

# Addressing Health Inequities for Racialized Communities

## A Resource Guide



# Acknowledgments

The following individuals and organizations contributed to the development of this resource guide:

- ▶ Subha Sankaran (author) and Suzanne Schwenger (Health Nexus)
- ▶ Dianne Patychuk, Kwasi Kafele and Christine Oluwole-Aina (Health Equity Council)
- ▶ Mantreh Atashband, Torshie Sai, Maila Mananquil (students)
- ▶ Rose Cathy Handy (Project Consultant, French)
- ▶ Project Advisory Committee members, (for a full list of Advisory Committee members, see Appendix) Local Partners, Presenters and Participants
- ▶ Cover design idea – Gayathri Naganathan

## Disclaimer

The resources and programs cited throughout this guide are not necessarily endorsed by Health Nexus and the Health Equity Council. While the participation of the advisory committee contributed to the development of this resource guide, final decisions about content were made by Health Nexus and the Health Equity Council

Aussi disponible en français.

This document is available online at [www.healthnexus.ca/projects/building\\_capacity/index.htm](http://www.healthnexus.ca/projects/building_capacity/index.htm)

*This document has been prepared with funds provided by the Government of Ontario. The information herein reflects the views of the authors and is not officially endorsed by the Government of Ontario.*

*Health Nexus and Health Equity Council thank you for your interest in, and support of, our work. We permit others to copy, distribute or reference the work for non-commercial purposes on condition that full credit is given. Because our resources are designed to support local health promotion initiatives, we would appreciate knowing how this resource has supported, or been integrated into, your work ([equity@healthnexus.ca](mailto:equity@healthnexus.ca)).*



*your health promotion specialist  
votre spécialiste en promotion de la santé*

## Health Nexus

[www.healthnexus.ca](http://www.healthnexus.ca)

180 Dundas Street West, Suite 301

Toronto, ON M5G 1Z8

Telephone: (416) 408-2249

Toll-free: 1-800-397-9567

[info@healthnexus.ca](mailto:info@healthnexus.ca)



## Health Equity Council

[www.healthequitycouncil.ca](http://www.healthequitycouncil.ca)

[healthequitycouncil@gmail.com](mailto:healthequitycouncil@gmail.com)

# Introduction

Ontario is experiencing huge demographic shifts, particularly in the larger urban centres. It is estimated that by 2017, one in five people in Canada will belong to a community of colour. By 2017, more than half of Toronto's population will be people of colour<sup>1</sup>. This growing number of Ontarians belong to what are called '*racialized communities*', a term that is replacing '*visible minorities*' or '*ethnocultural communities*'. In Ontario, members of racialized communities include newcomers to Canada as well as established immigrant and Canadian-born communities. The percentage of Francophones in racialized groups has also increased in every region.

Health equity is about those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair. While Ontario does not collect data about racialized communities in a consistent manner, there is growing indication that racialized communities have poorer access to the determinants of health – income, education, employment, housing, etc. – and poorer health outcomes. When the issue of racism and discrimination are added to this, racialized groups become even more vulnerable and inequities in health are compounded. The project literature review discusses this in detail.

## Building Capacity for Equity in Health Promotion

The Building Capacity for Equity in Health Promotion project<sup>2</sup>, funded through the Healthy Communities Fund of the Ontario Ministry of Health Promotion and Sport, focussed on addressing inequities in health experienced by racialized communities especially low income communities. It did this by working with those who promote health in these communities, people in public health, community health centres and in community organizations, to build capacity to reduce health inequities for racialized groups. Specifically, the project focussed on physical activity, mental health promotion, and healthy eating, re-defined by the project as healthy eating/food security.

How and why racialized communities face marginalization and exclusion in relation to access to the determinants of health, and positive health outcomes must be understood if we are to reduce health inequities. Policies and practices can systemically disadvantage racialized communities, including racialized francophone communities. This can happen even if it is not intended. Health equity research shows that taking a *whole of population* approach to health promotion and health education runs the risk of actually widening inequities, because advantaged groups are in a better position to access and take advantage of information, incentives and programs. Because of this, equity needs to be considered at all levels – policy and strategy, designing actions and programs, and implementation and evaluation.

<sup>1</sup> See [www.colourofpoverty.ca](http://www.colourofpoverty.ca)

<sup>2</sup> See appendix for a project summary

## Purpose of this guide

This Guide is a tool to support the capacity and effectiveness of those who are engaged in health promotion to reduce racialized health inequities. It brings together resources and initiatives identified through the process of developing and delivering the project. The focus on physical activity, mental health promotion, healthy eating/food security are examples of entry points to address racialized health inequities, and direct attention to the broader, underlying causes that need to be addressed.

## All of us have a role to play in reducing health inequities

This resource guide is meant for frontline workers, managers and supervisors, or those who work in some other capacity in the promotion of health in our communities. This may also be of interest to funders and policymakers.

Addressing health inequities is not the responsibility of frontline health promotion workers alone. Often, barriers to addressing health inequities come from the policies, priorities and overall structures within which we operate – be they to do with organizations, local institutions, or governments at various levels. Even so, there are ways of working that can shift within these parameters, even as we work to shift structures and make broader changes in collaboration with others. In this resource guide, there are both ideas for use by individuals working in the promotion of health, as well as for organizations and structures.

## Health inequities must be addressed at many levels

This guide is organized so that those working in different areas of health promotion can reflect on their work, learn from successes in the field, and incorporate new ideas into their practice. This resource guide is meant to be read in conjunction with the project literature review that synthesizes the literature and research on health inequity among racialized communities.

This guide begins with an overview that includes:

- ▶ Definitions and basic concepts
- ▶ The continuum of strategies to address health equity from universal/colour blind, through diversity and cultural competence to an anti-racism /anti-oppression approach that truly addresses equity concerns for racialized groups.

Further sections are organized according to key stages of health promotion programming and service delivery, as well as larger themes:

- ▶ Locating and understanding ourselves and others
- ▶ Program planning
- ▶ Service delivery
- ▶ Engaging communities
- ▶ Partnering and collaboration
- ▶ Organizational issues
- ▶ Research and policy

This resource guide is also available in French. Since not all programs and services, resources and tools or research are available in both languages, we outline, in some cases, different examples in the English and French versions of the guide. This guide is based on the following sources:

- ▶ Results of an online survey
- ▶ Research by project staff, including students and volunteers
- ▶ Input from project partners
- ▶ Proceedings of project conferences/learning labs

This guide is intended to remain a live document which will be updated. Please send comments and suggestions to [equity@healthnexus.ca](mailto:equity@healthnexus.ca).

# Overview

## Definitions and Basic Concepts<sup>3</sup>

To be healthy and to have physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. **Health** is, therefore, seen as a **resource** for everyday life, not the objective of living (Ottawa Charter for Health Promotion, 1986).

**Health inequities** are differences in health that are unfair and avoidable because they result from social and health conditions, policies and practices that can be changed.

Resources for health include access to the **social determinants of health** such as adequate income, employment, safe housing and working conditions, nutritious food, and freedom from discrimination and violence, etc. These social determinants of health are based on evidence and also have a foundation in human rights declarations, charters and laws. The social determinants of health (SDOH) and the social determinants of health inequity (SDHI) are not the same. The latter focuses on distributive aspects and on structural and social arrangements that create health inequities.

The World Health Organization (WHO) defines **health promotion** as “the process of enabling individuals and communities to increase control over the *determinants of health*” partly through political actions, creating a healthier environment. Health Promotion is not merely about educating people to change their behaviour, although it is often seen as focussing on healthy lifestyles. In actual fact, health promotion is about changing the conditions under which people can lead healthy and fulfilling lives.

**Racialization** is the process where racial categories are socially constructed as different and unequal in ways that lead to social, economic and political impacts<sup>4</sup>.

The Ontario Human Rights Commission (OHRC) describes communities facing racism as “racialized.” The OHRC **Policy and guidelines on racism and racial discrimination** states:

*The term “racialized person” or “racialized group” is preferred over “racial minority,” “visible minority,” “person of colour” or “non-White” as it expresses race as a social construct rather than as a description based on perceived biological traits. Furthermore, these other terms treat “White” as the norm to which racialized persons are to be compared and have a tendency to group all racialized persons in one category, as if they are all the same.*

**Racialized groups** refers to the populations earlier identified by Statistics Canada as “visible minorities” a term that Statistics Canada has recently discontinued. It has instead been replaced by the term “population groups”.

**Statistics Canada’s** category of “Population Groups” is based on the Employment Equity Act which defines them visible minorities as “persons”, other than Aboriginal peoples, who are non-Caucasian in race or non-white in color.’ Categories include: Chinese, South Asian (East Indian, Pakistani, Sri-Lankan, etc.), Black (e.g. African, Haitian, Jamaican, Somali), Filipino, Latin American, Southeast Asian (Vietnamese, Cambodian, Malaysian, Laotian, etc.), Arab, West Asian (e.g. Iranian, Afghan), Korean, Japanese, those, n.i.e. (‘n.i.e.’ means ‘not included elsewhere’), and those who belong to multiple population groups.

<sup>3</sup> From the project literature review.

<sup>4</sup> Grace-Edward Galabuzi, 2001. Canada’s Creeping Economic Apartheid, The economic segregation and social marginalization of racialised groups. Toronto, ON. CSJ Foundation for Research and Education

Racial groups are socially constructed – so which groups experience stereotyping, social exclusion, racism, under-representation, different treatment, etc. varies by place or community and social context. For example in some communities or situations, having a name or an accent or what one wears can generate forms of discrimination, racism, etc. regardless of one’s actual ethnoracial identity with one or more of the groups included in the Statistics Canada populations listed here.

**Racialized Groups versus Newcomers** – Racialized groups can be newcomers, particularly those who have migrated to Canada in the last 10-15 years from non-European countries, established immigrant as well as Canadian-born communities. It is necessary to clarify this, as the terms “immigrant”, “newcomer” and “racialized communities” or “people of colour” are often used interchangeably. Because of the complex nature of inequalities, issues facing newcomers can be compounded by the fact that they may also belong to racialized communities. Conversely, members of racialized communities may face continued inequalities, despite being Canadian residents or citizens of long standing. Analysis of newcomer populations needs to be deepened through a racial equity analysis.

