Alliance for Healthier Communities
Advancing Health Equity in Ontario

Resolutions

As of October 7, 2020

To be presented to the

ALLIANCE Annual General Meeting-Part II

November 10, 2020, 5:30pm to 8:30pm

Virtual Meeting: via Webinar

NOTE
Board Composition Transition

In the approved By-laws passed June 2018 re Election of Directors, 11.3.1.1 states that the Board be afforded until June 1st, 2020 to meet the revised criteria for board composition. “This article shall become void June 1st, 2020 and shall be ipso facto deleted from the By-laws”

The Board has met its revised criteria for Board composition and the clause has been deleted effective June 1 2020.

BY-LAW RESOLUTION #1:
Definition of Comprehensive Primary Health Care

WHEREAS the membership voted to approve revised membership criteria, inclusive of "Deliver interprofessional primary health care or whose principal business directly relates to the determinants of health and that also delivers interprofessional primary health care" at its 2017 AGM; and

WHEREAS the current definition does not provide clarity in determining whether an organization meets the criteria of membership,

THEREFORE BE IT RESOLVED that clause 1.12 of the definitions be deleted from the By-laws and replaced with the following:

"Primary health care" is an approach to health and wellbeing centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing. Health care providers from diverse disciplines, including physicians and/or nurse practitioners, contribute to health and health services individually and through collaborative interprofessional practice providing whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. Primary health care ensures people receive comprehensive care - ranging from promotion and prevention to treatment, rehabilitation and palliative care.

Primary health care is rooted in a commitment to social justice and equity. Individuals, families and communities are empowered to optimize their health, as advocates for policies that promote and protect health and wellbeing and as co-developers of health and wellbeing. (Adapted from the World Health Organization, 2019)

For clarity, interprofessional primary health care must include provision of primary care services inclusive of a physician or nurse practitioner."

Moved and Seconded by Alliance Board Recommend Concurrence

Background:

One of the criteria for membership with the Alliance for Healthier Communities is to "Deliver interprofessional primary health care or whose principal business directly relates to the determinants of health and that also delivers interprofessional primary health care."

The definition in the By-law assists in the determination of whether an organization qualifies to be a member of the Alliance.

The Alliance Board reviewed the current definition of primary health care and felt that it was both out dated and did not provide sufficient clarity to assist with evaluating an organization's eligibility.

CURRENT DEFINITION in By-laws:
"Primary Health Care" refers to essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford (as defined by the World Health Organization). The greatest difference between primary care and primary health care is that primary health care is participatory in nature and involves the individual and their community in their overall health care including prevention and management.

PROPOSED DEFINITION:

"Primary health care" is an approach to health and wellbeing centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing. Health care providers from diverse disciplines, **including physicians and/or nurse practitioners**, contribute to health and health services individually and through collaborative interprofessional practice providing whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. Primary health care ensures people receive comprehensive care - ranging from promotion and prevention to treatment, rehabilitation and palliative care.

Primary health care is rooted in a commitment to social justice and equity. Individuals, families and communities are empowered to optimize their health, as advocates for policies that promote and protect health and wellbeing and as co-developers of health and wellbeing. (Adapted from the World Health Organization, 2019)

For clarity, interprofessional primary health care must include provision of primary care services inclusive of a physician or nurse practitioner.

GOVERNANCE RESOLUTION #1:
Member Rights and Responsibilities

WHEREAS it is considered a best practice to ensure members have clear understanding of their rights and responsibilities in relation to the Alliance for Healthier Communities**,**

THEREFORE BE IT RESOLVED that the following “Members’ Rights and Responsibilities” policy be adopted by the membership; and

BE IT FURTHER RESOLVED that this policy be included in the member application package and posted on the website.

Alliance Members’ Rights and Responsibilities

Your membership in the Alliance for Healthier Communities means that you are part of a vibrant network of community-governed primary health care organizations in Ontario. You are also part of a movement that works to improve the health and wellbeing of people and communities facing barriers to better health and advance health equity through comprehensive primary health care. Together, we stand for healthier people, healthier communities, a more inclusive society and more sustainable health system.

As a member of the Alliance, you have the following rights:

- in all interactions with the Alliance, to expect conditions, procedures, or decisions that are safe, welcoming, timely, non-discriminatory, free from oppression, equitable and dignified, and provide appropriate privacy and confidentiality;
- to be made aware of your rights and responsibilities and get access to all relevant policies and procedures;
- to be informed in a timely manner about any changes at the Alliance that may have impact on members and ways the Alliance operates;
- to be meaningfully consulted on issues that have a significant impact on the Alliance and member organizations;
- to participate and vote at the general meeting of the members, and to authorize another person to participate at the general meeting of the members and to vote in it on your behalf;
- to nominate or self-nominate a candidate to the Board of Directors of the Alliance;
- to submit resolutions for discussion by the general meeting of the members, as well as provide suggestions, questions and recommendations to the Board of the Alliance, Alliance Board committees, subcommittees and working groups;
- to use the services provided by the Alliance;
- to participate in the Performance Management and Information Management program that provides solutions, supports and tools to collect and analyse high-quality data to support evaluation, quality improvement and decision-making;
- to receive adequate French language services when such services are required;

- to receive reasonable accommodations, if required, when participating in the Alliance activities;
- to submit a complaint in accordance with the Alliance's complaint policy;
- at any time resign from the Alliance in accordance with the by-laws; and
- to exercise other rights set forth in the by-laws and policies of the Alliance.

As a member of the Alliance you have the following responsibilities:

- to uphold Alliance's vision, mission and values, and participate in the activities of the Alliance to help achieve our vision of the best possible health and wellbeing for everyone living in Ontario;
- to ensure that commitment to the Health Equity Charter and the Model of Health and Wellbeing / Model of Wholistic Health and Wellbeing is reflected in the strategic plan, policies and practices of your organization;
- to interact with the Alliance and other Alliance members in a manner that is safe, welcoming, timely, non-discriminatory, free from oppression, equitable and dignified;
- to be familiar with the documents and all available information about the Alliance, and to stay engaged with the Alliance and keep up-to-date on the new developments and current issues;
- to nominate a Board Liaison to maintain two-way communication between your Board and the Alliance Board and to connect the work of your organizations to a broader provincial landscape;
- to keep the Alliance Board informed on issues most pressing for your organization and flag issues of common concern across membership;
- to pay annual membership fees;
- to inform the Alliance of any changes that may impact eligibility to be a member of the Alliance;
- to comply with the provisions of the Alliance's By-laws.

When members act as vendors, the above rights do not apply and they need to comply with procedures and regulations applicable to other vendors.

Moved and Seconded by Alliance Board Recommend Concurrence

<u>Background</u>

The Alliance for Healthier Communities did not have a members' rights and responsibilities policy. Over the years, several members have asked to see one.

It was deemed prudent and a best practice to develop a "Members' rights and responsibilities policy".

The draft policy was reviewed by the Board Liaisons in 2019-20 on webinars. There was a written opportunity for feedback as well. Based on this feedback, the proposed policy was clarified and strengthened.

GOVERNANCE RESOLUTION #2:
Alliance Community Health Equity Builders Program

WHEREAS achieving the vision of the Alliance for Healthier Communities – "the best possible health and wellbeing for everyone" – requires growing the health equity movement across Ontario; and

WHEREAS the Alliance for Healthier Communities aims to strengthen our collective voice for people and communities facing barriers to good health and wellbeing; and

WHEREAS improving health and wellbeing outcomes for people and communities facing barriers requires building stronger connections among different parts of the health, social and community services systems,

THEREFORE BE IT RESOLVED that the following Community Health Equity Builders Program policy be adopted.

Community Health Equity Builders Program

The Community Health Equity Builders Program is open to non-profit organizations, networks and individuals that support the goals and mission of the Alliance for Healthier Communities. The Program participants can operate/work/live anywhere in the world.

The Community Health Equity Builders Program does not confer the rights of membership, including voting rights. However, participants will enjoy access to a range of member benefits and services, and become part of a growing movement to advance health equity in Ontario.

Participation criteria

To join the Community Health Equity Builders Program, organizations/networks/individuals need to:

- Demonstrate commitment to advancing the best possible health and wellbeing for people and communities facing barriers;
- Support the Alliance's vision, mission and values;
- Support Health Equity Charter;
- Support the Model of Health and Wellbeing.

Categories

- Organizations: open to non-profit organizations that are not eligible for Alliance or CACHC membership
- Networks
- Individuals
- Students

Benefits of joining the Community Health Equity Builders Program

- Timely access to health system developments, trends and analysis;
- Access to webinars and resources;
- Access to the Alliance's interactive portal;
- Free postings on the job board on the Alliance's website;
- Access to the latest primary health care research and evaluation;
- Reduced cost to attend the conference and learning events;
- Opportunities to lend your voice to important causes and participate in communication and advocacy campaigns;
- Opportunities to build connections with Alliance members and other health equity leaders across the province.

Fee structure

Organizations and networks	
Annual budget	**Community Health Equity Builders Program annual fee**
Under $100,000	$100.00
$100,000 - $300,000	$200.00
$300,000 - $500,000	$300.00
$500,000 - $1,000,000	$400.00
$1,000,000 - $3,000,000	$500.00
$3,000,000 - $5,000,000	$750.00
Over $5,000,000	$1,000.00
Individuals	
Individual category	**Community Health Equity Builders Program annual fee**
Researchers/consultants	$100.00
Individuals	$75.00
Seniors/Students	$25.00

Moved and Seconded by Alliance Board Recommend Concurrence

Background

Alliance for Healthier Communities had an associate member class in the past. It was disbanded after the Ontario Not-for-Profit Corporations Act was introduced and provided all class of members equal voting rights. The Ontario Not-for-Profit Corporations Act (ONCA) was scheduled to be proclaimed January 2020 but the deadline has not yet been met.

In 2017, the Alliance approved the new membership criteria. Since our rebrand as the Alliance, we have received a number of inquiries about membership from organizations that did not meet the membership criteria in their entirety, as well as from individuals who expressed interest in joining the Alliance. These organizations and individuals shared the vision and mandate of the Alliance and wanted to be part of the movement and network we were creating. In addition they were also interested in receiving access to information and educational resources provided by the Alliance.

The Alliance Board made the decision to not re-open the membership criteria. It was a long and thought-out process. There was also a concern that re-interpreting the current criteria may dilute them.

At the same time, the Board recognized that a larger network would allow the Alliance to speak with a stronger voice and strengthen our advocacy efforts, as well as bring in other organizations and individuals who serve the 22% of people facing barriers. An expanded voice would also help more people understand our vision for comprehensive primary health care and expand the support for the Model of Health and Wellbeing beyond the Alliance members.

Within this context, the Board decided to explore creating a new program that would create a bigger tent to bring in organizations and individuals who are committed to the Alliance's vision and mission and have a commitment to health equity but who otherwise do not qualify under the current membership criteria. We also believed that within the current health system transformation, especially in the context of OHTs that we needed to reach out to others and create space for a more united voice on key issues.

The Board was clear however, that the core of our brand - commitment to serving the 22%, the Model of Health and Wellbeing/Model of Wholistic Health and Wellbeing, the Health Equity Charter, and our values – would be non-negotiable.

What is the Community Health Equity Builders program?

The Community Health Equity Builders program is open to non-profit organizations, networks and individuals that support the goals and mission of the Alliance for Healthier Communities. The Alliance Program participants can operate/work/live anywhere in the world.

What are the goals of the program?

The goals of the program are to:

- Strengthen our collective voice for people and communities facing barriers to good health and wellbeing;
- grow the health equity movement across Ontario; and

- build stronger connections between different parts of the system.

