

Making Room for Health Equity: The role of community health centres in advocacy

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Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health.

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“Anytime we seek to interrupt inequality, it is advocacy.”

– CHC Executive Director, Toronto

Introduction

The three supervised injection sites set to open in Toronto this year are an example of how community health centres (CHCs) are pushing to improve health for all in the city. CHCs are well-positioned as advocates for health equity in Toronto due to their unique model of care. Advocacy can be defined as individual or group efforts to influence political, economic, social and institutional decisions. More specifically, public policy advocacy is “a range of activities [...] aimed at influencing decision makers to adopt policies that improve public health” (McCubbin, Labonte, & Dallaire, 2001). With this research, EDs were asked to define and describe how they understand advocacy in order to capture a full range of activities. CHCs use advocacy strategies in two ways: they advocate for policy change and they integrate advocacy into service delivery. Their capacity to advocate for policy change is however constrained by a lack of dedicated resources, service delivery priorities, accountability to funders, and non-profit restrictions. Addressing these challenges has the potential to enhance the capacity of CHCs, and the health sector more broadly, to respond to the upstream drivers of health inequities such as income inequality, precarious work, and discrimination. This report draws on qualitative interviews conducted with CHC executive directors to provide an overview of CHC advocacy work and to highlight opportunities and obstacles for advancing health equity in Toronto.

Background

Ontario’s 101 community health centres are community-governed, non-profit organizations that provide primary health care services as well as a range of health promotion, capacity building and community development programs (MOHLTC, 2015). CHCs work with clients and communities who face systemic barriers to health and offer programs that vary based on local needs (e.g. community gardens, youth programs, legal clinics). Compared to other primary health care providers in Ontario, CHCs see a greater number of clients who are newcomers, who live in low-income neighbourhoods, and who are more sick (Glazier, Zagorski & Rayner, 2012). To support this model of care, CHCs have inter-professional staff that often include nurses, nurse practitioners, physicians, social workers, health promoters, community health workers, and dietitians (MOHLTC, 2015). Through their Model of Health and Wellbeing (Figure 1), CHCs have committed to achieving action on the social determinants of health through partnership and advocacy (AOHC, 2016).

Locally and globally, advocacy has been recognized as a key health promotion strategy to influence the political, institutional, economic and social decisions that drive health inequities (CSDH, 2008; WHO, 1986). Health promotion is an important global movement to address the upstream factors that impact health beyond individual behaviour and treatments (WHO, 2016). The Bangkok Charter for Health Promotion in a Globalized World calls for the health sector to engage in political action and advocacy for a healthier world for all (WHO, 2006). Despite these calls, health organizations face considerable challenges when doing advocacy work (Cohen & Marshall, 2016; Chaudhry, 2015; Farrer et al., 2015; NCCDH, 2015).



Figure 1 Model of Health and Wellbeing (Association of Ontario Health Centres)

Research Methods

Using a qualitative grounded theory approach, this research aims to answer the following research questions:

- What advocacy is currently being done by CHCs in the City of Toronto to advance health equity?
- What are the conditions required for CHCs to do advocacy?
- What are promising strategies that enable advocacy at CHCs?

Grounded theory is an iterative approach which allows researchers to generate theory from data and is well-suited for this exploratory project due to the limited amount of research on this topic (Corbin & Strauss, 2008).

The executive directors (EDs) and chief executive officers (CEOs) of all 21 CHCs in the City of Toronto at the time of the study (i.e. Scarborough, Etobicoke, North York and downtown Toronto) were invited by workplace email to participate in the study. Participants voluntarily agreed to be part of the study and provided written informed consent before being interviewed. A total of 11 CHC EDs or CEOs participated in the study between February-May 2016 by taking part in one-on-one interviews (either in person or over the phone). Study participants are referred to as executive directors or EDs in this report to maximize confidentiality. The 11 EDs worked at CHCs that reflect the range of CHCs in Toronto including organizations in the downtown core as well as in the inner suburbs, and

organizations that work with populations across the city as well as those that work in specific neighbourhoods.

All of the interviews were audio-recorded and transcribed for analysis. The qualitative data management program Nvivo 10 was used to facilitate coding and analysis of the data. Ethical approval for this research was received from the Research Ethics Board at Ryerson University (REB 2015-397).