**Aboriginal Groups/First Peoples** (First Nations, Inuit, Metis) are included separately in recognition of their unique situation as original peoples while the rest of the population are immigrants or descendants of immigrants. This project did not specifically include First Peoples out of respect for self-determination, that projects for First Peoples should be led by First Peoples, but the project hopes to learn from the work of First Peoples in this area.

**Structural racism** refers to “a system in which public policies, institutional practices, cultural representations, and other norms work in ways which perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with ‘whiteness’ and disadvantages associated with ‘color’ to endure and adapt over time” (Aspen Institute, 2004). The terms “systemic racism,” “systemic discrimination,” “institutional racism,” and “cultural racism” are also used to describe system-wide operations of society that exclude numbers of particular groups.

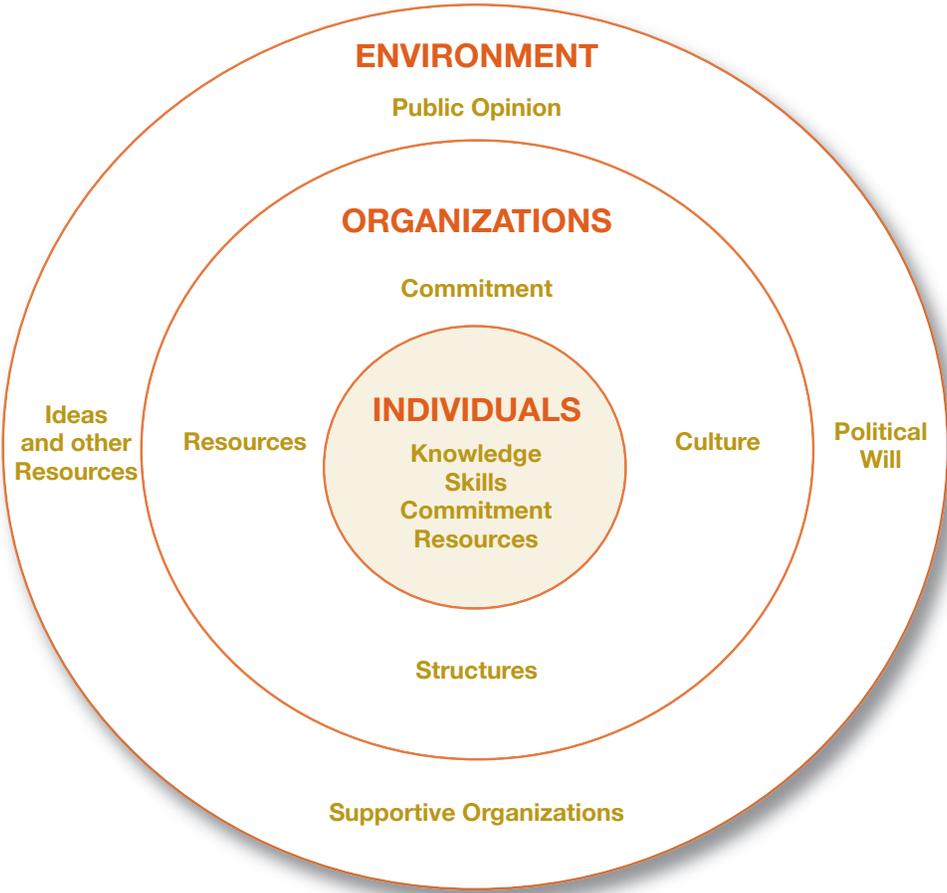
These are all distinguished from overt or **individual forms of racism** and discrimination that stem from conscious prejudice/racism and individual acts of discrimination. Internalization (self-blaming) of recurring and systematic discrimination, and individual and community responses (coping, anger/externalization, community mobilization, etc.) to the experience of discrimination are also important. However, it is often “daily hassles” and everyday actions of individuals that produce and perpetuate systemic racism<sup>5</sup>.

<sup>5</sup> For a more detailed discussion, see literature review.

[Capacity building](#) is recognized as important for sustainable health promotion programs and initiatives. **Capacity** refers to “the actual knowledge, skill sets, participation, leadership and resources” required by community groups to effectively address local issues and concerns. For people in the field of health promotion, building capacities refers to the particular types of services, programs and even goods they must provide to help communities, individuals or organizations address their health issues.

**Capacity for health promotion** means having the knowledge, skills, commitment, and resources at the individual and organizational levels and in the wider environment to conduct effective health promotion. [The Health Promotion Capacity Checklists: A Workbook for Individual, Organizational, and Environmental Assessment](#), from the Prairie region health Promotion Research Centre in Saskatchewan are useful tools for health promoters and their organizations to assess their own capacity. The figure below is taken from the workbook and helps conceptualize elements of capacity.

**Figure 1. The elements of health promotion capacity**



*From Health Promotion Capacity Checklists: A Workbook for Individual, Organizational, and Environmental Assessment*

## Continuum from Colour Blind to Anti-oppression

Health promotion programs and initiatives are often developed to serve “diverse communities” or “multicultural populations” or “immigrants and newcomers”, rather than addressing health equity for racialized communities. These differences in terminology can hide underlying assumptions and reflect different approaches to health promotion.

A useful way of looking at our work is to use the **framework to address racialized health inequities** developed through the project literature review, from “colour blind” to “culturally appropriate” to “anti-racism/anti-oppression.” The table below provides an overview. For details, see the literature review.

Examples	Universalism/ Colour blindness	Diversity/Cultural Competency	Anti-racism/ Anti-oppression
Description	<p><i>Provide everyone with the same treatment.</i></p> <p><i>Majority-group behaviours, values are the norm, “neutral”.</i></p> <p><i>Focus is on tolerating rather than accepting and valuing diversity.</i></p>	<p><i>Cultural competence emerged in the 1990s is defined as “comprehension of the unique experiences of members from a different culture through awareness of one’s own culture, empathetic understanding of oppression and critical assessment of one’s own privilege, resulting in the ability to effectively operate in different cultural contexts” (B).</i></p> <p><i>Diversity competence includes valuing diversity moving beyond accommodating it (J).</i></p>	<p><i>Antiracism calls for a critical examination of how dynamics of social difference (race, class, gender, sexual orientation, physical ability, language, and religion, country of origin) influence daily experiences often through institutions and inequitable access to resources and power and the historical, social, and political processes that have institutionalized and continue to maintain such unequal power (Dei,1996 Ng1991, Young 1995).</i></p> <p><i>Anti-oppression perspectives put structures of oppression and discrimination at the centre of analysis, attending to the diversity of oppression and their interlocking nature in order to eradicate oppression.</i></p> <p><i>Intersectionality implies examining how identities, social locations experiences and systems of oppression, along multiple axes of oppression (including race, gender, class, religion, ethnicity, ability, etc.) intersect in ways that shape experience and the configuration of power in society. Attention only to race or class is insufficient if it neglects the impact of other dimensions of identity/location (SH)</i></p>

Using different frameworks to approach health promotion can lead to shifts in what is prioritized, what is done, how it is done, how it is evaluated, and the impacts it has. Here are some elements of a culturally competent approach contrasted with a racial equity approach.

Racialized Health inequities Approach – some elements	Culturally Competent Approach – some elements
<ul style="list-style-type: none"> <li>▶ <i>Recognize intersecting forms of power and privilege, and how everyday interactions perpetuate discrimination and social exclusion, and work to dismantle individual, organizational and structural racism.</i></li> <li>▶ <i>Proactively tackling policies and practices that discriminate against racialized groups</i></li> <li>▶ <i>Ensure these groups have decision making roles, power and resources to participate in designing and delivering HP strategies</i></li> <li>▶ <i>Identify and expose health inequities, commit to reducing them</i></li> <li>▶ <i>Anti-racism, anti-oppression organizational change, including top management, organizational practices and processes, design of programs and services</i></li> <li>▶ <i>Promote awareness and identification of systemic racism/discrimination so that it can be challenged</i></li> </ul>	<ul style="list-style-type: none"> <li>▶ <i>Training for staff around how to work with diverse communities</i></li> <li>▶ <i>Culturally appropriate programs and services (e.g. indigenous and alternative forms of stress reduction)</i></li> <li>▶ <i>Targeted interventions based on disease rates among particular groups</i></li> <li>▶ <i>Scope and quality of programmes available to racialized groups often not addressed</i></li> <li>▶ <i>Underlying causes not addressed, and long term, fundamental changes may not occur</i></li> <li>▶ <i>Everyday racism may be unrecognized and unchallenged</i></li> <li>▶ <i>Essentialism and stereotyping can occur, distinctions within communities (political, historical, ethnic, social, etc.) may be ignored</i></li> </ul>

The [Health Equity Council's](#) People's Health Equity and Diversity Charter: A Framework for Action provides an overview and vision for addressing health inequities from an anti-oppression, racial equity perspective.

# Locating and Understanding Ourselves and Others

Before beginning to address racialized health inequities, it is important to understand the pathways by which racialized health inequities get created and exacerbated. Social position is an important element that helps to understand both where we are located in terms of the dominant discourse of power in our society, as well as where clients and communities are located in relation to it. The literature review shows how a number of determinants intersect to produce enduring inequalities among racialized communities. Understanding this is the starting point for building equity into our health promotion practice.

The [Colour of Poverty/Colour of Change](#) is a multi-sectoral, province wide initiative that has been doing pathbreaking work in the past four years to raise awareness and advocate around racialization and poverty. Their fact sheets are a powerful educational and mobilizing tool for change in local communities. CoP/C has chapters and activities happening in many parts of Ontario.

The report, [Inner City Health: Experiences of Racialization & Health Inequity](#), led by the Hamilton Urban Core CHC and partners, provides a number of examples of the way in which racialized health inequities operate and the pathways by which they get compounded.

This table on [Racism and Mental Health](#) helps to explain the ways in which racial exclusion and discrimination can happen, and provides possible areas of action.

This article by the same author provides a comprehensive overview of [racial discrimination and mental health](#) for racialized and Aboriginal communities that will help in understanding the adverse impacts of racism and discrimination on health.

