle cell anemia, disproportionately high rates of HIV infection, and a broad range of mental health issues related to race, culture and social exclusion.

These are typically not even on the radar of culturally incompetent health care service providers, she said.

The Black Health Alliance's work and effective advocacy are just part of the growing solution. Charles-Fridal cited the research and work of the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) as another example, as well as the expanding body of Canadian research on standards for the provision of services to diverse populations.

CULTURAL COMPETENCY

“In order to know where to go, you must know where you are.”

Floydeen Charles-Fridal

To value diversity and move beyond political correctness we need the capacity for cultural self-assessment. We must be conscious of cross-cultural interaction dynamics and know that we can become competent with practice. Here are some guides:

- 1 Be aware and sensitive to cultural and community differences.
- 2 Earnestly appreciate the contributions of individuals and groups, and the existence of diversity within racialized and marginalized groups themselves based on sexual orientation, nationalities, culture, and other identity traits.
- 3 Be willing to ask tough questions about where your organization stands and its existing limitations.
- 4 Recognize that where and by whom we deliver our services is just as important as the services we provide.
- 5 Practice a commitment to shared learning.
- 6 Engage your entire group, from reception to senior management and Boards of Directors, in the process of growth and evolution.
- 7 Attune and adapt services to the peoples you serve on an ongoing basis to reflect surface as well as the deep structures that affect each person.

Aboriginal community health now and then

The Courage to Heal

Using stories and images of Canada's residential school system, Anita Cameron painted a vivid picture of the ongoing struggles among Aboriginal populations. Cameron is Executive Director of the Wassay-Gezhig Na-Nahn-Dah-We-Igaming Health Access Centre, near Kenora.

Illustrating how political, cultural and social assimilation are at the core of oppressions that affect Canada's First Nations, Inuit and Métis populations, Cameron pointed to abundant research that documents the good health status of Aboriginal peoples in Canada prior to contact with European settlers.

At one time wholistic systems of health care connected mind, body, and spirit. Aboriginal peoples had balanced traditional diets. They were physically fit due to hunting and gathering, had a low prevalence of disease and used sophisticated traditional healing methods that included centuries-old natural medicines.

European contact, however, brought exposure to diseases like small pox and tuberculosis, killing entire bands and communities. New western foods increased the rate of diabetes and other illnesses.

Today Aboriginal populations suffer higher than average incarceration rates, lower education levels, lower standards of housing, sub-standard water in many communities, and a myriad of other environmental, social and economic obstacles.

Clearly, individual and community challenges in Aboriginal communities do not stem simply from poor socio-economic conditions but can be directly attributed to one of Canada's most shameful legacies — the residential school system.

Although Canada's shameful legacy remains, Cameron also painted a vivid picture of today's resiliency and hope. At the conclusion of her presentation she screened images of a gleeful, carefree young girl celebrating her birthday, summer vacation and other special occasions.



PHOTO PROVIDED BY ANITA CAMERON

Like countless young Aboriginal children across the country, this young girl is the first in many, many generations to be raised within her natural family.



PHOTO PROVIDED BY ANITA CAMERON

Individual and community challenges in Aboriginal communities can be directly attributed to one of Canada's most shameful legacies — the residential school system.





The Courage to Heal

“These are images of my colleague Cheryl’s daughter,” Cameron said.

“This young girl, like countless young Aboriginal children across the country at this very moment, is the first in many, many generations to be raised within her natural family.”

“Aboriginal people wish to move beyond blame to assume responsibility for breaking the inter-generational cycle of violence, poverty, and illness. It has taken over 500 years to get our communities to this state, but it will not take us 500 years to regain balance and health.”

“Many Aboriginal people are reclaiming their identity by practicing traditional methods that help the healing journey. We are finding the balance between modern and traditional practices to overcome the effects of colonization. We are moving towards a healthier tomorrow.”



PHOTO PROVIDED BY ANITA CAMERON

Epic Award Winners

The hallmark of CHCs and AHACs is program diversity and flexibility, customized to meet the needs of people and their communities. The annual EPIC Awards of the Association of Ontario Health Centres recognize innovative programs and activities, developed by staff, volunteers and partners. The following are the 2006 winners in the Programs & Services and Community Development categories.

PROGRAMS & SERVICES CATEGORY

SexAbility

**Anne Johnston Health Station (Toronto)
Planned Parenthood of Toronto**

SexAbility is a volunteer-based program that addresses gaps in healthy sexuality information, resources, and services for youth and young adults with mobility disabilities living in the City of Toronto.

SAGE (Seniors Achieving Greater Esteem)

Anne Johnston Health Station (Toronto)

SAGE targets physically frail, cognitively impaired seniors. Incorporating health promotion, disease prevention and community well-being, it provides client-centered care based on the principles of accessibility, self-determination, independent living and respect for diversity.

Food Access Programs

Guelph CHC

Since its inception in 1998 the *Garden Fresh Box* program provides high quality, nutritious, reasonably priced, fresh produce, based on locality of growers, seasonality, quality, variety and price. The non-profit, community-based fresh fruit and vegetable distribution system fulfills 350 orders a month.



©ISTOCKPHOTO.COM/GRAEME GILMOUR

The Garden Fresh Box program provides high quality, nutritious, reasonably priced, fresh produce.

lesbian, bisexual, transgender (GLBT) individuals and families. It helps assess governance, administration, personnel policies and procedures, service planning and delivery and the physical environment. Centretown CHC has provided basic GLBT training in Ottawa, Toronto and Hamilton with support materials that include a poster, videos and brochures, sample human resource policies, screening questions for interview guides, performance review questions, and other communication tools.

Club Ped

Sandwich CHC (Windsor)

Club Ped is a multidisciplinary program for people with diabetes. Besides walking together twice a week and socializing, participants have staff support for nutrition and exercise. A monthly aquafit class is held at a hydrotherapy pool located in a nearby rehabilitation hospital.



©ISTOCKPHOTO.COM/FRANCES TWITTY

Buy Local! Buy Fresh! Map

Guelph CHC

The Buy Local! Buy Fresh! Map connects families to farmers. The freely distributed edition of the 2005 map highlights locally produced food in Wellington County. Connecting the Health Centre with local farmers and farmer's markets, the Wellington-Waterloo Community Futures Development Corporation and county municipalities, it incorporates farm fieldtrips for preschoolers.

Rural Family Program

Gateway CHC (Tweed)

The Rural Family Program in Tweed is designed by the community for young families at risk due to isolation, lack of transportation, low income, high unemployment, underemployment, limited access to telephone (no pay-phones or cell phone reception), no banking facilities and no local food bank. The program includes early childhood development, immunization, well baby follow up and food security.

