

2018

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# Western Public Health Casebook 2018

## *Cases from the Schulich Interfaculty Program in Public Health*

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# TABLE OF CONTENTS

<b>PREFACE</b> .....	v
<b>ACKNOWLEDGEMENTS</b> .....	vii
<b>INTRODUCTION: Essential Skills for Public Health</b> .....	1
<b>CASE 1:</b> Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs .....	9
<b>CASE 2:</b> Good Food Box: Generative Relationships and Scenario Planning in Public Health .....	23
<b>CASE 3:</b> “School, Interrupted” .....	43
<b>CASE 4:</b> Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit .....	53
<b>CASE 5:</b> Making Oral Health Care More Palatable .....	71
<b>CASE 6:</b> On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health .....	89
<b>CASE 7:</b> Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations .....	107
<b>CASE 8:</b> “I Know You Want It”: Preventing Sexual Aggression in Bars .....	119
<b>CASE 9:</b> Managing Expectations: Lyme Disease .....	137
<b>CASE 10:</b> Middlesex-London’s Public Health Emergency: HIV in People Who Inject Drugs .....	145
<b>CASE 11:</b> Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan .....	165
<b>CASE 12:</b> Housing and Health: A Human Rights Approach to Wellbeing .....	175
<b>CASE 13:</b> The Abokobi Open Dump .....	195
<b>CASE 14:</b> Rural Residence and Associated Health Disparities: The Case of Chatham-Kent .....	209
<b>CASE 15:</b> Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts’ Plan to Become Accessible to All .....	219
<b>CASE 16:</b> Don’t Miss the Bus .....	241
<b>CASE 17:</b> Can Hospitals do Health Promotion? Making Hospitals a Place for both Care and Health through Health Promotion .....	247
<b>INTEGRATIVE WORKSHOPS</b> .....	267



# PREFACE

## INTRODUCTION

The Master of Public Health Program (MPH) at Western University is a 12 month full-time program that incorporates a 12-week practicum. The MPH Program curriculum includes innovations such as case-method learning, Brown Bag seminars, Integrative Workshops, field trips and career counselling. The Brown Bag seminars allow the students to hear from, interact and network with practitioners from the field. The faculty of the MPH Program are drawn from across campus, and represent a broad range of disciplines pertinent to public health.

## TEACHING CASES

Western's MPH Program relies extensively on the case based/experiential method of learning. The Program aims to deliver 60% of pedagogic material using the case-based approach – a unique feature not found in other MPH Programs worldwide. The case method of learning is not about the traditional lecture-style classroom setting, but is about the student being an active part of the learning experience, which means learning by doing. It introduces complex and often ambiguous real-world scenarios into the classroom, forcing students to think and make decisions sometimes with incomplete and inaccurate data.

The case method is a three-stage process that builds on each subsequent step. It starts with individual case preparation, followed by a small group discussion, concluding with a large group discussion (in the classroom) so that the learning objectives are met. To facilitate this process, all students are placed in a learning team of 5-6 members from Day 1 of their journey in the Program. The learning team forms the 'home' of the student for the academic year, and is the basis for peer-support, group and case work.

We view the case method as a vehicle to develop transformational learning, along with the students' leadership skills, teamwork ability, critical thinking capacity, and knowledge of disciplinary perspectives. However, there is a paucity of suitable public health cases to use for this purpose. Case-based pedagogy has been predominantly focused on business cases, which are often not directly suitable for a public health curriculum. In addition, existing health related cases often do not reflect the reality of Canadian and international health systems. Case repositories have few teaching cases that can be used by such programs, creating an opportunity for Western's faculty and practitioner colleagues to develop de novo cases by building on their research and practice experiences.

Along with faculty developed cases, Western has adopted an innovative model of building a catalogue of teaching cases in public health authored by students. As part of the MPH Program's Integrative Learning Experience (capstone course), the overall final deliverable for students is a teaching case and teaching note that is based on their Applied Practice Experience (practicum). Faculty members select the best cases, and work with the students to publish them in the annual ***Western Public Health Casebook***. Our faculty have actively incorporated these student cases in the curriculum, and we often involve the students (now alumni) in co-teaching these cases.

## INTEGRATIVE WORKSHOPS

Each year, we schedule full day ***Integrative Workshops***. The objective of these workshops is to pause and reflect on the past six to eight weeks of learning, and to integrate and synthesize interdisciplinary knowledge and practices learned in the various courses till then. The workshops model a real public health issue facing the community, with student teams having to

make decisions under time pressure, often with imperfect information, and present and justify these decisions to experts. Topics are chosen to complement rather than duplicate the materials being used in the courses, and reflect the expanded expertise available on campus beyond the course faculty members, as well as practice experts and community members. This is a team exercise, where students apply the materials and insights from their courses (in addition to the presentations by experts at the workshop) to answer the question(s) posed. Workshop deliverables vary and may include short reports, presentations to a panel of experts, letters to the editor, blog postings or policy briefs.

### **WESTERN PUBLIC HEALTH CASEBOOK 2018**

It is my pleasure to welcome you to this year's ***Western Public Health Casebook***. Herein you will find teaching cases authored by students, faculty members, and community partners, as well as summaries of the Integrative Workshops that were held in 2016/17. Cases are also available for download at <https://www.schulich.uwo.ca/publichealth/cases/>. Our goal is to create a searchable database of freely available public health cases on our website, for use by any program across the world. We welcome feedback and comments on these cases. To do this, please be in touch via the program's email: [publichealth@schulich.uwo.ca](mailto:publichealth@schulich.uwo.ca).

***–Dr. Amardeep Thind, Director  
Schulich Interfaculty Program in Public Health***

## ACKNOWLEDGEMENTS

The 2018 *Western Public Health Casebook* reflects the variety of ways in which public health, as a practice and mindset, fills our world. The cases contained within this book reaffirm that the ability to work within diverse and interconnected contexts is an essential skill for contemporary health workers. Public health is both a science and a passion for helping. Thank you to our team of students, faculty, staff, community members, and public health organizations who came together in the production of this Casebook.

We would like to express our gratitude to the following organizations (and the preceptors) who supported the training of our students and the development of the cases in this Casebook: Access Alliance Multicultural Health & Community Services, Lambton Public Health, Middlesex-London Health Unit, WellFort, Chatham-Kent Public Health, Health Justice Initiative, University of Ghana, North Bay Parry Sound District Health Unit, Aga Khan Foundation Canada, Parachute, Centre for Addiction and Mental Health (London), Public Health Agency of Canada, and Public Health Sudbury & Districts.

In particular, we thank Dr. David Butler-Jones, Senior Medical Officer and Atlantic Region Medical Officer for the First Nations and Inuit Health Division, Health Canada, for his commentary on the important role that public health continues to play in our increasingly complex world. As always, this Casebook would not be possible without the tireless, conscientious efforts of Courtney Hambides, Program Coordinator for the MPH Program, and the whole administration team. We appreciate the significant efforts all of the MPH staff put into producing this Casebook, and the faculty of the MPH Program in honing its content. We warmly thank our student case authors - members of the MPH Class of 2017!

*–Gerald McKinley and Shannon Sibbald*





# **INTRODUCTION TO THE CASEBOOK**



## Essential Skills for Public Health

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*David Jones (Butler-Jones), MD, MHSc, LLD(hc), FCFPC, FRCPC, FACPM  
Senior Medical Officer and Atlantic Region Medical Officer  
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It has been over 150 years since John Snow used basic epidemiologic techniques to identify the contaminated water responsible for causing the cholera epidemic. Much has changed since, notably life expectancy in developed countries has increased by over 30 years, and infant and child mortality has fallen dramatically. For example, a century ago approximately one-in-five Canadian children would not have survived to school age. We are rapidly approaching what some view as the top of our biological average lifespan.

So, is our work done? In many ways we're just starting.

The advent of antibiotics, antivirals, and vaccines have created an illusion that we can conquer infectious diseases. It is true that we have made remarkable progress; however, new and emerging pathogens, antibiotic resistance, infectious causes or facilitators of chronic disease, and the reality that many serious infections still have no recognized cause mean there will likely always be much work to do. There are also chronic diseases and injury to consider, as well as questions of how we can practically apply our knowledge of social determinants to create better health equity.

While the fundamental skills of public health: epidemiology, surveillance, prevention, and health promotion will continue to evolve, the fundamentals are still as relevant as they were a century ago. Nonetheless, it seems to me increasingly obvious that all that I learned in my training, while necessary, was not sufficient. Even more so, some things that were taught were plainly wrong, including varying aspects regarding the workings of the brain, immunity, and genetics. So, what then do I believe will be the essential skills for Public Health practitioners to succeed in this century?

There are of course the specific expertise and skills required to be a Public Health professional in a technical field such as epidemiology, health promotion, etc. However, in this commentary I will focus on the core skills and approaches that are valuable for anyone working in the field.

We tend to remember stories and related facts more easily than lists of facts on their own. Hence the value of case-based learning, and the sharing of stories and experience from which others can learn. A Master's program cannot hope to go into depth in all the areas that will prove valuable, and, in any case, we may not remember them when the time comes. The endeavor of a Master's, however, is a time to establish a pattern for life-long learning and good decision making which are essential for a successful career.

### **ASSESSING AND USING EVIDENCE**

We live in an increasingly complex, inter-related world. The internet and social media have made information and research ever more accessible. Unfortunately, it does so with little

discrimination as to whether what is claimed is true or not. Scientific Research has offered systematic ways to better understand our world, but it is not without limitations. So, how then do we make reasonable decisions about what is most likely correct? Critical thinking and discernment are essential in assessing the quality of evidence (knowing how to weigh evidence from different sources) to come to a reasonable conclusion. While we often call research findings “proof”, this is only true until better evidence comes along.

The probability of something being true increases substantially if other research, observational evidence, experience, and logical rules of causation all point in the same direction. Then one can certainly have better confidence, but we can typically only reference some of these criteria for any given problem.

As essential as Randomised Control Trials (RCTs) are in assessing new pharmaceuticals or procedures, they tell us little about our complex world and relationships, or individual variability in response. A simple example is a review of RCTs that look at the efficacy of antiviral treatment in seasonal flu outbreaks but is not predictive of their utility in a pandemic. While at one level they are the same disease, in reality they are very different. In pandemic flu, a novel virus can cause rapid overwhelming infection, so the ability to stop or slow viral replication can be life-saving. Whereas in seasonal flu, primed immune systems are already responding - anti-virals offer only a minimal advantage. It would be unethical to do an RCT with anti-virals in a pandemic; however, other non-RCT evidence gathered during the actual pandemic of H1N1 in 2009 illustrates how effective it was. One of many examples from Canada refers to young pregnant women being five times as likely to die during the spring outbreak. We mounted a campaign during the summer with physicians and the public to assure easy access to anti-virals with the emergence of flu symptoms. Despite many cases occurring in the fall, there were no reported deaths in pregnancy. Similarly, after the reintroduction of anti-virals in Northern communities, the need for medivacs to ICUs in the south essentially stopped, which also corroborated the experience of many pediatricians and ICU doctors. Additionally, local knowledge may explain why a statistical difference exists that contrasts with a researcher’s conclusions that were based upon their own experiences and assumptions. Knowing how to assess different types of evidence and being able to critically read the literature is important whatever we do.

As many of the situations we face are novel, or have little available research, there is a skill in being able to make good decisions in the absence of substantial evidence. This may be done by drawing upon the available information and experience, referencing analogous situations, and validating the decision by consulting other sources. Otherwise, we can be paralyzed, waiting for more evidence, which may never come. In the meantime, not making a decision is a decision, often to the detriment of those at risk. It is important for all decisions to be intentional and supported with logical reasoning, including the situations when not making a decision is the best course of action. It is always worth remembering that findings which fall outside the statistical norm are simply unlikely, but most certainly do exist. They are worth at least paying attention to, and if there are enough of them, questioning our initial assumptions.

When things don’t quite add up, it is important to investigate. For example, a complaint about residents in a group home being forced to defecate in buckets outside, which were then emptied over the fence, seemed implausible. However, a walk around the fence proved the complaint. I have always found it useful to get out of the office, to meet people, to see the situations and conditions directly, to develop a context, and to trust because it allows for enhanced information sharing that can help to expose the truth in each situation.

### LEARNING FROM HISTORY AND STORY TELLING

The history of Public Health is rich with examples of both success and failure.

It is essential to document, remember, and learn from both. Post-event evaluations are important, but even more so is to track what was done to address them. For example, following the Naylor and Senate Reports on SARS, which led to establishing the Public Health Agency of Canada, recommendations were followed, acted upon as appropriate, and tracked, in the hopes that we would not repeat the same mistakes. This then became the policy for other events, like the Listeria outbreak and Pandemic H1N1. Goethe is often quoted as saying that 'those who forget their history are condemned to repeat it'. We seem to go through cycles, whether as individuals or societies, of recognizing a problem, diagnosing and treating it, succeeding, and then, when we succeed, forgetting the process that was necessary for our success.

Fewer of us remember the packed pediatric wards with what are now vaccine preventable diseases; the iron lungs and rehab wards for polio; or, the brain damage from measles or whooping cough. Just as with the advent of antibiotics, the illusion that the next medical breakthrough will be the panacea, has risked ignorance of the fundamentals that make for health and wellbeing. History also teaches us a lot about calculated risk and trade-offs. In our risk-averse culture too often decision makers are afraid to solve a problem unless there is a way to account for all the potential side effects. Even if the problem is big and the side effect small, if they don't take on the issue they can rationalize it was not their issue to address in the first place, and, hence, nor will be the side effects. Change for the good cannot happen without some risk taking, and the incremental improvements have benefitted us all. However, if we must account for every small 'what if', little progress will be made.

Life-long learning includes not only our own history, but also that of other cultures and societies. Work pertaining to international development has much to teach us, including the value of appropriate technology and the sad legacy of colonialism. In Canada, the tragic history of colonial injustices inflicted upon Indigenous communities, including the legacy of residential schools, requires that one be knowledgeable in what it means to practically achieve reconciliation. This includes being able to understand and apply trauma informed policies and practice, and to learn from the rich culture and traditions that have sustained communities for millennia in the Americas.

We not only need to learn from the successes and the failures embedded in our history, but we must also then continue to tell the stories.

### POLICY AND PROGRAM PLANNING AND IMPLEMENTATION

Whether in medicine, or policy, or other remedies, a decision-making maxim that I live by is to seek solutions that are the *least intrusive, most effective, and come with the fewest side effects*.

Skill in characterising an issue, weighing the options, and finding and mapping out solutions is critical in long term success. Policy, program planning and management, strategic thinking, advocacy, proposal writing, and the program implementation process are all fundamental to its success.

Much of the issues faced in Public Health are complex, have no simple solutions, nor guarantee a likelihood success. We pursue them because they have important impacts or risks and we are constantly seeking ways to improve health and wellbeing and reduce inequities. This requires the ability and desire 'not to be right, but to get it right', which requires broad thinking, engaging others, and a clear plan. When that plan gets thrown off, as it will, the aptitude is in the ability to

rapidly access new options and continue movement towards the objective. Too often we see a disconnect between the various necessary steps. For example, researchers often get frustrated when their research, which after many years of investigation finally identifies a possible solution, is not quickly implemented. Somehow, not realizing that the effort to plan and implement the research may only be a fraction of what is required to move towards drafting policy, receiving funding, and implementing programs.

Evidence may be necessary for good decisions, but it is not sufficient. Implementation and sustainability are the more complex and challenging parts of the process. Instead, too often seemingly simpler solutions are chosen, which have little impact, or there is no commitment to long-term solutions that are needed to see an effect. The clinical counterpart is if we were only willing to provide one dose of penicillin to treat strep throat, we would conclude that treatment was a waste of time.

Thinking through and being able to articulate what it will take, what other options there are, how it can be done, and the associated risks and benefits in a coherent and concise way is critical to moving from idea to action.

### **WORKING WITH, AND INFLUENCING OTHERS**

Most of the impact of Public Health comes not from what we can manage or control, but how we influence others. Whether enhancing understanding, changing behaviour, or rewriting policy, we are successful through persuasion not force. A great many of us think that all we would need is to have the ear of a Minister, Deputy, or other political/organizational leader, if only for a moment, to implement the meaningful change for which we hope. It is also terribly clear how much relationships and effective communication matter to successful change. Who do we respect or trust? If we were to communicate our point louder or more forcefully will that change the mind of another? What about that elevator speech? Why, then, are some people more effective at getting ideas across?

The elevator speech, if it's a pitch, will likely not be heard. Being more forceful also usually entrenches the opposite view. When confronted in that way most people go to a 'happy place', and hope the interaction will not last long, rather than change a long-held belief.

It is not enough to have a compelling case. A receptive environment is a necessity, and, even if a Minister is on board, there are many ways in which the course of action may be diverted. Change requires something of a popular consensus, or at least sufficient numbers of those who understand, want to do it, and have the ability. Effectively building coalitions is critically important to address issues we can better do collectively. They will form and reform, depending on the issue and common interests of the people. Having skills that involve working with others, leading from within, supporting others, sharing credit, assuming responsibility, developing respect, and all the other characteristics that build good teams, are essential to success both inside and outside our institutions.

At the core, the one thing that we have, that no one else can take away, is our integrity. But we ourselves can give it up, and once gone it is almost impossible to recover.

While there are indeed a multitude of requisite skills, there are a few principles I have found helpful in chairing a range of coalitions, inter-sectoral, and intergovernmental processes or simply in working collaboratively with other organizations.

## Essential Skills for Public Health

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- **Respect:** We cannot influence who or what we do not respect. We don't need to like another or want to take them out to dinner, but if we don't respect their position or understand where they are coming from we are unlikely to get anywhere.
- **Make it Practical:** It is not enough to outline the problem. Have practical solutions or approaches upon which can be acted.
- **Have something to offer:** It can be quite compelling to be given an offer and explore the possibility of willingly contributing rather than a request to do something more than the status quo with limited resources.
- **Rule of Three:** Often organizations, groups, or committees get bogged down trying to find agreement. I find it helpful to categorize issues as follows:
  - Those that we essentially agree on, we do.
  - Those that we may differ on a bit, but not enough to oppose, we do.
  - Those that we likely will never agree on, we don't ignore, but we don't let them become more than 5-10% of our time and focus.

We need not agree on everything to work effectively on what we do.

### CONCLUSION

In this commentary there are many skills I have intentionally not mentioned that are specific to parts of public practice, and there are others equally important that a short commentary cannot hope to even touch on. The framing of issues and approaches in social determinants and One Health, requires practical approaches to programs and policies. Assessing and using evidence correctly, applying the lessons of history, policy writing, planning, managing programs, and collaboratively working with others, are important skill sets required to improve health and wellbeing and reduce inequities. Finally, Public Health practitioners have much to learn and contribute to the fundamental process of reconciliation with Canada's Indigenous population.

As the climate warms and we see more natural disasters, effects on social migration, and economies, and as social cohesion is threatened by growing inequalities and the political climate changes, the skills of Public Health practitioners will be needed more than ever. I have often referred to Public Health as a 'Team Sport'; therefore, if we are to truly succeed, is there really any expertise we can do without?





# CASES



## CASE 1

# Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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*Meriem Benlamri, HBSc, MSc, MPH (MPH Class of 2017)*

*Yogendra Shakya, PhD*

*(Senior Research Scientist, Access Alliance Multicultural Health and Community Services)*

*Shannon L. Sibbald, PhD (Assistant Professor, Western University)*

Zola Faraji leaned back in her chair and let out a momentous sigh. Zola and her colleagues were wrapping up a data analysis meeting in relation to one of their research projects – the *Best Practices in Refugee Health and Resettlement Services* project. It had been eight months since the launch of the project within the community-based research department at Access for Health and Settlement Centre (AHSC).

Looking outside the boardroom window on that late April morning, Zola noticed that the clouds were shifting unpredictably as they often did in Toronto this time of year. Sitting next to her was Jamila Ahmed, a young project coordinator, who was re-reading meeting notes at the table. Zola glanced over at Jamila and recognized an expression of curiosity on her face. This was the same curiosity that brought Zola to pursue a career in public health research.

The day was full of reflection and nostalgia, as it marked 11 years since Zola started working at AHSC. She held a role as a senior scientist at the organization, leading multiple research projects within the community-based research department. Zola knew that this particular project had captured her efforts and attention as early as the ideation stage over 14 months ago in a way that no other project had done so before. She glanced back at the shifting weather, recognizing that it was a reflection of the context from which the project arose.

The *Best Practices in Refugee Health and Resettlement Services* research project stemmed in reaction to the movement of thousands of refugees from Syria to Canada between 2015 and 2017, following the Syrian Civil War that began in 2011. As an unprecedented number of refugees entered the country, government and other cross-sector agencies were required to mobilize efforts to facilitate the resettlement process and provide accessible, equitable, and culturally-relevant health care within an environment of haste and chaos. There was a need for a fast and coordinated response within the health care sector, in collaboration with various other sectors.

As part of the community-based research department at AHSC, a community health centre that primarily services new Canadians, Zola and her team have access to colleagues from other parts of the organization. These individuals include service providers and senior-level management, who were active leaders in the establishment of a cross-sector response during the Syrian refugee crisis. This had put Zola in an ideal position to utilize her expertise and cross-sector relationships to document the response. Documentation of the response was meant to shed light on what worked and what did not when multiple agencies came together to

## Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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coordinate and establish systems that serviced a large cohort of refugees within an extremely short period of time.

Zola could envision how lessons learned from this response could greatly influence the implementation of systems that could better serve future cohorts of refugees. What barriers could have been avoided? What strengths could be further reinforced? What resources, collaborations, or communications were missing? These were all important questions that Zola and her team posed – all of which presented interesting findings.

Jamila finally looked up from her meeting notes and said, “most of the interviewed participants are concerned about seeing how their successes and failures may transcend this specific response. They are thinking about the impact these findings can have on how our systems react to future mass cohorts of refugees who may arrive in Canada.” Jamila’s academic background in public health and her personal interest in refugee health fueled her passion for this project. “You make a really interesting point, Jamila. We need to talk more about how we are going to enable our systems to use and implement these findings. Yes, we may have been able to capitalize on our positioning to document the response, but what good will it do if we aren’t able to showcase the potential impacts of our results? How can we create cross-sector understanding and incentive *to act* on these findings?” Zola replied.

Zola flipped through her papers until she found the knowledge mobilization plan that the team developed at the beginning of the research project. Zola made a point to never forget to bring knowledge mobilization plans to her research meetings. She understood the importance of exploring and answering impactful questions, but she made sure to never forget that answers can only make an impact when they are mobilized and implemented into subsequent action.

### BACKGROUND

#### The Humanitarian Crisis

As the senior scientist at AHSC, Zola was aware of the social determinants of health that affect new Canadians throughout their migration journey—such as the social and political factors that often lead to displacement. However, she also knew that the Syrian refugee crisis was unique due to its evolution into a large-scale humanitarian crisis. This crisis had unfolded under complex international political and social contexts that witnessed wildly contrasting civic and media engagement.

Throughout the research project, Zola often found herself reflecting on a statement made by the UN Human Rights Commissioner, Zied Ra’ad Al Hussein: he described the crisis as “the worst [human-made] disaster the world has seen since World War II” (United Nations News Services, 2017). The Syrian Civil War had displaced 6.5 million people within Syria (UNHCR, 2016), and led 5 million to flee the country and live as refugees in Turkey, Egypt, Iraq, Jordan, Lebanon, and North African countries (UNHCR, 2017b). Additionally, it had forced almost 1 million Syrians to request asylum in European countries (UNHCR, 2017a).

In 2015, the Canadian government and its citizens stepped in with a nationwide commitment to resettle 25,000 Syrian refugees. This ambitious commitment had a deadline of late 2015, which was later extended to the early spring of 2016. As the resettlement process was undertaken, advocacy groups and community agencies rallied the Canadian government to increase Syrian resettlement numbers, leading to the expansion of the commitment to a total of 40,000 Syrian refugees by mid-2017 (Government of Canada, 2017a).

## Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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### Sectors Involved in the Response

Within Ontario, 16,000 Syrian refugees were resettled, one third (5,345) of whom were located in the City of Toronto (Access Alliance Multicultural Health and Community Services, 2017b). These arrivals included government-assisted, privately-sponsored, and blended visa-office-referred refugees. Refugees are categorized based on the method of their sponsorship and support. For example, government-assisted refugees must be initially registered as refugees with the United Nations High Commissioner for Refugees (UNHCR), which then refers refugees to Canada. This resettlement is fully supported by the Government of Canada or the province of Quebec for up to one year (Government of Canada, 2016). Privately-sponsored refugees are supported in their resettlement by groups of Canadian volunteers who help refugees financially, socially, and emotionally for a minimum of one year (Government of Canada, 2017c). Meanwhile, blended visa-office-referred refugees are UNHCR-identified refugees who are matched with private sponsors. Blended visa-office-referred refugees receive social and emotional support from private sponsors for a minimum of one year, and combined financial support from the Government of Canada for six months and from private sponsors for another six months (Government of Canada, 2017b).

With such staggering numbers of refugees resettling in the province in a short period of time, governments and cross-sector agencies mobilized in response (Access Alliance Multicultural Health and Community Services, 2017b). Fifteen different sectors were involved in the response, including settlement, community and non-profit, housing, education, language, employment, food assistance, research, primary health care, and community health care (Exhibit 1). However, due to the urgent and frantic nature of the situation, there were many hurdles to meeting the health and resettlement needs of refugees, with additional limitations on capacity to evaluate effectiveness of services.

AHSC was one of the many primary and community health care organizations that participated in the resettlement efforts within the City of Toronto. Zola's colleagues at AHSC, including primary health care providers, social workers, health promoters, system navigators, and interpreters, all played a key role in working collaboratively to provide needed services.

Upon the government's announcement to resettle Syrian refugees in Canada in such large numbers, AHSC was among a long list of organizations that were not prepared to coordinate a response. However, the government did develop plans in response to immediate needs, activating a Ministry Emergency Operations Centre (MEOC) to share information and manage collaborations across levels of government and with regional partners. The province also mobilized the *Ontario Health System Action Plan* for Syrian refugees (Exhibit 2). The first three phases of the plan (*Phase 1: Identifying Syrian refugees to come to Canada*, *Phase 2: Processing Syrian refugees overseas*, and *Phase 3: Transportation to Canada*) were primarily undertaken by government agencies. Meanwhile, *Phase 4: Welcoming in Canada* and *Phase 5: Settlement and community integration* were key phases that providers and agencies, such as AHSC, became involved in (Access Alliance Multicultural Health and Community Services, 2017b).

### Access for Health and Settlement Centre and Its Role

Having worked at AHSC for 11 years, Zola knew that as soon as Canada made a commitment to resettle 40,000 Syrian refugees, AHSC would be at the frontline providing its services and resources. Up to this point, AHSC had exhibited a great commitment to providing client-centered care that is equitable, accessible, and inclusive to the most vulnerable newcomer populations. AHSC functions under an anti-oppressive and anti-racist framework that made this commitment and emphasis on health equity and the social determinants of health possible.

## **Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs**

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AHSC provides services such as primary care, illness prevention, health promotion, community capacity building, service integration, and community-based research. This marked AHSC as a respected leader in refugee health within the City of Toronto. The organization's vision and commitment was undoubtedly translated into passionate leadership to service Syrian refugees upon their arrival (Access Alliance Multicultural Health and Community Services, 2017a). In fact, AHSC applied its tradition of providing integrated and interdisciplinary leadership to support the Syrian refugees in the City of Toronto. In collaboration with numerous other community health centres in the City of Toronto, a model of care for a systematic response to the needs of the population was developed with two main care initiatives (CACHC, 2016).

The first initiative began as a collaboration with Crossroads Clinic, St. Michael's Hospital, and Queen West-Central Toronto Community Health Centre, forming a Primary Care Planning Committee. The committee, on which Zola's colleagues sat, eventually grew to 30 primary health care agencies, consisting of a large number of community health centres. This collaborative effort placed great emphasis on ensuring that a series of clinics would provide full health assessments to arriving refugees. Providing this access to primary care would act as a gateway to all other health care services (CACHC, 2016).

As a result, refugees staying in temporary accommodation sites, such as hotels, were connected with one of the 30 primary health care organizations for their full initial health assessment. Some of the temporary accommodation sites provided these health assessments via on-site, primary care clinics. However, in order not to overwhelm these on-site clinics, the Red Cross provided transportation between temporary accommodation sites and the 30 primary health care organizations committed to providing initial health assessments. Additionally, each of the 30 organizations provided refugees with a minimum of three months of follow-up care while they were connected to ongoing primary care practices (CACHC, 2016).

The second initiative was a collaborative effort with COSTI Immigrant Services. The initiative ran across accommodation sites and was meant to develop a primary care service model that addressed refugees' limited access to immediate care for acute and episodic medical concerns. This model was accomplished in partnership with Community Health Centre (CHC) partners. Refugees based in temporary accommodation sites had access to a triage assessment through which immediate health concerns were met by doctors and nurse practitioners from local CHCs, allowing for care and follow-up both on-site and in nearby centers. However, on-site care was not limited to primary health care (CACHC, 2016). Through a collaboration with Toronto Public Health, AHSC arranged additional on-site care, such as flu vaccinations and urgent dental assessments, as well as access to urgent dental care at affiliated off-site locations. Organizations representing sectors such as housing, education, language, employment, and food assistance also utilized these accommodation sites as hubs through which services and resources were provided (CACHC, 2016).

### **Post-Response**

Transitioning from a state of unpreparedness, to an integrated, collaborative, and interdisciplinary response that aimed to meet health and resettlement needs was a path full of challenges. It was also a path full of successful feats and opportunities for improvement. As the immediate response phase came to an end, Zola and her team saw that it was time to document the experience through a cross-sector perspective. The evaluation stage of any public health program or service is vital to its success, providing important insights on the achievements and challenges experienced to better serve the population at hand. Ideally, ongoing evaluations occur as programs or services run, enabling real-time planning,

## **Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs**

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coordination, and implementation improvements. However, in the case of the Syrian refugee response, there were too many moving pieces involved to coordinate an ongoing evaluation.

This limitation did not stop Zola and her team from working with colleagues across organizations and sectors to collect and share information regarding the response. With funding from United Way Toronto and United Way York Region, the objective of the research study was to document the response to the arrival of thousands of Syrian refugees within a short period of time and to identify evidence-based best practices that could inform future responses. Emphasis was placed on understanding the nature of cross-sector collaborations, system navigation supports, and the institutional factors that enabled these collaborations and successes. Additionally, attention focused on documenting the challenges faced, how agencies responded to those challenges, and providing a comparative context on how regional differences in Ontario contributed to variations in service planning (focusing on the City of Toronto, Region of Peel, and Region of Waterloo) (Access Alliance Multicultural Health and Community Services, 2017b). Findings would have an impact on both future waves of refugees and the Syrian refugee population.

The research study that Zola and her team designed encompassed lived experience perspectives through the engagement, recruitment, and training of two recently arrived Syrian Canadians in leadership capacities as “peer researchers”. Mona Sameh and Sami Aman participated in this community-based research study at each step of the research cycle, including research design, data collection, analysis, writing, and knowledge mobilization activities. Their perspectives as privately-sponsored and government-assisted refugees, respectively, were integral to the success of the research project. The team also ensured representation from a diversity of involved sectors and regions, interviewing 22 key informants who played direct and active roles in the Syrian refugee response. Key informants were senior-level leaders and frontline service providers, as well as key players in various roles across settlement, government, community development, and faith and non-faith-based organizations and groups. From these interviews, emergent themes were captured and analyzed – a process that Zola and her team had just concluded (Access Alliance Multicultural Health and Community Services, 2017b).

### **Study Results**

The *Best Practices in Refugee Health and Resettlement Services* research project revealed themes related to the successes and challenges that were experienced across sectors and organizations, leading to the development of recommendations for best practices. The following is a summary of successes and failures uncovered:

#### **Successes:**

Cross-sector Collaborations and Innovation	Innovative models of cross-sector collaborations enabled timely and integrated services for Syrian refugees. Dozens of collaborative working groups were created, taking on different shared responsibilities.
Temporary Accommodation Sites	Temporary accommodation sites became service hubs for innovative collaborations and services to meet needs. This included health, resettlement, and community services.



## Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

Humanitarianism and Goodwill	Humanitarianism and goodwill were exhibited by members of the public, service providers, and volunteers. This commitment allowed for immediate resettlement needs to be addressed in a timely and personalized manner.
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Source: Access Alliance Multicultural Health and Community Services, 2017b.

### Challenges:

Communication gap	A lack of sufficient data about the arrivals of Syrian refugees led to confusion and limitations on service preparations. This uncertainty negatively affected the planning of services.
Funding	Smaller agencies that were involved in the response were fiscally neglected. There were also funding gaps for specific kinds of services and supports, such as hiring interpreters, service coordinators, and additional staff.
Burnout	Service providers and volunteers were working very long hours. Staff felt overwhelmed and shocked, experiencing mental and physical exhaustion, as well as burnout and isolation.
Fairness and equity	Unequal amounts and types of services were available between different cohorts of Syrian refugees, and between Syrian refugees and refugees from other countries.
Poor coordination	It was difficult for agencies to put different response elements together because there was poor initial coordination between agencies and a lack of a central coordinating group. This lack of unity meant that some agencies took on a significant load of work while others were underutilized.
Meeting community-specific needs	Meeting needs related to larger family sizes, conflict-inflicted complex health issues, and preferred settlement locations close to Syrian or Arab populations in the Greater Toronto Area was challenging.
Navigating the health system while meeting complex needs	Refugees exhibiting complex or specific health needs experienced difficulty navigating the health system during the initial response, and they were not being seen by service providers fast enough.
Interpretation barriers	Interpretation is already an existing structural barrier within the Canadian health care system, and it was a key challenge during the response, making it more difficult to navigate the health system.
Access to pregnancy and reproductive care	There was a lack of information on the number of pregnant women arriving in Canada and the related urgency of care that was needed. Minimal preparation was made to meet the sexual and reproductive health needs of this population, including birth control.

Source: Access Alliance Multicultural Health and Community Services, 2017b.

## Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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### KNOWLEDGE MOBILIZATION: FROM EVIDENCE TO ACTION

Sitting in the AHSC boardroom, Zola shifts her focus from findings to knowledge mobilization. She begins to examine the knowledge mobilization plan developed by her team at the beginning of the project. Zola's experience over the years has taught her the importance of integrated knowledge mobilization as part of the research cycle. Integrated knowledge mobilization goes beyond the documentation of research results through reports and publications, a process commonly known as end-of-grant knowledge mobilization (CIHR, 2012). Integrated knowledge mobilization encompasses knowledge producers and users (such as policy makers, health professionals, and individuals with lived experience) in the synthesis, adaptation, and dissemination of evidence into co-produced products, tools, and events (CIHR, 2012; Powell, Davies, & Nutley, 2016; Phipps et al., 2016). The goal of integrated knowledge mobilization is to bridge the gap between evidence, and practice and/or policy change. The integration of knowledge producers and users within the knowledge mobilization process ensures that developed resources are more relevant and useful (CIHR, 2012). For example, research questions that are formulated and explored in collaboration with physicians are more likely to uncover findings that are relevant to physicians' perspectives. Additionally, when findings are adapted into a resource or event through co-production, physicians are most likely to be reached and engaged in the content and its application.

Ultimately, research is conducted to learn about public health issues with the goal of improving the systems that function to positively impact the health and lives of populations that are serviced. To enable findings to have more meaningful population-level impacts, active efforts need to be made in moving findings forward as action-based recommendations through various channels, reaching identified individuals or organizations who can guide, influence, and alter relevant practice or policy (Access Alliance Multicultural Health and Community Services, 2011).

In fact, through the incorporation of integrated knowledge mobilization, the research agenda is broadened, allowing for more interactive dialogues to develop surrounding research questions of interest and enabling greater perspectives and impacts to arise (Access Alliance Multicultural Health and Community Services, 2011). Potential impacts move beyond project end dates. At AHSC, integrated knowledge mobilization can take on many forms, including:

- The development of community capacity for understanding evidence
- The creation of materials and tools that help knowledge users utilize evidence to influence and enact practice and policy change
- The development of relationships to influence and enact practice and policy change
- The facilitation of workshops and events that engage community, service providers, and policymakers in constructive partnerships that mobilize collaborative reflection and subsequent action
- The development of capacity for stakeholders to lead and participate in knowledge mobilization (Access Alliance Multicultural Health and Community Services, 2011)

All in all, integrated knowledge mobilization not only leads to knowledge uptake, but it influences practice and/or policy-based action — thus completing the knowledge-to-action cycle that research initially aims to enact (Access Alliance Multicultural Health and Community Services, 2011).

Zola and her colleagues develop knowledge mobilization plans at the beginning of research projects, updating them throughout the lifespan of projects. Dissemination does not have to begin at the end of a research project. It should be planned at the beginning and executed throughout the research cycle, increasing access and control of knowledge. Sharing information

## Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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about the development of the research question, the process of establishing the research design, and the frameworks utilized to analyze data is valuable (Access Alliance Multicultural Health and Community Services, 2011; Powell, Davies, & Nutley, 2016; Phipps et al., 2016).

Dissemination requires deliberate planning, resources, and time. Knowledge mobilization plans identify the who, what, where, when, why, and how of sharing information (Access Alliance Multicultural Health and Community Services, 2011). Essentially, knowledge mobilization attempts to meet people where they are at, aiming to carry them to a frontier of action.

Why	Plans must identify key objectives and prioritize them, thus setting the framework for all subsequent strategizing and action – what information needs to be shared?
Who	Key audiences must be distinguished based on goals and scans for potential vital partnerships must be conducted – who needs to learn about findings, who can help guide influence change, and what kind of change must be mobilized (i.e. grassroots-level, agency-level, policy-level, or more than one level)?
What	Facilitators and barriers to knowledge uptake and use must be examined – what factors stand in the way of turning research into action (i.e. political landscapes, organizational contexts, lack of motivation, incentive, funding, contextual understanding, accountability, time, or understanding on how to incorporate findings into practice or policy concretely)?  How do these facilitators and barriers influence dissemination priorities and goals, message framing, the list of intended audiences, and timelines?
How	Effective, relevant, and innovative channels must be assessed – how will identified audiences be reached, and how can various traditional and innovative mediums be utilized to maximize the impact of reach (i.e. mass media, magazines, websites, blogs, conferences, brown bag lunches, community events, workshops, symposiums, infographics, animations, video screenings, development of action-focused toolkits, etc.)?
When and Where	Where can we find our audience, and when is the best time to reach them?

### NEXT STEPS

The knowledge mobilization plan in Zola’s hands defined the who, what, where, when, why, and how of the team’s knowledge mobilization strategy. It was clear to the team why this work was important, and they developed a good sense of which sectors and stakeholders to engage. The team also distinguished a steady timeline of when and where activities could be implemented.

Zola looked up at Jaden Butler, the newest addition to the team who filled a new highly anticipated role within the department – knowledge broker. “Jaden, what can we do to mobilize this new knowledge that we possess? How can we make sure our stakeholders are able to use it? How can this plan guide us to enable and empower stakeholders to implement our recommendations across sectors?”

# Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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## EXHIBIT 1

Sectors involved in the Syrian refugee response, organized by degree of involvement.