In this [online learning module](#) from York University, read and hear about discrimination experienced by immigrants and refugees. Click on “Home” to access the full course. <http://obsidian.atkinson.yorku.ca/aksoci3624u/modules/mod07/activities/act-01.html>

A series of [TVO interviews with Dr. Kwame Mckenzie of CAMH](#) about racism, culture and mental health, can be found here: <http://www.tvo.org/TVO/WebObjects/TVO.woa?videoid?111411710001>

This brief video from the [Association of Ontario Health Centres \(AOHC\) conference in 2010](#) reflects on anti-racism and white privilege: <http://aohcconference2010.posterous.com/peggy-mcintosh-opens-day-two>

The [Power Flower](#) is an excellent tool that can be used to understand the various intersecting factors that come together in the life of an individual, family, community, group or organization, and shape their conditions, opportunities and outcomes for health and prosperity. This example is taken from work done with Aboriginal Communities in British Columbia. You can read about this tool in [Educating for a Change](#), by Rick Arnold, Bev Burke and others who originally created it. A similar tool is found at [the Green Justice Resource Kit](#) of the Youth Environment Network. The [Centre for Addiction and Mental Health](#) (CAMH) uses this very successfully as part of their [health equity, diversity and anti-oppression training and capacity building](#) – [www.problemgambling.ca/EN/Documents/AReviewClinicalCulturalCompetence.pdf](http://www.problemgambling.ca/EN/Documents/AReviewClinicalCulturalCompetence.pdf)

You can apply the power flower whoever you are – a planner or policy maker, manager or frontline worker, a client or community member, even a group or team. It can help you to understand your relative areas of privilege and lack of privilege, and the systems which support these. Think of the different elements as potential strengths rather than as deficits, and how you can work with these. This is an asset-based perspective.

It is not only enough to understand the hidden pathways by which racialized communities experience disadvantage and marginalization, but also we also need to understand the hidden pathways by which white privilege operates. [Expanding the Circle: People who care about ending racism](#), by Ann Curry-Stevens helps us understand this, and shows ways in which we can use that understanding to shift our day to day practice.

[Dismantling Racism: A Resource Book](#) (English) is a powerful and rich source of ideas, strategies and information about the impact of racism and what can be done about it.

# Program Planning

Health promotion is about enabling people to take control over their access to the determinants of health. This table below, adapted from the work of Michael Marmot (chair of the [WHO Commission on the Social Determinants of Health](#)) shows the shift in emphasis that takes place when we move from focussing on individual behaviour change in health promotion, to addressing causes of health inequities.

Conventional questions	Health equity questions
<ul style="list-style-type: none"><li>▶ <i>How can we reduce disparities in the distribution of disease and illness?</i></li><li>▶ <i>What social programs and services are needed to address health disparities?</i></li><li>▶ <i>How can individuals protect themselves against health disparities?</i></li></ul>	<ul style="list-style-type: none"><li>▶ <i>How can we eliminate inequities in the distribution of resources and power that shape health outcomes?</i></li><li>▶ <i>What types of institutional and social changes are necessary to tackle health inequities?</i></li><li>▶ <i>What kinds of community organizing and alliance building are necessary to protect communities?</i></li></ul>

From [unnaturalcauses.org](#) – adapted from the work of Michael Marmot

To promote health so that benefits can be sustained means to move from addressing **consequences** of inequities to addressing their **causes**. This is sometimes called “moving upstream.” [The Case for Prevention: Moving Upstream to improve health for all Ontarians](#) presents a convincing case for this.

You can find a [self-directed course on the Social Determinants of Health](#) here.

[HP101](#) is another online course on health promotion developed by a number of Ontario organizations.

A growing body of literature is available on serving diverse communities or multicultural populations. Many of these do not start from an anti-racist or anti-oppression standpoint. The way we define the issue can shift the solutions we offer, the resources we allocate, the way we implement our programs, and most importantly, the impact we can have on health in racialized communities. **Moving from a whole of population approach to recognition that there is no uniform population is a good starting point to reduce inequities.**

When planning programs and services, bringing in an equity lens is the way to begin. This is an example of an equity lens from the [Rapid Equity Focused Health Impact Assessment](#) of the Australian Better Health Initiative. It asks the following questions:

1. What is the initiative trying to do?
2. Is there evidence of inequality?
3. Who may be disadvantaged by the initiative?
4. Are there likely to be unanticipated impacts?
5. What are the key recommendations for implementation?

An approach to program planning that seeks to predict potential impacts prior to even beginning an initiative is called Health Impact Assessment (HIA). The [National Collaborating Centre for Healthy Public Policy](#) is a good starting point for an introduction to HIA. Used initially in policy development, HIA has applicability to program planning. Health Equity Impact Assessment (HEIA) is HIA with an equity lens.

Two versions of HEIA adapted for Ontario have been recently developed. One is for use by Local Health Integration Networks (LHINs) and their funded agencies and the other for use by public health agencies. Both can be adapted and used for community organizations as well. They can also function for overall organizational planning as well as for programs.

The [Ministry of Health and Long-Term Care](#) Health Equity Impact Assessment tool can be found here.

The [Ontario Agency for Health Promotion and Prevention](#) Health Equity Impact Assessment tool can be found here.

---

There are a variety of health promotion planning tools that you may be already familiar with. The ones below have a clear understanding of equity and can be useful starting points for programs to address inequities. Some of them are framed in terms of equity in general, that can be adapted to specifically address racialized groups.

Public health in Ontario has a key role to play in advancing health equity. The Ontario Public Health Standards of 2009 have clearly identified action on the determinants of health and of health inequities as areas for public health to act. The [Sudbury and District Health Unit](#) as well as [Region of Waterloo public health](#) and [Toronto Public Health](#) have all taken leadership roles in this area.

[First Steps to Equity](#) is an invaluable resource to support the new Ontario Public Health Standards from a health equity perspective. It includes identifying, reporting and using information about health inequities and tailoring strategies to inform actions that meet the needs of priority populations. It provides ideas, steps, examples and resources to support people and organizations working for equity in health in Ontario.

# Key Equity Questions



From: Patychuk D and Seskar-Hencic D. November 2008. *First Steps to Equity. Ideas and Strategies for Health Equity in Ontario 2008-2010*. Toronto.

The [Community Health Centre model](#) is one that recognizes health inequities, and works from a community based perspective to provide health care as well as health promotion services to local communities. The [Association of Ontario Health Centres](#) recognizes health inequity, and operates from an anti-oppression perspective as described above. In Toronto, the [Taibu CHC](#) is specifically focussed on working with the Black community, based on a recognition of racialized health inequities. This underlies the work of the whole organization and the programs and services it offers. Another CHC that names and works to address racialized health inequities is the [East Mississauga CHC](#).

A useful new resource is the [Evidence Informed Practice Workbook, 2nd edition \(September 2010\)](#), from Unison Community and Health Services, Toronto. This practical resource produced in a Community Health Centre will be of tremendous use to health promoters and managers in their work. Although framed as evidence-informed practice, it has a strong equity focussed analysis that will help in addressing health among racialized communities.

Many community organizations are actually doing health promotion, even though they may not describe their own work in that manner. [Count Me In](#) is an initiative about inclusion, defined as the feeling and reality of belonging. Inclusion is a health promotion strategy. A toolkit produced by the project helps practitioners develop inclusive and equitable programs with communities. Starting from the premise that communities can define what is good for them, it offers a discussion, a workbook and worksheets that helps practitioners to engage communities as they plan programs with them.

The Pan American Health Organization's [Guide for Documenting Health Promotion Initiatives](#) can be adapted for use at the program planning stage, in terms of what an equity focused health promotion intervention should look for. The following processes are identified that make for a successful health promotion initiative, including equity elements:

- ▶ Meaningful participation of all stakeholders
- ▶ Critical dialogue
- ▶ Shared power and responsibility
- ▶ Project action planning and evaluation
- ▶ Evolving leadership
- ▶ Sustained mobilization of resources
- ▶ Critical reflection and systematic monitoring
- ▶ Ongoing educational and training opportunities
- ▶ Develop and attract champions
- ▶ Generate public awareness of evidence-based project successes
- ▶ Influence public policy and decision-making bodies
- ▶ Work with relevant social movements, private sector organizations and advocacy groups
- ▶ Improve knowledge exchange and community-academic partnerships

The [National Collaborating Centre for Methods and Tools](#) is a place to find information and self learning tools for your work.

Local level data is important for program planning. In 2010-11, all 36 Healthy Communities Partnerships (most of them integrated with the local Public Health Unit) were engaged in extensive data collection to create a snapshot of the overall health of their communities together with recommended actions for 2011-12. This was part of an exciting new initiative undertaken through the [Healthy Communities Fund](#) of the Ontario Ministry of Health Promotion and Sport that can have impact on reducing health inequities.

To find out more about the Healthy Communities Partnership in your area, please contact your local Public Health Unit. [Click here](#) to find your local Ontario public health unit.

[Primer to Action: Social Determinants of Health](#), is an electronic resource for health professionals, lay workers, volunteers and activists from different sectors to understand and influence how the social determinants of health impact chronic disease. Set in an electronic, easy to read format, with hundreds of links and resources, it is a practical resource for busy health and community workers, activists, in their capacity as staff, volunteers or community members.

Primer to Action provides a point of entry to understand and take action on six health determinants: Income, Employment, Housing, Food Security, Education and Inclusion. It offers concrete suggestions for change in the community, the workplace and the broader society.

The [Toronto Intensive Research on Neighbourhoods & Health Initiative \(Toronto-IRONHI\)](#) project looks at how “health opportunity structures” differ across neighbourhoods and affect health outcomes. Its primary objective is to improve understanding of the pathways and mechanisms linking neighbourhoods and health and to inform policy and community action about how neighbourhood-based interventions could address health disparities.

One of the products to come out of this project is the [Centre for Research on Inner City Health – Rapid Assessment Tool for Small-Area Health Needs](#). This tool was developed to quickly and reliably assess small-area health status and health needs for use by decision-makers and service providers as well as community groups and non-profit providers of publicly-funded services. The tool allows users to collect information on several topics including health status, health care use, health behaviours and neighbourhood services. A 'tool kit' has also been developed that includes a manual and user guide as well as a set of best practices for knowledge translation to guide potential users from the survey planning stage all the way to the final stages of data interpretation and dissemination.

