

# The Untold Story: Examining Ontario's Community Health Centres' Initiatives to Address Upstream Determinants of Health

L'histoire inconnue : examen des initiatives des  
centres de santé communautaire en Ontario sur la  
question des déterminants en amont de la santé



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## Abstract

*Background:* Unlike traditional primary care centres, part of the Community Health Centre (CHC) mandate is to address upstream health determinants. In Ontario, CHCs refer to these activities as Community Initiatives (CIs); yet, little is known about how CIs operate. The objective of this study was to examine the scope, resource requirements, partnerships, successes and challenges among selected Ontario CIs.

*Methods:* We conducted qualitative interviews with 10 CHC staff members representing 11 CIs across Ontario. CIs were identified through an online inventory, recruited by e-mail and interviewed between March and June 2011.

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*Results:* Most CIs aim to increase community participation, while addressing social isolation and poverty. They draw minimal financial resources from their CHC, and employ highly skilled staff to support implementation. Most enlist support from various partners, and use numerous methods for community engagement. Successes include improved community relations, increased opportunities for education and employment and rewarding partnerships, while insufficient funding was a commonly identified challenge.

*Conclusions:* Despite minimal attention from researchers and funders, our findings suggest that CIs play key capacity-building roles in vulnerable communities across Ontario, and warrant further investigation.

### Résumé

*Contexte :* Contrairement aux centres de soins primaires traditionnels, une des tâches des centres de santé communautaire (CSC) consiste à traiter la question des déterminants en amont de la santé. En Ontario, les CSC désignent ces activités sous le nom d'initiatives communautaires (IC); cependant, on connaît peu leur fonctionnement. L'objectif de cette étude était d'examiner l'étendue, les besoins en ressources, les partenariats, les succès et les défis présents dans un certain nombre d'IC en Ontario.

*Méthode :* Nous avons mené des entrevues qualitatives auprès de 10 employés de CSC, représentant 11 IC en Ontario. Les IC ont été répertoriées par un inventaire en ligne puis approchées par courriel; les entrevues ont eu lieu entre mars et juin 2011.

*Résultats :* La plupart des IC visent l'accroissement de la participation communautaire tout en traitant les questions d'isolement social et de pauvreté. Ils tirent un financement minimal des CSC et font appel à du personnel hautement compétent pour appuyer leur mise en œuvre. La plupart comptent sur le soutien de nombreux partenaires et emploient plusieurs méthodes pour favoriser l'engagement communautaire. Les succès comprennent une amélioration des relations communautaires, de meilleures occasions pour la formation et l'emploi ainsi que des partenariats fructueux, alors que l'insuffisance du financement figure parmi les défis les plus évoqués.

*Conclusion :* Malgré le peu d'attention qui leur est accordée par les chercheurs et les bailleurs de fonds, nos résultats font voir que les IC jouent un rôle important dans le renforcement des capacités auprès de communautés vulnérables en Ontario. Cela mérite de plus amples recherches.

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**C**OMMUNITY HEALTH CENTRES (CHCs) HAVE EXISTED IN NORTH AMERICA FOR nearly half a century. Although their structures and functions have changed over time and vary by jurisdiction, a common element has been their recognition of the influence of upstream, non-clinical factors on the health of people they serve. Recently, there has been a substantial increase in the number of CHCs in Ontario, driven in part by a belief in

the importance of CHCs' activities to address these non-clinical determinants (MOHLTC 2005). And yet, these activities, referred to as Community Initiatives (CIs), have not been systematically studied. Given the importance of the social determinants of health (SDOH) (CSDH 2008), and the growing body of literature demonstrating how these SDOH operate at the neighbourhood level (Collins et al. 2009; CPHI 2006; Lemstra et al. 2006; Macintyre et al. 2008; Mair et al. 2008; Pampalon et al. 2007), there is a critical need to understand this aspect of CHCs' work. This study sought to examine the scope, resource requirements, successes and challenges CHCs face in implementing CIs to address local-level health determinants in Ontario. Our findings offer insights into the less visible work of CHCs in Ontario, and deliver a unique contribution to the CHC literature that has been primarily focused on clinical- and behavioural-based components of CHCs' work.