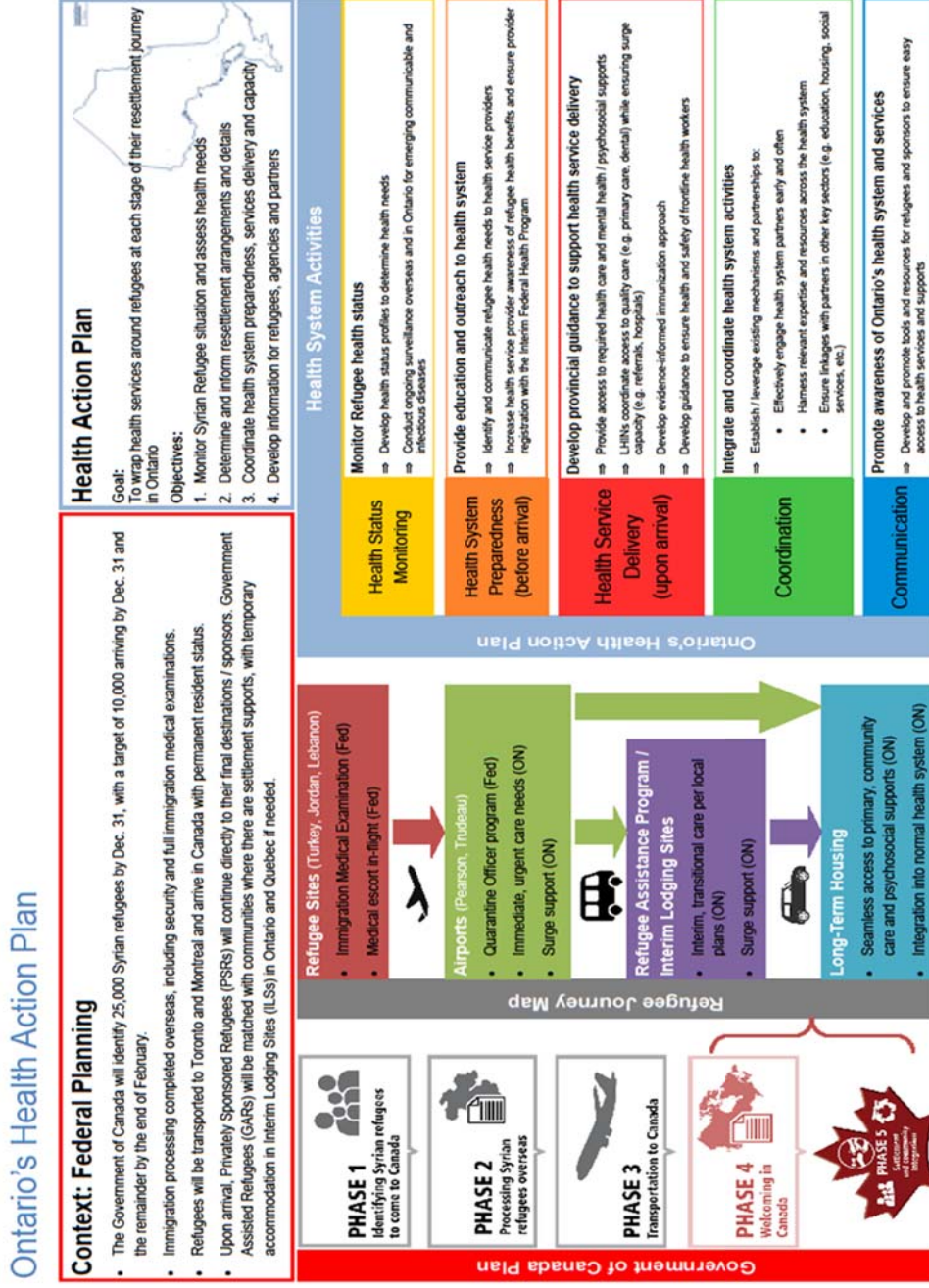


Source: Access Alliance Multicultural Health and Community Services, 2017b.

# Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

## EXHIBIT 2

### Ontario's Health Action Plan in response to the Syrian refugee resettlement effort.



Source: Ministry of Health and Long-Term Care, 2015.

## Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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## INSTRUCTOR GUIDANCE

### Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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#### BACKGROUND

The Syrian Civil War has displaced 6.5 million people internally within Syria (UNHCR, 2016) and has led 5 million to flee the country and live as refugees in Turkey, Egypt, Iraq, Jordan, Lebanon, and other North African countries (UNHCR, 2017). In 2015, the Canadian government and Canadian citizens stepped in with a nationwide commitment to resettle 25,000 Syrian refugees. Due to community-based rallying, the commitment expanded to a total of 40,000 Syrian refugees by mid-2017 (Government of Canada, 2017). In response to this urgent and unprecedented arrival of refugees, hundreds of community agencies and many community groups across Canada banded together to provide services and supports to Syrian families (Hansen & Huston, 2016; Access Alliance Multicultural Health and Community Services, 2017).

Various sectors were represented in this effort: healthcare, settlement, community and non-profit, housing, education, government, language, sponsor groups, children's services, community and civic participation, police and safety, faith-based organizations, research, employment, and food assistance. Among organizations that represented these sectors, Access for Health and Settlement Centre was a community health centre that situated itself in a temporary accommodation site, serving primary health care, interpretation, and other community services (Access Alliance Multicultural Health and Community Services, 2017).

Through this effort, Dr. Zola Faraji, a senior scientist at Access for Health and Settlement Centre, and his community-based research team began to recognize the importance of documenting the manner in which the response was unfolding around them within the Greater Toronto Area (GTA). Zola knew that upon the government's announcement to resettle so many Syrian refugees in Canada, none of the sectors and agencies who were to participate were adequately prepared to coordinate a response that matched the urgency of the situation. However, the response had been a remarkable one but not without its successes and challenges. Therefore, Zola conducted an environmental scan to document how service provider agencies within the GTA planned and delivered health, settlement, and other services for a large number of refugee families within a short period of time through a cross-sector perspective (Access Alliance Multicultural Health and Community Services, 2017). The study findings captured key successes and challenges that informed the development of best practices for refugee health and resettlement services, particularly in relation to future large-scale arrivals of refugees.

## **Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs**

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Now, Zola and her team are at a crossroad. They possess vital research findings and must develop recommendations as well as relationships with key players across various involved sectors. The team is developing a knowledge translation strategy. How can Zola and her team develop and implement a strategy that ensures that knowledge is not only shared but implemented into action? How can this research be utilized in a knowledge-to-action framework to benefit these vulnerable populations in the future?

### **OBJECTIVES**

1. Understand the importance of evaluating services to identify gaps, leading to the development of, or investigation for, evidence-based recommendations to implement improvements.
2. Demonstrate the importance of sharing knowledge and research – internally and/or externally – to facilitate the process of best-practice implementation within an organization, within a sector, or cross-sectorally.
3. Design innovative tools and strategies through which knowledge translation goes beyond sharing information but rather builds capacity for action.
4. Coordinate important collaborations and relationship-building opportunities in the process of implementing successful knowledge-to-action initiatives.
5. Evaluate public health's current limitations and responsibilities to mobilize organization and system-level changes through knowledge translation and to protect and promote the health of vulnerable populations.

### **DISCUSSION QUESTIONS**

1. Why was it important for Access for Health and Settlement Centre to launch a research project to uncover lessons learned in relation to the Syrian refugee response?
2. What were some of the incentives for Zola and her team at Access for Health and Settlement Centre to collect and share information beyond their organization?
3. What avenues did Access for Health and Settlement Centre consider in terms of knowledge and information sharing? What other innovative avenues should they consider?
4. What is the difference between simply sharing knowledge and sharing knowledge for the purpose of action or change? What is the significance in the difference?
5. How should Access for Health and Settlement Centre use their recent research and relationships to build capacity and enable systems-level change to be implemented cross-sectorally—for example, what are some of ingredients that have to be considered to do this successfully?
6. What are some of public health organizations limitations when it comes implementing effective knowledge translation initiatives?
7. How do public health professionals become advocates and build interest in knowledge translation and mobilization? How do public health professionals build competencies in knowledge translation and mobilization?
8. Is it public health's responsibility to translate research into tools or methods that facilitate positive changes to services, the healthcare system, and society at large? What role does public health need to take?
9. What are some of the potential impacts of a best practice knowledge-to-action model on for future refugee surges? How can such a model aid the coordination of services within the healthcare sector and other related sectors?

### **KEYWORDS**

Refugee health; refugee settlement; knowledge translation; knowledge mobilization; knowledge exchange; integrated knowledge mobilization; implementation science; Syrian refugee response; best practices; evidence-based; managing health services.





## CASE 2

### Good Food Box: Generative Relationships and Scenario Planning in Public Health

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*Andrew Butti, BSc, MPH (MPH Class of 2017)*

*Amy Campbell, BSc (Community Health Promoter, North Bay Parry Sound District Health Unit)*

*Jessica Love, RD (Registered Dietitian, North Bay Parry Sound District Health Unit)*

*Amardeep Thind, MD, PhD (Professor, Western University)*

As Amy Campbell walked down the gentle slope of North Bay's Fraser Street towards her meeting with the Good Food Box advisory committee at the Nipissing District Housing Corporation's (NDHC) head office, she was not prepared for the unpleasant news that was awaiting her. The first order of business on the agenda was a funding update from committee chairperson and NDHC employee Valerie Kelcey and, unfortunately, the message was not good. The Good Food Box's funding had expired and had not been renewed. In light of this information, the committee knew that if an alternative source of funding was not found, the coordination of the Good Food Box program in the North Bay region would cease to exist within two months, leaving hundreds of families with reduced access to an affordable source of fresh fruits and vegetables.

As the committee voice from the North Bay Parry Sound District Health Unit, Amy's mind was scrambling for a solution. She had a deeply personal connection to the project and its goal of increasing food accessibility for low-income individuals and families, as she was a key figure in the primary implementation of the Good Food Box program in other regional sites for the past five years. Ever since the NDHC took on the responsibility of the Good Food Box's coordination, the Health Unit's only involvement was through the Good Food Box advisory committee, which was comprised of a number of community partners whose insights strengthened the program. Amy wanted to provide as much assistance on behalf of the Health Unit as she could, and she had a number of questions for her manager and other members of the Healthy Living team. Was it the responsibility of the Health Unit to rescue the Good Food Box? How had the trajectory of the Health Unit changed since it first supported the implementation of the Good Food Box? Did the current mandates and policies of the Health Unit support a food-procurement program, such as the Good Food Box? And, if the Good Food Box is beyond the Health Unit's authority, how can the Health Unit's actions continue to support immediate food security issues addressed by the Good Food Box program if it no longer exists?

#### **NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT**

The North Bay Parry Sound District Health Unit is one of 36 public health units located within the province of Ontario and one of seven located in Northern Ontario. Based in the City of North Bay and with regional offices in both Parry Sound and Burk's Falls, the Health Unit serves most of the Nipissing District and all of the Parry Sound District for a total service population of over 120,000. Within this total catchment area, there are 31 municipalities, four unorganized areas, and six First Nation reserves (North Bay Parry Sound District Health Unit [NBPSDHU], 2017).

## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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The Health Unit provides many services and supports throughout the community under a number of organizational umbrellas. At a macro level, the Health Unit is divided into five executive teams: Clinical Services, Community Services, Corporate Services, Finance, and Human Resources. These five categories are then further subdivided into 29 programs/service areas. These include, among others, Communicable Disease Control, Environmental Health, and Planning and Evaluation. Amy and her coworkers work in the Healthy Living program, which falls under Community Services. The programming of the Healthy Living team focuses on health promotion for chronic disease, injury prevention, and substance misuse.

The provision of health care and public health interventions and programs in Northern Ontario is traditionally very difficult due to the diversity of the population in terms of language, culture, and geography. Covering an area of nearly 800,000 square kilometers and spanning two time zones, it is no surprise that Northern Ontarians face greater barriers to achieving good health than the rest of the province. The region has greater rates of smoking and obesity and reduced access to health services and the tools necessary to live a healthy lifestyle, such as healthy foods. These broader social determinants of health have resulted in a progressively widening mortality gap between Northern and Southern Ontario (Health Quality Ontario, 2017). This climate, under which the Health Unit functions, presents unique challenges for Health Unit employees in the design, implementation, and evaluation of regional programs. As a Health Unit employee, Amy is aware of these challenges, and her daily work is imbued with a focus on marginalized groups, equity, and an upstream approach to population health. The Good Food Box project meshed well with Amy's approach to supporting healthy eating as a foundation for good health.

### **THE GOOD FOOD BOX**

The Good Food Box project in North Bay is a food volume buying program with the purpose of supporting chronic disease prevention through the promotion of increased fruit and vegetable consumption. Like all Good Food Box programs, the North Bay Good Food Box is rooted in the community and was informed and shaped by local wants, needs, resources, and demographics. It emerged organically in 2012, when the dietitians and health promoters in the Healthy Living team at the Health Unit observed a need for increased access to fresh produce for low-income individuals in the community.

As with any community-focused project, the development of the Good Food Box in North Bay required a rigorous planning process. Amy and her team followed a general model for the development of the Good Food Box business plan that was first outlined by McCue et al. (2011). First, a needs assessment was conducted to identify potential community partners and local interest groups as well as the breadth of need within the region. Next, the Healthy Living team hosted a strategic planning process to identify the guiding principles and objectives of the Good Food Box program. Strategic planning demands "broad-scale yet effective information gathering, clarification of the mission to be pursued and issues to be addressed along the way, development and exploration of strategic alternatives, and an emphasis on the future implications of present decisions" (Bryson, 2011). Finally, they used both the needs assessment and the strategic plan to inform the development and implementation of the Good Food Box program in North Bay.

The conceptual foundation of North Bay's Good Food Box is to increase the accessibility of healthy fresh fruits and vegetables for low-income individuals and families through a bulk-buying program. This is of vital importance, as low socioeconomic status (SES) households have greater access to unhealthy foods and reduced access to healthy foods, which has resulted in higher rates of obesity in these households (Ravensbergen, Buliung, Wilson, & Faulkner, 2016).

## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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Good Food Box programs provide not only increased physical access, but increased financial access to healthy foods. Health Unit staff collected regional data that indicated that the bulk-buying process is able to reduce costs for customers by up to 30% when compared to shopping for the same products at a traditional grocery store. Research evidence shows projects such as Good Food Box programs, which have grown as grassroots projects throughout Canada, have been proven to increase food accessibility among food-insecure families (Loopstra & Tarasuk, 2013). Furthermore, the increase in accessibility to fresh fruits and vegetables is negatively correlated with the development of poor health and chronic disease states, which results in a positive impact on quality of life (Rose Bell, Rose, Roll, & Dupont, 2014).

In conjunction with the provision of fresh produce, the Healthy Living team also incorporated tools to improve food education and nutrition literacy into the Good Food Box model. The Good Food Box team at the Health Unit wanted to focus on more than just food accessibility, as nutrition literacy is also linked to a healthier dietary eating pattern (Wall, Geary, Pearson, Parnell, & Skidmore, 2014). Overall, low health literacy, of which nutrition literacy is a key component, is associated with poor health outcomes (Spronk, Kullen, Burdon, & O'Connor, 2014). To incorporate the nutrition literacy piece into the Good Food Box model, it was decided to include a newsletter in each box that highlighted a seasonal fruit or vegetable and contained nutritional and storage information as well as a few easy and inexpensive recipes that incorporate the monthly produce. The newsletter also included information to support daily physical activity, as a healthy diet does not function in isolation in the achievement of good health.

Each Good Food Box is packed at a central site and delivered to pick-up sites within the community during the third week of every month. They are available in small \$10 boxes for single individuals or small families and in larger \$20 boxes for larger families. The Good Food Box has a number of committed volunteers who regularly donate their time to help pack the boxes and deliver them to pick-up sites. Individuals who have already placed an order for a box will then pick their box up on the third Wednesday of the month. For lower income families who use the Good Food Box, this timing provides support in the greatest time of need: when cupboards become bare towards the end of the month and before the next social assistance payment is scheduled.

The Good Food Box program is largely self-sustaining. Each month, the boxes are pre-paid for by the consumers at community partner sites. These community partners act as the liaison between the customers and the NDHC. The funds are then funneled to the NDHC, which uses the money to purchase the produce in bulk. The food is purchased from a local wholesaler, packed by volunteers, and paid for in whole by the consumers. Aside from the funding required to support the Good Food Box coordinator position and minor delivery charges, the program requires no extra injection of funds.

Over time, North Bay's Good Food Box project has become an established social venture with growing interest and recognition in the region. It has become a regional enterprise, with boxes regularly being shipped to smaller communities within the Nipissing District, such as Mattawa and West Nipissing. The program also provides much needed fresh fruits and vegetables for Temagami, a rural community within the Nipissing District but beyond the Health Unit's service area, which does not have a local grocery store. The program has a number of engaged community partners who provide similar services, such as the local soup kitchen which advertises the Good Food Box to members of the community at easily accessible locations and occasionally provides donations or food subsidies to the Good Food Box program. The program

## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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has developed into an example of the power of effective community engagement and interorganizational partnerships.

### **HISTORY**

The Good Food Box program in North Bay was not the first of its kind, but rather one example in a long list of Good Food Box projects throughout the province. The first Good Food Box program was established in Toronto in January of 1994 by FoodShare, a not-for-profit organization established in 1985 to coordinate emergency food services and to gather and allocate food. In the wake of the hunger crisis in the 1980s and the failure of food banks to address rising hunger in the city, the Good Food Box emerged from an exploration of cooperative buying systems to find alternative avenues for change. Whereas food banks and the provision of emergency sources of food only have a short-term effect on individual hunger, the Good Food Box was able to have a longer lasting and more impactful influence on, not only hunger, but nutrition as well. The Toronto chapter grew from a small program packing 40 boxes in a basement facility to packing over 4,000 boxes a month in its 7,000 square foot warehouse. The FoodShare Good Food Box program has stimulated the creation of dozens of other Good Food Box programs throughout Canada (Morgan & Scharf, 2008).

Inspired by the success of other Good Food Box programs, Amy and the Healthy Living team at the Health Unit wanted to implement a Good Food Box in the North Bay/Parry Sound region. Particularly, the success and expansion of a Good Food Box program in another northern community, Thunder Bay, proved to the Healthy Living team that such a program had promising potential within a northern context. With passion and determination, Amy and her colleagues planned, implemented, and coordinated North Bay's Good Food Box project during its first years. The Good Food Box was integrated into the portfolios of members of the Healthy Living team, and the coordination of the project became part of their job responsibilities. After a year under the direct guidance of the Health Unit, the Good Food Box project organically shifted to the NDHC when funding was procured by the NDHC for a joint Good Food Box coordinator/tenant engagement position. The NDHC was a logical governing body for the Good Food Box, as the NDHC's organizational approach to programming was more downstream and hands-on and often involved direct client interaction. The set-up costs associated with the initial implementation of the project, such as the packing boxes and materials and the scales required to portion produce, had already been covered by the Health Unit in the first year of the program. Aside from the cost associated with a coordinator's salary, the Good Food Box program was self-sufficient and, as long as the funding continued for the coordinator's position, the project seemed to have a bright and sustainable future.

At the May Good Food Box advisory committee meeting, Valerie Kelcey, committee chairperson, provided the most recent service numbers for the program: 147 boxes for the month of March and 163 for April. In April, there had also been 30 delivered to West Nipissing and 47 delivered to Mattawa. It seemed that the program was on its usual summer uptick. Valerie also expressed the interest of increasing the Temagami packing to twice a month and expanding the program to South River, another regional municipality in Parry Sound District. The Good Food Box was performing well and increasing food accessibility for low socioeconomic status individuals and families throughout the region. Amy was pleased with the success of the local project and proud of her involvement with the initial implementation.

### **NIPISSING DISTRICT HOUSING CORPORATION**

Valerie Kelcey and Isaac Hass, the Good Food Box program coordinator, were extremely passionate about the work they were doing with the Good Food Box program. Both Valerie and Isaac were employees of the NDHC, which is a housing corporation that serves the whole of the

## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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Nipissing District. Its primary roles were to manage geared-to-income housing units in the region, with a specialization in housing for seniors, single individuals, and families, as well as manage a rent supplementation program (District of Nipissing Social Services Administration Board, 2013). The NDHC also administered a number of programs that did not fall into the category of housing but did attempt to address food accessibility challenges for their clients in the region. These programs included the Good Food Box program and a Pantry Swap program, where individuals could trade canned items for fresh eggs, milk, and other perishable items (District of Nipissing Social Services Administration Board, 2016).

The NDHC facilitated their programming over a service area that encompassed a population of roughly 87,000 individuals over 17,000 square kilometers, which included 11 municipalities, two First Nation reserves, and two unorganized areas (District of Nipissing Social Services Administration Board, 2013). The service catchment area for the NDHC is different from the Health Unit, which can cause confusion in service delivery. The NDHC includes all of the Nipissing District and none of the Parry Sound District, whereas the Health Unit includes all of the Parry Sound District and only a portion of Nipissing District. Most notably, it excludes the town of Temagami and Bear Island First Nation, which are under the jurisdiction of the Timiskaming Health Unit. The responsibility of the NDHC within the Good Food Box program was to procure funding for and employ a Good Food Box coordinator on a part-time basis. This coordinator was to oversee the day-to-day functioning of the program.

### **CORPORATE MERGER AND FUNDING CRISIS**

A few weeks prior to Amy's May meeting with the Good Food Box advisory committee, the NDHC had been reorganized and integrated into the District of Nipissing Social Services Administration Board to allow for increased alignment and integration of social services for clients in the region. The social services board has the same service area as the NDHC and works in affordable housing procurement for Nipissing District residents; however, the social services board has a broader portfolio of social services, which also includes childcare-related programs, the Ontario Works and Ontario Disability Support program, and the provision of emergency medical services throughout the area (District of Nipissing Social Services Administration Board, 2013). Upon the merging of the two organizations, the services that the NDHC had provided had come under review. It had to be determined if they would continue to fund many NDHC services within the new organizational body by evaluating the NDHC program's fit with the social services board's funding criteria and if the financial resources existed to support these programs.

Prior to the integration of the NDHC into the social services board, the Good Food Box program had received funding from a variety of funds and organizations over the years. In 2014, the NDHC secured funding for a Good Food Box coordinator through the Community Health Funds, which was a grant supported by the provincial government and funneled to municipalities within Ontario. The Good Food Box coordinator position and, therefore the Good Food Box itself, was supported by this grant for both 2014 and 2015. In 2016, the position was funded by another provincial grant: the Community Homelessness Prevention Initiative. When this funding was initially granted in 2014, the NDHC became a flow-through agency for the Good Food Box project, which meant that its role was to take the established vision and purpose of the Good Food Box set out by the Health Unit and operationalize the project within the community.

The Good Food Box itself required no extra funding once initial implementation was complete. The money paid by Good Food Box customers covered the cost of the fresh produce provided in the box, and the packing was done by volunteers. The funding that was being requested by the NDHC would cover the cost of the Good Food Box coordinator position as well as a few

## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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minor monthly delivery charges. Now that the program had a strong foundation, Valerie and Isaac expected the program to only cost between \$12,000 and \$15,000 per year. These funds would provide the salary required to support the coordinator position, which was currently being filled by Isaac, and the \$75 monthly flat charge for the delivery of the Good Food Box to surrounding communities.

In the months prior to the May Good Food Box advisory committee meeting, Isaac and Valerie prepared grant applications to support the Good Food Box coordinator position. As the grant applications were prepared, there existed, in the back of both Isaac and Valerie's minds, the inevitable expiration of funding along with the potential threat of non-renewal. They fully believed in the Good Food Box program and in the importance of the work they were conducting, which clouded their outlook on the possibility of funding. To Isaac and Valerie, non-renewal seemed impossible; however, after the merger with the social services board, their most promising funding application to the Healthy Communities Fund for \$30,000 was rejected, citing insufficient funds and a failure to meet criteria.

Isaac and Valerie were dumbfounded. They had to think quickly and determine what the next steps would be. Leading up to the May Good Food Box advisory committee meeting, Isaac and Valerie brainstormed a strategic plan. At the meeting, they presented their plan to the members of the advisory committee. Isaac was given advance pay until the end of June, and he kindly offered to volunteer his time until funding could be procured. Valerie and Isaac were also applying to the Grow Grant and the Local Poverty Reduction Fund for funding, which were both components of the Ontario Trillium Foundation. Additionally, they provided a letter to all committee members asking for donations from local businesses and city residents to support the Good Food Box program.

Although they had made good progress in the face of an alarming situation, Amy wondered if it was enough. How long would Isaac be able to volunteer his time? He was passionate, but eventually, he would experience program delivery fatigue. This did not seem to be a sustainable solution. Were Isaac and Valerie overconfident that they would receive funding through the Grow Grant or the Poverty Reduction Fund? If so, should they apply to more grants or focus more energy on raising funds locally? If they were to focus locally, were community businesses and local residents already being asked to donate too often? Would the community fundraising campaign be successful in supporting the Good Food Box program and, if so, for how long? There were so many questions and further considerations running through Amy's mind. She had to return to the Health Unit and discuss the situation with other members of the Healthy Living team.

### **HEALTH UNIT AND HEALTHY LIVING TEAM**

Upon her return to the Health Unit's offices, Amy requested an emergency meeting. She had to relay the news from the Good Food Box meeting and discuss the situation with her colleagues. The meeting brought together a number of key individuals in Healthy Living. Included in the discussion was Amy herself, who brought to the table 15 years of experience as a Community Health Promoter at the Health Unit; Jessica Love and Talia Durand, both Registered Dietitians working in food insecurity; and Chris Bowes, Manager of the Healthy Living program. The news Amy communicated to her three coworkers from the Good Food Box committee meeting was distressing. The major question that was on everyone's mind was if the provision of emergency funding to the NDHC for the support of the Good Food Box coordinator position fell within the responsibilities of the Health Unit. To elucidate the answer, the Healthy Living team had to ask many more questions of the Good Food Box program, of the shifting organizational objectives of

## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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the Health Unit to align with the 2018 modernization of the Ontario Public Health Standards (OPHS), and of the broader environmental context.

The Healthy Living team wondered if the Good Food Box could be classified as an upstream societal response or as a downstream individualistic approach to food accessibility within the region. On the one hand, the Good Food Box had a specified target population and provided the boxes on an individual basis; however, the boxes were available to anyone who wanted to participate in a bulk-buying produce program, and they did provide an upstream approach from the perspective of chronic disease prevention. Jessica had done some further research into what other health units in Ontario do to support local Good Food Box projects. She found that the results were just as varied as the ideas being proposed at the Healthy Living meeting. Some health units had minimal to no involvement, others approached the Good Food Box distally by organizing volunteers or focusing on communication, whereas two provincial health units fully coordinated the Good Food Box. It seemed that there was no set precedent as to how the Health Unit should approach this challenge.

The internal and external climate of the Health Unit was also in a transitory period. The Health Unit was in the process of shifting its focus to align with the new OPHS that were set to be released in January of 2018. The new OPHS aimed to reframe public health within the broader context of healthcare and to utilize public health's strengths to "inform and reorient the health care system" (Ministry of Health and Long-Term Care, 2017). The new OPHS addressed the need for increased integration between public health and the health care system and had a strong focus on an upstream approach to public health programming. They filled in a health policy gap that existed in the old standards as they provided a policy framework for public health programs and services. Overall, the foundation of the OPHS was shifting towards upstream approaches to public health and advocacy for policy change and away from direct service delivery. A comparison of the old and new OPHS is included in Exhibit 1. To the Healthy Living team, the new OPHS seemed to exclude the direct coordination of a program such as the Good Food Box from the mandate of a health unit.

Recent developments in the greater public health environment were also having an influence on the decision-making process. The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) had recently released a position statement on how Registered Dietitians in Ontario working in public health were expected to confront household food insecurity through support and advocacy for income-related policy changes (Exhibit 2) (Ontario Society of Nutrition Professionals in Public Health, 2015). Announcements by the provincial government, made in 2017, to change income policies were also fresh in the minds of each individual at the Healthy Living boardroom table. Premier Kathleen Wynne had recently announced the basic income pilot project, where over a three-year period, the government would guarantee a basic minimum income to eligible participants and families regardless of employment status (Exhibit 2) (Government of Ontario, 2017b). Premier Wynne had also announced a gradual increase of Ontario's minimum wage over the coming years to \$15 per hour by January of 2019 (Exhibit 2) (Government of Ontario, 2017a). The increase was expected to allow individuals working minimum wage jobs to meet the cost of living, which includes the cost of eating healthy. It seemed that the approach to food insecurity was moving upstream and away from direct food provision programs such as the Good Food Box.

### **NEXT STEPS**

Amy and the Healthy Living team have a difficult decision on their hands. With so many considerations and potential avenues to choose from, it will not be easy. Although many alternatives exist, the Health Unit has to consider its role within the broader health care system



## Good Food Box: Generative Relationships and Scenario Planning in Public Health

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and its role within provincial public services as a public health unit; simultaneously, they also have to balance their responsibility to residents of the community of North Bay and of the larger Northeastern Ontario region. It will be difficult to determine how the Health Unit will continue to support immediate food security issues addressed by programs such as the Good Food Box, while also considering the Health Unit's OPHS-informed organizational focus to support policy change.

It seemed to the Healthy Living team that the next steps are to reach out to various stakeholders whose interests were intertwined with the Good Food Box program. Considering how to optimize stakeholder relationships is key in establishing generative relationships – relationships that generate novel solutions to a complex situation or problem. An excellent way to assess the potential for generative relationships among stakeholders is by using the “STAR” model. The “STAR” model can represent the four dimensions of a generative relationship. The four dimensions are **S**eparateness or differences, **T**alking and listening or “tuning,” **A**ction opportunities, and **R**eason to work together. Strong generative relationships will contain stakeholders that have differing backgrounds, skills, perspectives, or training (S); have opportunities to talk, listen, and challenge ideas (T); be able to act on the talk to create something new (A), and there must be a mutual benefit to working together (R) (Exhibit 3) (Zimmerman & Hayday, 1999).

While analyzing stakeholders for generative relationship potential, Amy and her team will also have to balance differing and opposing viewpoints to come to a solution that pleases all groups involved. Throughout this process, they must utilize an upstream lens to household food insecurity that fits within the role of health units being carved out by the new OPHS and the recent policy announcements from the provincial government. To do so, undergoing a scenario planning process seemed to be the perfect tool to analyze the situation and the stakeholders involved and to establish a plan to move ahead (Exhibit 3). The Healthy Living team wondered who would have to be involved in the Good Food Box conversation to diversify perspectives. Who were the stakeholders involved in the Good Food Box dilemma and what could each person bring to the discussion? In the absence of funding, the Healthy Living team would have to bring together all relevant stakeholders to determine the next steps for food insecurity programming in the region. In light of the new OPHS and shifting Health Unit focus, how would the Healthy Living team be able to maximize collaborative efforts while fostering a generative relationship between these stakeholders? It would not be easy, but Amy and the Healthy Living team were ready for the challenge.

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

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### EXHIBIT 1

#### Ontario Public Health Standards Comparison (2008, 2018)

The Ontario Public Health Standards (OPHS) identify the minimum expectations for public health and services to be delivered by Ontario's 36 boards of health

##### OPHS (2008)

- No explicit definition of public health
- Comments on the scope of the OPHS in promoting the health of the population as a whole
  
- Does not provide public health policy framework
- Comments on public health being an essential part of the health care system
  - Public health compliments the health care system by reducing the demand for health care services
  - No comment on the integration of public health into the health care system
  
- Foundational Standards
  1. Population Health Assessment
  2. Surveillance
  3. Research and Knowledge Exchange
  4. Program Evaluation
  
- Relationship between the Principles, the Foundational Standard, and the Program Standards (Figure 2)

##### OPHS (2018)

- Provides definition of public health
  - The focus of public health is on the whole population
  - What unifies public health is its focus on prevention, upstream interventions, and societal factors that influence health
  
- Provides public health policy framework (Figure 1)
- Comments on the transformation of the public health sector since 2008
  - Changes in the role of public health within the broader health system
  - Changes aim to maximize public health's contributions to improve the health of the population and leverage public health's strengths to inform and reorient the health care system
  
- Foundational Standards
  1. Population Health Assessment
  2. Health Equity
  3. Effective Public Health Practice
  4. Emergency Preparedness, Response, and Recovery
  
- Description of the Principles, the Foundational Standards, and the Program Standards (Figure 3)

Source: Ministry of Health and Long-Term Care, 2018.

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

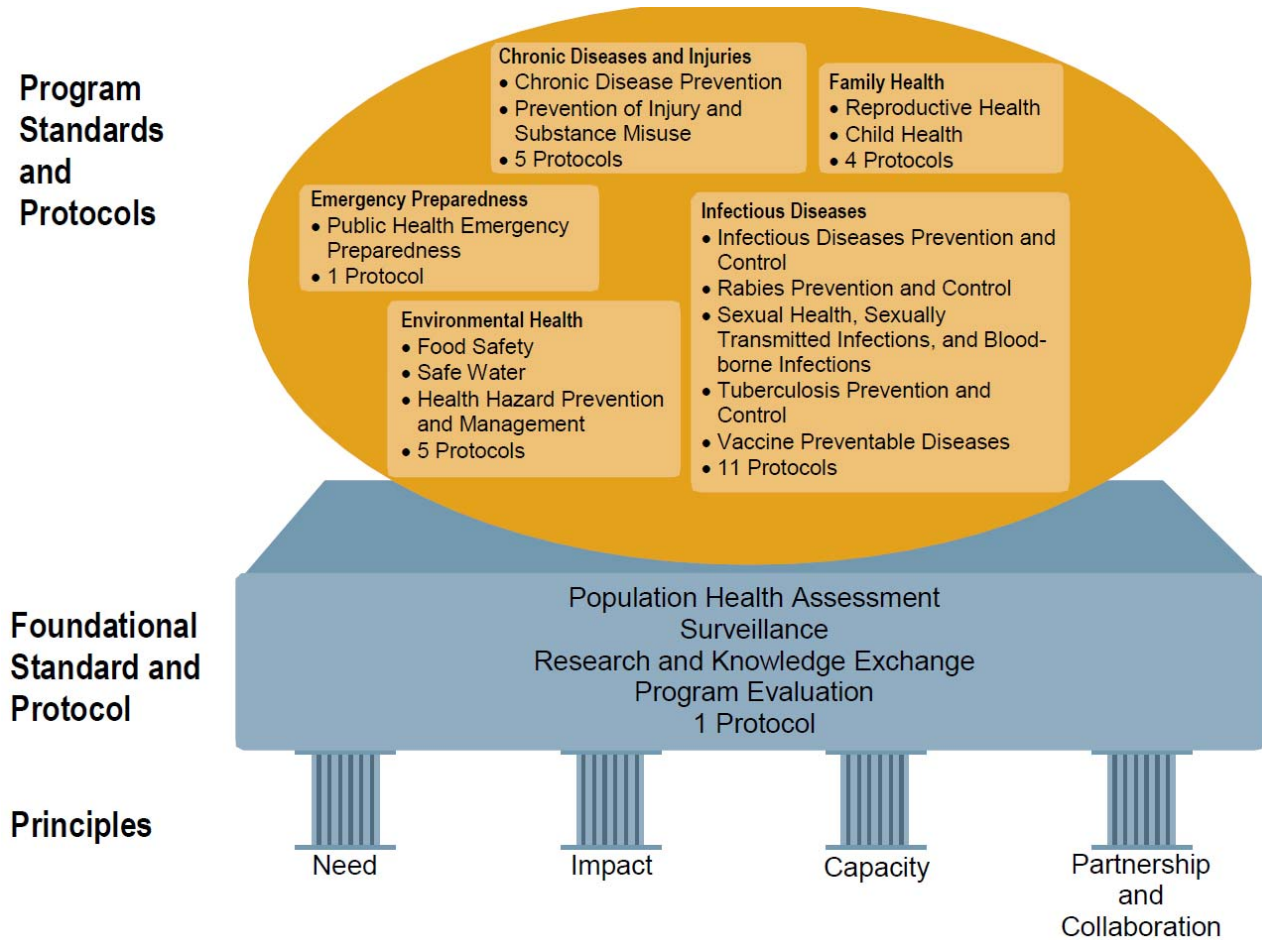
**Figure 1: Policy Framework for Public Health Programs and Services**

<b>GOAL</b>	To improve and protect the health and well-being of the population of Ontario and reduce health inequities					
<b>POPULATION HEALTH OUTCOMES</b>	<ul style="list-style-type: none"> <li>Improved health and quality of life</li> <li>Reduced morbidity and mortality</li> <li>Reduced health inequity among population groups</li> </ul>					
<b>DOMAINS</b>	<b>Social Determinants of Health</b>		<b>Healthy Behaviours</b>		<b>Healthy Communities</b>	<b>Population Health Assessment</b>
<b>OBJECTIVES</b>	To reduce the negative impact of social determinants that contribute to health inequities		To increase knowledge and opportunities that lead to healthy behaviours		To increase policies and practices that create safe, supportive and healthy environments	To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
<b>ENABLERS</b>	Legislation	Funding	Evidence	Agencies & Associations	Municipal & Federal Governments	Partner Organizations
<b>PROGRAMS AND SERVICES</b>	<b>GOALS</b>					
	<ul style="list-style-type: none"> <li>To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system</li> <li>To reduce health inequities with equity focused public health practice</li> <li>To increase the use of current and emerging evidence to support effective public health practice</li> <li>To improve behaviours, communities and policies that promote health and well-being</li> <li>To improve growth and development for infants, children and adolescents</li> <li>To reduce disease and death related to infectious and communicable diseases of public health importance</li> <li>To reduce disease and death related to vaccine preventable diseases</li> <li>To reduce disease and death related to food, water and other environmental hazards</li> <li>To reduce the impact of emergencies on health</li> </ul>					
<b>PARTNERS</b>	Health Care (including Primary, Community, Acute and Long-Term Care), Education, Housing, Children and Youth Services, Community and Social Services, Labour, Environment, Agriculture and Food, Transportation, Municipalities, Non-Governmental Agencies, Public and Private Sectors, Academia, and Indigenous communities and organizations					

Source: Ontario Public Health Standards, 2017.

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

**Figure 2: Relationship between the Principles, the Foundational Standard, and the Program Standards**



Source: Ontario Public Health Standards, 2008.

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

**Figure 3: Description of the Principles, the Foundational Standards, and the Program Standards**

Principles							
<b>Need</b>	Boards of health shall continuously tailor their programs and services to address needs of the health unit population. Need is established by assessing the distribution of social determinants of health, health status, and incidence of disease and injury.						
<b>Impact</b>	Boards of health shall assess, plan, deliver, and manage their programs and services by considering evidence, effectiveness of the intervention, barriers to achieving maximum health potential, relevant performance measures, and unintended consequences.						
<b>Capacity</b>	Understanding local public health capacity required to achieve outcomes is essential to ensure the effective and efficient delivery of public health programs and services. Boards of health shall strive to make the best use of available resources to achieve the capacity required to meet the standards.						
<b>Partnership, Collaboration and Engagement</b>	Boards of health shall engage and establish meaningful relationships with a variety of sectors, partners, communities, priority populations, and citizens, which are essential to the work of public health and support health system efficiency.  Establishing meaningful relationships with priority populations includes building and further developing the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the community and/or organization.						
Foundational Standards							
Population Health Assessment		Health Equity		Effective Public Health Practice		Emergency Preparedness, Response, and Recovery	
Program Standards							
Chronic Diseases and Injury Prevention, Wellness and Substance Misuse	Food Safety	Healthy Environments	Healthy Growth and Development	Immunization	Infectious and Communicable Diseases Prevention and Control	Safe Water	School Health

Source: Adapted from Ontario Public Health Standards, 2008; Ontario Public Health Standards, 2017.

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

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### EXHIBIT 2

#### Ontario Society of Nutrition Professionals in Public Health Position Statement, Basic Income Pilot, and Minimum Wage Increase

- |                                  |   |
|----------------------------------|---|
| <b>OSNPPH Position Statement</b> | <ul style="list-style-type: none"><li>• Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario</li><li>• The root cause of food insecurity is poverty</li><li>• Adults in food insecure households have poorer self-rated health, poorer oral health, greater stress, and are more likely to suffer from chronic disease; children have increased risk of mental health issues; and teenagers are at a greater risk of depression, social anxiety, and suicide</li><li>• Food charity does not work as it does not address poverty, and it absolves governments of their responsibility to ensure the basic right to food security</li><li>• A basic income guarantee would ensure income at an adequate level to meet basic needs and for people to live with dignity, regardless of work status</li><li>• The indirect costs of poverty are far higher than the costs of lifting people out of poverty</li></ul>   |
| <b>Basic Income Pilot</b>        | <ul style="list-style-type: none"><li>• A basic income is a payment to eligible families or individuals that ensures a minimum income level regardless of employment status</li><li>• Three-year pilot taking place in Hamilton, Brantford, and Brant County; Thunder Bay; and Lindsay</li><li>• Up to 4,000 individuals will participate in the pilot</li><li>• Participants will be randomly selected based of a set criterion<ul style="list-style-type: none"><li>○ 18-64 years olds;</li><li>○ living in one of the pilot locations for the past 12 months or longer, and;</li><li>○ living on low income (under \$34,000/year if single; under \$48,000/year if a couple).</li></ul></li><li>• Participants will receive up to \$16,989 per year for a single person, up to \$24,027 per year for a couple, and up to an additional \$6,000 per year for a person with a disability (amounts will decrease by \$0.50 for every dollar an individual earns through work)</li><li>• Other support programs will decrease payment dollar for dollar</li><li>• Expected to have impacts in food security, stress and anxiety, mental health, health care usage, housing stability, education and training, and employment and labour market participation</li></ul> |
| <b>Minimum Wage Increase</b>     | <ul style="list-style-type: none"><li>• Ontario's current minimum wage is \$11.40 per hour</li><li>• The provincial minimum wage will be phased in over an 18-month period</li><li>• It will rise to \$14 per hour on January 1, 2018 and to \$15 per hour on January 1, 2019</li><li>• After that it will rise annually with inflation</li><li>• 9.2% of Ontario's population (540,000 people) earn minimum wage</li></ul>   |

Source: Adapted from Ontario Society of Nutrition Professionals in Public Health, 2015; Government of Ontario, 2017b; Government of Ontario, 2017a.