[Geographic and Numeric Information Systems](#) is an initiative of the Social Planning Network of Ontario that uses Geographic Information Systems as a powerful tool to aid in planning and decision making.

[People Places Processes](#) is an equity-focussed health promotion workbook from Australia, based on a useful differentiation of equity aspects into equity of access, opportunity and outcomes, suggesting population wide, targeted, place-based, plus a lifecourse approach to interventions. A list of questions to use as programs are planned helps embed equity into the work of health promotion.

## Evaluation

This resource guide does not contain a separate section on evaluation. However, there are evaluation related suggestions in some of the resources referred to above. Here are some further links.

[Working Together: The Paloma-Wellesley Guide to Participatory Program Evaluation](#) is a recent publication directed especially to non-profits who provide frontline services. The guide identifies the element of participatory program evaluation.

- ▶ Proactive and Inclusive
- ▶ Moves from Fault Finding to Collective Learning
- ▶ Changes the Invisible to Visible
- ▶ Increases Relevance and Meaning
- ▶ Increases Credibility
- ▶ Builds Evaluation Capacity
- ▶ Provides Comprehensive Information for Better Decision-Making
- ▶ Transparent and Accountable

Within this broad equity focussed approach to evaluation, the website [Evaluation Tools for Racial Equity](#) contains a step by step guide with associated tips and tools to assist in evaluating initiatives to address racial equity. [Racial Equity Tools](#), a companion site provides further materials.

This [Equity Evaluation Tool](#) from Australia can be used as a guideline for evaluating equity components of community interventions. According to it, practitioners must be able to a) articulate the equity issue, b) situate their activity and c) describe the pathway linking their program or practice to health equity. Each step is broken down into suggested questions to ask, to build in an equity lens.

[The Prevention Institute](#) (US) website provides further discussion and tools on evaluation from a health equity perspective.

## Further Resources

- ▶ The [OHPE](#) and [le Bloc-Notes](#) offer searchable databases of information on health promotion
- ▶ The [CERIS virtual library](#) is an excellent source of research
- ▶ The [National Collaborating Centres for Public Health](#) with a focus on knowledge exchange are important sources of information
- ▶ The [Canadian best practice portal on chronic disease prevention](#) has a searchable database of best practices in chronic disease prevention.
- ▶ Many local health units put out equity focussed reports and fact sheets about their community (e.g. Region of Waterloo, Sudbury and District Health Unit, Toronto Public Health, Peel Health), as do Local Health Integration Networks.
- ▶ [Ontario Council of Agencies Serving Immigrants](#) (OCASI) is an umbrella agency that is a voice for issues of immigrants in Ontario that has a number of papers and reports on their website.
- ▶ [Social Planning Networks](#) and research departments of universities are also good sources of information
- ▶ [Health-evidence.ca](#)
- ▶ [Health Equity and Prevention Primer \(US\)](#) – <http://www.preventioninstitute.org/tools/focus-area-tools/health-equity-toolkit.html>
- ▶ This award winning documentary and educational website [www.unnaturalcauses.org](http://www.unnaturalcauses.org) (US) has a wealth of information and resources that can support equity initiatives.

## Health Promotion Initiatives

The following section lists overall health promotion initiatives, as well as initiatives in the three focus areas of Mental Health Promotion, Healthy Eating/ Food Security, and Physical Activity that offer promise for addressing racialized health inequities. In each section are also links to tools and resources that can be used.

### Mental Health Promotion

Mental health is an integral part of health. Mental health can affect physical health and the other way round. Level of income, job security, access to food, education, social inclusion, etc. are factors that affect us both mentally and physically. A growing body of research into areas of newcomer mental health, indicators of discrimination, refugee trauma, etc., is deepening our understanding of the mental health of racialized communities, and potential areas for action. The literature review provides ample documentation to show how racism and discrimination can affect the health of racialized communities.

The Canadian Mental Health Association's (CMHA) [Mental Health Promotion Toolkit](#) is a good starting point to understand the concept of mental health promotion, and to learn from effective practices in the field.

The Centre for Addiction and Mental Health resource [Best practice guidelines for mental health promotion programs: Children & Youth](#) offers examples of effective mental health promotion at work. It identifies the following guidelines for doing this work.

1. [Address and modify risk and protective factors that indicate possible mental health concerns.](#)
2. [Intervene in multiple settings, with a focus on schools.](#)

3. [Focus on skill building, empowerment, self-efficacy and individual resilience, and respect.](#)
4. [Train non-professionals to establish caring and trusting relationships.](#)
5. [Involve multiple stakeholders.](#)
6. [Provide comprehensive support systems that focus on peer and parent-child relations, and academic performance.](#)
7. [Adopt multiple interventions.](#)
8. [Address opportunities for organizational change, policy development and advocacy.](#)
9. [Demonstrate a long-term commitment to program planning, development and evaluation.](#)
10. [Ensure that information and services provided are culturally appropriate, equitable and holistic.](#)

*[Opening Doors](#) is an innovative project that offers interactive peer-led workshops that address mental health, racism and discrimination. This project is coordinated by the Toronto branch of the Canadian Mental Health Association, Across Boundaries Ethnoracial Mental Health Centre and Access Alliance Multicultural Health and Community Services, and is focused on strengthening, fostering and cultivating healthier communities in Ontario. [Click here](#) to view a presentation made at the Facing Racism in Health Promotion event organized as part of the project.*

*The [Centretown Laundry Coop](#) is a great example of an initiative that promotes mental health, even while it is not explicitly stated as such. It provides affordable laundry to people on low incomes in a safe supportive environment where at the same time they can develop and use their skills to improve their quality of life and contribute to the community. The Laundry Co-op is the only one of its kind in North America. [www.communitylaundrycoop.ca](http://www.communitylaundrycoop.ca)*

*[PEACH – Promoting Education and Mental health](#) supports at-risk youth and their families by responding to their needs and providing opportunities for quality relationships, education, and skills development. As an alternative to street violence, PEACH offers youth the academic, social and economic tools to stay in school, gain employment and make positive life choices during their formative years<sup>6</sup>.*

[Refugee Mental Health – Promising Practices and Partnership Building Resources](#) is for people who work with refugees in Canada, particularly those who provide settlement, health and other social support services. The material is written for front line workers, program managers and the leaders of agencies, and is informed by their ideas and expertise.

[India Rainbow Community services of Peel](#) runs innovative programs for seniors including a highly successful Adult Day Program where seniors are brought to the centre and are engaged throughout the day in preventative and curative wellness programs.

[Women of the World](#) is a program at the London InterCommunity Health Centre that provides a space for women to support each other, develop skills and enhance their health. <http://lihc.on.ca/immigrant-and-ethno-cultural-communities/>

<sup>6</sup> This description is taken from: <http://www.evaluationontario.ca/Events/RossiterWilsonPargassingh.html>

The [Ryerson-Wellesley Determinants of Health Framework for Urban Youth](#) provides a useful template through which we, as a society, can work together to better ensure the health and well being of urban youth today for a better social, political and economic outcomes for tomorrow.

[Ementalhealth.ca](#) is an online mental health resource directory that helps people find out where to get help for mental health problems in their region.

The [Validity Project](#) is a partnership of research, community programs and product development at CAMH to explore the psychosocial risk factors associated with depression in young women. Findings are used to enhance services for young women experiencing depression. It has grown beyond a research project to become a vibrant, sensitive community of women dedicated to helping young women and preventing depression. The project has created resources/videos and held live events with topics around racism, and health equity for marginalized and racialized women in accessing mental health services.

### Healthy Eating / Food Security

Food security is about more than eating healthy – it is about having access to adequate, appropriate, nutritious and affordable food for all. Many communities, including racialized groups, face growing food insecurity. The book by Grace Edward Galabuzi – Canada’s Creeping Economic Apartheid – and work done by the Colour of Poverty shows that racialized communities face disproportionate poverty, which includes food insecurity. Food security initiatives are important ways in which communities can empower themselves and their health. However, mainstream food security initiatives based on Eurocentric models may not always address the food insecurity that racialized communities face.

*The [Afri-Can Food Basket](#) is a non-profit community food security (CFS) movement that is committed to meeting the nutrition, health and employment needs of members of the African Canadian community, in particular, those who are economically and socially vulnerable. Programs include sustainable agriculture, youth development, local food access and food justice.*

*[Food Security Research Network](#) from Thunder Bay is a network focussing on northern issues and concerns. One research study looks at environmental impacts on traditional food sources.*

*Feeding the mind, body and soul – Rexdale Community Health Centre, [www.rexdalechc.com](http://www.rexdalechc.com)  
Through this program, racialized/marginalized youth have open discussion and seek support around barriers to accessing health services in the GTA and learn about healthy eating and cooking on a budget.  
The feedback from the youth has provided insight into youth focused health program delivery in the Rexdale region, specifically for racialized and newcomer youth.*

**Toronto** has been a leader in the area of food policy. [Food Connections](#) is a food strategy for the city. Read about the work of the [Toronto Food Policy Council](#) and find links to their reports here – [www.toronto.ca/health/tfpc\\_index.htm](http://www.toronto.ca/health/tfpc_index.htm)

The [Peer Nutrition Program](#) of Toronto public health delivers culturally and linguistically appropriate nutrition programs to parents, grandparents and caregivers of children aged six months to six years in diverse underserved communities. By providing tools, resources and skills in culturally appropriate languages, the program increases knowledge and access to healthy eating on a budget.

Community specific food guides for the city of Toronto are available here – [www.greenbelt.ca/resources](http://www.greenbelt.ca/resources)

**FoodNet Ontario** is a food security network whose goal is to support a province-wide network to increase the capacity of Ontario communities to provide access to safe, affordable, nutritious and culturally appropriate food by:

- ▶ bringing people, ideas and resources together
- ▶ facilitating communication and collaboration among organizations;
- ▶ educating the public and key decision-makers about community food security; and
- ▶ promoting best practices.

[Food Secure Canada](#) is an organization that works to build food security in Canada and globally.