What are the criteria to join the program?

The criteria for the joining the program are to:

- Demonstrate commitment to advancing the best possible health and wellbeing for people and communities facing barriers;
- Support the Alliance's vision, mission and values;
- Support Health Equity Charter;
- Support the Model of Health and Wellbeing.

Can current Alliance members opt for the Community Health Equity Builders program instead of full membership?

Organizations that are eligible for Alliance and/or CACHC membership cannot join the Community Health Equity Builders program.

How is the program different from the full Alliance membership?

The Community Health Equity Builders program does not confer the rights of membership, including voting rights, participating in committees and joining the Alliance Board, submitting resolutions, and so on. In addition, only Alliance members are eligible to receive operational and resource management support provided by the Alliance.

What will the Community Health Equity Builders participants receive?

The program participants will enjoy access to a range of benefits and services and become part of a growing movement to advance health equity in Ontario. Some of the benefits include:

- Opportunities to lend their voice to important causes and participate in communication and advocacy campaigns;
- Opportunities to build connections with Alliance members and other health equity leaders across the province;
- Timely access to health system developments, trends and analysis;
- Access to webinars and resources;
- Access to the Alliance's interactive portal;
- Access to the latest primary health care research and evaluation;
- Reduced cost to attend the conference and learning events;
- Free postings on the job board on the Alliance's website;

Will the program dilute the focus and impact membership services provided by the Alliance?

The Community Health Equity Builders program participants will have access to the resources already produced by the Alliance, including webinars, communication materials, learning events, etc., and therefore will not require any additional staff resources. Staff time required for the program will be minimal and will include processing applications and maintaining the registration lists.

Will the program be worth the efforts to launch and promote it?

The Alliance will develop evaluation criteria to measure the effectiveness and the impact of the Community Health Equity Builders Program.

GOVERNANCE RESOLUTION #3:
Health Equity Charter 2020

WHEREAS the Health Equity Charter together with the Model of Health and Wellbeing or Model of Wholistic Health and Wellbeing (for Indigenous organizations) are criteria for membership and are foundational documents that guide our collective efforts recognizing and confronting barriers to equitable health, and help bring us closer to our vision of "the best possible health and wellbeing for everyone in Ontario;" and

WHEREAS the original Health Equity Charter was approved by the Alliance for Healthier Communities membership in 2012. Since then, several members have identified gaps in the Health Equity Charter, and the dialogue on health equity has evolved. We are now called on to examine issues of structural inequities, systemic racism, colonialism and white supremacy. We are also called on to make commitments to action. Therefore, it was recognized that it is timely to do a Health Equity Charter refresh; and

WHEREAS the Alliance's goal is that the Health Equity Charter becomes a living document that guides our collective journey on health equity,

BE IT RESOLVED that the members of the Alliance approve the Health Equity Charter 2020, as presented; and

BE IT FURTHER RESOLVED that the Alliance will provide ongoing support to members as they put the Health Equity Charter into action and will develop a range of educational resources and materials, including a short version of the Charter, infographics, a resource guide, posters, webinars and any other supports identified in consultation with the members; and

BE IT FURTHER RESOLVED that each member of the Alliance endorse the Health Equity Charter as a criteria for membership and submit such Board resolution to the Alliance; and

BE IT FURTHER RESOLVED that each member's Board renew its commitment to the Health Equity Charter and review its progress on putting the Charter into action annually; and

BE IT FINALLY RESOLVED that each member submit to the Alliance an annual self-assessment of the progress on their Health Equity journey, so that the Alliance can develop a relevant educational program to support our members and can ensure that collectively, the Health Equity Charter becomes a living and relevant document. The Alliance will develop the self-assessment tool in consultation with the members.

Moved and Seconded by Alliance Board Recommend Concurrence

Health Equity Charter Draft – September 2020

The Health Equity Charter is a commitment to action by the Alliance for Healthier Communities and Alliance member organizations to recognize and confront barriers to equitable health. We commit to be bold, strategic and relentless in challenging these barriers and addressing the needs of the people and communities we serve to achieve our vision of the best possible health and wellbeing for everyone living in Ontario.

We can only achieve our vision of the best possible health and wellbeing by creating the conditions for everyone to have a fair opportunity to reach their full health potential in relationship with their communities. Today in Ontario, not all populations have this fair opportunity. People in certain population groups live shorter than expected lives, face discrimination in accessing health services and the social determinants of health, or deal with preventable health conditions. This is not due to any factors inherent in the communities most affected by them. Rather, major gaps in population health outcomes have deep roots in historical and current systems of power. Some populations are seen as expendable, are marginalized and excluded from decision-making; have inadequate access to resources in our society from food and housing to transportation to literacy to social inclusion; and face a life of discrimination and racism. The results are health disparities that are avoidable and unjust. The goal of health equity is to remove unjust and remediable differences among groups of people.

To achieve health equity, we commit to collective action to eliminate health inequities and inequitable access to health care, advance better health outcomes and address barriers that prevent certain populations from living a healthy life, including, but not limited to, Indigenous people, Francophones, Black and racialized communities, those who are Two Spirit, lesbian, gay, bisexual, trans, and/or queer (2SLGBTQ+), people living with disabilities and mental health challenges, isolated seniors, new immigrants and refugees, migrant workers and those without a documented status, people who use drugs and those experiencing homelessness, as well as low-income and underserved communities in both rural and urban areas. We will achieve health equity by improving our own practices, working closely with the communities we serve, challenging other institutions, and facilitating change within the broader community, province and country.

ACKNOWLEDGEMENT OF TRADITIONAL INDIGENOUS TERRITORIES

We recognize that the work of the Alliance for Healthier Communities and Alliance members takes place across what is now called Ontario on traditional territories of the Indigenous people who have lived here since time immemorial and have deep connections to these lands. We further acknowledge that Ontario is covered by 46 treaties, agreements and land purchases, as well as unceded territories. We are grateful for the opportunity to live, meet and work on this territory.

Ontario continues to be home to vibrant, diverse Indigenous communities who have distinct and specific histories and needs, as well as constitutionally protected and treaty rights. We honour this diversity and respect the knowledge, leadership and governance frameworks within Indigenous communities. In recognition of this, we commit to building ally relationships with First Nation, Inuit and Métis peoples in order to enhance our knowledge and appreciation of the many histories and voices within Ontario. We also commit to sharing and upholding responsibilities to all who now live on these lands, the land itself and the resources that make our lives possible.

BELIEFS AND VALUES

This Health Equity Charter is built on a recognition that historical and current systems of power, rooted in white supremacy, colonialism, patriarchy and capitalism, have created conditions where certain populations are seen as expendable, are marginalized and excluded from decision-making, and have inadequate access to resources in our society. The results of these inequities and marginalization are health disparities experienced by many groups across Ontario. While often seen as inherent, poor health outcomes are, in fact, caused by health inequities that are avoidable, discriminatory and unjust.

We further recognize that racism, especially against Indigenous and Black people, is pervasive and systemic in modern institutions. Ontario’s health care system is not an exception. The colonial legacy in Canada, which is deeply intertwined with slavery, and the subsequent and ongoing dispossession of Indigenous and Black people, continue to have negative impacts on their individual and collective health and wellbeing.

The work of achieving the best possible health and wellbeing for everyone in Ontario requires a health equity approach that embodies the values, policies, and practices aimed to address discrimination and oppression in all its forms. This approach is indispensable to confronting racism, including in our own practices and organizations as well as the broader community and society at large. The goal of a health equity approach is to dismantle barriers, eliminate health inequities and improve access to health care, especially for those who have historically faced and continue to face discrimination and disadvantage. To achieve this goal, each Alliance member organization serves people who have been most excluded economically, socially and in mainstream health services.

The Health Equity Charter is rooted in the following shared beliefs and principles:

Social justice and human rights approach: Access to the highest attainable standard of health is a fundamental human right. Everyone deserves equal access to a full, vibrant life, which is essential to a healthy and just society. We believe working together toward health equity and equitable access to health care is a necessary step toward achieving this vision.

Broader concept of health: Health is a state of the best possible physical, mental, social and spiritual wellbeing. Many health problems are not only medical or biological but are caused by the circumstances in which people live, grow, work and age, and the systems that are put in place to deal with illness. These conditions are, in turn, shaped by political, economic and social forces.

Shared responsibility: The creation of equitable opportunities for health is a societal responsibility that requires all sectors – government, public sector, businesses, faith groups, broader community and civil society – to address the systemic and structural conditions that foster inequities. Only by working in solidarity and supporting each other in our journeys toward health equity can we achieve the best possible health and wellbeing for everyone in Ontario.

Distribution of power: Approaches to achieving health equity should build on and enhance existing strengths and assets of historically and currently excluded or marginalized groups. These groups need to have a strong voice and recognized power in defining and solving problems.

Integrity and cultural humility: Through active listening, unlearning and re-learning, we must acknowledge and challenge our internal biases and work to hold each other accountable to personal and organizational growth. Everyone is starting from a different place in this journey and we will work to meet people where they are.

Indigenous Health in Indigenous Hands and commitment to reconciliation and ally relationship:

Our work to advance Indigenous health equity stands apart within our broader commitment to health equity, and is shaped by specific histories and current realities of First Nations, Inuit and Métis peoples in Canada. Our work of advancing Indigenous health equity is rooted in our commitment to reconciliation, meaningful ally relationships and Indigenous people's rights to self-determination, which includes our commitment to Indigenous Health in Indigenous Hands. It starts with the recognition and realization of the individual and collective rights of Indigenous people as outlined in Canada's Constitution, treaties and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), as well as the implementation of the Calls to Action identified in the Truth and Reconciliation Commission of Canada Report and The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

AFFIRMATIONS

Based on our commitment to reconciliation, ally relationship and Indigenous Health in Indigenous Hands:

We recognize that the effects of more than five centuries of colonization -- including genocide, dispossession and displacement from traditional lands, forced assimilation and disengagement from ancestry, culture and language, residential schools and the Sixties scoop, the Indian Act, among many other oppressive colonial policies, practices and legislation -- have resulted in disproportionately poor health outcomes for Indigenous people across Canada.

We recognize that the health and wellbeing of First Nations, Inuit and Métis communities continue to be affected by neo-colonial practices, disrespect for Indigenous sovereignty and self-determination, racism impacting Indigenous peoples, intergenerational trauma and inequitable resource allocation.

We recognize Indigenous rights to self-determination, including Indigenous Health in Indigenous Hands, and affirm that Indigenous health care needs to be planned, designed, developed, delivered and evaluated by Indigenous-governed organizations.

We recognize and respect diverse cultural practices, traditional knowledge, lands, medicines and resources as essential to the health and wellbeing of Indigenous people.

We recognize the importance and principles of culturally-safe engagement that respects Indigenous governance, knowledge systems and timelines.

For everyone living in Ontario, based on our shared beliefs and principles:

We recognize that many groups in Ontario experience health disparities, including, but not limited to, Indigenous peoples, Francophones, Black and racialized communities, those who are Two Spirit, lesbian, gay, bisexual, trans, and/or queer (2SLGBTQ+), people living with disabilities and mental health challenges, isolated seniors, new immigrants and refugees, migrant workers and those without documented status, people who use drugs, and those experiencing homelessness, as well as low-income and underserved communities in both rural and urban areas. For individuals who identify across multiple groups, barriers to good health and wellbeing often intersect and compound. Health equity principles demand that we tailor our responses to their needs and address the barriers they face with equal urgency.

We recognize that to eliminate health inequities, we must address underlying social, economic and environmental determinants of health, including but not limited to: income, social and employment status, education, housing, transportation, access to services and public spaces, all of which are often shaped and perpetuated by bias, injustice and inequality.