# Good Food Box: Generative Relationships and Scenario Planning in Public Health

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## EXHIBIT 3

### Stakeholder Analysis, Generative Relationship (“STAR” Model) and Scenario Planning Tools

#### Stakeholder Analysis

Stakeholder	Strengths, Weaknesses, Opportunities, Threats (SWOT)
Health Unit – Healthy Living Program	<ul style="list-style-type: none"><li>- Initially began the North Bay Good Food Box program</li><li>- Interest in the objective of the Good Food Box program, increasing food accessibility for low-income populations</li><li>- Conscious of shifting OPHS, organizational trajectory, and broader public health context</li><li>- Concerned about the optics of the decision</li><li>- Unsure of where the Good Food Box would be positioned on the upstream/downstream continuum</li></ul>
Health Unit – Board of Health (BOH)	
NDHC	
North Bay low-income population	
Mattawa	
West Nipissing	
Temagami	
South River	

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

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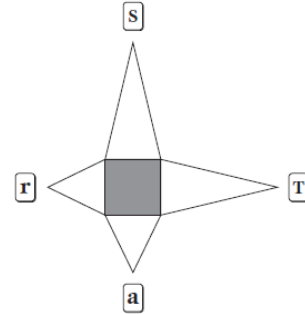
### “STAR” Diagrams

#### Stakeholders

##### “STar” (BOH and NDHC)

- An ST relationship is one where the two parties who came together represented diverse perspectives, but had no reason to work together, so there were no real action opportunities (Zimmerman & Hayday, 1999)
- The relationship between the BOH and the NDHC would be an example of a “STar” relationship: both parties have a reason to discuss and listen and they have ‘separate’ viewpoints; however, the BOH does not have the ability to have direct actions that will influence the Good Food Box program and, due to this, the two parties do not have a reason to work together without other stakeholders involved.

#### “STAR” Model



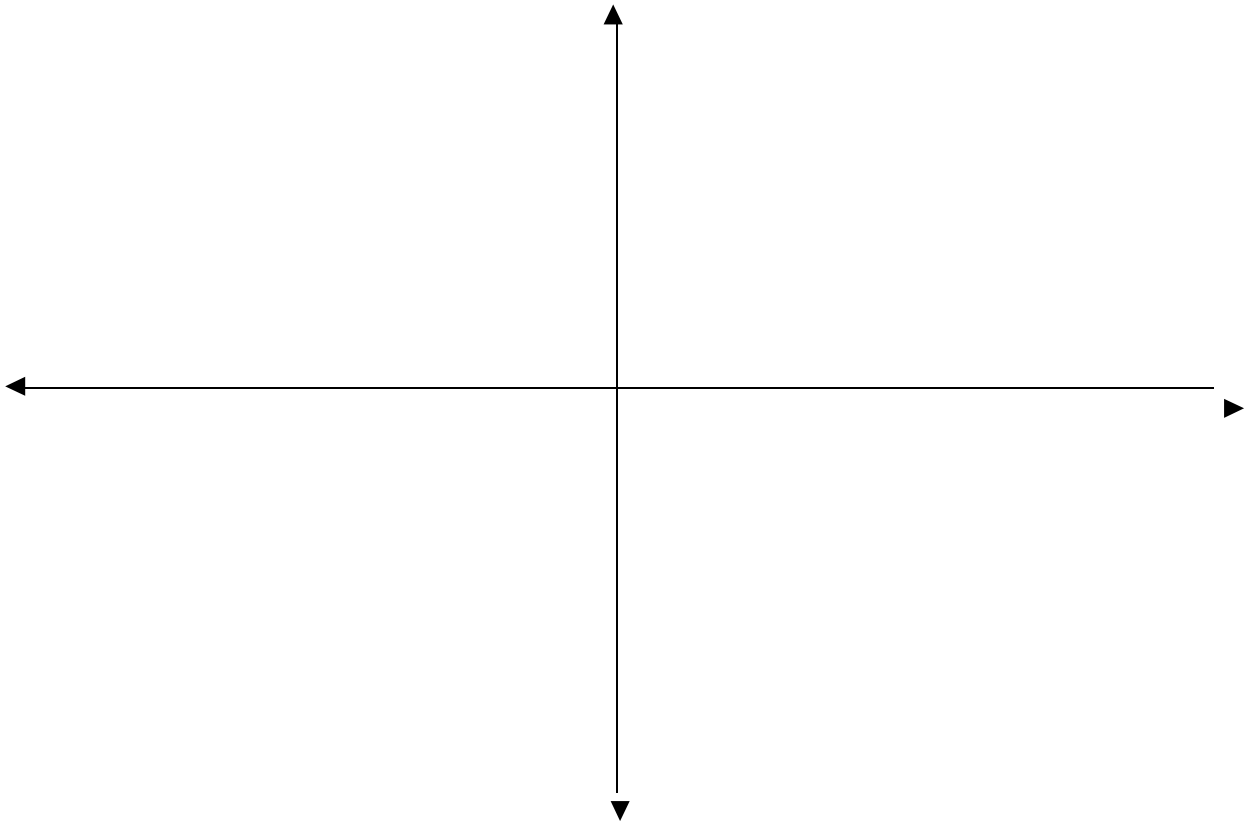


## Good Food Box: Generative Relationships and Scenario Planning in Public Health

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### Scenario Planning

1. Identify and understand the organization
2. Map trends (past) and driving forces (present)
  - Relevant trends (past)
  - Driving forces (present)
3. Identify stakeholders (previously completed) and key uncertainties
  - Key uncertainties
4. Create scenarios and assess their implications (Scenario Matrix)



## **Good Food Box: Generative Relationships and Scenario Planning in Public Health**

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5. Create strategies based on scenarios (for actionable scenarios)

6. Decide on an action plan

Source: Adapted from Zimmerman & Hayday, 1999; Scearce & Fulton, 2004.

## Good Food Box: Generative Relationships and Scenario Planning in Public Health

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## INSTRUCTOR GUIDANCE

### Good Food Box: Generative Relationships and Scenario Planning in Public Health

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#### BACKGROUND

The Good Food Box project in North Bay, Ontario is a bulk food-buying program with the purpose of supporting chronic disease prevention through the promotion of increased fruit and vegetable consumption. Good Food Box increases the accessibility of healthy, fresh fruits and vegetables for low-income individuals. Unfortunately, the Nipissing District Housing Commission, whose responsibility it was to procure funding for and employ the Good Food Box coordinator, was unsuccessful in renewing funding. Without funding, the Good Food Box program would cease at the end of June. Amy Campbell, North Bay Parry Sound District Health Unit employee and member of the Good Food Box advisory committee, and the rest of the Healthy Living team grappled with what the Health Unit could and should do in such a situation. This was especially difficult considering the trajectory of the Health Unit's programming towards more upstream interventions and the release of the new Ontario Public Health Standards (OPHS), which advocates for policy change. The broader public health context was also shifting towards more upstream solutions to food insecurity. All of this would have to be considered when determining the Health Unit's responsibilities and approach to the Good Food Box project.

#### OBJECTIVES

1. Identify and analyze stakeholders essential to planning.
2. Utilize scenario planning to brainstorm a number of potential action items for the Healthy Living team.
3. Define the role of public health units in accordance with the Public Health Standards, such as the new OPHS, set to be released in 2018.

#### DISCUSSION QUESTIONS

1. Why is it crucial to identify stakeholder relationships that will lead to generative relationships in complex situations? How can stakeholder analysis tools such as the "STAR" model be used as a tool to perform this task?
2. Why is scenario planning important for an organization undergoing a period of uncertainty and change? Why is it important to follow the detailed steps of the scenario planning process?
3. After the analysis of the Health Unit's role in the Good Food Box case, what niche do you see public health units filling within the broader health care system? Why is it important for organizations to delineate a role within a larger system and to maintain their services within these boundaries?

#### KEYWORDS

Food accessibility; generative relationships; scenario planning; OPHS.



## CASE 3

### “School, Interrupted”

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"Ok... yep... sounds good." Hanging up the phone, Susan Miller began to rub her temples as she thought about the upcoming committee presentation.

Susan Miller was a health promoter at the Great Lakes County Public Health Unit, and she had recently been tasked with planning and implementing a school-based mental health intervention for youth in her community. The project was a public health response to concerned parents and teachers who were witnessing an increase in mental health issues among youth. The number of students displaying disruptive behaviour had increased among the younger school-aged students, while the high schools in Great Lakes County were experiencing an increase in the number of suicide attempts in their student population. These trends had not gone unnoticed by the public health unit, who had been in the process of collecting evidence around mental health interventions in order to address youth mental health in the region.

The health unit decided to put Susan as the lead on the project, because she had once occupied a position as a school health promoter during her employment at the health unit. Susan had a lot of success in supporting and advocating for the changes made to the sexual health curriculum that had some difficulty in uptake among parents and teachers. Despite the long uphill battle, Susan was successful, and the health unit felt her experience and existing relationships within the school board would be helpful in trying to introduce first time mental health interventions in schools.

As a lifelong resident of Great Lakes County, Susan had an intimate understanding of the people, the geography, and the disparities that can exist between neighborhoods. The north side of the county is situated along the edge of one of the Great Lakes and is a popular vacation spot for many Ontarians. The eastern and south-eastern portions of the county are comprised of rural farmlands and small villages in between fields of corn and wheat. Citizens living in rural areas face geographical barriers to mental health facilities, since they must rely on drives of up to an hour and a half to access specialized health services within the urban centres. These areas are located in the western and south-western portions of the county. The greatest population density is located just north of the large petrochemical industrial park, which employed a large majority of citizens who are not involved in agriculture.

The great diversity that exists in the county is one of the reasons that Susan decided to stay and work in her community. However, the diversity also means that there will be different health needs and concerns for citizens depending on the part of the county where they live. Susan began to stare out her office window. She leaned back in her chair and thought: how would she be able to serve the needs of such a diverse county, especially in a new and developing area like mental health prevention? Susan knew the first thing she needed to do was to hold a stakeholders meeting with all the relevant figures and partners in the community. This meeting

would help shed light on the areas of concern of parents, teachers, and schools, thus creating focus areas for possible school-based mental health interventions.

### BACKGROUND

The definition of mental health and well-being put forth by the World Health Organization (WHO) was chosen by the health unit to guide their work in the field of mental health. This definition describes optimal mental health as, “[...] a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014). While this definition describes what the ideal mental health state should be, it was Susan’s task to find methods and tools for her intervention that would help the youth in the community reach this standard.

The increase in youth mental illness experienced in the County of Great Lakes is not an isolated event and reflects the current Canadian statistics surrounding youth mental health. A number of studies suggest that the prevalence of mental health issues in Canada affect as many as 14% of Canadian children between the ages of 4 and 17, while in Ontario, around 20% of children and youth experience a mental illness at any given moment (Waddell, McEwan, Shepherd, Offord, & Hua, 2005; MHASEF Research Team, 2017). The statistics only represent a fraction of mental illnesses that have been diagnosed in youth; the journey to diagnosis in the fragmented mental health system in Ontario presents parents and youth with many challenges (Schwean & Rodger, 2013).

In Canada, the mental health systems follow a similar organization to that of traditional healthcare, in that provinces and territories have the freedom and the jurisdiction to create health plans and policies addressing the specific needs of their citizens (Schwean & Rodger, 2013). When thinking about mental health and more specifically the mental health of youth, the national children's or youth mental health strategy is encompassed under the first national mental health strategy, *Changing Directions, Changing Lives*, that was unveiled by the Mental Health Commission of Canada in 2012. While this document provided guidance, the province of Ontario decided to move forward with an interdisciplinary strategy on mental health when the three ministries of Education, Health and Long-Term Care, and Children and Youth Services, launched Ontario's Comprehensive Mental Health and Addictions Strategy (Government of Ontario, 2016). This strategy produced the document *Open Minds, Healthy Minds* which focused on building school-based capacity regarding mental health literacy, implementing programs for early identification, and improving the mental health resources in schools (*Open Minds, Healthy Minds*, 2011). The province of Ontario was following the guidance of the national mental health strategy, as it tried to combat the rise in mental illness that it was seeing in its population.

Susan had been noticing, during her conversations with parents, the mental health system was focused mostly on treatment and diagnosis of mental illness rather than focusing on prevention and building of protective factors. As a public health practitioner, Susan understood the power of investing in prevention to lower the number of patients who require and access costly, specialized treatment services. This prevention would be more effective before the youth begin to display any mental illness. Susan recalled that for most mental health difficulties, the age of incidence, or the age at which mental illness is diagnosed, was before 24 (Mental Health Commission of Canada, 2013). This indicated the importance of focusing her intervention efforts on elementary through to high school students in order to have the greatest impact.

Susan understood that the goal of her intervention was to modify the risk factors associated with developing mental illness or to develop protective factors to lower the likelihood of developing mental illness later in adulthood (Waddell, McEwan, Shepherd, Offord & Hua, 2005). The risk factors involved in the development of mental illness can range from the child’s genetic predisposition to the social environment where the individual lives and goes to school (Waddell, McEwan, Shepherd, Offord & Hua, 2005). The main issue is that these risk factors are not isolated and tend to interact and lead to multiple health outcomes. (Waddell, McEwan, Shepherd, Offord & Hua, 2005). This reinforced Susan’s intuition that her intervention would need to be multifaceted in order to minimize multiple risk factors.

### **SCHOOL-BASED MENTAL HEALTH**

Soon after being assigned the project Susan began collecting information about the youth in the region as well as any trends in the data concerning their mental health. According to the most recent figures released in the province of Ontario since 2006 there had been a 53% increase from 2006 of emergency department visits for children and youth concerning mental health and addictions care (MHASEF Research Team, 2017). Of these visits, the most commonly reported issue was anxiety, followed by substance-related disorders, and also mood disorders (MHASEF Research Team, 2017). Just under half of these youth and children had no prior contact with a physician (MHASEF Research Team, 2017). This information painted a picture for Susan that most youth and children were accessing emergency health care when their mental health symptoms became more severe and this is one of the most expensive areas of the healthcare system. The goal of public health is to intervene early in schools to build resiliency and positive mental health skills in youth to decrease the number of individuals that make it to a crisis stage.

During her review of the literature, Susan found that school-based mental health interventions could be divided into three types: promotion, prevention, and treatment. The first, promotion, is focused on several determinants of mental health in the general population or a high risk group. The second, prevention, is aimed at increasing early detection and intervention. Lastly, the third option, treatment, is concentrated on recovery and minimizing the possibility of relapse (Min, Lee, & Lee, 2013). While Susan could see the value of having all three types, she knew that she needed to make a decision about which type of intervention she would suggest to the school board.

Susan recalled her meeting with Jeanette Gillespie, the principal of a local elementary school. The meeting was held at the school, which opened Susan’s eyes to the reality of a rural elementary school. During her short visit, she was able to observe the same students coming in and out of the front office for similar disciplinary issues after every recess. She could tell that the teachers on duty had to manage the other children and the end disciplinary action was left with the principal—something that would distract Jeanette from her own administrative work.

"You see, last year there were cuts to special education from the Ministry of Education. This resulted in a decrease in the number of educational assistants we could have in the school and this was our first year functioning without a Child & Youth Worker on site," Jeanette explained.

"This meant that there was an increased burden on teachers for managing children with high needs or behavioral issues as well as trying to teach the curriculum to the other students."

Back in her office, Susan shook her head thinking about this conversation. Her initial idea for implementing a school-based mental health intervention was to have the teachers present and implement the intervention, but from what Jeanette was explaining, there would be a potential push back from teachers with the introduction of a school-based intervention. This dilemma



would need to be managed, because the literature that Susan had reviewed suggested that interventions that are implemented by teachers are better at sustaining longer term effects since the lessons being taught in mental health can be reinforced in the classroom even during other lessons (Franklin, Kim, Ryan, Kelly, & Montgomery, 2012). Another benefit to using teachers is that they would already have developed relationships with, and an understanding of, each of their students, and they could concentrate more on certain themes for specific students or for a specific class depending on the year. The connection between students and their teachers has been shown to predict positive social and emotional outcomes, better interpersonal relationships, academic success, and lowered involvement in risky health behaviours (Waters, Lester, & Cross, 2014).

The only challenge mentioned in the literature that could be an issue for the implementation would be ensuring the quality of the implementation from each teacher. Each teacher who would be implementing an intervention would require training as well as resources to help with the implementation and ensure its efficacy in changing youth behaviour. The studies indicated that licensed mental health professionals who deliver interventions were found to have a greater effect; however, there is a threat to the sustainability of a program if it were to end and the practices taught to students remained solely with those students, rather than being reinforced in the school.

This thought brought Susan back to her conversation with a local high school principal, Nathan Hughes. While he would love to implement a preventative mental health intervention, his concerns are that with the current capacity that they have they are only suited to address acute mental health crises. When he mentioned talking to mental health nurses that work in the schools he said that they can barely make it out of the high schools because they are consistently on hand trying to manage a crisis either related to suicide or to substance misuse.

“While it would be great to have a class or lesson in the school that teaches positive mental health, I just can’t picture the logistics,” he said during their meeting. “Unless there was a curriculum change, it would be difficult to find time during the school day to implement any additional material, and if it is offered after school, there would be issues with supervision and attendance of those students who really need these lessons. Those who are currently dealing with mental health issues in high schools already have their hands tied with serious cases. Therefore, prevention work is usually the first thing to be placed on the back burner.”

The differences between the elementary and secondary schools in the region would need to be taken into consideration depending on the type of intervention Susan would recommend. The types of intervention would and should differ depending on the age groups and also must take into consideration the capacity and hours of the school day for each setting.

### **PARENT INVOLVEMENT**

At the last parent involvement committee meeting that Susan attended just before being assigned this project she heard parents voice their concerns for their children’s mental health. This committee is an overarching meeting that is representative of all the parent councils in the county. One of the most passionate parents at this meeting was Maria Silber, a concerned parent who lost a nephew recently to suicide. Maria was very involved in the lives of her children, participating in the school parent council and in this overarching parent involvement committee.

## **“School, Interrupted”**

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"As members of this committee and parents ourselves, we have witnessed, experienced, and/or heard the difficulties in trying to seek mental health care for our youth," Maria stated in an exasperated tone.

"As many of you may know, my own sister just recently lost her son to suicide. After years of behavioural issues in schools and months of trying to navigate the hoops of our mental healthcare system, she was left feeling helpless when her son ended his life while he was waitlisted to see a specialist." Maria took a few moments to herself before continuing. "She was a single mother who worked two jobs to keep a roof over their heads and food on the table but that also meant she wasn't able to participate in parent council meetings or to take the extra time that my nephew may have needed from her. The building of mentally strong children should not fall solely on parents—the community that exists in the school should find ways to supplement what is being taught at home so that we don't lose any more lives."

Susan could recall the emotion with which she spoke and the tension in the room when Maria finished talking about her nephew. What Susan drew from Maria's story, more than anything, was the complicated lives most of the parents in the community lead and how it presented an obstacle for creating sustainable change in youth behaviour. From the literature, an important aspect of school-based interventions that was repeatedly mentioned was the involvement of parents in the mental health promotion intervention. The support of family and parents should be involved at all levels of mental health promotion. It has been shown that interventions that focus on strengthening protective factors within families, such as resilience, may be most effective for families that have one or more of the risk factors (Whitson, Kaufman, & Bernard, 2009). By improving parent-adolescent communication, there was a decrease in violent behaviour and positive attitudes towards drugs (Ruiz-Casares, Drummond, Beeman, & Lach, 2017).

Despite the importance of family involvement there exist several barriers and challenges that are not unique to the school environment but are particularly complicated to resolve, as Maria's story highlighted. How could Susan make a meaningful change in the lives of youth by involving their parents if their parents have competing commitments such as work? Or are there transportation issues in coming to the school or another location for a parent skills training session? This would need to be taken into consideration for any intervention that would be implemented at the elementary or high school level.

### **GOVERNANCE STRUCTURE**

In the province of Ontario, health units are governed by a board of health. While there are five different structures in which a board of health can be organized, the three common models are autonomous boards, regional (upper tier) boards, and single tier boards (Ministry of Health and Long-Term Care (MOHLTC) & Ministry of Health Promotion and Sport (MOHPS), 2011). Autonomous boards have the ability to operate separately from the administrative structures of their municipality with the creation of their own policies and procedures, or they can be integrated into the municipal structure of their county and operate under their policies and procedures. In the case of the latter, they can have citizen representatives or provincial appointees serving on the board (MOHLTC & MOHPS, 2011). Regional boards operate under the mandate and authority of the regional council with no citizen representatives or provincial appointees (MOHLTC & MOHPS, 2011). Lastly, single-tier boards of health operate under the mandate and authority of the local city council, where the council members are appointed to the board of health (MOHLTC & MOHPS, 2011).

For Susan Miller, her health unit falls under the autonomous board structure, with the board of health for the county being represented by County Council members such as the mayors of the local municipalities within the county as well as county councillors. The responsibilities of the board of health have been outlined in the Ontario Public Health Standards, and it makes them accountable for the assessment, planning, delivery, management, and evaluation of public health programs, as well as addressing public health needs (*Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, 2017). Susan would need to keep in mind the role of the board of health as she moves through the steps of planning and implementing a school-based mental health intervention. None of the individuals who comprise the board of health for Great Lakes County hold an academic or professional background in health, let alone mental health, which means that when Susan prepares to present for this audience, she would need to tailor her information for a non-health audience.

### **ROLE OF THE SCHOOL BOARDS**

While Susan had begun her discussions with the front line workers in the school, such as teachers and principals, the school board directors are the major actors that would need to sign on before any intervention is implemented. In Great Lakes County, there are two school boards: the Catholic school board and the public school board. Each has employed one mental health lead in order to address mental health in their schools. During her conversation with the public school mental health lead, Angelina Powers, Susan uncovered the process that she would have to undergo prior to a meeting with the school board director.

“As you might guess the school board director, Andy Hynes, is very busy. My job is to make sure that if he is to sit down to discuss implementing an intervention within his schools that the intervention addresses a need in the student population, and that it will be effective in addressing this need,” Angelina said between sips of her coffee.

“Even if Andy agrees to begin the process of selecting and implementing a school-based mental health intervention, one intervention may not work for all the schools,” Angelina continued to explain. “Since each school has a unique set of school improvement goals that have been deemed as important by the school, any mental health intervention that is implemented should also be in line with these goals to facilitate the implementation process for staff and teachers.”

While none of this was new to Susan, it indicated that the initial planning process could be very time consuming if she were to consult with each school individually in order to establish how their school improvement goals would align with a particular intervention. Perhaps her relationship with Angelina and the other mental health lead would become a very key partnership in order to increase the efficiency throughout this project.

### **MANAGING EXPECTATIONS**

In the area of health promotion, there is an increased use of theories and frameworks grounded in implementation science that are used to ensure the use of evidence to inform practice (Gaglio & Glasgow, 2012). Another definition explains that implementation science is, “[t]he scientific study of methods to promote the systematic uptake of research findings and other EBPs [evidence-based practices] into routine practice, and, hence, to improve the quality and effectiveness of health services”. (Eccles & Mittman, 2006). For Susan, both of these definitions reinforced her planning process in trying to use the most recent data in mental health promotion and combine it with the tools and frameworks described in implementation science. This ensures the maximum uptake of improved habits in mental well-being, which in turn, reduces risk factors associated with mental illness later in life.

## “School, Interrupted”

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Susan saw one major obstacle to the successful implementation of her intervention: managing the expectations of all the stakeholders who would be involved. As is the case with high profile cases of mental illness, the focus and attention was on emerging mental illness rather than mental health promotion. Many of the solutions proposed by families aimed to increase mental health services such as therapy or mental health beds. Susan knew that one of her biggest challengers would be to have these families, who are viewed as champions for change in their own communities, switch gears away from acute mental healthcare delivery to upstream social behavioural interventions that can be implemented in elementary schools.

Similar to the families, the school board representatives would have a hard time agreeing to developing mental health promotion interventions for youth not yet displaying mental illness, when they are preoccupied daily with secondary level prevention for adolescents. However, these two groups would not remain in consensus for very long once the question of who will be involved with and delivering the intervention arises. As Susan had explored earlier, the role of using teachers as intervention coordinators would involve negotiations and discussions with not only the teachers but also their employer, their school board, and their unions. They would need to determine the length of time that each teacher would dedicate to mental health promotion and what subject learning time would need to be cut in order to deliver these new lessons.

On the other hand, parents and legal guardians may be asked to spend more time with their child at school during the intervention period or at other times to complete exercises. Many parents may begin to point fingers at the teachers and school board for not ‘doing their job’ and creating more work for parents.

### **CONCLUSION**

Susan had only a few weeks before the committee meeting where she would be presenting her recommendations on school-based mental health interventions for schools in the Great Lakes region. Prior to this meeting, Susan’s goal was twofold: find a way to convince the stakeholders of the importance of an intervention focused on mental health promotion in the elementary-school years and identify potential barriers that exist for each stakeholder involved in the intervention.

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## INSTRUCTOR GUIDANCE

### “School, Interrupted”

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#### BACKGROUND

Due to the fact that there is currently no national youth mental health strategy, each jurisdiction is faced with managing and preventing mental health issues in their communities. Through school-based mental health interventions public health professionals have the potential to impact a large portion of youth in their community in a setting with which youth are already familiar. Susan Miller, a health promoter with the Great Lakes Public Health Unit, has been tasked with making recommendations about what type of mental health intervention should be implemented in the local elementary and high schools. The main objective of this mental health intervention will be to enhance protective factors among youth as well as to decrease the risk factors that can lead to developing further mental health issues in adulthood.

#### OBJECTIVES

1. Follow Public Health Ontario's steps to program planning for a mental health intervention.
2. Identify barriers and facilitators to the implementation of a school-based mental health intervention.
3. Apply strategies to involve stakeholders such as parents in a mental health intervention.
4. Discuss the roles and responsibilities of the various stakeholders in developing an intervention.

#### DISCUSSION QUESTIONS

1. Which option do you feel is best for an elementary school intervention and for a high school and why?
2. Which stakeholders should be involved in the different processes of the intervention? Are there any missing from the case? Justify your choice.
3. Which implementation theory/theories should Susan be using throughout her project? Justify your answer.
4. List the barriers and facilitators that exist for the implementation of a school-based mental health intervention based on the location of the school (i.e., rural vs urban) in Great Lakes County?
5. How will the program be evaluated and which organization will head the evaluation process?

#### KEYWORDS

School-based mental health; program planning; stakeholder analysis; implementation science.



## CASE 4

### Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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*Shannon L. Sibbald, PhD (Assistant Professor, Western University)*

Samara Lewis was sitting at her desk in the Planning and Evaluation department as she planned and organized discussion points for one of her upcoming Safe and Positive Space workgroup (SPSWG) meetings. As the workgroup lead she must ensure that all relevant and pressing issues will be included in the agenda and discussed at the next meeting. She sat and thought about her next steps and which would be the most effective in reaching her goal to fully implement a Safe and Positive Space at the North Bay Parry Sound District Health Unit (NBPSDHU).

Samara, along with the supportive managerial team and Board of Health at the health unit, believe strongly that issues related to LGBTQ2S+ (Lesbian, Gay, Bisexual, Trans, Queer or Questioning, Two-Spirited) health and health equity are crucial and important to address. The implementation of a Safe and Positive Space within the health unit will increase health equity matters among the workplace as well as address the unique intersectionality that exists within this population and the Northern, bilingual, and Indigenous context.

The implementation of a Safe Space will prove challenging but be beneficial—instilling change within an organization is a laborious endeavor. It is essential to have a team that appreciates innovation and that is passionate about catalyzing positive change. The health unit is undergoing a massive transformation, and the creation of a Safe and Positive Space will further facilitate the organizational direction.

#### **NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT**

The North Bay Parry Sound District Health Unit is a public health unit that operates within the Nipissing-Parry Sound district, which is within the Northern area of Ontario, Canada (North Bay Parry Sound District Health Unit, n.d.a). Within this district, the health unit provides services to over 120,000 residents, and its catchment area consists of 31 municipalities, four unorganized areas, and nine First Nations Reserves (NBPSDHU, n.d.b). The City of North Bay, known as the Gateway to the North, is located four hours north of Toronto and west of Ottawa and holds the health unit's main office (NBPSDHU, n.d.b). The City of North Bay is home to two lakes and ample recreational options, resulting in a high quality of life for its residents (NBPSDHU, n.d.b). The city is also composed of post-secondary institutions and lively arts, cultures, and sports communities (NBPSDHU, n.d.b). In addition, North Bay prides itself on its large bilingual community as well as its strong ties to the Nipissing First Nations. A health unit branch office is also located in the Town of Parry Sound (NBPSDHU, n.d.b). Parry Sound is located two hours



## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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north of Toronto and is a large commercial centre, rich in art, culture, sports, and heritage (NBPSDHU, n.d.b).

The health unit's purpose within the community is to promote, prevent, protect, and prepare (NBPSDHU, n.d.a). The health unit's vision lies in promoting and facilitating "a healthy life for everyone in our communities" and its mission aims "to foster healthy living within our communities by preventing illness, promoting healthy choices, and providing trusted support and information" (NBPSDHU, n.d.c). The NBPSDHU's values encompass "honesty, compassion, transparency, accountability, collaboration and excellence" (NBPSDHU, n.d.c).

The health unit is composed of 29 different programs and provides a wide range of public health services that aim to help and augment health in all populations within the community. The health unit is responsible for implementing programs and services that promote health, prevent disease, protect vulnerable populations, and prepare for and respond to emergencies that can ultimately impact population health (NBPSDHU, n.d.a). Within the city of North Bay, there are several LGBTQ2S+-safe organizations. However, service and knowledge gaps still exist.

Five executive teams exist at the health unit: Clinical Services, Community Services, Corporate Services, Finance, and Human Resources. These different teams oversee and manage their respective programs and services throughout the health unit. The Board of Health ensures that the health unit is providing the community with adequate public health programs and services.

### **SAFE AND POSITIVE SPACE RATIONALE**

The health unit strives towards becoming a Safe and Positive Space for its LGBTQ2S+ community. The latter indicated, within its 2016 annual report, that to reach its goal in promoting healthy sexuality, it needs to commit to becoming a Safe and Positive Space for all members of the LGBTQ2S+ community in their service area (NBPSDHU, 2016). The health unit's goal is to become an inclusive and welcoming space, with services and amenities that are equitable and accessible to all sexual and gender diversities, for both employees and clients alike (NBPSDHU, 2016).

In addition, the implementation of a Safe Space aligns with the first priority of the NBPSDHU 2014-2018 Strategic Plan: fostering healthy behaviours in children and youth (NBPSDHU, 2014). First, the health unit believes in using a positive mental wellness approach to promoting healthy sexuality within children and youth and addressing any issues prior to the development of risky behaviours (NBPSDHU, 2014). In other words, the implementation of a Safe Space will promote healthy families and positive sexual, preconception, and reproductive health as well as the accurate and consistent transmission of a healthy sexuality message to all gender and sexual diversities (NBPSDHU, 2014). Second, the ultimate goal is to create a Safe and Positive Space for the LGBTQ2S+ community within the Health Unit's service area.

The health unit is expecting its new building to be complete at the end of summer 2017 where Safe and Positive Space recommendations can be fully implemented within a contemporary atmosphere. Due to ongoing managerial and executive support, Samara and her Safe and Positive Spaces workgroup will build knowledge and capacity within the health unit and its staff, ensuring that their goal of creating a welcoming space is achieved.

### **POSITIVE SPACE CHAMPION: SAMARA LEWIS**

Samara Lewis is a public health nurse specialist in the Sexual Health department at the health unit, and has significant experience with the social determinants of health. Samara has worked

## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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at the health unit for 13 years and has a Master of Public Health. Since September 2016, she has been provided with a professional development opportunity. Thus she was placed on special projects in the Planning and Evaluation department where one of her main tasks was to create and lead a Safe and Positive Spaces workgroup. As the workgroup lead, she is expected to develop an appropriate work plan that addresses the health equity issues facing the LGBTQ2S+ community and that assesses organizational readiness for a Safe and Positive Space. In addition, the workgroup must decide on what next steps to take, which recommendations to follow, which guidelines to incorporate, and on how to deliver training and education to health unit staff.

The health unit's 2014-2018 Strategic Plan (NBPSDHU, 2014) and 2016 Annual Report (NBPSDHU, 2016) address the need for a Safe and Positive Space within the health unit and indicate its plans to commence the implementation of such a space in the near future. This organizational vision enables Samara and her workgroup to implement forward-thinking and positive changes within the health unit.

Samara is a hard-working, dedicated, and innovative individual. As a public health nurse, Samara understands the complexities of the social determinants of health and health equity, and the ways in which these concepts manifest themselves within the lives of vulnerable populations. Her thorough understanding of these concepts also stems from the fact that she is co-chairing the Health Equity Action Committee and leading the Collaborative Hepatitis C and Urban Health Outreach workgroup committees. The Urban Health Outreach workgroup is currently addressing the health service gaps for the homeless population in North Bay. Samara is a Positive Space champion and a true advocate for progressive change.

### **HEALTH DISPARITIES IN THE LGBTQ2S+ COMMUNITY**

The LGBTQ2S+ community is a vulnerable and marginalized community. This community is invisible to many Ontario health organizations, even though it accounts for 1-1.25 million of Ontario's population (Association of Ontario Health Centres, n.d.). The LGBTQ2S+ community possesses specific health needs resulting from discrimination and social isolation and, thus, are susceptible to greater health disparities (AOHC, n.d.). Factors such as homophobia, biphobia, transphobia, cultural differences, and systemic oppression also negatively impact the health of those within the LGBTQ2S+ community (Rainbow Health Ontario, 2014a). Most healthcare providers do not receive formal education or training related to LGBTQ2S+ health, specifically in terms of providing culturally sensitive, competent, and safe care (AOHC, n.d.; RHO, 2014a), resulting in health inequities.

Consequently, due to these unsafe environments, individuals who identify as LGBTQ2S+ may refrain from seeking health care and from providing specific personal information to health care providers (RHO, 2014a). Ultimately, the LGBTQ2S+ community receives a lower quality of health care than the general population (RHO, 2014a). In addition, significant gaps still exist in LGBTQ2S+ policy development and research (AOHC, n.d.).

In general, the LGBTQ2S+ community faces many unique health concerns and are at an increased risk for specific health issues, including mental health, substance abuse, smoking, depression, cancer, diet, weight, and body image issues (RHO, 2014a).

Organizations, particularly those that provide health care services to the community, should be aware of these specific health needs and should be trained and capable of addressing these issues in a safe and appropriate manner, as a means to increase health equity within this

## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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vulnerable population. According to a Rapid Response Survey conducted by the Ontario HIV Treatment Network (2014), a facilitator to LGBTQ2S+ health care includes specifically the creation and implementation of a Safe, Gay-Positive Space that is free of violence, stigma, and discrimination (Globerman & Mitra, 2014). Other important LGBTQ2S+ health facilitators include the provision of culturally sensitive health care, based in human rights principles and the creation of inclusive health policies and procedures at the organizational level, thus facilitating the provision of safe, accessible, and equitable health services (Globerman & Mitra, 2014).

### **SAFE AND POSITIVE SPACES**

A Positive Space refers to an organization that is open, welcoming, inclusive, equitable, and accessible to all sexual and gender diversities and whose policies and practices reflect a supportive environment and personnel for both clients and staff (Ontario Public Health Association, 2011). Welcoming spaces are spaces that help to connect individuals and to strengthen communities (WHAI, 2017). Safe and welcoming spaces aim to build warm, inclusive, and friendly environments, and these spaces can often act as safe havens from stigmatization and discrimination (WHAI, 2017). In addition, a Safe and Positive Space applies to an organization in which all employees and staff are educated and trained on the issues surrounding gender, sexual diversities, and human rights and possess the ability to direct clients and patients to the appropriate resources (OPHA, 2011). When developing and implementing Safe and Positive Spaces, it is imperative to also consider and acknowledge the needs, desires, and strengths of the organization's various staff teams (WHAI, 2017). A significant amount of work and advocacy awaits Samara throughout this implementation process. However, the creation of a Safe and Positive Space within the health unit ensures that the organization will provide safe and appropriate services to all members of the LGBTQ2S+ community, including its employees.

A safe and welcoming space encompasses three components: physical space, organizational culture and atmosphere, and individual staff actions (WHAI, 2017). A positive physical space refers to the ways in which the target community will experience and develop a sense of connection with the space (WHAI, 2017). Features like all-gender washrooms, inclusive posters, and gender-neutral intake forms aid in appropriately receiving clients and patients in this positive physical space. Organizational culture and atmosphere refers to inclusive policies and a welcoming ambiance, as policies lay the foundation for the ways in which individuals interact within the organizational space (WHAI, 2017). As for individual staff actions, the staff should be kind and warm and treat everyone with respect, patience, and dignity (WHAI, 2017). Individual actions, such as oral language and body language, provide the basis to building trust within the organization (WHAI, 2017).

Pride symbols, such as the Pride flag, should be openly displayed throughout the organization to demonstrate that said organization is a Positive Space (OPHA, 2011). Significant effort is required to enact policies and procedures that achieve optimal cultural sensitivity and health equity (OPHA, 2011). Rainbow Health Ontario (2014b) provides Safe and Positive Space stickers that organizations can openly display for clients and staff (see Exhibit 1).

There is no official designation or criteria for a Safe Space within an organization. The Ontario Public Health Association's Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgender, Two-Spirit, Intersex, Queer, and Questioning Equity workgroup has developed a personal assessment tool, by which individuals can evaluate their levels of LGBTQ2S+ cultural competency (OPHA, 2011). In addition, the Ottawa LGBT Cultural Competency Project (2004) has developed a workplace assessment tool, which enables an organization to evaluate its environment, policies, practices, and procedures to ensure that they are facilitating a Safe and

## Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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Positive Space (OPHA, 2011). Lastly, the Ontario Council of Agencies Serving Immigrants' Positive Spaces Initiative has developed 25 recommendations to creating a Safe and Positive Space within an organization (Ontario Council of Agencies Serving Immigrants, n.d.).

Many socially conscious organizations have created and developed training, resources, workshops, educational guides, tools, and training kits to aid organizations that are either in the Safe Space contemplation phase or in the implementation process. It is important to share resources, as this further facilitates the sharing of accurate information among organizations. The Ontario Public Health Association, the Ontario Public Service Pride Network, the Ontario Council of Agencies Serving Immigrants' Positive Spaces Initiative, Rainbow Health Ontario, and the 519: Space for Change are all examples of organizations that have taken leadership roles in raising awareness on Safe and Positive Spaces and that have created tools for interested organizations (see Exhibit 2). In addition, the Safe Zone Project (n.d.) and the Ontario Public Service Pride Network's 2010 *Being Ourselves at Work* campaign (Milne, 2012) are two examples of the ways in which organizations are advocating for the human rights and the health equity rights of the LGBTQ2S+ community (see Exhibit 2).

