Middlesex-London Health Unit

Action on Poverty
Environmental Scan 2011

June 2011

MIDDLESEX-LONDON HEALTH UNIT

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Introduction

"Income is perhaps the most important social determinant of health. Level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use. In Canada, income determines the quality of other social determinants of health such as food security, housing, and other basic prerequisites of health."[1]

Recently, the Social and Research Planning Unit released a "Fact Sheet: Low Income in London" (February 2011) with some unsettling facts[2]:

- Our low-income rates (except for seniors) are higher than in Ontario and Canada.
- One in seven households is unable to afford shelter that meets adequacy, suitability, and affordability norms.
- Emergency shelter usage rates have declined, but is relatively high compared to other municipalities.
- The growth in families using the London Food Bank since 2001 exceeds population growth
- Our unemployment rate is among the highest in the country and our participation rate is among the lowest.

The Middlesex-London Health Unit (MLHU) has a long history of providing programs and services to meet the needs of those living in our community in poverty. In particular, initiatives that address food security, the annual publication of the Nutritious Food Basket Protocol, onsite delivery of care to families at community clinics and women's shelters, and the provision of essential and emergency dental care for eligible children in need are few such examples. Despite these efforts to date, public health in Canada is frequently rebuked for focusing on healthy lifestyle and behavioural approaches rather than on the social determinants of health that includes supporting political action.[3,4] Other challenges identified that interfere with more widespread action includes the lack of clarity regarding what public health should or could do; limited existing evidence; bureaucratic organizational characteristics; limitations in organizational capacity; the need for leadership; more effective communication; and supportive political environments.[5]

Challenges aside, there is a growing interest in taking action on the health determinants within public health in Ontario. Notably, Sudbury and District Health Unit and Waterloo Region Public Health are well-known innovators that have published numerous documents, tools, and frameworks with a focus on health inequities.

In early 2011, in preparation for strategic planning, the Health Unit Senior Management Team commissioned a report which would inform an implementation plan for public health strategies to address poverty. The Senior Management Team developed Terms of Reference attached as Appendix A. Brenda Marchuk, Community Health Nursing Specialist, was seconded to fulfill the role of Project Coordinator.

The process undertaken was as follows: a scan of the literature was conducted; MLHU program and services directed towards those living in poverty were mapped; efforts in our community to address poverty were captured; resources from leading innovator public health units across the province were studied. The result is a summary of key recommendations for MLHU action on addressing poverty to move us forward into the future.

Key Terminology

Determinants of Health: "The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions." These factors are referred to as the determinants of health. They include the following 12 determinants[6]:

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social and physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture
- Language

Health Equity: This term "implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[7]

Health Inequities: "Health inequities are differences in health status experienced by various individuals or groups in society that are systematic, socially produced (and therefore modifiable), are judged to be unfair or unjust."[8]

Poverty[9]: Currently, Canada does not have a national definition of poverty but a number of statistical indicators. Probably the best known include the Low-Income Cut-Offs (LICOs), Low Income Measures (LIMs), and various Market Basket Measures.

Ontario has developed a "deprivation index" that is a list of items which are widely seen as necessary for a household to have a standard of living above the poverty level. The locally agreed upon measure of poverty is based on the Low-Income Cut Off (LICO).

London's Ending Poverty Implementation Team has opted to define poverty from a "standard of living" perspective that measures poverty in relation to community norms and standards. According to the Children & Youth Network poverty *is being unable to fully participate in society as a result of inadequate income.*

Priority Populations: are those population groups at risk of socially produced health inequities.[10]

Review of the Literature

The overall intent of this component was to address the following questions:

- What are effective measures to address poverty?
- What is Public Health's role in addressing health determinants and inequities?

Key reports were identified through:

- Specific search of PubMed limited to English articles published from 2008 to the present
- Recommendations from other public health experts
- Targeted international, national and provincial government websites
- Search of websites of Ontario health units that are known to be innovators or early adopters in the area of social determinants of health
- Reference lists of relevant articles and reports for potential additional references

The literature search revealed an extensive amount of literature from sources in all sectors. The "London's Anti-Poverty Strategy: Literature Review" conducted by the City of London in 2008[9] provides a comprehensive understanding of poverty with a focus on local indicators of poverty (Appendix B). This profile of poverty in London includes the number of people living below Statistic Canada's Low Income Cut Off (LICO), local social assistance caseloads, food bank use, shelter use, and bankruptcy rates. In addition, the report provides an overview of anti-poverty strategies in a variety of jurisdictions that are known innovators such as the United Kingdom and Ireland; the provinces of Quebec and Newfoundland; and the municipalities of Lambton, Hamilton, Halton and Niagara.

It should be noted that some health associations have produced position statements on the social determinants of health. These include the Canadian Public Health Association,[11] and the Canadian Nurses Association. [12] The Chronic Disease Prevention Alliance of Canada also produced a position statement in 2007 on addressing income-related food security.[13]

Below you will find a non-exhaustive summary of some of the more recent major reports addressing the social determinants of health, including reports specific to public health in Canada. While an attempt was made to look at literature on poverty, valuable reports that addressed all the social determinants of health or health equity were included due to the interrelatedness of the issues.

Recent Major Reports Addressing Poverty and the Social Determinants of Health

- *Breaking the Cycle: Ontario's Poverty Reduction Strategy*[14] – 2009: The strategy sets a target of reducing the number of children living in poverty by 25 per cent over the next 5 years. Some examples of recently implemented provincial anti-poverty strategies include dental care for low income children up to age 18, incremental increases in the minimum wage, rolling out of full-day kindergarten in some schools, and the creation of the Ontario Child Benefit.

- *Building Foundations: Building Futures: Ontario's Long-Term Affordable Housing Strategy*[15] – 2010: The strategy includes simplifying rent-geared-to income calculations, improving wait lists for social housing, helping victims of domestic violence, consolidating housing and homeless programs, and providing municipalities with more flexibility to make decisions based on local need.

- *Health Equity Through Intersectoral Action: An Analysis of 18 Country Case Studies*[16] – 2008: This report includes the importance of community engagement at the local level in addition to whole-of-government approaches; building a strong case for intersectoral action; establishing clear roles and responsibilities; securing long-term resourcing; and the complexity of monitoring the processes and outcomes of intersectoral work.

- *In From the Margins: A Call to Action on Poverty, Housing and Homelessness*[17] – 2009: This document makes 74 recommendations to the federal government. Most of the recommendations are about existing policies and programs that are described as entrapping people in poverty rather than lifting them out of poverty. In terms of health, the Committee recommends central agencies address the negative health outcomes associated with poverty; advocate for a national pharmacare program; and together with provincial and territorial governments provide physical health services for people who are homeless.

- *Poverty and Chronic Disease: Recommendations for Action*[18]- 2008: Key recommendations of this report include increasing income transfers and income generally; ensuring adequate housing; and advocating for groups most vulnerable to poverty. Potential program-level recommendations include the importance of conducting a health equity audit when developing initiatives, and targeting vulnerable populations as well as the overall population; initiatives should consider equity issues to avoid inadvertently causing health inequities. Other recommendations include the need for a national anti-poverty strategy; measurable targets for the reduction of poverty; increased evaluation of interventions; increased awareness about the link between poverty and health; and the importance of working intersectorally.

- *Poverty is Making Us Sick: A Comprehensive Survey of Income and Health in Canada*[19] – 2008: This survey explores the most recent evidence on the relationship between income, key social determinants of health, and important health outcomes in Canada using data from the Canadian Community Health Survey (2005).

- *Social Determinants of Health: The Canadian Facts*[1] – 2010: This document provides an overview of 14 social determinants of health, why they are important to health, how we compare to other wealthy nations, and outlines policy implications for each determinant. Recommendations in the report about income inequity include increasing the minimum wage and enhancing social assistance for those unable to work; progressive taxation; and more unionized workplaces.

- *WHO Commission on the Social Determinants of Health final report*[20] – 2008: WHO established the Commission on the Social Determinants of Health in 2005 to address the health inequities seen within and between countries. The report called *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* contains three recommendations:
  1. **Improve the conditions of daily life** (e.g. early childhood development, quality housing and clean water, fair employment and improved working conditions).
  2. **Tackle the inequitable distribution of power, money, and resources** (e.g. address gender inequity, strengthen public sector leadership in the provision of health-related goods and services).
  3. **Measure and understand the problem and assess the impact of action.** (e.g. common global framework of indicators, debt relief and aid supports social determinants of health policy-making and action).

Recent Reports Addressing Poverty and the Social Determinants of Health Specific to Public Health in Canada

- *Activities to Address the Social Determinants of Health in Ontario Local Public Health Units*[21] – *2010*: This newly released report from the Joint Association of Local Public Health Agencies (alPHa)/OPHA Working Group on Social Determinants of Health) is a summary of a survey conducted of provincial health units during the summer of 2010. For further discussion of the findings, see the report section entitled **Activities to Address Poverty in Select Public Health Units and Appendix C.**

- *Developing Performance Indicators for Social Determinants of Health, Health Inequities, and Priority Populations in the Ontario Public Health Standards*[21] *– 2011*: This report by the Access, Equity and Social Justice Work Group, OPHA/alPHa Work Group on Social Determinants of Health offers potential indicators that can be used to monitor Boards of Health's progress and performance in addressing the determinants of health and reducing social inequities.

- *Implementing Local Public Health Practices to Reduce Social Inequities in Health*[23] – 2010: This report from Sudbury & District Health Unit (SDHU) was produced with funding from EXTRA (Executive Training for Research Application), which is a program of the Canadian Health Services Research Foundation. It is a summary of an extensive literature search and analysis. The resulting report outlines ten promising practices at the local public health level with potential to reduce social inequities in health. These are:
    1. Targeting with universalism*
    2. Purposeful reporting
    3. Social marketing*
    4. Health equity target setting
    5. Equity-focused health impact assessment*
    6. Competencies/organizational standards
    7. Contribution to evidence base
    8. Early childhood development
    9. Community engagement
    10. Intersectoral action.

  *SDHU has decided to initially focus on practices related to targeting with universalism, social marketing, and equity-focused health impact assessment.

- *Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice*[5] *– 2011*: This newly released environmental scan prepared by the National Collaborating Centre for Public Health provides an overview of key challenges, needs, gaps, and opportunities for public health with regards to the social determinants of health. Four key roles for public health action on health determinants are identified as:
    1. **Assess and report on the health of populations** describing the existence and impact of health inequalities and inequities and, effective strategies to address them.
    2. **Modify/orient public health interventions** to reduce inequities including the consideration of the unique needs of priority populations.
    3. **Engage in community and multi-sectoral collaboration** in addressing the needs of priority populations.
    4. **Lead/participate and support other stakeholders** in policy analysis, development and advocacy for improvements in health determinants and inequities.

- *The Chief Public Health Officer's Report on the State of Public Health in Canada: Addressing Health Inequities*[24] – 2008: This report presents information about the current health status and uneven distribution of health across the population. The report includes a list of actions to ameliorate poverty such as social investments, improved community capacity for the design and implementation of strategies to address the social determinants of health, improved multi-sectoral action, and improved public health leadership.

- *Reducing Health Disparities: Roles of the Health Sector*[25]: Discussion Paper-2005: This report presents four key policy directions for the health sector:
    1. Make health disparities reduction a health sector priority.
    2. Integrate disparities reduction into health programs and services.
    3. Engage with other sectors in health disparities reduction.
    4. Strengthen knowledge development and exchange activities.

Common themes from the literature regarding public health's role in addressing determinants of health includes the importance of intersectoral collaboration, policy advocacy, building capacity of public health staff, improving organizational leadership, and strengthening knowledge exchange.

Expectations for Public Health Action Within the Ontario Public Health Standards

Explicit expectations for public health action on the determinants of health are embedded within the Ontario Public Health Standards (2008)[6]. Health Units are directed to identify "priority populations" through surveillance, epidemiological studies, or other research. Priority populations are defined as those groups "that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level." Public health professionals are required to modify universal programs to meet the needs of priority populations, or develop specific strategies that address health inequities and the social determinants of health.

Requirements #3, 4, and 5 of the Foundational Standard state:

Requirement #3: The board of health shall use population health, determinants of health and health inequities information **to assess the need** of the local

population, including the **identification of** populations at risk, to determine those groups that would benefit from public health programs and services (i.e., priority populations).

Requirement #4: The board of health shall **tailor public health programs and services** to meet local population health needs, including those of priority populations, to the extent possible based on available resources.

Requirement #5: The board of health shall **provide population health information, including determinants of health and health inequities** to the public, community partners, and health care providers, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).

Three of the Standards identify specific program requirements, outcomes, and indicators related to priority populations. These include:

- Skill development in the areas of **food and healthy eating practices**, (Chronic Diseases and Injuries Program Standards).
- Provision of **tobacco cessation** programs and services (Chronic Diseases and Injuries Program Standards).
- Use of a comprehensive health promotion approach to increase the capacity of priority populations to **prevent injury and substance misuse** (Chronic Diseases and Injuries Program Standards).
- Outreach to priority populations in collaboration with community partners to link them to **information, programs and services related to reproductive health, child health, and healthy sexuality** (Family Health Program Standards, Infectious Diseases Program Standards).
- Outreach **clinics to priority populations to provide provincially funded immunization** (Infectious Diseases Program Standards).

Recently, the Access, Equity and Social Justice Work Group, OPHA/alPHa Work Group on Social Determinants of Health has developed social determinants of health and priority population indicators for Boards of Health. [22]

Activities to Address Poverty at the Middlesex-London Health Unit

During the months of March and April 2011, mapping of MLHU programs and activities and staff membership on community committees related to poverty, were captured by the Community Health Nursing Specialist (Appendix D).

An attempt was made to provide a consistent approach to data collection that identified the priority population targeted (e.g. population groups experiencing persistent low income based on national and local data)[9,11]; how the priority population was identified; if the practice related to one of the ten promising practices identified to reduce social inequity by Sudbury & District Health Unit[23]; what modifications of activities were made to meet the priority population needs; and finally, the Ontario Public Health Standard met by the program or activity.

The following are some observations made of the MLHU programs and activities related to poverty. For example, mapping revealed:

- Multiple examples of engagement in community and intersectoral collaboration to address the needs of priority populations.
- Membership on multiple local committees that address **programs and services** for individuals living in poverty (Hunger Relief Action Coalition, Intercommunity Health Centre, London Food Bank, London Community Resource Centre, Special Risk Hoarding and Senile Squalor Coalition, London CAReS committee, London Community Plan on Homelessness Committee).
- Some representation on **local anti-poverty strategies** (Child and Youth Network Ending Poverty Working Groups, Hunger Relief Action Coalition).
- MLHU delivers **seven programs identified in Ontario's Poverty Reduction Strategy** (Healthy Babies Healthy Children, free vaccination/immunization programs, Children in Need of Treatment (CINOT), Healthy Smiles Ontario, Pre-school Speech/Language Programs, Infant Hearing Programs, Blind-Low Vision Program).
- The majority of our poverty strategies fall under the Family Health Program Standard and the Chronic Diseases and Injuries Program Standard of the Ontario Public Health Standards (2008).
- Several examples of public health interventions that have been modified to meet the unique needs and capacities of priority populations (e.g. low/no cost, bus tickets distributed, multiple locations of clinics with consideration of location of priority populations, materials translated).
- Several examples of school-based programs that address poverty (e.g. Snack/meal programs, Ending Poverty Neighbourhood Demonstration Project, Health Promoting

School approach, Sexual Health Outreach Clinic).
- Several examples of food security initiatives (e.g. Nutritious Food Basket Protocol, community gardens, healthy eating in youth group home settings, grocery store tours for immigrants, collective kitchens, food literacy programs for vulnerable youth, Grow Cook Learn, support of Community Food Advisors).
- Minimal examples of participation in advocacy efforts to reduce poverty (formal Board statements, direct advocacy as an organization or as part of a community coalition).
- A lack of a consistent framework for addressing poverty, or use of equity-focused assessment tools in the planning of programs and services to reduce the possibility of contributing to health inequities.
- Few examples of community engagement that involved priority populations in problem identification, intervention planning, and evaluation.
- Some organizational activities to enhance staff capacity with regards to the social determinants of health or health inequities in the past led by the PHRED program.

Activities to Address Poverty in the City of London and Area

London has been actively addressing the issue of poverty for many years. In 2008, the City of London Municipal Council endorsed in principle the "25-in 5: Network for Poverty reduction" declaration.[26] In addition, Middlesex County has one identified anti-poverty strategy.

Generally, community partners mentioned that what is needed to improve the impact of anti-poverty efforts in London and area is the involvement of "systems partners" such as the Health Unit to leverage resources, understand the big picture, and ultimately strengthen advocacy efforts. In addition, the importance of having strong, knowledgeable staff representation at the committee level was articulated.

Some key examples for both London and Middlesex County include, but are not limited to:

Mayor's Anti-Poverty Action Group (MAPAG)[27]
In 1997, the Mayor's Anti-Poverty Action Group (MAPAG) under the leadership of Mayor Dianne Haskett developed an integrated strategy to ensure that the basic needs of all Londoners were being met and to address the negative stigma faced by those living in poverty. Still in existence today, the 2009 MAPAG funded activities includes:

- The Heat and Warmth Program (THAW) that assists low income Londoners who are experiencing a utility crisis with financial assistance by paying their unpaid utility bills.
- Health Access Vouchers that provides low income Londoners with access to urgent over-the-counter pharmaceuticals through a one time voucher.
- Implementation of the Extreme Temperature Protocol when directed to do so by the Medical Officer of Health. Designated centres provide a place for people to warm or cool down, obtain water, nutrition and cots.
- Participation in the organizing of the "All our Sisters National Conference" held May 9-11, 2011 that highlighted the issues faced by women experiencing poverty and homelessness.
- Financial support for the services and activities related to London CAReS street outreach strategy (See further details below).

London Community Housing Strategy (LCHS)[28]
In June 2010, the City of London released their latest 5-year housing strategy for the municipality. The LCHS builds on work started a decade ago with the Affordable Housing Task Force and local initiatives such as Hostel to Homes, London CAReS, and the No Fixed Address Demonstration Project. The Health Unit is identified as a key stakeholder particularly with respect to supporting the vulnerable to obtain and remain in healthy housing. The latest strategy reflects three integrated components that address housing continuums:

- Life cycle (different needs for youth to seniors)
- Needs and Supports (the range of interventions and housing types required from independent living with no supports to fully supported)
- Types of accommodation (crash beds, emergency shelters, market rental housing etc.).

London Community Plan on Homelessness (CPH)[29]
The London Community Plan on Homelessness is an extension of the London Community Housing Strategy and was released in November 2010. This 5-year strategy will address:

- Integration between housing and homeless programs and services
- The opportunity and future role of shelters
- Alignment of services and interventions to focus on housing and solutions to homelessness
- Supportive housing and housing with supports
- Improving discharge planning and prevention services while still meeting needs

- Understanding who is served and their needs while striving for reductions in homelessness and increasing access to housing.

London and Middlesex Local Immigration Partnership (LMLIP)[30]
This is a joint initiative of Citizenship and Immigration Canada and the Ministry of Citizenship and Immigration Ontario designed to strengthen the role of local and regional communities in serving the needs of immigrants through a local partnership. In June 2010, LMLIP completed its local Community Immigrant Strategic Plan. The Employment Sub-council includes programs in the areas of mentorship, bridging, job search, credential assessments, and employment and employment supports for immigrants.

London CAReS Community Addiction Response Strategy[31]
In 2009, the Community and Protective Services Committee launched a 5-year plan called "London CAReS" aimed at improving the health outcomes of street involved and homeless individuals who live with the effects of poverty, addiction, and mental illness. Components included providing safe haven community centres, feet on the street outreach, van outreach, 24 hour telephone service, and syringe recovery. This program is currently under review and the funding secure until September 2011.

Middlesex Supports[32]
This County Council program supports low income Middlesex residents with children. The types of programs that may be eligible for funding must help prevent and reduce the depth of child poverty, promote attachment to the workplace, and provide stimulus to promote healthy growth in children who would not be able to participate without these supports. Some examples of programs funded include: Supporting Working Parents (Lucan), Ailsa Craig Playgroup, Supporting Children's Healthy Development through Play and Literacy (Komoka-Kilworth), Family Service Thames Valley (Parkhill, Strathroy, Lucan, Glencoe, Dorchester), Strathroy Mutual Aid Parenting Program, Southwest Middlesex and Strathroy Caradoc-Can I Play Too?, and Seats for Safety.

Ending Poverty Implementation Team of the Child & Youth Network[26]
The Child and Youth Network (CYN) is addressing poverty with the goal of reducing the proportion of London families who are living in poverty by 25% in five years and by 50% in 10 years.

Specific CYN 2010 strategies included:

- Increased awareness and engagement of the community in understanding poverty through the launch of the Real Issue campaign using web, social and print media.
- Reduction of the impact of poverty through the development of a microloan fund; a Basic Needs Beacon framework; support for the creation of both the London Community Housing Strategy as well as the London Community Plan on Homelessness; and London's Food Charter.
- Strategies to break the cycle of poverty such as the hiring of a Community Development Coordinator to be hosted by MLHU to begin the implementation of the Grade 7 Wrap Around project; review of breakfast programs; and the exploration of opportunities for a project targeting women and/or newcomers.

Colour of Poverty Campaign-London
London is one of six communities to be funded by the Trillium Foundation with the goal of collecting and analyzing data linking race and poverty, and to develop programs to bridge the gaps. In London, a community consultation meeting and panel discussion was held in February 2010.
http://www.colourofpoverty.ca/

Hunger Relief Action Coalition
This coalition produces meal programs and food bank depots' information on a monthly basis. It creates a platform for coordination among meal providers and food bank depot representatives.

Life*Spin[33]
In existence since the late 1980's, this not-for profit organization provides information, support and community-based programs to low-income Londoners. Some of these programs and services includes: Community Housing Project, Peer Lending Circles, Women's Resource Centre, The Green Market Basket, Pocket-sized Farms, and the Free Store.

United Way London[34]
In the past year, more than 4,000 households accessed one of four United Way funded neighbourhood resource centres in London, where they were able to access emergency supports like baby food and diaper banks, meal programs and employment supports.

United Way has four impact areas: poverty, beginnings & transitions, mental health, and community principles. In terms of poverty, their vision includes ensuring that everyone's basic needs are met; has the skills, supports and information they need to be engaged in our community and make their best possible contribution; and is financially stable.

United Way is involved in many existing anti-poverty strategies in our municipality.

Activities to Address Poverty in Select Public Health Units

Activities to Address the Social Determinants of Health in Ontario Local Public Health Units: Summary Report[21]

In the summer of 2010, the Joint OPHA/alPHA Working Group on the Social Determinants of Health conducted an online survey of Ontario's health units to map local public health activities and needs addressing health inequities, social determinants of health and/or poverty reduction strategies (Appendix C).

- Sixty-four percent of all Ontario public health units responded across the province.
- Fifty percent of respondents stated that the determinants were identified as a priority in their health unit's strategic plan.
- Almost all agreed that community engagement, multi-sectoral collaboration, and support for policy advocacy were appropriate activities for health units to utilize in order to address the determinants of health.
- Other suggested activities included increasing awareness of the determinants, assessing and planning for priority populations, or using equity-focused assessments or a social equity lens in policy and program development.
- Many mentioned that contributing to the provincial system to build capacity and coordination was also an appropriate role for health units.

Health Units were asked specifically about their involvement in Ontario's Poverty Reduction Strategy.

- All responding health units reported that their organization delivered elements of the programs identified in the provincial Poverty Reduction Strategy. All participating health units indicated they provide Healthy Babies Health Children programming, and the majority provides free vaccination/immunization and the Children in Need of Treatment (CINOT) program.
- Ninety-six percent of responding health units outlined their involvement in the Early Learning programs as described in Ontario's Poverty Reduction Strategy.
- Health Unit involvement with School Poverty Reduction Programs is variable with the strongest levels of involvement reported with student nutrition programs, healthy school strategies and after school activities.
- Health Unit involvement in community poverty reduction programs noted in the provincial strategy was limited largely to the Community Use of Schools, and the Community Hubs.
- Responding health units identified most frequently that they formally advocated for an increase in minimum wage or a long-term affordable housing strategy in their respective communities.

Policy advocacy and staff skill development were two areas identified by public health units as requiring additional support in order to further their work addressing the determinants. Additional areas of support included knowledge brokering services, strategies, tools and checklists and infrastructure to share information. The report points out that these capacity building needs could be addressed by such organizations as alPHa, OPHA and the Ontario Agency for Health Protection and Promotion.

Early Ontario Pubic Health Innovators

Although many Health Units are paying attention to the social determinants of health, some health units have taken a more deliberate and focused approach. Two of these are:

1. Sudbury & District Health Unit (SDHU)

The SDHU Board of Health created a Determinants of Health Position Statement in 2005. Since that time, the SDHU has taken leadership with OPHA/alPHa to develop an action plan for public health, a resolution on the determinants as a mandatory public health program, and produced advocacy and discussion papers.[35]

The health unit uses the terminology "inequities in health" defined as "those health inequities that are systematic, socially produced (and therefore modifiable by society's actions), and are judged to be unfair and unjust." [36]

Early on SDHU adopted the "Rainbow model" of the main determinants of health originally developed by Dahlgren and Whitehead[7] as a guide to promising actions to reduce health inequities in their community. This model consists of four layers: 1) Individual lifestyle factors, 2) Social and community networks, 3) Living and working conditions, 4) General socioeconomic, cultural, and environmental conditions.

In 2008, they conducted an internal scan of their health unit's activities related to health inequities using a "Health Equity Mapping Checklist" based on the multilevel Rainbow model. Their findings included:[37]

- Few existing SDHU programs and activities that specifically included socioeconomic priority populations in their planning/delivery/evaluation.
- Staff expressed uncertainty about their role with regards to non-health sector issues such as housing, income security and education.
- A misperception of advocacy with little recognition of the contribution of research, and or community awareness raising activities to long-term social change.

- The term priority population was more frequently applied to any group to whom an activity was specifically directed (e.g. women, students, employees), rather than those at risk of socially produced health inequities.

An extensive literature search in 2010 led to the identification of ten evidence-informed promising practices to decrease social inequities.[23] These include: 1) targeting with universalism, 2) purposeful reporting, 3) social marketing, 4) health equity target setting/goals, 5) equity-focused health impact assessment, 6) competencies/organizational standards, 7) contribution to evidence base, 8) early childhood development, 9) community engagement, and 10) intersectoral action.

Currently, they are developing a 10-year plan for SDHU programming to reduce social inequities in health after conducting a visioning process with staff in the spring of 2010. They have developed the OPHS Planning Path process to provide managers and staff with information, processes and tools to assist with planning using evidence, and an equity-focused approach. [35]

2. Waterloo Region Public Health[38]
The Region of Waterloo Public Health has developed a framework for equity-based population health assessment and planning based on the current Ontario Public Health Standards. The model consists of seven steps to guide program and/or policy planning, development, implementation, and evaluation. It has been piloted and the framework will be updated.

Summary

New emphasis on poverty reduction strategies presents an opportunity for the Middlesex-London Health Unit, in collaboration with our community, to advance the anti-poverty work at the local and provincial level. In 2006, MLHU identified "enhancing barrier-free access to health services" as an area of focus in our organizational strategic plan. This resulted in the translation of key resources in different languages including French; the review of educational material for appropriate literacy levels; and the distribution of bus tickets and taxi vouchers in some programs to address transportation barriers for clients. In light of the volume of evidence on the impact of poverty on health, recent literature on public health's role integrating social determinants and health equity into our practice, in addition to the increased emphasis on priority populations in the OPHS (2008), it would behoove us to consider including the determinants of health as a significant strategic focus in our 10-year plan.