Using a semi-structured interview guide, the one-on-one interviews explored a number of aspects of CHC advocacy which included: 1) How do EDs understand advocacy for health equity, 2) What are examples of advocacy initiatives that the CHC has lead or been involved in, and 3) How do EDs define success in this work? (See Appendix A for full interview guide.) As data analysis was conducted concurrent with the process of data collection, additional probes were added to the interview guide as themes emerged from the data analysis.

Data analysis began as soon as the first interview was completed and transcribed. Two team members independently read and conducted open coding of three interviews and from this developed a coding list. The coding list included repeating themes from interviews. One team member coded the remaining interviews using the coding list as well as coding for new themes. As the interviews were conducted and transcribed, the coding framework was revised to add newly generated themes using the constant comparison methods of grounded theory (Charmaz, 2000). New codes were developed that describe participants' accounts in their own words; these codes were applied and adapted to data as collected with the aim of reaching saturation of themes. Theme memos were used to understand relationships between themes and to identify points of consensus as well as variation. Iterative data collection and analysis continued until the point when theoretical saturation was achieved: "the point in the research when all the concepts are well defined and explained," when a level of variation exists within the concepts, and when relationships between concepts have been explained (Corbin & Strauss, 2008).

Findings

Health Equity Advocacy at CHCs

Community health centres are well-positioned advocates for health equity due to their unique model of care.

The executive directors in this study represent CHCs that work with a range of client populations in the downtown core, inner suburbs, and across the City of Toronto. Although these CHCs have different missions, work with different clients and communities, and provide different services, EDs described a common commitment to health equity. They

do this by improving access to health care services for clients and communities that face systemic barriers, and by addressing the social determinants of health (specifically housing, income, settlement, employment, food security, transportation, early child development, education, and discrimination based on gender, racialization, age, language and ability). EDs articulated how their work is driven by an understanding of how the social determinants of health impact health and health equity.

“[The social determinants of health framework] has been a real enabler for us and a real organizer for us. And the reality is certainly in the City of Toronto, there are so many systemic barriers that are just unjust and inequitable.”

“We bring an expression of the relationship between health and the different issues that we’re dealing with. So that’s a lens that others don’t necessarily bring to the discussion. Right, if we’re talking about welfare rates, it’s really us, community health centres, and public health that talk about the impact of poverty on health. And that’s a huge role to play, that’s a huge thing. And to challenge governments to include a health analysis, health impact assessment, or analysis on their policies and procedures, that’s something that we are and should continue to lobby for.”

Advocacy is an essential and integrated part of CHC’s health equity mandate. EDs understood advocacy as efforts to reduce systemic barriers to health and influence decisions made at an individual, organizational, sector, neighbourhood, city, regional, provincial, federal, and global levels. CHCs use advocacy strategies in two ways: 1) individual and organizational-level advocacy that is integrated into service delivery, 2) advocacy that aims to influence municipal, provincial and federal policy decisions.

1) Individual & Organizational Level Advocacy

Every ED described how advocacy strategies are integrated into primary health care and social service delivery in order to provide accessible and responsive services and address systemic barriers to health.

“By the nature of what we’re doing [...] I think that staff, they’re always advocating for the youth that they’re serving.”

“Anytime we seek to interrupt inequality, it is advocacy.”

“So everything I told you about being the first ones for the this, the first ones for that, is done through advocacy of course. It’s identifying a need or a gap in services and saying well these services are available in English but not available in French.”

“The one-to-one advocacy is essential and it’s the main role whether it’s navigating the health care system or keeping people housed or keeping people’s income support, we need to do that a lot.”

Most CHC staff advocate on a one-on-one basis for individual clients everyday. Staff provide referrals, care coordination, and system navigation to help clients access more comprehensive health and social services, such as specialist care, housing supports, and social assistance benefits. This one-on-one advocacy is necessary to overcome the many barriers clients face when navigating complex health and social service systems.

To address barriers to care for client populations and communities, CHCs tailor new or existing services and approaches to better reach existing clients and to respond to new client populations. For example, many CHCs employ peer workers to support programs with the aim of improving outreach and service delivery while building the skill, knowledge and networks of clients. CHCs secure multi-service funding and partner with other service organizations in order to make additional health and social services available to clients, such as community gardens, eviction prevention, supervised injection sites, and legal clinics. In a number of cases, expanding services, such as supervised injections sites, requires sustained long-term advocacy efforts that involve a range of strategies including partnership development, research, community consultation, and work with municipal, provincial and federal governments.