GLBT Cultural Competency Project

Centretown CHC (Ottawa)

The GLBT Cultural Competency Project is an organizational tool for health and resource centres that care for gay,

COMMUNITY DEVELOPMENT CATEGORY

Give Yourself Credit

Guelph CHC

Give Yourself Credit is a program for street involved and vulnerable youth. It offers access to educational opportunities delivered in diverse and creative ways. In breaking down the barriers to education, it enhances learning and assists in breaking the cycle of poverty and homelessness with training in life skills, and mental and emotional health.

From Community Engagement to **Community Governance**

Over the past decade, researchers and health system experts have agreed. Investment and community governance in primary health care build effective and sustainable health systems. What those services should look like and how to realize their full potential is the next challenge.

A look at the way CHCs and AHACs are already doing it in Ontario is the perfect departure point. Peter McKenna is the Executive Director of the Merrickville CHC. Athens, a neighbouring town, is just 30 kilometers down the road. In the late 1970s each town faced a critical health services shortage. Each established a non-profit corporation and undertook aggressive fundraising campaigns. Each campaigned to attract physicians and nurses. That's where the similarities end.

Athens retained its three physicians who established a health service organization (HSO). Merrickville established a Community Health Centre, which opened its doors in 1984 as Ontario's first rural CHC. Over time, Merrickville's community-governed board expanded services far beyond traditional clinical services to include dietitians, physiotherapists and others. With roots in the community, the board also established breakfast groups at the schools, farmer's health programs and many other health promotion activities, kept the local bank from closing its doors and has now ventured into housing.

When Merrickville received the welcome news that it was going to receive a CHC, the town's only financial institution, the Royal Bank of Canada, was weeks away from permanently closing its doors. The new CHC's board of directors gave RBC exclusive rights to the centre's financial management and Royal Bank officials agreed to maintain the branch, thereby averting the sort of decline often precipitated in rural



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The Merrickville example shows that the community engagement road leads to responsive and innovative programs, grounded firmly in the social determinants of health

areas by the loss of a major institution such as a bank.

The CHC spirit of community engagement is contagious.

Merrickville has an aging population. Many couples want to down-size their residences without moving out of town, away from family and neighbours. The CHC's solution to an absence of appropriate housing of this sort in Merrickville was to create a nonprofit corporation, the Trillium group, to develop a multi-million dollar alternative housing development geared to the specific needs and desires of the

downsizers. In this way, Merrickville can remain a thriving and enduring community.

And the beat goes on. Today Merrickville is discussing its priorities and needs with the new LHIN and is mentoring neighbouring Smiths Falls in its bid for a new CHC.

The small town way of supporting neighbours and the community also happens to be the CHC way. According to a recently commissioned AOHC review of trends and benefits of community engagement and local community governance in healthcare, the journey from 'engagement' to 'governance' is healthy.

The United Way's 2006 Strong Neighbourhoods Report states that, when they are involved in planning for their own healthcare needs and resources, communities create strong, vibrant, relevant healthcare organizations with a history of long-term sustainability.

A New Zealand-based study says that the major difference between community-governed non-profit and for-profit primary care practices lies in their ownership and governance arrangements.

Community governed non-profits enhance health equity because they are more likely to have high-quality management policies and to carry out local service planning and community needs assessments.

"They are also found to have policies and practices in place that reduce financial and cultural barriers to access of services," AOHC Executive Director Adrianna Tetley says.

Tetley says the community engagement road starts with information and consultation, moves on to involvement and collaboration, through partnerships and delegated authority, to autonomy and empowerment.

"At this highest level, community engagement respects and is guided by community and neighbourhood dynamics," she says.

At its most mature stage, community engagement respects expertise *and* transfers decision-making power. The burden shifts from the shoulders of politicians, government administrators and health professionals alone to the local community as a whole.

According to the the United Way's 2006 Strong Neighbourhoods Report, when communities are involved in planning for their own healthcare needs and resources, they create strong, vibrant, relevant healthcare organizations with a history of long-term sustainability.

The evidence shows that such a balance in decision making creates new energies. It leads to responsible, flexible programs and services and is key to long-term sustainability. Ensuring accountability, it provides a sense of ownership, builds community capacity and leads to broad development of partnerships. Overall service integration also saves money by decreasing avoidable pressure on health services and reducing unnecessary duplication of services.

As Merrickville shows, the community governance road leads to responsive and innovative programs, grounded firmly in the social determinants of health. CHC and AHAC Boards of Directors all over the province are on this road today, moving beyond the usual "front row" of those who are actively involved in community, health and social issues to those who have not always had a fair chance to participate.

"Although expertise is important for the journey, CHC and AHAC board members must first and foremost understand and believe in the CHC model; they must have a passion and commitment to the philosophy and be aligned with the values of their organizations," says Tetley.

Community health care in action

“The Health Quality Council’s report this year listed just a few examples of the role CHCs are playing in improving access to care in Ontario. The fact is we could have probably put in sixty.”

Ray Hession – Chair, Ontario Health Quality Council
AOHC Conference Presentation, June 8, 2006

From Resistance to Celebration: A Home Grown Solution to Address Change in the Community

SOUTH RIVERDALE CHC

Jason Altenburg – Urban Health Manager
Raffi Balian – Harm Reduction Project Coordinator
Leah Palmer – Social Worker/Case Coordinator
Lynne Raskin – Executive Director
Pat Wilson – Nurse Practitioner

Since it opened its doors in 1976 South Riverdale CHC has been forced to constantly reinvent itself, its organizational culture and range of services. The centre has rebounded from decreased welfare rates, increasingly restrictive immigration laws, threats to Public Health care accessibility, inadequate housing and shrinking social resources.

Though experts say that organizational change occurs over three to five years, South Riverdale’s experience shows that change is perpetual. Organizations can rise to that reality as long as there is organizational commitment to doing so. Work that South Riverdale CHC has undertaken in this regard has brought the centre face to face with its internal and external challenges, and has demonstrated how we learn from one another as we embrace change. Take this simple declaration of human rights, for example: “I am a human being too.”

The statement was an unscripted showstopper, ringing out from the video monitor during a low-budget documentary screened at this AOHC conference workshop. The face and voice behind the message was a that of a self-described drug addict, speaking out on behalf of a growing community of people in the South Riverdale area, in east Toronto. Even in the compassionate community health centre movement, his people are at risk of being spurned.

Responsiveness to drug use is one of several examples of how South Riverdale CHC has adapted over time to the changing dynamics. “When I first came to the centre,” noted Raffi Balian, “many people

CHCs and AHACs are working every day to break down barriers to health care and support communities across the province. In example after example, throughout the course of AOHC’s 2006 Conference, we demonstrated how we are tackling the underlying causes of illness and building bridges between high quality health care and community supports. These conference workshop reports show how we are making sure that services adapt to rapidly changing rural, urban, and suburban social dynamics. CHCs have been Medicare’s Best Kept Secret. These stories shout it from Ontario’s rooftops.

told me there were no drug users in the community. There was little understanding of harm reduction and I was told that drug addicts were not allowed to come to the centre.” South Riverdale CHC subsequently convened a Community Advisory Committee made up of drug users and health professionals who work with drug users. They discovered quickly that, indeed, drug use was a growing area of concern within the community and that significant barriers existed to coordinating outreach and care for individuals with addictions, including drug users. Within a year the centre had initiated a harm reduction program that has since grown tremendously in scope and reach.