Early adopter organizations within the province have provided many useful documents and processes to assist public health action on broad determinants of health. Specifically, Sudbury & District Health Unit has made accessible multiple resources summarizing their internal processes as they work towards achieving its vision of health equity. This includes a revision of their planning processes, resource allocation to identify local priority populations and effective public health practice, a community social marketing campaign, and staff development.[39] At this time, however, outcomes that speak to the effectiveness of a deliberate focus on the determinants of health are not available.

This report summarizes key literature on poverty that can form the basis of MLHU moving forward to address this complex issue. A synopsis of health unit programs and activities, community and other health units' efforts to address this important determinant of health is documented. All this information has led to the identification of three recommendations listed below.

Recommendations

MLHU has a long and rich history of providing direct services to those individuals in our community living in poverty, and working effectively with the community to address health needs. What is relatively new in our practice is engaging in community efforts to break the cycle of poverty including leading and supporting other stakeholders in policy advocacy. Recent reports emphasize the importance of engaging the priority population in the identification, planning, implementation and evaluation of strategies. The following are some specific recommendations to advance our efforts on poverty reduction:

1. Build staff capacity in the areas of community engagement as well as policy advocacy.

2. Increase surveillance that identifies local priority populations in order to help staff target health promotion strategies to meet their unique needs.

3. Finally, enhance community understanding of the issue and strengthen political action on poverty with purposeful reporting of the relationship between health and social inequities, along with the intentional dissemination of this information to a wide audience.

References

1. Mikkonen, J., & Raphael, D. (2010). Social *Determinants of Health: The Canadian Facts*. Toronto, ON: York University School of Health Policy and Management.

2. Social Research & Planning Unit, Social and Community Supports Division, Community Services Department. (2011). *Fact Sheet: Low Income in London*. London, ON.

3. Raphael, D. (2009). *Escaping from the Phantom Zone: social determinants of health, public health units and public policy in Canada*. Health Promotion International, 24(2), 193-235.

4. Raphael, D., Curry-Stevens, A., & Bryant, T. *Barriers to addressing the social determinants of health: Insights from the Canadian experience*. Health Policy, 88(2008), 222-235.

5. National Collaborating Centre for Determinants of Health. (2011). *Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. Retrieved April 2011, from http://read.chcm.ubc.ca/2011/04/19/integrating-social-determinants-of-health-and-health-equity-into-canadian-public-health-practice-environmental-scan-2010/

6. Ontario Ministry of Health and Long-Term Care. (2008). *Ontario Public Health Standards*. Toronto, ON: Queen's Printer for Ontario.

7. Whitehead, M., & Dahlgren, G. (1991). *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Future Studies. (as cited in Sudbury & District Health Unit. Priority Populations Primer: A few things you should know about social inequities in health in SDHU communities, 2009).

8. Public Health Agency of Canada. (2007). *Crossing Sectors-Experiences in Intersectoral Action, Public Policy and Health*. (as cited in Sudbury & District Health Unit. *Priority Populations Primer: A few things you should know about social inequities in health in SDHU communities*, 2009). Retrieved April 2011 from http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/9app-eng.php#a

9. Social Research & Planning Unit, City of London. (2008). *London's Anti-poverty Strategy: Literature Review*. London, ON: Author. Retrieved March 2011 from http://www.london.ca/d.aspx?s=/About_London/socialissues.htm#Poverty

10. Sudbury & District Health Unit. (2009). *Priority Populations Primer: A few things you should know about social inequities in health in SDHU communities*. Sudbury, ON: Author.

11. Chronic Disease Prevention Alliance of Canada. (2008). *Poverty and Chronic Disease: Recommendations for Action*. Ottawa, ON: Public Agency of Canada. Retrieved May 2011, from www.cpha.ca

12. Canadian Nurses Association. (2009). *Position Statement: Determinants of Health*. Ottawa, ON: Author. Retrieved April 2011 from http://cna-nurses.ca/cna/

13. Chronic Disease Prevention Alliance of Canada. (2007). *Food Security in Canada-A Leadership Opportunity Towards Health Promotion and Reduction in Chronic Disease*. Ottawa, ON: Chronic Disease Prevention Alliance of Canada. Retrieved May 2011 from www.foodshedproject.ca/pdf/CDPAC.pdf

14. Government of Ontario. (2009). *Breaking the Cycle: Ontario's Poverty Reduction Strategy*. Toronto, ON: Queen's Printer for Ontario.

15. Ministry of Municipal Affairs and Housing. (2010). *Ontario Long-Term Housing strategy*. Toronto, ON: Queen's Printer for Ontario. Retrieved April 2011 from www.ontario.ca/housing

16. World Health Organization, Public Health Agency of Canada. ( ). *Health Equity Through Intersectoral Action: An Analysis of 18 Country Case Studies*. Retrieved April 30, 2011, from http://www.phac-aspc.gc.ca/publicat/2008/hetia18-esgai18/pdf/hetia18-esgai18-eng.pdf.

17. Eggleton, A., Segal, H., (2009). *In From the Margins: A Call to Action on Poverty, Housing and Homelessness*. Ottawa: ON: The Standing Senate Committee on Social Affairs, Science and Technology.

18. Chronic Disease Prevention Alliance of Canada. (2008). *Poverty and Chronic Disease: Recommendations for Action*. Ottawa, ON: Public Agency of Canada

19. Lightman, E., Mitchell, A., & Wilson, B. (2008). *Poverty is making us sick: A comprehensive survey of income and health in Canada*. Toronto, ON: Community Social Planning Council of Toronto and the Wellesley Institute.

20. World Health Organization. (2008). *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: Author.

21. Joint OPHA/alpha Working Group on Social Determinants of Health. (2010). *Activities to Address the Social Determinants of Health in Ontario Local Public Health Units Summary Report.* Toronto, ON: Author.

22. Access, Equity and Social Justice Work Group, alpha/OPHA Work Group on Social Determinants of Health. (2011). *Developing Performance Indicators for Social Determinants of Health, Health Inequities, and Priority Populations in the Ontario Public Health Standards*. Toronto, ON: Author.

23. Sutcliffe, P., Snelling, S., Lacle, S. (2010). *Implementing Local Public Health Practices to Reduce Social Inequities in Health*. EXTRA/FORCES intervention project. Sudbury, ON: Sudbury and District Health Unit.

24. Butler-Jones, D., (2008). *The Chief Public Health Officer's Report on the State of Public Health In Canada: 2008 Addressing Health* Inequalities.

25. Public Health Agency of Canada. (2205). *Reducing Health Disparities : Roles of the Health Sector.* Canada. Retrieved April 2011 from http://www.phac-aspc.gc.ca/ph-sp/disparities/ddp-eng.php

26. Child & Youth Network. (2010). *London's Child & Youth Agenda 2010 Progress Report: Doing what is best for our children, youth, and families*. London, ON.

Child and Youth Network. (2008). *The Best for Our Children, Youth and Families: The First Three Years of London's Child and Youth Agenda to 2015*. London, ON: author.

27. Corporation of the City of London. (1997). *Report of the Mayor's Anti-poverty Action Group*. London, ON: Author.

28. Corporation of the City of London. (2010). *London Community Housing Strategy*. London, ON: Author.

29. Corporation of the City of London. (2010). *London Community Plan on Homelessness*. London, ON: Author.

30. The London and Middlesex Local Immigration Partnership, *Immigration Portal*. Retrieved April 19, 2011, from http://immigration.london.ca/about-us/LMLIPBackground.htm

31. City of London. (2010). *London CARes*. Retrieved from http://www.london.ca/d.aspx?s=/london_cares/default.htm

32. Bennett, S. (2009). *Application Process-Middlesex Supports*-2011. London: ON.

33. Life*spin. (2010). Retrieved from http://lifespin.com/

34. United Way of London & Middlesex. (2010). Retrieved from http://www.uwlondon.on.ca/poverty.html

35. Sudbury & District Health Unit. (2010). *Social Inequities in Health and the Sudbury & District Health Unit: Building Our Path for the Next 10 Years*. Sudbury, ON: Author.

36. Sudbury & District Health Unit (2010). *Sudbury & District Health Unit OPHS Planning Path: Pilot Version for 2010 Planning*. Sudbury, ON: Author.

37. Sudbury & District Health Unit. (2009). *Overview of the Health Equity Mapping Project: A report on process, results, and recommendations for practice*. Waterloo, ON: Author.

38. Region of Waterloo Public Health. *Evidence and Practice-based Planning Framework with a focus on health inequities*. Waterloo, ON: Author.

39. Sudbury & District Health Unit (2009). *The Health Equity "Mapping" Project: Taking Stock and Moving Forward to Reduce Social Inequities in Health*. Sudbury, ON: Author.

MIDDLESEX-LONDON HEALTH UNIT

Terms of Reference
Addressing Poverty: A Project Proposal
January 21, 2011

Purpose:

To develop an implementation plan for public health strategies to address poverty.

Objectives:

1) To review the literature on effective measures to address poverty.

2) To review and document current programs/activities involving staff to address poverty.

3) To prepare a report summarizing the findings in 1) and 2), together with recommendations for future direction.

4) To review and document key current community initiatives intended to address poverty.

5) To assess how other selected Health Units are addressing this issue in their community.

6) To make comment on how poverty (Social Determinants of Health) is (are) included in the Ontario Public Health Program Standards.

Timeline:

3 months

Accountability:

Project coordinator reports to Senior Management Team

LONDON'S ANTI-POVERTY STRATEGY

Synopsized Literature Review

Prepared by:
Social Research and Planning
for
Discussion Purposes
April 4, 2008.

THE PROBLEM

The breadth and depth of poverty is significant and enduring. The harm done to children, youth and families living in poverty, with insufficient food, shelter, clothing and supports, has lifelong consequences for them with respect to their health and future social and economic prospects. In London, 17 per cent of all individuals (55,785) and half (51%) of our recently arriving immigrant population, between 1996 and 2001 live with low-income. Almost half (41%) of the growing Aboriginal population live with low-income. Thirteen per cent of all families (11,685 families) and one out of five children, live at or below the low-income cutoff (LICO). Of the 11,685 families living with low-income, 38 per cent are lone parent families.

Child and family poverty affects everyone. The research on every front is clear and compelling. Dollars invested in children and youth to provide the conditions for healthy development save us huge social and economic costs later. In order for our children, youth and families who are struggling with poverty, to have a sense of belonging in our community, relationships need to be developed through employment, skill development, volunteer opportunities, recreation, leisure and cultural activities, child care and early learning opportunities. Meeting children's fundamental needs is not a choice; it is a community responsibility which has tremendous rewards for all concerned.

DEFINING POVERTY

In the absence of a national definition of poverty for Canada, definitions from the literature and from various jurisdictions are summarized below:

Jurisdiction	Definition of Poverty
Lambton County	Poverty is when a person or a community is deprived of, or lacks the essential resources required, for a minimum standard of well-being. These resources include the necessities of daily living such as food, safe drinking water, clothing, shelter, health care, access to information, education, social status, political power or the opportunity excludes them from taking part in activities which are an accepted part of daily life in society.
Hamilton	Individuals and families experiencing poverty lack the adequate resources to maintain a decent standard of living, and to participate fully in the life of the community. While poverty is not only an income issue, it is always related to income and access to resources.
Niagara	No specific definition. The literature review report defines poverty based on the following four aspects: 1. monetary measure (i.e. living below the LICO or MBM) 2. social determinants of health framework (i.e. impact of poverty on health, well-being and outcomes) 3. individual's experience of powerlessness, voicelessness and social exclusion 4. broader impacts of poverty for the community.
Bedford, United Kingdom	Is a life situation people may find themselves in, if their income and resources are not enough to allow a standard of living, which is relative to, customary, widely encouraged and approved in the societies in which they belong.
Canadian Council on Social Development	To be poor is to be distant from the mainstream of society and to be excluded from the resources, opportunities and sources of subjective and objective well-being which are readily available to others.
Ireland	Poverty is deprivation due to a lack of resources, both material and non-material, e.g. income, housing, health, education, knowledge and culture. It requires a threshold to measure it.
Quebec	The condition of a human being who is deprived of the resources, means, choices and power necessary to acquire and maintain economic self sufficiency or to facilitate integration and participation in society.

THEORIES OF POVERTY

There are many competing theories in the literature for poverty reduction and elimination, but it is important to choose what is relevant and believed to be responsible for the problem being addressed. Here, five theories of poverty are presented:

Theory	**What causes Poverty?**	**How does it work?**	**Potential Community Development responses**	**Community examples to reduce poverty**
1. Individual	Individual laziness, bad choice, incompetence, inherent disabilities	Competition rewards winners and punishes those who do not work hard and make bad choices	Avoid and counter efforts to individualize poverty, provide assistance and safety net	Drug rehabilitation, second chance programs, making safety net easier to access, use training and counseling to help poor individuals overcome problems
2. Cultural	Subculture adopts values that are non-productive and are contrary to norms of success	Use community to the advantage of the poor; value diverse cultures, acculturation, and community building; alternative socialization through forming new peer groups	Head Start, after school, leadership development within subcultures, asset-based community development	Head Start, after-school leadership development within subcultures, asset-based community
3. Political-economic structure	Systematic barriers prevent poor from access and accomplishment in key social institutions including jobs, education, housing, health care, safety, political representation, etc.	Selection criteria directly or indirectly exclude some groups of persons based on inappropriate criteria	Community organizing and advocacy to gain political and economic power to achieve change; create alternative organizations	Policies to force inclusion and enforcement

Theory	What causes Poverty?	How does it work?	Potential Community Development responses	Community examples to reduce poverty
4. Geographic	Social advantages and disadvantages concentrate in separate areas	Agglomeration, distance, economies of scale, and resource distributions reinforce differences	National redistributions, concentration of development on local assets	Redevelopment areas, downtowns, rural networking, urban revitalization
5. Cumulative and cyclical	Spirals of poverty, problems for individuals (earnings, housing, health, education, self confidence) are interdependent and strongly linked to community deficiencies (loss of business and jobs, inadequate schools, inability to provide social services), etc.	Factors interact in complex ways. Community level crises lead to Individual crises and vice versa, and each cumulate to cause spirals of poverty	Breaking the spiral of poverty with a spiral of success through a comprehensive program that addresses both individual and community issues	Comprehensive CDC programs that build self-sufficiency in a community reinforced environment, programs that link individual and community organizations, asset-based approaches

Source: Bradshaw (2007:10-11)

While poverty is thought of only in terms of financial resources, financial resources alone do not explain why some individuals may achieve success in exiting poverty, where others do not. In reality, there are a number of other resources that support people leaving poverty. These include emotional, mental, spiritual and physical resources, as well as support systems, relationships and role models, knowledge of hidden social rules, and coping strategies.

Bridges Out of Poverty: Strategies for Professionals and Communities, 2003

MEASURING POVERTY

According to Sweetman (2008), Canada does not have an "official" poverty line, but it has a number of related statistical indicators which are sometimes used to measure poverty. These measures may be categorized as being: income-based; cost-of-living-based; or quality of life-based. The most popular of the measures include the following:

Low- Income Cut Offs (LICOs) (income based)

Statistics Canada's LICO is the oldest and most widely used measure of low-income in Canada, and is updated regularly. The LICO does not claim to measure poverty, but rather to define a set of income cut-offs below which people may be said to be living in "straitened circumstances." The approach is essentially to estimate an income threshold at which families are expected to spend 20 percentage points more than the average family on food, shelter and clothing (i.e. LICOs thresholds reflect spending 63% or more of after tax income and 55% of pre-tax income on food, shelter and clothing). LICOs are published for both pre- and post-tax income levels by family and population size. Statistics Canada prefers using post-tax figures as an indicator of low-income as this takes into account the redistributive impact of taxes. Some families in low income before taking taxes into account are relatively better off and not in low income on an after-tax basis.

Pros	Cons
✓ well known and statistically valid ✓ readily available, consistently used and updated annually ✓ adjusts for inflation ✓accounts for changes in spending patterns, household and community size ✓supports the view that poverty is relative ✓corresponds to public perceptions ✓responsive to economic inequality & polarization as well as being responsive to changes in living standards and income growth ✓some evidence, as highlighted in the CCSD publication Income and Child Well-being, that the LICO line provides a meaningful approximate break-point in terms of child outcomes	×no official status as poverty measure ×difficult for general public to understand ×measures relative income, not "poverty" ×does not account for cost of living ×does not take into account complexities of sub-populations (single parents, disabled) ×sensitive to economic cycles ×20% rule argued to be arbitrary ×three areas of expenditure on which LICOs are based are the most basic, but hardly exhaustive

Statistics Canada's Low-Income Measure (LIM) (income based)

The LIM defines low-income based on relative income levels. Households with an income below 50% of median household income of the same family size are defined as low-income. Income levels are adjusted for family size (and type) using an internationally accepted scale. Unlike the LICO, LIM is not adjusted for different community sizes. LIM is often used for international comparisons. This measure is primarily concerned with income inequality and social inclusion. LIM answers the question: "How many Canadians have an income lower than 50% of the median income for all families of the same size in a given year in Canada?"

Pros	Cons
✓ simple to calculate and understand ✓ accounts for the number of adults and children present in family ✓ readily used for comparisons between countries	×no official status as poverty measure ×similar to LICO in terms of its "relative" nature ×does not account for cost of living ×no detailed geographic component ×does not tell us directly if the poor have sufficient income to meet their basic needs

Market Basket Measure (MBM) (cost of living)

The MBM is a "goods and services" indicator of low-income, measuring the cost of purchasing a pre-determined basket of goods and services for the year 2002[1]. The basket includes: Foods from Health Canada's Nutritious Food Basket; Shelter costs (estimated as median rent including utilities for two- and three-bedroom apartments; Transportation costs; Clothing and footwear costs estimated by the Winnipeg Social Planning Council; and Allowances for other expenses (personal, educational supplies, recreation and others). Persons living in families with disposable incomes below their Market Basket Measure (MBM) threshold are living with low-income. MBM disposable family income is the income remaining after-taxes and mandatory payroll deductions, and after out-of-pocket spending on child care, and non-insured but medically-prescribed health-related expenses such as dental and vision care, prescription drugs and aids for persons with disabilities.

[1] Statistics Canada, on Human Resources Development Canada's behalf, collected data on the cost of goods and services in the basket to calculate thresholds for 19 specific communities and 29 community sizes in the ten provinces. 2000 is the first year that the MBM has been calculated.

Pros	Cons
✓ more transparent and easier to understand than LICO ✓ sensitive to geographic cost differences ✓ recognizes different family sizes and compositions	×not promoted as “poverty line” ×not updated regularly – last update was 2006, reflecting the cost of a basket of goods in 2002 ×debate over what should be included in the basket (see Fraser Institute Basket of Goods) ×updates prices only, with minor adjustments to goods included ×not based on an adequate conceptual premise of social inclusion and could distract attention from relative poverty and income inequality

Fraser Institute Basket of Goods The Fraser Institute argues that no one is poor if they can meet their basic needs. To define poverty, the Fraser Institute calculated the cost of a basket of basic necessities required for subsistence including food, clothing, shelter, and some limited additional items. Absent from the basket are items which the great majority of Canadians take for granted, such as coffee, a daily newspaper, and cable TV. There is also no allowance for access to recreation or culture.

Community Affordability Measure (CAM)

This measure was developed by the Federation of Canadian Municipalities Quality-of-Life Reporting System. It is defined as the ratio of income levels (after-tax) to the cost of living based on the market basket. It does not measure communities against an ideal or theoretical standard, but against the aggregate total of all communities participating in the Federation of Canadian Municipalities Quality-of-Life Reporting System.

Deprivation (quality of life)

Some jurisdictions have chosen to go beyond traditional measures of poverty (which is more related to the lack of resources, particularly financial resources, needed to acquire modern goods and commodities) and have developed measures of deprivation (both material and social). Deprivation may be defined as "a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which the individual, family or group belongs." This disadvantage may occur at various levels, for example, with regard to food, clothing, housing, education or work. A person may be considered deprived to the extent

that he or she falls below the level attained by the majority of the population or below what is considered socially acceptable. [2]

Pros	Cons
✓ more of a social inclusion measure as it goes beyond income as a measure of poverty	×more complicated than other measures ×not all data as readily available, particularly for smaller levels of geography like neighbourhoods ×debate over what should be included and over the relative importance of each of the indicators in the overall index ×list does not take into account individual preferences (assumes similar values and lifestyles)

Canada does not currently have a standard index of deprivation, however, Human Resources and Social Development Canada (HRSDC) has developed Indicators of Well Being that include measures related to health, social participation, leisure, family life, housing, work, learning, financial security, environment and security. The Federation of Canadian Municipalities has developed Quality of Life indicators that include many of these same indicators. Appendix 1 details the specific items used by Ireland to measure deprivation.

Other Measures

There are also other measures that are not called poverty lines, but they serve as indicators to measure the level of poverty. These include (but are not limited to) the National and Provincial cut-offs for social assistance receipt, for the Goods and Services Tax rebate, the Canada Child Tax Benefit and the National Child Benefit, and eligibility for the Working Income Tax Benefit.

Bottom Line

No one measure is useful in all contexts and some measures go in opposite directions. For example, if income increases at all levels, poverty is decreasing by absolute measures (example: MBM). If earnings inequality has increased at the same time, then poverty is increasing by relative measures (example: LIM). Understanding the relevant issues is a better basis for policy and administrative practice than are reactions on any single “poverty line”.

Recommendation: Small, standard set of diverse measures that reflect income and issues related to low-income.

[2] Townsend P. Deprivation. J Soc Policy 1987;16(2):125-46.

INDICATORS OF POVERTY FOR LONDON

This profile of poverty in London is based on selected indicators that have historically been used to measure poverty in our community, including the number of people living below Statistic Canada's Low Income Cut Off (LICO), and social assistance caseloads.

London Low Income Rates that are of Concern

Population Group	Low income rate
All individuals	17%
Children and youth age 0 to 24 years	46%
Lone parent families	47%
Recent immigrants	51%
Visible minorities	36%
Aboriginal people	41%
Working age adults with disabilities	29%

London's size and status as a central or core city to the Census Metropolitan Area (CMA) contribute to these higher low-income rates.

Groups with higher low income rates tend to be less present in London's labour market for a variety of reasons and, if employed, tend to have lower earnings.

Women within each of the vulnerable subgroups (families, particularly lone parent families, recent immigrants, visible minorities, Aboriginal and individuals with disabilities) have higher low-income rates than do the men of these groups.

Social Assistance

- approximately 8,000 children under the age of 18 live in families receiving social assistance from Ontario Works or the Ontario Disability Support Program (2008)
- just over 4,500 families with children received social assistance through Ontario Works or the Ontario Disability Support Program. Just over 700 of families of these families were working (2007)

Neighbourhoods with Low-Income

There is evidence that neighbourhood income impacts the outcomes of children living with low-income. Children living in a neighbourhood with a relatively low incidence of low-income may have better outcomes than children living a neighbourhood with a relatively high incidence of low-income.

- One-third of London's census tracts have low-income rates of 20% or higher and one half of low-income Londoners live in census tracts with low-income rates above 20%
- Aboriginal identity people are more likely than other groups with high low-income rates to live in a neighbourhood with a high low-income rate: one out of ten Aboriginal people with low-income live in a London neighbourhood with a low-income rate of over 40%.

ROOT CAUSES OF POVERTY

Macro Level

Economic Trends	Political Trends
increased polarization of the Canadian labour market into high-skilled, high-paying jobs on one end of the spectrum, and low-skilled, low-paying jobs on the other end	deregulation of business; privatization of state owned business; elimination of trade barriers; reduction/dismantling of the welfare state; and restructuring the national workforce in order to increase industrial and economic flexibility

***Erosion of the middle class; growing "working poor" population; and a growing income gap*.**

Micro Level

Many factors combine to keep individuals from realizing their full potential: these factors may be both a cause and an effect of poverty. For example a lack of "marketable skills" limits employment options and subsequent income potential and may be viewed as a potential cause of poverty. An individual living with low-income may face barriers such as the ability to pay for skills training or the lack of access to transportation to access skills training and as such a lack of marketable skills may also be an effect.

- *Employment, Education and Income:* There are strong positive relationships between income and education, and income and employment. As level of education increases, employment and income tend to increase. Higher skilled occupations (which tend to be higher paid) typically require higher education. At the same time, having a lower income is a barrier to obtaining the higher education needed to be competitive for higher paying occupations.

***Of concern: London has a comparatively high proportion of low-income workers in high-skill occupations*.**

- *Housing*: Lack of income and the lack of affordable housing may result in individuals and families paying a significant portion of their income on shelter or choosing to live in substandard housing that is more affordable. Living in substandard housing has a negative impact on health. Poor health has negative impacts on employment and, therefore, income.

- *Food Insecurity*: Pay the rent or feed the child? This is the choice that must be made by many low-income families. To prevent eviction and homelessness, the choice is rent. Inadequate nutrition prevents children from succeeding in school, and has a negative impact on health. These, in turn, limit future success and opportunities for higher education and employment.

- *Health*: Poor health is associated with a decreased ability to earn employment income, and less ability to participate in educational and training opportunities. Living with health issues is costly as well, as a result of significant out-of-pocket medical and medically-related expenses.

- *Child care*: Access to affordable, high quality early learning and child care programs promote children's well being while enabling their parent(s) to earn income or participate in educational or training opportunities. The lack of a universally accessible system of early learning and child care services in Canada serves as a factor contributing to and perpetuating low-income. The participation of lone parents in the labour force also requires supportive work environments, family and friends who can lend emotional and physical support, affordable housing and other supports in the community including recreation and transportation.

- *Children and Basic Education:* Children and youth with low-income do not perform as well in school. Children in low-income families are more likely to exhibit developmental delays and delinquent behaviours. Youth with low-income are more likely to leave school early. One reason for early leaving may be the need to supplement family income. Poor educational outcomes have long-lasting effects in terms of employment and income.

- *Affordable Public Transportation:* While access to affordable transportation supports an individual with low-income to access opportunities such as education, training, recreation and employment, and to obtain goods and services at competitive prices, living with low-income may limit housing options. In order to afford housing, access to transportation may be compromised.

- *Crime:* While low-income does not necessarily cause crime, living with low-income is a significant risk factor for involvement in criminal activity. Individuals with a criminal record limits an individual's employment options. High crime rates may drive residents and businesses who can afford to move out of a neighbourhood, limiting the availability of goods and services and potential employment. People with low-income may need to move into a neighbourhood with higher crime as the housing may be more affordable.

- *Recreation:* Recreation helps children to develop healthy bodies, healthy minds and healthy relationships. Participation increases community involvement and has been shown to improve self-esteem and academic performance. Children and families with low-income tend to participate less in recreation activities. Cost, knowledge, lack of transportation, and lack of accessible and safe facilities may contribute to lower participation rates.

- *Social exclusion:* Social exclusion denies some individuals and groups the same rights and opportunities as are afforded to others in their society. Simply because of whom they are, certain groups cannot fulfill their potential, nor can they participate equally in society. It hurts them materially making them poor in terms of income, health or education by causing them to be denied access to resources, markets and public services. It can also hurt them emotionally, by shutting them out of the life of their community.