We recognize the impact that racism has had – and continues to have – on the health and wellbeing of racialized people and communities. We further recognize the intersecting and compounding impact of other forms of marginalization, exclusion and oppression, including, but not limited to, homophobia, transphobia, sexism, ageism, ableism, xenophobia, anti-Semitism, Islamophobia, and classism.

We recognize that while certain groups -- including Indigenous people, Francophones, Black Canadians, people who are 2SLGBTQ+ -- may share similar experiences due to their race, ethnic or cultural origin, gender identity or sexual orientation, no group is homogeneous. We acknowledge the diversity of experiences, perspectives and needs within each group.

We recognize the continuous presence of Francophones in Ontario over the past 400 years and the rich diversity within a French-speaking community that includes recent immigrants. We acknowledge that Francophone communities have specific needs and constitutionally protected rights. Language and culture play an essential role in the provision of health care services, and Francophone populations require equitable access to quality health services in French to achieve their optimal health and wellbeing.

We recognize that historical and current systems of oppression, including slavery, police violence and anti-Black racism, impact present-day experiences of Black people in Ontario, whether they are descendants of people who were enslaved, recent immigrants or those whose families immigrated to Canada a long time ago. Anti-Black racism has shaped and continues to shape public policy, decision-making and services and has resulted in disproportionately poor health outcomes for Black communities.

We recognize that people who are 2SLGBTQ+ continue to experience stigma and discrimination in all aspects of their lives and face poorer health outcomes as a result. We further recognize that members of 2SLGBTQ+ communities have diverse and distinct experiences and needs shaped by their sexual orientation, gender identity, race and ethnicity, age, and place of residence, among other factors.

We recognize a high prevalence of structural, collective, historical and interpersonal violence in the lives of those we serve, especially among women and girls, Indigenous people, Black communities, and people who are 2SLGBTQ+, and those who identify across multiple identities . Experiences of trauma and violence affect individuals, families and communities and impact physical, mental, emotional and spiritual health and wellbeing.

We recognize that the health and wellbeing needs of seniors are often unacknowledged and ignored. Seniors who experience other forms of marginalization are particularly vulnerable to poverty, social isolation and poor health.

We recognize the distinct health needs of populations living in rural, remote or isolated settings where their health and wellbeing is impacted by a lack of resources, poor access to health care and social services, inadequate transportation, food insecurity, poverty and social isolation, especially among seniors.

We recognize that, due to poor planning and inequitable resource distribution, people living in low income and underserved urban neighbourhoods face multiple barriers to good health, including a lack of access to affordable housing and childcare, overcrowding, higher levels of pollution, limited healthy food options, and a lack of green spaces and public facilities.

We recognize the distinct health needs of immigrants, refugees and migrant workers. We further recognize the distinct health needs and rights of people who are uninsured or without documented status.

We recognize the expertise and knowledge in the communities we serve. Transformative change is only possible when people are supported to increase control over and improve their health, and communities are actively involved in identifying issues and developing solutions.

COMMITMENTS

In our work with Indigenous members, partners and communities:

We will increase our awareness, respect, and support for Indigenous communities' cultural protocols and practices, local knowledge and decision-making systems, and we commit to work with Indigenous members, partners and communities in a manner that honours and respects Indigenous voices, leadership, knowledge and governance frameworks.

We will identify and dismantle organizational practices that undermine Indigenous Health in Indigenous Hands, and we will build our capacity at all levels of the organization to serve Indigenous clients in an equitable and safer way that includes a trauma-informed approach to care.

We will support Indigenous-led research and abide by the First Nations' principles of OCAP (ownership, control, access and possession) and similar principles adopted by Métis and Inuit communities that assert Indigenous people's control over data collection processes in their communities, as well as ownership and control over how health and related information can be used.

We will build ally relationships with Indigenous members, other Indigenous organizations and communities they serve across Ontario, and support Indigenous-led calls for changes in health policies and practices to be more respectful of the rights and knowledge of Indigenous people.

We will incorporate in our own practices and advocate for broader implementation of the Calls to Action identified in the Truth and Reconciliation Commission of Canada Report and

The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

To advance health equity in our own organizations:

We will adopt health equity as an underlying principle and apply a health equity lens in planning, service delivery and decision-making throughout our organization by assigning priority to population groups who have the greatest health needs and least access to services.

We will develop and implement internal policies, systems, programs, and services that actively promote equity.

We will develop evaluation strategies that measure health equity efforts and health equity results to continually improve our practices and will report organizational progress to our communities, funders, members, partners, and each other.

We will build a strong community governance system that is reflective of the people and communities we serve and will continuously improve our Boards' capacity to advance health equity at organizational and system levels.

We will collect and protect -- in the best interests of the people and communities we serve -- high-quality socio-demographic and race-based data to better understand and document their needs and develop evidence-based solutions.

We will actively engage the people and communities we serve in making decisions at every level of the organization, including the planning, design and delivery of programs and services.

We will continuously examine our internal biases and develop anti-racism/anti-oppression strategies to identify, name and confront practices that reproduce oppression and its structures within our organizations.

We will develop human resource policies and practices designed to ensure that the diversity of the communities we serve is reflected at all levels – volunteer, staff, management, and governing boards – in our organizations.

We will ensure our policies, procedures, resource allocation and staff training meet the linguistic, cultural and other needs of the diverse communities we serve.

We will develop our capacity to deliver equitable, trauma-informed, people-centred, and culturally safer care and will build strong partnerships with other organizations that may be better suited to provide culturally safe care for certain populations.

We will actively engage in the work of learning and unlearning to understand what decolonization should look like in the context of health care, and we commit to implement decolonizing practices in our organizations.

To advance health equity within the broader community:

We will model organizational culture change and share best practices and lessons learned by directly engaging in partnership with other organizations and learning with the broader health equity movement.

We will collaborate with health partners and the broader community to ensure equity is an underlying goal of an integrated, high-performing health system.

We will support and collaborate with organizations and community groups that are challenging the social, economic and environmental conditions that cause health inequities for marginalized communities, including the Francophone, Black and racialized, and 2SLGBTQ+ communities.

We will document the causes of, impacts of, and potential solutions for health inequities, and will advance public policy responses proposed by communities to reduce health inequities.

We will advocate with different levels of government for better resource allocation to meet the needs of underserved communities in rural and urban areas.

We will support broader provincial, national and international movements that work to eliminate health inequities and improve the health and wellbeing of people and communities facing barriers to health and wellbeing here and around the world.

Background

What is health equity?

At its core, health equity is “giving everyone the opportunity and resources they need to achieve their optimal health and well-being”[1]. The World Health Organization has identified health equity as a global public health priority[2]. Health equity requires a clear and measurable commitment to “the fair distribution of resources needed for health, fair access to the

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[1] https://www.allianceon.org/sites/default/files/documents/Somerset%20West%20CHC_HE%20Profile.pdf

[2] Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization; 2008 [cited 2012 Sept 21]. Available from: www.searo.who. int/LinkFiles/SDH_SDH_FinalReport.pdf.

opportunities available, and fairness in the support offered to people when ill"[1]. While pursuing improved health for the general population, health equity takes a concentrated approach to relieve the disproportionate burden of ill health among socially and economically marginalized populations.

Health Equity and Ontario:

We know the highest exposure to health risks are very much related to race and poverty. In fact, these are the strongest indicators of poor health. There is a lot of data showing that Indigenous and racialized communities experience broader health disparities.

A 2012 report by the Association of Ontario Health Centres shows the range of clients living in poverty is between 11 and 22% across regions, with the Ontario average at almost 16%. When you add the intersectionality of race, gender, ethnicity, ability, sexual orientation, gender identity, linguistic capability, class and rurality, approximately 1 in 5 people living in Ontario are at a higher risk of poor health outcomes.

Although poverty is the largest contributor to inequities in health access, experience and outcomes, addressing health inequity will require us to consider a much more holistic approach. Health inequities are shaped by multiple intersecting and compounding identities and histories. Canada's colonial history has resulted in deep structural inequities, systemic racism and white supremacy. The new Health Equity Charter recognizes these impacts and is a call to action to address these issues of power; to be allies with those most deeply impacted , especially the Indigenous, Francophone, Black and 2SLGBTQ+ communities and to take action at the organizational and system levels.

Our Journey

The Health Equity Charter together with the Model of Health and Wellbeing or Model of Wholistic Health and Wellbeing (for Indigenous organizations) are foundational documents that guide our collective efforts recognizing and confronting barriers to equitable health, and help bring us closer to our vision of the best possible health and wellbeing for everyone in Ontario. Official endorsement of these documents is part of the membership criteria.

The Health Equity Charter was approved by Alliance membership in 2012. Over the past few years, the Alliance for Healthier Communities has been working with members to ensure all member boards pass a resolution to officially endorse the Health Equity Charter. While the

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[1] Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up part 1. Geneva: World Organization; 2006 [cited 2012 Sept 21]. Available from: www.euro.who. int/__data/assets/pdf_file/0010/74737/ E89383.pdf

majority of members endorsed the Charter, several organizations, particularly those serving Indigenous and Black communities, expressed concerns about the Charter and whether it still aligns with our evolving understanding of health equity, ally relationship and reconciliation, anti-Black racism and its impacts on the health and wellbeing of Black people. In addition, we heard some members say that they think that their Board signed the Charter but that they couldn't remember.

Since 2012, there have also been considerable developments in the external landscape of health equity work in Canada and internationally, specifically in regards to the four priority populations of the Alliance for Healthier Communities: Indigenous communities, Black communities, Francophone communities and 2SLGBTQ+ communities. Some of these advancements include: Truth and Reconciliation Commission of Canada: Calls to Action report (2015), Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019), Ontario's acknowledgement of Anti-Black racism and consequent action plan to tackle it (2017), the United Nations International Decade for People of African Descent (2015-2024), the update of the White Paper on Francophone health in Ontario (2018), and more. Internally, the Alliance passed a resolution on Indigenous Health in Indigenous Hands, and has been working to build an ally relationship with the newly formed Indigenous Primary Health Care Council.

The Alliance Board reflected on these developments and the feedback from various members and asked: How could the Health Equity Charter become a living document that is more relevant to the current situation, at the organizational and sector level?

In 2019, the Board decided to do a refresh of the Health Equity Charter with a goal to create a documents that is more comprehensive, robust and actionable and that is more relevant to the current situation and includes commitments to specific actions.

In September 2019, the Alliance conducted consultations with Black Health Committee, Francophone Advisory Group, Rainbow Committee, and Indigenous Primary Health Care Council. The input received during consultations was used to draft the first version of the revised Charter.

In January, the first draft was shared with all members and by March we received feedback from 32 members. Thank you to those who took the time to provide the input. The majority of you were very supportive of the draft and made concrete recommendations to strengthen the first draft.