Advocacy strategies are used to create internal organizational change at CHCs in order to make services more accessible and inclusive. For example, some CHCs in Toronto have made efforts to make their organizations more accessible for trans clients and for clients living with disabilities through staff training and mentorship, developing partnerships between service providers, internal policy change, and community outreach.

This individual and organizational-level advocacy goes beyond basic service provision and is seen as critical to achieving CHC’s health equity missions. Through this work, CHCs aim to improve client and community health by: increasing the number of clients accessing services at CHCs and other organizations; expanding funding for local health and social services; prioritizing the needs of people facing barriers in regional health planning processes; raising awareness about health conditions within communities; and increasing client’s networks, civil engagement and capacity. CHCs integrate this type of advocacy into their role and responsibilities as service providers. Ultimately, EDs highlighted both the limits and opportunities of service provision in contrast with policy and system-level change.

“I mean success I think would be having legislative change and things like that but for us it’s a different kind of advocacy that’s not always the end result

sometimes for us, it is just two more youth were served or got the service they need.”

“We advocated for [housing support services] and I think it’s been very successful but that’s a very small kind of one-to-one success. It’s not making more affordable housing, it’s not really impacting on poverty as an issue overall but it is obviously having an effect for that individual.”

“The advocacy in service is centred around individualized clients, or individual groups, or not individuals but groups of clients. So the ability to pull back and look at the system and to look at systematic change is diminished.”

“You know what that’s such a difficult question in terms of success around an initiative. Because you know the social conditions don’t change that fast as you know. So our successes may be minimal but what I see as success is the engagement of people. So when I see people engaged and interested and coming out to the meetings and being involved and wanting to participate in whatever that advocacy effort is, to me that is something.”

2) Municipal, Provincial & Federal Policy Advocacy

In addition to individual and organizational-level advocacy, CHCs advocate for legislative and policy change to address health inequities and the social determinants of health. They have led or been involved in advocacy initiatives where policy change goals have been realized at various levels of government: neighbourhood and municipal (e.g. reversed City budget cuts, installation of new bike lanes), provincial (e.g. expansion of OHIP eligibility for babies born in Ontario to parents without citizenship status, changes to the Ontario sexual health education curriculum); and federal (e.g. reversal of cuts to the Interim Federal Health program for refugees).

At a neighbourhood and city level, several CHCs work with resident-led groups, other service providers, and municipal decision-makers and departments to improve neighbourhood-level resources and to advocate for municipal policy change. Some CHCs support resident-led advocacy groups, such as neighbourhood tenant associations, anti-racism campaigns, and anti-poverty actions groups, by providing space, food, child care, capacity-building, or administrative support. Others work with residents, legal clinics, and landlords to improve housing quality, support tenant rights, and increase resident involvement in neighbourhood redevelopment projects. CHCs engage with municipal policy making by giving deputations and working with local counsellors to advocate for affordable housing, increased shelter space, community recreation, and affordable and accessible transportation in Toronto.

CHCs also lead and participate in provincial and federal policy advocacy. For example, a number of CHCs have been involved in coalitions to expand access to health care for medically uninsured clients in Ontario, to reduce provincial employment insurance waiting periods, to update the Ontario sexual education curriculum, to increase the provincial minimum wage, to advocate for national prescription drug coverage, and to call for the reversal of cuts to federal refugee health care. These campaigns often involve several advocacy strategies such as research, community engagement, multi-sector coalition building, lobbying and legal strategies.

While EDs cited advocacy successes, they highlighted the importance of the political environment when doing policy advocacy (i.e. political will, political windows of opportunity, and levers for change). EDs described several long-term efforts to create policy change that involved multiple stakeholders and multiple strategies that did not initially lead to policy change due to a lack of political will. They spoke about the importance of long-term, multi-sectoral advocacy work, building relationships with decision-makers, and being aware of political windows of opportunity.

“The challenges are staying the course, being strategic, being respectful and actually not dismissing anybody [...] If the intent is to just create awareness then our obligation is to actually embrace everybody and people choose to stay or leave.”

“That takes years and a lot of work but that’s what you have to do. I know when to push, when to pull back. [...] So it’s a window and you have to take advantage of it.”

While working towards long-term policy change success, EDs identified valuable process outcomes: documenting and raising awareness of health disparities amongst policy makers, the public, and other organizations; keeping an issue on the policy agenda; increasing organizational capacity; and coalition building.