### LEGISLATION AND THE CODE

Within the *Ontario Human Rights Code* (the *Code*), sexual orientation and gender are both protected grounds against discrimination. As indicated within the *Code*, it is illegal to discriminate against an individual based on sexual orientation or same-sex partnership status (OPHA, 2011). Discrimination based on gender identity is legally protected under the "sex" category of the *Code*. This protection includes transsexual, transgender, and intersex individuals, cross-dressers, and any person whose gender identity or expression is, or is perceived to be, different from their assigned sex at birth (OPHA, 2011). Discrimination, among its many forms, can be manifested systemically, particularly in terms of non-inclusive policies (OPHA, 2011). Individual rights to be free from discrimination apply to, but are not limited to, employment, facilities, and services (OPHA, 2011). In addition, the Gay, Lesbian, Bisexual, and Transgender Health Care Consumer's Bill of Rights indicates that LGBTQ persons of all ages possess the human right to access full and equal health care services and to do so in a safe, inclusive, and welcoming environment (OPHA, 2011). Moreover, these individuals have the right to health care services that are comprehensive, inclusive, and culturally appropriate and sensitive (OPHA, 2011). The workgroup has been accessing these toolkits and testing which components would most benefit its staff and community, paying close attention to the different levels of intersectionality that exist within the local context and its different population groups (i.e., French and Indigenous).

Employment and labour legislations have been put in place in order to ensure that organizations and agencies adhere to the *Human Rights Code* in regards to basic LGBTQ2S+ human rights. The workgroup is aware of these regulations and their legal requirements to be implemented within organizations. The workgroup plans to extend beyond these basic regulations and to implement safe and inclusive policies and procedures within the organization as a whole. Human Resources (HR) will communicate with the SPSWG in terms of the activities that HR is required to implement—to ensure that the workgroup and HR are not duplicating efforts (Lewis, 2017a).

### SAFE AND POSITIVE SPACES WORKGROUP

The health unit's SPSWG was established sometime between December 2016 and January 2017 and is being led by Samara Lewis as part of her role as a public health nurse specialist. The purpose of the SPSWG is to raise awareness, build capacity, change attitudes, develop a

## Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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plan of action, and implement said plan in order to achieve a safe, positive, and welcoming space at the NBPSDHU. The workgroup is composed of members of various departments and is consequently facilitating capacity and awareness building and knowledge translation among every team within the health unit.

Samara and her workgroup members have created their very own mission, vision, and values statements, which aid in guiding their work in an appropriate and consistent manner across the health unit. The SPSWG's vision consists of a "safe and inclusive space for our LGBTQ community". The workgroup's mission is "to create a welcoming and supportive environment for our LGBTQ community through education, policies, relationships, and an organizational culture that affirms differences, fosters diversity, and cultivates inclusivity". The workgroup's values consist of "respect, trust, open mindedness, compassion, humility, inclusivity, advocacy, and courage". The team has also established expected workgroup outcomes and their associated indicators and activities, which have been further compiled into a logic model. In addition, Samara and her team have conducted scenario planning, enabling them to investigate and to explore all the possible outcomes that may arise throughout the implementation process. This tool provides the workgroup with the ability to determine specific factors, influencers, and driving forces; such as politics, finances, and organizational culture; that may facilitate or inhibit their Safe Space progress. The workgroup can then be proactive and develop action plans that target each potential outcome that they identified in their scenario planning.

Based on the 2014-2018 NBPSDHU Strategic Plan's Priority # 1: fostering healthy behaviours in children and youth through the use of a positive mental wellness approach in promoting healthy sexuality (Strategic Plan 2014-18 Priority 1 Aim 1.1), the workgroup's three short-term outcomes include: 1) "NBPSDHU staff and executive team are aware of the direction, outcomes, vision, mission, and values of the SPSWG"; 2) "Communities across our districts are made aware of our direction and progress towards becoming a Safe and Positive Space"; and 3) "Awareness of the status of current organizational culture surrounding LGBTQ2S+ and becoming a Safe and Positive Space" (Lewis, 2017b). The three long-term outcomes consist of 1) "NBPSDHU staff viewing the workplace as a Safe and Positive Space"; 2) "Members of the community viewing the NBPSDHU as a Safe and Positive Space"; and, 3) "NBPSDHU staff and community members who self-identify as a member of the LGBTQ community feel more welcomed, included and safe while working and using health unit services" (Lewis, 2017b). The workgroup has also discussed the social aspects of their outcomes and expressed that they hope to create a space that feels like a "big comfy couch" for their staff and clients (Lewis, 2017c).

To achieve a Safe and Positive Space, Samara, as the workgroup lead, has taken the initiative to meet and discuss with two health unit staff members who were instrumental in the implementation of the *Baby Friendly Initiative* (BFI) within the health unit. Because of its tremendous success, the workgroup will follow the process that the health unit undertook to receive its BFI designation. The BFI took 17 years to implement at the NBPSDHU, and the Safe and Positive Spaces workgroup hopes to achieve its goal in a shorter timeframe. The process to implement the BFI included an organizational self-appraisal, a timed plan of action, the creation of a committee, Board of Health approval, a numerous amount of capacity and awareness building meetings, and the development of relevant policies and procedures, training, and education within the organization (Lewis, 2017a). BFI is an on-going successful endeavor, as it was achieved through policy and education (Lewis, 2017a). The workgroup will need to present its case in a positive light backed by relevant literature and best-practice evidence to gain momentum (Lewis, 2017a).

## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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When asked about her reasoning behind the use of the BFI process to aid in the Safe Space implementation, Samara indicated that “given the success of our organization and our BFI designation, the SPSWG plans to learn from the successes and the challenges of the BFI designation to ensure equal success”. It is clear that using a previously successful implementation process will only benefit the workgroup in its journey towards becoming a Safe and Positive Space.

Members of the workgroup have been attending workshops and trainings to ensure that the workgroup is composed of Positive Space champions. In addition, trained members of the SPSWG will wear Pride flag buttons on their lanyards to demonstrate to other staff members and clients that they are Positive Space champions and are aware of their responsibilities and accountabilities as champions.

A major concern facing the workgroup is the fact that Samara’s role in the Planning and Evaluation department ends in September 2017 and consequently, so does her role as the workgroup lead. Because of this, the future of the workgroup is unknown.

### **NEW HEALTH UNIT BUILDING**

The North Bay Parry Sound District Health Unit is in the final process of building a larger, more innovative and modern building to serve its clients within the community. The new building’s purpose is to address inefficiencies and inadequate work spaces that exist at the NBPSDHU (North Bay Parry Sound District Health Unit, n.d.d). The Health Unit currently provides its services from three buildings in North Bay and two branch offices; one in Burks Falls and one in Parry Sound (NBPSDHU, n.d.d). The consolidation of North Bay’s three offices into one larger, main building will enable the Health Unit to provide more accessible, accommodating, effective, and efficient services to its clients and provide appropriate workspaces for its staff and their programs (NBPSDHU, n.d.d).

As per the 2014-2018 Strategic Plan and the 2016 Annual Report, the health unit has committed to becoming a Safe and Positive Space for the LGBTQ2S+ community (NBPSDHU, 2014; NBPSDHU, 2016). Thus, the new health unit building will possess all-gender washrooms, where members of all sexual and gender diversities may feel included, free, and welcome to use the washrooms of their choice. The new building will also possess traditional male and female washrooms to accommodate those who identify as male or as female.

It is certain that new dynamics will emerge from such a move. The workgroup’s hope is that this new building provides a fresh start and implements a Safe and Positive Space for staff and clients alike.

### **NBPSDHU AND A SAFE AND POSITIVE SPACE: A GOOD FIT?**

The SPSWG has been working relentlessly to find the most effective and impactful ways to implement a Safe and Positive Space at the North Bay Parry Sound District Health Unit. Though the SPSWG possesses managerial support, it goes without saying that modifications to organizational climates often result in several challenges and obstacles.

In terms of the Health Unit staff, organizational culture, climate, and readiness for change will be assessed through a survey. The survey will evaluate factors such as workplace attitudes and staff readiness for Safe and Positive Spaces, establishing baseline measures for the workgroup. The group has sent out a Research, Planning, Implementation, Dissemination, and Surveillance (RAPIDS) request to the Health Unit’s Planning and Evaluation department, which will enable

## Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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the group to conduct staff data collection throughout the organization. Extraneous variables, such as a lack of education and training on LGBTQ2S+ matters may impact and confound the answers that the respondents provide on the survey. A significant factor that may impact the ways in which the staff view the importance of a Safe and Positive Space consists of the real and perceived lack of visible diversity within this Northern-Ontarian context. Importantly, the intersectionality that exists between the LGBTQ2S+, Indigenous population, and French populations within this context must be considered, as each population brings about a unique set of needs, desires, and complexities. It is not only important to provide culturally sensitive services to the LGBTQ2S+ community but also to the many subgroups and cultures that fall within this umbrella term.

There are many challenges that may arise throughout the implementation of a Safe and Positive Space. The process of fully implementing this space and conducting an environmental scan to ensure that this space has been fully achieved may prove to be extremely lengthy. The capacity and the available resources at the health unit may not be sufficient to complete this task in a short timeframe. In addition, different health unit departments may hold different views and beliefs and may have different needs for a Safe Space. This is a difficult obstacle to overcome, as full consensus throughout the organization may not be achieved. Furthermore, due to staff turnover, it is difficult to assess the sustainability of the workgroup and of its achieved outcomes. The health unit may benefit by making tailored Safe and Positive Spaces training mandatory, ensuring that all new employees are aware of the work behaviour that is expected of them. Effective knowledge translation will be imperative to overcome the challenges associated with staff turnover. Knowledge translation may also entice committed individuals to become Positive Space champions at the health unit.

The workgroup, in addition to creating their outcomes, also established the social cultural aspects associated with the outcomes. This will enable the workgroup to evaluate the feelings and experiences of their staff and clients once the team succeeds in achieving their outcomes (Lewis, 2017c).

During one of their monthly meetings, the workgroup created a “wish list” that encompassed the following:

1. No resistance from staff in their contribution to the creation of a Safe and Positive Space.
2. The feeling of a “*big comfy couch*” for staff and clients.
3. The resources and capacity to evaluate programs and services to ensure they accurately reflect LGBTQ2S+ language and issues.
4. An increased visibility and recognition that the health unit is a Safe and Positive Space.
5. The knowledge, skills, and self-efficacy to advocate for the LGBTQ2S+ community.
6. An appropriate screening tool to assess the Health Unit’s current resources to ensure that they are inclusive and culturally sensitive (Lewis, 2017c).

One of the most significant challenges in implementing a Safe and Positive Space within an organization is the lack of evidence-based best practices. Lengthy recommendations, guidelines, and checklists exist; however, they are not consistent nor are they standardized. In addition, there are suggestions, trainings, and workshops that an organization should follow and participate in as well as mandated and legally required employment practices. The 519, a Toronto agency and registered charity, is an organization that is committed to the health, happiness, and participation of the LGBTQ community and to providing services, space, and

## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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leadership that promote inclusion, empathy, compassion, and respect (The 519, n.d.a). The 519 has created an infographic within their *Creating Authentic Spaces* document (Hixson-Vulpe, n.d.) that provides suggestions on how to create a welcoming space within an organization (see Exhibit 3, The 519, n.d.b). Nonetheless, health units possess the freedom to choose which recommendations to implement, resulting in inconsistencies across health units. Consequently, it is difficult for an organization to create their own Safe Space criteria and standards of practice that reflect the needs of both the organization and the LGBTQ2S+ population. In addition, there is no official Safe and Positive Space designation, therefore making it difficult to evaluate when a true Safe and Positive Space has been achieved within the organization. However, the health unit may benefit in merging existing standards of practice and creating their own to suit their organizational context.

Despite these challenges, the health unit possesses significant managerial support and a committee that is determined to catalyze positive change within the organization and to increase health equity for the LGBTQ2S+ community. September is approaching quickly and it will be necessary to establish a framework upon which future Positive Space champions can continue the Safe and Positive Space work. Many tools, trainings, and resources exist to help facilitate this process, and the committee is hard at work in finding the most comprehensive and appropriate resources for the North Bay Parry Sound District Health Unit.

### **THE IMPLEMENTATION OF A SAFE AND POSITIVE SPACE**

Samara has been tasked with a challenging goal. Many steps need to be undertaken to successfully implement changes within an organization. It is up to Samara and her workgroup to decide which next steps are the most effective in reaching their goal in the shortest amount of time. Good things take time, and so does achieving a Safe and Positive Space.

To initiate the implementation process, Samara and her workgroup have put in a RAPIDS request for a survey to evaluate organizational culture and readiness. This will establish a starting point for the implementation of a Safe and Positive Space. The survey will enable the workgroup to assess staff opinions and the current atmosphere at the health unit and will facilitate the next implementation steps. The workgroup is also consulting the Ontario Public Service Pride Network's Safe Space model (Milne, 2012) and the *Being Ourselves at Work Campaign* in hopes to implement a similar framework. It is not always necessary to reinvent the wheel. Often, it is beneficial to see what other organizations have done, evaluate their successes and challenges, and replicate what has been successfully achieved within one's own organization.

The workgroup is in the process of developing an informative presentation for an upcoming Program and Services Managers Committee (PSMC) meeting. The ultimate goal of this presentation is to persuade the program managers to make Safe and Positive Spaces a mandatory agenda item for all department meetings. This presentation is crucial in reinforcing to the managers the importance of a Safe and Positive Space and ensuring that they understand the urgency of raising Safe and Positive Space awareness among the health unit staff. In terms of the workgroup's plan of action, some next steps have been developed and elaborated upon that will help achieve the implementation of a Safe Space (see Exhibit 4A).

One workgroup success consists of the inclusion of the health unit on the Find Refuge website, a site that is aimed at providing a list of organizations that contain all-gender, gender inclusive, and accessible washrooms (Refuge Restrooms, 2017).



## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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Due to the multidimensional nature of this process, it will be necessary for Samara and her team to conduct a routine environmental scan to assess the Safe Space progress within the health unit. It will also be essential to provide a platform within which the LGBTQ2S+ community can provide feedback on the health unit's Safe Space progress, as outlined within the logic model. To help achieve this goal, the health unit had a guest speaker from Rainbow Health Ontario come to discuss LGBTQ2S+-specific health issues and barriers (NBPSDHU, 2016). This presentation was also conducted to aid the health unit in building capacity, staff skills, and knowledge for providing equitable, accessible, and appropriate health services to the community and raising awareness on staff accountability (NBPSDHU, 2016). There are many practices that an organization can undertake to aid in their Safe and Positive Space implementation and to ensure that the latter is contextually relevant and considers the various levels of intersectionality that exist within a Northern Ontario context (see Exhibit 4B). Consequently, the staff survey will aid in identifying which Safe Space practices are realistic and appropriate to implement within the health unit, based on staff readiness and organizational culture, and which are the most efficient given the time restraints.

### **CONCLUSION**

Time is of the essence. Only a few months remain until Samara will return to the sexual health department and will no longer lead the Safe and Positive Spaces workgroup. The workgroup must develop an appropriate plan of action prior to September to ensure that the Safe and Positive Spaces work does not end when the workgroup does. Further marginalization of this population will occur if the workgroup is dissolved.

One question still remains: who will lead the Safe and Positive Spaces initiative once September arrives? Ideally, a Positive Space champion will step up and take on the workgroup lead position. This will ensure that the work will continue and that further Safe Space actions may be implemented, resulting in the health unit confidently earning its Pride sticker.

As Samara prepped for her next workgroup meeting, she could not help but think about the progress that has been made and all of the work that has yet to be completed. Predominantly, consultations with members of the Francophone and Indigenous communities who identify as LGBTQ2S+ will also be necessary to target the needs of these unique and intersectional groups. It is up to Samara to ensure that the right decisions are being made, the right steps are taken, and the right populations are consulted to guarantee that a culturally appropriate and contextually relevant Safe and Positive Space is created and implemented within the North Bay Parry Sound District Health Unit.

EXHIBIT 1

lesbian • gay  
bisexual • trans  
two spirit • queer



this is a  
**POSITIVE SPACE**  
that welcomes and  
supports everyone

Source: Rainbow Health Ontario, 2014b.

## Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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### EXHIBIT 2

List of resources and websites that can be used to aid organizations in becoming Safe and Positive Spaces:

- The Ontario Public Health Association: <http://www.opha.on.ca/getmedia/125e32e7-f9cb-48ed-89cb-9d954d76537b/SexualHealthPaper-Mar11.pdf.aspx?ext=.pdf>
- The Ontario Council of Agencies Serving Immigrants' Positive Spaces Initiative: <http://positivespaces.ca/>
- Rainbow Health Ontario: <https://www.rainbowhealthontario.ca/>
- The 519-Space for Change: <http://www.the519.org/>
- The Safe Zone Project: <http://thesafezoneproject.com/>
- The Ontario Public Service Pride Network's 2010 Being Ourselves at Work Campaign: <http://canadiangovernmentexecutive.ca/being-ourselves-at-work/>

# Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

## EXHIBIT 3

### CREATING A WELCOMING ENVIRONMENT

#### THE PERCEIVE AND FEEL FRAMEWORK

A welcoming environment feels safe. It is a space where people can find themselves represented and reflected, and where they understand that all people are treated with respect and dignity. This happens when services consider, and are equitable and accessible to all members of the LGBTQ community, including clients, staff, and volunteers.

A SPACE WHERE PEOPLE CAN FIND THEMSELVES REPRESENTED AND REFLECTED AND WHERE THEY UNDERSTAND THAT ALL PEOPLE ARE TREATED WITH RESPECT AND DIGNITY.

#### PERCEIVE

physical environment and language



Service users/staff must be able to look around their physical environment and see positive and inclusive symbols, images, and artwork.



Service users/staff must be able to look around and see positive and inclusive brochures and pamphlets that represent their experiences.



Service users/staff must be able to hear positive and inclusive language and be comfortable using inclusive and positive language.

#### FEEL

overall environment, which imparts a sense of safety



Service users' and employees' gender identities and expressions are acknowledged, affirmed, and respected.



There are visible and verbal reminders that the agency is a safe place.



Accessible/supportive processes are available that allow people to raise issues and concerns, and to feel that they have been acknowledged and that there will be follow-up.



Service users and staff are aware that communication goes two ways.

#### MATERIALS



Put up inclusive posters and stickers. Think about the reading material in your waiting rooms and the people represented in them.

#### LANGUAGE



Make sure that inclusive and affirming language is the standard. Educate employees and make sure your policies reflect the changes to Ontario's *Human Rights Code*.

#### FORMS



Make sure forms have a space for legal name and another name (some people don't go by their legal name). Make sure forms reflect only what you need to know.

#TRANSINCLUSION

INFOGRAPHIC DESIGN BY:  
LIGHTUPTHE SKY.CA



Source: The 519, n.d.b.

## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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### **EXHIBIT 4A**

The Safe and Positive Spaces workgroup's action plan includes:

1. Forming a subgroup for mandatory comprehensive and tailored staff training;
2. Creating LGBTQ2S+ resource sheets for staff and clients;
3. Developing a form of messaging (posters, digital communication, social media...) to demonstrate that the NBPSDHU is a Safe and Positive Space "work in progress";
4. Creating a bucket on the health unit's intranet to provide the staff with Safe and Positive Spaces resources (conversation starter activities, glossary of terms, guidelines, posters...);
5. The inclusion of the Ontario Public Service Pride Network videos on team agendas to aid with Positive Space education;
6. The finalization of the SPSWG's logic model and scenario planning;
7. Developing a workgroup work plan; and,
8. Developing recommendations for more inclusive and gender-neutral patient forms.

Source: Lewis, 2017a.

### **EXHIBIT 4B**

Safe and Positive Space practices that could greatly benefit the North Bay Parry Sound District health unit include:

1. Inclusive and gender neutral intake and referral forms that provide a blank space for "sex", that explain why the "sex" is required, and that provides space to indicate pronouns, gender identity, and a preferred name;
2. Normalizing the conversation. This can be achieved by commencing meetings with pronoun identification and creating email signatures that contain the person's appropriate pronouns. This can also be achieved by recognizing one's responsibility, as a public health professional, to be aware and informed of LGBTQ2S+ health barriers and facilitators;
3. Implementing a standardized interview question regarding the importance of LGBTQ2S+ issues for prospective employees, volunteers, and placements. Thus, instilling and maintaining positive change within the organization;
4. Creating an inventory of Safe Space organizations within the North Bay and Parry Sound areas and contributing to the "in progress" Positive Spaces Network of North Bay and Area. It is important to share individuals and resources among organizations and ensure constant communication channels;
5. Conducting focus groups with members of the LGBTQ2S+ community to see if the health unit is inclusive to all gender and sexual diversities, to ask where the NBPSDHU can improve, where it is lacking, how it is perceived in the community, and if the health unit staff should be further trained in Positive Spaces. By doing so, the health unit will gain essential and valuable feedback and will be acknowledging important lived experiences; and,
6. Displaying posters and providing information that is inclusive of all diversities and that portray LGBTQ2S+ families.

## Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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## INSTRUCTOR GUIDANCE

### Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit

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*Samara Lewis, BSc, MPH (Public Health Nurse Specialist, North Bay Parry Sound District Health Unit)*

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#### BACKGROUND

Samara Lewis is a public health nurse specialist at the North Bay Parry Sound District Health Unit (NBPSDHU). Samara has been tasked with creating a Safe and Positive Spaces workgroup that will aid in the implementation of an LGBTQ2S+ Safe and Positive Space at the health unit. Priority number one in the health unit's 2014-2018 Strategic Plan aligns directly with the creation of said spaces, as the health unit is committed to provisioning healthy sexuality messaging and to ensuring safe, welcoming, and accessible health services to all sexual and gender diversities. Safe and Positive Spaces act as facilitators in achieving health equity for the LGBTQ2S+ community. In September 2017, Samara will return to the Sexual Health department—her home department. Consequently, the future of the workgroup is unknown. Will a Positive Space champion step up and commit to leading the workgroup? Will the health unit achieve health equity for the LGBTQ2S+ community? Time is of the essence.

#### OBJECTIVES

1. Consider the complexities involved in gender and sexual diversities, as well as familiarity with the appropriate LGBTQ2S+ terms.
2. Identify contextual organizational factors that may facilitate or inhibit the implementation of a Safe and Positive Space.
3. Analyze policies to assess inclusivity and cultural competency.
4. Discuss and understand the importance of implementing a Safe and Positive Space in a public health organization.
5. Develop a context-specific implementation plan for Safe and Positive Spaces.
6. Discuss roles, responsibilities, and accountabilities that public health professionals have in ensuring health equity and inclusivity for the LGBTQ2S+ community.

#### DISCUSSION QUESTIONS

1. What are effective strategies in ensuring the implementation of a Safe and Positive Space?
2. How can public health professionals advocate for the rights of the LGBTQ2S+ population in terms of safe and equitable health services?
3. How do Safe Spaces facilitate health equity within the LGBTQ2S+ community?
4. What are potential challenges that may arise in implementing a Safe and Positive Space?
5. How can an organization ensure that it is providing safe and welcoming services to its clients?



## **Big Comfy Couch: The Implementation of an LGBTQ2S+ Safe and Positive Space Within a Public Health Unit**

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6. What steps are the most effective in creating a Safe and Positive Space (i.e. inclusive policies, all-gender washrooms, positive space stickers, etc.)?

### **KEYWORDS**

LGBTQ2S+ health; Safe and Positive Space; implementation research; health equity; cultural competency; cultural safety; inclusivity.

## CASE 5

### Making Oral Health Care More Palatable

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#### INTRODUCTION

In a time of governmental change and a shift to patient-centered care, a local community health centre (CHC) realizes the need for reform in the way oral health care is being provided, spurred by a recent influx of underserved residents and increasing rates of dental decay. Under the leadership of this CHC, with a vision of equitable oral health care, Emily, a health promoter with experience in oral health promotion and Nick, a Master of Public Health candidate with oral health research experience, are in charge of devising a way to improve the accessibility and quality of oral health in the municipality.

CHCs are not-for-profit, community-governed, values-based health organizations providing inter-professional services to promote health, prevent illness and injury, and build capacity. They provide these services through different clinics including diabetes, HIV, physician, and dental clinics. In the largely privatized Ontario dental industry, there are many barriers that at-risk individuals face. The dental clinic team at the CHC delivers oral health services to at-risk and vulnerable groups such as youth and the elderly who qualify for the Healthy Smiles Ontario (HSO) program, Ontario Works (OW), or the Ontario Disability Support Program (ODSP). In an effort to reduce dental inequities within the large municipality, Emily and Nick must collaborate and determine the appropriate measures to improve the oral health of the population. Historically, there has been little attention paid to population level oral health interventions other than water fluoridation.

A needs assessment was conducted by the CHCs using the coalition building tool to identify patients in each CHC's respective catchment areas who access oral health services. The assessment also identified barriers to access of oral health care (Exhibit 1). It was found that there was a need to improve the accessibility of oral health care; the cost of dental care was the leading reason preventing patients from accessing this service. These findings were reinforced by an in-depth analysis and report on the regional oral health status. The analysis found that, while there are basic services available to underprivileged youth and the elderly through HSO, ODSP, OW and the Region's Seniors' Dental Program (RSDP), there are still many gaps in research and coverage for other residents. The drawback of these programs is that the household income cut-off is quite low and is strictly enforced, leaving many residents to fall through the gaps, including working, middle-aged patients as well as youth and seniors whose income exceeds the cut-off.

Informed by the reports and by direction from the CEO of the CHC to implement an oral health coalition, Emily and Nick begin conducting some research to determine the best way to have widespread effects on improving oral health access. Looking to the United States as an example, the Centers for Disease Control and Prevention (CDC) has encouraged a state-wide

oral health coalition to drive initiatives to improve oral care on a united front. These oral health coalitions are shown to have great success and sustainability in the United States, as some oral health coalitions have advocated for the public for over 10 years (ASTDD, 2008). For this reason, Emily and Nick want to develop a regional oral health coalition.

### DEMOGRAPHICS

The region is one of the most diverse municipalities in Ontario, covering a large geographic area. The region currently has over 1.3 million residents, where around 50% of the population are immigrants. In addition, 7.8% of the residents are new immigrants, making the region culturally diverse and requiring targeted and culturally appropriate care. This includes making care more accessible for residents with different needs and those who have trouble accessing care for socio-demographic reasons. It is estimated that the median annual household income after taxation is around \$69,000, with a prevalence of low income of 12.6%. Due to the vast geographic area, ranging from heavily populated urban centres to small rural farmland, there are many challenges to servicing all subgroups of this population.

### ORAL HEALTH DISEASE

Poor oral health is a silent epidemic that affects the most vulnerable citizens. It is essential to deliver equitable and accessible oral health services to avoid dental caries health, as it can have extreme repercussions to overall health. The World Health Organization (WHO) defines oral health as “a state of being free of mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing” (WHO, 2012). Untreated tooth decay has risen in prevalence and is one of the most common conditions worldwide (FDI World Dental Federation, 2015). Oral health disease has been linked to increased risk of nutritional deficiencies, HIV infection from oral sores, cardiovascular disease, cancers, diabetes, and respiratory disease (FDI World Dental Federation, 2015). This emphasizes the global burden that oral health disease poses on population health, as it affects nutrition, overall health, and psychological wellbeing. It is also difficult to access care for the many health conditions that result from oral health disease. The prevalence of oral health disease is most commonly found in under privileged individuals and vulnerable groups with low socio-economic status. For these reasons, these groups are also disproportionately negatively affected by the symptoms of dental disease. Dental caries are still a major oral health problem in most industrial countries, affecting 60-90% of the population (WHO, 2012).

Canadians spend around \$12.5 billion annually on dental services (Canadian Dental Association, 2013); however, there are still inequities in accessing these services and a strong polarization of dental services in favour of southern Canadian cities. These high costs are incurred due to the privatization of the dental field. Reports show that Canada has one of the lowest rates of publicly funded dental care, equating to 6% of total spending, whereas the United States’ oral care funding equates 7.9% of government funds (Picard, 2014). In the European context, such as the NHS in the United Kingdom, dental care is included in the universal health care coverage plans, therefore, reducing the financial barriers in accessing dental care (NHS, 2018). When oral health disease progresses to the point where it is severe, emergency treatment and a visit to the Emergency Room (ER) is needed. It is estimated that such dental ER visits cost the US approximately \$1.6 billion in 2012 (Wall & Vujicic, 2015). This is the equivalent of \$749 per visit for a preventable disease.

### ORAL HEALTH CARE IN THE REGION

Oral health is an important contributor and indicator for the overall health of an individual. Dental decay is also preventable. While it may not be life threatening, it can have physical, social, and psychological impacts that lead to more costly treatment options. Dental decay prevention is widely regarded as a pressing issue, and municipal water fluoridation is regularly accepted as the most common and most cost effective method of preventing dental caries. Water fluoridation is the sole, population-based, oral health initiative, as individual practices, such as regular brushing and flossing, are not well practiced at the population level.

Currently, there are approximately 62 dentists per 100,000 residents in the region, which means that the area is well served. Nick notes that this is close to the Ontario average of 66 dentists per 100,000. However, only 66% of residents have access to dental insurance, and the type of coverage varies between age groups and immigrant status, leaving some with full coverage and others with little to none. Due to the high costs associated with oral health care, many of those who cannot afford to go to a dentist end up delaying their visits for routine checkups until they visit a dentist for an emergency procedure, either at a clinic or at the hospital.

In the Ontario healthcare system, oral health is not covered under the Ontario Health Insurance Plan (OHIP), which covers most fees associated with basic health care for residents of Ontario (Ontario OHIP, 2017). For those who do not have the coverage needed through dental insurance or through personal savings, there are some government funded programs. However, on average, the household income cutoff for these programs is approximately \$20,000, depending on the number and demographic of family members within the household (Ontario Works, 2012) (Exhibit 2). This income cutoff for government assistance is strictly enforced, leaving many stranded when trying to access financial help and dentists who accept these government programs (such as the CHC dental clinic).

### ONTARIO ORAL HEALTH INSURANCE COVERAGE

For those who need financial assistance with oral health services, Ontario provides a few options. Children under the age of 17 from families of financial hardship can qualify for preventative and emergency services under the HSO program (Ministry of Health and Long-Term Care, 2016). The region also provides similar services for seniors who can prove they need preventative treatment, extractions, root canals, or one-time prostheses. However, those who are not able to access youth or senior programs due to age are left with little assistance. Individuals with low household incomes and those with disabilities have access to OW and ODSP; however, these programs require a significant amount of paper work and are strictly enforced with their requirements. Another challenge is that these programs are not well advertised and residents are often not aware of them.

### ORAL HEALTH COALITION

Oral health coalitions have shown that a broad-based committee could work to improve the oral health of a region, as seen in multiple circumstances in the United States (ASTDD, 2008). The coalitions that have already been developed have multiple stakeholders from different backgrounds who have a large network of constituents as seen in the oral health coalition frameworks developed by the CDC (Exhibit 3). This broadens the legitimacy and the public power of the coalition, giving them the power to set the agenda for oral health care.

A coalition has two definitions: “an organization of individuals representing diverse organizations, factions or constituencies who agree together in or to achieve a common goal”; and “an organization of diverse interest groups that combine their human and materials resources to effect a specific change the members are unable to bring about independently”

## Making Oral Health Care More Palatable

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(ASTDD, 2008). Using these definitions, an oral health coalition would bring together multiple interest groups with similar visions and backgrounds in different areas of expertise to improve the oral health of a population of interest. Oral health coalitions also aid in the alignment of priorities for oral health initiatives in the region.

In the United States, there are currently eight state-level oral health coalitions, four collaborative partnerships developed through commissions and task forces, and five collaborative partnerships with a focus on oral health. These coalitions and partnerships are paving the way for best practices and unity among oral health providers. The best Canadian example is the Saskatchewan Oral Health Coalition. Other regional coalitions include the Toronto Oral Health Coalition and the Niagara Dental Health Coalition, both in the province of Ontario.

### STEERING COMMITTEE

Since the founding of the region's CHC, the CEO has aimed to implement an oral health coalition for the region in order to improve the oral health of its residents, and it is now up to Emily and Nick to bring it to fruition. Previously, the political climate was not ideal for oral health reform, but, with municipal and provincial elections within a year, the political climate is perfect for change. With the strong leadership and backing of the region's CHC, Emily was able to collaborate with the regional oral health manager. Using her expertise in health promotion, Emily was in charge of gathering a small group of powerful decision makers, such as councilors, influential dental professionals, and community leaders, in order to form a steering committee for the coalition. Emily worked tirelessly, reaching out to the community to gain interest and further her vision for oral health in the region. This passion was also shared by Nick, who has a similar vision and passion for oral health. At first, Nick spent weeks catching up on reports, council meeting minutes, and the demographic composition of the region in order to gain a better understanding of the residents. Nick was in charge of developing the supplementary material to help support and inform the groundwork for the development of the coalition. Informed by the American examples, Nick developed a stakeholder list for the steering committee and briefing note (Exhibit 4) on the frameworks that different oral health coalitions use as a basis to start the regional coalition.

The steering committee consists of the CEO, the region's oral health director and manager, the oral health manager from the CHC, and the CEO of a social change advocacy group, as well as Emily and Nick. Before the first meeting, Emily and Nick spent weeks revising all the presentation materials and planned an agenda for the steering committee meeting with the CEO of the CHC. The agenda consisted of developing a purpose for the coalition, terms of reference, framework, and future meetings for the steering committee.

The first meeting was chaired by the CEO, and all the members of the steering committee were in attendance. Meeting members called upon Emily and Nick as references to the research that they conducted surrounding oral health coalitions and what has been done before. During the first meeting, the steering committee agreed upon the utility of an oral health coalition. However, the purpose of the coalition still needed to be determined, including whether the coalition would be focused on creating programs or participating in advocacy work. Although the framework of a broad-based coalition was insisted upon, a community led partnership would result in the best sustainable outcomes. Organizational roles were also determined. The CHC would be the driver and main face of the coalition moving forward; however, the region would provide resources and data. The social planning council would lend a hand in the expertise needed for building coalitions and engagement of the community as it plays a governing role in community building initiatives in the region. The committee agreed to communicate over the next few months to develop a specific mission and vision for the coalition, terms of reference, and a purpose for the

coalition in order to provide documents when recruiting stakeholders. After the first steering committee meeting, Emily and Nick were relieved that their work had been well received and they believed the right people were at the table to kick off the coalition; however, the majority of the work had yet to be done.

### **COALITION BUILDING**

Oral health coalitions must have a broad base of stakeholders in order to engage more public action. The steering committee decided that, in order for the coalition to be successful, they must be a grass-roots initiative and have a close tie to the diverse, local community. As directed by the steering committee, the next steps are to create the mission and vision of the coalition, garner support, maintain financial stability, and engage stakeholders who align with the mission and vision of the coalition (Exhibit 5). The coalition must identify the key stakeholders to lead the group. These stakeholders would hold a permanent seat in the coalition and will have the most input into the coalition's agenda. In addition, other influential organizations and people will need to be recruited for different roles in the development of the coalition. Emily and Nick must now help create a purpose and terms of reference for the coalition as well as decide on a strategic plan to determine which stakeholders should sit on the coalition as it is developed and what is the correct communication plan for each of the stakeholders. With limited resources available, it is important to maximize and prioritize stakeholder engagement techniques.

### **CONCLUSION**

Emily and Nick return to their office and stare at each other, grinning. Their work has kick-started an oral health coalition in the region; however, the hard work has just begun. Without adequate resources, they are left to determine the best way to develop this oral health coalition's purpose, terms of reference, stakeholder list, and engagement plan on a tight budget and limited support. They sit at a round table, referring to the regional oral health coalition briefing note (Exhibit 4), trying to determine the best way to proceed. Stacks of paper and journals surround them, as they are about to start the implementation process of the oral health coalition. They are left with many questions: What stakeholders should they invite to the coalition? Who are the best representatives? How will they engage the stakeholders? How can they engage and garner more participation from the community to improve oral health for the region? How will the coalition be sustainable? The first coalition meeting is a month from now. Nick stands up and closes the door as they get to work.

## Making Oral Health Care More Palatable

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### EXHIBIT 1 Coalition Initial Needs Assessment

1. If your Coalition has a written mission statement, please write it below.
2. If your Coalition has written goals or objectives, please write them below. If they are in the form of an action plan or formal document, please include a copy.
3. In general, what are the main functions of your Coalition? (Check as many as apply)
  - Information and Resource Sharing
  - Planning and Coordination
  - Technical Assistance and Training
  - Advocacy and Community Change
4. How many organizations are represented on your Coalition?
5. Please list your Coalition's most active and committed member organizations (or attach a member roster).
6. How often does your Coalition meet?
7. If your Coalition has working committees, please list them below.
8. If your Coalition has elected leadership, please list the offices held.
9. Thinking about your Coalition, what are its most significant successes, i.e., what accomplishments are your coalition members most proud of?
  - a.
  - b.
  - c.
10. Again, thinking about your Coalition, what are its most significant challenges, e.g., lack of resources, commitment, time, organization?
  - a.
  - b.
  - c.
11. If your Coalition could develop further and implement significant change, what could you imagine being achieved?
  - Within the next few months...
  - Within the next year...
  - Within the next five years...
12. Add any other information that would help us to learn more about your Coalition.

Source: Coalitions Work, n.d.

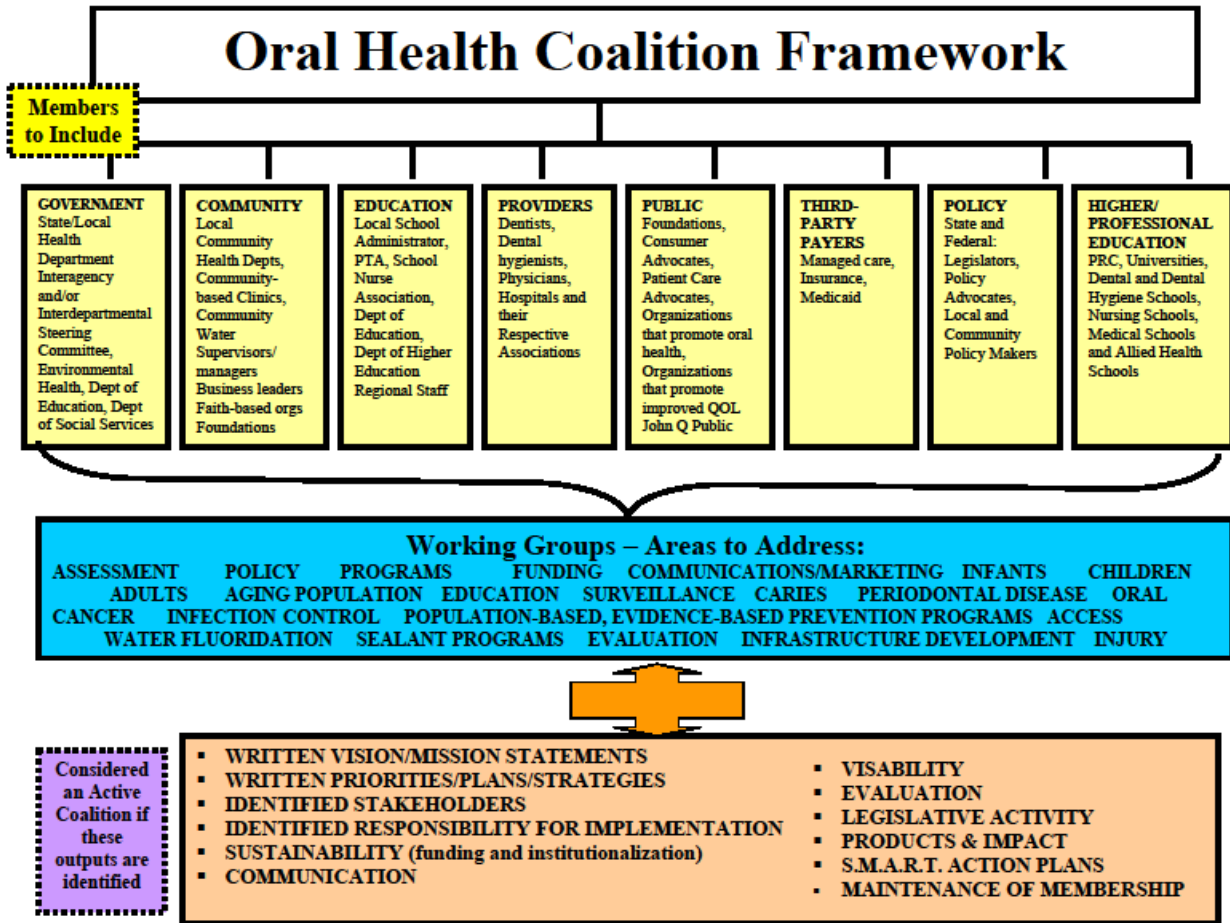
**EXHIBIT 2**

<b>Table 3: Total income from all sources compared to common poverty measures for selected households on Ontario Works and the Ontario Disability Support Program Toronto April 2010</b>				
Household	Total income	Percent of common poverty measures for Toronto		
		After tax low-income measure	After tax low-income cut-off	Market Basket Measure
<b>Ontario Works</b>				
Single adult	\$7,878	(\$16,810) 47%	(\$18,930) 42%	(\$16,642) 47%
Two adult couple	\$13,669	(\$23,534) 58%	(\$23,039) 60%	(\$23,298) 57%
Lone parent - one child	\$18,351	(\$23,534) 78%	(\$23,039) 80%	(\$23,298) 79%
Lone parent - two children	\$23,384	(\$28,578) 82%	(\$28,688) 82%	(\$28,292) 83%
Two adult - one child	\$20,141	(\$28,578) 70%	(\$28,688) 70%	(\$28,292) 71%
<b>Ontario Disability Support Program</b>				
Single adult	\$13,362	(\$16,810) 80%	(\$18,930) 71%	(\$16,642) 80%
Two adult couple	\$20,557	(\$23,534) 87%	(\$23,039) 89%	(\$23,298) 88%
Lone parent - one child	\$24,795	(\$23,534) 105%	(\$23,039) 108%	(\$23,298) 106%
Lone parent - two children	\$29,996	(\$28,578) 105%	(\$28,688) 105%	(\$28,292) 106%
Two adult - one child	\$27,197	(\$28,578) 95%	(\$28,688) 95%	(\$28,292) 96%
<p>Source and assumptions: Calculations by Social Assistance Review Advisory Council; two adult couple on Disability Support assumes one with disability; one child under 6; two children one under 6 and one over 6; no earned or other income; low income measure from 2007 up-dated to 2010 by CPI; low income cut-off from 2008 updated to 2010 by CPI; Market Basket Measure from 2007 up-dated to 2010 by CPI. The Market Basket Measure and the low-income cut-off are geographically specific. Toronto was chosen as the highest cost and most populous region in Ontario. The poverty measures listed do not take into account the additional costs of disability and so overstate the relative financial position of the Ontario Disability Support Program.</p>				

Source: Government of Ontario, 2012.