### Origins of Community Health Centres in North America

CHCs in North America tend to operate in lower-income neighbourhoods, and/or serve specific marginalized populations (e.g., lesbian-gay-bisexual-transgender [LGBT], street-involved youth, etc.). Initiated in the 1960s, CHCs in the US were very much influenced by the civil rights struggles at the time (Geiger 2005), and from their inception, were committed to addressing the root causes of ill health in the communities they served (Wright 2005). While CHCs in Canada serve similarly marginalized communities, one of the driving forces for their emergence in this country was that of cost containment (Albrecht 1998). The traditional fee-for-service model for physician payment was placing immense pressures on provincial healthcare systems in the country, which led many provinces to start experimenting with alternative primary care models that utilize lower-cost medical professionals (e.g., nurse practitioners) (Suschnigg 2001), and can often achieve greater integration of care. But, while cost containment was a key driver, many CHCs emerged across Canada out of community-driven advocacy for improved access to comprehensive, primary care services where they were lacking (Suschnigg 2001).

### CHCs in Ontario

The Province of Ontario started experimenting with 10 pilot CHCs in the early 1970s, and by 2004, there were 54 communities being served through primary or satellite CHC locations (AOHC 2008). The greatest expansion, however, has taken place in the past decade; following considerable investment from the Provincial Liberal Government (MOHLTC 2005), there are now 101 CHCs across the province, 55 of which are primary locations (MOHLTC 2013). Every CHC in Ontario is funded by their region's Local Health Integration Network (LHIN), and governed by community-elected boards of directors (MOHLTC 2013). As CHCs work to eliminate barriers to primary healthcare for vulnerable populations, they are typically established in neighbourhoods across the province where priority populations are heavily concentrated (AOHC 2008).

Ontario's CHCs commonly strive to deliver services that are comprehensive, accessible, client- and community-centred, interdisciplinary, integrated, community-governed, inclusive of the SDOH and grounded in a community development approach (AOHC 2008). Ontario's CHCs also operate under the CHC Model of Care, which outlines five service areas (AOHC n.d.): primary care, illness prevention, health promotion, community capacity-building and service integration. To date, most research on CHCs has focused on the primary care (Adashi et al. 2010; Dahrouge et al. 2010; Gusmano et al. 2002; Muldoon et al. 2010; Tu et al. 2009), and health promotion and disease prevention (Hills and Mullett 2005; Hogg et al. 2009; Kisely and Chisholm 2009; Pelletier et al. 1997; Richard et al. 2005; Watson-Jarvis et al. 2011) elements of their work.

In contrast to the clinical- and behaviour-based approaches, the community capacity-building component of CHCs' work is delivered through CIs, defined as "a set of activities intended to strengthen the community's capacity to address factors affecting its collective health" (AOHC 2009: 9). For example, the Regent Park CHC's Pathways to Education aims to lower high-school drop-out rates through targeted supports for "academically at-risk" youth and their parents, while the Centretown CHC's Laundry Co-op provides opportunities for employment for low-income families (AOHC 2008). To facilitate their CI-based work, CHCs employ health professionals whose work focuses on upstream health determinants, including health promoters, community health workers and community developers. It is through the work of these individuals that CHCs engage in community capacity-building, and address social justice issues in their communities (Pérez and Martinez 2008).

## Study Objectives

The objective of this descriptive study was to document the scope, resource requirements, successes and challenges of implementing CIs in Ontario. This knowledge gap is problematic, given that community capacity-building has greater potential than clinical- or behaviour-based services to generate long-term, sustainable improvements to health for communities as a whole (Hawe 2009). This paper aims to reduce this knowledge gap, by building awareness of the community capacity-building work of Ontario CHCs, and by laying the foundation for evaluative research on the population health impacts of these initiatives.