MODELS OF SUCCESS FROM OTHER NATIONAL AND PROVINCIAL JURISDICTIONS

In the political arena, the fight against poverty is usually regarded as a social goal and many governments have institutions or departments dedicated to tackling poverty. One of the main debates in the field of poverty reduction is around the question of how actively the state should manage the economy and provide public services to tackle the problem of poverty. Broad approaches include: economic growth, direct aid (such as through income support programs), and social improvement (such as increasing affordable housing and affordable child care, subsidizing employment, skills training, reducing taxation, reforming labour laws, et cetera).

The United Kingdom and Ireland

The United Kingdom and Ireland have recently been cited as examples of countries that have successfully reduced poverty and social exclusion and as potential models for the establishment of anti-poverty strategies in Canada. Both of these jurisdictions have benefited from strong economic and employment growth.

United Kingdom	**Ireland**
Goal: reduce child poverty by 25% by 2005, by 50% by 2010 and eradicate by 2020. *Key Objectives:* labour market participation; financial security for families; protect the most vulnerable; improved access to public services; mobilization. *Initiatives:* national minimum wage; tax credits for low-income earners and parents; supports to people with disabilities and seniors; expenditure increases on education, employment assistance, housing, child care and health.	*Goal:* to reduce consistent poverty from 9% to 15% in 1994 to: under 5% to 10% between 1997 and 2004; between 2% and 4% by 2010; and to eliminate it entirely by 2016. *Key Objectives:* focus on population groups found to be consistently poor or at greatest risk of poverty, (for example people who are unemployed (particularly over a long term); children; unattached adults; lone parents; and people with disabilities. *Initiatives*: investments in the social protection system, increasing key services such as income support, education and training, employment supports, health care, housing and transport.

Canada

In Canada, there has never been a national anti poverty strategy although: the House of Commons unanimously resolved to eliminate poverty among Canadian children by the year 2000 (1989); a national poverty reduction strategy has been endorsed by the Standing Senate Committee on Human Rights (April, 2007); and the House of Commons Standing Committee on Finance in its pre-2007 budget consultations put forth a recommendation asking the federal government to set a specific target and timeline to reduce child poverty in Canada. In the absence of a national anti poverty strategy Quebec and Newfoundland have developed provincial strategies.

Quebec	**Newfoundland**
Goal: to make Quebec one of the industrialized societies with the least poverty by 2013 *Key Objectives:* raising the standard of living of social assistance recipients and low income earners and assisting people make the transition from social assistance to employment. Also committed to the broader objectives of reducing social exclusion, prejudice and inequalities. *Initiatives:* passed the Act to Combat Poverty and Social Exclusion (2002): $2.5 billion allocated in 2004-05 over five years for full indexation of social assistance benefits; creation of a participation premium for social assistance recipient who are able to work; establishment of a work premium; increase in the minimum wage; a new universal tax credit for low income families with children; programs to facilitate the entry of young people and new immigrants into the labour market; and development of high-quality early learning and child care services	*Goal*: transform Newfoundland and Labrador from a province with the most poverty to a province with the least poverty over the next decade (2005) *Key Objectives*: Improved access and coordination for those with low incomes; A stronger social safety net; Improved earned incomes; Improved early childhood development; and Better educated population *Initiatives*: numerous initiatives reflect a comprehensive, integrated and multi-faceted approach that addresses "the connections between poverty and gender, education, housing, employment, health, social and financial supports, and tax measures, as well as the link between women's poverty and their increased vulnerability to violence

Ontario

The recently created Provincial government's cabinet committee on Poverty Reduction, chaired by Deb Matthews, Minister of Children and Youth Services, is currently developing a poverty reduction strategy with measures, indicators and targets scheduled for completion in late 2008.

The Committee is reviewing how best to organize and align the current system of supports to ensure more effective investment and efficient administration. The government has committed to working with communities and other governments to expand opportunities for all Ontarians and to reduce poverty over the long term. Examples of some early initiatives include:

- Children and Youth
  - Dental care for low income children up to age 18
  - Student nutrition program
  - Increasing the number of Parenting and Family Learning Centres
  - Initiatives to reduce post-secondary education costs
- Quality of Life
  - Strengthening access to services through 211 Ontario
  - Creation of the Ontario Child Benefit
- Low Income Ontarians
  - Investing in social housing
  - Asset building strategy
  - Increase in social assistance rates
  - Increase in the minimum wage
  - Improving facilities for children and vulnerable populations
  - Property and sales tax credits for low income seniors.

SCAN OF STATEGIES FROM OTHER MUNICIPALITIES

Many individuals and families are trapped in poverty because of policy and systemic failures. Systemic issues are typically based on gender, race and ethnicity, and disability which lead to higher levels of unemployment and lower wages, oftentimes regardless of the level of education attained. In addition, due to a system of low wages and precarious work Canada has a high and growing number of people who are known as the working poor.

Reducing poverty requires that we become aware of and removing barriers that keep individuals and families from achieving self-sufficiency - barriers such as lack of access to adequate employment, child care, transportation or health care; food insecurity; poor housing; low educational outcomes; low income and the inability to afford things like child care, transportation, housing, recreation, school fees and clothing; cultural and language barriers; and discriminatory beliefs and practices.

The Association for Municipalities in Ontario (AMO) recommends that municipalities develop local targets.

The following six principles developed by the World Bank and International Monetary Fund for policy making in low-income developing countries may be useful in guiding the development of London's anti-poverty strategy:

1. results oriented with targets
2. comprehensive, integrating macroeconomic, structural, sectoral and social elements (for example: considering economic growth policies, infrastructure investment, labour market policies, education, health, and safety net policies)
3. "country drive" (in our context – "neighbourhood driven")
4. participatory with all stakeholders involved
5. based on partnerships between government and other actors
6. long term, focusing on reforming institutions and building capacity as well as short term goals

Strategies adopted by other local level jurisdictions in Ontario are included as examples of local approaches that incorporate a multi-faceted response to poverty in their individual communities. While the approaches vary in detail, they are fairly consistent in that they involve many stakeholders; they began by defining what poverty means to their community and how it impacts their community. The strategies include educating the broader community about the issues and why community and government action is

important. The approaches adopt the core foundations to a poverty reduction strategy: "upgrading living conditions" and "strengthening local supports". The challenge is to determine initiatives and actions that will have the most impact.

The following table summarizes the approaches taken by select municipalities in Ontario:

Municipality	**Strategies**
Lambton's Child Poverty Task Force	Adopted the "Circles Campaign" Model of poverty reduction. Aims to: • Change the mindset of the community so it wants to and thinks it can end poverty; • Change the goals (policy, law) of the system to end poverty; • Empower people in poverty to help solve community problems while transitioning out of poverty themselves
Hamilton's Roundtable for Poverty Reduction	Tackling root causes: Affordable Housing, Food Security, Income Security, Accessible Transportation, Social Inclusion, Safe Neighbourhoods. The three levels of strategy are as follows: • "macro" strategy - a broad community-level approach focused at the foundational community supports, policy and systems level change required for poverty reduction • Five Critical Points of Investment driven by strategic outcomes defined by a starting point partner • Local strategies and community solutions will be assessed to build community knowledge, synergies and best-practice approaches – includes information sharing, community education, advocacy, policy work
Halton	No specifically defined strategy, however, strategies for comprehensive housing and quality of life for seniors have been developed as two components of the strategy
Niagara	• Decrease poverty through advocacy • Appropriate and flexible supports which address the broader determinants of health for adults living in poverty • Mitigate the negative effects of low income on children and youth through programs and services • Monitor progress

APPENDIX ONE

MEASURING POVERTY IN THE UNITED KINGDOM AND IRELAND

United Kingdom

Measuring Poverty

- The UK has a "tiered approach" that includes three measures of poverty:
  - Absolute low income – families with children living below 210 pounds weekly, adjusted for inflation; goal is to see families' real income rise over time
  - Relative low income – similar to our Low Income Measure and Ireland's "at risk of poverty" measure - 60% of median household income
  - Deprivation and income combined – will eventually be similar to Ireland's Consistent PovertyDeprivation measure (still under development)

Targets and Timelines

- The UK uses relative low-income as the lead measure, and it is the measure used in relation to its' commitment to end child poverty
  - 25% reduction in children living in low-income families (60% median household income) by 2005
  - 50% reduction in same by 2010
  - Elimination of child poverty by 2020

Sub-Indices

- The UK also annually releases Opportunity for All which reports on 41 separate indicators to help gauge the success of its poverty strategy – the indicators provide more detailed data
- Indicators are grouped into 4 categories:
  - Children and Young People (indicators include Low Income Rates, Children in Workless Households, Teenage Pregnancy, School Attendance, Obesity, etc)
  - People of Working Age (Low Income Rates, Employment Rates, Employment Rates for Disadvantaged Households, Education Levels, Smoking Rates, etc)
  - People in Later Life (Low Income Rates, People Contributing to Non-State Pensions, Health Life Expectancy)
  - Communities (Employment Rates in Deprived Areas, Crime Rates, Housing Adequacy Statistics)

APPENDIX ONE

Ireland

Measuring Poverty

- Ireland uses 2 measures of poverty:
- "At Risk of Poverty" which is essentially the equivalent of our Low-Income Measure but at 60% of median household income
- "Consistent Poverty" which links a Deprivation Index to the "at risk of poverty" measure – this is the lead poverty measure that is connected to Ireland's poverty reduction timelines and targets

At Risk of Poverty

- Essentially our Low-Income Measure but 60% of the median household income
- Ireland also provides data annually broken down in gradients of 50%, 60% and 70%
- Also provides data by different population groups and households (ie. single parents)
- At Risk of Poverty (i.e. low-income) rate:

2003	2004	2005	2006
19.7%	19.4%	18.5%	17.0%

Deprivation Index and Consistent Poverty

- Ireland's benchmark measure that is used in its Poverty reduction strategy is called Consistent Poverty
- The measure is derived from a Deprivation Index compiled from questions on the annual European Union Survey on Income and Living Conditions
- Persons lacking two of the following 11 items are regarded as experiencing deprivation:
    - Two pairs of strong shoes
    - A warm, waterproof overcoat
    - Buy new, not second-hand clothes
    - Eat meals with meat, chicken or fish (or vegetarian equivalent) every second day
    - Have a roast joint or its equivalent once a week
    - Had to go without heating during the last year through lack of money
    - Keep the home adequately warm
    - Buy presents for family and friends at least once a year
    - Replace any worn furniture
    - Have family or friends round for a drink or meal once a month
    - Have a morning, afternoon or evening out in the last fortnight for entertainment

- People whose income falls below the relative poverty line (60% median income) and who experience two or more areas of relative deprivation are considered to be in consistent poverty
- Consistent poverty rate (persons):

2003	2004	2005	2006
8.8%	6.8%	7.0%	6.9%

APPENDIX ONE

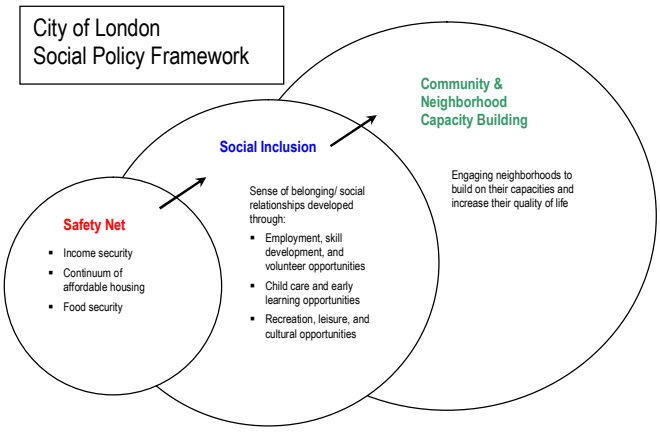
Targets and Timelines

- In 2007 Ireland launched the second phase of its poverty reduction strategy called National Action Plan for Social Inclusion 2007-2016: Building an Inclusive Society.
  - The targets and timelines are as follows: “reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016”

APPENDIX TWO

LONDON'S SOCIAL POLICY FRAMEWORK. GUIDING PRINCIPLES

The development of London's anti-poverty strategy may be guided by our Social Policy Framework. The Social Policy Framework is based on the guiding principles of equity and inclusion, dignity and self-sufficiency, and partnerships and accountability.



Equity and Inclusion

- Services, opportunities, and community activities should be accessible to all Londoners. Affordability is one of the most important factors in accessibility.

- All Londoners should have access to basic needs including adequate and appropriate food, and safe and affordable housing.

Dignity and Self-Sufficiency

- Policy solutions must work with people's whole lives, and respond to the interconnections of life issues and experiences, such as health, mental health, housing, employment, family supports, social inclusion, and quality of life.

- One size of service delivery does not fit all. Service providers need to empower and work with individuals, families, and communities to identify solutions that will meet their unique needs.

- Income security alone is not the solution to ending poverty. Social policies should not be "band-aid" approaches that simply help people to pay the bills, but should promote opportunities for long-term self-sufficiency.

Partnerships and Accountability

- All three levels of government play a role in establishing and implementing a system of social and economic policies that support self-sufficiency.

- Government, or the public sector, cannot address social policy issues alone. The remaining two "pillars of society" - the private sector and the voluntary sector - have important expertise and resources to contribute to developing local responses to community issues.

Activities to Address the Social Determinants of Health in Ontario Local Public Health Units

Summary Report

Prepared by:
Joint OPHA/alPHa Working Group on Social Determinants of Health

December 2010

Acknowledgments

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Executive Summary

In the summer of 2010, the Joint Association of Local Public Health Agencies/Ontario Public Health Association Working Group on Social Determinants of Health administered an online survey of Ontario's health units to map out the scope of local public health activities and needs in addressing health inequities, social determinants of health (SDOH) and/or poverty reduction.

Twenty-three (64%) Ontario public health units responded and actions on the social determinants of health were evident in the work of the majority of health units across the province.

Virtually all strongly agreed that community engagement, multi-sectoral collaboration, and support for policy advocacy are appropriate domains of public health unit activity on the SDOH. Health units also noted that additional roles in action on the SDOH could be adopted by health units, including increasing awareness of the SDOH and assessing and planning for the health needs and impacts of priority populations. Notably, health units did not see their role limited to their local context. They also mentioned that contribution to the provincial system to build systemic capacity and coordination was also appropriate for health units to consider.

The wide variety of formats and topics that health units are using to communicate about the SDOH demonstrates the vigorous ways in which the SDOH are woven into health unit activity through the essential public health functions of population health assessment and surveillance. Health units are creating reports and research and awareness campaigns on an impressive array of the determinants and populations.

Health units' actions on the SDOH also encompass many strategies to modify interventions for priority populations. These include adapting the types of offered services; reducing income, physical and geographic barriers to access programs; and changing program formats. Health units are also explicitly addressing determinants like social support by fostering supportive social networks and coordinating client care and referrals to other resources. The ability of health units to play that nodal function suggests that health units have a wide span of reach and connectivity into their communities.

When health units were asked about areas requiring support to address the social determinants of health, policy advocacy and staff skill development were listed as the top areas for improvement at the local level. They also noted practical items such as knowledge brokering services, strategies, tools and checklists, and infrastructure to share information. These needs prompt potential for centralized bodies such as alPHa, OPHA the Ontario Agency for Health Protection and Promotion and others, to support learning opportunities to build capacity at the local level.

Health units listed numerous forms of activity with components of the Ontario Poverty Reduction Strategy. In describing public health engagement in the provincial poverty plan, this report is the only one of its kind detailing public health activity with provincial poverty reduction initiatives. It is therefore expected to be informative to the provincial government, the Ontario Agency for Health

Protection and Promotion, the OPHA, alPHa, Council of Medical Officers of Health (COMOH) and all Ontario health units.

In summary, the survey demonstrates strong support for and a wide range of local public health actions underway to address health inequities, SDOH and/or poverty reduction. The survey also provides direction regarding the areas in which local public units require support in order to work more effectively to address SDOH.

Ontario public health units clearly have strong interest and investment in this important area. The public health system and the health of Ontarians would benefit greatly from the leveraging of this energy through provincial leadership and coordination, the development of specific tools and supports and opportunities to learn from each other and from applied research.

Introduction

In the summer of 2010, the Joint Association of Local Public Health Agencies (alPHa)/Ontario Public Health Association (OPHA) Working Group on Social Determinants of Health administered an online survey (see Appendix A) of Ontario's health units. The purpose of the survey was to 1) determine activities that health units carry out to address health inequities and social determinants of health (SDOH), 2) highlight public health initiatives to stimulate knowledge/experience exchange among health units, and 3) identify areas where health units could best be supported by the Joint alPHa/OPHA Working Group on Social Determinants of Health. Questions related to key roles, practices and barriers for public health organizations and their staff in taking action on the SDOH were informed by discussion between the Joint Working Group and the National Collaborating Center for Determinants of Health. This survey follows the publication of the *Ontario Public Health Standards 2008,* a guideline that established the determinants of health and reduction of health inequities as fundamental work for public health in Ontario and reinforced the need for evidence-informed public health practice.

This assessment sought to develop a pan-Ontarian picture of the policies and practices that are most often used in different settings and with different high-risk populations. It also sought to increase awareness of public health practices that support initiatives outlined within *Growing Stronger Together: Ontario's Poverty Reduction Plan (2008)* by the Government of Ontario. It also sought to disseminate those findings to increase awareness of these practices and so that practice could be replicated elsewhere where there is an assessed fit for purpose.

A letter of invitation and a link to the online survey was sent to the Medical Officer of Health in each of the 36 Ontario health units. The instructions indicated that one survey for each health unit should be completed by a "response team" made up of key professionals involved in SDOH activities. The survey was available from July 29, 2010, until September 24, 2010.

Of the 36 health units that were invited to participle, 64% (n=23) completed the survey. A summary of the results follows.

Results

Question 1 – Response Rate

More than half (64%) of Ontario health units responded to the survey. A brief follow-up questionnaire was sent to non-responding health units to determine the reasons for not participating. Half of the non-responding health units responded to the questionnaire and cited workload, timing issues or internal communications failures as the reasons for not participating.

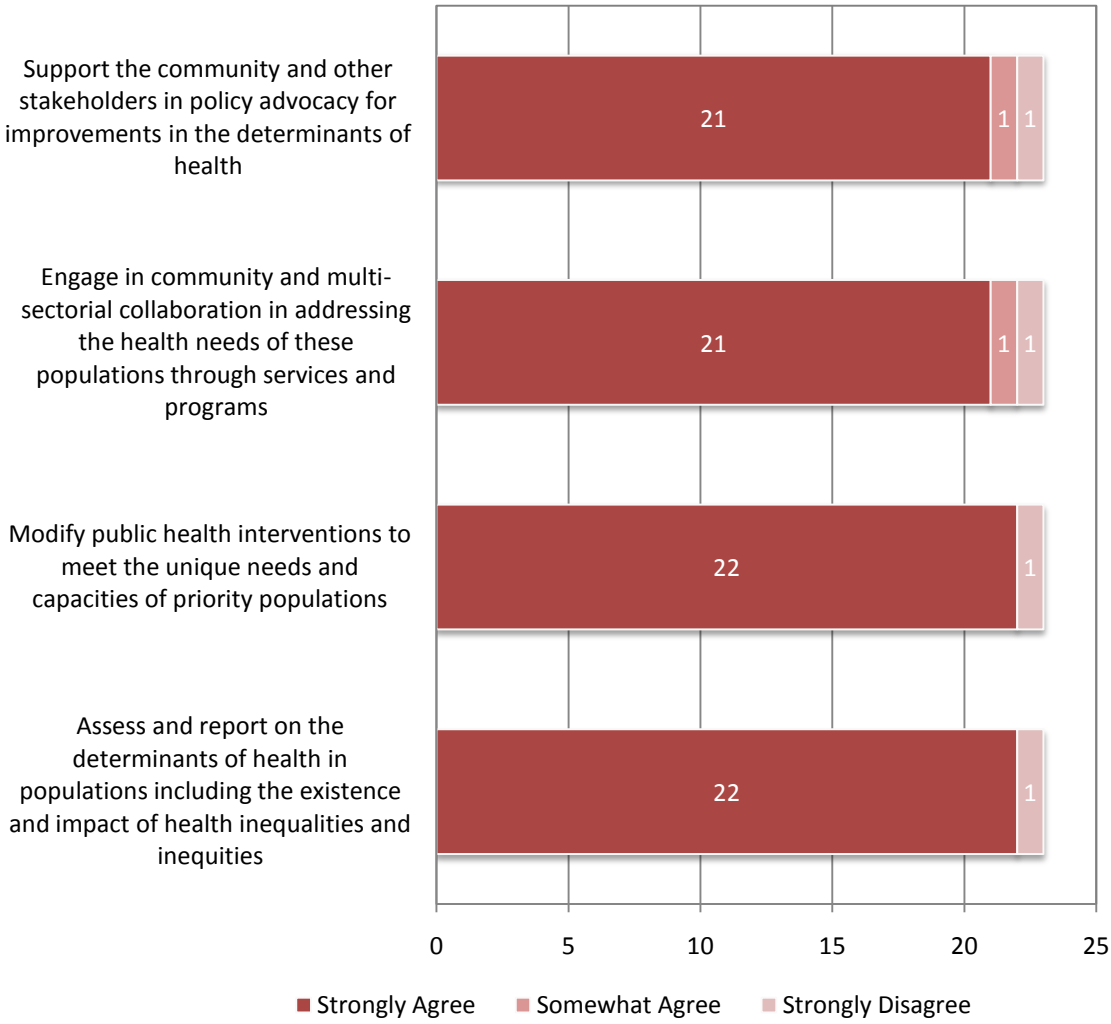
Question 2 – Public Health Unit Roles in Action on the SDOH

Ninety six percent of responding health units strongly agreed that it is a public health role to assess and report on the determinants of health in populations. This population assessment function is not limited to describing the facts of health inequalities and inequities but also detailing their population impact. Similarly, all but one of the participating health units strongly agreed that it is the role of public health units to modify public health interventions to meet the unique needs and capacities of priority populations.

Responding health units expressed strong support for the statement that it is a public health unit role to engage in community and multi-sectoral collaboration in addressing the needs of populations through services and programs. In addition, participants conveyed strong agreement with supporting the community and other stakeholders in policy advocacy for improvements in the determinants of health. Only two health units selected the response options "somewhat agreement" or "strong disagreement" for community engagement and policy advocacy.

In summary, respondents almost unanimously endorsed that assessment and reporting on the determinants of health and modification of interventions to meet the needs of priority populations were appropriate roles for public health units to employ in action on the SDOH. Almost all of the responding health units (91%) strongly agreed that community engagement, multi-sectoral collaboration, and support for policy advocacy are appropriate roles for public health units in this domain. A small minority of responding health units (4%) moderately endorsed collaboration and policy advocacy or frankly opposed the concept that health units should adopt these roles in addressing SDOH.

To what extent do you agree that the following are roles for public health units in taking action on the social determinants of health (SDOH)?



Question 3 – Public Health Unit Roles in Action on the SDOH

The survey asked participants if there were additional important roles for public health units to take action on the SDOH. One health unit did not respond to this question. More than half of the health units (n=13) identified additional roles for health units to consider. The additional roles described by health units include the following (frequency in brackets):

- Increase awareness of SDOH (5)
- Advocate for policy change on SDOH (2)
- Assess and plan for priority populations (2); analyse the differential impact of SDOH on diverse communities
- Use equity health impact assessments or social equity lens in policy and program development (2)
- Evaluation and research on SDOH
- Coordinate and build provincial/local capacity
- Support equity and access to health services

Question 4 – Examples of Public Health SDOH Action

Health units were asked to identify examples of public health action (practice, policy, and/or research) that they have taken to address the SDOH under four categories of activity. Twenty-two health units provided examples in the responses summarized below (frequency in brackets). These examples provide a "high level" glimpse of how health units are involved in SDOH action:

1) The following are the examples of the assessment and reporting on the determinants of health in populations including the existence and impact of health inequalities and inequities:

- Health status reports/Epidemiology reports (11)
- Report cards on SDOH and topics
    - perinatal health, (at-risk) youth/child health, health inequities, drug use and social support and physical environment, tobacco, physical activity, food security, breastfeeding, air quality, poverty reduction, housing, labour force, oral health, housing in the north, neighbourhoods
- Research on priority populations
    - those with lower income (3), (at-risk) youth (2), seniors (2), those with mental illness (2), Anabaptist communities, Aboriginal populations, immigrants, rural communities, those who use injection drugs, perceptions of poverty, and at-risk neighbourhoods; +/- collaboration with academia
- Surveillance through programming
    - CINOT [Children In Need of Treatment emergency dental services program for low income families] , Healthy Babies Healthy Children program/child health, Nutritious Food Basket, sexual health services
- Surveillance through the Rapid Risk Factor Surveillance System (3)
- Incorporation into strategic plan (2)

- Community education and awareness campaigns (2)
- Board of Health Reports on SDOH
- Board of Health Working Group
- Organizational redesign to create an Access and Equity Unit in the health unit
- Medical Officer of Health presentations to partners (e.g. hospitals)
- Mapping SDOH with Geographic Information Systems
- Development of a deprivation index based on a Québec model
- Literature reviews (built environment)
- Qualitative research (photography of the lived experience of parents with low income)
- Analysis and dissemination of Health Alert and Air Quality alerts in relation to at risk neighbourhoods and populations
- One health unit noted in this section that they do not have an epidemiologist

2) Modification of public health interventions to meet the unique needs and capacities of priority populations:

- Offering services to meet the needs of priority populations
    - needle exchange (2), infection control for those using injection drugs, prenatal nutrition (2), prenatal classes, community kitchens, food skill programming for low income adults, dental services for low income adults, CINOT [program to clients age up to 18 years, substance misuse information and resources for at-risk youth, small group formats to reach at-risk youth, sexual health services for adolescents and those with multiple gender orientations, immunizations and tuberculosis programming and linkage to broader supports for newcomers, tuberculosis programming for those in homeless shelters, school health programs in priority neighbourhoods
- Reduced or no fees for services
    - smoking cessation (6), prenatal registration subsidy (2), prenatal vitamins, sexual health services for those without OHIP, birth control, rabies clinics (2), frozen meal subsidy, food handler certification (2), mental health services, emergency dental treatment fund, emergency dental care for Ontario Works [Social Assistance] recipients, car seat and helmet coupons
- Location or targeting of programming and services for priority populations
    - wellness centre, sexual health services (3), prenatal classes, infant safety equipment, clinics/vaccine clinics, food security and nutrition programs, schools, Best Start hubs, services in shelters for the homeless, parenting program in mental health centre, preschool program at subsidized housing sites
- Access to income support (e.g. dietary allowance [3], bus/taxi transportation [3])
- Service coordination (4) and referrals to resources to meet client needs
- Adaptation of education to small group settings (2)
- Provision of supportive social networks
- Development of education resources with ethnic/culturally diverse groups
- Creation of client-centred environments including physically and wheelchair accessible and welcoming spaces, translation services and provision of literacy materials, and assistance such as help with completion of consent forms

3) Engagement in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs:

- Participation in community groups/committees
  - community gardens/kitchens/food boxes (9), oral health coalition (3), positive school coalition, youth development, Healthy Communities Partnership
- Participation in Local Poverty Reduction teams (5)
- Substance misuse services (3)
- CAPC [Community Action Program for Children] and CPNP [Canada Prenatal Nutrition Program] (3)
- School boards and schools (3)
- Social housing, municipalities on tobacco-free spaces and multi-sectoral service hubs (3)
- Homelessness housing group (2), Homeless shelters for immunization
- Participation on Basic Needs Committee (2)
- United Way (2)
- Veterinarians (2)
- Participation in Best Start/Children Services Networks (2)
- Youth engagement in tobacco use (2)
- Participation on Resilience Collaborative/Canadian Index of Wellbeing
- Child Youth Family Services Coalition
- Health Canada
- Immigrant Employment Network, Multicultural Centre for Immigrants for Early Years services, Refugee Health Network
- University and Non Governmental Organization for Tuberculosis screening
- Crime Prevention Council
- Harm Reduction Coalition for research
- Family visitors in Healthy Babies Healthy Children (HBHC) program
- Food banks
- Early Years Centres
- Planning Department (built environment)
- Police
- Teen Centre
- Primary health care providers