Challenges

Despite many successes, EDs expressed a central tension that while action on health equity and the social determinants of health is critical to their missions, their ability to advocate for policy change is constrained by accountability to funders, service delivery priorities, a lack of dedicated resources, and non-profit restrictions.

CHCs are primarily funded through regional Local Health Integration Networks (LHINs) which are funded by the Ministry of Health and Long-Term Care. LHINs prioritize the funding

and delivery of primary health care and evaluate CHC's performance predominately using clinical indicators (e.g. client encounters, cancer screening rates). While EDs understand the critical role of policy to address health inequities, they emphasized their primary role and responsibility as service providers.

"We're not an advocacy organization, we are not, we are not, we are funded as a health centre, a CHC, we are funded to deliver programs and services, advocacy absolutely happens and should happen but it's not what we do."

"We will be involved in non-violent types of demonstrations and things like that but in general we wouldn't have staff do that as part of [our CHC], they would join that on their own. And that's because that's not what we're paid to do. We are paid to work for our clients and make sure that we deliver the best services possible which I think includes you know if we see a systemic issue or something that's in the way of doing that then we have an obligation to try to meet with decision makers and work together to try to resolve the situation or to change it as best as we can."

LHINs prioritize service delivery and do not provide dedicated funding for advocacy activities at CHCs. EDs described the challenges in resourcing policy advocacy and the need to be strategic with advocacy due to this lack of dedicated funding. The tasks required to support policy advocacy such as meeting with decision makers, convening clients and community residents, or developing campaign materials are rarely resourced and do not integrate as well into service delivery responsibilities. For example, while health promoters, community health workers, social workers, or outreach workers do the bulk of community development and convening work that supports advocacy, these staff members are also expected to balance other aspects of their roles (e.g. one-on-one and group work). For CHCs that are committed to policy advocacy, staff often do advocacy off the "side of the desk" as they balance this work with other responsibilities. EDs described the complexity and limits of resourcing sustained policy advocacy:

"To the extent that we're able to orient [advocacy] programmatically, we can do it, it can get resources. To the extent that it's about me going to meet with the government and talking about these issues and doing policy briefings and writing some of that material, it's not resourced. We don't have a policy analyst here, we don't have one in the [CHC] sector or in Toronto. So there's a lot of that work that is off the side of the desk. And that's a problem and limits how well we're able to do it. That's a real barrier."

"There's a lot of issues so you do prioritize also based on what's happening in the external environment [...] if you're in a situation where the governments at

each level are not very receptive to certain kinds of messaging, there's probably no point in you know putting a lot of energy into that. So you need to read the external environment I think as well and just what your members and clients need."

In addition, the Canada Revenue Agency ([CRA], 2003) restricts the use of non-profit resources for political activities and prohibits partisan political activity. CHCs must ensure advocacy work is non-partisan and that they do not dedicate more than 10% of their revenue to non-partisan political activities to comply with these CRA requirements. EDs identified that these rules regarding non-partisan political activities have created confusion and an advocacy chill for non-profit organizations across Canada.

EDs reported that because of these constraints, organizations have become more focused on service provision, have decreased their policy advocacy efforts, and have had to use different tactics to influence change. For example, one ED spoke about how their CHC would give deputations, write opinion pieces, and give presentations but would not participate in demonstrations due to expectations from funders. While other EDs spoke about striking a balance where CHC staff could participate in demonstrations, but only during their own time, and not on behalf of the organization.

Opportunities

Addressing these advocacy challenges has the potential to enhance the capacity of community health centres, and the health sector more broadly, to respond to the upstream drivers of health inequities in Toronto.

Despite several constraints, all EDs in this study expressed a desire to increase the amount and effectiveness of their advocacy. EDs described the less tangible outcomes of hope and resistance that sustain the advocacy efforts of CHC staff, clients, and communities in the face of social and health inequities.

"One of the successes of advocacy is keeping that zeal alive, that change is possible, that things can be different, that we need not resign ourselves to live forever with these sets of inequalities and that for me is quite powerful as a success [...] that for me is quite powerful from the perspective of folks who experience inequality seeing, maintaining kind of the dignity of resistance. Because there's a great dignity of resistance because it says that we will not settle with inequality forever."

“Well if you can improve the lives of your patients, that’s basically it. If you can improve the life of your patient and can improve the resilience of your patients while also the resilience of your community and vitality of your community and keep it willing to move forward is very important.”