Key themes

- Revisions were comprehensive, provided more clarity for members and no gaps were identified.
- Revisions were timely considering the health system transformation and expressed the need for tools to help utilize the new Charter in the OHT context.
- While supporting the focus on the four priority groups, a few members commented that their centre doesn't serve all of the priority populations identified in the Charter and therefore felt it is not as relevant to them.
- Some groups were omitted: low income and underserved communities, people living with mental health and addictions, Muslims, refugees. Not enough focus on seniors.
- Simpler language, less jargon and simplified short version.
- Emphasize the need for data ownership and control for all groups, similar to OCAP principles for Indigenous communities.
- Request for better clarification of what Indigenous Health in Indigenous Hands means.
- Highlighted the need for more education around structural inequities, systemic racism, colonialism and white supremacy.
- All members expressed the need for tools and resources suggested with top three being: resource guide, webinar series and one-page infographic.
- Other tools and resources identified: health equity impact assessment tool, sample QIP, menu of possible actions. There was also a request to have the Charter to be translated in multiple languages, not only English and French.
- In terms of accountability, a few respondents felt that it should be up to members how they implement the Charter into action. A few suggested imbedding health equity principles in QIPs and accreditation standards. Other suggestions included mandatory health equity training for Board and staff, yearly reports and/or questionnaire that would help organizations reflect on what they've accomplished. There was a strong emphasis on making the accountability process celebratory in nature, rather than "judgmental" with opportunities to share innovations, issues and challenges between members, profiling outstanding examples of putting the Health Equity Charter into action in the Board to Board, during webinars, on the website.
- 78% of respondents agreed there was a need to endorse the new Charter. It was also suggested that endorsement of the Charter should be revisited on a regular basis, considering the Board turnover.

Since the first draft of the Charter was shared with members at the beginning of 2020, Ontario along with the rest of the world has been impacted by the coronavirus pandemic. The COVID-19 crisis has exposed and amplified the health inequities Alliance members have long worked to address.

Over the past few months, we have also seen a growing Black Lives Matter movement in Canada and across the world. It has laid bare the pervasive nature of anti-Black racism in all systems, including the health care system, its multiple negative impacts on the health and wellbeing of Black communities, and the need to take a stronger stance on white supremacy, Canada’s legacy of colonization and slavery, and racism against Black and Indigenous people.

Based on the members’ feedback and most recent events in Ontario, Canada and around the world, the Health Equity Charter was edited to provide more clarity and put a stronger focus on the systems of powers that produce health inequities.

In addition, we are proposing that all members endorse the new Health Equity Charter as it is significantly different from the original Charter.

The Board recognizes that members are at different points in their journey of understanding and implementing health equity and we will be providing ongoing support in your journey on making the Health Equity Charter a living document.

To enable this, we will be developing a short version of the Health Equity Charter, a resource guide, webinars, infographics and other educational supports. In consultation with members, we will also be developing a Board self-assessment tool so that you can measure your progress.

Some of you have already asked for tips on how to begin the journey. See Appendix A for some starting points.

Appendix A: Health Equity Board Self-Assessment Guidelines (draft)

1. Strategic Planning:
    a. Does your mission, vision and values articulate the barriers to good health and wellbeing that people in your communities face, especially those who experience the biggest health inequities, including but not limited to, Indigenous, Francophone, Black communities and 2SLGBTQ+?
    b. Do your strategic directions address the barriers to health and wellbeing for your priority populations?

2. Governance:
    a. Does your Board reflect the voices of your identified priority populations including but not limited to Indigenous, Francophone, Black communities and 2SLGBTQ+?
    b. Do you review the Health Equity Charter as a governance policy on an annual basis?
    c. Have you registered as a board to take the Inclusive Leadership in Governance course?

3. Programs and Services:
    a. Does your organization make every effort to meaningfully engage your priority populations in programs and services planning, implementation and evaluation?
    b. Are the program and services based on unique principles and values of the four priority groups?
    c. Do your evaluation processes examine differentiated outcomes that reflect the unique barriers and needs of your priority groups?

4. Data Collection and Analysis
    a. Does your organization take all possible steps to ensure that it collects quality socio demographic and race based data? Do you then analyze the data by priority populations to determine differentiated outcomes to inform planning, outcome evaluation and reporting?
    b. Is there a required data report for your Board?

5. Training and Capacity Building
    a. Does your organization undertake training and capacity building initiatives for board and staff to increase understanding of health equity as it relates to

structural inequities, systemic racism, colonialism and white supremacy and how they impact your priority populations?

POLICY RESOLUTION #1:
Addressing Anti-Black Racism

WHEREAS anti- Black racism is an oppressive force present in every system and structure governing everyday life; and

WHEREAS racism is a fundamental determinant of health and anti-Black racism negatively impacts health outcomes for Black communities; and

WHEREAS health equity is only achievable when avoidable, unfair or remediable differences are eliminated and addressed; it can only be achieved when fair opportunities and conditions exist which allow everyone to reach their full health potential; and

WHEREAS Black people in Canada are a distinct group with a distinct history and experience; and

WHEREAS the after-life of slavery and continuing legacies of anti-Black racism mean that Black people experience disproportionately higher rates of poverty and poorer health outcomes, in addition to encountering and navigating anti-Black racism in health, social services, education and the justice system; and

WHEREAS Black communities experience disproportionate exposure to violence, which impacts health outcomes; and

WHEREAS Black communities have called for the recognition of anti-Black racism as a public health crisis that manifests in many different forms; and have been joined in these calls by other experts and providers; therefore

BE IT RESOLVED that the Alliance take a leadership role in advocating for systems change to facilitate action for a more equitable, just and inclusive Ontario; and

BE IT RESOLVED that the Alliance and all member centres stand in ally relationships and solidarity with Black communities to disrupt and end oppression, while working to advance structural and systemic change; and

BE IT RESOLVED that the Alliance for Healthier Communities call on all levels of government and public health agencies to declare anti-Black Racism as a public health crisis; and

BE IT FURTHER RESOLVED that the Alliance develop an anti-Black racism and anti-oppression education program for all member boards and staff; and

BE IT FURTHER RESOLVED that all members commit to collecting race-based and sociodemographic data to understand the disparities in their communities and among the clients they serve; and

BE IF FURTHER RESOLVED that the Alliance and its members commit to demonstrating leadership and taking actions in addressing anti-Black racism in our practices and within the broader system by:

- recognizing the role of anti-Black racism in producing health inequities;
- implementing organization wide comprehensive anti- racism training and anti-oppression training, with a focus on the many iterations of anti-Black racism;
- reviewing all existing projects and initiatives to ensure impacts of anti-Black racism are considered; and
- addressing anti-Black racism within the sector that isolates and contributes to Black health workers and experts exiting the sector; and

BE IT FINALLY RESOLVED that the Alliance advocate for the Ministry of Health to recognize Black populations as a distinct population group and fund a comprehensive Black Health Strategy.

Moved and Seconded by Alliance Board Recommend Concurrence

Background

Historical and current systems of power, rooted in white supremacy, colonialism, patriarchy and corporate-governed capitalism, have created conditions where certain populations are seen as expendable, marginalized and excluded from decision-making, and have inadequate access to resources in our society. The result is health disparities experienced by many groups across Ontario. While often seen as inherent, poor health outcomes are, in fact, caused by health inequities that are avoidable, discriminatory and unjust. Black people in Canada have been deeply impacted by these processes.

The after-life of slavery and continuing legacies of anti-Black racism mean that Black people experience disproportionately higher rates of poverty and poorer health outcomes. In all facets of life, Black people contend with anti-Black racism. Healthcare is no exception; here too Black people encounter and navigate anti-Black racism. Studies have shown differential access to care based on race. These inequities influence well-being profoundly. A range of factors produce these outcomes, most importantly the social determinants of health, institutional practices and anti-Black racism.[1]

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[1] Black Health Alliance. (2020). 2020 Black Experiences in Health Care Symposium. Retrieved from https://www.healthcommons.ca/s/Full-Report-Black-Experiences-in-Health-Care-Symposium-2020.pdf

Anti-Black racism is a public health crisis that manifests in many different forms, including police violence in Ontario and around the world. Black people are routinely denied access to the healthcare services that are a basic human right. Black children are given lower levels of pain management as white children. Black women receive cervical cancer screening at lower rates than any other population group. People suffering from sickle cell anemia are treated as drug seekers. People living with mental health conditions are turned away or offered culturally unsafe healthcare, leading to increased rates of suicide and suffering.[1]

At the same time, Black communities bear the disproportionate burdens of racism and discrimination in housing and labour markets, placing them at higher risk of both communicable diseases like COVID-19 (at work as personal support workers and other essential service workers, and at home in close or unsafe living conditions), and chronic conditions like diabetes, hypertension and mental health conditions caused by inequitable living conditions and the daily stresses of living under the macro and micro conditions of structural, systemic and individual racism.

Racism, inequity and dehumanization are deeply embedded in our social structures, daily lives, neighbourhoods and healthcare organizations. This affects every single person in our province and the world – unequal societies have worse health outcomes for all people than more equal ones. The work of confronting anti-Black racism is the work of advancing health and wellbeing for all.

The Current Moment

Black communities are grieving. 2020 is a moment where we are all called to faster action to confront anti-Black racism in all its manifestations.

In 2018, the Canadian Public Health Association released a position statement acknowledging that racism is a public health issue. Ontario, like other provinces and territories in Canada, is a place that struggles to contend with the harms of white supremacy and where legacies of colonization, slavery, structural inequality and systemic discrimination deeply impact the lives of Black people.

In June, 2020 the Alliance for Healthier Communities made an organizational commitment to addressing anti-Black racism. The Alliance called for anti-Black racism to be recognized as a public health crisis and called for sector wide commitments to advance anti- Black racism, health equity and community wellbeing.

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[1] Alliance for Healthier Communities. (2020). Anti-Black Racism impacts health and as healthcare organizations we must act now. Retrieved from https://www.allianceon.org/news/Anti-Black-Racism-impacts-health-and-healthcare-organizations-we-must-act-now

It is now time for all Alliance members to collectively make organizational and sector wide commitments addressing anti-Black racism. While member commitments have been made to anti-oppression and anti-racism (2014), and the members endorsed a resolution on Indigenous Health in Indigenous Hands (2018) no specific commitments have been made recognizing anti-Black racism specifically or recognizing Black people in Canada as a distinct group with a distinct history and experience.

In June 2020, Black health leaders within the sector urged allies to make commitments to addressing the many iterations of white supremacy and anti-Black racism by standing in solidarity with Black people. They called on the sector to commit to interrupting cycles of violence and taking action to address anti-Black racism through the recognition of anti-Black racism as a public health crisis.[1]

It is critical for Alliance members to address anti-Black racism across the sector. This resolution should be paramount in guiding how to stand in ally relationships and solidarity with Black communities at this critical juncture.

Let’s join our Black Leaders call to ensure that this is not an issue that only Black people care about. This is everyone’s business.