4) Support the community and other stakeholders in policy advocacy for improvements in the determinants of health. Health units were instructed to provide examples that could include action that addresses the determinants of health as a whole, the framework, or individual determinants alone or in combination:

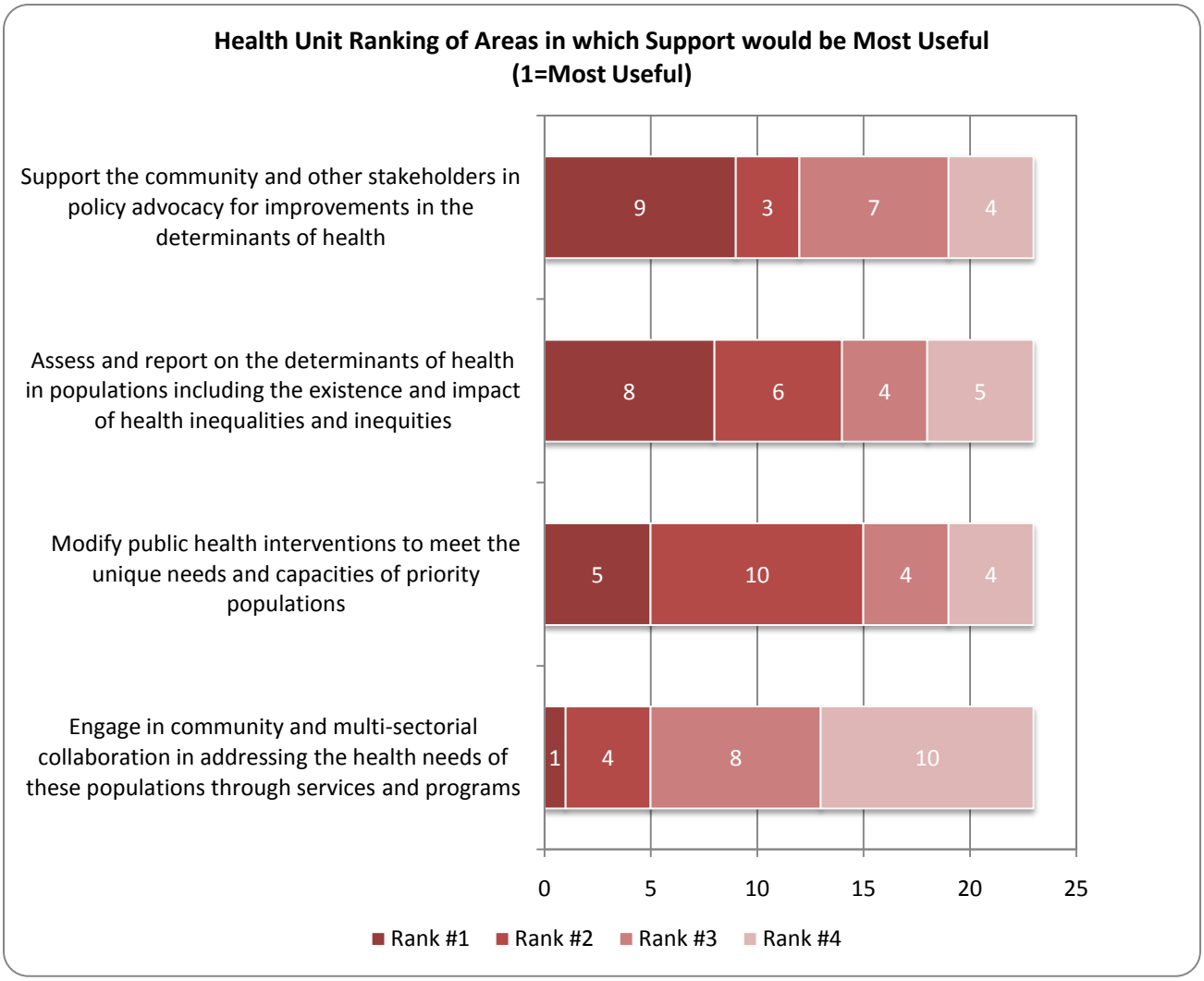
- Access to food/food security (7)
- Active transportation/transportation access (4)
- Built environment (bike trails, bicycle racks on public transportation) (4)
- Fair wages and employment/employability (4)
- Access to recreation (3)
- Regional Official Plan / Planning department (3)

- Tobacco in perinatal populations, smoke-free housing policy, tobacco-free spaces
- Safe housing (2)
- Weather and sun safety (2)
- Child health (2)
- Dental care affordability and access to free dental care for low-income families (2)
- Expanded eligibility for publicly funded services (Human papillomavirus vaccine and Ontario Health Insurance Plan coverage for new immigrants with tuberculosis)
- Workplace health
- Bullying prevention
- Baby-friendly initiative
- School nutrition policy
- Literacy

Question 5 – Support Required for Public Health SDOH Action

Health units were asked to rank from 1 (would benefit most from support) to 4 (would benefit the least from support) areas in which they would need support to address the SDOH.

The matter which the most health units indicated they would benefit the most from support was, supporting the community and other stakeholders in policy advocacy for improvements in the determinants of health. Nine health units ranked this assistance as the area in which they would benefit most from support. The next most highly ranked need for support was selected by about one third of respondents. Eight health units indicated they would benefit most from support in assessing and reporting on the determinants of health in populations, including inequity and its impact. Overall, when first and second rankings are combined, respondents selected these three areas with similar frequencies. Health units were least likely to select support for engaging in community and multi-sectoral collaboration as the area in which they would most benefit from support. This suggests that there are opportunities for health units to benefit from support to encourage communities in policy advocacy, assess and report on health determinants, and modify public health interventions to meet the needs of priority populations.


Health Unit Ranking of Areas in which Support would be Most Useful
(1=Most Useful)
Support the community and other stakeholders in policy advocacy for improvements in the determinants of health
9
3
7
4
Assess and report on the determinants of health in populations including the existence and impact of health inequalities and inequities
8
6
4
5
Modify public health interventions to meet the unique needs and capacities of priority populations
5
10
4
4
Engage in community and multi-sectorial collaboration in addressing the health needs of these populations through services and programs
1
4
8
10
0
5
10
15
20
25
Rank #1
Rank #2
Rank #3
Rank #4

Question 6 – Helpful Tools, Strategies, and Resources

Sixteen health units responded to this question that asked them to identify practice tools, strategies, or other resources that they thought would be helpful to other public health units' work to address the SDOH. The types of tools, strategies, and resources suggested included (see Appendix B for precise topics, resources and sources):

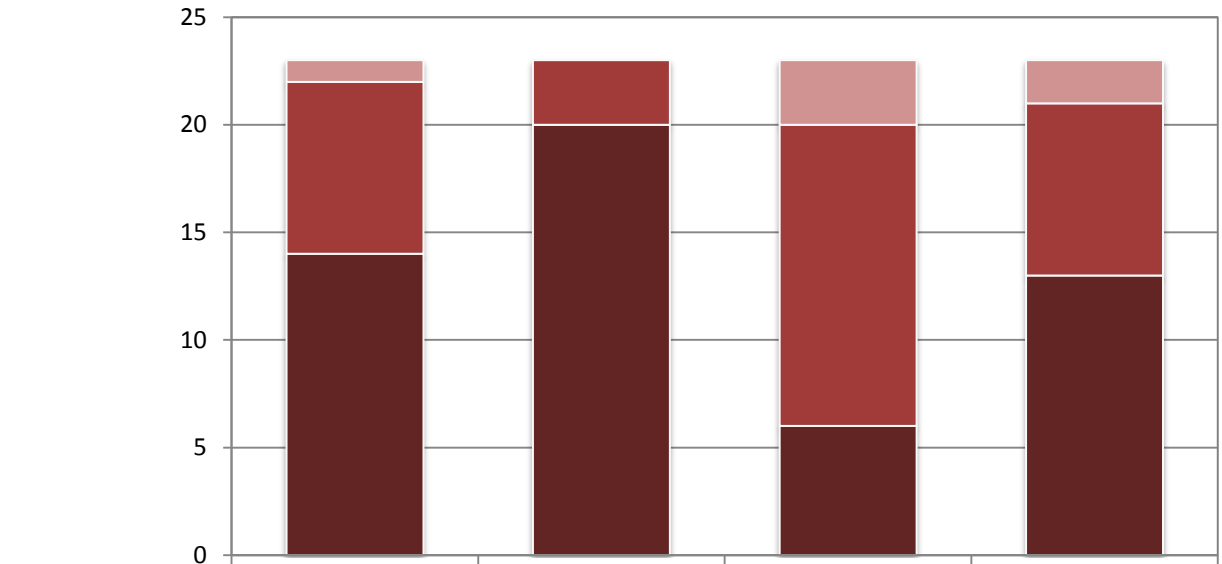
- Equity-focused health impact assessment tools/lens/checklists
- Academic articles
- Literature/ Systematic reviews
- Grey literature
- Consensus statements/ Position statements
- Practice guidelines
- Videos
- Factsheets
- Reports on priority populations and areas, resources for working with particular populations, area profiles, neighbourhood level mapping and the concept of the "Priority Neighbourhood" based upon socio-economic/health need data
- Data sets and indices
- Do the Math Calculators
- Planning frameworks, practice framework and tools, results-based analysis tool to identify local needs and develop a joint plan of action
- Action plans, operational plans
- Logic models
- Evaluation materials
- Focus groups
- Board game
- Scenarios
- Listserves
- Websites
- Training materials, staff diversity training curriculum
- Engagement frameworks
- National/world agency resources (e.g. National Collaborating Centres for Public Health, Public Health Agency of Canada, World Health Organization)
- Service delivery models
- Job descriptions
- Terms of reference
- Translation experience
- Experiential knowledge

Question 7 – Key Health Unit Challenges and Gaps

Twenty-three health units identified key challenges/needs/gaps for public health units/staff to better address the SDOH. Most (87%) respondents strongly agreed that education, training, and skill development of the existing and future workforce was a key challenge. The next most commonly expressed challenge was a need for stronger organizational/system leadership. Just over half (56%) of respondents strongly agreed that a key challenge was organizational routines to address SDOH in planning cycles. Ninety percent of respondents strongly agreed or somewhat agreed that all of these areas represented key gaps impacting health unit capacity to address the social determinants of health.

Health units provided more variable responses concerning the nature of need for development of abilities in managing external partnerships. This area received the highest rate of disagreement from respondents (13%) that it was a key gap. Respondents listed additional challenges and gaps in addressing the social determinants of health including (frequency of selection in brackets):

- Access to (local) data (2)
- Human resources (2)
- Increased awareness (2) (+/-of public health role)
- Local public health unit governance (2)
- Lack of simple language to talk about SDOH with the public
- Partnership support
- Reciprocal support for committee participation
- Linkage of information to Ontario Public Health Standards
- Building capacity
- Funding
- Leadership
- Connection to social services



	Stronger organizational / system leadership	Education / training / skill development of the existing and future workforce	External partnerships	Organizational routines to address SDOH in program planning cycles
Strongly Disagree	0	0	0	0
Disagree	1	0	3	2
Somewhat Agree	8	3	14	8
Strongly Agree	14	20	6	13

Question 8 – Systemic Needs for Assistance

Health units were asked to rank the top three items from a list of seven items that would be of greatest assistance to strengthen public health organizations'/systems' actions to address the SDOH.

Health unit respondents prioritized their first choice for systemic assistance in the following list (frequency of selection in brackets):

- Knowledge brokering service (provision of best practice advice tailored to local context) (10)
- Steps/strategies to move awareness to action (10)
- Tools/checklists for addressing SDOH (health impact assessment, program planning framework; conducting situational/needs assessments) (9)
- A support structure for sharing of information and issues among public health staff/organizations (e.g. networks; communities of practice) (7)
- Summaries of existing evidence on the relationship between SDOH and particular health outcomes (e.g. equity-focused health impact assessments) (6)
- Key messages/tools for engaging internal and external stakeholders (including Boards of Health) (5)
- Case studies of public health organizations' actions to address SDOH (4)

The top three rankings were assigned to knowledge brokering, steps and strategies to move awareness into action, and tools and checklists.

Other themes identified in descending order of frequency included:

- Human (2) and financial resources
- Provincial support structure for joint health unit action
- Assistance with common core indicators set development and monitoring tools
- Tools for action
- Prioritization of SDOH at the ministry level
- Lead agency
- Connection with particular communities (Mennonite, Aboriginal)

From the list below, rank the top three items that would be of greatest assistance to strengthen public health organizations'/systems' actions to address the SDOH (please rank only 3).			
Answer Options	**Rank 1**	**Rank 2**	**Rank 3**
Case studies of public health organization's actions to address SDOH	1	4	1
Summaries of existing evidence on the relationship between SDOH and particular health outcomes (e.g. equity focused Health Impact Assessments)	2	3	2
Tools/checklists for addressing SDOH (e.g. Health Impact Assessment, program planning framework; conducting situational/needs assessments)	3	4	6
Knowledge brokering service (provision of best practice advice tailored to local context)	7	0	4
A support structure for sharing of information and issues among public health staff/organizations (e.g. networks; communities of practice)	5	3	3
Key messages/tools for engaging internal and external stakeholders (including Boards of Health)	2	4	0
Mentoring by experienced peers	0	0	1
Steps/strategies to move from awareness to action	1	4	6
Other	5	0	0

Question 9 – Opportunities for the Joint Work Group on SDOH

The purpose of the Joint Work Group on the Social Determinants of Health was identified for health unit respondents. Its purpose is to foster improvements in social inequities in health for the population of Ontario, applying the following strategic approaches:

1. Promoting the inclusion of activities to address the social and economic determinants of health within the mandate of local public health units in Ontario;

2. Identifying, recommending, and supporting the provincial advocacy efforts of alPHa and OPHA for improvements in inequities in health; and

3. Monitoring advocacy efforts and policy changes at the provincial and national levels that impact inequities in health.

Given this purpose, six of the areas previously identified in Question #8 as areas requiring assistance were also identified by more than three quarters of respondents as activities the Joint Work Group should endeavour to provide. While there was less support for knowledge brokering, 11 respondents still identified this as an activity the Joint Work Group should strive to provide.

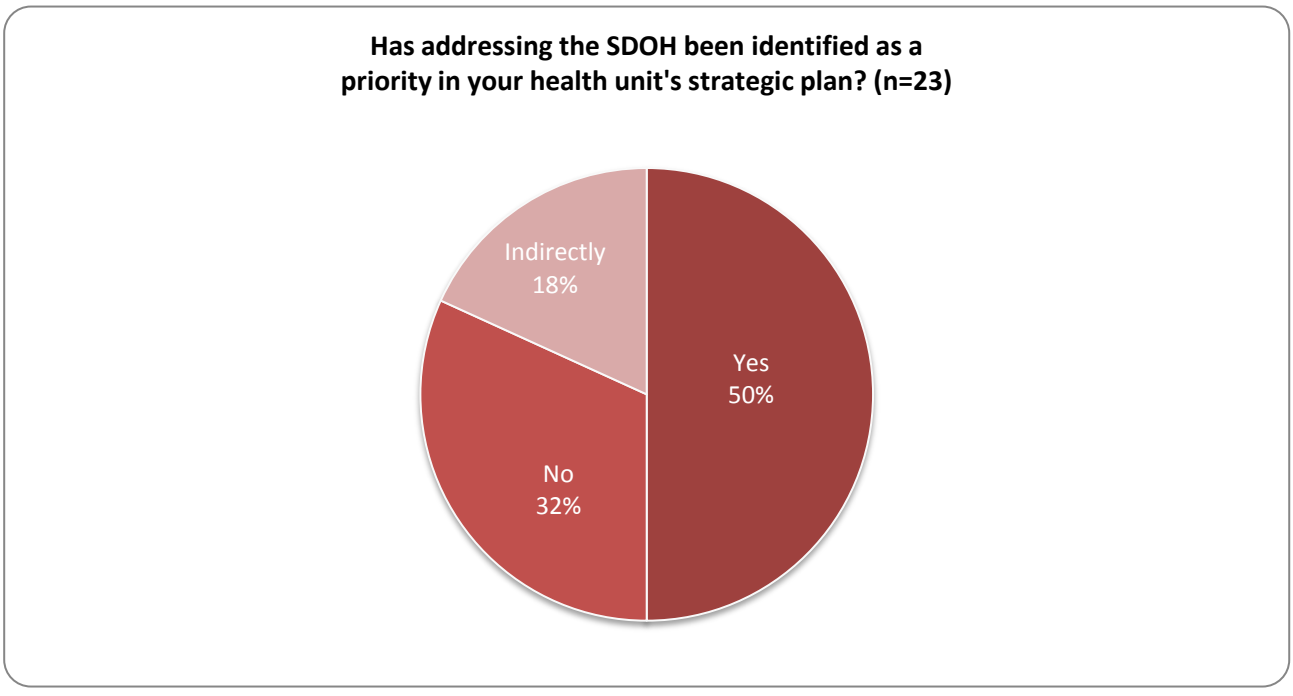
Other themes identified by respondents included:

- Funding hiring of personnel with skill set and capacity for the work
- Ontario Agency for Health Protection and Promotion collaboration (knowledge exchange)

Which of the items listed in Question #8 do you think the Joint Work Group should endeavour to provide? Check all that apply.	
Answer Options	**Response Percent**
Case studies of public health organization's actions to address SDOH	74%
Summaries of existing evidence on the relationship between SDOH and particular health outcomes (e.g. equity-focused Health Impact Assessments)	70%
Tools/checklists for addressing SDOH (e.g. Health Impact Assessment, program planning framework, conducting situational/needs assessments)	83%
Knowledge brokering service (provision of best practice advice tailored to local context)	65%
A support structure for sharing of information and issues among public health staff/organizations (e.g. networks, communities of practice)	78%
Key messages/tools for engaging internal and external stakeholders (including Boards of Health)	78%
Mentoring by experienced peers	17%
Steps/strategies to move from awareness to action	65%
Other	9%

Question 10 – Health Unit Strategic Plans and the SDOH

Fifty percent of respondents identified that SDOH have been identified as a priority in their health unit's strategic plan, while 18% indicated that SDOH have been indirectly identified as a priority. Thirty-two percent of respondents indicated that their health unit's strategic plan had not identified the SDOH as a priority. With a total of 68% of respondants identifying SDOH as a priority, either directly or indirectly, in their strategic plan, health units are well underway to meeting anticipated Board of Health Organizational Standard Performance requirements in this domain.

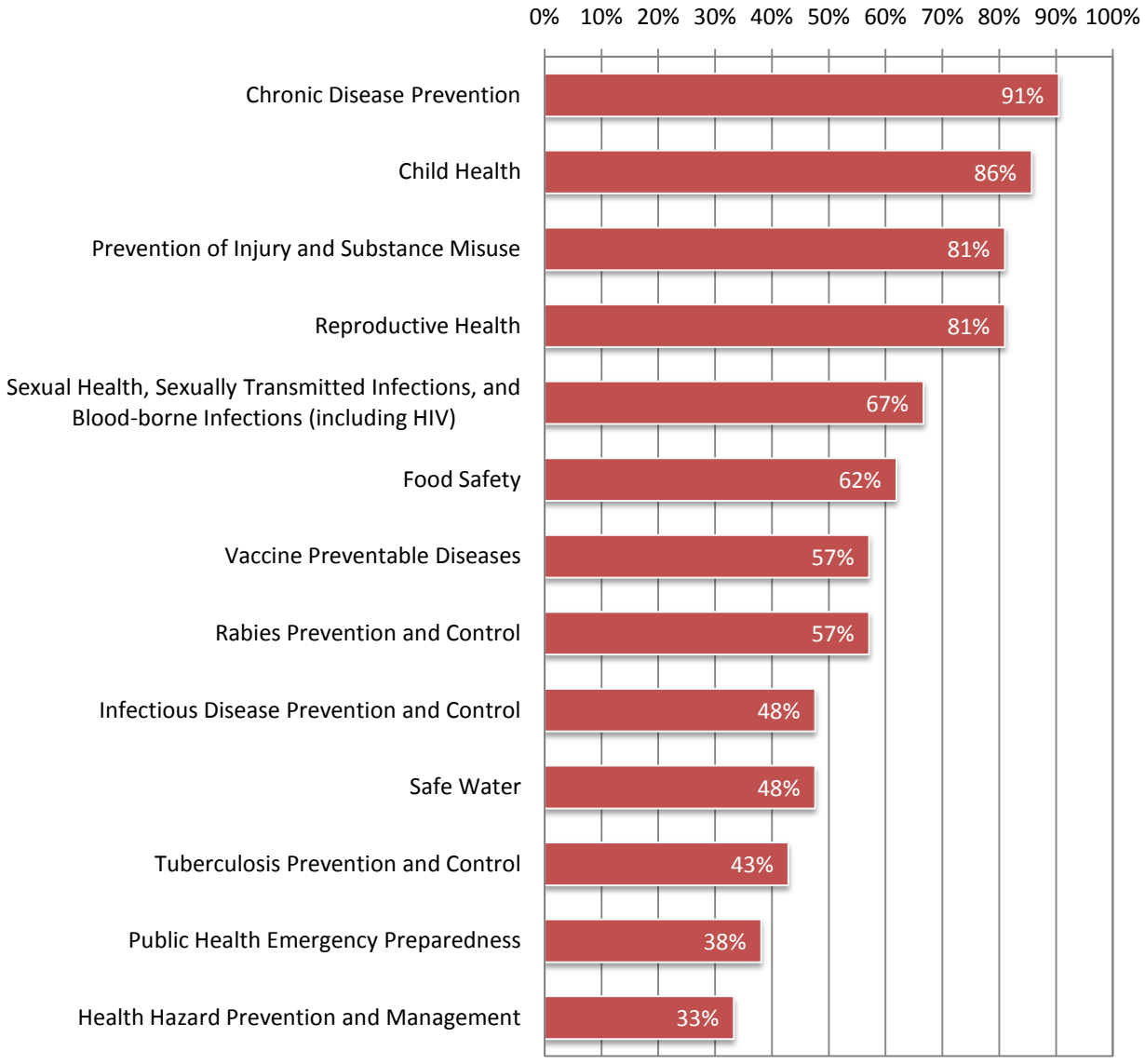


Question 11 – Local Identification of Priority Populations

Respondents cited efforts by health units to identify local priority populations in all Ontario Public Health Standards program areas. The most frequently mentioned areas for priority population assessment existed in chronic disease prevention, prevention of injury and substance misuse, reproductive health, child health, and sexual health.

Respondents named methods to identify local priority populations. These included situational assessments as part of routine planning; using data from sources such as the Canadian Community Health Survey, Early Development Instrument (EDI), Statistics Canada, and funders; and finally tapping into the information available from partner agencies servicing priority populations.

Percentage (%) of Health Units Identifying Local Priority Populations, by OPHS Program Area



Question 12 – Challenges in Reaching Priority Populations

Many challenges exist in reaching priority populations. Twenty-one respondents identified the following challenges (frequency in brackets):

- Overcoming barriers such as transportation, lack of phone, child care, language and literacy, social isolation (12)
- Engaging/reaching/recruiting members of priority populations (7)
- Tailoring interventions to specific populations. Members of populations with low income may feel uncomfortable in the same program with those who have higher income. Diversity of populations
- Identification of priority populations (3)
- Building trusting relationships with priority populations (5)
- Accessing physical locations of priority populations (2)
- Large rural geography challenges the ability to plan and deliver services(e.g. long distance travel) (4)
- Difficulty in reaching sup-populations of priority populations (4)
    - Street involved persons, Aboriginal populations, teens and low-income youth, those on Ontario Works, working poor, single mothers, high-risk seniors living on their own
- Cultural barriers and awareness (4)
- Literacy levels (3)
- Language to relay messages/effective communication (2)
- Resources, budget, and funding (5)
- Expense of service delivery (3)
- Staff capacity (4)
- Balancing ministry priorities
- Waitlists for services
- Planning time
- Limited scope to directly address the basis of inequities
- Data, local and systematic, to follow trends and impact (3)
- Tension/competition between population-based approach and focus on priority populations (2)
- Subsidies for services
- Best practices
- Poor outcomes (tobacco cessation)
- Poor coordination among agencies and internal staff reaching the same families
- Policy advocacy is challenging

Question 13 – Local Advocacy on the SDOH

Twenty health units provided examples of advocacy efforts related to the SDOH:

- Provincial and or national consultations (6)
  Affordable housing strategy, Nutritious Food Basket Report, Resilience Collaborative, special diet allowance/Put Food in the Budget campaign, adequate income support, Make Poverty History, 25 in 5
- Community committees and coalitions including:
  Basic Needs, Oral Health, Poverty Reduction Coalition, Healthy School Nutrition, Community Gardens, Healthy Communities Initiative, Regional Food Summit, Community Services Committee, Housing network, Smoke-free housing, Regional Immigrant Employment Network, Dental Coalition
- Advocacy on food security (7); Do the Math Challenge (3); Distributing Nutritious Food Basket results (6)
- Support for subsidies (bike helmets, car seats, nicotine replacement therapy)
- Council presentations; all-candidates meetings on poverty and social issues (3)
- Media releases, newspaper advertisements, television/posters/brochures/displays (3)
- Board of Health motions/resolutions (2)
- Position papers and focused reports (2) (e.g. child poverty, SDOH)
- Input into Municipal/Regional Official or Transportation plan (2)
- Letter to Premier, presentations to members of federal/provincial parliament (2)
- Postcard signing
- Input into workplace policy
- Incorporation of SDOH in strategic planning (2)
- Health Impact of Poverty initiative
- Youth inclusion
- Smoke-free playgrounds
- Advocacy for services in underserviced areas
- Advocacy for expanded access to services (dental for low-income populations; access to Ontario Health Insurance Plan for new immigrants)
- Advocacy for increases to the minimum wage and social assistance rates
- Lecture series (Hastings Lecture to highlight SDOH)

Question 14 – Community Partnerships

Twenty health units identified the types of community partnerships, committees and coalitions (e.g. education, business, political, NGOs, health, etc.) they are involved with to address the SDOH (frequency in brackets):

- Non-Governmental Organizations
  - Social Planning council (4), Best Start/Better Beginnings (3), Early Years Service Integration Committee (3), Community fairs, Triple Parenting, Children's Aid Society, Fight against Impaired Driving, Ontario Safer Bars, Biosphere Reserve, Social Services, Lung Association, Rotary Club, YMCA, United Way (2), Academic Research Partners
- Health
  - Hospital (4), Substance Use Prevention Coalition (3), Community Health Centre (2), Family Health Centre/Team (2), Local Health Integration Network, multi-health unit working groups, Community Mental Health Program, Residential Energy Efficiency Program
- Municipal
  - School boards (7), Council (2), By law and Building, Libraries, Housing, Parks & Recreation, Police and Fire (2), Planning Department
- Community
  - Basic Needs Committee (2), Chamber of Commerce (2), Seniors Safety Gathering, Family Resource programs, Development and Community Planning groups, Canadian Prenatal Nutrition Committee, PROMPT (municipal, legal, consumer, community agency committee), Community Living, Members of federal/provincial parliament, faith organizations (2), volunteers, Immigrant Employment Network, Neighbourhood Associations, Community Centres, Food roundtable, festivals, Garden council, Healthy Communities Coalition, Safe Communities, Poverty Reduction Network, Food Security Working Group, Neighbourhood Hub, Children's Alliance, Recreation groups, Youth Coalitions, Workplaces, First Nations, child care agencies