South Riverdale’s clientele is now very diverse and includes the street-involved, the homeless, drug users, sex trade workers, immigrants and refugees, the working poor, as well as the more well-heeled of south east Toronto.

As more Ontarians move toward a more equitable, integrated and responsive provincial health care system, South Riverdale’s success is forging the creation of a common, if shifting, understanding of the real meaning of quality primary health care based on an organizational commitment to adapting to change over time. Among their many lessons, staff from the centre all cited the critical role of the centre’s Board of Directors in helping to drive and support responses to perpetual change.

Innovative Ideas to Overcome Isolation

Jan Inguanez – Registered Dietitian, Woolwich CHC
Nancy Martin – Social Worker, Anne Johnston Health Station CHC

For generations, Low German-speaking Mennonites (LGSM) have lived isolated lives in Canada because of their strong faith in educational freedom, including the right to refuse military service.

Today they are overcoming a tragic cycle of low birth weight infants, through community health initiatives like *Gesundheit Fur Kinder* prenatal and well child program.

Woolwich Township and Wellesley Township Mennonites now have group programs and home visits with Family Support Workers, who offer services in partnership with Woolwich Family Services and by trained peer workers and culturally competent health professionals.

Jointly sponsored by the Public Health Agency of Canada (CPNP) and Woolwich Community Health Centre, the empowering change that has taken place through this program has been brought about by the community itself.

The ancestors of these German-speaking Mennonites immigrated to Western Canada from Eastern Europe in search of religious freedom, beginning in 1874. Just after the first World War, the community purchased 155,000 acres of land in the state of Chihuahua, Mexico and between 1920 and 1922 over 6,000 Mennonites left Western Canada for Mexico.

Families who chose to stay, or who are moving back to Canada, have paid dearly. Being monolingual, with low incomes, isolated, and with



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South Riverdale’s clientele is very diverse and includes the street-involved, the homeless, drug users, sex trade workers, immigrants and refugees, the working poor, as well as the more well-heeled of south east Toronto.

very large, closely spaced families, they have survived with little basic knowledge about health and nutrition. The *Gesundheit Fur Kinder* prenatal and well child program began with a request from a Woolwich community partner for primary care services to serve the LGSM.

This led to Clinic Days for immunizations, prenatal care and well baby checks. Eventually some health and nutrition education became possible through funding received under *Canada’s Prenatal Nutrition Program* in 1995. During this period and a 10-week leadership training course provided for Peer Nutrition Workers, trust began to grow and differences began to melt away.

Progress has been gentle.

In the first years of the program, women were invited to one session a month at a prenatal and postnatal group and the process was appointment driven. The supportive environment, with the availability of child care and transportation, has helped it grow to include affordable midwifery, breastfeeding and well baby support, access to early language skills and school readiness support, and vouchers for vitamins, infant cereal and food.

Mindful community engagement is the key – built on the knowledge and confidence brought by emerging community leaders through the recruitment and training of Peer Nutrition Workers. The process has broken through generations of isolation.

Support for LGSM families has been significantly expanded from children’s services to a *Father’s Workplace Literacy Program* and cooking skill opportunities for over 60 families.

In a second portion of this workshop, staff from the Anne Johnston Health Station CHC in Toronto described the *Seniors Cyber Group*, a partnership with Baycrest Geriatric Hospital in which severely

isolated seniors participate in a weekly support group via internet, utilizing head phones and web cameras.

Participants in this program are provided with the equipment and are trained on the computer in order to access the Baycrest Geriatric Hospital Web Site which hosts the support group. An experienced therapist and group counsellor from the Anne Johnston Health Station facilitate the weekly cyber-meetings. The *Seniors Cyber Group* is breaking down isolation for seniors who do not often leave home due to disability, phobias, bad weather, and other factors. In making strong connections with each other, participants are enhancing their overall network of support. The project is linked to the CHC's broader *Seniors Home Health Program* through which other frail, isolated seniors are accessing primary health care in their own homes, creating a rich continuity of care, support and learning.

Reducing Client Poverty: Linking Upstream and Downstream Advocacy

Kathy Hardill – Nurse Practitioner, Regent Park CHC
Melissa Melnitzer – Family Physician, Parkdale CHC
Denis Michel – Social Worker, Regent Park CHC
Deb Phelps – Health Promoter, Central Toronto CHCs

Even if she manages to raise her socio-economic status, a child living in poverty will carry an increased risk of heart disease with her for the rest of her life. That's why CHCs are prescribing hunger clinics with special diet allowances to low-income people. Parkdale CHC, Central Toronto CHCs and Regent Park CHC are located in diverse inner city neighbourhoods in Toronto, where poverty and homelessness are major factors determining health. The three CHCs are proving the clinics to be a high-impact, preventive intervention for thousands.

In the face of multiple challenges, the three centres practice what they call "upstream" and "downstream" strategies, as well as individual and systemic advocacy.

For example, the program *Health Providers Against Poverty (HPAP)* is a coalition of physicians, nurse practitioners and other providers who combine health interventions with assisting clients to qualify for ODSP (Ontario Disability Support Program) benefits.

Since 2005, HPAP has used this and other kinds of direct action political strategies like *Raise the Rates: Special Diet Campaign* to address inadequate social assistance. The concept has managed to attract the positive attention of academics, other health care providers, lawyers, professional associations, and various levels of government. Its growing support network now includes the Association of Local Public Health Agencies (alPHA), Registered Nurses Association of Ontario (RNAO), City of Toronto Board of Health and Ontario Medical Association Section of CHC/AHAC Physicians.

The City of Toronto has also gotten on board with recommendations for a 40 percent increase in social assistance rates and a comprehen-

The *Seniors Cyber Group* is making a major impact in breaking down isolation for seniors who do not often leave their homes due to disability, phobias, bad weather, and other factors. Participants are making strong connections with each other, enhancing their overall network of support.

sive document called *Continuing Erosion of Ontario Work Benefit Rates*.

Perfectly adaptable in other communities, the HPAP model has spawned active contingents in Sudbury, Belleville and several remote areas.

Building Inclusive Community Organizations

Matthew Garrison – Human Resources Director, Sandy Hill CHC
Kara Symbolic – Community Animator Eastern Ontario, Ontario Healthy Communities Coalition
Lisa Tolentino – Diversity Coordinator, Ontario Healthy Communities Coalition

Mathew Garrison is straightforward about how Sandy Hill Community Health Centre made itself an equitable, accepting and welcoming environment for staff, clients and the community. He knows how it came to recognize, encourage and share diverse opinions, values and uniqueness.

"We strive to deliver appropriate services and we do not tolerate any form of prejudice," he told workshop participants.