EXHIBIT 3



Source: CDC, n.d.

### EXHIBIT 4 Regional Oral Health Coalition Briefing Note

#### Findings

Regional oral health coalitions can provide guidance and recommend specific direction for public initiatives and government programming to improve oral health status. The coalition can also identify areas of need and problems at the local level, provide support, set priorities, and develop plans to improve oral health. It will also help increase collaboration between sectors to reach a united goal and streamline processes to make them more efficient, therefore, cutting costs. Best practices show that an oral health coalition should be comprised of multiple parties and a broad variety of constituencies, so that oral health becomes a pressing issue that extends beyond regular borders and fields that respond directly to the problem. The literature shows seven points regarding the importance of coalitions:

- Enable organizations to become involved in new and broader issues
- Demonstrate and develop public support
- Maximize power and public perception of individuals and groups in a joint effort
- Minimize duplication and centralize decision making
- Mobilize action, resources, and initiatives in ways only a larger organization can
- Provide an avenue for recruiting participants and public engagement
- Exploit new resources

*Enable organizations to become involved in new and broader issues*

Organizations that have been in the community and work alongside the community know the key issues and stakeholders to contact in the region. However, there can usually be a large disconnect between organizations and the people they serve. For this reason, coalitions can facilitate knowledge transfer, so that community members can have a voice and advocate for what they need, as oppose to organizations determining the agenda. By bringing a broad base of stakeholders to the table, it creates a forum where the diffusion of knowledge can be catalyzed in the environment of the coalition. This transfer can spark new ideas and initiatives, steering the dialogue to the interests of the community.

It is often seen that organizations and departments have become more siloed, even more so for specialized departments in large organizations. The departments lose sight of the bigger picture and fail to communicate and share information, therefore, leading organizations who might have similar goals to “reinvent the wheel”. By creating this forum for open discussion and collaboration, new projects can include organizations with special skills that may not be the organization’s main area of focus; however, their skills would be a great asset. This would create a multidisciplinary team that can carry more integrated and difficult projects that individual organizations cannot undertake on their own. This also relieves some individual organizations, who feel burdened by the responsibility to manage and carry out the projects. With more collaboration, the workload can be spread out and managed more efficiently.

*Demonstrate and develop public support*

The most interesting component of a coalition is the way that it harnesses the interest and knowledge from a large, broad, diverse group of individuals and organizations within a region. Although many have differing visions of what they want to see, when proper collaboration occurs with multiple organizations with similar visions and missions, the skills they bring to the coalition would have great potential in creating change in the community. With input and

## Making Oral Health Care More Palatable

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collaboration along side community members and advocates, the coalition can gain more public support and trust from the community they serve. Those with lived experiences and who want to make a change in the community are crucial in developing the agenda for the coalition. This will allow for a broader acceptance of the advocacy work and interventions that the coalition develops, as the community would feel like they have a voice and means of input to the coalition.

When the community has an open line of communication with the coalition, it is possible to serve the community better as well as determine the unmet needs of the community. Once the needs are known, the committee can develop an appropriate intervention based on input from community advocates. This process can gather and develop widespread public support and action for the coalition.

### *Maximize power and public perception of individuals and groups in a joint effort*

The development of the coalition and the process of coalition building can bring many benefits to both the community and the organizations that are collaborating. By bringing together a broad base of organizations, both large corporations and smaller companies, organizations with input from the community have the potential of garnering more power in the region. The larger organizations may have more power in the markets but can also be disconnected from the community, therefore, gathering more information and connectivity with the people they serve through smaller organizations and community groups. However, the community groups, advocates, and small organizations can gain more power from the larger organization which allows them to have more support in order for them to be heard, which otherwise might be more difficult to attain.

The coalition will especially increase the legitimacy and the backing in recourses behind community efforts. By creating a larger base of individuals with the same vision and mission, different credentials can increase the effectiveness of the actions of the coalition and individuals. It will also help any single individuals or organization achieve goals that may be beyond scope individually.

### *Minimize duplication and centralize decision making*

Coalitions tend to unify and encourage collaboration among a multidisciplinary group; therefore, it can help reduce redundancies and centralize efforts. It is common to see that large organizations lack communications across the sector and seem to “reinvent the wheel” by working on similar projects but do not share their work or methods with others. This is commonly seen in public health and can also occur in other oral health coalitions. Sharing methods and information across disciplines and sectors can improve the efficiencies of organizations and their initiatives to result in widespread change and success. The coalition can reduce these tendencies of repeating similar work and services between smaller groups, thus, centralizing efforts that can increase positive outcomes and productivity.

Coalitions can also act as a central hub for both information and decision making. Having a centralized area for information on specific issues with multiple resources available can be useful for community members and policy makers when it comes to improving oral health outcomes, especially when coordinating large-scale projects. Bringing together professionals and community advocates to the same table concentrates the skillsets needed to develop the proper policies or actions that adequately fill the needs of the community in a sustainable and

## Making Oral Health Care More Palatable

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effective way. This can also improve the trust and communication between groups who may not normally work together or between groups who may normally compete with one another.

*Mobilize action, resources and initiatives in ways only a larger organization can*

Coalitions give the opportunity for actions to be taken on many initiatives that are pressing for the local community. The benefit of having a coalition is the united front it provides and the multiple individuals collaborating to take action on multiple projects. This makes it easier and adds more power and resources behind initiatives that may otherwise fizzle out before implementation. Coalitions, therefore, have the ability to get the ball rolling and mobilize multiple talents from different organizations and sectors and coordinate the appropriate resources and approaches to implement actions. Without the coalition, these actions may not come to fruition, as single individuals or organizations may not possess the resources or power needed to achieve the same results.

*Provide an avenue for recruiting participants and public engagement*

Coalitions are multidisciplinary collectives of individuals and organizations, therefore, providing a forum that forms a diverse group. For this reason, it is possible to create an avenue to recruit new individuals and groups who were not part of the original coalition as it begins to grow. The coalition can include and recruit a broad base of participants; such as political representatives, local businesses, professionals, human services, social and religious groups, educational institutions, and grassroots groups and individuals. All participants can join as long as they align with the mission and vision of the coalition as they could bring more resources and power to the coalitions to achieve actions.

*Exploit new resources*

The multidisciplinary broad base of participants in the coalition creates an environment that encourages flexibility. By recruiting new and multiple participants, it allows the coalition to reach into resources from a larger resource pool that single organizations would not be able to access. This allows the coalition to exploit new resources from different areas and unify them for one cause—which is essentially what makes the coalition more efficient in achieving goals and actions set out by the coalition.

The literature has also identified seven factors of alignment to enhance coalitions' impacts by changing behavioral and population level health:

- Clear vision and mission
- Action planning and programming
- Developing and supporting leadership
- Iterative feedback process
- Technical assistance and support
- Securing financial resources
- Importance of outcomes

Vision and mission

In any collaboration, especially in large groups, it is essential to develop and determine a clear mission and vision at the beginning of the coalition. This will help with alignment of all other groups who will be partners as well as set the agenda for the coalition. Having an established

## Making Oral Health Care More Palatable

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vision and mission that are clear can help streamline the work process of the coalition to achieve the appropriate actions. This process can generate support and awareness of the coalition while reducing conflicts of interest when partners are recruited. If the partners are included and collaborate in the process, it strengthens the partnership making the coalition more efficient. Once the vision and mission is developed, it is important to evaluate it as the coalition begins to operate; they may need to revise and re-develop to adapt to the changes in the environment.

### Action planning and programing

Open communication and planning is imperative for success in an open partnership. For oral health coalitions, action planning refers to the planning processes that will inform and lay out the actions of the coalition. Much like a needs assessment, this planning process will identify areas where the coalition will focus efforts as well as find the resources required to achieve them. The process will also establish timelines, communication plans, ways to gain support, and accountability.

### Developing and supporting leadership

Strong and transparent leadership is crucial for effective collaborative partnerships. For oral health coalitions, leadership teams are a small group of decision makers who have experience in the dental field, in community outreach, and in coalition building. Also, it is important to build partnerships with community champions in key sectors to gain more support in specific communities. By including members in decision making through consensus and democratic processes, it will increase support and satisfaction, community participation, and the effectiveness of the coalition. Leadership needs and skills may change through the maturity of the coalition. At the beginning stages, it will be important to have good facilitations, planning, and listening skills at the table in order to get the coalition started while gaining insight and support from those who want to be part of the coalition. When the coalition is more established, they will need strong advocacy, negotiation, and mitigation skill to bring change to the community. When the leadership team is successful, they will inspire strong collaboration, commitment, and action within the coalition and the community. Through strong leadership, it will be easier to create a broad-base of stakeholders and create involvement that is sustainable.

### Iterative feedback process

System level change and health partnerships tend to be a long-term commitment where outcomes are realized over time. In order to achieve the aim of population-level, health outcome improvement, iterative feedback is required to constantly evaluate the coalition and sustain support. By evaluating outcomes, especially intermediate ones, we can determine what is working and how to improve what is not. This will help document the progress of the coalition, publish its accomplishments, identify barriers, and reconfigure actions in order to be more effective in achieving outcomes.

### Technical assistance and support

Technical assistance and support can enhance the partnership by improving community assessments and leadership organizations and by facilitating meetings, action planning, evaluation, social marketing, and fundraising. These improvements are usually conducted by consultants or external parties from the coalition; however, it can also be conducted by the

## Making Oral Health Care More Palatable

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coalition members if there is capacity to do so with assistance from different resources, such as written materials and toolkits.

### Securing financial resources

In order for the coalition and partnership to be sustainable, it is important to constantly secure funding for the coalition. The funding is usually used for social marketing, mobilizing community partners and action, or new initiatives. Hiring members to implement actions can have a better outcome within the community. However, attaining financial supports may depend on the communities and the amount of community buy-in and support.

### Importance of outcomes

Usually outcomes of the coalition are important to a core group of members and community members, however, by incorporating them into the coalition, there would be more widespread consensus of prioritizing these outcomes. The more positive outcomes and messaging that are promoted by the coalition, the more the community will begin to realize the issue at hand, which can help secure human and financial resources to benefit the desired outcomes. This can be achieved by constant documentation and updates to the community on key indicators and by distributing reports to key stakeholders, funding organizations, media, and community members. With a constant evaluation process of outcomes, the development of the coalition and its importance in the community can be demonstrated.

Since the oral health coalition will be a public entity, the evaluation of the coalition should be a crucial element when providing quality services to the region. The evaluation will help create quality improvements in the coalition and the programs it develops. The evaluation should also include their outcomes and impact based on the mission and values sought out by the coalition. The evaluation can help

- Build capacity of coalition and community;
- Achievement of objectives and ways to improve them;
- Provide accountability;
- Educate leadership; and,
- Improve best practices and effectiveness of oral health coalitions.

## Recommendations

The governance structure in the US is different. Its government encourages oral health coalitions through the Centers for Disease Control and Prevention, creating a market and foundation for the formation of coalitions by providing a framework. However, in Ontario, there has neither been much precedence set for oral health coalitions nor best practices for oral health coalitions; for this reason, the recommendations for the Oral Health Coalition (OHC) will be primarily based off of US oral health coalitions as well as well-established Canadian coalitions.

Action plan for coalition development:

- The formation of the OHC should have four stages: (1) steering committee formation, (2) coalition formation, (3) implementation, and (4) outcomes
  1. Formation of a small influential group (five to six members) with large networks and resources to recruit the necessary key stakeholders for the coalition

## Making Oral Health Care More Palatable

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- Create OHC mission and vision statement
  - Determine key stakeholders
  - 2. Formation of the OHC with a broad base of stakeholders from multiple levels of government and from the public and private sectors. Stakeholders must have similar visions and missions as the OHC and should align on a common goal of improving the oral health of residents of the region. Organizational representatives must have power within their agencies to make decisions on behalf of the organization.
  - 3. Implementation of initiatives, policy and action discussed in regular coalition meetings
  - 4. Outcomes of each action should be measured and evaluated
- Implement the best practices of oral health coalitions as stated above section findings

### Action plan for coalition:

- Creation of strategic plan
- Iterative evaluations of initiatives
- Shift perceptions of public, policy makers, and health providers around oral health
- Build an effective health infrastructure that meets the oral health needs of the region
- Remove barriers in accessing oral health
- Foster partnerships

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Source: Created by authors.

### EXHIBIT 5

#### COALITION VISION, MISSION & GOALS

##### SWOT Analysis

- **Strengths** - internal factors that allow coalition to take advantage of opportunities or reduce barriers
- **Weaknesses** - internal factors or challenges that prevent coalition from taking advantage of opportunities or reducing barriers
- **Opportunities** - external factors that allow coalition to take action, build membership, or improve community
- **Threats** - external factors that hinder goal attainment, sustaining momentum, or long-term survival

##### VISION

- Shared by members & easily communicated
- Broad enough to include diverse viewpoints
- Inspiring & uplifting

**Smoke Free \_\_\_ is a community where all residents are healthy and tobacco free!**

##### MISSION

- Describes what group is going to do
- Concise: Gets point across in 1 sentence
- Outcome-oriented: Explains outcomes coalition is working to achieve
- Inclusive: Doesn't limit sectors or strategies that may be involved in projects

**To bring diverse organizations and individuals together to change policies, systems and environments related physical activity.**

- Phrase used to brand coalition or market it to public
- Short & "catchy"

**Eat Better --- Move More!**

##### GOALS

- Broad statements that refer to specific results of initiative
- Long range – not time dependent – Dreams with Deadlines

##### STRATEGIES

- How organization will reach goals & objectives
  - Fit resources & opportunities; Minimize barriers
  - Reach priority populations
- Should be well defined:
  - Measurable
  - Directly related to objectives
  - Identify those responsible for carrying them out

Source: Coalitions Work, (n.d.).



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## INSTRUCTOR GUIDANCE

### Making Oral Health Care More Palatable

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#### BACKGROUND

Oral health is a major indicator for overall health; however, it is not covered under the Ontario Health Insurance Plan (OHIP), making oral health care relatively inaccessible to a large population. A large and diverse municipality has recently conducted a needs assessment that shows that there is a need to improve accessibility to dental care for its citizens. A Community Health Centre (CHC) spearheaded the development of an oral health coalition to help unify and steer the direction of oral health care in the region. The goal of the coalition is to bring oral health to the forefront of healthcare. Under the supervision of the CHC's CEO, a health promoter, Emily, and a Master of Public Health candidate, Nick, must help inform and develop the oral health coalition through a steering committee. This set-up is based on the American example of state-wide oral health coalitions. With the guidance of regional oral health leadership, Emily and Nick must develop a stakeholder engagement plan which identifies key stakeholders, a purpose, and terms of reference for the coalition, all with backing from the literature and other oral health coalitions.

The goal of this case is for the reader to practice skills in identifying a broad base of stakeholders, engagement, and health promotion strategies and in developing multidisciplinary work. Through the development of the case, readers will work in groups to determine appropriate stakeholders and the utility of coalition building. These skills relating to stakeholder engagement, critical thinking, and planning in a multidisciplinary team can be used in multiple areas of public health when needing to garner a broad-base of support for programs or initiatives for policy change.

#### OBJECTIVES

1. Develop a stakeholder analysis and engagement plan.
2. Apply health promotion strategies to help the community improve their oral health (Health Belief Model).
3. Understand the importance of coalition building and multidisciplinary team work by identifying methods of improving health equity and the relevant social and cultural determinants of health that can be targeted.

#### DISCUSSION QUESTIONS

1. What key stakeholders did your team identify?
  - a. Why are they important members for the coalition?
  - b. How would you go about engaging them?
2. What is the utility of an oral health coalition?
  - a. How can coalitions be used in public health?
  - b. What is the mission and vision that you came up with for the coalition?

## Making Oral Health Care More Palatable

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3. How would you organize and facilitate development of the coalition?
4. Should the region make oral health a priority?
  - a. How would they go about it?
  - b. From the team perspective, would an oral health coalition improve oral health outcomes in the region?

### **KEYWORDS**

Oral health; coalition; collaboration; health promotion; health equity.

## CASE 6

# On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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Aidan Norman sat down at his desk and let the events of the meeting he had attended sink in. During this meeting Aidan was appointed the manager of Parachute's newest initiative: the Vision Zero Network. Aidan was thrilled; he had been at Parachute for three years but had never taken on a project of this size before. Parachute is a national charity dedicated to preventing injuries and saving lives and Parachute's Vision Zero Network would attempt to reduce fatalities and serious injuries on Canadian roads to zero. Aidan would be responsible for leading the Vision Zero team as they implemented a social marketing campaign that provided educational and awareness raising resources to the public as well as Parachute's stakeholders. His goal would be to determine how Parachute's resources could go beyond basic marketing and lead to actual changes in public behaviour and attitudes towards road safety. More importantly, he would have to devise an evaluation plan that assessed the effectiveness of these resources. A public health social marketing campaign, such as this, would rely on feedback from the public to determine if the material was in fact leading to change. Funders and stakeholders of the Vision Zero Network would want to see evaluation results to ensure that their investment had been put to good use. Aidan knew that the management team had a gold-standard evaluation method in mind, however, Parachute lacked both the funding and time to complete the technique. Aidan knew that the next few months were going to be filled with obstacles, but he looked forward to the new challenge.

### BACKGROUND

Injury is the number one killer of Canadians aged 1 - 44 and results in 16,000 deaths and 60,000 disabilities annually. The financial toll of injury to the Canadian economy is a staggering \$27 billion annually, costing more than heart disease and stroke. The brunt of the economic burden is faced by the publicly funded health care system, where there are upwards of 3.5 million emergency room visits per year. More importantly, the emotional impact and potential years of life loss of those injured can be devastating to families, friends, and communities (Parachute, 2015).

Of the thousands of preventable injuries that occur each year, a large proportion of these injuries take place on the road. Every year, approximately 2,000 Canadians are killed and 165,000 are injured on our roads (Parachute, 2015). Canada has one of the highest motor vehicle fatality rates among high-income countries, and transport-related injuries remain the leading cause of death for children under the age of 14 (WHO, 2015 & Parachute, 2015). Vulnerable road users, such as pedestrians, motorcyclists, and cyclists that lack protection

## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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when travelling on the road, accounted for 27% of the road fatalities between 2010 and 2014 (Transport Canada and Canadian Council of Motor Transport Administrators, 2016). To combat these trends, the three main causes of road incidents (distracted driving, impaired driving, and speeding) must be addressed.

Parachute has made road injuries a priority and focused activities to address the root causes of road injury and fatality. Through knowledge translation, innovative solutions, and collaborative partnerships, Parachute aims to educate the public and initiate policy change to create a safe environment for all Canadians. Preventable injuries are just that: predictable and preventable. Through Parachute's activities Canadians are given the tools and knowledge required to make smart and safe decisions.

### PARACHUTE – LEADERS IN INJURY PREVENTION

*“Preventing Injuries. Saving Lives.”*

Parachute is a national charity dedicated to preventing injuries and saving lives. Parachute was established in July 2012 when four organizations united: Safe Communities Canada, Safe Kids Canada, SMARTRISK, and ThinkFirst Canada. The purpose of Parachute is to make a meaningful and measurable reduction in the emotional and financial impact of preventable injury in Canada. This includes decreasing the incidence and severity of injury and reducing the social, financial, and emotional impact of injury to individuals, families, and businesses, and ultimately reducing the financial cost of injury to the healthcare system. Parachute strives to shift the way Canadians view preventable injuries by inspiring individuals to commit to safer practices. To do this, Parachute designs and implements innovative, evidence-based strategies with an aim to support behaviour change. Solutions are developed at the national level but delivered in ways that meet the needs of individual communities.

As a registered charity, Parachute relies on external funding to support its endeavours. The majority of the funding received by Parachute is provided by corporate sponsorship from insurance companies such as State Farm Insurance, TD, and Great West Life. Other sources of funding include individual donations, fundraisers, foundations, and grant funding from the federal and provincial government. Most funding is designated to specific projects, meaning that donors have a specific task in mind when providing the funding. Consequently, Parachute must be able to show stakeholders that their requested task was completed and that the specific project outcomes were achieved.

Through funding and partnerships with stakeholders across the country, Parachute is able to offer many programs across Canada. These programs are designed to help people reduce their risk of injury and live life to the fullest. They address a variety of injury prevention issues, such as child injury prevention, concussions, motor vehicle collisions, and fall prevention. Recently, Parachute's stakeholders identified a need for a network that could bring together key players in road safety initiatives. To fulfill this need, Parachute implemented the Vision Zero Network to create awareness about current road safety issues and the solutions that should be applied to tackle these issues.

### VISION ZERO

*“Only by working together can we drive meaningful change.”*

The goal of Vision Zero is to reduce fatalities and injuries on Canadian roads to zero. Vision Zero tackles the three large contributors to road incidents: distracted driving, impaired driving,

## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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and speeding. Vision Zero provides informative resources about road safety and advocates for policy change, enhanced regulation, and road infrastructure changes. These activities aim to enhance pedestrian and cyclist safety, increase seatbelt use, implement safer speed limits, and educate the public on the dangers of distracted and impaired driving.

The original Vision Zero was founded in Sweden in 1997 (Parachute, 2017a). Since then, Sweden has achieved one of the lowest traffic-related fatality rates in the world. Pedestrian fatality rates have decreased by 50% in the past five years and road fatalities have decreased by 34.5% from 1997 to 2009 (Parachute, 2017b). Since its implementation in Sweden, the Vision Zero road safety initiative has been approved in various other countries and provinces, including Edmonton, Toronto, and British Columbia (Parachute, 2017c).

The Parachute Vision Zero Network is facilitated by Parachute from its offices located in Toronto, Ontario. Parachute serves as the hub that brings together key players in the Vision Zero movement in Canada. To achieve similar successes as Vision Zero in Sweden, Parachute must find ways to implement solutions that are relevant to the Canadian context. A large part of this will be accomplished through a social marketing campaign that provides resources (e.g. educational information) to the Canadian public using a website and a social media account (Twitter).

### **SOCIAL MARKETING**

Social marketing is a program planning technique that draws on marketing concepts to elicit behavioural change in a target population (Grier & Bryant, 2005). Social marketing in the context of public health has the potential to change health-related behaviours in the public and lead to positive health outcomes. Social marketing campaigns have proven successful in public health. For example, social marketing activities have helped to improve immunization rates, access to clean drinking water, and global health conditions (e.g. the elimination of leprosy in Sri Lanka) (Williams, Dewapura, Gunawardene, & Settinayake, 1998).

Changes in infrastructure and enforcement are most effective in improving road safety. Although behaviour change is least effective in this regard, it is necessary to create a shift in culture (Johansson, 2009). The Vision Zero social marketing campaign will attempt to address the need for behaviour change by providing resources that persuade road users in Canada to abandon risky behaviours (e.g. speeding) and engage in safe practices (e.g. ignoring texts while driving). Social marketing can target a specific audience, as well as policy makers who have the capacity to make changes in legislation (Grier & Bryant, 2005). Through its efforts, Vision Zero aims to influence policy makers and members of the public to prioritize road safety and to implement changes to road infrastructure that reduces risks and hazards on the road.

In social marketing there is the fundamental concept of exchange where the social marketer encourages the public to change their behaviour in exchange for some benefit(s) or consequence(s) that the behavior can bring about. For example, one may be convinced by a social marketing campaign to put their cellphone away while driving to reap the benefit of increased vigilance and safety for those in their vehicle and surrounding road users. In order to be most effective social marketing needs to discover which benefits are most important to the target population and then use those benefits to market the “product” or behaviour desired. The perceived benefit must also outweigh the perceived cost of making the behavior change. In the case of cellphone use the added protection must be valued more than the benefits of being able to answer texts and emails while driving. These concepts are then communicated to the public

## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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through communications and promotional activities that appeal to the target population, such as advertising, media, and signage (Grier & Bryant, 2005).

### THE VISION ZERO SOCIAL MARKETING CAMPAIGN

The Vision Zero team sat in the Parachute office boardroom discussing the elements they would like to include in the Vision Zero social marketing campaign. Aidan looked around the room at his team and tried to determine how everyone's skills could be utilized for the campaign. His team consisted of Tammy from the Communications team, Jane from the Knowledge Translation team, Joe from the IT team, and Bridget from the Solutions team.

The team began the meeting by discussing the most effective way to reach their target audience. "Since our audience will be a subset of Parachute's existing audience and other similar groups, we should use tactics that Parachute has found are successful in reaching the public," said Aidan. Aidan referred to his notebook and explained: "Our previous research and evaluations have shown that Parachute's website and Twitter account garner the most followers. Perhaps, the most appropriate choice would be to do the same and create a Vision Zero Network website and corresponding Twitter account."

"We'll have to conduct some more research to find out what kind of material should be posted," said Jane. "Traditionally, in public health, experts deliver the messages that they believe will alter the public's behaviour. It is a mistake to think that the public would behave differently if they only knew more facts about road safety. We have to take a different approach with this social marketing campaign. We should take this opportunity to determine what the public's understanding of road safety is and then work with them to communicate lessons that will actually lead to behaviour change."

"There definitely needs to be a balance," said Tammy. "We need to find a way to provide educational information that raises awareness but also includes interesting pieces that keep our readers and followers engaged." Tammy walked over to the whiteboard and began writing down her suggestions. As she wrote she said, "Let's be strategic with the content that we post, so that the material targets the audience we're trying to reach with each platform. Based on the evaluation results regarding the types of audiences that view Parachute's platforms, the website should provide information to stakeholders, and the Twitter account should cater to the interests of the general public", said Tammy. Everyone agreed the website should contain all of the data heavy resources and the Twitter account should contain a mix of interesting statistics, graphics, current events, and videos.

Tammy then began to hand out a document that she had written and said, "I've conducted some research on the tone and tactics we should employ when writing our social media posts. This is a communication guideline outlining the rules that each post should follow." Aidan flipped through the document and noticed that the main emphasis was on the avoidance of shaming individuals or organizations. The posts should avoid taking on an accusatory tone or blaming any particular party in the event of a road incident. Posts should instead highlight the benefits of engaging in safe practices on the road and tell readers what they should do versus what they should not do. For example, a post about the importance of bike helmets could state "remember to wear your helmet when riding your bike" rather than "don't ride your bike if you're not wearing a helmet" (Centers for Disease Control and Prevention, 2012).

Aidan felt that although the meeting had been productive so far, the campaign seemed a bit generic. He wanted to know how they could lead to actual change. To express his concerns

## **On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health**

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Aidan said, “So now that we have the foundation figured out, let’s discuss what we are trying to accomplish with this campaign. I’ve reviewed a few other injury prevention campaigns and most of them have found that Canadians are well aware of the safe practices that they should be engaging in to avoid injury. Yet during moments of decision making, they opt for risky behaviours because they’re simply easier or because they feel as if they can avoid injury” (The Community Against Preventable Injuries, 2017).

Aidan elaborated, “With this in mind, we have to develop a campaign that inspires Canadians and gets them to realize that they are not immune to road incidents. We need them to see that preventable injuries happen to everyone and that activities like jaywalking, cycling without a helmet, and speeding can have consequences and are not worth the risk.”

“I completely agree,” said Bridget. “Making people feel bad about their decisions isn’t going to change their behaviour. We need to get them to stop feeling apathetic about engaging in risky behaviours on the road” (The Community Against Preventable Injuries, 2017).

The team spent the remainder of the meeting discussing the specific Parachute material that should be posted to accomplish this task. Using the results of previous evaluations done by Parachute and other injury prevention campaigns, the team concluded that the website would contain infographics, case studies, videos, blog posts, and a Vision Zero Network that users could join to receive quarterly updates on Vision Zero in Canada. The Twitter account would post a mixture of current news relating to road safety/design and awareness raising educational information. The team decided to launch both the website and the Twitter account on May 8<sup>th</sup>, 2017.

### **SOCIAL MARKETING IN PUBLIC HEALTH**

Aidan sat at his desk reviewing the content that had been posted to the Vision Zero platforms (see Exhibit 1 & 2). It had been a week since the launch, and Aidan thought that everything looked great. There was a balance between educational material and current events reporting as well as a good use of visuals to keep readers engaged. As he continued to peruse the material, Aidan decided that now would be a good time to evaluate if the public was reacting to the material in the way that the research had suggested they would. Parachute could continue to post what they thought would lead to behavior or attitude change, but if the public viewed the content as ineffective, then the purpose would be defeated. Parachute needed to devise an evaluation plan to determine if their resources were influencing the public in the intended manner.

Aidan wanted to address this issue early on in the implementation stages to ensure that the evaluation could be carried out at several points during the launch (e.g. every two months). He knew they had to find some way to reach out to members of the target audience to determine which activities should be sustained and which required alteration. The feedback would be helpful for all aspects of the campaign – from the broad concepts to the specific material used (Grier & Bryant, 2005). The question was how to reach out to these individuals and what to ask.

From his past work experience Aidan knew that the evaluation would need to measure both attitude and behaviour changes in the public. Mostly because the campaign would first have to impact the knowledge and attitudes of the public if it intended to result in behaviour change. Changes in attitude could be measured through simple comparison of individuals before and after they were exposed to Vision Zero materials. Evaluating behavioural change on the other hand is more complex (Robertson & Vanlaar, 2016).



## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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Aidan knew that public health campaigns, such as Vision Zero, were often difficult to evaluate due to the lack of immediate or apparent results (Grier & Bryant, 2005). Parachute could not simply disseminate road safety resources and expect to see a reduction in road incidents overnight. Even if the resources could cause road users to engage in safer behaviours, the results would take time to affect collision rates. Furthermore, any reduction found in road incidents cannot be directly attributed to Vision Zero, as there may have been numerous factors influencing the reduction (e.g. stricter police enforcement, increased cost of distracted driving fines) (Robertson & Vanlaar, 2016). The evaluation, therefore, has to take a multi-faceted approach, including a qualitative data analysis (e.g. public perceptions of Vision Zero) and a quantitative data analysis that links Vision Zero to the road incident rates at the time. This way Parachute can make an evidence based argument that positive changes in road incidents coincide with its activities.

### EVALUATION

Aidan organized a meeting with the Vision Zero team that afternoon to discuss possible campaign evaluation strategies. He sat before the team and explained his concerns. “We need to find a way to evaluate the success of the Vision Zero social marketing campaign. We can judge popularity by tracking the number of Twitter followers or individuals joining the Vision Zero Network through the website, but we need more. We need to determine if our resources are actually persuading members of the public to value injury prevention and in turn causing them to engage in safer practices on the road. If we can develop an effective evaluation plan, we can ensure that our resources are leading to change.”

“Good point,” said Tammy. “An evaluation of our impact is something that we really need to present to stakeholders. Investors are expecting us to lower the prevalence of road incidents, and they want to see tangible results, such as X number of people were more aware of a road safety issue after viewing the Vision Zero website. Ultimately, this will allow us to show stakeholders that their money has gone to good use and give them an incentive to continue to provide funding.”

“Does anyone have any suggestions of how we can go about the evaluation?” asked Aidan. The room fell silent for a moment. It was apparent that this would not be easy.

Jane broke the silence, “I don’t know exactly how we can go about our own evaluation, but I was speaking to our new CEO, Lisa, and she was really inspired by the evaluation done by one of our partners, the Community Against Preventable Injuries, more commonly known as Preventable. Preventable is an injury prevention not-for-profit organization in British Columbia and Alberta that also targets attitude and behavioural change through their social marketing campaign. We can model our evaluation after theirs.”

“That’s a great idea,” said Aidan. “We should first test whether our target audience has similar knowledge, attitudes, and behaviours to those tested by Preventable. If so, it is reasonable to take a similar approach and mirror that campaign evaluation.”

“Okay, let’s think of Preventable as the gold standard that we are working towards,” said Bridget. “The team at Preventable sent me the details of the evaluation that they completed, so I can forward that to everyone for review.” After a brief pause, Bridget continued. “The only issue is that the evaluation done by Preventable both exceeds our budget and timeframe. We’re going to have to find a way to perform a high quality evaluation that uses aspects of Preventable’s for a fraction of the price.” She rifled through her folder and found a document, then continued: “We

## **On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health**

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recently did an evaluation of our Safe Kids program, maybe we can find some way to strike a balance between the Preventable evaluation and what we have done in the past.”

“Okay, let’s all review the Safe Kids and Preventable evaluations and then reconvene to brainstorm ideas,” said Aidan.

### **SAFE KIDS WEEK EVALUATION**

Safe Kids Week (SKW) is a national awareness week that brings attention to the issue of preventable injuries among children (Parachute, 2016). During Safe Kids Week, Parachute’s community partners hold various recommended best practice activities and events across Canada, including community fairs and booths at related events. Parachute helps organize these events by providing SKW toolkits that contain items such as storybooks, helmet fitting and concussion bookmarks, and Parachute temporary tattoos. These materials can be distributed to parents and children attending the events and are designed to present important lessons to parents and children in a relevant and engaging way.

In 2016, SKW took place from May 30<sup>th</sup> to June 5<sup>th</sup> in communities across Canada. The 2016 SKW evaluation was based on a survey administered to Parachute’s community partners in June of 2016. The survey consisted of 21 short answer and multiple choice questions that collected information about the different types of events hosted by each participating organization, the type of media coverage received during the events, and the usefulness of the SKW toolkit items. More specifically, survey questions aimed to determine the demographics of participants who attended the event, the toolkit items that were most used, the type of online channels used to promote the event, the effectiveness of the resources in raising awareness, the types of injuries most prevalent in their community, and areas of improvement. For example, the survey asked questions such as: “Did you work in partnership with other organizations or groups (i.e. schools, community groups, not-for-profits, fire, etc.)?” and “Were the community toolkits helpful in getting the campaign messages across?”

The 2016 survey was completed by 65 organizations across Canada. Results found that the majority of organizations that lead community events were health centres or hospitals and approximately 7,000-8,000 children and adults attended SKW events. A third of the participants reported having media coverage at their event and more than 70% of the respondents indicated that they had used one or all components of the toolkit. Overall, the results were positive, and 59% of participants indicated that they had raised awareness of child safety through their events.

The results from SKW gave Parachute insight into which components of SKW stakeholders and community partners prefer (e.g. useful items in toolkits, types of drafted social media statements that can easily be dropped into their own social media messaging) and where SKW activities took place, to give them a sense of reach. For the past five years, Parachute has been using these evaluation results internally to tweak the next year’s campaign and to inform the fund development team of the characteristics and preferences of their stakeholders. This feedback aids in ensuring that future SKW resources are even more effective and appropriate for their audience.

Through the process of evaluating SKW, Parachute found that certain evaluation techniques were more successful than others. In particular, evaluation components that Parachute had control of or access to (e.g. number of toolkits ordered) were more successful, as these results could easily be quantified. Components (e.g. number of people reached) that relied on

## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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Parachute's community partners to collect and return information or complete pre-or post-campaign surveys were less successful. Stakeholders often reported that they lacked the time and capacity to return the requested information. As a result, in future evaluations Parachute would prefer to find ways to access information in a more automated way, to allow for more robust data collection that can help inform future activities.

### PREVENTABLE

*"If you think serious injuries just 'happen', have a word with yourself."*

Preventable launched an injury prevention social marketing campaign in British Columbia in 2009 and in Alberta in 2012. They have since partnered with Parachute to bring the campaign to other jurisdictions in Canada. The focus of Preventable is to "develop and deliver an evidence-based social marketing program to reduce serious injury" (The Community Against Preventable Injuries, 2017). Similar to Parachute, Preventable is aiming to raise awareness and shift societal attitudes and behaviours related to injury prevention.

Preventable takes a departure from traditional public health communication and employs mass media, social media, partnership programs, and guerilla marketing activities to convey the messages of their campaign. Their marketing activities aim to garner attention and elicit a rational or emotional response from viewers. Notable campaign activities include an eight-foot-tall banana peel in downtown Vancouver (see Exhibit 3) and a grand piano suspended in mid-air, meters above a sidewalk. These exhibits were meant to communicate the message that most accidents are not accidents at all; most of the time we can see them coming, just like a huge banana peel or grand piano (The Community Against Preventable Injuries, 2017).

To develop the campaign Preventable conducted a needs assessment over three years to gain an understanding of consumer preferences and the context in which they would deploy their campaign. The needs assessment consisted of literature and data reviews (e.g. hospitalization and mortality data), regional surveys, and focus groups that measured the knowledge and attitudes of the public. These data points provided Preventable with valuable information on the type of material that would best suit their audience as well as a venue to test their creative approach (The Community Against Preventable Injuries, 2017).

Using the findings of their needs assessment Preventable developed an evaluation plan that assessed the effectiveness of their campaign. The evaluation consisted of surveying and conducting focus groups with samples of British Columbians that represented their target population (adults from the age of 25 to 55). Evaluations were initially completed once per week during the first six months and then every three to four months subsequent to that. Participants were divided into two groups: those exposed to the campaign and those with no prior exposure. Measures such as awareness, attitudes, and self-reported behaviours associated with injury prevention were examined. Additionally, of those exposed, "recall" and "response" were studied. "Recall" of Preventable advertising was tested to determine if the advertising had been noticed, and if the brand had been associated with it. "Response" was tested to determine if the advertising had triggered a rational or emotional response (The Community Against Preventable Injuries, 2017).

Results of their evaluation show that those exposed to the campaign score significantly better (5% to 15%) on measures of awareness, attitudes, and behaviours than those who have not seen the campaign. In particular, participants who had seen the advertising were more aware of the magnitude of the injury prevention issue and more likely to take precautionary actions. Of

## **On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health**

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those who were exposed to the campaign, 65% considered Preventable a trustworthy brand, and 63% believed that Preventable had good and innovative advertising. The campaign was also associated with a significant reduction in injury-related deaths in the target population of 25-55 year olds (The Community Against Preventable Injuries, 2017).