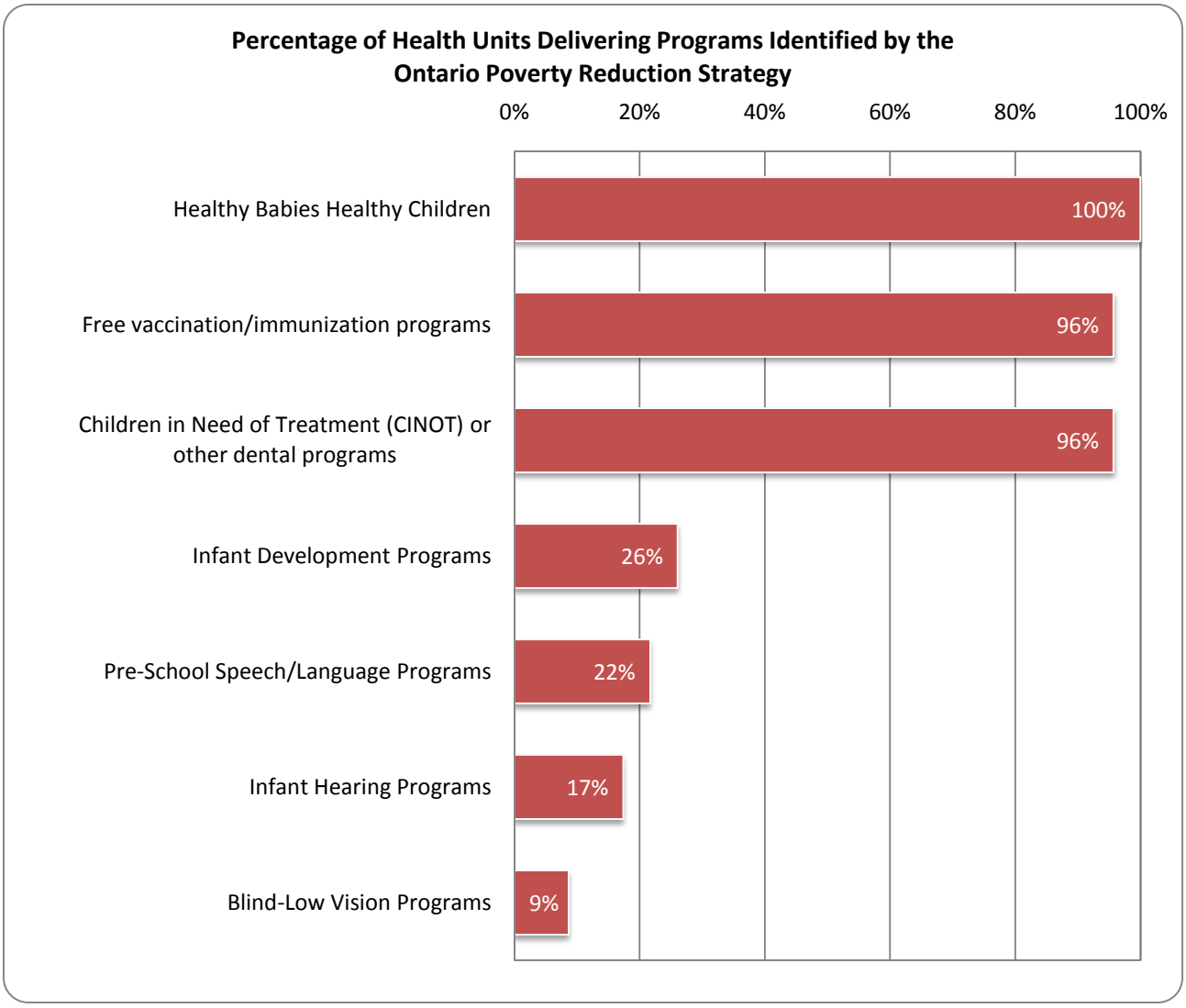
Health Unit Involvement in Ontario's Poverty Reduction Strategy Programs (Questions 15 – 21)

Question 15 – Ontario's Poverty Reduction Strategy Programs Delivered by Health Units

All responding health units reported that public health delivers elements of the seven programs identified in Ontario's Poverty Reduction Strategy. One hundred percent of participating health units indicated that they provide Healthy Babies Healthy Children programming and 96 % indicated that they provide free vaccination/immunization programs and the Children in Need of Treatment or other dental programs. Health units offer other programs less often: just over a quarter deliver Infant Development programs while about 20% or less provide Pre-School Speech and Language programs, Infant Hearing and/or Blind Low Vision programs.

Challenges health units face in delivering these programs to meet the needs of priority populations included:

- Limited funding (10)
- Geography and isolation, remoteness, northern/rural (5)
- Transportation (4)
- Demand capacity imbalance/waitlists (4)
- Awareness among professionals and community (2)
- Difficulty contacting clients (2), Lack of phone/insecure housing
- Child care (2)
- Population growth (2)
- Language
- Ministry forms in unclear language
- Finding common goals among partner agencies
- Limited primary care support resulting in increased public health role in service delivery
- Access to service providers
- Staff training for work with marginalized groups
- Time
- Long-term commitment
- Moving from program-centred to a client-centred system under the Ontario Public Health Standards

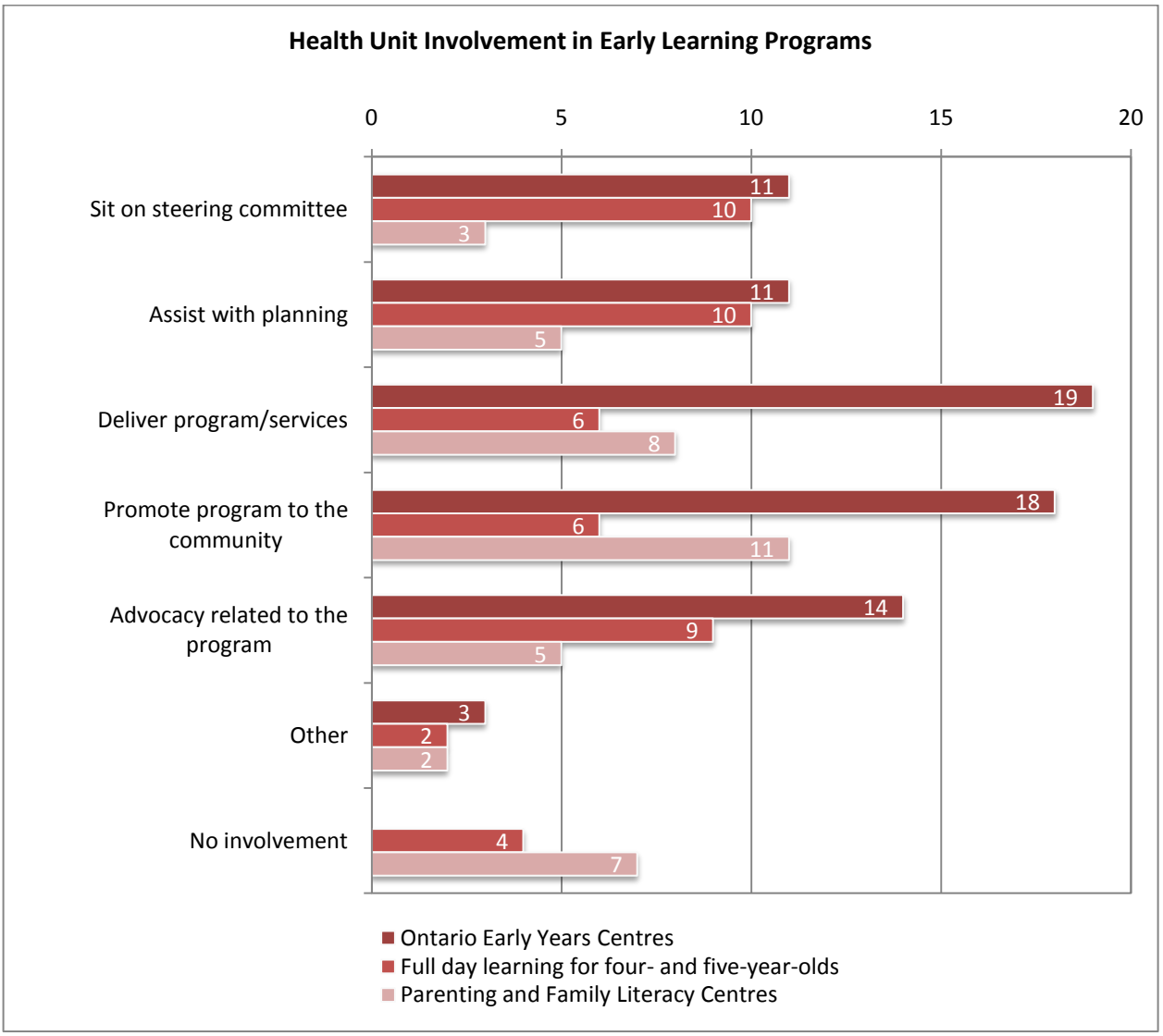


Question 16 – Health Unit Involvement in Early Learning Programs

Twenty-two health units described their involvement in the Early Learning programs as articulated in Ontario's Poverty Reduction Strategy. All health units have involvement with Ontario Early Years Centres. This involvement ranges from sitting on steering committees, assisting with planning, delivering programs, promoting the program in the community, and advocacy related to the program. A large majority (82%) of responding health units are involved with full-day learning for four-and five-year-olds with 45% of the respondents sitting on steering committees and assisting in planning. Although 32% indicated no involvement with Parenting and Family Literacy Centres, half of the health units promoted these programs to the community.

Other areas of involvement described by participants included:

- staff training
- partner
- engagement with subcommittee planning



Question 17 – Health Unit Involvement in School Poverty Reduction Programs

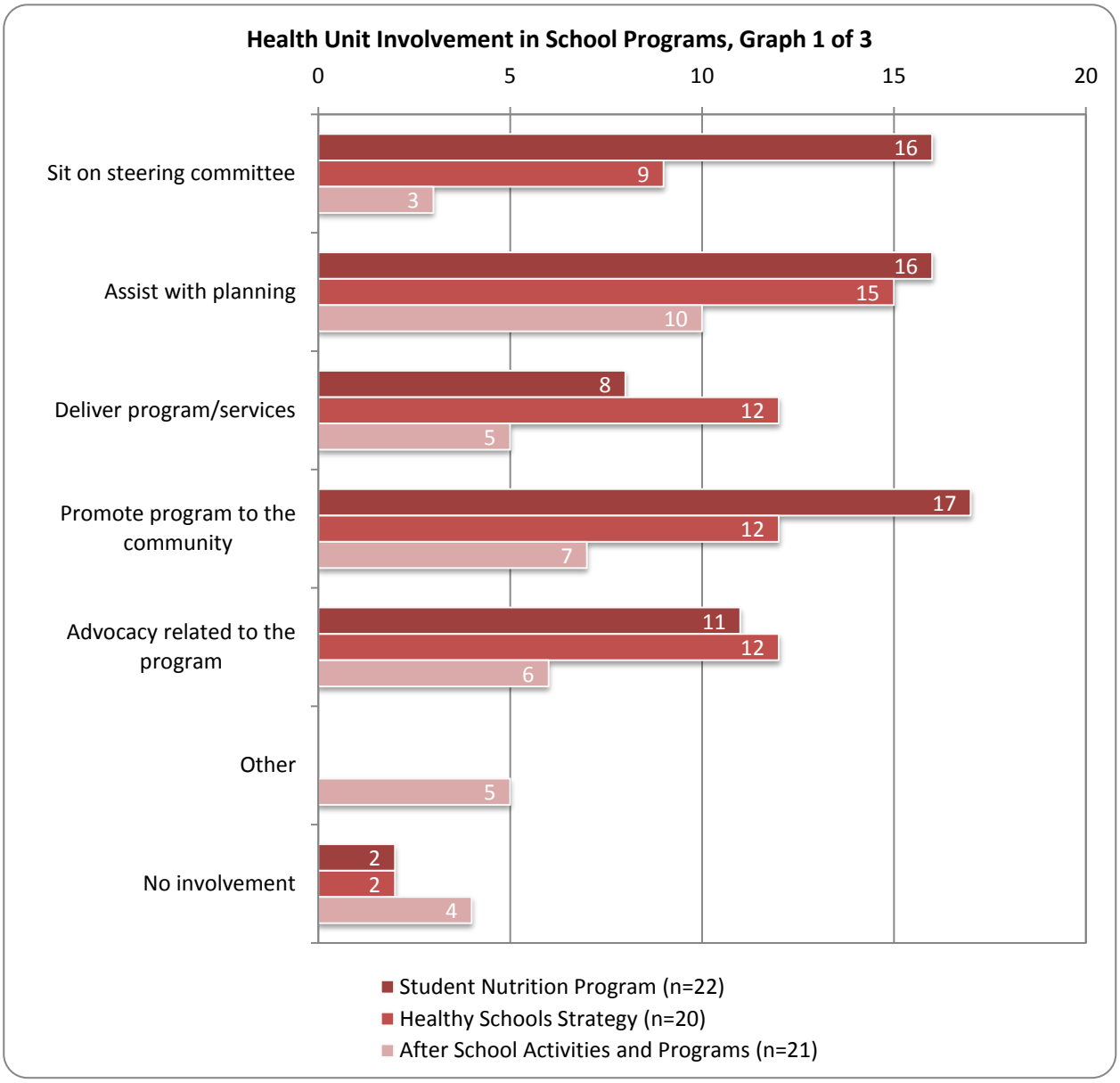
The number of respondents who identified health unit involvement in the school programs has been identified below. (A description of these programs can be found on pages 10-13 of Ontario's Poverty Reduction Strategy.). Involvement ranged from sitting on steering committees, assisting with planning, delivering programs, promoting the program, and advocacy related to the program.

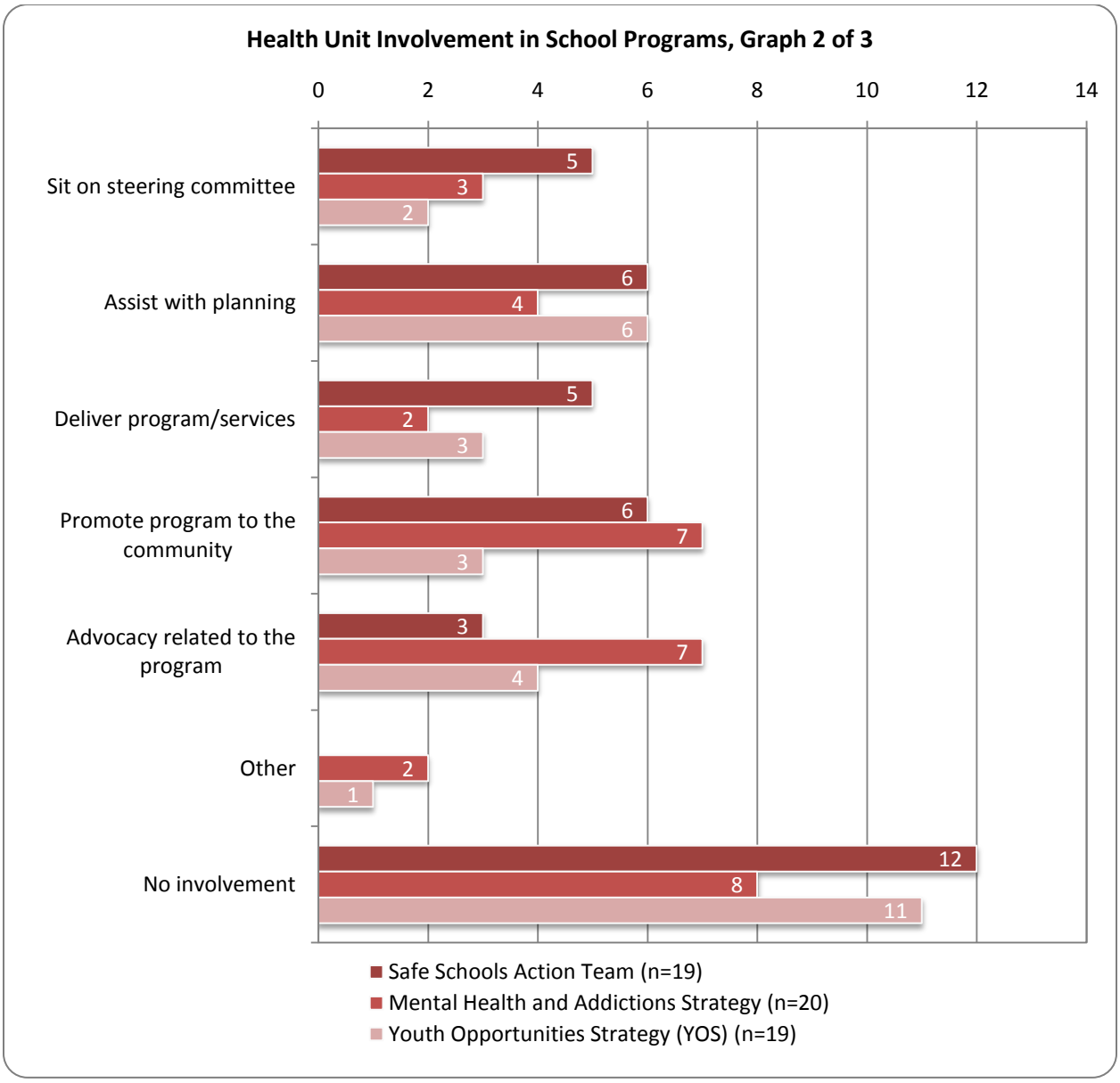
- Student Nutrition Program (20)
- Healthy Schools Strategy (18)
- After School Activities and Programs (17)
- Mental Health and Addictions Strategy (12)
- Youth Opportunities Strategy (8)
- Student Success Teams (7)
- Safe Schools Action Team (7)
- Access to School Activities (7)
- Parent Engagement Office (4)
- Literacy and Numeracy Secretariat (LNS) through the Ontario Focused Intervention Partnership (2)

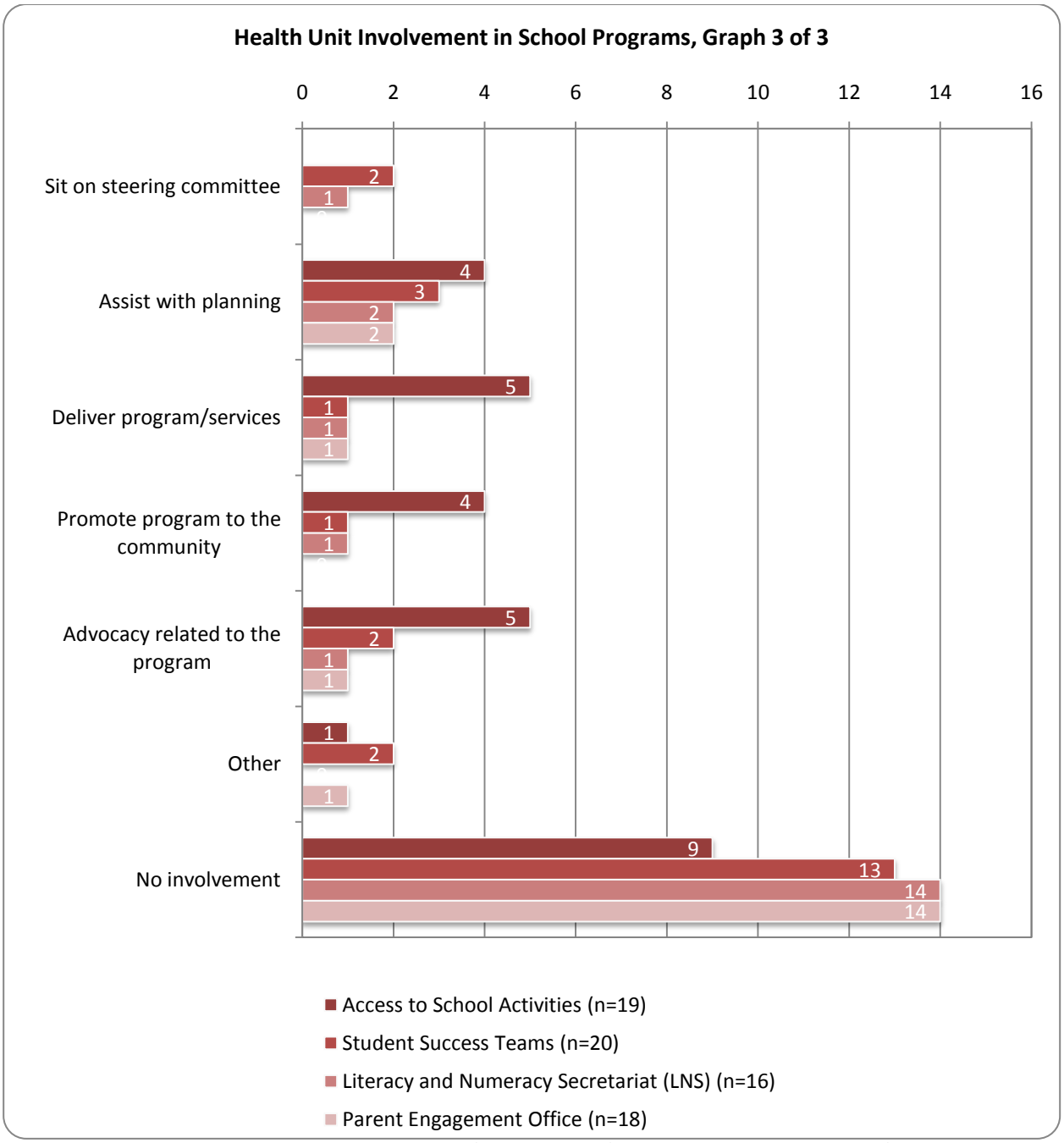
Other involvement identified by respondents included:

- program development in healthy eating, physical activity, and tobacco (3)
- specific staff liaise with school boards
- promote and refer schools and parents to community mental health
- organized workshops in mental health for school staff and community agencies
- promote universal access to school programs for healthy food and recreation
- train the trainer sessions for after school programs
- support upon request
- student placements at the health unit
- inspections of after school sites
- mental health research
- peripheral involvement due to challenging rollout of initiative
- lead in planning

Health unit involvement with the School Poverty Reduction Strategies is variable, with the strongest levels of involvement reported in more traditional program areas, such as nutrition and healthy schools.


Health Unit Involvement in School Programs, Graph 1 of 3
0
5
10
15
20
Sit on steering committee
16
9
3
Assist with planning
16
15
10
Deliver program/services
8
12
5
Promote program to the community
17
12
7
Advocacy related to the program
11
12
6
Other
5
No involvement
2
2
4
Student Nutrition Program (n=22)
Healthy Schools Strategy (n=20)
After School Activities and Programs (n=21)


Health Unit Involvement in School Programs, Graph 2 of 3
0
2
4
6
8
10
12
14
Sit on steering committee
5
3
2
Assist with planning
6
4
6
Deliver program/services
5
2
3
Promote program to the community
6
7
3
Advocacy related to the program
3
7
4
Other
2
1
No involvement
12
8
11
Safe Schools Action Team (n=19)
Mental Health and Addictions Strategy (n=20)
Youth Opportunities Strategy (YOS) (n=19)



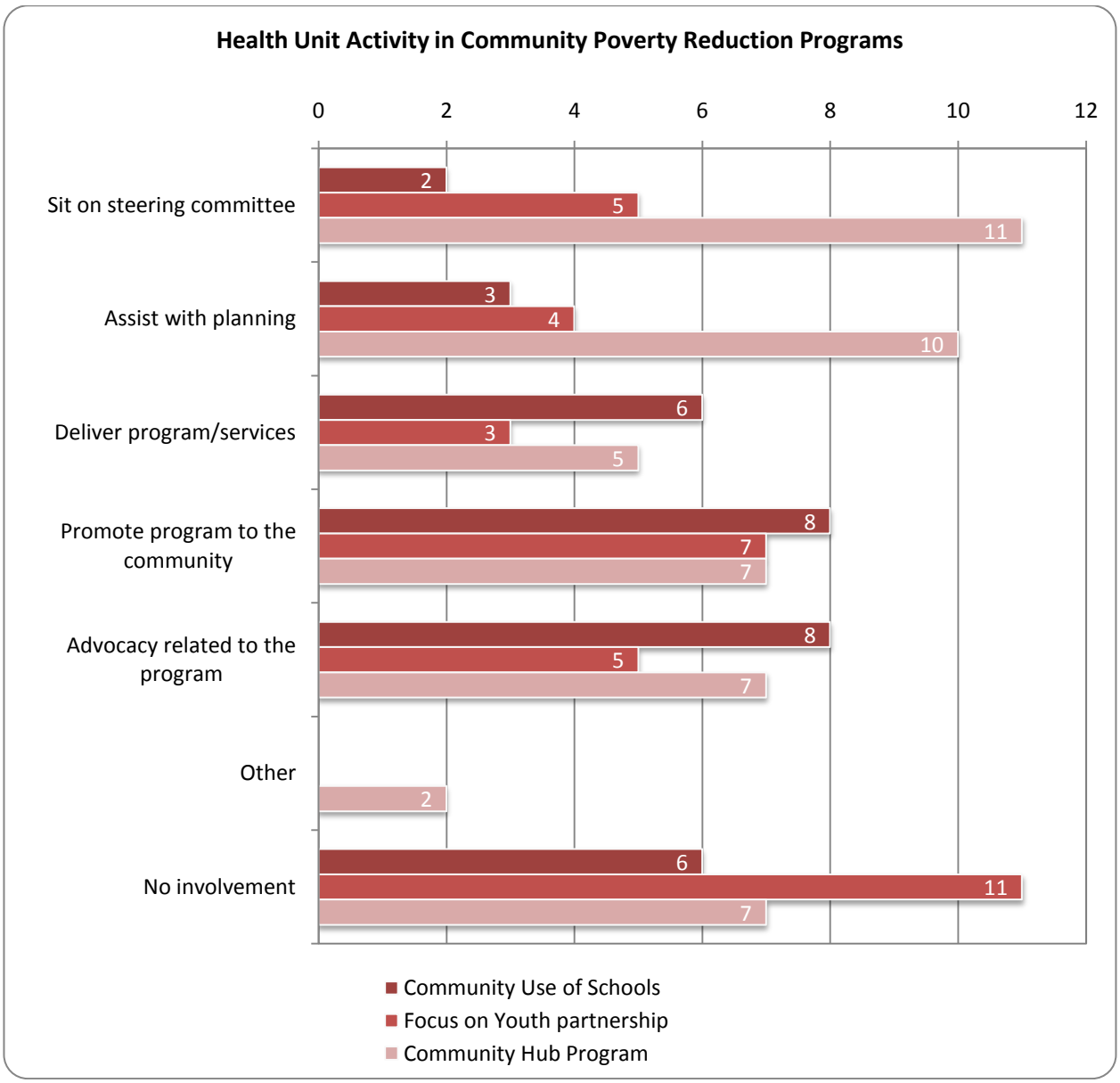
Note: Not all responding health units provided answers for each program; frequencies within each program therefore do not all sum to the same number.