He also has five bits of good advice to those embarking on similar journeys.

"Start thinking about it; raise the issue through information and education; determine the right time; anchor the goal in other areas and activities; establish a framework for implementation and evaluation; and, celebrate progress!"

Ideas that worked at Sandy Hill CHC include revising the vision statement to include diversity and ensuring that agencies representing diverse groups were included in the strategic planning consultation process.

In terms of the Board of Directors, Sandy Hill CHC actively recruits members from identified diverse populations and includes diversity training as part of its Board orientation.

"The Board has to know the importance of immediately developing diversity policies and practices," Garrison says, "with a policy to monitor and evaluate progress in the area of diversity."

At Sandy Hill CHC, Board development always includes issues related to its diversity vision.

This kind of leadership, in turn, has led to a mandatory diversity training program for staff, management and Board members, a diversity workplan in conjunction with a standing diversity committee and a Centre profile that includes demographics and other relevant data to better serve and consult a wide variety of population groups.

The centre's comprehensive list of organizations, agencies and other contacts that are representative of the community at large is an ongoing resource to all staff in the delivery of services and programs, and in development of community partnerships.

We Are Not All Equal: Providing Effective Health Care Services for Black Women and Women of Colour

WOMEN'S HEALTH IN WOMEN'S HANDS CHC

Linda Cornwell – Community Health Promoter

Esther Wangari Tharao – Community Health Promoter

Mercedes Umaña – Therapist

Breast cancer, prostate cancer, diabetes, hypertension, sickle cell anemia and HIV/AIDS are more prevalent among blacks in Canada and other wealthier countries than the average population. In Canada, the reality is witnessed daily in practice at centres like Women's Health and Women's Hands CHC.

The Toronto-based CHC provides primary health care and support to women of African, Caribbean, Latin American and South Asian backgrounds from across the Greater Toronto Area. Though Canada does not yet collect statistics by race specifically, the incidence and prevalence of disease among racialized groups shows up in research of academics and community groups, as well as in public data from other countries such as the United States and the United Kingdom.

For women, health is often linked to a host of other social and economic pressures including gender-related oppression and abuse, the strains of child care in a new country and obligations to family in a country of origin.

Since systemic racism has an impact on the community at large, workshop presenters described how all health services must strive to provide inclusive and effective health care and support programs that incorporate diverse cultural values, beliefs, norms and practices.

Women's Health in Women's Hands CHC advocates for acknowledgement that health is affected by genetics, socioeconomic status, lifestyle habits, and environmental influences that include racism, sexism, homophobia and other oppressions.

We Are Not All Equal also challenges inappropriate or inaccessible health care systems and the enduring impact of traumas experienced by individuals who are immigrants to Canada and/or who experience oppression due to race, culture, ethnicity and other factors.

HOW ALL SERVICE PROVIDERS AND ORGANIZATIONS CAN CHANGE

- Validate the client as a racial individual living in a society shaped by social and systemic racism. This means eliminating the "I don't see colour, I just see people" mentality which denies identities, attributes and stories.
- Allow individuals space to voice their pain, anger and frustration with the lack of support and silence from various communities and institutions.
- Confront and challenge socially constructed myths and images of race, and in the case of black women and women of colour, myths of hyper-sexuality, aggressiveness and mothering tendencies.
- Incorporate the affirming message into health care and health promotion that hardship and struggle are not inevitable.
- Replace the immobilized victim stereotype with notions of 'resistance' and 'agency'. Highlight narratives of resistance into the stories of clients and build their capacity to act as their own advocates.

The Early Years Program: Interdisciplinary Teams, Partnerships and Capacity Building

Debra Lee – Registered Nurse, Four Villages CHC

Sonja Nerad – Community Program Manager, Access Alliance Multicultural CHC

Soheila Pashang – Social Worker, Four Villages CHC

Sulana Perelman – Dietitian, Four Villages CHC

Thuy Tran – Health Promoter, Access Alliance Multicultural CHC

To be cut off from family, friends, and culture is bad enough. What is even worse is when isolation is compounded with the burdens of poverty, status, newcomer and settlement issues, racism, discrimination, mental health, addiction or development challenges.

The Four Villages CHC and Access Alliance Multicultural CHC offer a number of outreach and delivery models, but the most successful are proving to be a couple of innovative early years care and support programs for families.

The Toronto-based *Interdisciplinary Home Visits (IHV)* program places children first. Part of an *Early Years 2 Program*, it is delivered by an interdisciplinary team of social workers, community health workers, a nurse and a dietitian.

Co-ordinated in partnership between Four Villages CHC, the Davenport Perth Neighbourhood Centre and Parkdale CHC, the benefits of addressing the overall primary health of entire families are becoming evident. Besides time savings, client comfort and trust, the home visits open the possibility of addressing other physical, nutritional and socio-economic needs of

isolated families. Sharing the cost of interpretation services is just one tangible example of the added benefits of partnership.

Intangibles, like trust, are another. Trust is earned over time and the child-focused approach enables the team to provide referrals for additional support where necessary. The team, in turn, benefits from improvements to their own time management capacity, safety and comfort.

A second groundbreaking program, delivered by the Access Alliance Multicultural CHC, is the *Newcomer Women Peer Intervention Program (NWPIP)*, which recruits and trains recent immigrant and refugee women to reach out, in their own language, to other women with young families.

In familiar settings, the new peer workers have ample capacity to not only identify concerns and needs, but to link women to appropriate care and support services. By identifying priority neighbourhoods using the latest City of Toronto data, and by building partnerships with local services for immigrant women that complement the CHC-based programs and services, the program is gradually building relationships that are moving through the barriers of urban isolation.

Increasing Inclusiveness of Services Through Value Based Practice

Leslie McDiarmid – Manager, Community Services/Early Years, South-East Ottawa Centre for a Healthy Community (CHC)

Building on strength, not weakness, being mindful of the power of language, fostering relationships and respecting boundaries are at the heart of the inclusive service model at the South East Ottawa CHC, where all people, ideas and participation are tops.

The concept of value based practice has been distilled from the centre's *Better Beginnings Better Futures* experience, says Leslie McDiarmid, who manages the *Community Services/ Early Years* program. "Non-compliant," "at-risk populations" and "vulnerable families" are just some of the stigmatizing leftovers from the old client-centered model.

Even finger pointing posters like "don't drink and drive" are under the Ottawa CHC's social microscope, where the talk has shifted from "targeted" to "focused" programming. Focused programming is for anyone who wants it. Targeted programming is a relic being replaced by more empowering, people-centered visions. It is now understood to be exclusive to groups or individuals deemed deficient in some way or other.

Shifting power relationships that favour interdependence and shared responsibility over the loneliness of independence or the weakening of dependence requires more than such mindfulness of language.

Context also creates or minimizes power. Anyone who has ever done

time in a cold waiting room knows that space can make people feel well or ill, better or worse.