## Methods

### *Methodology and ethics approval*

This study involved semi-structured interviews with CHC employees responsible for the administration and/or delivery of a CI, thereby offering an in-depth understanding of how CIs operate within the CHCs' catchment areas. Ethics approval was granted by the McMaster University Research Ethics Board in December 2010. From June 2010 to March 2011, the research team consulted with the Association of Ontario Health Centres (AOHC), a

not-for-profit group that represents and advocates on behalf of CHCs in Ontario (AOHC 2005), for several purposes: to learn more about how CHCs operate in Ontario, to raise awareness and stimulate interest in the study among staff at Ontario's CHCs and to have access to an online inventory of CIs taking place across Ontario (described below). While feedback was solicited from AOHC staff in the study's early stages to ensure the findings would have relevance to CHCs, all final decisions regarding study design, implementation, analysis and interpretation were made by the research team.

### *CI sampling frame*

Due to financial and human resource constraints, many of Ontario's CHCs are unable to offer comprehensive information about their CIs on their websites, posing a significant barrier to identifying and recruiting relevant CIs for this study. Serendipitously, in December 2010, the AOHC launched a web-based CI inventory tool, to which CHC staff voluntarily inputted data about CIs taking place at their CHC. An evaluative tool that had been developed by the AOHC formed the basis of the data fields in the inventory (Underhill and Jackson 2009), and gathered information about numerous variables ranging from initiative objectives, target populations and health determinants and partnerships. As of March 1, 2011, information for 59 CIs spanning 27 CHCs across Ontario had been inputted into the inventory. Each of the 59 CIs entered in the AOHC inventory by March 1st was considered for in-depth interviews. We chose to review only CIs inputted into this inventory for two key reasons. First, the inventory allowed us to review and compare CIs in a comprehensive and standardized way, which enabled us to overcome the challenge of inconsistency about CIs on CHC websites. And second, the inventory granted us access to contact information for CHC staff who are empowered and motivated to share information about their CIs (and thus more likely to be willing to participate in this study).

### *CI sampling strategy*

Drawing from the World Health Organization's conceptual framework for the SDOH (CSDH 2008: 43), as well as Hawe and Potvin's (2009) definition of a population health intervention (Hawe and Potvin 2009), CIs were deemed eligible for inclusion (N = 31) if they: (a) addressed some aspect of social position (i.e., income, occupation, education, gender or ethnicity/race); (b) reduced risk in successive cohorts by adopting upstream approaches and targeting the wider community (e.g., addressing hunger through action on increasing affordable food options); and (c) had potential to be sustainable over the long-term (e.g., building community capacity, fostering professional and leadership skills). Correspondingly, CIs were excluded a priori (N = 28) if they did not address social position, if they adopted more clinical or downstream approaches to health promotion and if they were likely to have only a short-term impact in their communities. Thus, excluded CIs were those that focussed on issues such as physical activity, air quality, food banks and meal programs. Additional CIs were excluded post priori (N = 14) to minimize burden for participants who had already agreed to discuss another CI at their CHC, as well as to limit redundancy by CI type.