Question 18 – Health Unit Activity in Community Poverty Reduction Programs

Health units were asked to explain their involvement in community programs noted in Ontario's Poverty Reduction Strategy, namely the Community Use of Schools, Community Hub, and Focus on Youth Partnership. More than two thirds of respondents were involved with Community Use of Schools and the Community Hubs. Respondents described many roles that health units assume ranging from sitting on a steering committee to promoting the program.

Other identified involvement included:

- School team involvement in professional development for local promotion and planning
- Community Hub model support without provincial funding



Question 19 – Health Unit Activity in Other Poverty Reduction Programs

The survey queried participants about health unit activities in other programs related to Ontario's Poverty Reduction Strategy. Involvement included:

- CINOT expansion/dental services for low-income families (6)
- local/provincial Poverty Reduction Working Group (2)
- programming: immunization, low-cost birth control and education, child health (2)
- planning for: full-day learning for 4/5-year-olds, child care, student nutrition, mental health promotion
- inspection of housing
- data gathering
- Canada Prenatal Nutrition Program
- Community Opportunities Fund
- Canadian Mental Health Association
- Bridges Out of Poverty Training
- local food security initiatives; sourcing funding for food skills programs

Question 20 – Ontario Poverty Reduction Program Funding

The survey asked respondents if they had any involvement with projects funded by particular grants such as the Urban and Priority High Schools and the Community Opportunities Fund. Only two health units indicated involvement with Parents Reaching Out Grants. No health unit indicated involvement with the other grants mentioned in Ontario's Poverty Reduction Strategy, in particular the Learning Opportunities Grants, Urban and Priority High Schools, or the Community Opportunities Fund.

Health unit project activity with the Parents Reaching Out Grants included:

- priority primary and elementary schools
- assisting schools to obtain grants
- promotion of positive body image in youth

Question 21 – Advocacy on the Ontario Poverty Reduction Strategy

The initiatives below were identified in Ontario's Poverty Reduction Strategy. Ten respondents to the question indicated the initiatives where their health unit advocated (e.g. formal Board statements, input of staff members to community consultations, direct advocacy as a health unit only, or indirectly as part of a community network).

For which of the following initiatives has your health unit advocated (e.g. formal Board statements, input of staff members to community consultations, direct advocacy as a health unit only, or indirectly as part of a community network).

Check all that apply.

Answer Options	Response Percent	Response Count (n=14)
Student assistance programs (grants, loans, etc.)	7%	1
Skills to Job Action Plan	14%	2
Increase minimum wage	86%	12
Hire new Employment Standards Officers	0%	0
New legislation to improve access to temporary help agencies	7%	1
Increase funding for the Provincial Rent Bank Program	29%	4
Expand OSIFA loan eligibility	0%	0
Develop long-term affordable housing strategy	79%	11
Post-secondary earnings exemption	0%	0
Extend Up-Front Child Care Benefit	14%	2
Extend time period to request internal review	0%	0
Creation of an independent Social Policy Institute	7%	1
Development of Sustainable Procurement Strategy	7%	1
Social Innovation Generation (SiG)	0%	0
Development of Social Venture Capital Fund	7%	1

Specific activities related to the above initiatives were described by the respondents as:

- Participation in federal/provincial/local consultations on housing (4)
- Advocacy for increased funding to Provincial Rent Bank program (2)
- Support of community coalitions with access to data (2)
- Development of local reports on Child Poverty and Poverty Report Card
- Meeting with local Member of Provincial Parliament
- Letter to Premier
- Job Action Plan
- Advocacy for OAHPP to be designated the policy institute

Question 22 – SDOH Measures and Instruments

All 23 respondents indicated that they were currently using or would like to use specific population health measures to inform their work. The most popular instruments in use are the Early Development Instrument, Birth Weights, and the Low-Income Measure. Survey participants cited interest in working with Graduation Rates, the Ontario Housing Measure and the Deprivation Index. The following indicators and instruments and their frequency of current use by respondents are listed below:

Does your health unit use any of the following measures to inform their work? Check all that apply. (n=23)

Answer Options	Currently using	Not using, but would like to use	Not interested in using	Not sure
Early Development Instrument (School Readiness)	17	5	0	1
EQAO Score (Educational Progress)	4	9	4	5
Graduation Rates (High School Graduation Rates)	9	10	1	3
Healthy Birth Weights (Birth Weights)	22	1	0	0
Low Income Measure: 40% (Depth of Poverty)	9	12	0	0
Low Income Measure: 50% (Low Income Measure)	11	10	0	0
Housing Measure (Ontario Housing Measure)	7	14	1	1
Deprivation Index (Standard of Living)	4	16	0	1

Other measures used by health units included:

- Low-Income Cut-off
- Rapid Risk Factor Surveillance System
- Canadian Community Health Survey
- Deprivation Index developed by the Institut national de santé publique du Québec

Question 23 – Use of SDOH Measures and Instruments

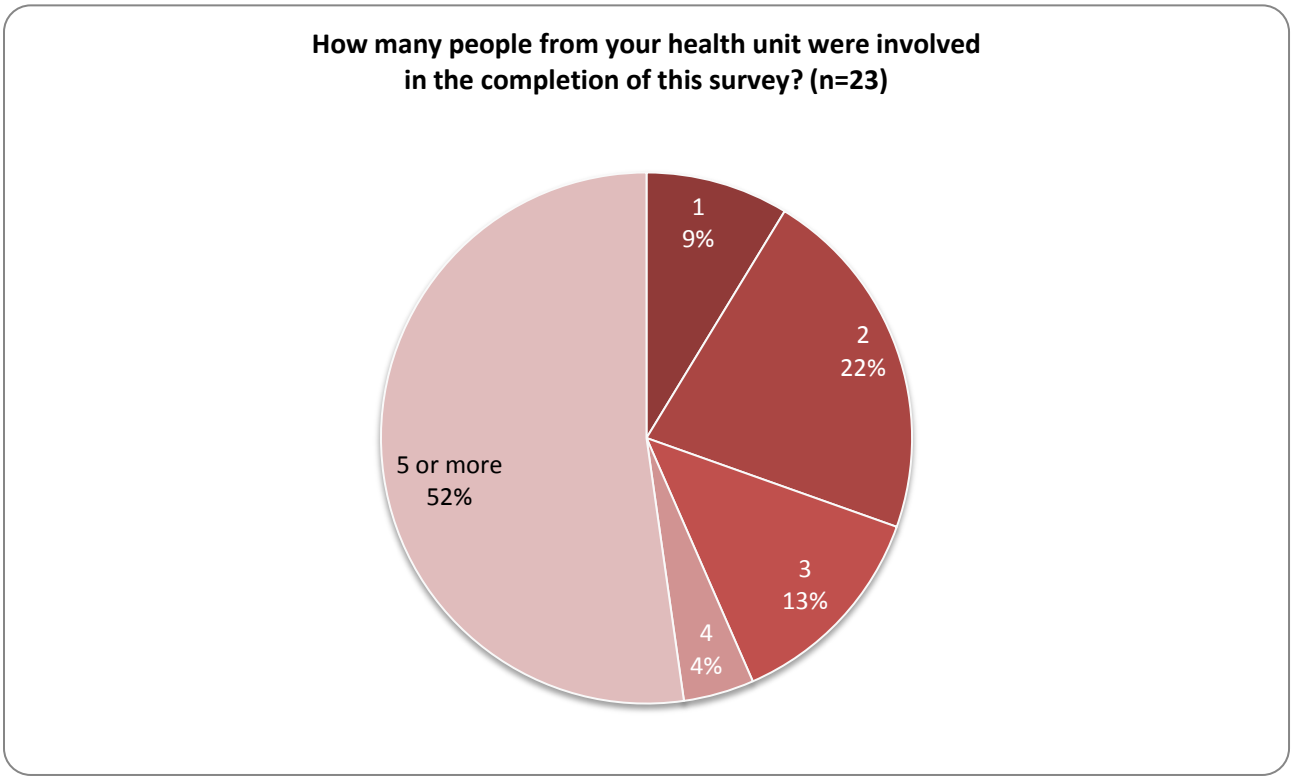
For the measures mentioned in question #22 that are currently being used by health units, respondents described how the instruments were deployed to inform their work:

- Identification of priority populations (7)
    - EDI used to determine location of Best Start Hubs (4), Income and housing indicators for planning and identification of demographics and priority populations, EDI for Healthy schools programs (2), Rapid Risk Factor Surveillance System/Canadian Community Healthy Survey

- Monitoring of trends/outcomes (6)
- Increasing awareness (7)
    - graduation rates and EDI/advocacy Low income cut-offs, low-income measure/housing
- Program planning justification (6) (Birth weights used to support need for prenatal education/parent support groups/dental program)
- Resource allocation (4)
- Mapping of service availability
- Targeting of needs assessment
- Program description
- Program evaluation

Question 24 – Health Unit Survey Completion by Staff

More than half (n=12) of respondents indicated that five or more people from their health unit participated in the completion of the survey. Only a single health unit reported that the survey was completed by one individual.



Question 25 – Positions Involved in Survey Response

Multiple public health staff participated in the completion of this survey at the local health unit level. Eighteen health unit responses identified the following participants:

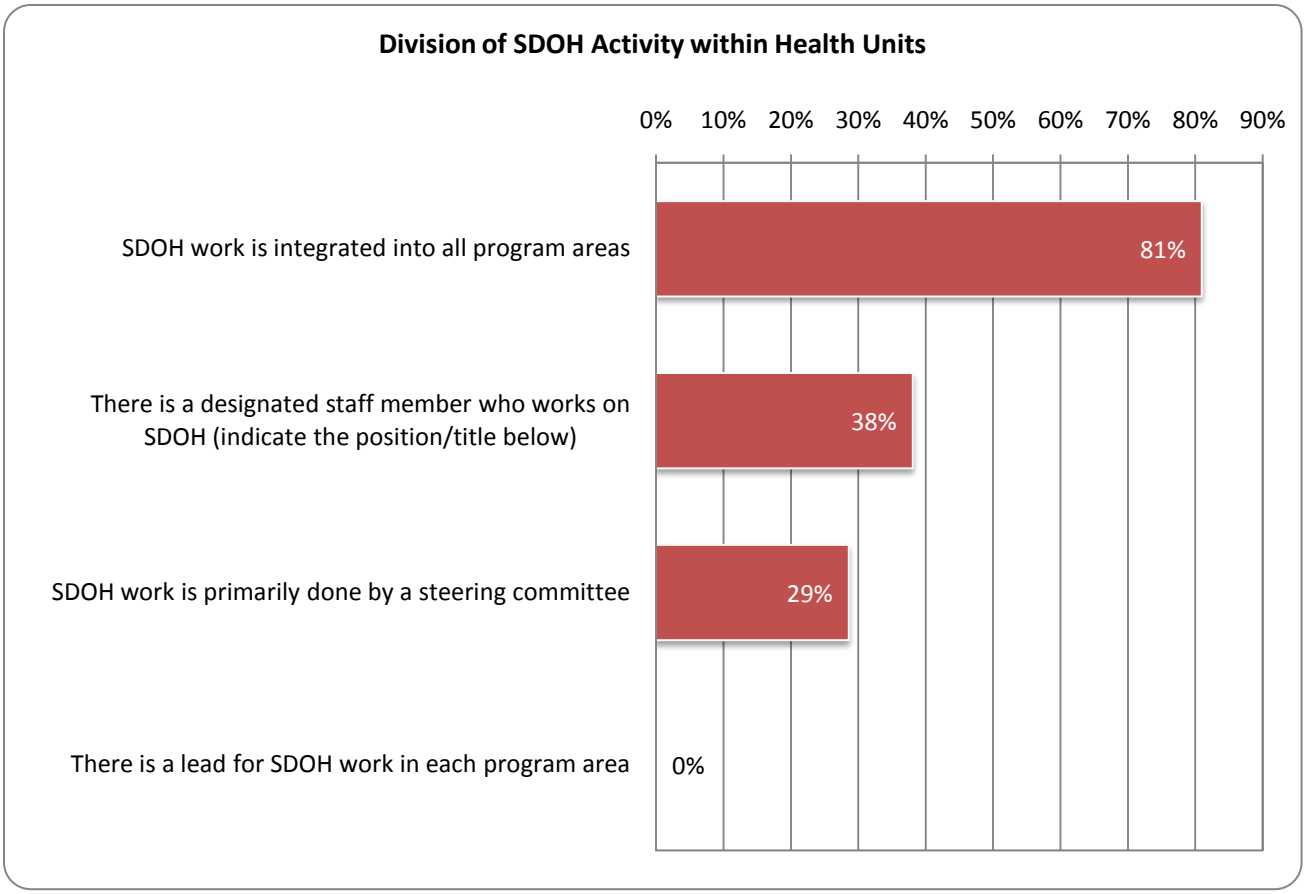
Which of the following positions were involved with the completion of this survey? Check all that apply.

	%	Count
MOH/AMOH	30	7
Director	65	15
Manager	65	15
Staff	52	9
Other	9	2

Participants listed other types of respondents: epidemiologists (2), consultants/senior advisors, health promoters, and public health nutritionist.

Question 26 – Division of SDOH Activity Within Health Units

More than 80% of survey respondents indicated that work related to SDOH is integrated into all program areas at their health unit. Almost 30% indicated that work is primarily done by a steering committee and almost 40% revealed that there is a designated staff member who works on the SDOH. These identified leads hold position titles such as: Health Promoter (2), Policy and Planning Specialist/Research and Policy Analyst (2), Steering Committee, Public Health Nutritionist, Community Developer and Senior Advisor. No health units have a lead for SDOH work within each program area.


Division of SDOH Activity within Health Units
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
SDOH work is integrated into all program areas
81%
There is a designated staff member who works on SDOH (indicate the position/title below)
38%
SDOH work is primarily done by a steering committee
29%
There is a lead for SDOH work in each program area
0%

Discussion

Actions on the social determinants of health were evident in the work of the majority of health units across the province. With almost two thirds of health units responding to this survey, virtually all strongly agreed that community engagement, multi-sectoral collaboration, and support for policy advocacy are appropriate domains of public health unit activity on the SDOH. Health units also volunteered that additional roles in action on the SDOH could be adopted by health units, including increasing awareness of the SDOH and assessing and planning for the health needs and impacts of priority populations. In particular, the use of equity-focused health impact assessments and a social equity lens in policy and program development were mentioned as a particular operational strategy. Notably, health units did not see their role limited to their local context. They also mentioned that contribution to the provincial system to build systemic capacity and coordination was also appropriate for health units to consider.

The wide variety of formats and topics that health units are using to communicate about the SDOH demonstrates the vigorous ways in which the SDOH are woven into health unit activity through the essential public health functions of population health assessment and surveillance. Health units are creating reports and research and awareness campaigns on an impressive array of the determinants and populations. Notably, one respondent mentioned that they do not have an epidemiologist. The absence of this important public health human resource would limit a health unit's ability to evaluate, analyze, and publicize local issues on the determinants of health. Nevertheless, increased knowledge of the impact of the SDOH is likely a desired interim state to build the case for decisive action on reducing health inequity. Health units involved in raising the awareness of the SDOH will need to have a vision of how they will measure the success and impact of campaigns to increase the profile of the SDOH.

In addition to population assessment and surveillance, health units' actions on the SDOH encompass many strategies to modify interventions for priority populations. These include adapting the types of offered services; reducing income, physical and geographic barriers to access programs; and changing program formats. Health units are also explicitly addressing determinants like social support by fostering supportive social networks and coordinating client care and referrals to other resources. The ability of health units to play that nodal function suggests that health units have a wide span of reach and connectivity into their communities. Illustratively, respondents listed many partners and coalitions they engage with in multi-sectoral collaboration. These cooperative ventures cover many health issues and include multiple types of organizations at different levels of scope including local, provincial and national initiatives. The prominence of food-oriented initiatives such as community gardens/kitchens/food boxes and food security as an advocacy issue suggests that public health activity in this sphere has gained considerable momentum recently. Many advocacy issues listed by respondents stem from the environmental health realm, including housing, transportation, the built environment, and protection from weather and the elements. In combination with the previously mentioned activities on income support and food security, health

units seem to be prioritizing collaborative work to address the fundamentally basic needs (food, shelter, income) of their populations.

When health units were asked about areas requiring support to address the social determinants of health, policy advocacy and staff skill development were listed as the top areas for improvement at the local level. This need prompts potential for centralized bodies like the Ontario Public Health Association, the Association of Local Public Health Agencies, or the Ontario Agency for Health Protection and Promotion to submit learning programs to build advocacy capacity at the local level. In addition, the public health field can explore the meaning of "public health support to the community" because this could involve a number of enabling activities such as assistance with proposal writing and grant requests and action planning. Finally, the low rate of selection of community engagement, multi-sectoral collaboration, and partnership as needing improvement, indicates that these are areas of self perceived strength for health units.

Indications of what health units specifically need to advance their work on the SDOH is evident in the practical items health units requested for assistance, such as knowledge brokering services, strategies, tools and checklists, and infrastructure to share information. Respondents saw the Joint Work Group on the Social Determinants of Health as a potential resource for outputs in these areas. Despite the many challenges health units listed as barriers to reaching priority populations and addressing the SDOH, they still listed numerous community partnerships and forms of activity with components of the Ontario Poverty Reduction Strategy.

Finally, health units are experimenting with a number of population health measures to inform their work on the SDOH. These measures are used to identify priority populations, monitor trends and outcomes, inform program planning and targeted resource allocation, and increase awareness. The sources for some of this data traditionally lie in sectors outside of health. Therefore, improving surveillance and population health assessment on the SDOH will necessitate enhanced relationships with agencies in domains such as housing, education, social and economic development, and planning.

Limitations

Although more than 60% of Ontario public health units responded to this survey, conclusions may be limited by systematic differences between participants and health units that chose not to respond. Similarly, although a health unit's staff could collaborate to answer the survey, a particular respondent may not be aware of all of the actions in which their health unit is engaged to address the social determinants of health. To prompt complete answers, most of the questions allowed respondents to select more than one option. Despite many areas of apparent consensus between participating health units, the large diversity of geography, population, and resources across health unit catchments can limit the appropriateness or feasibility of a particular action to address the social determinants of health.

Conclusions

Although there was some clustering of answers on actions that public health units are taking on the SDOH, there was also a large range, which suggests that health units may obtain new ideas to augment their current activities by reading the breadth of activities of their peers.

Health units are engaged with a wide variety of community partners. These examples might also spark some new opportunities for coalition building or programming.

The array of tools used in practice by responding health units could form a useful library for practitioners. It is likely that not everybody working on the SDOH is aware of every listed resource, so the compendium created by this survey should be disseminated broadly. The development of a tool box and an electronic portal would aid in sharing resources, tools, practices and in knowledge brokering.

The language and concepts around the SDOH are complex. Some respondents noted that simple language needs to be created to communicate these large ideas to different audiences. However, there seems to be some discrepancies among health units' understanding of "the population health approach". Some respondents reported a focus on priority populations as contradictory to population health. This suggests that there is room for developing or disseminating common definitions and understanding of the constructs of population health and the SDOH.

This report describes public health engagement in the provincial poverty plan. This survey summary is the only report of its kind detailing local public health activity with provincial poverty reduction initiatives and therefore can inform the provincial government, the Ontario Agency for Health Protection and Promotion, the OPHA, alPHa, Council of Medical Officers of Health (COMOH), Boards of Health and all Ontario health units.

A possible role for public health includes building community capacity for policy advocacy, which could involve a number of community enabling activities.

Systematic and coordinated assistance to health units to advance their work on reducing social inequities in health can involve concrete services and items such as knowledge brokering services, specific implementation strategies and tools or checklists and infrastructure to share information. Respondents specifically mentioned health equity impact assessments, social equity lenses for policy, and program development.

Sources for some of the "social" data that are determinants of health inequities lie in sectors outside of health. Therefore, improving surveillance and population health assessment on the SDOH will necessitate enhanced relationships with agencies in domains such as housing, education, social and economic development, and planning.

Next Steps

- The report will be shared with all Ontario health units.

- This report will be widely disseminated to the public health community, including the Chief Medical Officer of Health, the Ministry of Health Promotion and Sport, the Ministry of Health and Long-Term Care, the Ministry of Education, the Ministry of Children and Youth Services, the Ontario Agency for Health Protection and Promotion, alPHa, COMOH, Boards of Health and OPHA. The Joint Working Group on Social Determinants of Health will seek opportunities for discussion of system-wide supports to advance local health unit and public health professional associations' work on reducing social inequities.

- The Joint Working Group on Social Determinants of Health will request a meeting with the Chief Medical Officer of Health to discuss public health practice implications arising from this report.

- The Joint Working Group on Social Determinants of Health will request a meeting with the Minister responsible for Ontario's Poverty Reduction Strategy to discuss and highlight the significant actions of public health to mitigate or eliminate social conditions that produce inequities in health.

Appendix A – Survey Questions

1. For which of the following health units do you work?

2. To what extent do you agree that the following are roles for public health units in taking action on the social determinants of health (SDOH)?

    - Assess and report on the determinants of health in populations including the existence and impact of health inequalities and inequities
    - Modify public health interventions to meet the unique needs and capacities of priority populations
    - Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs
    - Support the community and other stakeholders in policy advocacy for improvements in the determinants of health

3. In addition to those listed in Question #2, do you believe there are additional important roles for public health units in taking action on the SDOH?

4. Please identify examples of public health action (practice, policy, and/or research) your health unit has taken to address the SDOH in each of the four areas below:

    (1) Assess and report on the determinants of health in populations including the existence and impact of health inequalities and inequities
    (2) Modify public health interventions to meet the unique needs and capacities of priority populations
    (3) Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs
    (4) Support the community and other stakeholders in policy advocacy for improvements in the determinants of health

    These examples could include action that addresses the determinants of health as a whole, the framework, or individual determinants alone or in combination. Please provide specific example(s) – (e.g., name/type of initiative, name of project leader, name of report, etc.)

5. In which of the following areas does your health unit need the most support? Please rank the four roles according to how much your health unit would benefit from additional support. (1 = would benefit the most from support in this area, 4 = would benefit the least from support in this area)

    (1) Assess and report on the determinants of health in populations including the existence and impact of health inequalities and inequities
    (2) Modify public health interventions to meet the unique needs and capacities of priority populations
    (3) Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs
    (4) Support the community and other stakeholders in policy advocacy for improvements in the determinants of health

6. Please list any practice tools, strategies or other resources that you are aware of and think would be helpful to other public health units' work to address the SDOH? (where possible - include the name and how to access)

7. What are the key challenges/needs/gaps for public health units/staff to better address the SDOH?

    - Stronger organizational/system leadership? (e.g. explicit expectations for public health units to address SDOH; identification of SDOH action as priority; resource allocation targeted to SDOH work)
    - Education/training/skill development of the existing and future workforce? (e.g. in applying SDOH-based frameworks and tools; conducting SDOH-based analysis; establishing priorities)

- External partnerships? (e.g. skills to engage partners; areas for joint action)
- Organizational routines to address SDOH in program planning cycles? (e.g. application of equity lens to steps of planning cycle; integrating SDOH activities into organization)
- Other (please specify)

8. From the list below, rank the top 3 items which would be of greatest assistance to strengthen public health organizations'/systems' actions to address the SDOH? (please rank only 3)

    - Case studies of public health organization's actions to address SDOH
    - Summaries of existing evidence on the relationship between SDOH and particular health outcomes (e.g., equity focused Health Impact Assessments)
    - Tools/checklists for addressing SDOH (e.g., Health Impact Assessment, program planning framework; conducting situational/needs assessments)
    - Knowledge brokering service (provision of best practice advice tailored to local context)
    - A support structure for sharing of information and issues among public health staff/organizations (e.g., networks; communities of practice)
    - Key messages/tools for engaging internal and external stakeholders (Including Boards of Health)
    - Mentoring by experienced peers
    - Steps/strategies to move from awareness to action
    - Other (please specify)

9. The purpose of the Joint Work Group on the Social Determinants of Health is to foster improvements in social inequities in health for the population of Ontario, applying the following strategic approaches:

    (1) Promoting the inclusion of activities to address the social and economic determinants of health within the mandate of local public health units in Ontario;
    (2) Identifying, recommending and supporting the provincial advocacy efforts of alPHa and OPHA for improvements in inequities in health; and
    (3) Monitoring advocacy efforts and policy changes at the provincial and national level that impact inequities in health.

    Given this purpose, which of the items listed in Question #8 do you think the Joint Work Group should endeavor to provide? Check all that apply.

    - Case studies of public health organization's actions to address SDOH
    - Summaries of existing evidence on the relationship between SDOH and particular health outcomes (e.g., equity focused Health Impact Assessments)
    - Tools/checklists for addressing SDOH (e.g., Health Impact Assessment, program planning framework; conducting situational/needs assessments)
    - Knowledge brokering service (provision of best practice advice tailored to local context)
    - A support structure for sharing of information and issues among public health staff/organizations (e.g., networks; communities of practice)
    - Key messages/tools for engaging internal and external stakeholders (Including Boards of Health)
    - Mentoring by experienced peers
    - Steps/strategies to move from awareness to action
    - Other (please specify)

10. Has addressing the SDOH been identified as a priority in your health unit's strategic plan?

11. Describe any efforts by your health unit to identify local priority populations in each of the following program areas:

    - Chronic Disease Prevention
    - Prevention of Injury and Substance Misuse
    - Reproductive Health
    - Child Health

- Infectious Disease Prevention and Control
- Rabies Prevention and Control
- Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections (including HIV)
- Tuberculosis Prevention and Control
- Vaccine Preventable Diseases
- Food Safety
- Safe Water
- Health Hazard Prevention and Management
- Public Health Emergency Preparedness

12. What challenges exist in reaching priority populations and in which program areas?

13. Describe any advocacy efforts by your health unit related to the SDOH (e.g.: “Put Food in the Budget”).

14. Which types of community partnerships (e.g. education, business, political, NGOs, health, etc.) is your health unit involved with to address the SDOH? Describe the extent of this involvement.

15. Which of the following programs does your health unit deliver? Check all that apply. (A description of these programs can be found on pages 8-11 of "Ontario's Poverty Reduction Strategy.")

    - Healthy Babies Healthy Children
    - Free vaccination/immunization programs
    - Blind-Low Vision Programs
    - Pre-School Speech/Language Programs
    - Infant Development Programs
    - Infant Hearing Programs
    - Children in Need of Treatment (CINOT) or other dental programs

    What challenges does your health unit face in delivering these programs to meet the needs of priority populations?

16. Which of the following best describes your health unit’s involvement in the early learning programs below? Check all that apply. (A description of these programs can be found on page 9 of "Ontario's Poverty Reduction Strategy.")

    - Ontario Early Years Centres
    - Parenting and Family
    - Literacy Centres
    - Full day learning for four and five-year-olds

    If you selected "other" for any of the above, please describe your involvement.

17. Which of the following best describes your health unit’s involvement in the school programs below? Check all that apply. (A description of these programs can be found on pages 10-13 of "Ontario's Poverty Reduction Strategy.")

    - Student Nutrition Program
    - Healthy Schools Strategy
    - After School Activities and Programs
    - Mental Health and Addictions Strategy
    - Youth Opportunities Strategy (YOS)
    - Literacy and Numeracy
    - Secretariat (LNS) though the Ontario Focused Intervention Partnership (OFIP)
    - Student Success Teams
    - Safe Schools Action Team
    - Access to School Activities
    - Parent Engagement Office

    If you selected "other" for any of the above, please describe your involvement.