Simple common wisdom tells us that real decision makers are those who are most effected by, and know most about, whatever is the issue at hand.

By acknowledging exclusionary power relations and working to change them, thankfully South East Ottawa CHC is in the lead.

Serving-Up Health in Non-Traditional Settings: Healthy Child Screening Strategies

Sandra Almeida – Early Years 2 Program, Davenport-Perth/ Parkdale/Four Villages CHCs
Cliff Ledwos – Program Director, Davenport-Perth Neighbourhood Centre
Falko Schroeder – Nurse Practitioner, Parkdale CHC

Since the comfort level of clients is paramount, holistic care and support provided in school settings, daycares, and faith-based centres is often more conducive to healing and health promotion than the typical health centre or doctor's office. Operating since 2003 under the umbrella of Queen Victoria Partners for Early Learning in Toronto, the Four Villages CHC, Davenport Perth Neighborhood Centre, and Parkdale CHC have partnered in *Healthy Child Screening Strategies*, a program geared toward isolated, marginalized, newcomer and disenfranchised families for whom clinical settings represent access barriers.

Sessions include screening of an average of 30 children. About three to five children in each screening session to date have been identified as in urgent need of care. The screenings work because they reach well beyond the physical health of the youngsters to address the cluster of related issues that affect their daily lives and that of their families — speech and language, nutrition, vision, dental, hearing, socio-emotional-behaviour and settlement.

The program ensures that timely referrals for assessment outside the scope of the team's professionals also happen in comforting settings and in a seamless fashion.

A variety of other learnings have emerged from the screenings including ways to engage schools, daycares and other early years settings in the process; how to better involve primary care practitioners for families already connected to primary care; how to engage specialists in private practice for follow-up needs, including working with families without OHIP access; how to ensure translation services; and best practices for overall logistical coordination. Manuals have been developed by the program to outline site-specific examples, as well as a general manual that includes guidance on establishing similar programs including budgets and sample forms.



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Breaking Down Barriers: Integrated Service Delivery for Individuals and Families Without Legal Status

Cliff Ledwos – Program Director, Davenport-Perth Neighbourhood Centre
Eugenia Messner – Counselor, Davenport-Perth Neighbourhood Centre

People without legal status are exceedingly vulnerable to exploitation and abuse. Based in the west end of downtown Toronto, the Davenport Perth Neighbourhood Centre (DPNC) is improving the well-being of non-insured and undocumented individuals. Its *Newcomer Action Committee (NAC)* links and integrates Settlement Services with other DPNC services. In supporting people without status, it provides education for its staff, its board and its community. DPNC also maintains links with other city-wide networks and coalitions addressing the issues.

By reducing stigma, debunking destructive myths and creating more open and accepting climates in which undocumented individuals can achieve the support and dignity they deserve, DPNC provides the necessary support for integration into Canadian society and settlement. It is also making a great contribution to Toronto's overall public health.

DPNC's innovations include primary care and counseling services and peer support and leadership development. All cut across many peer groups and focus on support for women, men and youth. The following are a few specific examples:

Ready for School/Success by Six

School readiness and parent support programming for newcomer/undocumented families.

Dedicated Settlement Services

Resources to address complex settlement issues, with United Way support.

Primary Care

Dedicated resources for primary care and counseling services to individuals without status.

Immigration Course

Eight week instruction on immigration policy and advocacy strategies specific to people without status.

Organizational Change to Enhance Rural Health Services

Kathy Bresett – Program Director, North Lambton CHC
Bill Davidson – Executive Director, Langs Farm Village Association CHC
Denise Squire – Executive Director, Woolwich CHC

While quality primary health care acknowledges community economic, political and cultural diversity it also means incorporating lessons learned in daily practice and adapting to changing social dynamics. Often, this requires the courage to change organizational structures, services and connections to groups in the community. Easier said than done, of course.

Organizational change can lead to new relationships and processes. These technicalities of growth sometimes disturb existing relationships. Confused, individuals may question the vision and mission of which they are part and may need reassurance.

Staff from Langs Farm Village Association CHC, Woolwich CHC, and North Lambton CHC made these challenges abundantly clear in their conference workshop on organizational change in the rural context.

For each of these southwestern Ontario CHCs the changes were accelerated by the opening of satellite centres in communities located outside of their original catchment areas.

The opening of Satellite CHCs required simultaneous adjustments to organizational management and planning as well as to the realities and needs of the new communities.

All agreed that taking time to build an inclusive governance relationship with the new communities increased the profile of the CHC, and helped to achieve buy-in and support. But they also said that the transition hurts.

Effective organizational change means shaping a common understanding of the desired destination and agreement on how to get there, and it's not as easy as it sounds. CHC staff and Boards need support through transition.

For North Lambton CHC, which opened a satellite site at Kettle Point, it took training staff around Aboriginal culture, developing new cultural competencies, leasing space on First Nation Territory, re-tuning the centre's governance structure, and determining how to appropriately rotate staff between the main centre at Forest and the satellite site at Kettle Point.

Staff noted that greater effort is required to coordinate health promo-

tion programs with existing First Nations programs and to educate volunteers on the CHC's overall vision. The work continues.

Woolwich CHC, which has served part of the adjacent rural Township of Wellesley for more than a decade, also had to adapt its governance structure and community relationships when it established a new Satellite centre there.

Langs Farm Village Association CHC highlighted the need to clearly define, in advance, the reciprocal relationship between the main centre and the Satellite centre to avert potential tensions and optimize services.

The upside for all in the growing community health movement is the new relationships that are forming. In extending old ones and adding new ones, CHCs are keeping community outreach upfront. It is intense, and ongoing. And, in the process, service providers are not only looking at the community; they are looking at themselves as well.

Children Breathe Easy: Improving Air Quality in School Environments

Maria Miller – Chair, Indoor Air Quality Workgroup
Anne Phillips – Environmental Health Promoter/Researcher, South Riverdale CHC

Improving indoor air quality in local schools is another important health promotion goal for the South Riverdale CHC in east Toronto. Workshop presenters described how community concern over poor air quality in one local school led to development of a powerful coalition that has not only addressed the local problem, but has developed tools and resources to help other jurisdictions and community groups do the same.

At Blake/EAST School in east Toronto, poor indoor air was affecting the performance and health of both children and school workers. Blake/EAST is one of numerous sealed schools built in the 1970s that was designed with energy conservation in mind. However, while meant to be energy efficient, sealed schools pose a long list of challenges related to indoor air quality including a lack of windows that open, classrooms that have worn carpeting and which may not have been changed in 30 years, deteriorating ventilation systems and ductwork, and poor yearly maintenance of heaters, air conditioners and ventilation systems due to educational cutbacks.