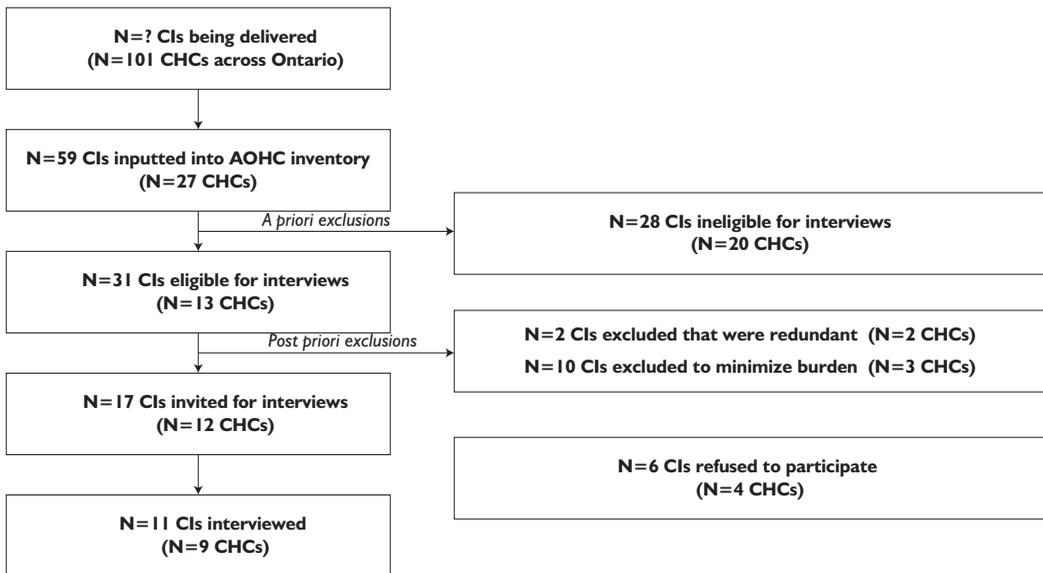
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Based on this strategy (Figure 1), we invited staff members for N = 17 CIs to participate in in-depth interviews. Drawing from staff contact information provided for the CI inventory, each CI staff person was contacted by e-mail and requested to participate in an interview at their convenience. In the recruitment e-mail, each interviewee received a letter of information and consent form, which was signed and returned prior to the interview. We conducted interviews with 10 CI staff representing N = 11 CIs (one staff member was interviewed for two CIs, and we received refusals for N = 6 CIs). Three interviewees chose to keep their identity confidential. Of the remaining eight CIs, five were from the Champlain LHIN, and the remaining three came from other regions across the province (Table 1).

**TABLE 1.** Descriptive summary of CIs interviewed for study

CHC	CI name (abbreviated name)	Interviewee's position	Short-term objectives	Long-term objectives
South-East Ottawa Community Services	Community-In-Action (CIA)	Community developer	Building social networks; training for civic participation	Creating female leaders for the community
Western Ottawa CRC	Country kitchen (CK)	Community developer	Building capacity and social networks; creating a program at low cost	That the program becomes self-sustaining
Centretown CHC	Enhancing LGBT Cultural Competence in Seniors Sector (ELGBT)	Health promoter	Increase awareness of LGBT issues in seniors sector	Support healthy ageing of older LGBT population
South-East Ottawa Community Services	No Community Left Behind (NCLB)	Community developer	Prevent crime	Address SDOH through an integrated approach
Centretown CHC	Ontario Seniors Action Network (OSAN)	Community developer	Advocate on key issues affecting seniors in the City, fight social isolation	Influence municipal decisions that affect well-being of seniors
Stonegate CHC	Stonegate Food Programme (SFP)	Community health worker	Meet immediate hunger needs, build social networks around food	Build community capacity for local food production
The Youth Centre	Take the Lead (TTL)	Community developer	Increase youth engagement	Improve career potential for at-risk youth
Grand River CHC	Community Garden Project (CGP)	Health promoter	Increase number of community gardens and access to food	Increase food security, environmental sustainability
Suppressed	Anonymous CI 1 (Anon1)	Community development worker	Variable, depends on the issue	Alleviate poverty
Suppressed	Anonymous CI 2 (Anon2)	Health promoter	Increase food access and social cohesion, calm traffic, improve access to informational resources	Improve neighbourhood capacity for change, increase collaboration
Suppressed	Anonymous CI 3 (Anon3)	Community outreach worker	Increase experience with recruitment and training processes	Increase prospects for employment, self-esteem, confidence