[Everybody's Food Budget Book](#) from Ottawa public health shows how to shop and cook on a limited income. This successful resource is being used by a number of other health units in Ontario, including Durham, Renfrew and others.

## Further Resources

Windsor Essex County, is one of the areas on the province to have faced growing poverty as a result of the recession. The area has been active in matters relating to food security and recently set up a [Food Matters Committee in 2010](#) to look at food security.

<http://pathwaytopotential.ca/docs/Windsor-Essex%20County%20Community%20Food%20Matters%20Report.PDF>

The [CHC Food Security Handbook](#) provides a description of food security initiatives undertaken by CHCs in the GTA that will be useful to others who want to start similar initiatives in their communities.

[Making the Business Case for Good Food Box Programs](#) – this scan outlines what a good food box program is and how to go about setting up one in a community.

[http://ohcc-ccso.ca/en/webfm\\_send/501](http://ohcc-ccso.ca/en/webfm_send/501)

## Physical Activity

The importance of physical activity for health cannot be limited to education about this for members of racialized communities. A shift from lifestyle focussed interventions to the upstream conditions under which people can be physically active and healthy, including income, employment, access to food, education, housing are often more important to address. At the same time, access to facilities for sport and recreation that are inclusive and non-discriminatory are also important.

The Ontario Council of Agencies Serving Immigrants has created an [Inclusive Model of Programming in Sport and Recreation for Immigrant and Refugee Youth](#), that incorporates anti-racist principles.

The 12 elements of the model are

- ▶ Combine education with sports and recreation activities
- ▶ Introduce familiar and popular sports and recreation activities
- ▶ Encourage Parental involvement
- ▶ Develop youth leadership by offering basic training in officiating and coaching
- ▶ Build working relations and collaborations with other service providers
- ▶ Ensure that facilities are within geographical reach of youth
- ▶ Develop supportive internal organizational structure and top management support
- ▶ Create Funding Opportunities and develop strategies for working with funders
- ▶ Mobilize Communities
- ▶ Ensure Programming Reflects diversity and cultural sensitivity
- ▶ Operate under an anti-oppression and anti-racism framework
- ▶ Acquire transportation for youth

Recommendations include:

- ▶ Bring together community-based, immigrant- and refugee-serving organizations to implement the model
- ▶ Promote the model to mainstream sports and recreation organizations
- ▶ Promote dialogue and collaboration between the settlement agencies and mainstream organizations
- ▶ Train staff and recreation leaders
- ▶ CIC should include the sports and recreation component in settlement funding

*Systemic ways in which neighbourhoods inhabited by communities of colour can be disadvantaged when it comes to playground facilities can be seen in [this story](#) by Catherine Porter in the Toronto Star. Next read about the response of local women – the [Thorncliffe Park Women’s Committee](#) – and how their determination and collective action addressed playground access for their children.*

*The [YOUNG MUSLIMAHZ](#) program of the Scadding Court Community Centre, Toronto offers a social/recreational program with diverse athletic, social and arts-based activities like cooking, skating, basketball, arts & crafts, workshops, women’s only swimming, field trips and more. It provides a place for Muslim and non-Muslim young women to come together to make friends, have fun, learn, develop skills, build confidence, be active in the community and explore the intersection between different faiths and cultures.*

The [Recreation Access for Children and Youth of Hamilton’s Diverse Communities: Opening Doors, Expanding Opportunities](#) report, outlines the challenges and barriers facing racialized communities when it come to sport and recreation with excellent suggestions on how to address these.

**PADEC** (Promoting **P**hysical **A**ctivity **A**mong **D**iverse **E**thno-cultural **C**ommunities), is a collaborative project between university researchers, public health professionals and peer educators whose role is to work with immigrant communities to increase their healthy behaviours and decrease barriers to health and social services.

The programs described in this article from the [Ontario Health Promotion E-Bulletin](#) provide further examples of how physical activity programs with an equity focus can be created in partnership with racialized communities.

## Service Delivery

The best designed programs can fail if they are not delivered appropriately. Programs and services need to be accessible (in all senses of the term), equitable, and delivered in a welcoming and non-discriminatory manner. Recruitment of appropriate staff is important, and training staff in anti-racist and culturally competent service delivery are factors that organizations must pay attention to.

[Across Boundaries](#), an ethnoracial mental health centre has deepened its understanding of anti-oppression principles and what they mean for day-to-day work in their agency. This [How We Do It](#) manual presents what they have learned over their many years of work.

They identify the following principles underlying an anti-racist service delivery model<sup>7</sup>:

**Racism, racial abuse and racial violence affect the health and mental health of individuals and communities.** In other words, racism is itself a distinct social determinant of mental health, as well as a root cause of other social determinants of health, such as poverty or inadequate housing.

**Individual and systemic racism present barriers to quality health and mental health services.** These barriers include the inappropriate use of interpreters, culturally-inappropriate treatment methods, and traditional mental health providers who impose their own values and perspective on populations they know very little about. These barriers deter racialized people from using mental health services, or lead them to defer seeking help until they are in desperate need.

**The way to multiculturalism is through anti-racism.** Some organizations aim to improve their services by adopting “culturally competent” approaches. These approaches can be a good first step. But only an anti-racist analysis can truly respond to the underlying sources of ongoing trauma – not just of culture shock, but of ongoing racism and unmet expectations – or lead to the organizational and structural changes needed in the mental health system.

**There is a diversity among racialized people who**, in addition to race, may also be discriminated against on account of their religion, language, ethnicity, class, gender, sexual orientation, disabilities, age, country of origin and citizenship status. Truly holistic care must respond to the intersectionality of all forms of oppression.

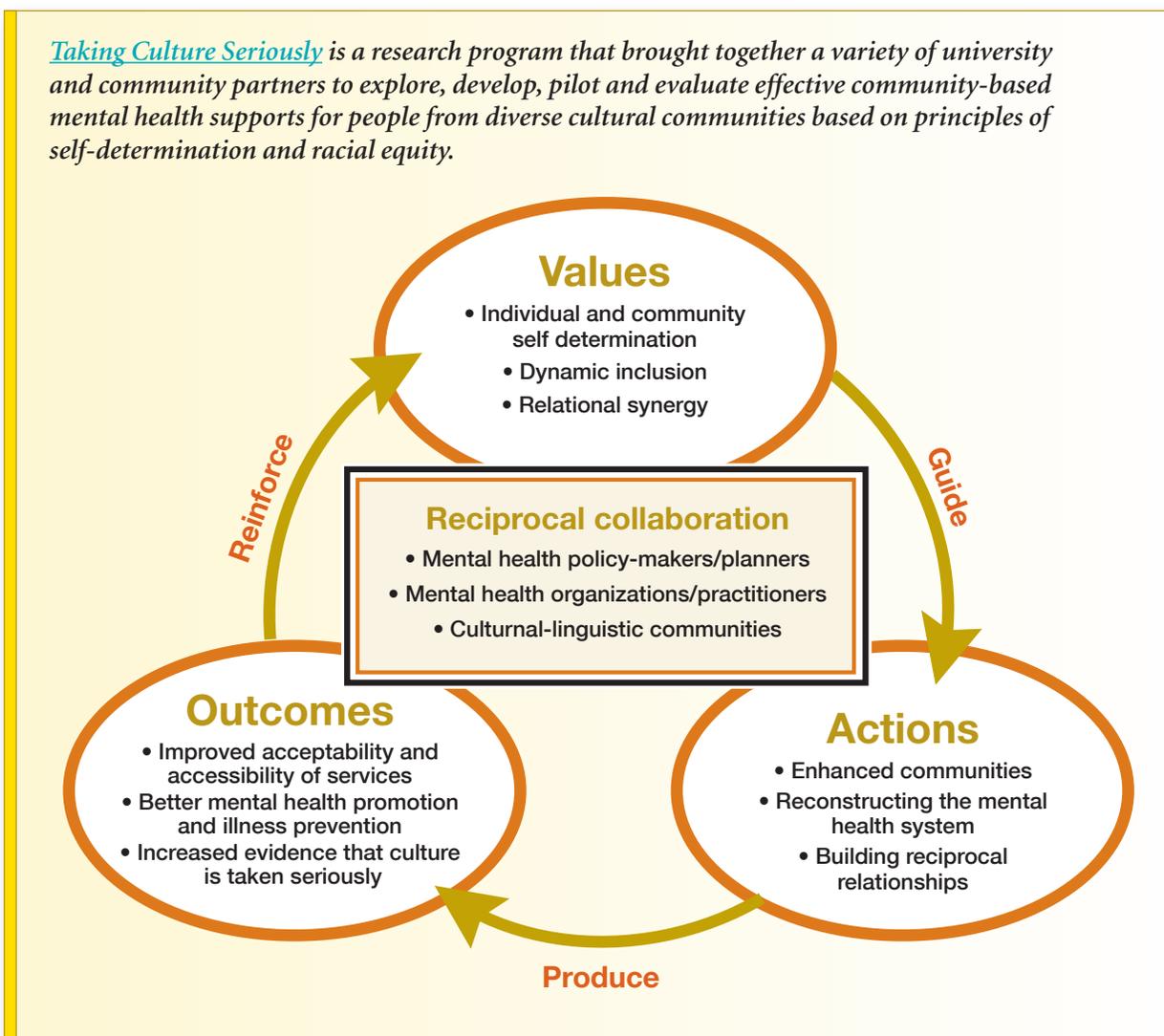
**Anti-racist practice is a strategic approach to addressing all forms of oppression in the mental health system.** A focus on racism does not mean we are competing with other “isms” or are creating a hierarchy of oppressions. Instead, we see anti-racism as an entry point. We believe that any substantive progress made through anti-racist practice will lead to meaningful change in addressing all inequities and oppression in the mental health system.

<sup>7</sup> Text taken from actual manual.