The results of Preventable's evaluation also demonstrated the type of approach and tactics that Parachute should employ with their own campaign and evaluation. In particular, Preventable's evaluation results indicate that the general public knows what they should do to prevent injuries, however, they require a prompt to remind them to perform these actions during moments of decision making. For example, if a driver knows that they should provide cyclists with one meter of space on the road, and while driving they remember a meaningful message that reminds them of this rule, they will be more likely to maintain a safe distance.

Moreover, the public does not want to be told what to do, hence Preventable's "have a word with yourself" approach. This approach reminds people to use common sense, rather than scolding them or scaring them using facts and figures. From these findings, Parachute has learned that their messaging must resonate with their target population, and as a result, any evaluation techniques employed must test whether their messaging is accomplishing this task.

In terms of evaluation methods, Parachute found Preventable's use of rolling four-week Angus Reid surveys administered to British Columbians to assess whether their activities had been seen, remembered, and understood particularly successful. As well as, Preventable's use of data collected from provincial injury sources (e.g. deaths, hospitalizations) to map when Preventable activities were 'in market' with subsequent timeframes of injuries. In an ideal evaluation of Parachute's Vision Zero campaign these methods would be employed as well.

### **BARRIERS**

As Aidan reviewed the material, he could clearly see the barriers that Parachute's Vision Zero would face when implementing an evaluation plan similar to that of Preventable or SKW. In terms of the SKW evaluation, it was a cost-effective and appropriate method of reaching out to the community partners that engaged in SKW activities. However, the intended audience of SKW differs from that of the Vision Zero social marketing campaign, and this has a large impact on the transferability of the SKW evaluation to Vision Zero. SKW had a defined population of partner organizations that participated in the SKW activities, whereas the Vision Zero social media messages and resources reach a large number of individuals that cannot be tracked as easily. The SKW events were also restricted to a week timeframe, whereas the Vision Zero initiatives can be accessed at any point in time and for any length of time.

In terms of Preventable, the main barrier was funding. Preventable had obtained government funding from public, private, and not-for-profit partners. This funding not only gave them the opportunity to deliver wide spread advertisements for their campaign, such as television commercials broadcasted on TV and large-scale displays, but also allowed them to conduct a more comprehensive and costly evaluation. In particular, Preventable initiated rolling surveys to the public every week during the first six months and every three to four months afterwards. Commissioning a professional surveying organization is very costly, especially when repeatedly conducted.

Parachute also had limited human resources that it could contribute to the Vision Zero evaluation. Parachute only consists of 22 employees and five departments overseen by a Senior Leadership Team. The five departments include Corporate Services, Communications &

## **On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health**

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Marketing, Solutions/Government Stakeholder Relations/Knowledge Translation, Fund Development, and Office of the CEO. Members of the Vision Zero team originate from these various departments and as a result have duties associated with their roles in their respective departments (see Exhibit 4).

Preventable performed labour intensive activities such as focus groups to gauge public opinion on their campaign. Aidan knew that his Vision Zero team members already had numerous responsibilities at Parachute and did not have the time or resources to contribute to similar activities. If Parachute was to have Preventable as its gold standard, it would have to find a way to gather high quality data on public opinion at little-to-no cost.

How could Parachute conduct an evaluation using methods such as rolling surveys and intensive, time consuming data collection with limited resources? The last thing Aidan wanted to do was spearhead a poorly executed evaluation that was unable to provide meaningful and valid information about the impact of their efforts.

Aidan was stumped. Would the team be able to create a strong evaluation plan that met their needs? Parachute didn't have any other options. It would be impossible to reallocate funding from other programs to Vision Zero and employee resources were already scarce as it was. They would either have to settle for a realistic evaluation plan or find a new funding source.

### **CONCLUSION**

Aidan walked towards the boardroom. Today was the day that the team would develop an evaluation plan. Aidan mentally went over the checklist that he had created. By the end of the meeting, his goal was to have an evaluation timeline, a work flow chart to identify the staff members involved and their roles, budget expenditure estimates, and a data collection plan. He knew this would probably be a long meeting. Although the team could draw inspiration from the SKW and Preventable evaluations, they would have to determine how they could collect data from their target audience and what questions they should be asking. The process was going to require a lot of work, but Aidan knew it was something that had to be done. As Aidan reached for the door, he took a deep breath and entered the room.

# On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

## EXHIBIT 1 Vision Zero Twitter Content

**ROAD INFRASTRUCTURE**  
**ADVANCE STOP LINES**

From 2004-2006 11% of pedestrian fatalities occurred when pedestrians were struck and killed by drivers of vehicles that failed to yield the right-of-way

A study in Halifax, NS found that pedestrian/motorist conflicts were reduced by 74.2% to 89.8% when a sign and advance pavement markings were introduced

**RUMBLE STRIPS**

Rumble strips on road edges and centre lines create a vehicle vibration that alerts inattentive or drowsy drivers that they are leaving their lane

Texting while driving makes a crash or near-crash 23 times more likely than if the driver weren't sending a text message. If the phone buzzes while you're driving, you don't have to answer it immediately. It can wait.

Image Source: National Association of City Transportation Officials <https://nacto.org/publication/urban-bikeway-design-guide/intersection-treatments/bike-boxes/>

Source: Canada Safety Council, But the Odds

Source: Parachute Vision Zero (2017, June 2), Parachute Vision Zero (2017, June 27) & Parachute Vision Zero (2017, July 29).

# On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

## EXHIBIT 2 Parachute Vision Zero Network Website

**Parachute VISION ZERO NETWORK**

HOME THE ISSUE THE SOLUTION RESOURCES WORD ON THE STREET BLOG THE NETWORK SUMMIT 2017 FRANÇAIS DONATE

**THE ISSUE**  
Learn about the issue of motor vehicle collisions.  
Learn more about the issue →

**THE SOLUTION**  
Vision Zero takes a systems approach to motor vehicle collisions.  
Find out about Vision Zero →

**RESOURCES**  
The Network has a wide variety of resources that will help you to learn more about Vision Zero, what's being done in Canada and how to go about doing it in your community.  
See the resources →

**JOIN THE NETWORK**  
Only by working together can we drive meaningful change. Parachute has built a Vision Zero Network of hundreds of road safety organizations and advocates who want safer roads in Canada.  
Join us! →

**JOIN THE NETWORK**  
Follow us!

**LATEST WEBINAR**  
The Safe Systems Approach in the Netherlands; Adoption, implementation and lessons learned

**LATEST BLOG POST**  
Using Drones to Make Roads Safer  
Nov 21, 2017  
Unmanned Aerial Vehicles (UAVs) or "drones" are being used by traffic engineers and road safety professionals to enhance data collection and road safety efforts. On September 8, 2017, we sat down with Mark Hearson, a Rhodes Scholar in civil engineering and Transport Infrastructure Specialist from Fireseeds North Infrastructure in Winnipeg, to discuss how drones are changing traditional approaches to road safety.  
Read More →

**WORD ON THE STREET**  
SEPTEMBER 2017  
VIDEO  
The Parachute Vision...  
Parachute Vision Zero Network's  
Read More →

**WHO HAS IMPLEMENTED VISION ZERO IN CANADA?**

Map data ©2018 Google, INEGI Terms 1,000 km

**INFOGRAPHIC**

Source: Parachute Vision Zero Network, 2017a.

## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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### EXHIBIT 3 Preventable Public Displays

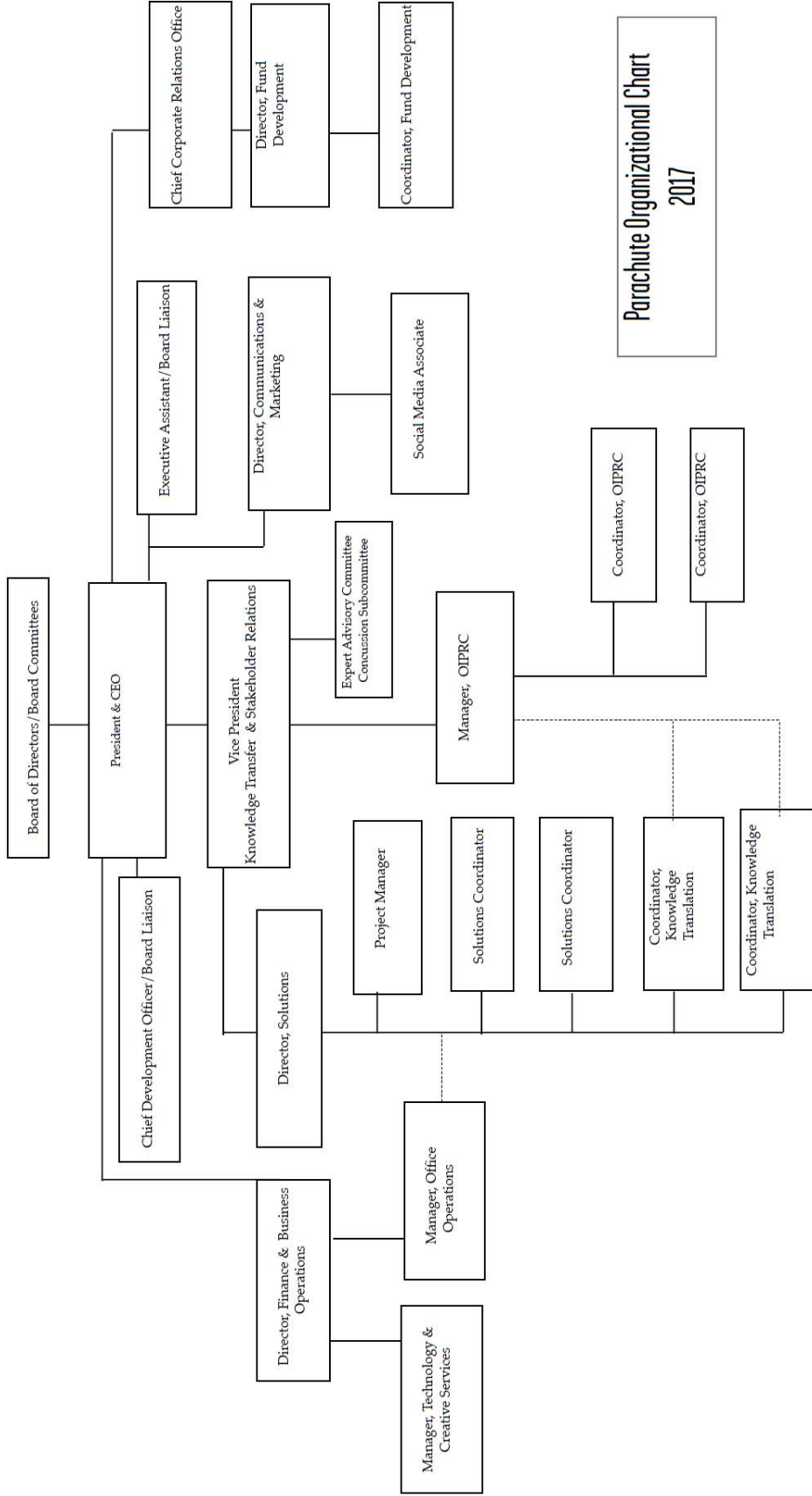


Source: The Community Against Preventable Injuries, 2017.



**On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health**

**EXHIBIT 4  
Organization Chart of Parachute**



Parachute Organizational Chart  
2017

Source: Parachute, 2017d.

## On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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## INSTRUCTOR GUIDANCE

### On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health

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#### BACKGROUND

Parachute is an injury-prevention charity that has started the implementation of the Vision Zero Network to address road safety in Canada. Vision Zero aims to reduce fatalities or serious injuries on the road to zero through advocacy for policy change and road infrastructure. A large part of these goals will be accomplished through a social marketing campaign that provides resources (e.g. educational information) through a Vision Zero website and social media account (Twitter). As a registered charity, Parachute relies on funding from stakeholders to sustain its programs. Consequently, Parachute must prove to stakeholders that its initiatives have contributed to change and are worth the investment. Aiden Norman, the manager of the Vision Zero project, has been assigned the task of rolling out the social marketing campaign and ensuring the effectiveness of its resources. Aiden must determine if Parachute's Vision Zero social marketing campaign can lead to changes in public perception, knowledge, attitudes, and behaviors in regard to road safety. To accomplish this task Aiden must conduct an evaluation of the Vision Zero resources and their impact. The Parachute management team has a gold-standard evaluation method in mind yet lacks the resources and funding to employ the technique. How will Aiden evaluate the effectiveness of the social marketing campaign on a limited budget without compromising on quality?

The goal of this case is to apply theories of behaviour change and evaluation techniques for social marketing campaigns in public health to develop a suitable, context-specific evaluation plan for Vision Zero.

#### OBJECTIVES

1. Discuss the need to evaluate public health interventions to maintain stakeholder engagement and program sustainability.
2. Apply the theories of behaviour change to the Vision Zero campaign.
3. Develop an evaluation plan for the Vision Zero social marketing campaign.
4. Identify the barriers that public health organizations face when evaluating programs.

## **On the Road to Change: The Difficulties of Evaluating Social Marketing Campaigns in Public Health**

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### **DISCUSSION QUESTIONS**

1. What are the benefits of using a social marketing campaign in public health?
2. Describe and apply the four theories of behaviour change (for example: Theory of Planned Behaviour, Health Belief Model, Protective Motivation Theory, Transtheoretical Model of Change)
3. Why is it important to evaluate public health campaigns?
4. What are the features of an effective public health evaluation?
5. Why is it difficult to evaluate public health campaigns?
6. What barriers does Parachute face when developing an evaluation plan similar to the gold standard evaluation performed by Preventable?
7. How would the development of a Logic Model for Parachute's Vision Zero social marketing campaign contribute to the evaluation?

### **KEYWORDS**

Program evaluation; social marketing; road safety; injury prevention; health promotion.



## CASE 7

### Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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*Amardeep Thind, MD, PhD (Professor, Western University)*

Lance Sewell, Manager of the Environmental Health Team at the Middlesex-London Health Unit (MLHU), stepped out of the rainstorm and into his office. Sewell set down his umbrella to dry off and checked his email. June is a busy month for the Environmental Health Team with inspections, outdoor pools reopening, new vector borne disease programming, and private well water programming; this meant emails are continuously flowing in with updates from the team.

Sewell clicked on the first email, opening a draft for a heat warning to approve, for June 11<sup>th</sup> to June 12<sup>th</sup>. As part of the Heat Alert Response System (HARS), the Health Unit issues a heat warning when Environment Canada's forecast calls for:

- a temperature of 31° C or higher with a low of at least 20° C for two consecutive days, or;
- a Humidex of 40 or higher for two consecutive days.

An extended heat warning is issued when either of these conditions is expected to last for longer than two consecutive days.

This was the first heat warning for 2017. In 2016, the Health Unit issued its first heat warning on July 6<sup>th</sup>, nearly an entire month later than the warning in 2017. Sewell marked this email as a priority item due to the time sensitive nature of sending it out and the need for a public service announcement. In addition to approving the heat warning, Sewell added the topic of extreme heat to the next team meeting's agenda. The team will need to discuss prevention messaging about heat-related illness and make sure the community has the information they need to be safe for this heat event and for future warnings. Since extreme heat events are happening earlier in the season and are expected to become more frequent and more intense, the team needs to make sure the prevention messaging about heat-related illness is reaching the community in a timely and effective manner.

This heat warning is not the only extreme weather event that has hit the Middlesex-London community this year. Multiple rainfall warnings and flood watch notifications had also been issued for the region. News reports of flooded streets, homes, and farmland within the Middlesex-London region, neighbouring regions, and other Canadian provinces had been very frequent this year.

The Environmental Health Team is aware that extreme weather events are expected to increase in the Middlesex-London region in the future. But is the public aware? Extreme

## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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weather events may be defined as: a weather variable, such as rainfall, that occurs near the upper or lower range of values that are regularly observed for that variable (IPCC, 2012). According to climate change projections, Southwestern Ontario is expected to see an increase in the frequency and intensity of flooding, extreme temperatures, severe winter storms, and an increase in the spread of disease vector species (Berry, Paterson, & Buse, 2014). It is clear the Middlesex-London region is already experiencing these impacts through heat warnings, rainfall warnings, and increased Lyme disease risk (Lyme disease risk area shown in Exhibit 1).

How can the MLHU increase preparedness, reduce risks, and prevent injury when it comes to climate change-related health impacts? Does the Health Unit's current messaging, initiatives, and strategic planning reflect climate change projections? Who is the MLHU currently reaching with their messaging? These were all questions Sewell planned to pose to the team at the Environmental Health Team meeting next week. Given the current extreme weather events and future projections, Sewell decided he needed to mobilize his team to develop a plan for addressing climate change adaptation and preparedness within the community. The first step will be a strategic communication plan to ensure the Health Unit effectively communicates risk and personal protection measures to the community moving forward.

### BACKGROUND

The Ontario Ministry of Health and Long-Term Care published the *Ontario Climate Change and Health Toolkit* in 2016, which provides tools and guidelines for health units to conduct local climate change adaptation and vulnerability assessments. It also provides tools for identifying climate change vulnerability indicators, local projected changes to health risks, and tools for prioritizing action items. These tools can assist Ontario's health units in supporting Ontario's Five Year Climate Change Action Plan (2016-2021) and Ontario's Adaptation Strategy and Action Plan (2011-2014). The Adaptation Strategy outlines priority actions related to human health and climate change (MOE, 2011), including:

- Raising public awareness about Lyme disease
- Raising awareness about the health hazards of climate change
- Supporting the development of risk management tools to manage heat-related diseases
- Integrating adaptive solutions into drinking water management
- Developing guidance for storm water management

The MLHU is already engaged in initiatives that address many of the actions listed above—for example, increasing public awareness about West Nile Virus and Lyme disease. This priority action also falls under the mandates of the Ontario Public Health Standards. These standards provide a framework for public health programming (MOHLTC, 2008). The modernized standards, effective January 2018, include a new section, Healthy Environments, which identifies climate change as a topic area to address. Climate change is clearly a priority area for the province and for local health units.

Sewell reviewed the draft of the modernized Standards and decided to bring up some of these key points at the next team meeting to emphasize the importance of aligning climate change initiatives with the new Standards and with the provincial Action Plan. He added this action item to the meeting agenda after the discussion points around heat warnings.

## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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### CLIMATE CHANGE & HEALTH IMPACTS

There are six health impact categories related to climate change that are presented in the *Ontario Climate Change and Health Toolkit* (Ebit et al., 2016):

- Temperature extremes
- Extreme weather events and natural hazards
- Air quality
- Water and food borne diseases
- Infectious diseases transmitted by vectors
- Stratospheric ozone depletion

These health impact categories may have varying effects on communities within Ontario, depending on geographic, economic, social, environmental, and political determinants.

### THE MIDDLESEX-LONDON REGION

Within Ontario, Canada, there are 36 public health units. The Middlesex-London Health Unit serves the City of London and the eight municipalities that make up Middlesex County (see Exhibit 2). The City of London and Middlesex County are collectively referred to as the Middlesex-London region. This is a landlocked region. The City of London is a large urban centre with a population of 383,822 (City of London, 2017). Middlesex County is a rural area made of towns, villages, hamlets, and agricultural land and has a population of 71,704 (Statistics Canada, 2017). This rural area of the County also covers a large geographic area (see Exhibit 2).

For the Middlesex-London region, climate change is expected to create conditions for earlier spring run-off, more frequent and intense storm surges, and heavy precipitation (Berry, Paterson, & Buse, 2014). Extreme precipitation may increase the frequency and severity of flooding in Ontario.

In addition to extreme precipitation, Southwestern Ontario is expected to face extreme temperatures and severe winter storms. A greater number of winter storms with freezing rain are expected, and freezing rain may result in power outages, where entire communities are vulnerable to medical care and health services disruptions, road closures, accidents, and cold-related illness (Berry, Paterson, & Buse, 2014). At the opposite end of the spectrum, Southwestern Ontario is expected to experience a greater number of extreme heat events during the spring and summer, which, in turn, may result in an increase in heat-related illness (Berry, Paterson, & Buse, 2014; Ebi et al., 2016). This is evident in hospitalization data in Southern Ontario, which show an 11% increase in emergency department visits during extreme heat events (Bishop-Williams, Berke, Pearl, & Kelton, 2015).

### HEALTH PROMOTION CONSIDERATIONS FOR RURAL COMMUNITIES

Rural areas, as a whole, are often categorized as vulnerable due to their large geographic area, inadequate public transportation, and lack of access to health services and community resources when compared to their urban counterparts (Health Canada, 2011). These factors must be addressed when planning health promotion programming and communication strategies for rural communities.

Populations vulnerable to climate change impacts, such as extreme heat, may include the homeless or under-housed, individuals that work outside or spend a lot of time outside (exercising or active commuting), the elderly, infants and children, and individuals with chronic illness or disabilities (Health Canada, 2011). These populations may present differently in urban versus rural areas. For example, there may be a greater homeless population in the



## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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urban centre, and health units may target interventions to this priority population. Whereas in rural populations outdoor workers, infants, and the elderly may be the focal target populations. The elderly and those who live in isolation in rural areas may have less access to communication channels (e.g. social media, internet) to obtain timely information. Rural residents may have less access to community supports than those in urban centres due to greater distance from community centres and from their neighbours (Health Canada, 2011). Individuals who do not have access to reliable transportation may have trouble accessing services in the town centres. The distance from hospitals may also impact timely treatment of heat-related illnesses for those who live in rural communities.

Occupational exposure to climate change effects is another key factor for rural communities. In Middlesex County, construction and agriculture are amongst the top five industries that employ the residents (Statistics Canada, 2013). Outdoor workers may be exposed to extreme heat from spending extended hours outdoors.

Access to resources is another key consideration (TORC, 2009). Health Canada (2011) identifies cooling facilities and clean drinking water as key aspects of being prepared for a heat-related emergency. Heat adaptation initiatives have been found to be unevenly distributed between urban and rural areas – the majority are located in cities and municipal town centres (Nayak et al., 2015). Many rural areas do not have large community centres or organizations that provide access to air-conditioned areas. This is evident in the lack of available information on cooling centres in Middlesex County. The City of London provides information on community centres and public pools for residents to cool off during a heat warning, but there is no mention of cooling centres that are available throughout the rural area of Middlesex County. There is a clear gap in services and communications for rural residents during an extreme heat event. Additionally, Middlesex County does not have a public transportation system, so individuals who lack mobility or who do not own a vehicle may not have easy access to cooling centres even if they were available. Availability of information, effective communication channels, and access to services are key considerations when planning communications campaigns and associated programming for rural areas.

### CLIMATE CHANGE-RELATED COMMUNICATIONS AT THE MLHU

The MLHU currently uses social media and online communication channels (e.g. the Health Unit's website) to disseminate messaging around extreme heat. The Environmental Health Team attends some community events to engage with members of the community each year, and many of these events are located in the urban or town centres.

Communication channels and community partnerships are better established in the urban areas that the MLHU serves (e.g. City of London) and it is time that the team put effort into making sure information reaches the rural community as well. The MLHU does not currently have a strategic communication plan in place to disseminate climate change-related information to the rural community. Considering the expected increase in the intensity and frequency of extreme weather events, it is important that the rural residents understand the risks, where to get information, personal protective measures, and adaptation strategies.

How can the team better reach the rural population with health messaging? What other channels exist to reach the rural population that have yet to be used or that could be enhanced? Strategies should be based on best practice recommendations and implementation depends on the team's budget and resources. Sewell decided to put together

## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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a list of some potential communication challenges and opportunities that he could present to the team for discussion at the meeting.

### COMMUNICATING WITH RURAL POPULATIONS

#### Challenges

- A challenge for the Health Unit is the large geographic area of Middlesex County. If the Health Unit staff would like to engage with the rural population or disseminate information at community events this will require more staff time, travel time, and attending a greater number of local events to engage with the public. The City of London has a greater population density and hosts many events that may have large number of city residents passing through. Urban event attendance may therefore have a larger reach. The team will have to look into outreach opportunities within the rural areas.
- When planning communication strategies occupation is an important consideration, especially when determining how best to reach agricultural communities. How can the team best reach communities whose residents work long, irregular hours? It can be difficult to reach these communities in the spring and summer seasons.
- Language can be another barrier to effective communication. There are populations in the rural community who speak Low German and many migrant farm workers who speak Spanish. Are appropriate educational resources available for organizations and agricultural operators to provide to these populations about responding to extreme heat events?
- Social media can be an affordable channel that reaches a large population. But who is following the MLHU Twitter, Facebook, and Instagram accounts? What do those demographics look like and would heat messaging reach the intended target population?
- The MLHU has strong community partnerships within the city, whereas, partnerships still need to be established in the rural areas. Partnerships can allow for increased message dissemination through expanding social networks. These could be web-based connections where resources are shared through partner websites, or partners may disseminate print materials at events or within their organizations. Partners may also display digital screens or host presentations related to extreme heat. The MLHU has a strong partnership with the rural libraries but there may be an opportunity to expand partnerships with municipalities, conservation authorities, recreation centres, and smaller rural organizations.

#### Opportunities

- The MLHU surveyed rural residents in 2017 to gain a better understanding about how they obtain weather related information. The team can utilize this data to inform their communication strategy. Survey respondents reported obtaining weather related news and information from the following sources: mobile phone-based applications, websites, friends and family, the local radio, and news reported on television. The team may be able to enhance communication through some of these local channels. Local media and farming magazines have been identified as methods to communicate with the agricultural community (Asplund, Hjerpe, & Wibeck, 2013). This may be a strategy the MLHU team could explore moving forward.
- Additionally, the use of interpersonal channels may be an effective strategy for communicating with rural populations (Health Canada, 2011; Williams et al., 2013). Community champions, peer-learning, workshops, and participatory decision-making (where the public has the opportunity to contribute ideas to prevention and adaptation

## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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strategies) are all successful ways to engage the community and exchange knowledge (Schmidt-Thomé et al., 2013; Stewart & Rashid, 2011; Woodall, White, & South, 2013). Sewell and his team have to decide which channels are the most appropriate and effective for increasing communication and engagement with the rural population.

- Other teams at the MLHU already have connections in rural schools for school health and dental programming. These connections may be useful for any youth-targeted communication planning.

### CONCLUSION

Sewell approved the draft public service announcement for the heat warning, and finalized the meeting agenda for next week.

The team will need to enhance communication efforts for each of the climate change topic areas but each topic has different messaging, partners, and considerations, and cannot be addressed all at once. The team will develop a communication strategy for their heat-related messaging first. The team has already developed some communication material for this topic area and can work on expanding partnerships and communication channels into the rural community.

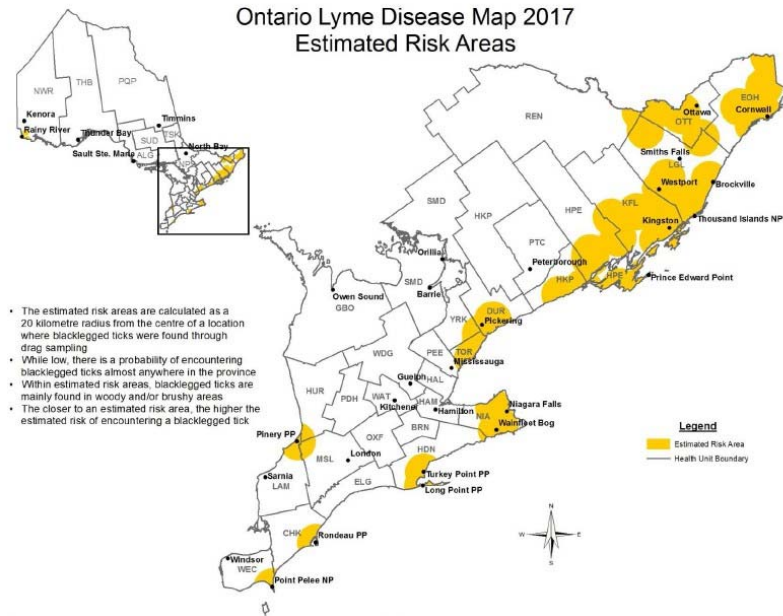
Sewell hoped that a small, enthusiastic, working group can be formed to take on this challenge. The group will need to prepare a proposal to present to the Health Unit's communications team by the end of the month, in order to have any communication material developed by the summer.

The team will need to develop a communication plan outline, defining exactly who their target population is, what communication channels they will employ, key stakeholders and engagement strategies, materials, and a budget outline. With the recent extreme heat events, the sooner the team can enhance its communication and engagement with the rural population who they serve, the better prepared this population will be for future events.

# Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

## EXHIBIT 1

### Estimated risk areas for Lyme disease in Ontario including county boundaries

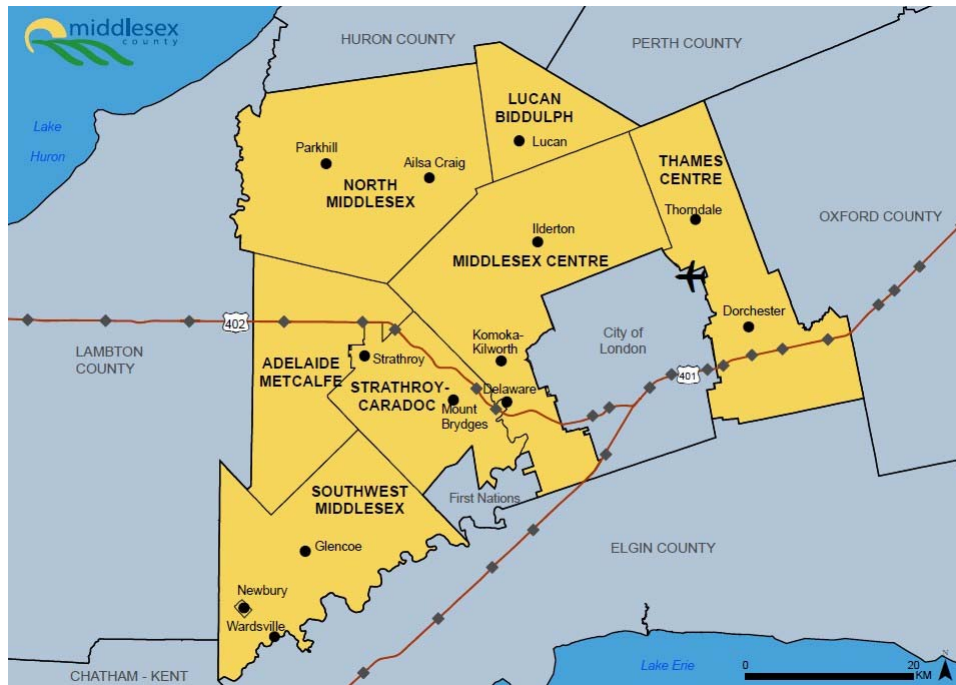


Source: PHO, 2017.

# Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

## EXHIBIT 2

Map of Middlesex County, highlighting the eight municipalities



Source: Middlesex County, 2016.

## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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## INSTRUCTOR GUIDANCE

### Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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#### BACKGROUND

Climate change is expected to increase the frequency and intensity of extreme weather events and extreme temperatures (heat and cold) in Southern Ontario. Climate change-related impacts (i.e., flooding, heat, storms, tornados, etc.) may increase the risk of heat-related illness, respiratory disease, food-, water-, and vector-borne disease, and injuries in the Middlesex-London community. The Ontario Public Health Standards mandate local public health units to increase awareness of environmental health hazards, to prevent or reduce exposure to health hazards, and to work to create healthy environments. The Middlesex-London Health Unit (MLHU) conducts surveillance for vector-borne disease, disseminates heat warnings to community partners, and prepares for emergency planning in the community. The MLHU has identified a need to increase communication and awareness of climate change-related health impacts in the rural population of Middlesex County, focusing on extreme heat. There is currently no strategy in place for reaching the rural population with heat-related health messaging. To fill this gap, the health unit needs a comprehensive communication strategy targeted at the rural population.

#### OBJECTIVES

1. Develop clear goals and/or objectives for a health communication strategy.
2. Analyze the differences between urban and rural areas with respect to the communication channels available, barriers or enablers to receiving information, and access to health-related services.
3. Apply course tools and theories to develop effective strategies, appropriately segment an audience, and demonstrate the ability to develop targeted messaging.
4. Recognize the challenges associated with communicating information on a complex topic.

#### DISCUSSION QUESTIONS

1. What are some of the health effects associated with climate change? Who is most at risk?
  - a. Are there potential opportunities associated with climate change? For who?
2. What needs to be considered when developing communication strategies for rural populations? Describe differences between urban and rural areas with respect to communication channels and vulnerabilities.
  - a. What are some barriers to communicating climate change science?
  - b. Are there barriers to communicating with rural populations?
  - c. Describe strengths of rural communities that could be used when developing communication strategies.



## Local Climate Change Adaptation: Developing a Communication Strategy for Rural Populations

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3. What health promotion model(s) or theories could be applied in developing a competitive communications strategy?
4. How might community partnerships assist with message dissemination and what are some challenges that exist when collaborating across sectors?

### KEYWORDS

Communication strategy; climate change; rural health; community engagement; knowledge translation; adaptation.

## CASE 8

### “I Know You Want It”: Preventing Sexual Aggression in Bars

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Centre for Addiction and Mental Health)*  
*Mark Speechley, PhD (Professor, Western University)*

Brian Patterson is the owner of The Judge & Jester Tavern in London, Ontario. His father bought the business in 1999, and Brian assumed ownership 15 years later in 2014. Under his management, The Judge & Jester grew its customer base with students from Western University, who have nicknamed the bar “JJ’s”. The Patterson family has dealt with all manner of economic and legal challenges over their ownership, including a recession shortly after Brian took over, and JJ’s has stood strong through it all. It has rapidly become a nightlife hotspot on “Richmond Row”, downtown London’s core shopping and entertainment district along Richmond Street.

However, JJ’s has come under scrutiny on social media regarding sexual assault cases reported at the venue, coinciding with the beginning of the 2016 fall semester as students flooded back into the city for the school year. Some groups have called for a boycott of the bar. Brian’s father had dealt with negative publicity and threats of closure before, and Brian was confident that he could withstand this latest hurdle, just as he had done earlier in his tenure. Still, JJ’s would not have survived without prudent and adaptive management, and Brian recognized that he would need to make some important decisions soon before the issue became worse.

#### “HERE’S OUR BEGINNING”<sup>1</sup>: FALL SEMESTER, 2016

Western University has a reputation of being a “party school”, with a vibrant and raucous collegiate culture that extends to the nightlife entertainment in downtown London. JJ’s has become a popular destination for students, benefitting from its proximity to Western’s campus and the substantial influx of student patrons during the school year.

To generate business during the winter months, JJ’s started offering extended happy hours on Mondays to Wednesdays with specials for \$2.50 shots. Brian had been thinking about offering themed cocktail specials for each day of the week as well, but he planned to see how sales went for the first couple weeks of December before making any other changes. So far business had been modest.

On Wednesday, December 7<sup>th</sup>, Brian was finishing a quick lunch before a scheduled meeting with his accountant when his phone buzzed. It was a Facebook message from Greg Boyadjian, his head of security.

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<sup>1</sup> Headings are quoted lyrics from the song “Blurred Lines” by Robin Thicke, a wink to the “Blurred Lines” paper published by Samantha Wells, PhD, and Kathryn Graham, PhD at CAMH.

## **“I Know You Want It”: Preventing Sexual Aggression in Bars**

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In the message, Greg asked “Did you see this?” and included a link to a Facebook post by Erinn Tee, dated December 6, with a photo of an arm that had a faint brown bruise across the wrist. The text read:

TW: SEXUAL ASSAULT

On Friday, December 2<sup>nd</sup>, I was sexually/physically/verbally assaulted at JJ’s.

When I was leaving the washroom, a man grabbed my wrist as I was walking past and yanked me towards him while his other hand reached around my waist and pulled my body against his groin. He said, “WANNA F\*\*\* ME?” It was a dim corridor and he was behind me and I was terrified. He yelled, “I KNOW YOU WANT IT”.

I twisted around and pushed him in the chest with my free hand to get out of his grip. My wrist was in pain and my head was spinning. Some people around noticed us and were about to intervene. He shouted, “F\*\*\* YOU” as I ran back to my table.

I told my friends what happened and we went to the bouncer, a large man with a tanned complexion dressed in black (I didn’t get his name).

His response was DISGUSTING:

“That area’s missed by our cameras so I can’t confirm your story.”

I’M SORRY I MADE IT ALL UP SINCE YOU DON’T HAVE IT ON F\*\*\*ING VIDEO.

“Why don’t you find the guy and confront him, if it’s that much of a problem?”

HOW DARE YOU ask a victim of assault to go back and face their attacker? HOW DARE YOU question my experience??!

My friends and I left, and I was shaking, crying, tired, and in disbelief. I found the bruises on my arm when I got home, and I took photos so they can’t question my evidence this time. I intend to email the manager to inform him of how badly his security staff handled this situation.

I’m writing this post because:

- 1) A sexual assault took place at JJ’s and people should know it is unsafe.
- 2) The bouncer and probably all staff at JJ’s need to have proper sensitivity training to deal with such situations appropriately in the future.

Two other women have reported being drugged and/or assaulted at JJ’s with stories similar to mine, and management/staff have been known to be irresponsible, dismissive and rude.

F\*\*\* JJ’s Ladies, be careful. You deserve to be safe and you deserve a bar that cares about your safety!

The post had 203 “reactions” expressing anger, support, and sadness. People commented below with sympathetic messages and called for a boycott of JJ’s.

## “I Know You Want It”: Preventing Sexual Aggression in Bars

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After Brian finished reading the post and comments, he replied to Boyadjian, “S\*\*\*. This is really bad. Were you there that night? Do you know who was working?”

“I was there but didn’t hear about this till now,” Boyadjian replied. After a short pause, Boyadjian sent another message, “I think it was Alex or Edwin.”

Brian checked his watch. He had fifteen minutes before he had to head to his meeting. “You at work? We should talk,” Brian stated.

“Yeah where are you?”

“Wendy’s. Be there in 5.”

At JJ’s, Brian found Boyadjian in the security office, reviewing camera footage.

“Find anything there?” Brian asked.

“Nothin’. I don’t doubt that it happened, but it probably was in the blind spot.” Boyadjian skipped ahead in the recording. “But here’s Alex talking to three girls who’ve brought him over by the washrooms.”

Brian watched with interest. “They seem pretty animated. Listen, I have an appointment, but I wanted to talk about how we’re handling this.”

“Okay, so Alex—or whoever it was—seriously f\*\*\*ed up and we’ll have to deal with that.”

“Right. Our first step has gotta be damage control, if that post is going viral. I haven’t received an email or anything from her yet, but I can contact her myself and pre-empt it. I expect my phone to be blowing up if the media gets hold of this.”

“Yeah. You deal with the press and communications, I’ll deal with our staff internally—getting the story from Alex and whoever else worked that night.” Boyadjian crossed his arms and looked out the doorway at the empty dance floor. “And also security. That’s on me.”

“It’s on all of us. Is this a big issue? Have girls been coming to you with complaints?”

“Nope. No more than usual, anyway. I mean, it happens—we’re talking students and alcohol here—but this one’s just a really loud, public complaint.”

“She has a point, though.”

“Sure. Look, don’t get me wrong—I *am* responsible for looking after patron safety, and I take it personal when s\*\*\* goes down in here. There can’t be no blind spots, anywhere. I’ll put in a camera, and in the meantime, post someone there to keep an eye out.”

Brian walked to the doorway and looked out towards the washrooms. “Maybe some better lighting too. But regardless, it happened, and our staff handled it in the worst possible way.”

“Oh, no doubt.” Boyadjian paused for a couple seconds. “And I’m not defending Alex’s response at all, but there are other times when it’s not so clear. Am I supposed to kick out any douche

## **“I Know You Want It”: Preventing Sexual Aggression in Bars**

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who catcalls a girl? What if she was grinding up on him on the dancefloor earlier? It’s impossible for us to see everything, and we’re asked to make judgments without seeing the context.”