FIGURE 1. Sampling Strategy for Interviews with CHC CI Staff



### *Semi-structured interviews*

The semi-structured, in-depth interviews were conducted by telephone from May to June 2011. For each interview, two team members were present; one to conduct the interview, and the other to take notes. The interview guide (see Appendix A at [www.longwoods.com/content/23977](http://www.longwoods.com/content/23977) for details) was subject to external peer-review, as well as review by the research committee of the AOHC. The length of the interviews varied between 23 and 73 minutes, and covered the following topics: objectives, origins and time frames; human, financial and organizational resource requirements; partnerships and community engagement; and successes and challenges. All interviews were audio-recorded, transcribed verbatim and managed using NVivo® qualitative analysis software. Interview transcripts were analyzed in a two-step process. First, transcripts were coded based on the interview topics described above. Then, convergent and divergent themes within each topic across CIs were identified and captured through exemplary quotes. While additional interviews could have been pursued with the N = 14 CIs that were excluded post priori, the researchers determined that data saturation had been achieved when no new ideas or themes had emerged for any of the interview topics by the end of the 11 interviews.

## Results

### *CI characteristics*

A range of CI types were interviewed for this study (Table 1). Three CIs dealt with issues relating to food security; another three trained marginalized groups (i.e., youth, people living in poverty) for civic participation and leadership; two worked towards empowering marginalized groups (i.e., LGBT, seniors) for self-advocacy; one offered job training for hard-to-employ groups; and two adopted a community development framework to stimulate neighbourhood-level capacity for change.

*Objectives, origins, time frame and sustainability*

There was considerable overlap between CIs in their short-term objectives, which generally focused on increasing engagement in the initiative, developing social networks and building community capacity and combating social isolation within the community (Table 1). The long-term objectives were more variable and unique, and tended to reflect the overarching goals of the initiatives. In terms of origins, roughly half of the CIs were newly developed initiatives, while the other half evolved from an existing initiative or from the broader community.

... it began in early 2008 with just a conversation between the Community Developer ... and then the rural health nurse, ... and we brought that idea into the community and said, hey how about this, and it just turned into a real kind of organic “this is what would make sense to the community” and people would be interested in doing this. (CK)

We also asked interviewees about the time frame and sustainability of the CIs. In terms of time frame, all interviewees had indicated that the CIs would ideally continue on indefinitely, although a few indicated that funding constraints threaten the long-term viability of the initiative. When asked about whether the CI could be self-sustaining without the CHCs' involvement, the responses were mixed. Two CIs were already self-sustaining with minimal CHC involvement, and for another, a self-sustaining initiative seemed a viable prospect:

I'd like to build greater community capacity so that our role can continually just maybe slow down and the community will have the capacity with the leadership and understanding the processes to continue without us. (CGP)

For others, however, the prospect of self-sustainability seemed unlikely for various reasons, including the centrality of the role played by the CHC in ensuring the initiative is operational and sustainable; that CHCs are often heavily invested in their CIs because they are demonstrative of the breadth of CHCs' work and the CHC Model of Care; and because of the immense challenges communities face in developing partnerships, maintaining momentum and accessing resources that are essential to the life of these initiatives.

... the centre can play a very helpful role ... in terms of being an organization that funds can be filtered through ... I think just because of the pressures on everyone's time that ... if there isn't someone really kind of standing behind it and keeping things moving forward, ... the momentum really slows down. (ELGBT)

To be honest, in a world where poverty exists, and where people's capacities are reduced because of systemic barriers to access to jobs, food security, access to education, as long as those types of barriers exist, it's going to pose challenges for the

neighbourhood to completely fly with it on its own, over a long period of time ....  
That's a goal, but there are systemic barriers to that happening. (Anon2)

### *Organizational and staff requirements*

Six of the CIs were staffed by one person, who tended to be a community developer, community outreach worker or health promoter. The remaining five initiatives were staffed by two to three people (e.g., one coordinating the CI, and another overseeing its management, promotions and budget), and these CIs often had external funding. Interviewees identified a range of knowledge and skills necessary to complete their work, including willingness to connect with the community and build partnerships; community needs/assets assessment; project management; budget management and allocation; volunteer management; facilitation, training and mentorship; communications, marketing and event planning and management; community engagement and conflict resolution; research and proposal writing; knowledge and understanding of the SDOH; familiarity of the political landscape of the city and/or province; and awareness of the strengths and needs of the target group (e.g., LGBT seniors, low-income rural dwellers, female immigrants).