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[1] Black Health Leaders. (2020). Statement from Black health leaders: Anti-Black Racism is a Public Health Crisis. Retrieved from https://www.allianceon.org/news/Statement-Black-health-leaders-Anti-Black-Racism-Public-Health-Crisis

POLICY RESOLUTION #2:
Addressing harms linked to policing by reallocating funds from policing to our communities

WHEREAS violence is a determinant of health and harms linked to policing impact health outcomes; and

WHEREAS evidence produced in Ontario shows that policing and law enforcement violence disproportionately harm Indigenous and Black people; and

WHEREAS policing is deeply impacted by systemic and structural racism; and

WHEREAS over 600 doctors affiliated with *Doctors for Defunding Police* have declared law enforcement violence a public health crisis and joined calls to defund police. Similarly, collectives of healthcare providers such as *Health Providers Against Poverty* also support calls to defund the police; and

WHEREAS since the 1990s spending on policing in Ontario has increased; however, investment in health and social services has not been proportionate. A lack of investments in health and social services as a proportion of overall budgets limits accessibility of alternative solutions to address health and social concerns. While policing spending grows, chronically underfunded health and social services are in crisis; and

WHEREAS federal and provincial policy makers have been slow to respond to community concerns and calls raised by Black and Indigenous communities regarding harms linked to policing; and

WHEREAS calls to redirect funds allocated to policing towards alternative community, health and social service sectors are grounded in a recognition of the importance of addressing socioeconomic factors and they must be understood as part of strategies and approaches that aim to address ongoing harm, structural and systemic racism and inequity; and

WHEREAS calls to reallocate funds from policing are to be understood and framed as part of strategies addressing anti-Black racism; and

WHEREAS changing dynamics in our communities mean police are often called in as first responders to address situations where alternative providers may be better suited to provide care,

THEREFORE BE IT RESOLVED that the Alliance and members show leadership and take action to raise awareness about health harms linked to state sanctioned policing violence as experienced by Indigenous and Black communities; and

BE IT FURTHER RESOLVED that the Alliance takes a leadership role and supports sector-wide learning to understand calls to defund policing and the links between expanding policing budgets and the under-funding of community, health and social services. Sector-wide learning will focus on the ways policing impacts Black and Indigenous communities and increase members understanding of policing and law enforcement violence as a public health crisis; and

BE IT FURTHER RESOLVED that the Alliance and members advocate for and support calls for equitable reallocation of resources towards community, health and social service sectors that provide alternatives to policing, while addressing underlying social and systemic drivers of inequity. The Alliance and members will advocate for a greater proportion of public funding to be directed towards community, health and social services; and

BE IT FURTHER RESOLVED that the Alliance call on Ontario's government to ensure that police are not the primary respondents in mental health crisis calls; this role must be designated to appropriately resourced and trained community led and trauma informed first responders; and
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BE IT FURTHER RESOLVED that the Alliance and members will continue to advocate for the decriminalization of drugs and people who use drugs alongside advocating for the repeal of laws criminalizing poverty (such as Ontario's Safe Streets Act which criminalizes panhandling); and

BE IT FURTHER RESOLVED that the Alliance advocate for the establishment of an independent public body responsible for police oversight; and

BE IT FURTHER RESOLVED that Alliance members in their practices will:

- Commit to sector-wide learning to understand calls put forward by movements advocating for Indigenous and Black lives
- Support and advocate for increased investments in community, health and social services
- Commit to the implementation of organization wide training, addressing policing and law enforcement violence as a public health crisis
- Implement organization wide comprehensive anti-racism and anti-oppression training, inclusive of content on anti-Black and anti-Indigenous racism
- Support training of community-led responders and call for ongoing funding to support this work
- Implement calls to action endorsed in supporting resolutions

BE IT FINALLY RESOLVED that the Alliance develop and implement a comprehensive knowledge translation plan to support implementation of these commitments.

Moved and Seconded by Alliance Board Recommend Concurrence

Background

Multiple movements for justice and equity have been amplified over the course of the COVID-19 pandemic, including the global movement for Black lives and calls to defund policing and to re-direct resources to communities. These movements gained momentum and traction after the killings of George Floyd, Breonna Taylor, Tony McDade and others in the United States. In Canada, the deaths of Regis Korchinski- Paquet, D'Andre Campbell, Rodney Levi and Chantel Moore, either at the hands of police or in their presence, galvanized communities to call for urgent action to address police violence directed towards Indigenous and Black people.

Experiences with policing in Canada are not uniform; they are deeply influenced by race, social and economic factors. In Ontario, Indigenous and Black people experience disproportionate harm and violence through policing[1]. Alliance members recognize Indigenous and Black communities as priority populations, and have made commitments to addressing structural and systemic factors that contribute to the oppression of both groups.

ABOUT POLICING

Various institutions fall under the banner of policing, including provincial and municipal police forces, the RCMP, Canadian Border services, immigration enforcement, justice and corrections. Policing costs across Canada have been on the rise since the late 1990s. In 2017/18, spending on policing reached $15.1 billion, a 2% increase from the previous reporting period[2]. Ontario reports the highest spending of any province in the country[3].

Increasingly, spending on policing is in sharp contrast to reduced investments and spending on fundamental health and social services across the province. As spending on policing grows, chronically underfunded health and social services are in crisis. Data shows ballooning base policing budgets, (Toronto's police budget exceeded $1Billion in 2019. It was the biggest budget line; more was given to policing than housing, transit, children's services and paramedic services[4]). Additionally, policing frequently receives significant portions of funding allocated to community and social services. In 2019, 99% of a $200 million Ministry of Children, Community and Social Services grant to support provincial Community Safety and Well-being (CSWB) Strategies was allocated to policing – on top of base budget funding. Community based

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[1] Black Lives Matter Canada (2020). Defund The Police. Retrieved from: https://blacklivesmatter.ca/defund-the-police/

[2] Statistics Canada (2019).Police resources in Canada, 2018. Retrieved from https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00015-eng.htm

[3] Ibid.

[4] Warzecha, M. (2020). Is the Toronto police budget really 'untouchable'? Retrieved from https://www.tvo.org/article/is-the-toronto-police-budget-really-untouchable

organizations with documented expertise and success in these areas received less than 1% of the grant[1]. Similar dynamics repeat themselves everywhere in Canada.

In 2020, *Doctors for Defunding Police*, (a coalition of over 600 doctors) officially recognized policing as a public health crisis and called for policing to be defunded. *Health Providers Against Poverty*, a coalition of healthcare providers made the same call. Policing disproportionately targets and impacts marginalized groups. Studies in Canada and Ontario show disproportionate harms linked to policing for key populations[2].

Violence linked to policing is a health crisis; and as such it must be addressed with health based solutions. Alliance members are well situated to advocate for community led and supported alternatives to policing. Additionally, as organizations committed to advancing health equity, the Alliance and members must address calls raised by communities about funds allocated to policing, as overall budget proportions, as opposed to proportions allocated to community, health and social service sectors.

This resolution marks a starting point wherein Alliance members will boldly advocate on the harms of policing against Black and Indigenous communities and address calls to fund communities to address underlying drivers of health and social inequity. Alliance and members undertake this work alongside commitments already made to stand in solidarity with Indigenous and Black communities.

Calls to defund the police vary in range from reform and resource reallocation to complete abolition of policing. Advocates note, calls to defund policing are “not calls to abandon communities to violence,”[3] rather they are calls to address foundational and structural factors that lead to violence

SUPPORTING POLICY/ POSITION STATEMENTS

The Alliance for Healthier Communities is a network of community led health organizations committed to seeing a transformative change to the health system in Ontario. In recent years, Alliance members have endorsed multiple resolutions and statements either directly linked to policing or which are of relevance to this conversation:

- Resolution: Decriminalization and safer supply
- Resolution: Indigenous health in indigenous hands
- Statement: Anti- Black racism is a Public Health Crisis

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[1] Wilmot, C. (2020). 99% of Ontario's funding for community safety and well-being pads police budgets. Retrieved from https://theconversation.com/99-of-ontarios-funding-for-community-safety-and-well-being-pads-police-budgets-140306

[2] DFDP Toronto. (2020). Policing is a Public Health Crisis. Retrieved from http://doctorsfordefundingpolice.com/

[3] Kaba, M. (2020). Yes, We Mean Literally Abolish the Police. Retrieved from https://www.nytimes.com/2020/06/12/opinion/sunday/floyd-abolish-defund-police.html

COMMITMENTS

The Alliance and members commit ourselves to undertaking sector wide learning to better understand calls to defund policing and better understand the links between expanding policing budgets and underfunded community, health and social service programs. Additionally, the Alliance and members will show leadership and take action to raise awareness about the harms linked to policing and disproportionate harms experienced by Indigenous and Black communities.

In our own practices, we will:

- Commit to sector wide learning to understand calls put forward by movements advocating for Indigenous and Black lives
- Support and advocate for increased investments in community, health and social services.
- Commit to the implementation of organization wide training addressing policing and law enforcement violence as a public health crisis
- Implement organization wide comprehensive anti-racism and anti-oppression training
- Support training of community led responders and call for sector funding
- Implement calls to action endorsed in supporting resolutions (see above)

In our work within the broader community, we will:

- Actively participate in and support the creation of community led and trauma informed alternatives to policing
- Advocate for the decriminalization of drugs and people who use drugs
- Advocate for the repeal of laws criminalizing poverty (such as Ontario's Safer Streets Act which criminalizes panhandling).

POLICY RESOLUTION #3:

Increasing access to injectable opioid agonist treatment (iOAT) and expanding access to safer drug supply programs

WHEREAS Ontario continues to struggle with the devastating effects of a poisoned/toxic illicit drug supply that has resulted in an opioid overdose crisis and a rise in opioid- related deaths; and

WHEREAS data from drug checking projects in Ontario clearly demonstrates the drug supply in the unregulated market has a high level of variation and toxicity; and

WHEREAS a stable, pharmaceutical grade drug is safer for people who use drugs than unknown substances purchased in the unregulated market; and

WHEREAS safer supply is an approach that focuses on saving lives by using existing pharmaceutical-grade medications as an alternative to highly toxic street drugs for people at risk of overdose; and

WHEREAS Health Canada is providing funding to pilot different models of care for people who use drugs, including injectable hydromorphone treatment, diacetylmorphine morphine treatment and safer supply tablet hydromorphone programs; and

WHEREAS Ontario’s Drug Formulary does not currently cover injectable hydromorphone in high enough doses for these programs; and

WHEREAS Community Health Centres have a long history of providing harm reduction services and were among the first group of health care providers in Ontario to provide Supervised Consumption Services. However, we continue to see that our ability to fully meet the health needs of people who use drugs is limited by the lack of access to injectable opioid agonist treatment (iOAT), (a pharmacological treatment intervention of high dose injectable hydromorphone that has been approved by Health Canada); and

WHEREAS there are strong evidence bases for the efficacy and cost effectiveness of injectable opioid agonist treatment (iOAT), evidence-informed practice frameworks and increasing bodies of research for safer supply programs; and

WHEREAS there is an urgency to scale up access to pharmaceutical opioids for people who use opioids who are purchasing drugs on the unregulated market,

THEREFORE BE IT RESOLVED that the Alliance and its members call on all levels of government to commit to action based on the emerging evidence generated by the safer supply pilot projects as part of a comprehensive, integrated response to Canada’s opioid crisis; and

BE IT FURTHER RESOLVED that the Alliance and its members call on the Minister of Health, through the Ontario Drug Benefit Program (ODB), to provide public drug coverage of high dose injectable hydromorphone for people who use opioids in Ontario in order to improve health outcomes, including reduced opioid-related morbidity and mortality; and

BE IT FINALLY RESOLVED that Alliance and its members call on the Ministry of Health to immediately commit to funding iOAT services where needed in Ontario, including adequate staffing resources and building capacity for manufacturing and delivery of injectable diacetylmorphine in Canada.

Moved by Sandy Hill CHC
Seconded by Parkdale Queen West CHC

Recommend Concurrence

Background

An estimated 15,000 people in Canada have died from opioid-related overdose deaths. The crisis is exacerbated by a tainted drug supply which drives poisoning and overdose related deaths. Criminalization forces people to turn to underground markets, where the strength and toxicity of substances is unknown and the risk of experiencing harms is higher. The ongoing COVID-19 pandemic has exacerbated the ongoing opioid crisis[1]. People who use drugs and advocates are calling for urgent action to address the crisis.

In July 2020, Health Canada recognized the opioid overdose crisis as one of the most serious public health crises and that the COVID-19 pandemic is worsening this crisis. The severity of the crisis prompted Health Canada to fund projects at multiple sites across Canada (including pilot projects in Ontario) to provide pharmaceutical-grade medication as an alternative to the toxic illegal drug supply.

Regulated Supply

Regulated supply programs include distributing substances to people who use drugs as alternatives to street-level drugs that may be contaminated with other additives such as fentanyl. These programs already exist in Ontario and other parts of Canada, making it possible for providers to prescribe drugs, such as hydromorphone, also called HDM, and diacetylmorphine or DAM (also known as prescription heroin) for people who use opioids.