18. Which of the following best describes your health unit's involvement in the community programs below? Include activities that you would consider to be supportive of these initiatives. Check all that apply. (A description of these programs can be found on page 20 of "Ontario's Poverty Reduction Strategy.")

    - Community Use of Schools
    - Focus on Youth partnership
    - Community Hub Program

    If you selected "other" for any of the above, please describe your involvement

19. Please describe your involvement in any other programs related to Ontario's Poverty Reduction Strategy.

20. Has your health unit been involved in projects funded by any of the following? Check all that apply. (A description of these programs can be found on page 12 of "Ontario's Poverty Reduction Strategy.")

    - Learning Opportunities Grants
    - Urban and Priority High Schools
    - Parents Reaching Out Grants
    - Community Opportunities Fund

    For those selected, please describe the project/s.

21. For the following initiatives, health units are unlikely to be directly involved, but may have an advocacy role. The initiatives below were identified in "Ontario's Poverty Reduction Strategy."

    For which of the following initiatives has your health unit advocated (e.g., formal Board statements, input of staff members to community consultations, direct advocacy as a health unit only, or indirectly as part of a community network). Check all that apply.

    - Student assistance programs (grants, loans, etc.)
    - Skills to Job Action Plan
    - Increase minimum wage
    - Hire new Employment Standards Officers
    - New legislation to improve access to temporary help agencies
    - Increase funding for the Provincial Rent Bank Program
    - Expand OSIFA loan eligibility
    - Develop long-term affordable housing strategy
    - Post-secondary earnings exemption
    - Extend Up-Front Child Care Benefit
    - Extend time period to request internal review
    - Creation of an independent Social Policy Institute
    - Development of Sustainable Procurement Strategy
    - Social Innovation Generation (SiG)
    - Development of Social Venture Capital Fund

22. Does your health unit use any of the following measures to inform their work? Check all that apply.

    - Early Development Instrument (School Readiness)
    - EQAO Score (Educational Progress)
    - Graduation Rates (High School Graduation Rates)
    - Healthy Birth Weights (Birth Weights)
    - Low Income Measure: 40% (Depth of Poverty)
    - Low Income Measure: 50% (Low Income Measure)
    - Housing Measure (Ontario Housing Measure)
    - Deprivation Index (Standard of Living)
    - Other (please specify)

23. For the measures in question #22 that you are currently using, please describe how they are used to inform your work (e.g., for what specific interventions?).

24. How many people from your health unit were involved in the completion of this survey?

25. Which of the following positions were involved with the completion of this survey? Check all that apply.

26. Who is involved in work related to SDOH at your health unit? Check all that apply.

    - SDOH work is integrated into all program areas
    - There is a lead for SDOH work in each program area
    - SDOH work is primarily done by a steering committee
    - There is a designated staff member who works on SDOH (indicate the position/title below)

Appendix B – Tools and Resources

"25 in 5" Network for Poverty Reduction
http://www.25in5.ca/aboutus.html

Bambra, Gibson, Sowden, Wright, Whitehead & Petticrew (2010). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. J Epidemiol Community Health, 64:284-291
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921286/?tool=pubmed

Best Start Resource Center: How to Work with Series
- Rural Populations http://beststart.org/resources/howto/pdf/rural_manual_fnl_web.pdf
- Francophones http://www.beststart.org/resources/howto/pdf/Francophones_manual_en.pdf
- Populations at Higher Risk http://www.beststart.org/resources/howto/pdf/HowTOGuide_2c.pdf
- Working with Youth http://www.beststart.org/resources/howto/pdf/YOUTH.pdf
- Working with Coalitions http://www.beststart.org/resources/howto/pdf/COALITIONS.pdf

Bridges Out Of Poverty Training
http://www.ahaprocess.com/Community_Programs/

City of Toronto Public Health
- Staff Diversity Training Curriculum (available upon request) http://www.toronto.ca/health/
- Practice Framework (available upon request) http://www.toronto.ca/health/

Do the Math
http://dothemath.thestop.org/dothemathchallenge.php

European Portal for Action on Health Equity: DETERMINE
http://www.health-inequalities.eu/

Hamilton Public Health Services Position Statement on the Social Determinants of Health (2009)
http://www.hamilton.ca/NR/rdonlyres/B9A5AD7E-CB58-4BA3-8F5D-1F5D51A54233/0/Apr27BOH09008SocialDeterminantsofHealthPositionStatement.pdf

Health Canada
- Lalonde Report (1973-1974) http://www.hc-sc.gc.ca/hcs-sss/com/fed/lalonde-eng.php
- Determinants of Health Working Group Synthesis Report http://www.hc-sc.gc.ca/hcs-sss/pubs/renewal-renouv/1997-nfoh-fnss-v2/legacy_heritage4-eng.php

Health Nexus: The Social Determinants of Health – 25 resources to support your work
http://www.healthnexus.ca/events/25th_anniversary/november.html

iEngage Bullying Prevention
http://www.iengage.ca/iengage/home

Institut national de santé publique du Québec (INSPQ)
http://www.inspq.qc.ca/english/default.asp

Invest in Kids
http://www.investinkids.ca/

Lambton Circles

http://www.lambtoncircles.com/

Middlesex London Health Unit

- Adventures in…Sex City (Sex Squad) http://www.healthunit.com/sectionList.aspx?sectionID=378
- RUCS Protocol (Routine Universal Comprehensive Screening for Woman Abuse) http://www.healthunit.com/articlesPDF/10819.pdf

Motivational Interviewing

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1463134/

Moving Forward

http://www.womenmovingforwardcanada.org/index.php?option=com_content&view=section&id=31&Itemid=76

National Collaborating Centers

- Healthy Public Policy http://www.nccph.ca/en/index.aspx?sortcode=2.0.1.5.7
- Determinants of Health http://nccdh.ca/
- Aboriginal Health http://www.nccph.ca/en/index.aspx?sortcode=2.0.1.5.6
- Methods and Tools http://www.nccmt.ca/
- World Health Organization: Commission on Social Determinants of Health - final report http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

National Collaborating Centre for Determinants of Health

http://www.nccdh.ca/index.html

National Institute of Building Sciences: Planning and Conducting Integrated Designs Charrettes – For example a Community Gardens Integrated Design Charrette (focus group)

http://www.wbdg.org/resources/charrettes.php

North Bay Parry Sound District Health Unit and North Bay and Area Social Planning Council

- "Poverty Reduction in Nipissing District: Perspectives and Priorities" May 2008 http://www.healthunit.biz/docs/Reports/PCWG%20POVERTY%20REPORT%20-%20Final%20(2).pdf
- "Poverty in Our Community: An Unsettling Reality" (video), November 2009 http://www.northbayandareaspc.com/resources.html
- "Ontario's Long-Term Affordable Housing Strategy", December 2009 http://www.northbayandareaspc.com/resources.html
- "Poverty Fact Sheet" February 2010 http://www.northbayandareaspc.com/resources.html
- "The District of Parry Sound Speaks Out on Poverty: A Call to Action", June 2010 http://www.healthunit.biz/docs/Reports/dpsprn_June_2010.pdf

North Western Health Unit

- Health Equity Lens – draft (available on request) http://www.nwhu.on.ca/
- Rationale Document ((available on request) http://www.nwhu.on.ca/

Nutritious Food Basket Protocol (2008)

http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/nutritious_food_basket.pdf

Nutritious Food Basket Survey Final Report (2007)

http://www.alphaweb.org/docs/lib_011550748.pdf

Offord Center for Child Studies, McMaster University: The Social Risk Index
http://www.apheo.ca/resources/events/2010/Session4B%20-%20Raos.pdf

Oliver S., Kavanagh, J., Caird, J., Lorenc, T., Oliver, K., Harden, A., Thomas, J., Greaves, A., Oakley A. (2008). Health Promotion, inequities and young people's health: A systematic review of research. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=2410

Ontario Agency for Health Protection and Promotion
- Dialogue on Reducing Health Inequities http://www.oahpp.ca/fr/resources/documents/presentations/2010apr27/Dialogue%20on%20Reducing%20Health%20Inequities%20Dr%20Heather%20Manson.pdf
- Health in All Policies Roundtable http://www.oahpp.ca/about/calendar/20100924.html
- Public Health Dental Symposium: Protecting, Promoting, and Building Equity in Oral Health in Ontario http://www.oahpp.ca/resources/documents/presentations/2010mar30/3_Quinonez.pdf

Ontario Health Promotion E-Bulletin
http://www.ohpe.ca/

Ontario Ministry of Education: Elementary and Secondary School profiles
- http://www.edu.gov.on.ca/eng/sift/schoolProfile.asp?SCH_NUMBER=165484&x=12&y=15
- http://www.edu.gov.on.ca/eng/sift/schoolProfileSec.asp?SCH_NUMBER=914010&x=15&y=18

Ontario Society of Nutrition Professional in Public Health (OSNPPH)
www.osnpph.on.ca

OPHA Food Security work group: Various resources
http://www.opha.on.ca/our_voice/workgroups/food_security.shtml

Patychuk & Seskar-Hencic. (2008). First Steps to Equity: Ideas and strategies for health equity in Ontario, 2008-2010.
www.healthnexus.ca/policy/firststeps_healthyequity.pdf

Perth District Health Unit
- Terms of Reference of SDOH Committee (available upon request) http://www.pdhu.on.ca/
- Logic Model and Operational Plan - Poverty and Health Program (available upon request) http://www.pdhu.on.ca/

Province of Ontario: With Our Best Future in Mind, Charles Pascal, Special Advisor on Early Learning
http://www.ontario.ca/en/initiatives/early_learning/ONT06_018865

Public Health Agency of Canada
http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php
http://www.phac-aspc.gc.ca/ph-sp/determinants/link-con-eng.php#related

Reeve & Rossiter. (2007). The Last Straw: A Board Game on the Social Determinants of Health
http://www.thelaststraw.ca/

Region of Waterloo Public Health

- Access and Equity Review Tool – Appendix E
  http://www.region.waterloo.on.ca/web/health.nsf/vwSiteMap/88EA895777E8A8AC8525717E0066B449/$file/Access&Equity.PDF?openelement
- Why We Need to Work with Priority Populations and How this Relates to Population Health
  http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds%5Cpdfs%5Cpopulation_healthy_summary.pdf
- A Process to Determine Priority Neighbourhoods http://www.region.waterloo.on.ca/phpdf/Link4.pdf
- Evidence and Practice-based Planning Framework with a focus on health inequities
  http://www.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/$file/EPPF_maindoc.pdf?openelement
- Tobacco Treatment for new Canadians
  http://www.otru.org/pdf/learn/LEARN_Tobacco_Treatment_for_New_Canadians.pdf
- Project Health Toolkit http://www.projecthealth.ca/

Region of Waterloo Public Health and the OPHA Access and Equity Social Justice Committee
How do I address health inequities in my program development?
http://www.opha.on.ca/resources/docs/OPHA-HealthInequitiesWkshp.pdf

Registered Nurses' Association of Ontario: Best Practice Guidelines
http://www.rnao.org/Page.asp?PageID=861&SiteNodeID=133
http://www.rnao.org/Storage/12/655_BPG_Women_Abuse.pdf

Results Based Accountability
www.raguide.org

Smoking Cessation: TEACH model
http://www.teachproject.ca/about.htm

Sudbury & District Health Unit

- Local Public Health Practices to Reduce Social Inequities in Health Progress Report 2
- http://www.sdhu.com/uploads/content/listings/EXTRAProgressReport2SDHUJuly2009_External.pdf
- Local Public Health Practices to Reduce Social Inequities in Health Final Report
- http://www.sdhu.com/uploads/content/listings/FINALIPPRSDHUMay2010.pdf
- OPHS Planning Path Pilot Version 2010
- http://www.sdhu.com/uploads/content/listings/OPHSPlanningPathPublicVersion_Feb2010.pdf
- Determinants of Health Position Statement (2005)
- http://www.sdhu.com/uploads/content/listings/PositionStatement_DeterminantsofHealth_May2005a1.pdf
- Overview of the Health Equity Mapping Project
- http://www.sdhu.com/uploads/content/listings/OverviewoftheHealthEquityMappingProject_January2009_Final.pdf

The Canadian Nurses Association

- Position Statement on Determinants of Health
- http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS_Determinants_of_Health_e.pdf
- Social Determinants of Health and Nursing
- http://www.cna-aiic.ca/CNA/documents/pdf/publications/BG8_Social_Determinants_e.pdf

The Institute of Public Health in Ireland (2008): Reports
http://www.publichealth.ie/iphwork/policyandprogrammedevelopmentandevaluation/healthinequalities

Tri-County Dental Health Coalition – Volunteer Dental Program
http://www.dentalhealthcouncil.org/programs.html

World Health Organization

- Closing the gap in a generation: Health equity through action on the social determinants of health http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
- Social Determinants Themes (former Knowledge Networks) http://www.who.int/social_determinants/themes/en/index.html

Wellesley Institute

- Health Equity Impact Assessment - A Tool for Driving Equity into Action http://www.slideshare.net/WellesleyInstitute/health-equity-impact-assessment-a-tool-for-driving-equity-into-action-may-182010-4156165
- Social Determinants of Health for Health Inequities - A Road Map for Health Equity http://www.slideshare.net/WellesleyInstitute/social-determinants-of-health-inequalities-into-policy-action

York University

- Social Determinants of Health listserv https://listserv.yorku.ca/archives/sdoh.html
- Health Promotion on the Internet listserv (Click4HP) https://listserv.yorku.ca/archives/click4hp.html

Appendix C – Glossary of Acronyms, Terms, and Public Health Programs

Best Start

Best Start is an initiative of the Government of Ontario. It is a plan to strengthen healthy development, early learning and child care services during a child's first years so that children are ready to learn by the time they start Grade 1.

Board of Health

A Board of Health is established under the Health Protection and Promotion Act, 1990. The Board receives its authority under this Act and superintends, provides, or ensures the provision of the health programs and services required by this Act.

CINOT [Children in Need of Treatment Program]

CINOT is a program of the Ontario Ministry of Health Promotion and Sport. This program is administered by Boards of Health and provides emergency dental care and out-of-hospital anesthetic coverage for low-income children aged 17 years and under.

CAPC [Community Action Program for Children]

CAPC is jointly managed by the federal government and provincial /territorial governments. CAPC provides funding to deliver programs that address the health and development of children (0-6 years) who are living in conditions of risk.

CPNP [Canada Prenatal Nutrition Program]

CPNP is a federally funded program that funds community groups to develop programs for vulnerable pregnant women to reduce health disparities.

CAS [Children's Aid Society]

Each of Ontario's 53 Children's Aid Societies provides child protection services as governed by the Child and Family Services Act.

Food Security

Food security exists when people have access to adequate, safe, affordable, nutritious food to meet dietary needs and food preferences. Food security is a basic human right of individuals and communities, and connects us to our families, our cultures, and our traditions. Promotion of food security requires a comprehensive approach that includes all components of the food system, from producers to consumers, and promotes regional food self-reliance.

HBHC [Healthy Babies Healthy Children]

The Healthy Babies Healthy Children program is funded by the Ministry of Health and Long-Term Care, Government of Ontario. The program is delivered by all 36 public health units and offers families with newborns information on parenting and child development and connects families with community services, as needed.

Healthy Communities Fund – Partnership Stream

The Healthy Communities Fund is an initiative of the Ministry of Health Promotion and Sport, Government of Ontario. The Fund has three components, including the Partnership Stream. This Fund provides resources for community priority setting and mobilization for policy change and creates an environment that promotes health. The priority areas of focus include physical activity, injury prevention, healthy eating, mental health, reducing tobacco use and exposure, and preventing alcohol and substance misuse.

LHIN [Local Health Integration Network]

In Ontario health care services are planned, funded and managed through LHINs. The authority to manage local health systems is through the Local Health System Integration Act, 2006. LHIN mandates, however, do not include public health or physician resources.

MOH [Medical Officer of Health]

Medical officers of health uphold provincial public health legislation and oversee the administration and delivery of public health services in their jurisdiction.

MOHLTC [Ministry of Health and Long-Term Care]

The Ministry of Health and Long-Term Care is frequently referred to as the Ministry of Health.

Make Poverty History

Make Poverty History is part of the "Global Call to Action against Poverty". The Make Poverty History campaign was launched in Canada in 2005.

25 in 5 Network

With a goal of reducing poverty by 25% in five years, this Network for Poverty Reduction consists of more than 100 Toronto and provincially-based individuals and organizations with a goal of poverty elimination.

Nutritious Food Basket

The Nutritious Food Basket is a standardized food costing tool that measures the real cost of healthy eating. Ontario public health units collect data from grocery stores each year to monitor the cost of eating nutritious food. The data is part of the Ontario Public Health Standards. The information is used to support and promote the development of food security policies.

OAHPP [Ontario Agency for Health Protection and Promotion]

The OAHPP was established under the authority of the Health System Improvements Act, 2007. The OAHPP provides research, scientific, and technical advice and support to protect and promote the health of Ontarians and reduce inequities in health.

OHIP [Ontario Health Insurance Plan]

OHIP is a provincially funded health coverage plan available to Ontario residents.

OPHS [Ontario Public Health Standards]

The OPHS are the guidelines for the provision of mandatory public health programs and services. These guidelines are provided to Boards of Healthy by the Minister of Health and Long-Term Care under the authority of the Health Protection and Promotion Act, 1990.

OW [Ontario Works]

Under the authority of the Ontario Works Act, OW provides temporary financial assistance and employment assistance to individuals in need in Ontario.

RRFSS [Rapid Risk Factor Surveillance System]

RRFSS is a telephone survey used to gather surveillance data on public health issues in Ontario.

SDOH [Social determinants of health]

The SDOH are those social conditions under which people live and that determine their health. These societal risk conditions rather than individual risk factors include education, income, social inclusion, housing, food security, transportation, etc.

Priority Populations

Priority populations are those population groups at risk of socially produced health inequities.

Service Coordination

Service Coordination Programs provide service coordination, frequently in support of families and individuals with a developmental disability.

Triple P

Triple P is used in reference to the Positive Parenting Program®. Triple P is an evidence-informed program that provides effective parenting support and intervention for families and caregivers in many different circumstances. Triple P has five levels of intervention. Support may be provided through group and/or individual interventions.

Mapping of Poverty Initiatives at MLHU (2011)

APPENDIX D

The following categories were used to complete the inventory of MLHU programs and activities related to poverty.

Name of the Activity/Brief Description

Program- includes components
Activity- stand alone strategies

Lead MLHU Contact:

FHS (Family Health Services)
EHCDPS (Environmental Health and Chronic Disease Program Services)
OHCHSHS (Oral Health Communicable Disease and Sexual Health Services)

Priority Populations[1], [2] (e.g. Population groups experiencing persistent low income based on national and local data)

Recent immigrants and refugee claimants
Lone parent families
Children and youth (age 0-24)
Aboriginal peoples off-reserve
Visible minority status
Work-limited persons living with disabilities or mental illness
Unattached individuals (living alone/with non-relatives)

[1] Percentage of population aged 18-60 in 2002 experiencing persistent low income between 2002 and 2006" table (as cited in Eggleton, A., Segal, H., (2009). *In From the Margins: A Call to Action on Poverty, Housing and Homelessness*. Ottawa: ON: The Standing Senate Committee on Social Affairs, Science and Technology).

[2] Social Research & Planning Unit, City of London. (2008). *London's Anti-poverty Strategy: Literature Review*. London, ON: Author.

Mapping of Poverty Initiatives at MLHU (2011)

How Priority Population was identified: (data sources such as CCHS, RRFSS, stakeholder analysis, observations, community needs assessments-formal or informal, professional judgment, consultations with service providers, other literature)

Comparison to Sudbury District Health Unit's (SDHU's) "10 Promising Practices to Reduce Social Inequities in Health in Public Health"[3]:

1. Targeting with universalism: targeting programs to disadvantaged groups while at the same time improving the health of the entire population
2. Purposeful reporting: on the relationships between health and social inequities in all health status reporting; presenting the evidence about health inequities
3. Social marketing: target audience segmentation and tailoring of interventions, including health communications, to disadvantaged populations to change voluntary practices; change the understanding and behaviour of decision makers and public to take or support action
4. Health equity target setting: Careful development and monitoring of indicators to measure success
5. Equity-focused health impact assessment: structured assessment to capture the health impact of proposed policies and practice; applies an equity lens to assess impact on inequities
6. Competencies/organizational standards: Enhancing the skill set of public health staff; making social inequities a priority for the organization with commitment to intersectoral and community engagement
7. Contribution to evidence base: intentional dissemination of knowledge base on addressing social inequities
8. Early childhood development: the greatest gains are experienced by the most deprived children. It involves a combination of services and policies designed through intersectoral collaboration and includes communities in program planning, implementation etc. Examples include: promotion and support of breast feeding, positive parenting practices, school-based interventions for low-income youth, detection of postpartum depression etc.

   Policy examples include: housing quality, integrated child development services, food security, smoking cessation, elimination of child poverty, promotion of equity between rural and urban areas etc.
9. Community engagement: emphasizes the importance of participation of members of vulnerable populations in problem identification, intervention planning and evaluation
10. Intersectoral action: providing leadership on health issues and working through coalition structures in sectors outside of health

Modifications of activities to meet priority population needs: (e.g. Materials have different literacy levels, languages; input of potential participants sought in planning; delivery site was carefully chosen to ensure physical access; transportation barriers were identified and options offered; child care needs were identified and solutions considered; potential cost barriers identified and managed)

OPHS (Ontario Public Health Standards 2008)

[3] Sutcliffe, P., Snelling, S., Lacle, S. (2009). *Research-Oriented Decision-Making to Guide Local Public Health Practice to Reduce Social Inequities in Health.* EXTRA/FORCES intervention project report 2. Sudbury, ON: Sudbury and District Health Unit.

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
NATIONAL PROGRAMS						
Smart Start For Babies This is a Canada Prenatal Nutrition Program that is administered at MLHU under the auspices of the Public Health Agency of Canada. The program is designed to meet the needs of pregnant women most at risk for poor birth outcomes (e.g. teens) • Intake and assessment • Referral and advocacy • Prenatal skill building • Postnatal skill building • Social support • Outreach strategies	Family Health Services (FHS) Nancy Summers	Lone female parents Children and youth (0-24)	Referrals from Healthy Babies Healthy Children program, shelters, physicians, community agencies Prenatal screens Program promotion	Early childhood development	Provide folic acid supplementation through distribution of free multivitamins Food vouchers, bus tickets Provision of kitchen supplies and education re nutritious cooking Healthy snack at each session Translation of resources	Reproductive Health Health Promotion and Policy Development Requirement #6 Child Health Health Promotion and Policy Development Requirement 5-8
PROVINCIAL PROGRAMS						
Healthy Babies Healthy Children Program (HBHC) HBHC is a prevention/early intervention initiative designed to help families promote healthy child development and help their children achieve their full potential. • PHNs visit families prenatally, postpartum until the age of 6 • PHNs contact all consenting postpartum mothers within 48 hours to offer a home visit or community visit • Liaison PHNs associated with various medical centres and hospitals • Family Home Visitors use skill	FHS Nancy Summers Suzanne Vandervoort Bonnie Wooten	Young families (prenatal/postnatal and preschool) with identified risk factors	Prenatal and postnatal screens and assessments Referral from community agencies, shelters, physicians, OEYCs, self referral etc.	Early childhood development	Multiple resources (e.g. pamphlets, DVDs) have been translated on a variety of topics (e.g. breast feeding) Distribution of Nicotine Replacement Therapy for free along with counseling to high risk families	Reproductive Health Health Promotion and Policy Development Requirement #6 Child Health Health Promotion and Policy Development Requirement # 4-8

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
based strategies to work with high risk families teaching, modeling, mentoring and coaching • Social Worker Project Pilot allowed MLHU to hire a Social Worker to provide services to select HBHC high risk families who required financial assistance, housing, employment and education, and immigration help. • Well Baby and Breast Feeding Clinics- drop in clinics available to all new parents. 16 clinics a week. **HBHC/liaison onsite delivery of services to priority populations** • PHNs meet weekly with clients at an "**Ask a Nurse" Well Baby Clinic in Limberlost neighbourhood** • PHNs meet with adolescent mothers prenatally and postnatally at the **Salvation Army Betheseda Centre** • PHNs meet weekly at **7 Women's Shelters** to provide health teaching, staff consultations, and teaching related infant growth and development, mental and physical health of parents and children etc.		Lone female parents Homeless or precariously housed People living on low incomes	Informal community needs assessment	Targeting with universalism Early childhood development	Distribution of home safety devices to high risk families if need identified Use of translators Social workers Peer mentors Onsite delivery of services Distribution of bus tickets, taxi vouchers to families seeking medical care	Reproductive Health Promotion and Policy Development Requirement #6 Child Health Health Promotion Requirement #8
tyke TALK This program provides speech and language services to children from birth to eligibility for entrance into senior kindergarten in the Thames Valley region. MLHU is the lead agency for the program and houses administrative	FHS Deb Shugar 3 support staff Services contracted	Children	Universally accessed program to all priority populations	Early childhood development	Community or home-based interventions No fees for service	Child Health Health Promotion and Policy Development Requirement # 6-8

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
office.	through multiple agencies					
Infant Hearing Program Southwest Region This program provides universal newborn hearing screening, audiologic assessment and follow-up supports and services to babies identified with permanent hearing loss across SW Ontario (Eligible until entrance into Grade 1). MLHU is the lead agency for the program and houses administrative office.	FHS Deb Shugar 3 support staff	Infants and children living with disabilities	Identified through universal screening and doctor referral	Early childhood development	Community based intervention No fees for service Assistance to obtain funding through Assistive Devices Program Home visit possible if transportation is a major barrier	Child Health Health Promotion and Policy Development Requirement # 6-8
Blind Low Vision Early Intervention Program This program provides early intervention services for children who are blind or have low vision and their families across SW Ontario (Eligible until entrance into Grade 1). MLHU is the lead agency for the program and houses administrative office.	FHS Deb Shugar 3 support staff	Infants and children living with disabilities	Identified through referral	Early childhood development	Community or home-based intervention No fees for service Assistance to obtain funding through Assistive Devices Program Home visit possible if transportation is a major barrier	Child Health Health Promotion and Policy Development Requirement # 6-8
Children In Need of Treatment (CINOT) • Provides essential/emergency dental care to a child's 18th birthday • Includes general anesthesia coverage according to age and dental criteria	Oral Health, Communicable Diseases and Sexual Health Services (OHCDSHS) Joan Carrothers	People living on low incomes Children and youth	Surveillance and assessment protocol	Early childhood development Targeting with universalism	Provide free of charge topical fluoride, fissure sealants, scaling, and care	Child Health Disease Prevention Requirement #12
Healthy Smiles Ontario This new program is for children 17 and under who do not have access to any form of dental coverage. If eligible, no cost dental care is offered to Ontario residents, an Adjusted Family Net	OHCDSHS Joan Carrothers	People living on low incomes	Screened based on financial need	Early childhood development Targeting with universalism	No fees for eligible persons	Child Health Disease Prevention Requirement #12