A study by Ilene Hyman and Sepali Guruge<sup>8</sup> on promoting health among new immigrant women has the following recommendations to make:

- ▶ Use behaviourally-focused strategies, recognizing that many cultural concepts with potential relevance to health practices (e.g., collectivism, ethnic identity) have not been adequately researched.
- ▶ Focus on reducing informational, cultural, linguistic, economic and systemic barriers to care.
- ▶ Use an empowerment philosophy.
- ▶ Use community “link leaders”, leadership and the media.
- ▶ Involve the community in planning, design and delivery of interventions.
- ▶ Be dynamic, as immigrants’ attitudes, beliefs and behaviours change as part of an acculturation process.

***Taking Culture Seriously** is a research program that brought together a variety of university and community partners to explore, develop, pilot and evaluate effective community-based mental health supports for people from diverse cultural communities based on principles of self-determination and racial equity.*



<sup>8</sup> <http://www.mendeley.com/research/review-theory-health-promotion-strategies-new-immigrant-women/>

This resource from the Best Start Resource Centre, [Reducing the Impact: Working with pregnant women who live in difficult life situations](#) is a guide for service providers who work with pregnant women including current research, strategies and recommendations and references to further resources. It contains ideas and suggestions for service providers that are transferrable to other areas of health promotion.

This [charter for offering services to women](#) came out of [Count Us In](#) an inclusion research project on women and homelessness carried out by the [Ontario Women's Health Network](#) and partners in 2006. Based on anti-oppression principles, it can be a checklist for self assessment by organizations. This same study found that the Toronto Public Library was regarded by the women as welcoming and inclusive.

1. Respect our rights and freedoms as women.
2. Support our needs as women.
3. Show us respect and treat us with dignity.
4. Recognize our rightful place as equals, with all of our human, political, social and economic rights.
5. Create safe spaces where discrimination is challenged and actively resisted.
6. Take the time needed to hear and understand us.
7. Strive to offer us helpful and timely assistance.
8. Involve us in your decisions as you plan and implement programs.
9. Ensure that your organization's staff and the materials you distribute recognize and reflect the diversity of the communities you serve.
10. Make your organization a place where each of us feels safe, welcome and free to be who we are.

*[Diversify the Source, Enhance the Force](#) – this project by the [Self Help Resource Centre](#) aimed to build capacity within newcomer communities, while also benefitting the organization where they were volunteering. This project included anti-racism training for staff as an ongoing component. Self help strategies are particularly useful when working with racialized communities as they are based on a democratic principle of peer leadership and power-sharing.*

The [Building Inclusive Communities Tips Tool](#) is a useful and practical guide on how to create a welcoming environment for racialized people with disabilities. It is brought out in partnership between the [Ethnoracial People with Disabilities Coalition of Ontario](#), [Women's Health in Women's Hands](#) and [Toronto Public Health](#).

An organization that has put equity and diversity at the centre of its work is CAMH – [http://www.camh.net/About\\_CAMH/Diversity\\_Initiatives/index.html](http://www.camh.net/About_CAMH/Diversity_Initiatives/index.html). See also [Culture Counts: Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/Ethnocultural Communities](#)

## Further Resources

[Strategies for working with newcomer women giving birth for the first time in Canada](#) – this resource has a good discussion of barriers experienced by recent newcomer women and their families (mostly racialized) and many useful ideas and hints that have a wider applicability than just reproductive health.

[This article](#) contains concrete suggestions on how to work with victims of torture, who may have specific needs.

## Some Models and Strategies

There are many models that have been found useful by organizations and groups working to eliminate racialized health disparities.

**Mainstream versus ethnospecific organizations** – Ethnospecific organizations often are more successful at serving their communities. Although it is not recent, many points in this [literature review by Jeffrey Reitz](#) are still relevant.

Related to this is the role that **settlement organizations** can play in community capacity building. The report from OCASI, [When Services are Not Enough](#), shows how there are positive, unintended consequences that can happen, namely capacity building, even though it is only settlement services that are being funded. The impact of funding cutbacks will run far deeper.

**One window service** – The [East Scarborough Storefront](#) is a celebrated example of how a partnership of community members and services working together provides accessible sites for community members of all ages and cultures to find and share solutions they need to live healthy lives, find meaningful work, play and thrive this operates.

**Peer based service delivery** – This report from the **Region of Waterloo Public Health** offers a good outline of what is meant by a peer program, and what its individual as well as community capacity building and other impacts can be. Peer based models can be beneficial for a number of stakeholder groups: members of the community, the peers who deliver the program, as well as the agencies and local sites where they are delivered, in addition to more long term social impacts.

**Self-help** – Self-help/mutual aid support groups are informal networks of individuals who share a common experience or issue. Members get together to share support. The primary focus of self-help is emotional support, practical support and information exchange.

**Women's Health Circles** (Ontario Women's Health Network) – is a tested methodology for educating low income and marginalized women based on field testing with marginalized women and women of colour in Ontario.

**Photo Voice** – is a more recent tool used to empower communities to take action on issues of concern to them. This example of a research initiative by the [Wellesley Institute](#) shows how powerful photovoice can be in addressing health equity issues.

**Communities of Practice** – are a way of people engaging to learn and practice together. An example of a successful community of practice to address equity issues is one carried out by the Black Creek CHC in Toronto. This was a practical way to enable service providers and consumers from a defined community to make progress on this issue. The [draft report](#) and [published evaluation](#) provide further details.

# Engaging Communities

Communities need to be engaged right from the start if health equity issues are to be meaningfully addressed. This takes commitment, time and resources to be done properly. Sometimes frameworks and expectations at the organization end can take precedence over the actual realities of communities, so it is good to build this into the plan itself.

**“Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.”**

*(Fawcett et al, 1995)*

Key principles of engagement identified by the Centres for Disease Control and Prevention (US) are:

- ▶ Purpose
- ▶ Know the community
- ▶ Build relationships
- ▶ Self-determination
- ▶ Partnership with the community
- ▶ Recognize and respect diversity
- ▶ Mobilize community assets, develop community capacity
- ▶ Flexibility
- ▶ Long term commitment

Read more about community engagement in [this report](#) and also in [this report](#).

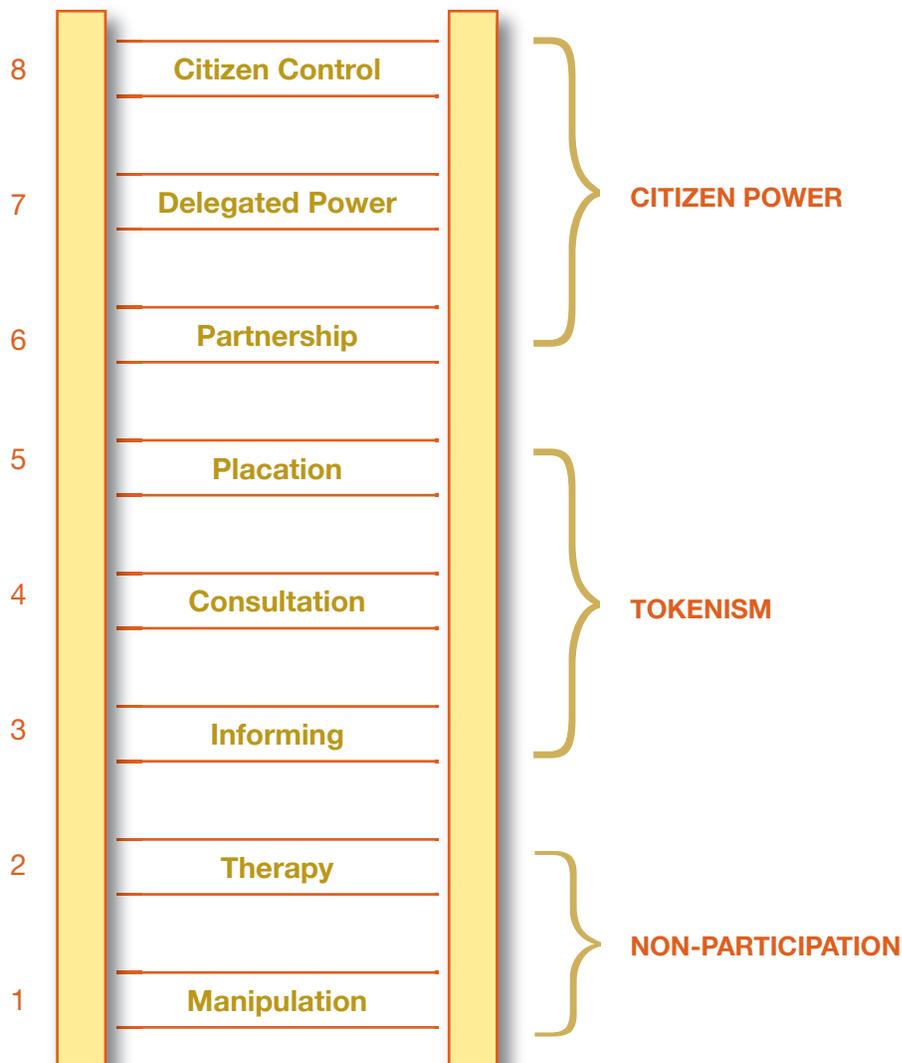
Building community capacity is an important part of health promotion and community development. We begin by looking at community assets rather than deficits and build on these. Read about [asset based community development](#) (English), based on the work of Kretzman and McKnight<sup>9</sup>. These resources from [Health Nexus](#) are based on a similar perspective that communities and groups have strengths that can be mobilized for their improved health.

Action for Neighbourhood Change is a series of pan-Canadian initiatives aiming to bring about long term sustainable change focused on community capacity building. This paper [Asset-based, Resident-led Neighbourhood Development](#) from the Caledon Institute looks back at the initial phase of this initiative. The paper “highlights the asset-based, resident-led approach pursued on the ground in the five participating neighbourhoods. It also considers the roles that government and voluntary sector partners at the national level can play in support of such initiatives.”

Community development is the process by which community capacity is built. On this page, you can download the Public Health Agency of Canada’s [Community Capacity Building tool](#) and user manual.

<sup>9</sup> <http://www.northwestern.edu/ipr/publications/community/introd-building.html>

The [Ladder of Citizen Participation](#) (see figure below) shows how to engage communities meaningfully. There can be many forms of community involvement, but the key question is how much power communities have to actually influence decision making, and how much accountability there is to communities on the part of decision makers.