In early 2002, a group of parents voiced concerns to their local School Trustee about this air quality problem. In response to an appeal from the Trustee to local support agencies, the South Riverdale CHC moved into action along with parents and a number of local groups including the Indoor Air Quality Work Group (IAQWG) and the Ontario Healthy Communities Coalition (OHCC). Teachers, the school principal, School Board facilities staff, the superintendent of schools and the CUPE Health and Safety representative quickly formed the Blake/EAST Indoor Air Quality Group.



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At Blake/EAST School in east Toronto, poor indoor air was affecting the performance and health of both children and school workers.

The coalition asked the Toronto District School Board (TDSB) to test carpet samples for mould and bacteria and the group conducted a walkthrough of the school using a checklist, which allowed them to identify some specific issues such as inadequate air circulation, variations in air quality from room to room, and air filters that needed cleaning.

As a result, a number of health hazards were immediately dealt with. Air filters were changed, and the default settings on the heating and ventilation system were adjusted to increase the percentage of fresh air coming in. The group also recommended that other issues be addressed: replacing all carpeting, investing in windows that open and conducting a review of the types of cleaning chemicals used at Blake/EAST and all other TDSB schools to ensure that they have the least possible negative impact.

The Blake/EAST Indoor Air Quality Group has continued to tackle these issues, and has succeeded in getting agreement from the TDSB to investigate air quality issues at other schools in the Toronto area.

Taking their learnings and advocacy to the next level, the group has produced *Children Breathe Easy: Improving Indoor Air Quality in Schools*, a compelling action guide for those concerned about the health of children and school-based workers. And, they have collaborated with a documentary film producer to create *The Blake/EAST Story: Children's Environmental Health and indoor Air Quality in Schools*, a video encouraging other school communities to get on board, showcasing members of the school community (parents, staff, school board trustees and union) uniting with air quality and health activists in the successful battle to upgrade air quality.

As one of the presenters put it, "Shouldn't all schools be safe and not hinder a child's ability to learn and develop? Children represent our future."

Community Health Centres and Harm Reduction

QUEEN WEST COMMUNITY HEALTH CENTRE (QWCHC) IN PARTNERSHIP WITH THE SAFER CRACK USE COALITION OF TORONTO (SCUC).

**Lorraine Barnaby – Harm Reduction Outreach Educator, QWCHC
Victoria Okazawa – Community-based Program Facilitator,
Parkdale CHC**

Barb Panter – Community-based Program Facilitator (QWCHC)

**Alan Simpson – Community-based Program Facilitator
(YouthLink)**

**Bo Yee Thom – Community-based Program Facilitator
(Breakaway)**

Substance use is not just a criminal issue; it is an individual, community and public health issue. Health services are now employing harm reduction methods to work with many individuals with substance abuse concerns, including crack users for whom Hepatitis C rates are growing at an alarming pace while basic connections to today's health services are withering.

These facts led to the formation of *The Safer Crack Use Coalition (SCUC)* of Toronto in 2000. With its focus on the well being of marginalized crack users and crack smokers in particular, much of the coalition's work takes place in areas where homeless people, sex trade workers and drug users live.

Comprised of community health centres, other community-based agencies, street health workers, harm reduction activists, crack users, policy makers and researchers, SCUC is lessening isolation and providing substance users with employment and skill development opportunities through programs like *Peer Education*.

It is also developing a comprehensive harm reduction model to address the health and social issues that face crack users and is facilitating information exchanges across Canada. The results are providing a needed advocacy forum and educating crack users and service providers at the same time.

A multi-method research project that used both a survey and focus groups across Greater Toronto is now giving the work new momentum.

Summarizing the key findings and themes from this study, workshop presenters spoke on behalf of the 108 crack users who participated in the research process.

Most users indicated they were homeless and used crack on a daily basis as a coping mechanism. Their health issues related to crack smoking included, but were not limited to, HCV, depression, anxiety, paranoia, foot problems and malnutrition. Many expressed deep

feelings of poor self-esteem, self-loathing and, in some cases, suicidal despair.

Their social concerns and determinants that have affected their health have included police harassment and violence, poverty, homelessness and various other forms of discrimination and social exclusion. Survey participants believed that the general public sees them as "worthless," which heightens their isolation and enlarges the crack use spiral.

By directly addressing negative stereotypes, discrimination and harassment, the coalition is calling on all service areas to work collaboratively against structural and systemic barriers that push users further and further to the margins and often result in death.

Turning the Tide: Social Inequities and Chronic Disease Management

Shannon Hartigan – Program Consultant, Public Health Agency of Canada (Atlantic Region)

"Effective community health strategies must address the root causes of inequities in society and recognize the connection between the social determinants of health, chronic disease and effective primary health care," said Shannon Hartigan, Program Consultant with the Atlantic Region Public Health Agency of Canada.

This workshop affirmed that social and economic factors are more influential than lifestyle, that inequities in society affect the entire population, not just the poor, and that chronic disease disproportionately affects vulnerable groups experiencing inequities.

Hartigan referred participants to *Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada* (2003), to highlight the PHAC's groundbreaking Canadian research in this area.

Hartigan's main message on chronic disease prevention and management is that health is multidimensional in the context of persistent inequities. It involves the physical, the psychological, the social, and the economic. Since chronic disease disproportionately affects vulnerable groups experiencing inequities, and since the pathways that lead from inequity to chronic disease are multiple and interdependent, solutions must be modifiable, multiple and interdependent.

Citing the example of low-income and poverty, Hartigan noted that many strategies designed to support population needs are not relevant to low-income groups and often serve to increase inequities. Strategies need to address the inequities manifested in low-income populations. This involves looking at the present situation in the context of historical and economic factors. It involves assessing present policies and the impact they have on health and well-being. It also involves looking at evidence from other regions and countries that might shed some light on how to go forward. As well, it also means discovering and building upon the strengths and wisdom inherent in communities, including the many positive initiatives like CHC programs.



Language as a Determinant of Health

France Gélinas – Executive Director, Le Centre de santé communautaire de Sudbury

Jean-Gilles Pelletier – Executive Director, Le Centre francophone de Toronto

For both families that trace their heritage to historical Francophone communities in Canada and for the scores of individuals (immigrant and Canadian-born) from Africa, Asia, Europe and the Caribbean who make up an increasingly large portion of Francophone Ontario, Francophone CHCs have become pillars of individual and community health. “Les CSC”, as they are known in French, are helping to ensure that Ontario is a thriving multicultural province. Ontario’s Francophone communities are case studies for the impact of language and education as determinants of health. Workshop presenters pointed to a legacy of government regulations and social policy that, for nearly a century, pushed minority Francophones into the social and political margin.

Assimilation was the goal of a 1912 amendment to the provincial Education Act. Regulation 17 of the Act made it illegal to teach in French at Ontario public schools and forbade the teaching of the French language in all publicly funded schools.

It was implemented despite recognition of French as an official language and Francophones as one of the two ‘founding nations’ of Canada in the British North America Act of 1867 (Confederation).

With expensive, private Church-based teaching the only alternative for Francophone families, schooling became an impossibility for most. Labour became the only choice for most.