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
Income of $20,000 or less, no access to dental coverage such as programs. through Ontario Works						
Counterpoint Needle Exchange Harm reduction services	OHCDSHS Shaya Dhinsa	People living on low income Homeless or precariously housed	Community needs assessment	Targeting with universalism	Free equipment for safe drug use	Prevention of Injury and Substance Misuse Health Promotion and Policy Development Requirement # 3
Free Vaccinations **Outreach clinics to priority populations** • Public health nurses will provide influenza clinics at various women and men's shelters in the fall.	OHCDSHS Marlene Price FHS Julie German (NP), PHNs	Homeless or precariously housed	Observation Community needs assessment	Targeting with universalism	Provision of free vaccines according to provincial eligibility criteria. e.g. HPV for all Grade 8 females, Hepatitis B for all Grade 7 students, many childhood vaccines	Vaccine Preventable Diseases Disease Prevention Requirement #7
• Public health nurses and the Nurse Practitioner provide influenza clinics at Limberlost and South London Community Centre.	FHS Julie German (NP), PHNs	People living on low incomes	Community needs assessment	Early childhood development	No health card required at immunization clinic Multiple annual influenza clinics throughout city and county with evening hours	
• Accessibility to disabled	PHNs	Persons living with disabilities		Targeting with universalism	Drive-thru option for influenza clinic	
• Outreach to several city and county group homes to screen and provide immunization to	PHNs	People with limited education		Early childhood development		

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
youth.						
Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol • Client's health assessment/risk review • STI, contraception counselling • Provision of counselling, diagnosis, treatment, and management of STIs • Pregnancy tests and comprehensive pregnancy counselling	OHCDSHS Shaya Dhinsa PHNs			Universal program	Provision of provincially funded drugs including low cost birth control, free condoms, morning after pill	Sexual Health, Sexually Transmitted Infections, and Blood-borne infections Requirements # 7-12
Outreach to priority populations with education • Presentations on sexual health issues (e.g. Elgin-Middlesex Detention Centre, CAS, London Intercommunity health Centre, Girl Guides (East end), Smart Start, variety of multicultural groups	PHNs	People living on low income Recent immigrants Homeless or precariously housed Unattached individuals	Consultations with service providers	Targeting with universalism Intersectoral actions	Free condoms	Sexual Health, Sexually Transmitted Infections, and Blood-borne infections Requirement #11
Onsite clinic services at South London Housing Complex **Bi-weekly clinic** to provide STI counselling, family planning counselling.	PHNs	People living on low incomes Recent immigrants	Community needs assessment	Targeting with universalism	Bus tickets Low cost birth control Referral	Sexual Health, Sexually Transmitted Infections, and Blood-borne infections Disease Prevention/Health Protection Requirement #7
Sexual Health Clinic at Montcalm Secondary School Part of a comprehensive strategy to address the sexual health needs of students. Set to commence May 2011.	PHNs Includes Jane Beradini from Young Adult Team/FHS	Vulnerable youth	Community needs assessment	Targeting with universalism	Referral Free condoms	Child Health Health Promotion and Policy Development Requirement # 8 Sexual Health Requirement #5, 6

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
Having a Baby Day Event held at St. Joe's for at risk youth in secondary schools.	Includes PHNs from Young Adult Team/FHS	Vulnerable youth	Identified by PHN or school personnel	Targeting with universalism	Free event	Sexual Health Requirement #5, 6
Nutritious Food Basket Protocol This survey is conducted annually in May as per protocol developed by the Ministry of Health and Long-Term Care. The MLHU dietitian includes the cost of basic needs such as shelter, transportation, personal care items, and clothing.	Environmental Health and Chronic Disease Program Services (EHCHPS) Ghezal Sabir	People living on low incomes		Purposeful reporting		Foundational Standard #3 Chronic Disease Prevention # 2,7
MLHU ACTIVITIES **Ensure the development and implementation of a youth engagement approach when working with at risk or marginalized youths and young adults.**	FHS Christine Preece Jacqueline Lindfield EHCDPS Linda Stobo Amy Yateman	Adolescents and Young Adults	Observations Research Literature	Community engagement Social marketing Universalism Early childhood development	Cost barrier removed One to one counselling Small group work Advocacy for marginalized youth Directly link youth to social and health agencies Non marginalized youth advocating for marginalized youth	Chronic Disease and Injuries Requirements: #6,7,8,10 Prevention of Injury and Substance Misuse Requirement #3 Child Health Health Promotion and Policy Development Requirement: # 4,5,7,8
Provide education and skill building opportunities for high risk youth at St. Leonard's (youth involved with criminal justice system). Directly link youth to health and clinic services at MLHU.	FHS Graham Smith Jacqueline Lindfield	Unattached youth involved with criminal system	Research Literature	Health Equity Target Setting Community engagement Early childhood development	Cost Barrier removed Multiple Services Interpersonal Skill Development	Chronic Disease and Injuries Requirements: #6,7,8,10 Prevention of Injury and Substance Misuse Requirement

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
						#3 Child Health Health Promotion and Policy Development Requirement: # 4,5,7,8
Provide education and skill building opportunities for street and homeless youth at Youth Opportunities Unlimited (youth centre) and Next Wave (Strathroy satellite office). Directly link youth to clinic services at MLHU.	FHS Jacqueline Lindfield Pat O'Connor	Transient youth	Observations Research Literature	Health Equity Target Setting Community engagement Early childhood development	Cost Barrier removed Multiple services Life skill development	Chronic Disease and Injuries Requirements: #6,7,8,10 Prevention of Injury and Substance Misuse Requirement #3 Child Health Health Promotion and Policy Development Requirement: # 4,5,7,8
Support snack/meal programs in schools	FHS Chris Callaghan	People living on low income	observations	Intersectoral action Early childhood development	Cost barrier removed	Chronic Disease Prevention Health Promotion and Policy Requirement # 3,8 Child Health Health Promotion and Policy Development Requirement # 8
Community gardens for diverse groups e.g. Spanish and Arabic • The Local Food Project worked in partnership with the London Community Resource Centre • MLHU staff provided consultation and financial support	FHS Lynn Prentice/Ginette Blake	Recent immigrants People living on low income	Observation Research literature City of London statistics	Community engagement Intersectoral action	Materials have different literacy levels, languages Transportation barriers were identified and options offered Potential cost barriers identified and managed	Foundational Standard #4 Child Health Requirement #4b, 5,7, 8
Develop best practices for healthy eating in youth group home settings related to food skills, food skill	FHS Chris	Unattached individuals living in group	Observation Research Literature	Intersectoral action Contribution to	Direct training to youth and staff Gaps in services	Chronic Disease prevention Requirement # 7,

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
development, food prep, equipment, and other aspects of cooking in a group home environment.	Callaghan Heather Thomas	homes (vulnerable youth)	Consultations with service providers Community needs assessment	evidence base Early childhood development	identified and addressed Will modify accordingly	8,12 Child Health Requirement #4,6, 7,8
Parenting support for Muslim population Work with Muslim Resource Centre, London Muslim Mosque, Centre for Addiction and Mental Health Planning a community needs assessment to address pre-migration trauma and parenting.	FHS Lynn Prentice Kristina Nairn	Recent immigrants	City of London statistics Consultations with service providers	Targeting with universalism Intersectoral action Community engagement	Program will be developed to address identified needs of Muslim population	Child Health Requirement #4-8
Speech pathologist provides assessment and referral at Rotholme women's shelter and family shelter on a monthly basis.	FHS Deb Shugar	Homeless or precariously housed	Consultations with service providers	Targeting with universalism Early childhood development	Onsite assessment and referral	Child Health Health Promotion and Policy Requirement #7,8
Provide **clinical outreach services** to vulnerable populations in the city and county eg. at risk. Family Health Clinics have existed since 2009. Includes a Primary Health Care Nurse Practitioner, Public Health Nurses, Registered Dietitians, and Lactation Consultants. Goal: to improve access for young families to receive health care, education about healthy lifestyles, and to improve their knowledge about healthy growth and development, developmental norms and community resources. Over 10% of the visits in 2009 were comprised of landed immigrants, visitors and refugees who did not have an OHIP card or Family Physician.	FHS Julie German	People living on low income Recent immigrants and refugee claimants	Community needs assessment	Targeting with universalism Early childhood development	Provides services at a variety of locations throughout London and Middlesex, 5 days a week.	Reproductive Health Health Promotion and Policy Development Requirement # 4,5,6 Child Health Health Promotion and Policy Development Requirement # 6, 7, 8
Parenting for ESL parents	FHS Muriel Abbott	Recent immigrants and refugee	Consultations with service providers	Targeting with universalism Early childhood	Interpretative services available Low literacy	Child Health Health Promotion and Policy Development

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
		claimants People with limited education	e.g. referrals from Settlement Workers in schools	development	materials Offered in neighbourhood schools Free of charge Different program levels based on needs	Requirement #8
Ending Poverty Neighbourhood Demonstration Project Led by the Education, Literacy & Employment, Training and Targeted Strategies Working Group of the Child and Youth Network The poverty reduction strategy aims to assist students through the transition years from grade 8 to grade 9 and helps them graduate from secondary school. By utilizing a comprehensive whole school approach, the project assists youth in grade 7 and supports them with their transition years through grades 8 and 9. The aim of the project is to keep the youth from entering poverty by helping them achieve positive educational outcomes which then in turn can result in engagement in the workforce.	FHS Christine Preece Jennifer Martino Community Development Coordinator	Children with identified risk of entering poverty (low academic scores, special needs, low income, mental health and behavioural issues)	Literature Research Community statistics	Targeting with universalism Community engagement Intersectoral action Health equity target setting Social Marketing Early childhood development		Chronic Disease and Injuries Requirements: #6,7,8,10 Prevention of Injury and Substance Misuse Requirement #3 Child Health Health Promotion and Policy Development Requirement: # 4,5,7,8
Health Promoting School approach to risk/priority students and schools In-depth consultations provided. The health promoting school approach contributes to health promotion goals of equity and empowerment by ensuring that students attain the knowledge and skills required for lifelong learning, work and citizenship.	FHS Christine Preece Heather Lokko Lead agency for CYN-strategic activity of poverty agenda	Elementary and Secondary school aged children	Research Literature Observations	Targeting with universalism Social Marketing Community engagement Intersectoral action Early childhood development	Cost barriers removed Free transportation when deemed necessary MLHU will supplement nutrition campaigns with healthy food samples if necessary	Chronic Disease and Injuries Requirements: #6,7,8,10 Prevention of Injury and Substance Misuse Requirement #3 Child Health Health Promotion and Policy Development Requirement: # 4,5,7,8

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
Youth Creating Healthy Communities **Objective:** To provide youth with social support networks that provide support, encouragement and a positive influence in all levels of their lives – individually, neighbourhood, city-wide and in broader systems. A youth led committee is creating action plans to address vulnerable youth issues.	FHS Jacqueline Lindfield	Adolescents and young adults living on low income	Vulnerable Youth Research Report	Community engagement Intersectoral action Early childhood development	Transportation provided Approaching youth where they are	Chronic Disease and Injuries Requirements: #6,7,8,10 Prevention of Injury and Substance Misuse Requirement #3 Child Health Health Promotion and Policy Development Requirement: # 4,5,7,8
Teen Prenatal 6 classes per session. Offered 4 times a year in conjunction with Smart Start for Teens. Provides overview of healthy pregnancy, optimal fetal development, awareness of and access to community supports, increased preparation for labour and delivery.	FHS Lori Davis Pat O'Connor	Adolescents and young adults living on low income	Community Needs Assessment	Targeting with universalism Early childhood development	No cost Bus tickets distributed or parking tokens	Reproductive Health Health Promotion and Policy Development Requirements # 3,4 6
Understanding Your Teen sessions for ESL parents Includes 4 sessions to assist newcomer parents to learn about parenting styles, teen growth and development, values and beliefs, and communication skills with the context of bi-cultural parenting.	FHS Muriel Abbott	Designed to meet the needs of Arabic speaking newcomer parents in South London	Results of focus groups	Targeting with universalism Early childhood development	No cost	Child Health Requirements #1, 4-8
Nobody's Perfect Series of 10 classes for families with children up to 24 months. Participants tend to be from priority populations.	FHS Young Families Team	Lone female parents Parents living on low incomes People living with limited education	Consultations with service providers e.g. CAS, Heartspace	Early childhood development	No cost program Bus tickets Low literacy materials	Child Health Requirements Health Promotion and Policy Development Requirements # 5-8
Partnership with Across Languages for the Intercultural Communication in Health Care project in 2010 to produce **educational tools for primary health**	FHS	Recent immigrants and refugee claimants	Observation and professional assessment	Intersectoral action	Changes to how questions are asked and acceptance of	Foundational Standard Requirement #4

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
care providers in London-Middlesex					cultural practices	
Develop and implement Healthy HOMES project for priority population with the Salvation Army Centre of Hope in collaboration with MLHU, City of London, Fanshawe College, Canadian Mental Health Association, UWO, London and Middlesex Housing Corporation • Assist with the development of the evaluation framework • Collaborate in delivery of healthy living and exercise program • Participate in advisory capacity	FHS Lynn Prentice	People living on low incomes Homeless or precariously housed	Consultation with service providers	Intersectoral action	Priority population needs will be considered	Child Health Requirement #4-6, 8
Work with tenants/local landlords/housing corporations to establish/implement safe housing standards eg. clean water, indoor air quality. Provide education to tenants and staff on a variety of health topics. Promote smoke-free environments and policies	EHCDPS Iqbal Kalsi Linda Stobo	People living on low incomes Unattached individuals People living with disabilities	observations	Intersectoral action Community engagement Early childhood development		Health Hazard Prevention and Management Health Promotion and Policy Development Requirements: #3,4 Disease Prevention/Health Protection Requirements: # 5-7,9
Safe Be Seen campaign to reduce deaths and injuries on roadways • Distribution of reflective bands to vulnerable children and youth	EHCDPS Joyce Castanza	Vulnerable children and youth	Road Safety literature City of London Neighbourhood Profiles	Targeting within universalism	Free item	Injury Prevention and Substance Misuse Health Promotion and Policy Development Requirements # 2, 3b, 4b
Advocacy for Living Wage Policy	EHCDPS Ghezal Sabir	People living on low incomes Unemployed or underemployed Persons living with disability	Literature	Early childhood development		Foundational Standard Requirement # 2, 5
Grocery store tours and cooking demonstrations for immigrants	EHCDPS Ghezal Sabir	Recent immigrants	Community needs assessment	Targeting with universalism		Chronic Disease Prevention Health Promotion and Policy Development

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
						Requirement # 8
Determining the health behaviours of first generation immigrants research project	EHCDPS Ghezal Sabir	Recent immigrants	Research	Purposeful reporting		Chronic Disease Prevention Assessment and Surveillance Requirement #1
Provide injury prevention outreach services to seniors through the **Stepping Out Safely Program.** Goal: to raise awareness about the risk factors for falls among older adults and to inform them of prevention strategies.	EHCDPS Amy Mak	People living on low incomes Unattached individuals Persons living with disabilities	Research	Targeting with universalism	Free transportation provided Hot lunch and snacks served	
Promote collective kitchens that are accessible to vulnerable populations	EHCDPS Ghezal Sabir	Recent immigrants People living on low incomes	Research/literature	Targeting with universalism		Chronic Disease Prevention Health Promotion and Policy Development Requirement # 12
Food Literacy programs **e.g. Cook It Up, Youth in Transition, Youth Opportunities Unlimited** Community-based cooking programs that target vulnerable youth. Cook It Up evaluation is pending.	EHCDPS Heather Thomas	Vulnerable children and youth	Recruited through community service programs e.g. Boy's and Girls Club, Youth Opportunities Unlimited	Targeting with universalism Community engagement Intersectoral action Early childhood development	Low literacy material Hands-on skill building No cost Convenient locations	Chronic Disease Prevention Health Promotion and Policy Development Requirement # 8
Grow Cook Learn Collaboration with London Community Resource Centre, East London Anglican Ministry, Master Gardeners of Middlesex-London Demonstrate gardening and cooking skills	EHCDPS Heather Thomas	People living on low income	Recruit through FHV in East, other networks with social services	Targeting with universalism Intersectoral action	Low literacy Language translation	Chronic Disease Prevention Health Promotion and Policy Development Requirement #8, 12
Community Food Advisors Provide educational sessions to the Community Food Advisors. Work with HOMES (Salvation Army).	EHCDPS Heather Thomas	People living on low income Recent immigrants	Through social service agency or self-identifying	Targeting with universalism Intersectoral action	Low literacy Language translation	Chronic Disease Prevention Health Promotion and Policy Development Requirement #8, 12
Tobacco Cessation education Support social service agencies working	EHCDPS	People living on low income	Consultations with service	Targeting with universalism	Free Nicotine Replacement	Chronic Disease Prevention

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
with vulnerable populations	Linda Stobo	Work-limited individuals with disabilities or mental illness	providers		Therapy through the STOP study for eligible individuals	Health Promotion and Policy Development Requirement #9
Play Live Be Tobacco Free after school program Funding from the Ministry of Health Promotion and Sports. Kits disseminated to specific high risk neighbourhoods	EHCDPS Linda Stobo	People living on low income	Observations	Targeting within universalism Early childhood development	Free resource Games require minimal equipment and implemented at low or no cost	Chronic Disease Prevention Health Promotion and Policy Development Requirement # 3, 9
Promote **Helmets on Kids** program that provides bike helmets to school-aged children The vision of the Helmets on Kids Partnership is to put a helmet on every child in London-Middlesex who has a financial need and provide education and awareness about bicycle helmet use	EHCDPS Berthe Streef	People living on low income	Observations	Intersectoral action Early childhood development	No cost to recipients	Prevention of Injury and Substance Misuse Requirement #3 and 4
Extreme Weather Alert The purpose of the Protocol is to alert local agencies, stakeholders and the media in a coordinated manner, of the Environment Canada forecast of extreme weather temperatures to ensure that the homeless and other persons vulnerable to the effects of extreme temperatures are protected during the periods of extreme heat and extreme cold conditions.	EHCDPS Iqbal Kalsi	People living on low income Unattached individuals Persons living with disabilities or mental illness Homeless or precariously housed	Canadian Institute for Health Information "Urban Physical Environments and Health Inequalities"	Targeting with universalism		Health Hazard Prevention and Management Health Promotion and Policy Development Requirements: #3, 4
Special Risk Citizens Health inspector available to assist seniors living in squalor and refers to organizations	EHCDPS Iqbal Kalsi	Unattached individuals		Targeting with universalism		Health Hazard Prevention and Management Disease Prevention/Health Protection Requirements: #5,6
REED multiple-year strategic direction on the social determinants of Health Included the following elements: • Intranet resources on the Social Determinants of Health				Competencies/organizational standards		Foundational Standard Population Health Assessment Requirements 1-5

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• Reflected in Research and Practice Symposiums for staff • Commitment to always examining the indicators of social determinants of health in analyses when possible • Librarian continues to share applicable reports to all staff						
TB clinics for refugees	OHCDSHS Cathie Walker	Refugees		Targeting with universalism	Interpreters provided Transportation provided to other communities if necessary for treatment No cost medication	Tuberculosis Prevention and Control Disease Prevention/Health Protection Requirement: # 5-9
Outreach Counseling regarding infectious diseases with individuals (e.g. Elgin-Middlesex Detention Centre, My Sister's Place, Salvation Army, Men's Mission, London Intercommunity Health Centre) Provide education to staff and counselling and referral of clients as necessary.	OHCDSHS Cathie Walker	People living on low income Unattached individuals Persons living with disabilities or mental illness Homeless or precariously housed		Targeting with universalism		Infectious Diseases Prevention and Control Health Promotion and Policy Development Requirement: # 4 Disease Prevention Requirement: # 8
Dental Clinical Services at MLHU Specific eligibility criteria e.g. 0-17 years of age, CINOT eligible, Ontario Works, HSO, or clients of Ontario Disability Pension	OHCDSHS Joan Carrothers	Vulnerable children and youth	Screened for eligibility criteria	Targeting with universalism	Services paid by social assistance programs	Child Health Disease Prevention Requirement # 12, 13
PREV-OH Preventive Oral Health Services for Ages Birth to 17 years • Screen for eligibility for dental care at no cost under CINOT • Specific eligibility criteria e.g. residents of London-Middlesex, 0-17 years, families receive Ontario Child Benefit or financial hardship and no dental plan	OHCDSHS Joan Carrothers	Vulnerable children and youth	Screened for eligibility criteria	Targeting with universalism Early childhood development	Cleaning and polishing of teeth, fluoride treatments and dental sealants	Child Health Disease Prevention Requirement # 12, 13

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Name of the Activity/Brief description	Lead MLHU contact	Priority Population	How Priority Population was identified	Practice used to address social inequities	Modifications of activities to meet priority population needs	OPHS
Smile Clean A dental cleaning program at reduced fees for persons on social assistance • Specific eligibility criteria e.g. residents of London-Middlesex, 18 years of age or older, clients of Ontario Works	OHCDSHS Joan Carrothers	People living on low incomes	Screen for eligibility	Targeting with universalism	Minimal charge	Child Health Disease Prevention Requirement # 12, 13
Dental Outreach education to priority populations e.g. Mutually Aid Parenting Programs (MAPP), Life Skills program for mentally challenged, Cross Cultural Learners Centre, CAS, Merrymount, Detention Centres.	OHCDSHS Joan Carrothers	People living on low incomes Work-limited persons living with disabilities Recent immigrants and refugee claimants	Consultations with service providers	Targeting within universalism		Child Health Health Promotion and Prevention Requirement # 5,6,7,8
Observational experiences for 4th year UWO medical students in the community elective "working with marginalized populations"	FHS Karen Jenkins OHCDSHS Bryna Warshawsky			Building competency in future health care professionals re marginalized populations		Foundational Standard Principles #3 Capacity

Mapping of Poverty Initiatives at MLHU (2011)

Name of the Activity/Brief description	Lead MLHU contact
MLHU MEMBERSHIP ON COMMITTEES ADDRESSING ISSUES RELATED TO POVERTY	
Child and Youth Network **Healthy Eating Healthy Activity Work Group** Working with an at risk community who have identified food skill development	EHCDPS Heather Thomas FHS Chris Callaghan
Child and Youth Network, **Ending Poverty Implementation Team** Specific strategies in 2010 included: increased awareness and engagement of the community in understanding poverty; reduction of the impact of poverty; and breaking the cycle of poverty.	FHS Chris Preece Heather Lokko EHCDPS Ghezal Sabir
City of London-ad hoc committee Makes decisions about funding allocations for projects geared to low income and homeless people.	OHCHSHS Cathie Walker
FHS Shelter Services Committee The original mandate was for staff to review shelter services and mentor staff. The committee continues to meet every 3 weeks. Current plans are to strengthen the link with other shelters and community agencies, and focus on social justice issues.	FHS Nancy Summers
Health Zone, Board of Directors In 2010, the Ministry of Health and Long Term Care approved funding for the creation of the Health Zone Nurse Practitioner-Led Clinic in London. The vision of the clinic is to improve the health and well-being of women, children and families who have limited access to primary health care services.	FHS Diane Bewick
Hunger Relief Action Coalition (HRAC) Produce meal programs and food bank depots' information on a monthly basis. Creates a platform for coordination among meal providers and food bank depot representatives.	EHCDPS Ghezal Sabir
Intercommunity Health Centre, Board Member This centre provides primary health care and social services in a welcoming setting to those who experience barriers to care. These barriers may include poverty, homelessness, language or culture, and complex and/or chronic health.	FHS Jim Madden

Name of the Activity/Brief description	Lead MLHU contact
conditions including mental health and addictions.	
London Community Plan on Homelessness Committee London's Community Plan on Homelessness is an extension of the London Community Housing Strategy (LCHS). Grounded in recommendations approved by Council in June 2010, the plan establishes policy and program direction until December 31, 2015 for homeless programs and services in London.	OHCDSHS Shaya Dhinsa
London Community Resource Centre, Board of Directors The London Community Resource Centre provides options and opportunities for people to grow, prepare, preserve, and enjoy locally grown food through the implementation of food security programs.	EHCDPS Heather Thomas
London Food Bank, Board of Directors The London Food Bank's mission is to help a caring community share its food resources by acting as a front-line agency assisting those struggling to make ends meet and to act as a food warehouse and work with other agencies that assist people in need.	EHCDPS Heather Thomas
London & Middlesex Local Immigration Partnership Council (LMLIPC) • Is the strategic planning body that ensures multiple stakeholders participate in planning and coordinating to enhance delivery of integration services to all immigrants. • Primary areas of focus-education, employment, health and wellbeing, inclusion and civic engagement, justice and protection services, settlement.	FHS Jayne Scarterfield Muriel Abbott Mary Lou Albanese
Planning and sponsorship of "**First National Forum on Housing & Safe Communities for Women in Canada**, May 9-11, 2011 • MLHU Public Health Nurse and Social Worker presented a framework for providing public health nursing services in shelters and homeless woman.	FHS Jayne Scarterfield Bernadette Garrity Jody Shepherd/Meaghan Bolack
Mission Services of London, Board of Directors Christian faith-based social service agency with a	FHS Diane Bewick

Mapping of Poverty Initiatives at MLHU (2011)

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focus on serving those who struggle with poverty and homelessness; men, women and children. Provide food, shelter, clothing, crisis intervention and rehabilitation. Includes Rotholme, Men's Mission, Mission Store, Quinton Warner House, Community Mental Health Program etc.	
Networking for an Inclusive Community (NIC) Promotion of access to services for people in London-Middlesex for whom language or culture pose barriers.	FHS Jayne Scarterfield
Northbrae Hub Planning Committee This project is a unique community collaboration to assist Kipps Lane residents in London through the provision of services focused on children, their families and neighbourhood.	FHS Ruby Brewer
Ontario Public Health Association Access, Equity and Social Justice Standing Work Group • Advocates for increased accountability of Public Health for addressing health inequities • Identifying issues and raising awareness by working in collaboration with others • Providing tools and resources to the Health Units to assist in program and policy development • Supporting organizational/staff capacity to reduce social inequities in health	FHS Jayne Scarterfield
Ontario Society of Nutrition Professionals in Public Health **Advocacy subcommittee** The purpose of the OSNPPH Advocacy Committee is to provide strategic guidance, coordination, and support to OSNPPH executive, membership, liaison groups and workgroups to establish the best means by which OSNPPH key messages are translated into advocacy.	EHCDPS Heather Thomas
Ontario Public Health Association-Provincial Child and Youth Health Workgroup In 2010/11 work plan priorities identified parenting, and early learning and care as major areas of focus.	FHS Diane Bewick

Name of the Activity/Brief description	Lead MLHU contact
Project Seniors Work with the police to provide an environmental health perspective as necessary.	EHCDPS Iqbal Kalsi
Provincial Advisory Committee of Integration of Social Workers into High Risk home visiting In 2009, MLHU participated in the Ministry of Children and Youth Services (MCYS) pilot project to test the services of a Social Worker in the Healthy Babies Healthy Children (HBHC) Home Visiting Program, and evaluate the impact of these services on families. The MCYS has reviewed the data and is making recommendations for the HHBC program.	FHS Suzanne Vandervoort
Provincial Council for Maternal and Child Health-SDOH subcommittee The Council is an expert advisory responding to the needs of the Ministry of Health and Long-term Care, and strategies for the maternal, newborn, child and youth health care system in the province. In addition, the Council is a resource to the maternal, newborn, child and youth health care system in Ontario to support system improvement.	FHS Diane Bewick
Regional Planning Committee for Prevention of Shaken Baby Syndrome This is a sub group of the SW Ontario Maternal Newborn Child and Youth Network. Their mission is to implement a primary prevention program in the SWO region through the collaboration amongst public health, hospitals, and community organizations.	FHS Bonnie Wooten
Special risk Hoarding and Senile Squalor Coalition Currently chaired by the Mental Health Association Request to MLHU can be made for funding on a one-time only basis for premises clean-up.	EHCHPS Iqbal Kalsi