From Sherry R. Arnstein – <http://lithgow-schmidt.dk/sherry-arnstein/ladder-of-citizen-participation.html>

The [International Association of Public Participation’s spectrum of participation](#) provides a good framework to see what the goals of participation are, and the tools that can meet the needs at different levels of participation.

Vancouver Coastal Health’s [community engagement framework](#) provides a useful outline to build on.

**Connecting the Dots** is a successful model of community engagement used by Health Nexus to organize over 15 community engagement events over 5 years. CTD is a dynamic, multi-sectoral, community engagement model that helps communities “work together differently” for better health outcomes and improved health for all. Key features:

- ▶ Creates a climate for creative change and sets the stage for further collaborative work in the community.
- ▶ Builds capacity through increased knowledge of resources (including people and organizations), as well as specific knowledge about a health-related issue.
- ▶ Bridges people from across the chronic disease continuum – health promotion, public health, hospitals, community services, and long-term care – and from sectors such as social services, education, housing, and recreation.

**Hamilton’s Centre for Civic Inclusion** – HCCI is a community-based civic resource centre, committed to working as a catalyst for anti-racist change across Hamilton. HCCI assists Hamilton, its major institutions, business, service providers, and residents to develop transformative processes that promote equity and create racism-free and inclusive environments in all areas of civic life.

**Youth Empowering Parents (YEP)** – YEP provides the essence of one-on-one tutoring for immigrant parents by utilizing an innovative model. By using one trained ESL instructor, the YEP program is able to teach multiple youths who are fluent in both English and their home native language. These youths then provide one-on-one tutoring to an adult of a similar background – either their own parent/guardian or another parent.

The concept for YEP was developed by a diverse group of youths who were seeking to give back to their local community in an innovative way. Following much determination and hard work, the first YEP program was implemented in the immigrant-populated neighbourhood of Regent Park, Toronto.

## Further Resources

See [www.count-me-in.ca](http://www.count-me-in.ca) for a toolkit on how to engage communities in developing inclusive programmes. This workbook shows how to engage the community to define the outcomes they want, and how to work to influence the determinants of health.

**Involve Youth 2** is a guide for engaging youth produced by Toronto Public Health, including a chapter on what it means to engage them using an anti-oppression framework.

The **Vibrant Communities** initiative of the Tamarack Institute, engages communities to reduce poverty. The Tamarack website contains a large number of resources on community engagement.

The **Waterloo Public Health Community Engagement Framework** is grounded in the new Ontario Public Health Standards, and provides a four step process of engagement.

Human Resources and Skills Development Canada’s **Community Development Handbook** and accompanying Facilitator’s Guide can be found on this page:

[http://www.servicecanada.gc.ca/eng/epb/sid/cia/comm\\_deve/handbook.shtml](http://www.servicecanada.gc.ca/eng/epb/sid/cia/comm_deve/handbook.shtml)

[The Kit – A Manual by Youth to Combat Racism through Education](#), is a resource for educators, community leaders, NGOs, peer educators, anti-racism activists – and especially youth – to engage people to take action to combat racism.

[Anti-Racism Vaccine](#) – This is a winning video for the March 21st, 2006 International Anti-Racism Video Competition done by the students of Holy Names High School in Windsor Ontario. The winning videos were broadcast over various Canadian channels. For more recent winning videos, check out the website: <http://www.cic.gc.ca/english/multiculturalism/march21/index.asp>

[Shadeism](#) – this documentary short is an introduction to the issue of shadeism, the discrimination that exists between the lighter-skinned and darker-skinned members of the same community. This documentary short looks specifically at how it affects young women within the African, Caribbean, and South Asian diasporas. Through the eyes and words of 5 young women and 1 little girl – all females of colour – the film takes us into the thoughts and experiences of each. Overall, ‘Shadeism’ explores where shadeism comes from, how it directly affects us as women of colour, and ultimately, begins to explore how we can move forward through dialogue and discussion (description from website).

## Partnering and Collaboration

Racialized health inequities are complex problems. Because of the intersecting and multidimensional nature of these disparities, solutions must likewise be multi-dimensional, multi-layered and involve all key stakeholders and sectors in a meaningful way. Very often the process of engaging in the partnership will have impacts on the intended outcomes, in addition to strong collaborative relationships that are themselves sought after outcomes.

*Ottawa provides a highly successful example of an intersectoral partnership called [No Community Left Behind](#). This is a social development initiative with the objective to prevent crime and address social determinants of health through a collaborative approach and integration of services at the neighbourhood level.*

*No Community Left Behind has now become a strategy development process at the neighbourhood level in which community development specialists, community policing professionals and neighbourhood activists and almost all concerned service providers collaborate to address factors that lead to communities’ vulnerability, crime, victimization, fear of safety, and social exclusion.*

*Working in close partnership with various other agencies, South East Ottawa Community Health Centre (SEOCHC) has effectively engaged and supported communities to restore their sense of safety and pave the way for effective service delivery. NCLB has now become a core component of the City of Ottawa’s Community Development Framework (CDF) for community engagement at the grassroots level. [http://www.nocommunityleftbehind.ca/main\\_e.htm](http://www.nocommunityleftbehind.ca/main_e.htm)*

*The NCLB initiative is part of Coalition of Community Health and Resource Centres of Ottawa – [www.coalitionottawa.ca](http://www.coalitionottawa.ca). Also see their paper [A Model for Service Collaboration and Integration](#).*

*[Diversity Thunder Bay](#) is an anti racism initiative that is taking on racism and discrimination directly through local partnerships. It has multiple partners and continues to grow. A major project has been partnering on institutional change with the police. Their learnings include:*

- *Institutional change, like all change, produces conflict*
- *Institutional change happens slowly, not in a linear way*
- *Perception is reality*
- *Substantiability needs to be built in early to maintain momentum of project work*

*For other anti-racism initiatives in northern Ontario, click here:*

*[www.debwewin.ca/antiracisminitiatives.htm](http://www.debwewin.ca/antiracisminitiatives.htm)*

*The Region of Peel has taken important steps in addressing in an integrated way the diversity in their region, where large numbers of racialized communities live. These include the multi-stakeholder planning and policy oriented [Peel Newcomer Strategy Group](#), a series of commissioned [papers on immigration in Peel](#), and a [Diversity and Inclusion Strategy](#).*

[Pathways to Education](#) is a celebrated intersectoral initiative that builds community capacity through supporting youth to stay in school. It began in the Regent Park neighbourhood of Toronto, inhabited mostly by newcomer racialized communities, and is now replicated across Canada.

A timely and innovative conference called [Building Equitable Partnerships Symposium](#) was organized by the Centre for Addiction and Mental Health and partners in 2008. The report, released in 2011, contains a wealth of insights, learnings and examples of how equity is to be built as partnerships are developed, maintained and evaluated

## Further Resources

[Health Nexus](#) has produced various resources that can help in partnership and coalition building.

[The Partnerships Analysis Tool](#) from VicHealth in Australia is a “resource for establishing, developing and maintaining productive partnerships” for health promotion.

[The Partnering Initiative](#) offers a number of tools in multiple languages related to partnering that will be of use to those working in health promotion.

[Colour of Poverty/Colour of Change](#) is an innovative, multiple stakeholder advocacy based coalition addressing poverty for people of colour in Ontario. CoP/C is organized through a steering committee and is active provincially through local lead organizations for different parts of the province.

An excellent toolkit for intersectoral action is available from the [Public Health Agency of Canada](#).

[The Prevention Institute](#) (US) has useful tools to assist in the process of partnering, including how to build coalition as well as a “collaboration multiplier” to interactively assess partner skills.

# Organizational Issues

Naming and recognizing racism and other form of discrimination and oppression is fundamental to an organizational foundation that can effectively address health inequities in communities. There can be no wall between change that we wish to make in communities, and the internal structures that facilitate this. Organizations serious about reducing health inequities must build it into their approach and write it into their policies. One of the important things to remember is that intent is different from impact. Organizations may unwittingly discriminate against certain groups of people, and it is not until policies, procedures and practices are examined from an anti-racist, anti-oppression lens that this may become clear. The examples below will suggest ideas and provide a starting place for understanding and action.

*An example of an organization that incorporates an anti-oppression analysis into its whole organization is [Access Alliance Multicultural Health and Community Services](#). Based on their [anti oppression policy](#), AA carries out a wide range of programs and services, in health promotion, health care and other areas, and is also a leader in the field of research into issues of racialization and its impact on communities.*

Other examples of an anti-oppression policies are those of [Sistering](#), [Canadian Council for Refugees](#), and [Immigrant Women’s Services of Ottawa](#).

An example of a project that brings an anti-racist, anti-oppression analysis to the work is the [Attachment Across Cultures](#) project in downtown Toronto, working on early child development initiatives.

***ACHIEVING CULTURAL COMPETENCE:** a diversity tool kit for residential care settings is an excellent resource from the Ontario Ministry of Children and Youth Services which incorporates anti-oppression and anti-discrimination principles at its core. It has an excellent discussion with examples of how there might be visible and non-visible ways in which discrimination and exclusion can occur.*

[Dancing on Live Embers – challenging racism in organizations](#) is a profound look at racism in organizations and how to address it in a fundamental way.

One way to look at how equitable an organization is, is to review and assess policies, procedures and practices through an equity lens. The [Diversity Self-Assessment Tool](#) from the Health Equity Council provides an excellent checklist for organizations to look at internal policies and practices through an equity lens.

Springtide Resources has produced the following resource that helps organizations look at their own policies through an anti-oppression lens – Ending violence against women – An Integrated Anti-Oppression Framework for Reviewing and Developing Policy: A Toolkit for Community Service Organizations is available at <http://www.springtideresources.org/resources/show.cfm?id=241> (scroll to bottom of page)

A more comprehensive introduction and workbook is the [Creating Inclusive Community Organizations](#) toolkit from the Ontario Healthy Communities Coalition.

[Cultural Competency – Self Assessment Guide for Human Service Organizations](#) – from the Cultural Diversity Institute, Calgary, Alberta is another tool.

[OrgWise](#) is a website created through the Organizational Standards Initiative of the Ontario Council of Agencies Serving Immigrants to help set organizational standards in the settlement sector. It contains numerous resources, tools and templates that can be used to build sector capacity.