In May 2019, noting that "the opioid crisis continues to be one of the most serious public health issues in Canada's recent history,"[2] the federal government approved the addition of injectable

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[1] Health Canada. (2020). Opioids, Data, Surveillance and Research. Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research.html

[2] Health Canada. (2019). *Government of Canada approves new treatment options for opioid use disorder and supports research.* Retrieved from https://www.canada.ca/en/health-canada/news/2019/05/government-of-canada-approves-new-treatment-options-for-opioid-use-disorder-and-supports-research-treatment-and-harm-reduction-projects-in-ontario.html.

hydromorphone to treat people with severe opioid use disorder. Diacetylmorphine was also added to the list of drugs marked for urgent public health need. Extensive studies show the efficacy of injectable hydromorphone. Yet injectable hydromorphone, in concentrations required for treatment (50mg/ml and 100mg/ml), is not listed on the Ontario Drug Benefit Formulary.[1] While Diacetylmorphine can be imported, it has not been added to Ontario's Drug Benefit program and must be accessed through Health Canada's Special Access Programme. These access issues present significant barriers.

iOAT (INJECTABLE OPIOID AGONIST THERAPY)

For people with severe opioid use disorder injectable opioids alternatives have been shown to reduce use of illicit drugs, keep people in care, reduce risks of incarceration and improve overall health and wellbeing.[2] These programs are known as iOAT. The drugs used for iOAT include hydromorphone and prescription heroin (diamorphine/diacetylmorphine). Randomized trials have shown that iOAT programs are feasible, safe, and effective when treating long-term, chronic injection opioid users for whom other options have failed.[3] Additionally, for people who keep using illicitly obtained opioids, iOAT has been shown to be superior, more effective and cost effective over the long run.[4]

iOAT is resource intensive in both financial resources and human capital. For example, patients may visit service providers several times in a day. The failure to make hydromorphone and diacetylmorphine more widely accessible in Ontario makes care prohibitive for most patients in Ontario.

Safer Opioid Supply Programs

Practitioners and organizations in Ontario are developing Safer Opioid Supply (SOS) Programs, which are low barrier models intended to reduce the risk of overdose through the development and implementation of community-based harm reduction focused safer supply programs. Similar programs exist in B.C. For example, a program at the Portland Housing Society (PHS) provides patients with tablets to take orally or to crush and inject. In Ontario, hydromorphone tablets are covered under Ontario's drug formulary.

Safer Opioid Supply programs exist at Parkdale Queen West CHC and London Inter-Community Health. In both programs, patients receive prescriptions for "carries" (or take homes), or they can consume supplies in supervised consumption sites, if they chose. However, observed consumption is not required. SOS programs are flexible, low barrier approaches, making them accessible to severely marginalized people. Criminalization of drug use and stigma, along with other systemic and structural conditions producing inequity, lead to the marginalization of people who use drugs. SOS programs that address these systemic and structural barriers

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[1] Toronto Board of Health (2019). *Expanding Opioid Substitution Treatment with Managed Opioid Programs.* Retrieved from: https://www.toronto.ca/legdocs/mmis/2019/hl/bgrd/backgroundfile-126527.pdf

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[3] Canadian Research Initiative in Substance Misuse (CRISM). (2019). *National Injectable Opioid Agonist Treatment for Opioid Use Disorder Operational Guidance*. Retrieved at: https://crism.ca/projects/ioat-guideline/

[4] Ibid.

provide critical care to otherwise severely marginalized populations. A community of practice for providers is currently being established in Ontario. To date, regulatory bodies for health care professionals and prescribers have neither endorsed nor released best practice guidelines addressing SOS. Greater engagement is needed with regulatory bodies to advance safer supply.

CONCLUSION

Ontario is in the midst of a monumental crisis. A comprehensive and multi-faceted strategy is needed in response. Along with risk reducing strategies, such as Consumption Treatment Services, Ontario needs well-resourced options to manage and treat opioid use disorders. Toxic supply is driving poisoning and deaths linked to overdose. The interventions and strategies described above reduce the use of illicit drugs, connect people to health services and reduce other harms linked to illicit substance use, such as incarceration. Furthermore, access to regulated opiates for people who use drugs reduce risks linked to poisoning and overdose. Ontario needs scaled up access to safe supply for people who use opioids. This includes expansion of program infrastructure and changes to regulations increasing accessibility of opioid management drugs (e.g., changes to provincial drug formularies).

In 2019, the members overwhelmingly supported the decriminalization of illicit drugs for personal use. This resolution is a logical next step to support this resolution.

POLICY RESOLUTION #4:
Commitment to Data Collection

WHEREAS members of the Alliance for Healthier Communities are committed to providing: “The best possible health and wellbeing for everyone living in Ontario”; and

WHEREAS in upholding the Health Equity Charter, “we understand Health Equity to be an approach that includes policies and interventions that address discrimination and oppression with a goal of eradicating social inequality and disadvantage for the purpose of reducing differences in health outcomes;” and

WHEREAS the Health Equity Charter calls on members to, in their **own practices,** identify, name and confront inequity by: “developing evaluation strategies that measure health equity efforts and health equity results and using the evaluation data to continually improve health equity practices;” and

WHEREAS at the AGM in June 2020, members were informed that **only 20% of Race, Gender and Sexual Orientation** demographic data is being captured and recorded; and

WHEREAS the Alliance has created a toolkit that includes training materials, data entry guidelines and monitoring tools to support staff training, consistent data entry and continued monitoring and benchmarking; and

WHEREAS if all members do not collect race, gender or sexual orientation data, we cannot provide evidence to advocate for our clients in these priority populations or tailor service delivery to improve care. Incomplete evidence makes it much more difficult to obtain funding and support for programs that help the most vulnerable; and

WHEREAS if we as a sector want to maximize our impact, we must ask for and collect data on ALL our key demographics. Collecting data is a critical element of program planning and it informs system response; and

WHEREAS we have a collective reputational risk by “not walking the talk”, for years, individual members and the Alliance have advocated for data collection, claiming that “we collect these data.”

THEREFORE BE IT RESOLVED that the Alliance for Healthier Communities calls on all of its member organizations to ask for, collect and monitor demographic data indicators, including race, gender and sexual orientation to achieve completion rates recorded within the EMR of at least 75% of all clients served by 2024

BE IT FURTHER RESOLVED that all member boards require the inclusion of the quality improvement measure on data completeness, previously adopted by the sector, in the quality improvement plans (QIPs) established for CHCs; that the member boards monitor progress in completeness of data; and that member boards reflect on disaggregated data to improve service delivery.

BE IT FINALLY RESOLVED that the Alliance for Healthier Communities release an internal annual sector wide report through the Board-to-Board report, Board Liaison meetings and to Executive Leaders on the progress of the completeness of race-based and sociodemographic data until we reach 75% completion rates.

Moved by Women's Health In Women's Hands CHC
Seconded by Planned Parenthood Toronto

Recommend Concurrence

Background

For years, Alliance members have recognized the importance of sociodemographic data collection. We have recognized that disaggregated data are vital for identifying disparities, monitoring the impact of interventions and eliminating systemic racism through action and systemic change. Despite this recognition, the rates of fully collecting these client data within their EMR are at 20%.

Internal Progress:

- In 2000, the Community Health Centres and the Association of Ontario Health Centres created an evaluation framework that included a logic model that described the goals, objectives of the CHC program, as well as prioritized data elements that included sociodemographic data. A significant training program was established at that time including in-person training, documentation and data entry guidelines, standardized intake forms and a series of data validation checks which ensured data were entered correctly. Through the early 2000s, that lack of data completeness was an ongoing issue.

- In 2013, the Performance Management Committee (PMC) endorsed and mandated the collection of additional sociodemographic and race-based data elements for all CHCs in Ontario based on the work done in the Toronto Central LHIN. This included the collection of data on race, sex, gender and disability. A series of webinars and trainings were developed to ensure that all members understood the changes and were provided tools to collect this new data. The new data elements were included in the NOD EMR. However, sites on Purkinje were not supported to collect this data. Yearly, PMC reported completion rates to the CHC Executive Leaders.

- At the 2017 Annual General Meeting of the Association of Ontario Health Centers (now the Alliance), a resolution on race-based and socioeconomic data included:

  - "Working in coalition and championing policies, systems and programs that address health inequities related to systemic racism, particularly anti-Black racism, anti-Indigenous racism and Islamophobia;
  - Providing leadership in advocating for the collection of appropriate race-based and other socio-demographic data, including the inclusive definition of Francophone;
  - Members prioritize the collection of approved race-based and sociodemographic data;
  - Advocate for base-funding for the Indigenous Our Health Counts Survey expansion and sustainability across Ontario;
  - Members have access to tools and supports to collect high quality, race-based and socio-demographic through their information management systems."

- In 2019/20, as members transition to PS EMR, they will be able to collect and use all sociodemographic and race-based data fields (previously Purkinje sites could not record race, sexuality or gender). The evaluation framework has been updated with data entry rules, rationale for collection and screen shots to assist with data entry.

- In 2020, the CHCs adopted a mandatory data quality improvement measure to include in their Quality Improvement Plans (QIPs) related to data completeness. Targets and plans for improvements were to be included in yearly QIPs. While this measure was developed for CHCs, it could be adopted by other members as well.

- In 2020/21, PMC has once again prioritized these data and an easy to use dashboard is being developed to benchmark and measure data completeness. This will be provided to all leaders quarterly and targeted quality improvement activities are being planned to support organizations to improve. This work will embrace our new vision as a learning health system. In addition to the dashboard, shared learning is underway to understand how to action these data to improve care and eliminate health inequities.

Despite this work at the staff level, there is considerable variation in data completeness and although some centres have managed to capture, record and tailor service delivery, the majority of organizations have a very low completion rate specifically for race, gender and sexuality orientation. (Notably, some centres with the highest complexity of sociodemographic and race based data have completion rates as high as 90%, while many more are at 0%). As of June 2020, the sector-wide average for collection of these three variables was only 20% of the clients served.

External Advocacy:

As a result of the resolution in 2017, the Alliance and members have loudly and consistently advocated for the collection of sociodemographic and race-based data.

- In 2018, the Alliance advocated to the MOHLTC and the Anti-Racism Directorate for the inclusion of the health sector in the Anti-Racism Act data collection requirements, and provided policy advice on anti-racism data standards which are reflected in the proposed regulation. The Anti-Racism directorate has a proposal to amend the Act to include health sector which is being reviewed by the Privacy Commissioner, and the MOH staff are working towards mandating the health sector to collect socio-demographic data.
- The Alliance proposed amendments to the People's Health Care Act, 2019 calling on the Ontario Health Agency and Ontario Health Teams to be held accountable to collect sociodemographic and race-based data to measure progress on health equity.
- The collection of data relevant to the inclusive definition of Francophone has been mandated and operationalized in the EMR for all CHCs in Ontario
- In 2020, as a result of advocacy by sector black health leaders, the Alliance and many others, the Ontario government announced the collection of race and sociodemographic data collection during the COVID-19 pandemic. In June 2020, the province introduced regulatory amendments to PHIPA to facilitate data collection.

Equity Standards:

- Since 2016, the Alliance has been an active participant working with the Canadian Institute for Health Information (CIHI) on equity data standards and has recently participated in the national CIHI and Canadian Public Health Association (CPHA) equity standards group, recommending sociodemographic and race-based data elements be collected across all Canadian jurisdictions
- The Alliance is also an active investigator on the Screening for Poverty and Related social determinants and intervening to improve Knowledge of and links to resources (the 'SPARK' study). This Canada-wide study is ensuring that data are not only collected but acted upon to improve and eliminate health inequities

As a result of this work and much more, the Alliance and its members are seen as an authoritative voice on equity based data.