Brian nodded. “It’s tough. Alright, I gotta run—I’ll order the camera tonight and we’ll talk later.”

### **“CAN’T LET IT GET PAST ME”: EMAIL, NEWS MEDIA, AND PHONE REQUESTS**

That evening, Brian arrived home and finally had a chance to check his emails. There was one from a woman named Erin Theriault. It described the same situation from the Facebook post with a couple new pictures of the bruise on her arm but using less colourful language. He wrote a reply, apologizing for her experience and expressing concern for how his staff handled the situation. He asked if she would be willing to meet to tell him more about what happened and discuss how to address the issue.

An email from Western University caught his attention.

Subject: Concerns About Sexual Assault at JJ’s

Good afternoon,

We are writing as part of Western’s Sexual Violence Prevention team, and we are responsible for reviewing and responding to incidents of sexual violence experienced by our students, staff and faculty. We strive to create a safe environment for everyone, on campus and beyond.

Last night, a Facebook post came to our attention. It describes a sexual assault that occurred at The Judge & Jester Tavern last weekend, and concerningly, the inappropriate and disappointing response by your security staff. In the past three months we have received reports from our students of similar cases at JJ’s, among other establishments.

We are planning a prevention initiative against sexual violence and saw this as an opportunity to start a conversation with you and other stakeholders around preventing sexual harassment, aggression and violence in bars and nightclubs. We believe you have a key role to play in promoting a safe nightlife environment for our students.

This is a community issue you ought to be alerted to, and we hope you will be interested in working together to address it.

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Christine Bellis, MSSc  
Sexual Violence Prevention Education Coordinator

Maria Lopez, M.Ed  
Judicial Affairs Coordinator

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## “I Know You Want It”: Preventing Sexual Aggression in Bars

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Another email caught his attention. It appeared to be from the media.

Subject: Request for comment re: sexual assault reported at JJ’s

Mr. Patterson,

I am a reporter for the London Free Press, and I’m writing a story about an alleged sexual assault reported to have taken place at JJ’s on Friday, December 2<sup>nd</sup>. A young woman described in a Facebook post her experience of being accosted outside the washroom, and how the security staff was callous and dismissive in handling her complaints. Here is her post:

<https://www.facebook.com/groups/uwoadviceforum/permalink/1364299210298789/>

Can you comment on the alleged assault, the way your staff dealt with the situation, and any response to address future incidents at your bar?

My deadline is 23:00 tonight, and the story will be published online at [www.lfpress.com](http://www.lfpress.com) early tomorrow morning. I value your time and comments on the matter.

Regards,  
Stephanie McCullough  
Digital Reporter  
The London Free Press

Brian began writing a statement to send back to the reporter. As he wrote on measures he would take moving forward, he thought of a blog post he had read a few months ago on *Tales of the Cocktail*, a website for bar owners and bartenders. The article had gained attention on social media, and he remembered that it offered some suggestions for tackling sexual violence in bar settings.

He looked it up, “7 Ways Bartenders Can Prevent Sexual Harassment and Assault” by T. Cole Newton, a bar owner in Louisiana (Newton, 2016). As he read it again, Brian recalled being amenable to many of the tips and intending to spur some changes at JJ’s. However, as the school year went on, the issue became less of a priority, and the motivation fizzled out. One line stood out: “Alcohol does not cause rape, but it’s often involved, and if bar owners do not actively work to mitigate the role that we inadvertently play as purveyors, then we become part of the problem” (Newton, 2016). Now was the time for him to be part of the solution.

He sent an email reply to Stephanie McCullough.

We at The Judge & Jester Tavern have proudly served the London community for twenty years, and we take reports of sexual assault, violence, and harassment very seriously. We are proud to be one of London’s premiere establishments, and, as an industry leader, we are responsible for creating an enjoyable and safe environment for everyone.

Ms. Theriault’s experience was an alarming incident that is being investigated by our management. The aggressive patron’s behaviour last weekend was unacceptable and had no place in our venue, or anywhere. Regrettably, the situation was not handled appropriately by our staff. We have been in contact with Ms. Theriault and will assist her in any way we can.

## “I Know You Want It”: Preventing Sexual Aggression in Bars

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We want to reiterate that we have a zero tolerance policy for any kind of harassment and we do train our staff to address situations like this. An internal review is being conducted to ensure that any mistakes are not repeated. We will be working with an advisory team to ensure that our community is free from sexual violence.

Sincerely,

Brian Patterson, Proprietor  
The Judge & Jester Tavern

As Brian was preparing to sleep, he continued to dwell on his statement about working with a team to combat sexual violence. He reached for his phone on his nightstand and fired off a quick reply to Christine Bellis and Maria Lopez, asking them to give him a call.

The following day, his phone rang.

“Hello? Brian Patterson speaking.”

“Hi, Brian—it’s Christine Bellis calling from Western Student Experience. Is this a good time for you?”

“Absolutely. Glad you called.”

“We received your email and we’re happy you’ve been so receptive. This is an important issue.”

“Thanks for reaching out. It’s honestly been something I’ve considered since September, but the incident last weekend made it top of mind,” Brian sighed.

“Oh, we’re in the same boat. The Facebook post went viral, but sexual violence has long been a problem we’ve counselled students about. It’s an issue everywhere, not just your bar. We just thought the social media buzz was an opportunity to start the conversation with you.”

“It’s too bad it had to come to this first, but I appreciate the chance to work with you on it. Last night, I was looking at some tips on preventing sexual assault in bars, but I’m sure you have some ideas too. What were you thinking?”

“Have you seen the “Ask for Angela” signs? Someone linked to it in the comments of Erin’s post.”

“Huh?” exclaimed Brian.

“It’s a poster in a bar bathroom, encouraging women who feel unsafe to go to the bar and ask for ‘Angela’, which is a code word to discreetly let the bartender know that they need help.”

“Oh, right. I’ve seen something similar before. It’s a neat idea. Part of me is skeptical that it would really work, but hey, at least they’ve gotten people’s attention.”

“That’s true—I don’t know how many people have ever actually asked for Angela. A lot of these campaigns have not been evaluated, actually,” Bellis admitted.

## “I Know You Want It”: Preventing Sexual Aggression in Bars

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“But I suppose the important thing is that patrons know the bartender is looking out for them and letting people know that we don’t tolerate sexual harassment here.”

“Exactly. Of course, it’d have to be coupled with training for bartenders to respond appropriately when someone comes to them. Ryerson is doing it at their campus pub” (Rizza, 2016). Bellis paused. “This was the problem with the incident at JJ’s, right? That the bouncer did not respond appropriately at all? Is there much about sexual assault in your staff training?”

“Honestly, no. Bouncers have enough on their plate with fights and rowdiness. Bartenders, I think they intuitively learn to take care of the customers—it’s a customer service job, after all—but there’s no formal training for sexual harassment, no. It never felt like something we needed to do.”

“There’s an approach called bystander intervention training (Banyard, Plante, & Moynihan, 2004) that may be worth considering. It started at college campuses, to encourage students not to be passive bystanders to their friends’ lewd behaviour, but it’s also been adapted for bars to help staff intervene when they notice sexual violence. I’ll send you some links after our call.”

Brian hesitated for a second. “I can see the promise, but I’m not sure my staff would agree. I’ll have to talk to them first.”

“Of course. There are many different strategies, and we should come up with a comprehensive plan. We still have a lot of work to do before we get other bars involved.”

“You know what, though? I’d suggest getting the police on board. It would help a lot in reaching out to other bar owners, and they’d have the resources to help coordinate this.”

“Great point. Maria’s in touch with the police, and I’ll ask her to contact them. Would you be able to join us in a preliminary meeting with them?”

“Certainly. Let me know when. Tuesdays and Wednesdays are usually best for me.”

“Great! I’ll be in touch. Thanks, Brian.”

“Thank you for contacting me. Happy to be a part of this. Have a good weekend.”

At home later that evening, Brian had some time to check his email and looked over the resources that Christine Bellis had sent him.

Subject: Training Programs

Hi Brian,

It was great to chat with you today. I’m excited that this is getting started. As promised, here are some links to bystander intervention training programs we could consider modelling our own program after.

Good Night Out: <http://www.goodnightoutcampaign.org/>

A campaign that started in London (the other one!) but has spread to regional organizers around the world. Maybe we could consider starting a London (this one!) chapter?



## “I Know You Want It”: Preventing Sexual Aggression in Bars

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Safe Bars: <http://safebars.org/>  
Started in Washington DC.

Arizona Safer Bars Alliance: <http://www.azrapeprevention.org/ASBA>  
A state-wide program launched in 2012. The site has an excellent YouTube video of a conference workshop on developing this training for campus communities.

Let me know what you think. I look forward to working with you on this.

Christine

Brian was intrigued by the idea of bystander intervention training for his bar staff, but he was unsure if they would be receptive to it. He went out to JJ's the following Saturday afternoon to talk to a couple of his bartenders as they were beginning their shifts.

### “BLURRED LINES”: THE ROLE OF BAR STAFF

JJ's was quiet when Brian arrived. There were two men seated separately at the bar, watching a golf tournament on the TVs, and a group at a table farther towards the back.

“Hey Brian, good to see you,” said Clarisse Cavanagh as she handed a customer a beer bottle. “Dealing with a lot lately, huh? Need a drink?”

Brian sighed. “You know it. We'll make things right, though.”

“Really, this isn't news. This is the business we're in. I've experienced it myself and it's pretty rampant.”

“Do you think it's a particular problem here?”

“Well, yes and no. There's always going to be, like, bad behaviour—I mean, we're serving alcohol, for Christ's sake. I was at Sandalwood House before I came here, and that was a bit of an older crowd, so you definitely notice a difference with the students. That's a big part of what makes JJ's, *JJ's*, y'know?”

“Yeah. What do you think about training staff to be more responsible for looking out for this sort of thing?”

“What, like SmartServe? Nah. It's not like the bartenders don't know or don't care. Our 'training' is just plain common sense. Like, just look out for people. I'm not here to play judge—and jester,” she smiled, before continuing, “but I do care about my customers. A lot of times, the lines are blurred and, like, it isn't our place to step in.” (Fileborn, 2017.)

“Do you think training could help staff recognize risky situations?”

“Okay, so there was like one time a guy was pushing a girl into the bathroom so I separated them, and they *flipped*. Boyfriend and girlfriend, apparently, and she's like, ‘He didn't mean it’. I'm like, now I just look like an idiot.” (Powers & Leili, 2016.)

“Yeah, it's a tough judgment call. I can't say whether these programs work, but I'm thinking the training could teach staff ways of stepping in without sticking their necks out too much.”

## **“I Know You Want It”: Preventing Sexual Aggression in Bars**

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“I think it’s experience and reading people more than anything. Like, I’d be open to it. Things need to change in our industry, that’s for sure. I just dunno if it’d make a difference, y’know?”

“Yeah. There are a bunch of options I’ve seen: staff training, posters (Exhibits 1 and 2), beer coasters (Exhibits 3 and 4). We need to figure out what makes sense for us and our bar—but it starts with me, and it starts with the staff.”

Brian left JJ’s and drove home, thinking about what they had discussed, and how he could use it to inform the meeting next week.

### **“EVERYBODY GET UP”: THE COMMUNITY MEETING**

Maria Lopez held the door open and offered a bottle of water. “Hi Brian, I’m so glad you could make it. This is Superintendent Nate Isaacs from the London Police Service.”

Isaacs extended his hand. “Good to meet you, Brian.”

“Glad to be a part of this. How big is the problem?” Brian asked.

“See, it’s hard to say. We’ve had an increase in sexual assaults in 2016—with 233 reports compared to 186 in 2015. But there are no overall trends, and it varies from year to year.” (London Police Service a, n.d.)

“But sexual assault is highly under-reported,” remarked Lopez.

“That’s right. It’s one of the most under-reported violent crimes, and estimates are that less than ten percent of sexual assaults in Canada are reported to police,” said Isaacs. (Queen’s Printer for Ontario, 2015.)

Brian ran his hands through his hair. “I think another part of this is that sometimes it isn’t clear what ‘sexual assault’ is. The lines are blurry—for both victims and perpetrators.”

Lopez was curious. “Do you mean women don’t report because they’re not sure if what happened to them would be considered sexual assault or taken seriously as a crime? And men don’t know where the line is between flirting and harassment?”

“Yeah, more or less. That’s the impression I get. Oh, and it’s also blurry for the bar staff you’re asking to help out. I was talking to one of my bartenders a couple days ago, and she said asking staff to step in puts them in a tough spot, where they have to make a judgment call on situations where it’s unclear whether there’s a real problem or not,” Brian said.

Isaacs nodded. “We appreciate that they have a tough job, but we also see them as a key part of our team in preventing sexual violence. In my view, I’d rather be wrong and slightly embarrassed nine times out of ten than to sit back passively and allow that one situation to escalate where someone ends up being taken advantage of and assaulted later that night.”

“The training could be designed to help bar staff recognize situations of sexual aggression and give them strategies to intervene appropriately,” added Christine Bellis.

“Maybe there could also be something in there to get women—or everyone—to be more aware of how to avoid risky situations themselves,” said Brian.

## **“I Know You Want It”: Preventing Sexual Aggression in Bars**

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Bellis furrowed her brow. “Well, we want to avoid placing the onus on women for avoiding sexual assault.”

Brian looked mildly agitated. “Sure. But I still think personal responsibility’s gotta play a small part, right? Nobody blames you for flaunting your wealth if you get mugged, but you still make an effort to stay alert when you walk home late at night, don’t you?”

Isaacs glanced at the two coordinators from Western. “We actually have some tips posted online on how people can stay safe when they go partying and drinking, and I believe you have similar resources on the Western site. We can still do better at spreading that message, though.” (London Police Service b, n.d.)

Lopez nodded. “Brian, you do bring up a good point about bringing more focus to the victims of sexual violence. We also need to do better at providing support and encouraging reporting.”

Brian looked at Superintendent Isaacs. “If you can get me a list of hotlines and support centres, I’d be happy to provide my staff with these resources to pass on to customers. Or posters? We did the same with your drunk driving signs. I dunno if a drunk student would read them, to be honest, but I guess it was something.”

Isaacs shrugged. “When you’re in the business of serving alcohol, there are going to be occasional problems—there’s no avoiding that. What we want is to be proactive and realize that we all have responsibilities to keep our community safe.”

“Oh, don’t get me wrong. I think this is a fantastic idea and really important. I want to work with you. I’m just playing devil’s advocate here and giving you things to think about so we do this right,” said Brian. “Believe me—I know my bar, I know my staff, and I know my customers.”

Isaacs nodded. “We respect that. It isn’t our place to come in and tell you how to do your jobs. But if your staff recognize that they have a vital role to play in preventing sexual violence, we want to offer the resources to help them achieve these goals.”

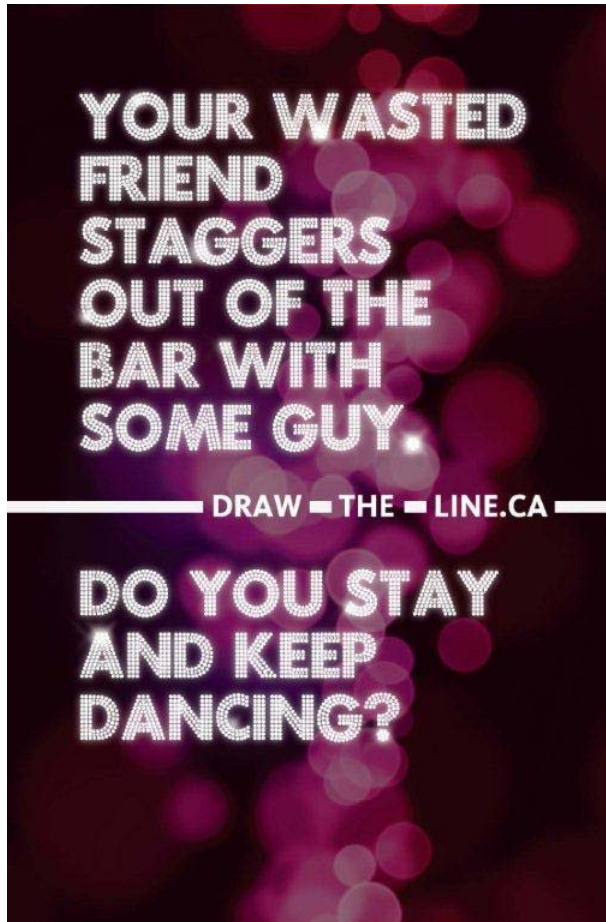
“I’m on board with you there. I’m excited to get this started.”

Superintendent Isaacs extended his hand to Brian and they shook. “Thanks, Brian. We appreciate how willing you’ve been to help us. I’m looking forward to working with you.”

### **“NO MORE PRETENDING”: MAKING A DECISION**

The meeting left Brian energized and eager to move forward. It was time to take action—the question was how? What would be needed to address sexual violence in bars and clubs in London’s nightlife economy? Should they adapt an existing bar bystander training program, put up “Ask for Angela”-type posters, launch a social marketing campaign to Western students, or develop some other approach? What would they need to do first to ensure that the intervention is sustainable and effective? What do they need to know in order to proceed?

EXHIBIT 1



Over half of all sexual assaults involve alcohol – and it’s the number one drug used by perpetrators. 

**WHY DRAW THE LINE**

When we look away from sexual violence we make it easier for the perpetrator to continue – and the violence. Every choice we make and every action we take – no matter how small – has the power to make a difference.

**WHEN TO DRAW THE LINE**

Consent matters. Only yes means yes. A friend who is wasted can’t consent.

**HOW TO DRAW THE LINE**

There’s always more than one option for a bystander. Take a stand safely and do something that you feel comfortable with. You could:

- **Check in with your friend:** “Are you ok?”
- **Make up an excuse to get him/her out the situation:** “Hey, our cab’s here.”
- **Call her phone:** Distract her and the potential perpetrator.
- **Tell the bartender or bouncer:** “I think my friend’s in trouble.”

**IT HAPPENED TO ME**

Remember, it’s never your fault. You’re not alone. Tell someone you trust. Help is available: [draw-the-line.ca](http://draw-the-line.ca) ←

**Sexual violence is everyone’s problem. Break the silence. Make it stop. Spread the word. Find out more at [draw-the-line.ca](http://draw-the-line.ca)**

  
  
Funded by: 

Source: Draw the Line, n.d.

**EXHIBIT 2**



**DOESN'T MEAN YOU GET TO HELP YOURSELF.**

sex without consent = sexual assault

**DON'T BE *THAT* GUY.**



[SAVEdmonton.com](http://SAVEdmonton.com)

Source: Sexual Assault Voices of Edmonton, n.d.

EXHIBIT 3



Source: Aisle 4, n.d.

EXHIBIT 4



Source: Voices of Hope, 2016.

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## INSTRUCTOR GUIDANCE

### “I Know You Want It”: Preventing Sexual Aggression in Bars

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*Justin Lui, MPH (MPH Class of 2017)*

*Samantha Wells, PhD*

*(Senior Scientist, Institute for Mental Health Policy Research,  
Centre for Addiction and Mental Health)*

*Mark Speechley, PhD (Professor, Western University)*

#### BACKGROUND

Brian Patterson is the owner of The Judge & Jester Tavern (JJ's), a fictitious bar in London's downtown entertainment district. JJ's is popular with students from Western University, but a viral Facebook post describing an experience of assault at the bar has generated negative publicity. Coordinators at Western University, Christine Bellis and Maria Lopez, reached out to ask Patterson if he would be interested in partnering with them and the London Police Service to develop a strategy to prevent sexual violence in London's bars and clubs.

Patterson has a deep sense of ownership over JJ's and is interested in making his bar safer but is also concerned about the response from his bar staff and the success of his business. He begins to brainstorm a list of ideas, drawing from programs that have been implemented around the world. How should they approach this problem within the London community? What will their intervention look like? What resources do they have? What do they need to know in order to proceed?

#### OBJECTIVES

1. Describe the social ecological factors contributing to men's sexual aggression against women in bars and clubs.
2. Critically appraise the literature on existing approaches in sexual violence prevention.
3. Identify ways to mobilize communities in sexual violence prevention.
4. Apply methods, strategies, and theories of behavioural change and health promotion.
5. Advocate for sexual violence prevention as an important public health issue.

#### DISCUSSION QUESTIONS

1. Is sexual violence a public health problem?
2. What are the social determinants of health contributing to sexual violence perpetration in bars? How would you frame them in a Social Ecological model?
3. Who are potential partners on campus and in the community who you would want to help develop a sexual violence prevention program?
4. What is the campus climate? What is the community climate? How could this help or hinder the implementation or impact of a sexual violence prevention program?
5. What are components that should go into a sexual violence prevention initiative?
6. What are some challenges in developing a new intervention without a substantial body of evidence to support it? Is program theory enough to drive your intervention?

#### KEYWORDS

Sexual violence; sexual assault; sexual harassment; alcohol; nightlife; prevention; health promotion; stakeholder engagement; needs assessment; program planning.



## CASE 9

### Managing Expectations: Lyme Disease

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*Nitin Mohan, MD, MPH (MPH Class of 2017)*

*Michel Deilgat, MD (Medical Advisor, Centre for Food-borne, Environmental and Zoonotic Infectious Diseases, Public Health Agency of Canada)*

*Ava John-Baptiste, MHSc, PhD (Assistant Professor, Western University)*

Dr. Kamal Karda arrived at her office Monday morning and was greeted with an urgent phone call from the Minister of Health. Newly appointed as the President of the Public Health Agency of Canada (PHAC), Dr. Karda had yet to settle into her new role. As she answered the phone, she could only imagine what information awaited her. Amongst her many priorities, she had been informed that Lyme disease would be a key component of the Minister's mandate and, as President of PHAC, Dr. Karda was expected to conduct a thorough analysis to formulate a plan on tackling the impact of and the issues surrounding Lyme disease in Canada. She was aware of the challenges surrounding Lyme disease and planned to draw on resources within the Agency to help shape her next course of action. She contemplated the roles of surveillance, policy, and communications as she gathered her thoughts. One thing was for certain: the margin of error was minimal to none. Her ability to formulate a plan would depend on strategic decision making, strong communication skills, and resourcefulness.

#### BACKGROUND

Lyme disease is a tick-borne zoonosis caused by *Borrelia burgdorferi* (Wormser, G. P. 2006). It has been known to illicit multisystem inflammatory disease symptoms. Rodents and ticks are the primary reservoirs of the disease. Lyme disease is primarily seen in the northern hemisphere and is the most commonly reported vector-borne disease in the United States, with an increase in cases being detected in Canada due to climate change. Lyme disease is characteristically known for a bullseye-shaped rash that appears at the bite site; however, this is not always the case.

The Public Health Agency of Canada (PHAC) engages in surveillance activity (PHAC, 2018). Of the many vector-borne diseases, Lyme disease has gained a significant amount of attention by the media in recent years due to rising incidences. Throughout the better part of two decades, various guidance documents have been formulated for Lyme disease as well as surveillance methods to help monitor the disease; however, minimal increases to funding have been granted. Currently, active surveillance is the primary way to gather data. However, in recent years, a push for passive surveillance has begun, due to the knowledge that many individuals who suffer from Lyme disease are not represented in the active surveillance data set.

Currently, PHAC relies on provincial governments to share data regarding confirmed cases of Lyme disease in order to track incidences and monitor trends. This form of active surveillance, while beneficial, has some pitfalls. Because of the unique clinical presentation of Lyme disease, it is not uncommon for some diagnoses to be missed, resulting in what patients and advocacy groups call "Chronic Lyme Disease." Chronic Lyme disease is believed to be a lingering, debilitating, clinical manifestation in patients who have been living with undiagnosed Lyme disease or Lyme disease that was diagnosed late in its clinical onset and thus, was not treated

## Managing Expectations: Lyme Disease

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immediately. While there is no conclusive medical literature to solidify the existence of Chronic Lyme disease, there is a clear consensus on the use of antibiotic therapy upon immediate detection of Lyme disease. Therapy often consists of three readily available antibiotics: Doxycycline, Amoxicillin, and Cefuroxime (PHAC, 2017). The fact that many Canadians travel to the United States for diagnosis and treatment makes gathering the data required to inform policy and best practices even more problematic. There is a growing movement from those affected by the disease to garner more funding for acute care management. The belief surrounding this train of thought stems from the ideology that those suffering from Lyme disease do not have enough avenues for diagnosis, treatment, and rehabilitation.

To address the challenges of surveillance, analysts within PHAC tabled a proposal to create an online Lyme disease survey. The goal of the survey is to consolidate information from Canadian patients who have been diagnosed within and outside of Canada. The ability to create this form of passive data gathering, combined with existing active surveillance, would allow PHAC to use a larger, more comprehensive data set to aid in decision making. Guidance documents, such as the Canadian Lyme disease framework tabled in the early 2000s, emphasized surveillance and preventative interventions such as increasing awareness in provincial parks and educating health professionals to improve diagnosis and reporting. Evidence-based studies have not yielded the necessary data to indicate a drastic increase in funding for Lyme disease in regards to acute care, clinics, and altering current diagnostic testing. The current government has prioritized mental health and chronic disease prevention, and, as such, the majority of funding has been reserved for these causes. PHAC's role is to continue surveillance and provide guidance through best practices to the public as well as healthcare professionals in order to help in the management and detection of Lyme disease. PHAC does not have the ability to mandate regulatory initiatives and acts solely as a guidance agency for provincial governments in regards to Lyme disease.

The phone call from the Minister did not surprise Dr. Karda. In recent years, there had been increasing pressure from advocacy groups such as The Canadian Lyme Disease Foundation (CanLyme) to increase funding. CanLyme is a registered non-profit charitable organization that is run by volunteers throughout Canada (CanLyme, 2017). CanLyme advocates for better funding of acute care services for those currently infected with Lyme disease. CanLyme argues that funding should be allocated for improved treatment and more reliable diagnostic options, such as dedicated diagnostic testing sites, improved testing, specific Lyme clinics, and broader use of antibiotics. While PHAC has engaged CanLyme in discussions about these issues, in recent years, there has been resistance on the part of the advocacy group due to their perception of the federal government not responding. CanLyme states that it is dedicated to promoting research, education, diagnosis, and treatment of Lyme disease (CanLyme, 2017), which is also aligned with PHAC's goals. However, PHAC has put emphasis on prevention, maintaining that Lyme disease is entirely preventable, and, with the correct precautions, the incidences could be greatly reduced, if not eradicated. Dr. Karda understood the frustrations of the advocacy group but wanted to maintain the Agency's evidence-based approach to public health practice. Keeping an open line of communication with CanLyme would be integral to bridging the divide between the two points of view.

The Lyme disease unit is a part of the Centre for Food-borne, Environmental and Zoonotic Infectious Diseases at PHAC (CFEZID) (PHAC, 2017). Headed by Epidemiologist Justin Gera, the unit conducts Lyme disease surveillance and, over the course of two years, has hired additional staff to assist with the increasing workload. Funding within the government is often a key issue, and while the costs associated with Lyme disease were rising, the data analyses within the Lyme disease unit suggested that focusing on prevention would yield the highest net

## Managing Expectations: Lyme Disease

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savings to the health care system. Preliminary analyses produced by Gera and the Lyme disease unit indicate that resource allocation towards prevention would result in the greatest impact on the health and wellbeing of Canadians, while also providing the most value for the funding allocated towards Lyme disease. Dr. Karda's top priority was allocating resources in an optimal way, aligned with evidence-based analysis.

While PHAC gathered information through surveillance and literature reviews, CanLyme garnered media attention and public support for Lyme disease funding. As the number of patients who suffered from Lyme disease increased, the ability to relay genuine heartfelt stories of those affected created a flurry of negative attention towards PHAC and highlighted the Agency's perceived inability to respond to calls for increased funding. Frustrations were beginning to rise on both sides, and within PHAC, media attention and pressure from CanLyme was creating conflicting ideologies with regards to the allocation of funds (preventative, treatment, testing, or a combination). Dr. Karda knew how crucial evidence-based public health principles were for bridging the gap between knowledge and application (Brownson, Fielding & Green, 2018).

Dr. Karda is tasked with garnering the support of her staff to deliver a unified message while supporting the Minister's mandate, acknowledging and addressing the advocacy group's concerns, and being fiscally responsible to the Canadian public. She must navigate the hurdles of building relationships with the various stakeholders (CanLyme, healthcare providers, public and patients, media, provincial governments, and PHAC employees) and exercising her leadership skills. Dr. Karda acknowledges the many systemic healthcare gaps and the natural frustration that accompanies delays in receiving care. As she continued to gather information for her analysis, she focused on maintaining an open dialogue with both the employees at PHAC and the patient advocacy group CanLyme.

Dr. Karda is now tasked with bridging the gap between her employees, the Minister, and the public's pressure and perception of PHAC's role and leadership in Lyme disease prevention and management. Precautions such as body checks after walking in high exposure areas are seen as the gold standard in early detection and treatment of Lyme disease and is an area that PHAC can promote to the public (PHAC, 2018). She also acknowledges that those suffering from Lyme disease rightfully would like answers that lead to immediate relief. There are more than adequate reserves for the antibiotics needed to treat Lyme disease, and there is no evidence indicating that creating Lyme-specific clinics would yield a change in incidences of the disease. Despite this, awareness and further education for healthcare providers seems like a logical step; however, there is no data currently available indicating the level of healthcare provider knowledge and ability to deal with the Lyme disease burden.

PHAC has a guidance relationship with the physicians of Canada but does not develop therapeutic protocols. It has traditionally provided information for patients and physicians alike. While new guidance documents are in the works, they are still months away from completion. Dr. Karda had asked for evidence-based documentation indicating the health outcomes and costs of Lyme disease in Canada, as well as supporting documentation from the United States, where there is more information available. She begins to synthesize the information and realizes that increasing funding for acute care management may not result in the best use of money for the overall healthcare system in Canada—a communication problem is the underlying issue. How will she, as President, ensure all parties involved truly understand PHAC's role in guidance? More so, she now has the opportunity to demonstrate to a large demographic PHAC's ability in monitoring and implementing public health initiatives that will have a lasting effect on the population of Canada.

## Managing Expectations: Lyme Disease

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During the last governmental regime, PHAC's role had been diminished, and many employees within the organization as well as the public were anticipating positive change and forward momentum with the new government. Within the organization there is great hope and optimism amongst the different divisions for increased funding, allowing for further research, surveillance, outreach, and awareness. Dr. Karda seeks to temper the expectations of staff and an already skeptical advocacy group who doubted PHAC's course of action based on a disagreement about the priorities surrounding Lyme disease.

Based on the information provided, she realizes she has three options: 1) increase funding for Lyme disease in acute care settings based on the increase in incidences in Canada. This will allow her to dampen the push from CanLyme, gain added public support, and satisfy some of her staff; 2) increase funding for surveillance measures which will allow her to gather more accurate data so that she can later make recommendations based on a comprehensive data set and better advise the public, healthcare providers, and advocacy groups; or, 3) provide a marginal increase in funding for acute care measures such as medical education seminars for physicians while continuing to raise awareness in high risk parks and forests, all while indicating that additional funding for passive surveillance measures will help the Agency accumulate necessary data. Each option has its pros and cons and success will be based on how the message is framed and delivered.

Regardless of Dr. Karda's decision, it is imperative that she bridge the gap between the stakeholders and control the expectations of various parties. She must understand the positions of all parties involved while delivering on the Minister's mandate.

An interesting alternative would be to present options to the department heads in a brainstorming session. These approaches are vital to finding out-of-the-box solutions.

### CONCLUSION

PHAC provides leadership and guidance to all the provinces and territories as well as healthcare providers and citizens. PHAC is responsible for using evidence-based decision making to best protect and prevent against threats to health. PHAC has a chance to make a great impact with the new Liberal government in leadership. Responsible decision making and impactful guidance is of utmost importance at this pivotal time. Strong leadership and communication are crucial. True leadership entails assessing the various options, understanding processes, accounting for different viewpoints, and working collaboratively in order to attain a collective aim (Popescu G. H., Predescu, V. 2016).

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## INSTRUCTOR GUIDANCE

### Managing Expectations: Lyme Disease

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#### BACKGROUND

Increasing cases of Lyme disease are creating public outcry. The Public Health Agency of Canada (PHAC) has been tasked with the surveillance and guidance for this tick-borne disease but has not seen additional funding. Evidence-based analysis has indicated the most impactful use of resources would be spent on prevention and awareness. Despite this information, the push for increasing the healthcare budget to allow for more Lyme disease funding is growing. A desire to increase resources for acute care in the hopes of better diagnostic testing, more freely prescribed antibiotics, and dedicated Lyme clinics is being put forward from advocacy groups. As climate change worsens, Lyme incidences rising in the foreseeable future is probable. As the president of PHAC, managing different stakeholders within and outside of the organization while managing expectations is crucial. The ability to engage and inform while maintaining a positive public perception is key, as this will lay the framework for other initiatives to launch in the future. Balancing this delicate situation while maintaining an evidence-based approach will take caution and strategic skills.

#### OBJECTIVES

1. Decision-making thought process.
2. Discussion around prioritization of resources.
3. Leadership in difficult situations when there are no definitive right answers.

Creating competing interest groups will be beneficial in dividing the classroom for productive debate and conversation.

#### DISCUSSION QUESTIONS

1. Is it necessary to appease all parties?
2. How should one prioritize decisions?
3. When to discuss and when to decide?
4. Do we truly understand the issue at hand? Are the right parties involved?
5. What does the evidence indicate? What is our responsibility to the evidence gathered and what is our responsibility to the public in the immediate situation and the future?

#### KEYWORDS

Leadership; stakeholders; prioritization; evidence.



## CASE 10

### Middlesex-London's Public Health Emergency: HIV in People Who Inject Drugs

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“Equity is the only acceptable goal.”  
– Paul Farmer

Biggs<sup>1</sup> injection-drug use (IDU) began when he was relatively young. At the age of 14, he ran away from his troubled home, seeking to find a better place to live. After failing to obtain accommodations through friends and family or in community shelters, Biggs found himself experiencing homelessness. As he navigated through his youth, Biggs found himself using drugs to help him cope with the suffering associated from living on the streets, dealing with addiction, leaving his troubled home, and failing to complete his high school education.

As he grew older, Biggs made multiple attempts to get his life ‘back on track’ by accessing services that were available to people who use drugs (PWUD) in his community. When things were going well for him, Biggs enjoyed volunteering at the same places where he was accessing services, helping others who he could relate to. During this time, Biggs’ lived experience allowed him to provide valuable feedback to these organizations, often helping them understand that the need of the client is not always what the provider thinks. He also became well-informed about the services that were available in his community and was working towards molding his life to help others. However, there were times when things would get challenging and Biggs would find himself back where he started. Finding himself where he started, of course, had little, if anything, to do with his willingness to improve his lifestyle. In fact, it never had anything to do with his desire to be healthy and serve his community. Discrimination, poverty, stigma, isolation, as well as other social and structural barriers often pushed Biggs back into homelessness and drug use.

“The bloodwork shows that you are HIV-positive. I am sorry,” said the HIV specialist from the Infectious Disease Care Program at St. Joseph’s Health Care. Jeffrey, known as ‘Biggs’ by his friends, was a 39-year old Caucasian male. He was a father, brother, son, and friend. He was also someone who injected drugs. Biggs was not surprised that he was HIV-positive. For years, he had seen many of his friends and loved ones diagnosed with HIV. He had become well aware that people who inject drugs (PWID) in general have significantly higher rates of HIV than the general population.

Biggs knew that something had to be done to prevent other PWID in his community from contracting HIV, a complex and serious illness that has many challenges. From his experiences accessing healthcare and social services in Middlesex-London, he recognized that health and

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<sup>1</sup> This character is the product of the author’s imagination and used in a fictitious manner.

harm reduction programs did not always meet the complex needs of the PWID population. Services available for PWID, such as those that rely on professional outreach workers to recruit, educate, and distribute harm reduction materials (e.g., brochures, posters, pamphlets), often operate under the “provider-client” model, which relies on the relationship between clients and providers to promote health (Small et al., 2012). However, services under this model do not always provide PWID with the treatment, support, and care they need (Broadhead et al., 1998). In fact, Biggs thought that health and harm reduction interventions that rely on the relationships between clients and providers lack comprehensive social, healthcare, and public health services and, thus, fail to address the complex needs of PWID (Lally, Montstream-Quas, Tanaka, Tedeschi, & Morrow, 2008; McLaughlin, McKenna, & Leslie, 2000).

As someone with lived experience, Biggs felt that he had the unique ability to address some of the gaps in Middlesex-London's service delivery. Biggs joined the Middlesex-London Health Unit's (MLHU) Citizen-Led Task Force<sup>2</sup> because he believed that he could provide peer-informed recommendations to MLHU that could help in the development of strategies aimed at reducing the barriers that hinder the ability of PWID to access resources and support services. Using his lived experience, Biggs felt that he could play a critical role in improving health and harm reduction interventions in his community, and by doing so, he could help protect his fellow PWID from contracting HIV and other infectious diseases.

Biggs had to answer many questions in order to help provide MLHU with a set of recommendations to help protect other PWID from becoming infected with HIV and/or other blood-borne diseases:

- What made London's PWID population more vulnerable to HIV infection compared to the PWIDs in other cities?
- Why were the rates of HIV infection disproportionately higher among PWID compared to the general population?
- Do PWID have access to adequate health and social services?
- How did Biggs' life conditions and those of other PWID (e.g., injecting drugs) restrict their capacity to make choices?
- How could MLHU and its community partners protect others like Biggs from the transmission of HIV?
- Did MLHU and its community partners have the capacity and resources required to put a stop to the alarming rates of HIV infection in PWID?

### BACKGROUND

In early 2013, MLHU began to see a significant increase in the number of infectious diseases that were being diagnosed. Like Biggs, other PWID seemed to be at a higher risk of being diagnosed with infectious diseases, such as Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), invasive Group A Streptococcus (iGAS), as well as endocarditis. These infectious diseases are disproportionately higher in PWID compared to other populations in Middlesex-London (Coleman, 2017). From his experience, Biggs understood that the complexity of treating those illnesses is further complicated by addictions and/or substance use.

In 2016, as the rates of HIV were declining across Ontario, the number of new cases of HIV continued to increase in Middlesex-London, particularly in the PWID population (see Exhibit 1). Biggs was one of the 61 new HIV cases that had been reported to MLHU that year—a record high number of new HIV diagnoses in Middlesex-London (Coleman, 2017). Perhaps the number

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<sup>2</sup> This Task Force is the product of the author's imagination and used in a fictitious manner.

of new HIV cases that were being diagnosed in Middlesex-London could be associated with increased testing, he thought. However, Biggs knew that he would need more information to be able to draw this conclusion.

In the past, Biggs had attended many educational workshops and was aware that the risk of HIV infection in PWID was high. He also recalled reading about the Scott County, Indiana HIV epidemic in 2015. In Indiana, by June 10, 2015, at least 150 PWID had been newly diagnosed with HIV—80% of them co-infected with HCV. Most of the people who were diagnosed with HIV in Indiana lived in rural communities, had no access to needle exchange programs, were young (median age 32 years), and Caucasian (Strathdee & Beyrer, 2015).

Biggs did not want to see his friends and loved ones become HIV-positive or acquire any of the other infectious diseases that PWID are at risk for. He knew that something had to be done to prevent Middlesex-London from becoming vulnerable to such a severe HIV epidemic.

### PERSONS WHO INJECT DRUGS IN MIDDLESEX-LONDON

While the exact number of PWID in Middlesex-London was unknown, estimates suggested that the PWID population was approximately 6,000 (Coleman, 2017). In comparison, Thunder Bay (Ontario) had 1,500 in 2017 (Thompson, personal communication, 2017), Calgary (Alberta) had 2,000 in 2017 (O’Gorman, personal communication, 2017), and the province of Saskatchewan had 5,000 in 2008 (Laurence Thompson Strategic Consulting, 2008). Relative to its population size, London had the largest population of PWID. In 2016, the Ontario Integrated Supervised Injection Site Feasibility Study (OISIS), which gathered data from Biggs and 198 other PWID in Middlesex-London, found that in the past six months 88.4%, 83.8%, and 71.4% of those surveyed had injected opioids, crystal methamphetamine, or both, respectively (Kerr et al., 2017).