This triggered a process where generation after generation of Francophone families became Canada’s official working class. Even when Regulation 17 was formally repealed in 1968, this pattern of oppression was anchored. Communities faced a major uphill battle climbing out of the trenches of generational poverty, highly-limited education, cultural embattlement and all of their effects upon individual and community health.

Workshop presenters cited recent data from sources such as the Canadian Community Health Survey (CCHS) that demonstrate a notably higher prevalence of illness and poorer lifestyle factors within Ontario’s Francophone population.

These include lower health status than the Ontario population, as self-reported; higher self-reported rates of certain chronic conditions, including asthma, bronchitis, and emphysema; higher than average rates of smoking; higher than average use of emergency services; and significantly less frequent use of dental services. Added to this, as the CCHS and Census data show, are lower levels of literacy, education, and income than the Canadian average.

Enter the centres de santé communautaire (CSC).

“Les CSC” have contributed greatly in addressing the historical impact of oppression for minority Francophone communities in Ontario. Although there are still only five in Ontario, presenters

AS MEMBERS OF THE BROADER CHC AND AHAC NETWORK, “LES CSC” PRACTICE FIVE PRINCIPLES OF SUCCESS:

- 1. Multidisciplinary/interdisciplinary health care teams composed of salaried providers**
- 2. A critical mass of French-speakers among health care providers and other staff**
- 3. Well-networked and connected in Francophone and broader communities**
- 4. Governed by members of the French language community**
- 5. French language community-driven**

demonstrated how their centres are making their mark, not only ensuring health care for families in their home language but also rebuilding a sense of pride, community capacity and support for Francophone communities throughout the province.

Food Security: Good Food Box Programs – Here Today, Gone Tomorrow?

Elaine Radway – Community Development Worker, North Kingston CHC
GFB Kingston Committee Members

Many individuals and families with low income say that the main barrier to healthy eating is lack of money. In numerous communities across Ontario, Good Food Box (GFB) programs enable people with significant income constraints to access high-quality, affordable fruits and vegetables. The North Kingston CHC (NKCHC) has been an active partner in the Kingston GFB Program and acts as one of 20 organizational and 10 residential pick-up sites throughout the city and in Gananoque, Sharbot Lake, and Napanee/Lennox and Addington.

Although available to anyone, the program is designed particularly to help remove barriers to healthy eating and healthy food choices for those with lower incomes. Kingston GFB is a community-driven, cost-recovery based initiative that allows any community resident to purchase a GFB of fruits and vegetables.

Purchases are made from a neighbourhood volunteer host site at the beginning of the month with pick up on the third Thursday of each month. GFB’s are prepared by volunteers and then delivered to host sites. Participants receive a box of fresh fruit and vegetables at a cost significantly lower than in the average grocery store and with a choice of three different sizes, based on personal preference and need.

As is common with many important community support programs, the Kingston GFB program started small and as the result of sheer passion and compassion. In September 1995, twelve community conscious women of varied backgrounds and skills, with the vision of affordable and accessible fruits and vegetables for all, came together to create the Kingston-based program. Since its inception, the program has expanded by leaps and bounds to offer between 500-800

GFBs to individuals and families in the Kingston area each month. Even in light of this expansion, a 2003 operational review and needs assessment revealed a great deal of unmet needs.

Despite this and the exceptional value, the program's survival is still precarious.

Workshop presenters noted that until January 2004, the Kingston program had operated as the only GFB program in Ontario that was completely volunteer-driven.

NKCHC intervened and began to provide community development assistance to the GFB committee, along with direct staffing to support the committee's city-wide planning, directly fulfilling NKCHC's mandate to alleviate the impact of poverty on health through food security and healthy eating.

The GFB committee continues to access the needed operational resources. In the eastern Ontario region, GFB programs and interested groups have also begun a dialogue on the potential for collaboration and the feasibility of regional support for GFB programs through CHCs.

Diabetes Care and Support: Strategies for Diverse Ethno-Cultural Communities

LONDON INTERCOMMUNITY HEALTH CENTRE

Christian Daboud – Community Worker

Stewart Harris – Family Physician

Betty Harvey – Nurse Practitioner

Michelle Hurtubise – Executive Director

Mauricio Marin – Community Volunteer

Jennifer Rayner – Data Manager

London InterCommunity CHC's *Latin American Diabetes Program (LADP)* was developed to improve diabetes awareness and outcomes for London's Latino population, and to help them live healthier, more active lives. In its six-year life, the program has garnered national and international praise as a leader in multicultural diabetes care. Its many accolades include the 2002 Peter F. Drucker award for Canadian non-profit innovation.

Diabetes is a significant problem in Latin American populations. In the United States, where the correlation between race, ethnicity and health status is more effectively measured, one in every four Latin American adults over age 45 has diabetes, and 30 percent of them do not know that they are diabetic. North America is home to an ever-increasing Latin American population. Collectively, individuals from Latin America make up Canada's fourth largest immigrant group and 80 percent of Latino-Canadians live in Ontario, many in the city of London.

The *LADP* works with the Latino Canadian community, the Latino-Canadian diabetic population and mainstream diabetes service providers to increase awareness of diabetes among Latino community members and to provide access to essential diabetes services and self-care skill development. Some of the barriers that currently limit access are language, economic resources and low self-care capacity.

Working with community partners, the *LADP* has developed and delivers six signature programs including an adult Saturday screening program, an IGT intensive risk management and prevention program, a children's diabetes risk assessment program, a children's intensive risk management program, a diabetes complication prevention program, and a diabetes specialist satellite clinic.

An interdisciplinary health care team including a nurse practitioner, an endocrinology expert, phlebotomists, a social worker, volunteer community workers, and a psychologist supports all facets of the program.

Clients, community members and health care providers alike are empowered through dynamic communications tools. Training packages are part of the process, including a pre-event work plan and check-list, a screening algorithm, a take-home risk profile form, post screening follow-up lists and a multimedia information Web site at www.pldiabetes.com.

In addition to on-site programs, staff have key partnerships with the Latino community, diabetes service providers and a number of inter-sectoral groups to target the broader determinants of health, like employment, physical activity, affordable food and diabetes self-care supplies, that affect the life of diabetes clients and their families.

London's award-winning formula for diabetes care and support turns the hierarchical clinical model upside down. According to the buzz, it's working.

Mobilizing Municipalities to Act on Social Inclusion

Cathy Cleary – Community Development Worker, Kingston CHCs
Marijana Majovic – Community Development Worker, Kingston CHCs

North Kingston CHC, Better Beginnings for Kingston Children, and Street Health Centre have participated in various coalitions to increase social inclusion for over 15 years. Among them is the *Social and Economic Inclusion Initiative (SEII)*, which undertakes municipal advocacy in a number of Ontario cities.