Interviewees felt their CHC facilitated development of knowledge and skills necessary for their work through, for instance, budgetary commitments for CI staff to attend conferences and workshops, and to participate in professional development training programs. One participant mentioned her involvement in a local network of community developers, while another stressed the importance of CHCs allowing CI staff to sit on local committees to build partnerships with outside agencies. Mentorship from within the CHC and from the AOHC was also identified as a key source of professional development.

Eight CIs had external sources of funding to support their initiative (previously, current or ongoing). The local municipal government was a common source for external grant support, while the United Way and corporate funders were also identified as key sources. Aside from salary support, CHCs' financial commitments to CIs were limited to in-kind contributions (e.g., printing and mail-outs, food for events) support and involvement from senior management to ensure CHC commitment was viewed as critical to the CI's sustainability.

### *Partnerships and community engagement*

With the exception of one, all CIs engaged multiple partners (Table 2). Partners ranged from other CHCs, municipal government staff and councillors, police services, public health units, universities, churches and schools, youth organizations, advocacy groups, community associations and local media outlets. As one interviewee explained, developing a partnership with an existing mobilized group helped to cement the CHC's role in the community as something more than a primary care centre:

They actually came to the Community Health Centre and sought us as an ally ... before we really had an identity within the community at the time ... And because of

my training and education in health promotion I saw this as a very key project to take on within our community and to establish our CHC as really looking at community health .... And so I was looking at that very strategically, saying ... we could really be attaching ourselves to a project ... and creating lasting partnerships through this garden initiative that will benefit the community and also us in establishing ourselves as more than just primary healthcare. (CGP)

In terms of raising awareness and engaging community members, most used a variety of written materials, including flyers, newsletters, sign-up sheets, brochures, posters and display boards (Table 2). Traditional media sources, such as local newspapers and radio stations, were also heavily used to promote the CI, as were strategies like e-mail distribution lists, websites, Facebook pages and photovoice. Finally, face-to-face approaches including conferences and workshops, community events, outreach at schools and informal gatherings were all mentioned as fundamental components of raising awareness and engaging the community.

### *Successes and challenges*

When asked about CI successes in general (Table 2), interviewees' responses focused on how the CI has facilitated establishment of social networks and relationships in the community, as well as uptake of the CI within the community (e.g., increased LGBT visibility, meeting immediate hunger needs, volunteers becoming employed). In terms of CIs' successes in addressing social position, responses ranged from improvements to household budgets, increased opportunities for post-secondary education and/or employment and increased awareness among service providers and politicians of challenges facing marginalized groups.

... we've made a conscious choice to work with active baby-boomers ... who have more resources and are highly skilled with a longer term goal of gaining benefits and opening doors for people who have less resources and who are more marginalized ... (ELGBT)

So they are owning something in which a lot of times we strip them of dignity and ownership of anything when we relegate them to social housing and [social assistance] and so I think in that regard, it's the things that are hard to measure and the things that are not tangible that are actually going to increase their socioeconomic environment ... (CGP)

Interviewees generally viewed all partnerships to be successful. For three CIs, partnerships with the local municipality were considered most beneficial in terms of offering access to City staff and resources, as well as lending legitimacy to the CI within the wider community.