“One of the things that I know is that if pain doesn’t move, it will crush you. So if there’s no where for our staff to take the pain of what they see and the injustice of what they see and to move it, then you know there’s a high risk of implosion. If the community sees no way to take their pain, the injustices that they’re experiencing and move those, then they’re going to be crushed. Right, there’s that, a sense of hopelessness and helplessness. So that there is somehow, something that can be done. Do something!”

Currently, some CHCs are integrating policy advocacy into all their staff’s work and making efforts to enhance advocacy capacity across their organization. For example, two EDs described how advocacy work was integrated into individual staff and team’s deliverables, logic models, and evaluations. These CHCs have developed position statements on key health equity issues related to their mandate that outlined their organization’s stance on the issue and recommendations for change. These documents were seen by EDs as a way to support staff’s work and to serve as an external communication and advocacy tool. Another CHC developed an internal advocacy statement that outlined the organization’s decision making processes for engaging in advocacy to increase clarity for staff. Some EDs suggested that advocacy training for their staff and sharing of advocacy tools, strategies and resources across the CHC sector could enhance their advocacy capacity.

To enhance sector-wide advocacy capacity, EDs spoke about the need for CHCs and other organizations to advocate together for policy change. Many EDs identified a need for dedicated resources to convene coalitions and planning tables that extend beyond the CHC sector and across funding boundaries. Some EDs highlighted the potential expanded role of networks, professional organizations, and local research and policy institutes to assist with providing administrative, strategic, and research support to health equity advocacy coalitions. For example, EDs highlighted the need for research support and partnerships to inform policy advocacy and the potential to draw on the existing CHC database to identify pressing health inequities and inform sector wide advocacy.

Discussion

Through interviews with CHC EDs across Toronto, this research found that advocacy is an integral part of CHCs’ work and is driven by organizational commitments to health equity and an upstream approach to health and well-being.

The National Collaborating Centre for Determinants of Health (2015) have identified that health equity advocacy should strive to impact decision-making to improve social conditions (NCCDH, 2015). This research found that CHCs are using a full range of advocacy strategies to advance health promoting policies. Guo & Saxton (2010) define advocacy as efforts aiming to influence local, provincial or federal policies by: conducting research, mobilizing community residents, working with the media, holding public events, working through the legal system, building coalitions of organizations, educating the public, sharing expert opinions, registering voters, and working directly with politicians or public servants. In addition to policy advocacy, CHCs integrate these advocacy strategies into service provision to improve access to health and social services for clients and communities. As funders prioritize service provision, this type of integrated individual and organization-level advocacy can be resourced and can directly support CHCs' missions and performance indicators. However, a sole focus on service delivery is limited in its ability to transform the upstream social determinants of health and can constrain organizations' abilities to advocate for policy change.

This research identifies key challenges CHCs face when resourcing policy advocacy due to funder expectations, service provider role, and non-profit restrictions. Cohen & Marshall (2016) likewise found that public health organizations face similar barriers to advocacy including a focus on service delivery, and limited organizational capacity and policy analysis to support advocacy. Chaudhry (2015) similarly found that CHCs across Canada face challenges in resourcing health promotion activities and coalitions more broadly, partly due to funder emphasis on health behaviours and lifestyle, competing organization pressures, and limited funding, staff and structures for health promotion and collaboration. As CHCs must prioritize service provision, resources are often limited to conduct the research, policy, and coalition building needed to do policy advocacy.

Considering the Future

CHCs in Toronto are committed to health equity advocacy but are grappling with several challenges. They have limited capacity to do policy advocacy due to a lack of dedicated resources, service delivery priorities, accountability to funders, and non-profit restrictions. It is important to continue to explore ways for CHCs to move forward, build on successes, and enhance their capacity to advance policy on health equity and the social determinants of health, in ways that mobilize the greatest possible use of existing, albeit limited resources.

CHC EDs identified that the Canada Revenue Agency's (CRA) rules that govern charities' participation in political activities constrained advocacy efforts. CHC EDs highlighted that the lack of clarity regarding CRA's political activity rules were administratively challenging, and had created an advocacy chill among non-profits. In 2016, the Minister of National Resources announced public consultations regarding these rules. In May 2017, the Consultation Panel on the Political Activities of Charities provided recommendations to the Minister informed

by the consultation process. The Panel recommended completely modernizing the legislative framework and the CRA's administrative position and policies to enable and maximize registered charities' ability to fully participate in non-partisan public policy dialogue and development. The Panel stated:

“We believe that implementing these recommendations will improve the quality of public policy dialogue and development in Canada, while reducing administrative complexity and cost for both the sector and its regulator. Further, our recommendations preserve the legitimate regulatory objective of prohibiting partisan political activity.”