## Further Resources

The Ontario Association of Children’s Aid Societies has produced a [discussion paper on anti-oppression](#) among children’s aid societies that will be useful for people working in that field.

The [University of Guelph](#) has produced a useful booklet about racialization, explaining the issue, defining terms, plus offering various suggestions.

The [Sierra Youth Coalition’s anti-oppression resource guide](#) is another useful resource.

The [Rant Collective](#) website has a nice discussion of anti-oppression, and offers strategies for how to facilitate workshops using this lens

[Racial Equity Tools](#) is an excellent site from the US, that has many resources that will be of use in different ways, along many of the ideas discussed in this guide. An Ontario resource is [available on this site – Anti-Racist Train the Trainers Programs: A Model](#) by the Doris Marshall Institute, Arnold Minors & Associates, and The Ontario Anti-Racism Secretariat. This secretariat is no longer in existence, but the work done during its time is still valuable.

# Research and Policy

These are two critical “upstream” areas where action to address health disparities needs to begin. Frameworks and structures determine in large part what kinds of social outcomes we have. If research and policy interventions do not create the conditions in which advances to equity can be made, then workers and practitioners on the frontline are waging a losing battle.

Commitment to a vision, allocation of material and non-material resources, and real (as opposed to tokenistic) accountability mechanisms are needed for real advances in reducing inequities. The [People’s Health Equity and Diversity Charter](#) provides a starting point for this.

There is growing recognition that health equity needs to be addressed in partnership with communities. The report Act [Locally: Community-based population health promotion](#), by Trevor Hancock, to the Senate sub-committee on population health identifies the key principles on which this is to be based, and highlights examples that show how this can be done. In the absence of such a vision, eliminating health inequities is unlikely to happen.

[Investing in Community Capacity Building](#) is a paper from the Caledon Institute that discusses the role of community capacity building in neighbourhood revitalization and the implications for the way in which such work is funded. It reviews recent trends in funding practices and discusses the nature of community capacity building, drawing upon the Action for Neighbourhood Change initiative as a case in point. The paper also identifies ten steps that funders can take to advance their efforts<sup>10</sup>.

The [Prevention Institute](#) (US) identifies the following policy principles to provide guidance for taking on the challenge of addressing health inequities. The principles include understanding the history of racism and segregation, focussing on conditions rather than individual behaviour, meaningful public participation, strengthening neighbourhoods, link equity solutions to global issues, address all age groups especially early life, working across multiple sectors of government and society, measuring and monitoring impact of social policy, giving voice to groups most impacted by inequities, eliminate inequity and invest in community.

Research is also needed into the impacts of existing policies. The lit review shows how policies can have unintended, and hidden impacts, contrary to intended outcomes. An excellent example of how policies for schools can widen the gaps is from work done by [People for Education](#). In a report on fundraising by schools, they showed how allowing schools to raise their own funds can result in schools in better off neighbourhoods being able to raise more money, and offer a better education to their students than schools in poorer neighbourhoods. Disparities can widen, even though the initiative was introduced to encourage community participation in schools and education. Facts about poverty tell us that poorer areas are often inhabited by members of racialized communities.

<sup>10</sup> Description taken from website

The [Racial Equity Theory of Change](#) of the Aspen Institute (US) provides a roadmap for how to create social change to address systemic racism and discrimination.

Intervention research is an emerging area of research. The Canadian Institute for Health Information has recently published a resource, [Population Health Intervention Research Casebook](#), focussed on health equity based interventions.

Health promotion is premised on the idea of population health, rather than healthy individual lifestyles, yet there continues to be a need to understand – and address large populations, sub-populations and individuals. Thus, those aiming to reduce health inequity require easy to use disaggregated data in addition to amalgamated, high-level statistics. This type of data is not yet adequately, or consistently, available, either through data collection by governmental policies and programmes, or through research. The Colour of Poverty/Colour of Change, Access Alliance Multicultural Community and Health Services and the Health Equity Council are engaged in an initiative to streamline access to data collection around racialized health inequities.

The [Ontario Human Rights Commission](#) (OHRC) resource, [Count Me In](#), provides guidelines for collecting human rights-based data. The Anti-racism and anti-discrimination for municipalities: Introductory manual from OHRC is another useful resource that local governments can refer to.

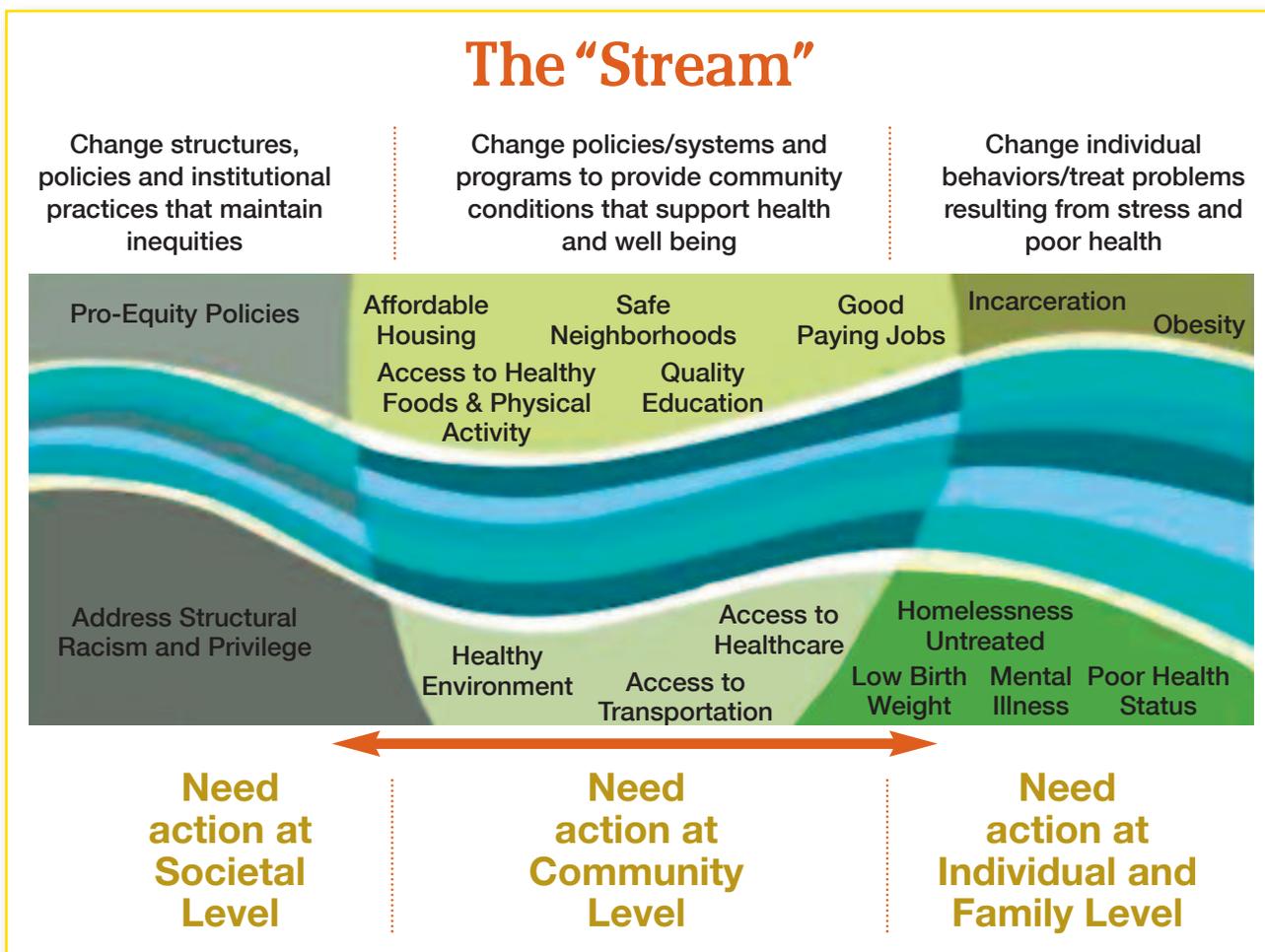
The [Office of Equity, Diversity and Human Rights](#) at the City of Toronto contains position papers, reports, and tools, as well as posters and educational materials.

[The Wellesley Institute](#) is a leading public policy institute focussing on urban health. Health equity is one of its strategic areas of interest. The website contains policy briefs, reports, as well as useful links.

This document by Paula Braveman will have wide applicability though intended for poorer countries – [Monitoring Equity In Health: A Policy-Oriented Approach In Low-And Middle-Income Countries](#) provides an eight step process in the assessment, intervention and monitoring of reduction in health disparities that is grounded in community involvement which needs to be at the core of reducing health inequities.

We close this resource guide by going back to the big picture – addressing inequities in health for racialized communities is part of the task of reducing health inequities in general. Interventions need to engage multiple players at multiple levels to address this in all its complexity, and each has a role to play in creating a healthy and equitable communities.

This figure from the [Equity and Social Justice page of King County \(US, Washington state\)](#) sums it up in a profound way, and shows us **where we can take action to reduce health inequities**.



Please let us know if you have found these resources useful. If you would like to recommend a resource, or have any other suggestions, please let us know at [equity@healthnexus.ca](mailto:equity@healthnexus.ca).

## Project Advisory Committee Members

**Uppala Chandrasekara**, Canadian Mental Health Association (Ontario)

**St. Phard Désir**, Conseil économique et social d'Ottawa Carleton

**Alain Dobi**, Réseau de soutien à l'immigration francophone (Centre-Sud-Ouest)

**Ann Doumkou**, London InterCommunity Health Centre

**Peter Dorfman**, Toronto Public Health

**Elsa Galan**, Multicultural Interagency Group of Peel

**Michael Kerr**, Colour of Poverty

**Stephanie Lefebvre**, Sudbury and District Health Unit

**Sume Ndumbe-Eyoh**, Regional Diversity Roundtable of Peel

**Cheryl Prescod**, Black Creek Community Health Centre

**Kelli Tonner**, South East Ottawa Community Health Centre

**Eta Woldeab**, Ontario Council of Agencies Serving Immigrants