**TABLE 2.** Partnerships, community engagement strategies, success and challenges for CIs

CI	Partnerships	Community engagement	Success	Challenges
CIA	Other CHCs, community resource centres, local initiative	Flyers to community housing coordinators, publicize at tenant association meetings	One participant started attending university	Inadequate funding
CK	Public health unit, family health team, community resource centre, city council, municipal committees, local churches, food producers, seniors groups	Existing connections, local media, newsletters, flyers, website, promotional materials to city council, informational video clip	Raised awareness and skills around budget-conscious food shopping and meal preparation	Reaching low-income households, lack of anonymity in rural setting
ELGBT	Municipal government staff, LGBT coalitions and networks, support groups, LGBT service providers	Existing connections, workshops, events at people's homes, local LGBT newspaper, poster, e-mail lists, Facebook page, website	Engaging LGBT baby-boomers because of their experience in advocating for rights that benefit all	Inadequate funding, competing priorities between partners, high staff turnover, community member burnout
NCLB	Law enforcement, youth organizations, community housing, recreation groups, mental health association	Community dinner, flyers	Bursary program for youth to attend post-secondary	Inadequate funding
OSAN	No partners	Booth in shopping malls, photovoice, website	Advocate for social housing for low-income seniors	Member recruitment and retention
SFP	Local food advocacy group, food bank, local church, public library, local restaurants, local schools	Local media, workshops, schools, sign-up sheets at farmers' market, newsletter, e-mails	Learning how to shop and cook food on a budget	Farmer retention, lack of partner cooperation
TTL	Local churches, community development council of Durham, John Howard Society, municipal government, local YMCA	Flyer, mentor packages to participating agencies, website, information sessions, talent show, local newspaper	Targeting under-served and at-risk youth to develop leadership skills and employment prospects	Relationship-building, competing priorities between partners
CGP	Aboriginal housing group, other CHC, mental health agency, children's services, municipal government staff, local university	Displays at community events, brochures, Facebook page, press releases, workshops, ads in local media	Marginalized individuals develop leadership skills that could help to secure employment	Unsustainable ownership model of initiative
Anon1	Local church, local social planning council	Existing connections, people with an interest just step up	Raising awareness of poverty in city among politicians and public	Competing priorities between partners
Anon2	Police services, landlords, schools, community associations, city councillor, boys and girls club, local mall, public health unit	Newsletter, community dinner, outreach with landlord and local schools, community foundation report profile	Increasing food security, employment opportunities	Neighbourhood diversity, inadequate resources
Anon3	Local newspaper, non-profit volunteer agency, education program at local university	Website, local newspaper, volunteer agency, flyers, recruit within CHC	Volunteering exposes them to all programs and services at the CHC	Volunteer recruitment

Common challenges to implementing CIs were identified, including inadequate funding, recruitment and retention of CI participants and competing priorities and levels of investment between partners (Table 2). While most interviewees had no challenging partnerships, a few cited conflicts with their partners, such as a lack of credibility within the community, personality conflicts, competing priorities between agencies and discrimination from partner agency members. Community opposition to the CI was not generally encountered, although two interviewees had cited a lack of understanding about the CI among the public as the root of some opposition. While most interviewees indicated that the funding was insufficient, one interviewee indicated that only a modest boost would be necessary, and a couple indicated that current levels were sufficient:

... it's not so much money as it is finding a way to work together in a sustainable way.  
(OSAN)

More funding would probably help in terms of being able to offer more workshops in the community ... but we definitely manage with the funding we have ... (Anon1)

## Discussion

The CIs described in this paper addressed multiple SDOH, many of which relate directly to social position (e.g., education, income, culture and social inclusion). And, while the CIs' long-term objectives reflected unique characteristics, the CIs' short-term objectives were generally focused on building social networks and recruiting participants. Given the importance of community support in ensuring the long-term viability of such initiatives (Lovell et al. 2011), and the well-established links between poverty and health, the findings from this study suggest that Ontario's CHCs have some capacity to reduce health inequities in the communities they serve. However, based on inventory data (results not shown), relatively few CIs across Ontario target conditions of unemployment, underemployment and low literacy – conditions that are commensurate with the education, occupation and income components of social position (CSDH 2008), and operate upstream of poverty. CHCs' limited work on these socioeconomic conditions may reflect the limitations of area-based initiatives (Thomson 2008), and suggests that some health determinants are more amenable to area-based intervention than others. The lack of emphasis paid to underemployment and unemployment may also be explained by the prevailing neoliberal environment within which these CHCs operate (Gore and Kothari 2012), and the difficulty of advocating for these issues within this climate (Navarro 1998).