These recommendations are encouraging and if realized have the potential to address some of the challenges CHCs experience when doing health equity advocacy.

Given the potential for a changing regulatory environment, CHCs and the Association of Ontario Health Centres could explore new possibilities regarding the extent and nature of CHC health equity advocacy moving forward. CHCs in Toronto have demonstrated the power of sharing resources and experiences through a number of successful advocacy coalitions, such as CHC efforts to establish supervised injection sites, and efforts to provide services to uninsured residents. CHCs can continue to identify and act collectively on cross-cutting issues that impact communities across Toronto. Existing sector networks and new online tools could be used to support ongoing information sharing of advocacy strategies, and organizational policies and practices that clarify and support CHC health equity advocacy. CHCs could explore opportunities to partner with research institutes and associations, which can leverage CHC's grounded experiences, and can result in stronger policy work that brings together a wider range of skills and voices.

Limitations

This study is a first step in understanding health equity advocacy in CHCs and highlights the advocacy strategies CHCs are using, and the organizational, political, and funding constraints and facilitators of advocacy. Nonetheless, there are some limitations to this work to be mindful of when interpreting these findings.

All CHC EDs in Toronto were contacted to participate in this research. Some EDs did not respond to the request. It is not clear why these EDs did not participate. The EDs who did not participate may have had different experiences of advocacy related to their work than those who did participate, which were not able to be included in this study. While this is a potential limitation, the study did include a range of participants who were engaged in advocacy in varying degrees and seemed to speak candidly about the challenges in their work. While not

all Toronto CHC EDs were interviewed, study participants represented CHCs with different client populations, in both the downtown core and inner suburbs, and with varying budgets, missions and services. This suggests that the report captures the variation that exists within the CHC sector in Toronto.

Due to the scope and timeline of this project, interviews were only conducted with CHC EDs. For this reason, this report is missing the perspectives of CHC staff, clients and residents, board of directors, and external stakeholders who could provide a fuller picture of CHC advocacy. This study highlights that health promoters and community health workers tend to lead the community development work that is often central to CHC advocacy; these staff are likely aware of additional conditions which facilitate and constrain advocacy. As well, community residents and CHC clients have a critical perspective on this issue that should not be missed as advocacy is often aimed to remedy the health inequities they experience. Future research and work on CHC advocacy should include these important stakeholders.

Finally, this study explores CHC advocacy in Toronto and may reflect a unique experience due to the density of health and social services in the region, the local regional history, and population demographics. There is value in looking at how these findings compare with the experiences of CHCs in other parts of the province. There is also value in exploring whether and how advocacy experiences and attitudes shift over time.

Conclusion

Community health centres respond to the impacts of social determinants of health everyday through their work with clients and communities who are experiencing health inequities. CHCs are uniquely positioned within the health sector to contribute to public policy change. Strengthening the policy, research, and convening capacity of CHCs, and the health sector more broadly, can improve our collective ability to advocate for policies that enhance the ability of all Torontonians to thrive and be healthy.

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Appendix A: Interview Guide

Introduction

- This interview will be no longer than 1 hour. A reminder that there are no wrong answers and I am not judging or evaluating your work. You can decide not to answer a question or end the interview at any time.

Questions

- Tell me about your CHC, your client population and your mission
- How many years have you been an ED here?
- What does advocating for health equity mean to you?
- Given this understanding, does your organization advocate around health equity?

If yes,

- What are some issues you have advocated for?
- How did you identify these issues/priorities?
- What are some examples of advocacy initiatives had your organization initiated or been involved in, in the past 5 years?
- What is an example of an advocacy success you've had? How do you define success in this work?
- Which staff members support this work?
- What is your role in this work?
- What are barriers you face in doing advocacy?
- What is the value of your organization doing advocacy?
- What would support your advocacy? What are the next steps/recommendations for CHC advocacy?

If no,

- Is advocacy something you would like to do?
- What are the barriers to doing advocacy?
- What are the necessary supports?
- What kind of resources would facilitate advocacy?