Individually and in collaboration with SEII partners, Kingston CHCs have also created a number of initiatives in Kingston, including *Room of One's Own (ROOO)*, a self-advocate program of individuals who are



homeless or have experienced homelessness. *ROOO*, an outgrowth of an *SEII* bridging process, shows how advocacy work with municipal stakeholders can forge links to provincial and federal supporters.

The *ROOO* has now established itself as the voice for people without homes in the community. The change has led to new investment, improved emergency shelter services and community understanding. A municipal sub-committee has established homelessness as a priority on the local social housing registry – groundbreaking work continues.

Unfinished business includes increases to the *Ontario Works Shelter Allowance*; more transitional housing, year-round funding for overflow emergency shelters and redirecting properties confiscated for tax arrears to non-profit housing.

Back in 2002 the *SEII* knew it needed to understand the fears and needs of the Kingston homeless and landlords. When it took its first steps, the group had no idea of the impact it was going to have.

With support of local organizations including Kingston CHCs, the *ROOO* used monthly meetings with landlords, Kingston city officials, and diverse service organizations to find common ground. Together they saw the need for increased shelter allowances, direct rent payment options to landlords (voluntary on the part of tenants), and a renter-landlord matching service with community service agency supports to both tenants and landlords experiencing tension or conflict during tenancy.

The landlords association in eastern Ontario invited *ROOO* members to their annual meeting in the fall of 2003 where landlord representatives and *ROOO* members made joint presentations to political representatives, including the Ontario Minister of Municipal Affairs.

The *ROOO* helped organize a bus tour for politicians and media, identifying the places where people sleep outside.

In making the frustrations and challenges real to city councilors, the mayor, their MP, and MPP, the media was able to bring the issue of homelessness into living rooms throughout the city. It's working.

Making It Happen From the Ground Up: Engaging the Community in Expansion of Access to Primary Health Care

Lee McKenna duCharme – Emerging Groups Team, AOHC
Sandy Sheahan – Emerging Groups Team, AOHC

These are exciting times not only for the CHC model in Ontario, but for primary health care, as defined by the World Health Organization. The Ontario Ministry of Health and Long-Term Care has approved 49 new Community Health Centres and Satellite CHCs, and 150 new Family Health Teams (FHTs) since 2004.

Of the FHTs, 24 in total are community-governed (CFHTs) and are aspiring to many of the character-traits that give CHCs and AHACs their strength. These include an interdisciplinary team of salaried health care providers, integration of health promotion and illness

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prevention programs with clinical care, and development of partnerships that build local community capacity.

Realizing this potential, and bringing new CHCs and CFHTs to life, however, requires much more than attaining the appropriate business papers, hiring staff and flicking on the light switch.

Members of the AOHC's Emerging Groups Team walked interested participants through two proven, foundational steps that lay the groundwork to the billing of CHCs and AHACs as "Medicare's best kept secret". These two steps bring CHC and CFHT-style community engagement to life.

The essential first step is a thorough assessment of local population health needs. Since CHCs and CFHTs respond to, reflect, and address these needs, the assessment cannot be done without getting out into the community, building trust and asking for honest input. The 'build it and they will come' approach does not work, nor does simply holding a single 'meet, greet and tell us what you think' session.

While it may take just a bit more time than a simple town forum, it demonstrates a true commitment to more than developing effective care processes, but to erecting a local health care centre that is invested in wellness and dedicated to improving the health and development of local environments.

Some methods that have worked include key informant interviews, community forum days, the use of websites, databases and existing community profiles, and attention to existing hospital emergency data and local determinants of health information, where it exists. The process is usually guided by a Steering Committee of between six and 12 members representing concerned citizens, service providers and other members of the community at large.

The second foundational step involves preparing to weather inevitable storms through the creation of a rich, dynamic community-governance structure. Again, this process cannot effectively take place in the absence of trust, good-will and a commitment to the long-term.

People in each community must be active in decision-making regarding the health of their communities. Such activity ensures accountability. Their decision making authority includes how best to apply resources on an ongoing basis to meet the changing needs of the community. Community Boards ensure that services provided to the community are relevant and appropriate and that the Board is accountable to the community and to the Ministry of Health and Long-Term Care.

PRINCIPLES OF Primary Health Care

ADAPTED FROM THE WORLD HEALTH ORGANIZATION
DECLARATION OF ALMA ATA

Ontarians are moving toward a more equitable, integrated and responsive provincial health care system. Our success depends on a common understanding of the meaning of quality primary health care in our communities. The following principles are adapted from the World Health Organization Declaration of Alma Ata. AOHC is not suggesting a single definition. We are clear, however, that Primary Health Care:

- 1. ENCOURAGES** all health sector organizations and providers to work in respectful collaboration with all related community-development sectors, including shelter, nutrition, education, justice, income assistance, immigration and settlement, the environment, agriculture, industry, public works and the media.
- 2. AFFIRMS** the main health issues in our communities by promoting and providing preventive, curative and rehabilitative services that ensure access to health care for all, particularly the most disadvantaged populations. Interventions focus on the major causes of mortality, morbidity and disability for those populations and reduce the leading risk factors to human health.
- 3. ACKNOWLEDGES** Canada's diverse economic, political and cultural characteristics and evolves from community-sensitive social, medical and health service research and public health experience. Prevention and promotion roles directly tackle known risk factors which are deemed to be the major determinants of health in the community.
- 4. EMPOWERS** culturally competent and technically-equipped health workers (including physicians, nurses, community workers, and other health professionals and staff) to work co-operatively at local and referral levels in response to the expressed health needs of their communities.
- 5. SUSTAINS** integrated, functional and mutually-supportive referral systems, leading to progressive improvements in comprehensive health care for all, with priority given to those most in need.
- 6. NURTURES** health systems in ways that are financially sustainable, supported by political leaders and the people served.
- 7. CREATES** enabling policies and institutional environments that are integrated with other policy domains and embrace responsibility for the pursuit of wider social, economic, environmental and development policy.



Completing the Vision

THE SECOND STAGE OF MEDICARE

June 7th-8th, 2007

Toronto, Ontario, Canada

Keynote speaker – The Honourable Roy J. Romanow



Medicare is a defining feature of Canadian identity. We are deeply attached to its underlying values: fairness, equity and the importance of looking after each other. But Medicare is not yet complete.

Tommy Douglas' original idea was that Medicare would evolve in two stages. He called the introduction of the public insurance plan to cover treatment expenses "a minor matter of law and taxation." The second and more significant stage of the Douglas vision was to keep people well.

That's why keeping people well is the focus of our upcoming AOHC conference. For two days participants will hear from leading health care decision makers on how federal, provincial and regional health authorities can move Medicare to its Second Stage.

As well, Ontario CHCs and other health providers will describe how they are already leading the way to Medicare's Second Stage.

"Let us not forget that the ultimate goal of Medicare must be to keep people well."

– Medicare founder Tommy Douglas

For more information watch AOHC's website: www.aohc.org
or send an email to: conference@aohc.org.