Summary:

Despite this work, the sector and its individual members have not prioritized the completeness of these data at the centre level. At the Annual General Meeting of the Alliance for Healthier Communities held on June 9 2020, it was highlighted to the membership that not all demographic data are being asked for and/or captured by all members of the Alliance.

This sector is often called upon to provide evidence on the most vulnerable populations in the province of Ontario. As experts, it is imperative that we collect all key, pertinent demographic data. In addition, we know that if we do not measure important equity data we cannot understand variations in health outcomes or tailor care to improve access. In addition, if we do not collect **race, gender or sexual orientation** data, the impact is that as a sector we are unable to provide fulsome evidence that will help us advocate for our clients, who belong to these priority populations. Moreover, incomplete evidence means it becomes much more difficult to ask for and obtain pertinent funding and support for programs designed to help those we serve.

If we as a sector want to maximize our impact, then we MUST ask for, collect and action socio-demographic and race-based data on ALL of our clients. The collection and subsequent action is a critical element of eliminating health inequities, by informing program planning and system response. This will help us remain transparent to the larger healthcare sector. If the priority populations that we represent, treat and support are not counted, then their needs will not be addressed!

The following resolution (Commitment to Data Collection) asks that that all Alliance members **ask for and collect** demographic data indicators including **race, gender and sexual orientation** for at least 75% of the clients served by 2024. It will be important that the resolution be anchored in moral accountability both at the sector and individual centre levels.

To assist centres, the Alliance, through the Performance Management Committee, will develop data entry tools and a monitoring dashboard, as well as tailored QI and learning activities to measure and benchmark members to ensure ongoing data improvement.

Let’s unanimously support this resolution and “walk our talk” to collect sociodemographic and race-based data in a serious, deliberate and persistent manner.

POLICY RESOLUTION #5:

Addressing Violence through a Public Health Approach

WHEREAS the consequences of violence have immediate, lasting and multigenerational effects on individuals, families and communities; and

WHEREAS violence disproportionately affects racialized people, women, sex and gender diverse people, those living below the poverty line and other marginalized groups, thereby further exacerbating inequality and marginalization; and

WHEREAS a "trauma-informed" approach suggests that violent acts are not symptomatic of "bad people" but, rather, are a negative health outcome resulting from exposure to numerous risk factors; and

WHEREAS exposure to violence leads to a range of negative health outcomes, including harms to mental health and increased risk of both chronic and communicable diseases, as well as increased risk of behaviours contributing to morbidity and mortality (e.g., heavy substance use); and

WHEREAS violence is predictable and preventable and almost never "senseless" or "random"; rather, it is an epidemic that spreads, clusters, and transmits through exposure; and

WHEREAS in order to prevent violence, the underlying social determinants of health need to be addressed; and

WHEREAS violence is often framed as the primary responsibility of law enforcement and the criminal justice system, and the current violence prevention model is fragmented and outdated; and

WHEREAS the impact of violence can be reduced through a public health approach, in the same way that public health efforts have prevented and reduced many negative health outcomes by addressing issues, such as workplace injuries, infectious diseases, smoking, seat belt use, and immunization; and

WHEREAS every interaction in the health system is an opportunity to prevent violence directly and the health system can play an important role in preventing the spread of violence; and

WHEREAS violence is a cross-sectoral issue requiring collaboration amongst partners not only in health but also in education, housing, social services, law enforcement, transportation, and others who are essential in addressing the causes of violence,

THEREFORE BE IT RESOLVED that the Alliance for Healthier Communities and its members call on all levels of government to address violence as a public health issue, to cooperate across jurisdictional boundaries and to fund promising approaches in reducing the incidences of violence in Ontario and across the country; and

BE IT FURTHER RESOLVED that we, the members of the Alliance for Healthier Communities, commit ourselves in demonstrating leadership by collaborating with partners to prevent the "transmission" of violence by addressing systemic and structural factors that contribute to epidemics of violence and support health-led interventions across the province, thereby reducing the incidence of violence in our communities.

Moved by Sandy Hill CHC
Seconded by Somerset West CHC

Recommend Concurrence

Background

A public health approach to violence is rooted in the scientific method, which can be applied to the issue of violence as illustrated below:

1) data collection on all aspects of violence, including the magnitude, scope and consequences of violence;
2) research on the causes and correlates of violence, as well as factors that increase and decrease incidences of violence;
3) exploration of different approaches to reducing violence; and
4) implementation of promising approaches.

Many jurisdictions have implemented a public health approach to reducing violence and have achieved success. These initiatives include Operation Ceasefire in Boston (mid 1990s), Chicago-Cease Fire (late 1990s/early 2000s), Scotland’s Violence Reduction Unit (mid-2000s), and many others.

Several of these models make use of "navigators" or community health workers, as well as outreach workers, prevention professionals, hospital responders, and violence interrupters. These individuals can help those involved in violent incidents and their families navigate systems, resolve differences, and choose alternative paths. They typically function as an integrated team across all sectors in a community.

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POLICY RESOLUTION #6:
Adverse Childhood Experiences and Resilience

WHEREAS extensive research has defined Adverse Childhood Experiences (ACEs) as including abuse, neglect and household dysfunction and has demonstrated that ACEs change brain development in ways that subsequently influence health trajectories and health outcomes; and

WHEREAS ACEs have a well-documented "dose-response" relationship to health conditions, including substance use and/or mental health disorders, diabetes, heart disease, cancer, stroke, COPD, substance use disorders and obesity; and

WHEREAS ACEs are not destiny. The impacts of ACEs can be mitigated or can be overcome in the presence of resilience, often enabled through the development of supportive relationships; and

WHEREAS primary, secondary and tertiary prevention approaches have been demonstrated to effectively improve health outcomes on a population health level; and

WHEREAS broad-reaching, complex problems, such as ACEs, are best tackled through cohesive, cross-sector, collective impact approaches; and

WHEREAS the Alliance for Healthier Communities' (the Alliance) Model of Health and Well-Being is richly aligned with an enabling foundation for sector-level leadership to prevent and mitigate ACEs; and to subsequently prevent and reduce ACEs on individual, neighbourhood and community-levels; and

WHEREAS upstream, resilience-building and innovative models are being piloted in several Alliance member centres, and have demonstrated promising results in reducing the incidence of ACEs; and

WHEREAS several Alliance member centres have begun to collectively organize around ACEs and resilience, including the development of a Community of Practice to share knowledge and promising practices,

THEREFORE BE IT RESOLVED that the Alliance prioritize knowledge mobilization about ACEs and resilience, including providing resources to enable the emerging ACEs Community of Practice; and

BE IT FURTHER RESOLVED that the Alliance increase knowledge, advocate, and encourage action to advance programs that prevent ACEs and strengthen resilience.

Moved by Guelph CHC
Seconded by Kingston CHCs

Recommend Concurrence

Background

In the mid-1990s, the Centre for Disease Control and Kaiser Permanente commissioned the Adverse Childhood Experiences (ACEs) Study, which established a direct link between childhood trauma and poor health outcomes in adulthood. The study asked adult respondents to report on 10 measures of childhood adversity across three domains: abuse, neglect, and household dysfunction. Findings determined that high doses of childhood trauma:

- Altered child brain development, and subsequently negatively impacted childhood growth and development;
- Was also associated with negative health and behavioural outcomes in adulthood, including physical and mental health challenges, substance use disorders, risky sexual behaviours, suicide attempts, aggression, cognitive difficulties, and poor work performance;
- Substantially increased risk of disease, disability, social and emotional problems, and early death;
- Increased the risk of 7/10 leading causes of death.

Armed with this knowledge, initiatives that prevent and mitigate ACEs and build resilience on individual and community-wide levels improve health outcomes. Across North America, prevention and early intervention strategies have demonstrated promise in this regard. Strategies that raise awareness, strengthen relationships within and around families, and improve social skill-building and community connectedness have the potential to positively impact health and wellbeing outcomes.

Alliance members are well-positioned to champion ACEs-informed initiatives in our centres and communities, enabled by our comprehensive upstream model of care, community-based partnerships and community development approaches. To do so, leaders at all levels across the sector require a robust understanding of ACEs, resilience, and the promising practices that prevent and mitigate their impact. Several Alliance members have been leading ACEs work in their respective communities, and are well-positioned, with the support of the Alliance for Healthier Communities, to spread their knowledge, promising practices, and community-wide leadership approaches to advance health equity.

The accompanying resolution seeks to prioritize ACEs and resilience within a Community of Practice, and ultimately advance initiatives that address and prevent ACEs across our sector.

This document was compiled from the following sources: 1) https://www.advokids.org/adverse-childhood-experience-study-aces/ 2) https://acescoalition.ca/ 3) Presentation slide deck prepared by Dr. Meredith Mackenzie, KCHC physician
4) https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf

POLICY RESOLUTION #7:

Right to Housing

WHEREAS the recognition of housing as a right is enshrined in international law. The right to housing under international human rights law is understood as the right to a safe and secure home in which to live in security, peace and dignity. It also entails meeting standards of adequacy, including standards relating to legal security of tenure, affordability, habitability, availability of services, accessibility, location and culture; and

WHEREAS In 2019, Canada recognized housing as a human right by passing the *National Housing Strategy Act.* This marks the first time Canada officially recognized that adequate housing is a fundamental human right, affirmed in international law; and

WHEREAS Canada recognized that housing is essential to the inherent dignity and wellbeing of the person and to building sustainable and inclusive communities; and

WHEREAS housing is a social determinant of health and wellbeing, necessary for preventing ill health and building healthy social and physical environments; and

WHEREAS Ontario entered into a bilateral agreement with the Federal government, which requires a provincial action plan under the national housing strategy; and

WHEREAS there is an urgency to expand access to housing to address inequitable health outcomes in Ontario, as exemplified by COVID-19,

THEREFORE BE IT RESOLVED, that Alliance and its members advocate for the implementation and uptake of Canada's commitment to the right to housing under federal legislation *(National Housing Strategy Act, 2019),*and international law (*Universal Declaration of Human Rights, 1948*); and

BE IT FURTHER RESOLVED that the Alliance and its members support action advancing "housing as a human right" legislation at the international, federal, provincial and municipal levels; and

BE IT FINALLY RESOLVED that the Alliance and its members call on the Minister of Health to recognize housing as a fundamental determinant of health, and to develop, advance and appropriately fund a housing strategy grounded in a rights' based approach.

Moved and Seconded by Alliance Board Recommend Concurrence

Background

Housing is a fundamental and critical determinant of achieving good health. Without adequate housing, individuals cannot attain or maintain good health. Health and housing are directly connected through a complex web of factors, including affordability, access, availability, habitability, stability and socioeconomic inequities.

The importance of housing as a determinant of health has become increasingly evident over the course of the ongoing COVID-19 pandemic. In Ontario, thousands were experiencing homelessness or were precariously housed before COVID-19. Subsequently, thousands more have lost jobs, financial security and housing as the crisis escalates. As the pandemic enters the second wave, many more will lose the already tenuous foothold they have on housing. The United Nations says "housing is the front line defense against the COVID-19 outbreak." The Alliance and members have a crucial role to play in advocating for housing as a health determinant during and beyond COVID-19.

In early 2020, the Alliance officially became a member of the National Right to Housing Network.[1] The network is dedicated to the meaningful implementation of the right to housing in Canada by:

1. Bringing together a network of civil society voices in a collective voice on the implementation of the right to housing;
2. Working with governments to develop Canada's right to housing architecture;
3. Identifying and mobilizing systemic challenges to test the right to housing in order to set precedent, address key gaps in the National Housing Strategy, and drive changes in housing policy and funding;
4. Exploring research on the right to housing; and
5. Supporting community initiatives to secure a housing rights culture and expanding the right to housing to provincial, territorial, and municipal jurisdictions.