The resource requirements of CIs from their host CHCs were minimal. Most operate on a very limited budget, and are typically staffed by one person for less than 20 hours per week. While CIs involve small budgets and limited staff, the individuals who work on these initiatives appear to be incredibly versatile, possessing knowledge and skills ranging from project management, research and grant writing, community engagement, partnership-building and promotional skills. Despite budgetary constraints, it is noteworthy that nearly every CHC

had no foreseeable plan to relinquish its role in the initiative over the long-term, which may be partly attributable to the community development orientation of the CHC Model of Care (AOHC n.d.).

The CIs generally engaged multiple, locally based partner agencies to assist with launching and operating the CI. The breadth of partnerships, and the limited budgetary commitment from CHCs, suggests that the burden of delivering these initiatives is really borne by the community-at-large. Thus, the mobilization and capacity of the wider community to implement these initiatives appears to be quite high, and is likely reinforced by the strong commitments of CI staff to engage community partners. Yet, despite efforts to build these social networks, recruitment and retention of partners and community members was reported as a key challenge with the CIs. This challenge may also help to explain the reluctance of CHCs to give up the leadership reins of CIs, especially if there is no other agency in the community that is willing to take a leadership role to sustain the initiative.

In terms of potential to improve the social position of area residents, many of the CIs reported successes through increased opportunities for higher education, stable employment, increased income and recognition of rights for marginalized groups. These opportunities may present for single individuals or small groups at a time, but if sustained over the long-term, such changes could facilitate fundamental improvements to health and well-being of the wider community and successive generations (Hawe 2009). Given the perpetual challenge of inadequate funding for these initiatives, initiating and sustaining CIs requires both long-term commitments from their parent CHCs, as well as recognition from the LHINs of the role these initiatives play in improving population health.

### *Limitations*

This study only examined Ontario-based CHCs, and thus may have limited generalizability to jurisdictions outside of Ontario. However, while the CHC Model of Care is based on Ontario's CHCs, the philosophy behind it is comparable to those guiding CHCs across Canada (CACHCA 2011), as well as in the US (Shea et al. 2012). We also had a small pool of interviewees (n = 10 individuals for 11 CIs), which was pre-constrained by the scope of the CIs that had been inputted into the AOHC inventory. Social desirability bias may also be present, if participants used the interview as an opportunity to tout their work, rather than offer more critical input. While interviews with individuals external to the CHCs may have generated more critical feedback (Weiss 1998), conversations with AOHC staff (Misra 2010) and our own interview findings suggested a high degree of popularity of these initiatives within the communities they serve, which we expect would have made it difficult to recruit individuals external to the CHC to discuss the CIs' weaknesses for fear of putting them at risk. Finally, this descriptive study sought only to document key characteristics of CIs being delivered by CHCs across Ontario, and to make informed judgments about the potential for these initiatives to reduce health inequities. Determining whether these initiatives are reducing health inequities requires intensive longitudinal study, and represents a key area for future research.

## Conclusions

While CHCs in Ontario are critical to providing vulnerable communities access to primary care, they also engage in broader initiatives that venture well beyond the health sector, and have the greatest potential for reducing health inequities at the local level. This study found that CHCs in Ontario implement a broad range of CIs that operate with dynamic staff, engage multiple partner agencies, use innovative strategies to recruit participants and have potential to effect change in the social positions of area residents. They draw minimal resources from their CHCs, yet inadequate funding does pose a threat to the long-term sustainability of CIs, and in turn, their capacity for success. While much of the work to address the SDOH needs to happen outside the health sector and at higher levels of government, our study illustrates the instrumental role CIs actively play in addressing the upstream SDOH at the local level in Ontario. Future evaluative research is needed to establish whether, and quantify the extent to which, these activities are reducing health inequities in the communities they serve.

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