In November 2017, Canada officially made a commitment to develop and implement a National Housing Strategy (NHS). The federal government introduced rights-based legislation to confirm its commitment to the right to housing, as guaranteed in the International Covenant on Economic, Social and Cultural Rights. The NHS Act brings Canada in line with international standards, which require the right to housing to be ensured, not only through policies and programs, but also through independent monitoring and access to hearings and effective remedies.

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[1] The National Right to Housing Network. See http://housingrights.ca/

By joining the National Right to Housing Network, the Alliance affirms that all people have the "right to live somewhere in security, peace and dignity," as stated by the United Nations. It also creates pathways for the Alliance and its members to call and advocate for the implementation of reasonable policies and programs to ensure the right to housing for all within the shortest possible time-frame. The most marginalized and vulnerable must be prioritized in access to housing.

By undertaking a resolution on the right to housing, Alliance members make a commitment to work with governments at both the provincial and federal levels to recognise housing as a determinant of health and as a fundamental human right in alignment with international law and as a critical element of effective health policy.

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POLICY RESOLUTION #8:
Maintain the current Ontario definition of disability for ODSP

WHEREAS the Ontario government announced reforms to the Ontario Disability Support Program Act in 2018 that include plans to change the definition of disability to align with the federal definition of disability for the CPP-D or the Disability Tax Credit; and

WHEREAS this change would narrow the definition to exclude a large number of people who are currently eligible for the program, such as people living with episodic disabilities or mental health disabilities, as the federal guidelines require the disability to be “severe and prolonged,” and it must prevent the ability to work at any job on a regular basis; and

WHEREAS the current definition of disability used by ODSP is an inclusive definition of disability. To meet the definition, one must have a substantial mental or physical impairment that is continuous or recurrent, and is expected to last one year or more, restrict daily living, and verified by health care professional; and

BE IT RESOLVED that the Alliance and its members call on the Minister of Children, Community and Social Services and the Provincial Government to maintain the current broad definition of disability used by the Ontario Disability Support Program to determine program eligibility rather than adopting the narrow federal guidelines, to ensure that people living with episodic disabilities, like those living with mental illness and substance use issues, remain eligible for disability social assistance.

Moved by Parkdale Queen West CHC
Seconded by Vibrant Healthcare Alliance

Recommend Concurrence

Background:
Changing the Definition of Disability for the purposes of ODSP.

There are two social assistance programs in Ontario:

- Ontario Disability Support Program (ODSP)
- Ontario Works (OW)

The 1997 ODSP Act established a program that would provide income and employment supports to eligible persons with disabilities and outline government, community, family and individual responsibilities in providing these supports. There are two components to ODSP: income support and employment support. To qualify for assistance, individuals must be residents of Ontario and meet specific criteria outlined in the Act. Additionally, a health status report filled out by a medical professional must be submitted.

For the purposes of the 1997 ODSP Act,[1] one qualifies as a person with a disability if:

a. the person has a substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more;
b. the direct and cumulative effect of the impairment on the person's ability to attend to his or her personal care, function in the community and function in a workplace results in a substantial restriction in one or more of these activities of daily living; and
c. the impairment and its likely duration and the restriction in the person's activities of daily living have been verified by a person with the prescribed qualifications.

The Issue:

An estimated 1 in 7 Ontarians live with disabilities, a number expected to increase as the population ages[2]. As of June 2019, there were 517,362 who required ODSP support to meet basic living expenses[3]. Patients accessing ODSP and other stakeholders have been calling for improvements to social assistance programs for years, such as increases in OW and ODSP rates and simplified processes for navigating ODSP, including a more easily accessible medical review process.[4]

In November 2018, the Ontario Ministry of Children, Community and Social Services announced changes to benefits for people living with disabilities.[5] Notably, the intention to redefine disability for ODSP eligibility was announced, but the new definition was not specified. Advocates have expressed concerns that the Ministry will introduce alignment with more restrictive definitions, such as the federal CPP Disability (CPP-D) definition. Notably, the CPP-D definition was developed prior to the modern recognition of disability rights and before Canada ratified major international conventions on disability rights.[6] Furthermore, the current CPP-D

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[1] Government of Ontario, (1997). Law Document- Ontario Disability Support Program Act, 1997, S.O. 1997, c. 25, Sched. B. Retrieved from https://www.ontario.ca/laws/statute/97o25b

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definition requires disabilities to be both severe and prolonged, and excludes temporary and episodic disabilities.[1]

In the provincial budget tabled in April 2019, the government announced funding cuts up to $1 billion from the Ministry of Children, Community and Social Services. Closer analysis of the budget revealed that these reductions would largely fall on social assistance programs, such as ODSP. To date, no further announcements have been made regarding the change to the definition of disability. However, people living with disabilities and advocates continue to call for the Ministry to retain the current definition of disability for the purposes of ODSP, especially given the impact of COVID-19.

In March 2020, as the impact of COVID-19 became evident, the Government of Canada announced the Canada Emergency Response Benefit or CERB. It provided $2,000 a month to people who lost income due COVID-19. The CERB has been extended as the pandemic continued, with an August, 2020 announcement that CERB would transition to Employment Insurance or EI. People living on ODSP could receive CERB as well. However, in Ontario, they are subject to claw-backs on their income, which advocates argue unfairly put vulnerable groups further behind. Changes to the definition of disability could even further impact their access to resources and increasingly isolate already vulnerable populations.

Implications:

Restricting the definition of disability will impact access to ODSP for people living with disabilities. These proposed changes mean many people who qualify for income support for basic living expenses will be ineligible in the future. Social assistance programs are a key safety net for Ontarians in need. They provide essential supports for people who are unable to work and assist Ontarians to reconnect with the workforce. Furthermore, poverty and limited access to safety nets are closely linked to worse health outcomes. Reforms that make ODSP inaccessible will have a detrimental impact and harm communities already facing many barriers. The ongoing COVID-19 crisis has highlighted the importance of extensive social supports for marginalized populations. Maintaining the current definition of disability ensures support is accessible to vulnerable populations.

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[1] Ibid

POLICY RESOLUTION #9:

Acknowledgement, Adaptation and Mitigation of Climate Change within the Community Health Sector

WHEREAS climate change is defined as a shift in long-term, worldwide climate phenomena associated with changes in the composition of the global atmosphere[1]; and

WHEREAS the World Health Organization states climate change to be the greatest global health threat of the 21st century;[2] and

WHEREAS the United Nations Intergovernmental Panel on Climate Change concludes that human influence on climate change is clear and it is extremely likely that human influence is the dominant cause;[3] and

WHEREAS climate change impacts the health of all people through: temperature-related morbidity and mortality; extreme weather events; poor air quality; food and water contamination; altered exposure to ultraviolet rays; increasing risk of vector borne infectious disease; and food insecurity, and that it indirectly impacts people by affecting labour capacity and population migration and displacement;[4] and

WHEREAS climate change disproportionately affects the health and wellbeing of vulnerable populations, such as children, seniors, low income and homeless people, those who are chronically ill, and rural and remote residents;[5] and

WHEREAS Indigenous peoples' health and wellbeing[6] and entire way of life are under grave threat due to climate change; and

WHEREAS tackling climate change will require a fearless, "all hands-on deck" response involving key stakeholders, including members of the Alliance for Healthier Communities, whether in a support or shared leadership role,

THEREFORE BE IT RESOLVED that the Alliance for Healthier Communities acknowledges the anthropogenic cause of climate change and the disproportionate impact on the health and wellbeing of people it has a mandate to serve; and

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[1] United Nations. United Nations Framework Convention on Climate Change. New York; 1992.

[2] World Health Organization. WHO calls for urgent action to protect health from climate change. Published 2015

[3] Intergovernmental Panel on Climate Change. Climate Change 2014: Synthesis Report. Contribution of Working Groups I, II, III to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change, Geneva: 2014

[4] Government of Canada. Climate and Health: Health Effects. Published 2018

[5] Government of Canada. Climate change and health: Populations at risk. Published 2018

[6] United Nations Permanent Forum on Indigenous Issues, Climate Change: An Overview. New York; 2007

BE IT FURTHER RESOLVED that the Alliance participate in the Ontario government's Climate Change Impact Assessment, and advocate for the inclusion of health equity as a key domain of resilience and the inclusion of experts from marginalized communities in the assessment process.

BE IT FINALLY RESOLVED that the Alliance amplify the efforts of its members working to mitigate and adapt to climate change, and further efforts that recognize ecological health and wellbeing as fundamental determinants of health within the Model of Health and Wellbeing through a member-driven Climate Change action group.

Moved by Centre de santé communautaire Chigamik CHC
Seconded by South East Grey CHC and South Riverdale CHC

Recommend Concurrence

Background

Climate change refers to a long-term change in weather conditions that is already underway. The main causes of climate change include humans burning fossil fuels to power their everyday lives, cutting forests, and releasing methane into the atmosphere through animal agriculture, food waste and the extraction and use of natural gas. As a result, unsustainable amounts of carbon dioxide and other heat-trapping gases have accumulated in the earth's atmosphere. This has caused polar ice caps to melt; sea levels to rise; precipitation patterns to change; and the number of extreme weather events – such as heat waves, hurricanes, floods and forest fires – to increase.

Climate change is a health issue because it threatens what we need to survive at a very basic level, including the air we breathe, the food we eat and the structures under which we find shelter. A World Health Organization (WHO) assessment estimated that between 2030 and 2050, a changing climate would cause an additional 250,000 deaths per year due to heat stress, diarrhea, malaria and malnutrition. In a 2019 report, the Council of Canadian Academies listed health and human wellness as one of the six areas of climate risk due to the "adverse impacts on physical and mental health due to hazards accompanying extreme weather events, heatwaves, lower ambient air quality, and increasing ranges of vector-borne pathogens."

Climate change, and the effect it has on the natural environment, is structural; it shapes systems, the daily conditions of life and, ultimately, opportunities for health and a dignified life. Those who already experience structural inequities, such as colonization, racism and low income, are often most vulnerable to climate change risks and impacts. A changing climate has the potential to worsen existing health inequities (see National Collaborating Centre on the Determinants of Health).

While the Model of Health and Wellbeing is not explicit about ecological determinants of health or sustainability, many Alliance member organizations across Ontario offer a variety of programs that can help individuals and communities adapt to climate change and strengthen their resilience. Co-designed with community members and fueled by cross-sector collaboration, these programs empower people to manage their own health while addressing the structural inequities that make climate change so devastating. For example, most members offer programs that promote food security and combat social isolation through community gardening and cooking, often designed by and for specific populations. Others include climate mitigation strategies, such as greenhouse gas reductions and energy efficiencies in their capital and infrastructure projects or transportation policies.

In recent years, the Alliance has expanded its advocacy on climate change, particularly with respect to health equity. For example, in 2019, Inuit climate activist and Nobel Peace Prize nominee Sheila Watt-Cloutier addressed the Alliance-CACHC conference on Indigenous Health and Climate Change and the role of community health. The Alliance also partnered with the Greenbelt Foundation to produce a report and communications series on health equity and climate change and contributed to Health Canada's National Climate and Health Assessment Report. In 2020, the Alliance signed, along with the Canadian Public Health Association and others, a submission related to climate and a green, healthy and just recovery from COVID-19.

We do not currently have a resolution about climate change, health and health equity and this is an opportunity to take a clear position on a significant health issue.