Biggs, like the majority of the PWID population, had experienced a myriad of inequalities that increased his risk of adverse health outcomes. Coping with day-to-day addictions, limited resources, stigma, and discrimination was extremely challenging for Biggs and resulted in constant stressful living conditions. His opportunities to engage in healthy behaviours, such as healthy eating, being physically active, or seeking adequate social and healthcare services, had significantly diminished as most of his resources had been directed towards IDU to relieve the symptoms of stress and dope-sickness. This suggested that Biggs, like other PWID, occupied a position within social hierarchies where social (e.g., stigma) and structural (e.g., poverty) inequities shaped his vulnerability to adverse health outcomes.

The Public Health Agency of Canada’s 2012 I-Track survey monitored the prevalence of HIV and other related infections, as well as the risk behaviours among people who inject drugs. The survey showed that the PWID population in Middlesex-London experienced structural as well as social inequalities. Many PWID reported unstable housing (56.9%), less than high school education (52.9%), less than \$1,000.00 monthly income (43.8%), and recent jail sentences (20.1%). Additionally, this survey revealed very high rates of unsafe injection practices (e.g., sharing needles and injecting in public spaces) among PWID (MLHU, 2013).

Thinking about his social position, Biggs wondered,

- How does discrimination, stigma, and lack of comprehensive social and healthcare services impact the health of PWID?

## Middlesex-London's Public Health Emergency: HIV in People Who Inject Drugs

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- How does the position that PWID occupy within society shape their vulnerability to adverse health outcomes?
- How does IDU make PWID more vulnerable to inequalities than the general population?

Finding answers to these questions would allow Biggs to develop and share recommendations with MLHU's Citizen-Led Task Force, which was aiming to address the social and structural inequalities that make PWID vulnerable to HIV and other infections.

### NEEDLE EXCHANGE PROGRAMS

IDU is a major risk factor for the transmission of blood-borne viruses, such as HIV and HCV. It is estimated that PWID are approximately 59 times more likely to contract HIV or HCV compared to the general population, as a result of the injecting practices and sexual behaviours associated with injection drug use (Challacombe, 2016; Degenhart et al., 2010). Harm reduction practices, such as needle exchange programs, aim to minimize the risks associated with IDU, including overdose and the transmission of HIV and HCV. By providing Biggs and the PWID population with harm reduction materials and information, needle exchange programs can decrease the likelihood that PWID will share drug-use equipment and, thus, reduce the risk of infectious disease transmission (Ksobiech, 2003).

The Counterpoint Needle Exchange Program in Middlesex-London is a partnership between MLHU and Regional HIV/AIDS Connection (RHAC) that provides harm reduction equipment. In addition to MLHU and RHAC, there are now a number of other satellite harm reduction sites in London, including My Sister's Place, Mission Services of London, and a few pharmacies. Each organization hosts a needle exchange program on-site (see Exhibit 2), and RHAC offers a mobile van that offers outreach harm reduction services. MLHU and RHAC offer harm reduction equipment to all PWID in Middlesex-London. Mission Services offers harm reduction equipment to anyone who is accessing their Community Mental Health Program, while My Sister's Place, a women-only program, only offers services to women. With the goal of decreasing the number of new HIV diagnoses in PWID, four pharmacies have agreed to provide needle exchange services in London (see Exhibit 2).

Biggs remembers what it was like accessing the Needle Exchange Program at RHAC. He recalls that clients who are seeking sterile harm reduction material walk into a room where all harm reduction equipment is available for them at no charge. Clients are given a black plastic bag, to maintain their privacy, where they can put their new and clean drug-consumption equipment (see Exhibit 3).

In 2016, the Counterpoint Needle Exchange Program distributed approximately 3,000,000 needles and syringes (Regional HIV/AIDS Connection, 2017b). Nevertheless, the number of new HIV diagnoses in PWID continues to rise in Middlesex-London.

- Are the needle exchange sites located in places that are not easily accessible for PWID?
- Why do PWID continue to be vulnerable to the transmission of HIV and other infectious diseases, even when harm reduction services, such as needle exchange programs, are available free of charge?
- Do PWID feel uncomfortable or judged by staff when they access harm reduction equipment?
- What impact do the hours of operation have on PWID's risk of contracting HIV?

## **Middlesex-London's Public Health Emergency: HIV in People Who Inject Drugs**

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These were critical questions that Biggs had to answer if he wanted to come up with recommendations to help stop the increase of HIV and other infectious diseases in the PWID population in Middlesex-London.

### **NEEDLE RECOVERY STRATEGY**

During the June 2017 London Victoria Park Kids Expo: London's Children Festival, a used needle was found by a father of three beside his two-year-old toddler (Ghonaim, 2017). On another occasion earlier that year, a six-year-old boy was pricked by a used needle while playing in the park (Sutherland, 2017). These incidents suggest that used needles and syringes continue to be discarded in public property across Middlesex-London.

*Did the number of needles that were found in Middlesex-London increase as a result of the increase in needles that have been distributed to PWID? (see Exhibit 4).*

At the community level, injection in public places and discarded injection-related equipment are a source of community concern (Kerr et al., 2017). Biggs, as many PWID, was well aware of how to safely dispose of his needles and acknowledged the risks of failing to do so. Biggs did not want to cause anyone any harm and was always making an effort to properly dispose of his injection-related equipment whenever he used drugs in public. But the fear of being caught with this equipment, the stares and comments he received from other people, and the location of safe disposal bins created barriers that made it harder for him to dispose of his used injection-related equipment safely.

With the intention of reducing the number of improperly discarded needles across the city, the City of London placed 17 safe disposal bins in London's Downtown Core (see Exhibit 5 & Exhibit 6). These bins are maintained by London CARES, specifically, their outreach team. The team empties the bins on a weekly basis or twice a week if it is in high use (Z. Eastabrook, personal communication, 2017). The London CARES outreach team is also responsible for responding to calls related to improperly discarded sharps found in public spaces. London CARES, however, is mandated as a housing organization that engages with individuals experiencing homelessness and supports their move off the street and into a home—not needle recovery. Additionally, the Counterpoint Needle Exchange Program is also heavily involved in the recovery of used needles and syringes. In 2016, approximately 1,800,000 used needles/syringes were returned through MLHU, RHAC, My Sister's Place, and London CARES (Regional HIV/AIDS Connection, 2017b).

Biggs wanted to understand what other jurisdictions were doing to decrease the amount of improperly disposed needle waste, so he contacted a number of health units to find out more about their needle recovery strategies (see Exhibit 7). By decreasing the number of discarded sharps found across the city, Biggs hoped he would help address the community's concern with improperly discarded injection-related equipment.

### **HEALTHCARE AND SOCIAL SERVICES**

Despite successful harm reduction programs and primary care efforts, the rates of HIV infection in PWID in Middlesex-London continue to rapidly increase. Although healthcare, social, and harm reduction services (see Exhibit 8) are in place for PWID, this population faces many barriers to accessing services. As someone who injected drugs, Biggs had firsthand experiences with poverty, homelessness, and unemployment, as well as stigmatization, discrimination, and marginalization. Living in poverty, for example, had often prevented him from meeting his basic living needs. For example, poverty prevented him from seeking healthcare and social services and also caused him to experience health problems, isolation, and further



marginalization (Canadian AIDS Society, 2004). Social and structural barriers further increase the risk that PWID will contract HIV as well as other infectious diseases (Canadian HIV/AIDS Legal Network, 2005; Frankish, Hwang, & Quantz, 2009; Public Health Agency of Canada, 2013).

In an effort to decrease the incidences of HIV and other infectious diseases in the PWID community, MLHU reallocated funds to establish an outreach team to work closely with PWID and key stakeholders in the community (Dhinsa, Hovhannisyan, Coleman, & Thompson, 2017). This team was intended to create a comprehensive, community-based care program to respond to the urgent need to reach PWID and other under-housed populations. The outreach team is developing a long-term care plan to address and improve infectious disease prevention, provide a linkage to treatment, increase adherence to medication, increase access to harm reduction services and support, and increase access to healthcare and social services. The outreach team also aims to help reduce health and social issues among PWID in London, Ontario.

- How would MLHU's outreach team meet the needs of PWID living with and at risk of HIV and other infectious diseases?
- How could they improve services in order to remove the barriers that prevent PWID, regardless of their HIV status, from obtaining much-needed healthcare and social resources?

Biggs knew these questions were not easy to answer, but in order to begin to provide better healthcare and social services to PWID in Middlesex-London, these questions needed to be answered.

### **BIGGS' DECISION**

While MLHU's decision to create an outreach team to help decrease the incidences of HIV and other infectious diseases in PWID had many positive elements, Biggs was not sure that this effort alone would have a significant impact on the overall health of the PWID population and the barriers that restrain them from accessing adequate healthcare and social services. Additionally, Biggs feared that the funds that had been reallocated to establish this team would not be enough and would impact the quality of other services. Biggs knew that something had to be done and that current efforts were not enough to meet the myriad needs of PWID.

Biggs' lived experience allowed him to recognize strategies that would help decrease the rates of HIV and infection in PWID. Specifically, Biggs realized that the combination of medical and social services could increase the availability and effectiveness of interventions aimed to address the needs of PWID in Middlesex-London. The combination of medical and social services, also known as wrap-around care, aims to link, retain, and support PWID in seeking healthcare services, medication adherence, and getting to their appointments on time (Jackson, 2015). These services also help PWID navigate the healthcare system to increase care and treatment adherence to meet their needs. Additionally, wrap-around care can include other supports, such as food assistance, housing support, mental health resources, and transportation.

If MLHU's outreach team was to succeed, Biggs believed that strategies that combined social and medical services needed to be developed to meet the needs of PWID in Middlesex-London.

- Did MLHU and other community organizations have the capacity and resources needed to put a stop to the increasing rates of HIV infection in PWID?

## **Middlesex-London's Public Health Emergency: HIV in People Who Inject Drugs**

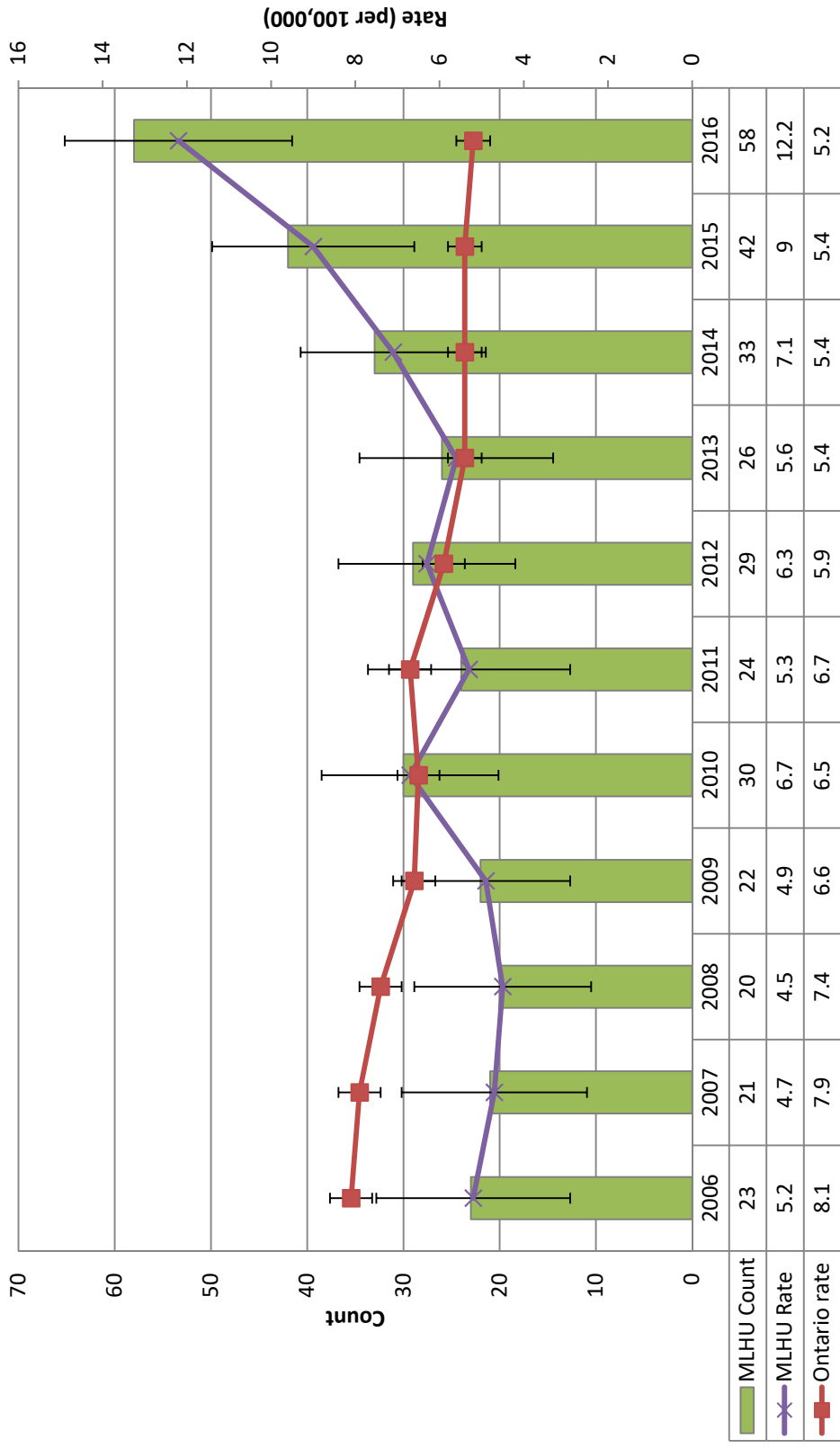
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- Which key stakeholders were essential to ensure that PWID received wrap-around care?
- How would these initiatives be funded?

### **CONCLUSION**

Biggs hoped that he would be the last PWID to be diagnosed with HIV in Middlesex-London, as he did not want any more of his friends and loved ones to become HIV-positive. Biggs was proud that MLHU and other community organizations were collaborating to decrease the rates of HIV in PWID, but he recognized that many challenges still lay ahead. What changes or improvements would provide adequate healthcare and social services, as well as remove the barriers that prevent PWID, regardless of their HIV status, from obtaining much-needed healthcare and social resources?

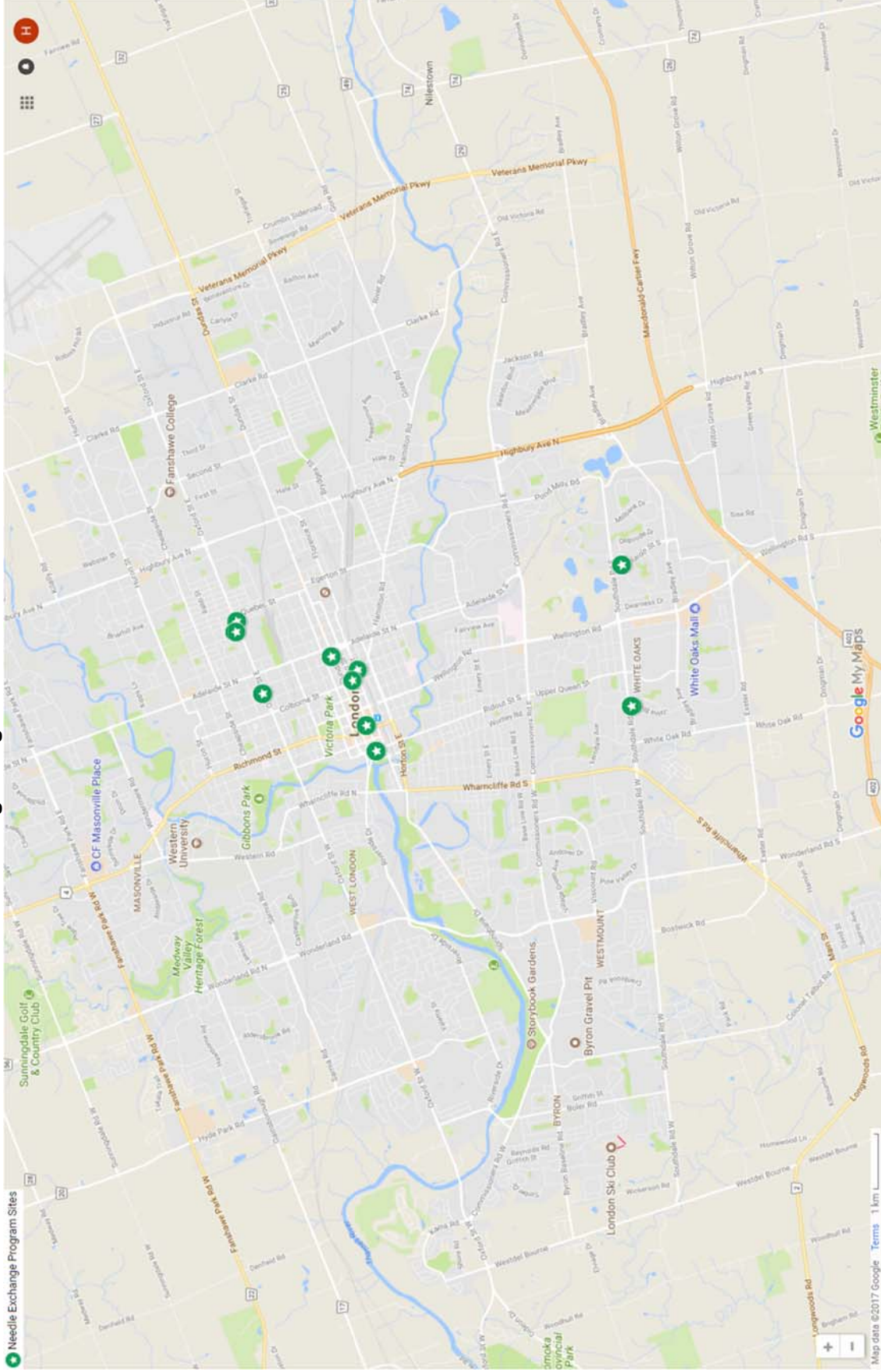
**EXHIBIT 1**  
**Reported count and crude rate of new cases of HIV in Middlesex-London and Ontario, 2006 -2016**



Source: Dhinsa, Hovhannissyan, Coleman, & Thompson, 2017.  
 Note: Ontario Rates Exclude MLHU. MLHU Count has been updated to 61.

# Middlesex-London's Public Health Emergency: HIV in People Who Inject Drugs

## EXHIBIT 2 Needle Exchange Program Sites in Middlesex-London



Source: Google. (2017). [Google maps of Needle Waste, Exchange & Recovery in London, Ontario, Canada]. Created and retrieved November 2017.

**EXHIBIT 3**

**List of Supplies Available at Counterpoint Needle Exchange Programs (Free-of-Charge)**

- New needles & syringes
- Biohazard sharps containers
- Cookers
- Ties
- Filters
- Vitamin C
- Alcohol swabs

- Sterile water
- Tourniquets
- Condoms & personal lubricant
- Snorting kits
- Safer inhalation kits
- Educational resources

Source: MLHU, 2016.

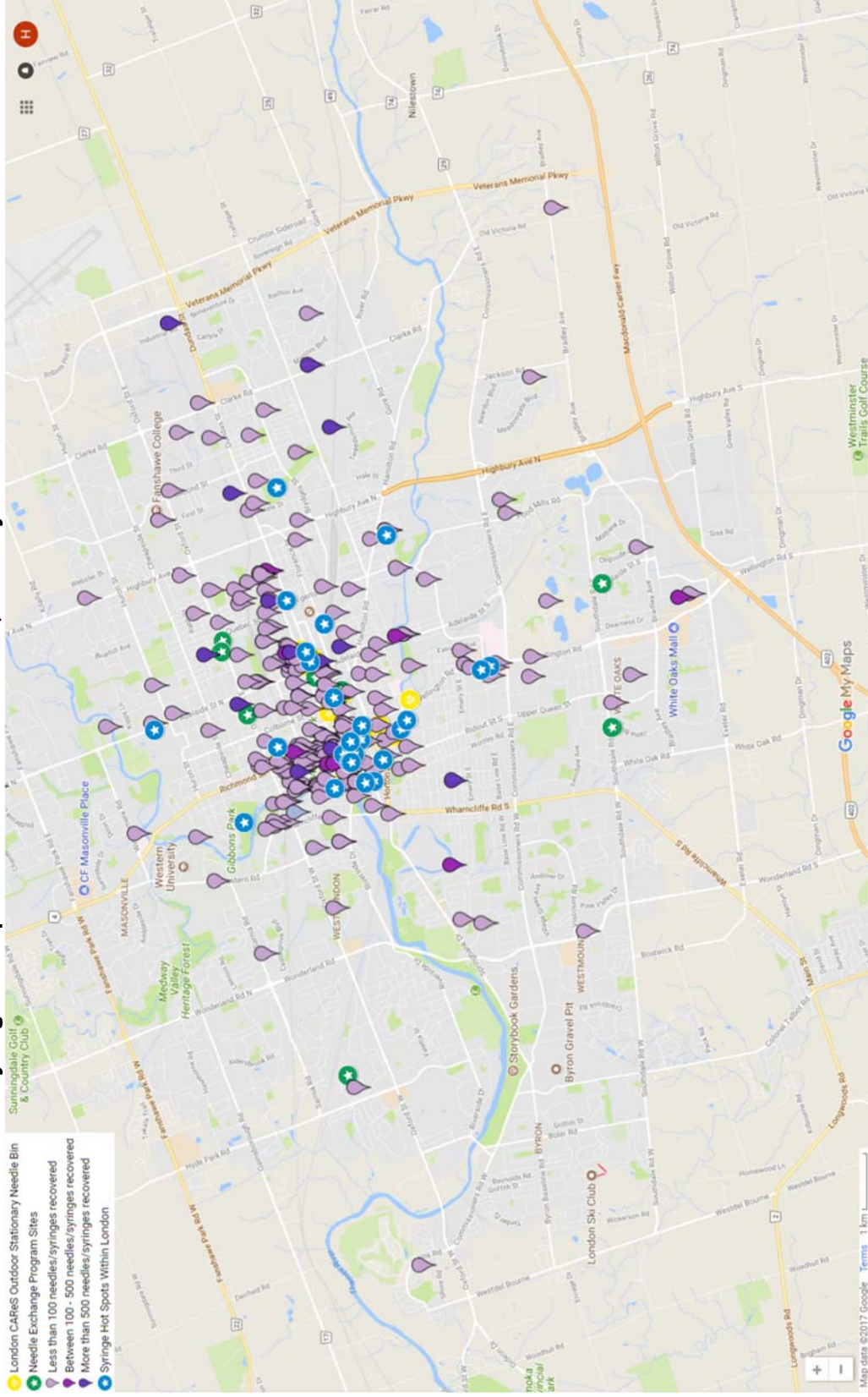
**Counterpoint Needle Exchange Program Hours of Operation**

<b>Counterpoint Needle Exchange Programs</b>	<b>Hours of Operation</b>
<i>Middlesex-London Health Unit</i>	Monday to Thursday: 9:00 a.m. to 7:00 p.m. Friday: 9:00 a.m. to 4:00 p.m. Weekends & Holidays: No Service
<i>Middlesex-London Health Unit – Kenwick Mall</i>	Monday to Wednesday: No Service Thursday: 11:00 a.m. to 1:00 p.m. & 2:00 p.m. to 4:00 p.m. Friday, Weekends & Holidays: No Service
<i>Mission Services of London</i>	Monday to Friday: 7:00 a.m. to 10:00 p.m. (service available to clients in Crash Bed Program) Weekends: Service is available through the Crash Bed Program
<i>Regional HIV/AIDS Connection</i>	Monday to Friday: 9:00 a.m. to 5:00 p.m. Weekends & Holidays: No Service
<i>Regional HIV/AIDS Connection Mobile Van</i>	Pick-up and delivery is available: Monday to Friday: 10:30 a.m. to 6:00 p.m. Weekends & Holidays: No Service
<i>My Sister’s Place (Women Only Program)</i>	Monday to Friday: 10:00 a.m. to 3:00 p.m. Weekends & Holidays: 11:00 a.m. to 2:00 p.m.

Source: Regional HIV/AIDS Connection, 2017a; MLHU, 2016.

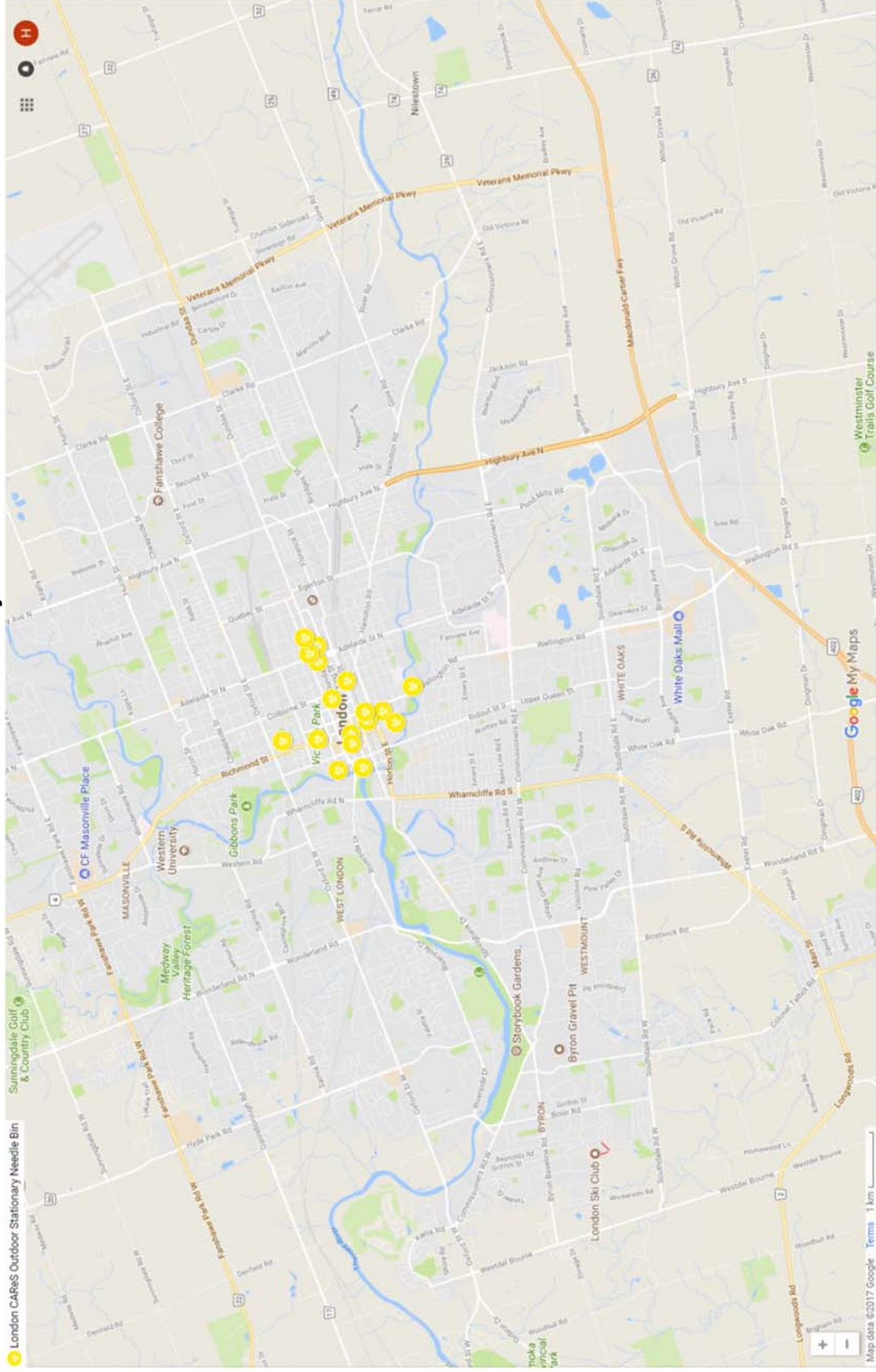
EXHIBIT 4

Needle Exchange Program Sites, London CAREs Outdoor Stationary Needle Bins, Request for Sharps Removal, and Syringe Hot Spots in Middlesex-London, January 2016 to November 2017



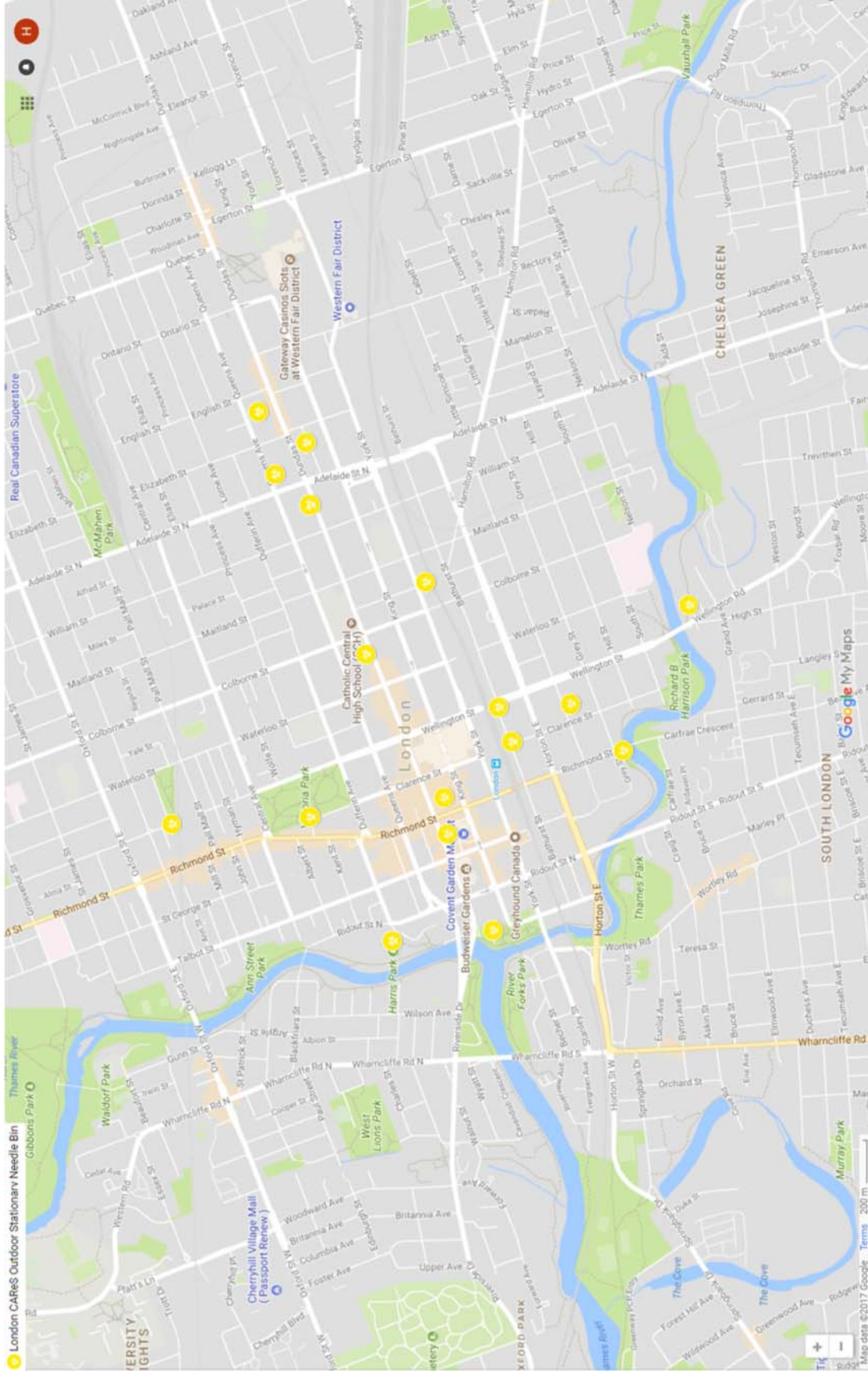
Source: Google. (2017). [Google maps of Needle Waste, Exchange & Recovery in London, Ontario, Canada]. Created and retrieved November 2017.

EXHIBIT 5  
London CArEs Outdoor Stationary Needle Bin Locations



Source: Google. (2017). [Google maps of Needle Waste, Exchange & Recovery in London, Ontario, Canada]. Created and retrieved November 2017.

**EXHIBIT 6**  
**London CARES Outdoor Stationary Needle Bin Locations (Zoomed-In)**



Source: Google. (2017). [Google maps of Needle Waste, Exchange & Recovery in London, Ontario, Canada]. Created and retrieved November 2017.



### EXHIBIT 7

#### Needle Recovery Strategy Environmental Scan: Summary of Findings

This report examines various strategies or models of needle recovery that have been adopted in Ontario (London, Ottawa, Thunder Bay, Windsor, and Toronto), Quebec (Montreal), Alberta (Edmonton and Calgary), British Columbia (Vancouver), Saskatchewan, Northern Ireland, and Australia. Please note that this information was collected through interviews, as well as a literature search conducted by Daniel Murcia (MPH Student/Program Evaluator). The findings presented here include the most recent data available.

The estimated number of people who inject drugs (PWID) in Canada ranged from 1,500 (Thunder Bay) to 12,000 (Vancouver) (2016 data). In 2015, Northern Ireland had an estimated PWID population of 26,227. In 2016, Australia had an estimated PWID population of 74,000.

The estimated number of needles distributed in Canada ranged from 600,000 (Ottawa) to 4,750,000 (Vancouver) (2016 data). In 2015, Northern Ireland distributed an estimated 342,580 needles. In 2016, Australia distributed an estimated 49,400,000 needles.

The estimated needle recovery rate in Canada ranged from 63% (London) to 96% (Saskatchewan). Some places claimed to have higher recovery rates; however, there is no supporting data available. Other locations did not have an estimated recovery rate available. Places with high needle recovery rates explicitly stated that sharps recovered included needles and syringes used for drug use as well as medical purposes (e.g., diabetic needles for insulin). The estimated needle recovery rate in Northern Ireland ranged between 31% and 70%. In Australia, needle recovery rates are no longer collected; however, older reports suggest it was approximately 70%.

The most common method of estimating the number of sharps recovered is by weighing disposal bins and biohazard containers. Other methods include using the size, volume, or number of biohazard containers returned and/or relying on self-reported data from clients. Improperly discarded sharps are counted individually. Some jurisdictions do not count the number of collected and/or returned sharps and the rationale for this was not reported.

The majority of sharps are recovered through needle exchange programs and pharmacies. Places with high recovery rates follow an 'exchange new for used needles' philosophy but also do not deny new equipment to users who do not have used equipment to exchange. Other successful models of needle recovery include needle drop boxes placed across the city, supervised injection sites, and available needle bins in private businesses, fire departments, and public restrooms.

Improperly discarded sharps are mainly recovered by outreach teams, peer support teams on the street, city wide clean-up campaigns, 24/7 sharps recovery hotline, and mobile vans that provide needle exchange services. Places aim to educate clients, whenever possible, on how to safely dispose of needles and the risks of failing to do so. This type of education has shown to be successful in reducing the number of improperly discarded sharps. Lastly, organizations that employ street outreach peers with lived experience contributed to decreasing the number of improperly discarded needles as well as increasing harm reduction and safe disposal education in the PWID population.

Organizations involved in sharps recovery include public health units, community centres, pharmacies, hospitals, fire and police departments, municipalities, provincial and federal governments, non-governmental organizations, not-for-profit organizations, domestic waste and recycling disposal facilities, and private waste contractors. In most cases, each organization is financially responsible for disposing the sharps they recover; however, places where one organization is financially responsible for sharps disposal reported higher recovery rates. Some locations have multiple organizations involved in the recovery of sharps and also produce high needle recovery rates.

Source: Created by author.

EXHIBIT 8

Healthcare, Social, and Harm Reduction Services Available for PWID

<i>Name of Program</i>	<i>Services Offered</i>
<i>Infectious Disease Care Program (IDCP)</i>	<p>Since 1990, the Infectious Disease Care Program of St. Joseph’s Health Care has served the needs of people living with HIV/AIDS. This program provides medical and psychiatric, nursing, social work, pharmacy, and nutrition services for HIV-infected and affected populations. Driven by care, compassion, comprehension, and confidentiality, the program’s aim is excellence in patient care. IDCP is the only HIV care program in the city (St. Joseph’s Health Care London – IDCP, 2017).</p>
<i>MyCare Program</i>	<p>The MyCare Program recognizes that many people living with HIV face barriers to access and treatment. A partnership between St. Josephs’ Health Care London and London InterCommunity Health Centre (LIHC) provides specialized HIV case management and primary care services to people living with HIV (St. Joseph’s Health Care London, 2017).</p>
<i>London CAREs</i>	<p>London CAREs aims to end homelessness in London, Ontario. It provides 24/7 street outreach services to support individuals experiencing homelessness move off the streets and into a home. It also offers a housing stability program that provides intensive case management support to individuals that have experienced persistent homelessness who are now housed. Lastly, London CAREs is responsible for the maintenance of safe disposal boxes in identified areas to collect sharps and assist with needle and syringe recovery (London CAREs, 2017b).</p>
<i>Options Clinic &amp; Anonymous HIV Testing</i>	<p>The London InterCommunity Health Centre’s Option Clinic provides a safe and private environment where vulnerable populations can be anonymously tested for HIV free of charge. It also provides education and support from non-judgmental counsellors. The Anonymous HIV Testing Program provides HIV prevention, testing, and counselling services to vulnerable populations on an outreach basis around the city. This program is coordinated by the Options Clinic (London InterCommunity Health Centre, 2015).</p>

Source: St. Joseph’s Health Care London, 2017; London CAREs, 2017b; London InterCommunity Health Centre, 2015.

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## INSTRUCTOR GUIDANCE

### Middlesex-London's Public Health Emergency: HIV in People Who Inject Drugs

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#### BACKGROUND

Middlesex-London is experiencing an alarming rise of new HIV cases in people who inject drugs (PWID). Despite a demonstrably successful harm reduction program and primary care effort, the rapid increase in HIV remains. To help reduce the incidence of HIV in PWID, in association with Regional HIV/AIDS Connection (RHAC), My Sister's Place, and the Middlesex-London Health Unit (MLHU), the Counterpoint Needle and Syringe Program in Middlesex-London distributed over three million needles in 2016. Nevertheless, healthcare workers continue to diagnose PWID with HIV and other infections. Of those needles distributed, only 1,895,798 were recovered through these organizations and, thus, improperly discarded needles have been spotted across the city on multiple occasions.

PWID in Middlesex-London face significant barriers when accessing care and support. Barriers, including, but not limited to, psychosocial (i.e., stigma, social support), structural (i.e., housing, treatment access, poverty), and institutional factors (i.e., patient-physician relationship), can hinder PWID from accessing adequate healthcare and support services. With an aim to address some of the barriers faced by PWID, the Middlesex-London Health Unit has established an HIV Leadership Team that works collaboratively with key system partners in the field of HIV treatment and support, substance use, and support for people who experience homelessness.

This case demonstrates the impact of social determinants of health such as poverty, homelessness, and inequalities in PWID's health, well-being, morbidity and mortality patterns, as well as their access to care. This case also highlights the importance of recognizing the influence of social determinants of health in the planning, implementation, and evaluation processes of public health programs to ensure that interventions are effective, cost-effective, and equitable.

#### OBJECTIVES

1. Explain the potential impacts of social inequalities on the health and well-being of PWID, the principles of harm reduction, the operation of needle exchange programs, and the needle recovery strategies. How does the position of a PWID in society impact their health outcomes?
2. Identify the needs of PWID in Middlesex-London and highlight current gaps in healthcare and social service models.
3. Describe the importance and benefits of wrap-around care.

### **DISCUSSION QUESTIONS**

1. What are the benefits of providing harm reduction services to PWID? How does wrap-around care improve these services?
2. What is the role of structural violence on restricting PWID's capacity to make choices? How does this influence the health and well-being of PWID?
3. How might inequalities of risk and outcome in PWID be addressed?
  - a. What are the most urgent needs?
4. How can services be improved to remove the barriers that currently prevent PWID, regardless of their HIV status, from obtaining much-needed healthcare and social support resources?
5. How can the general population be educated about harm reduction?
6. How can MLHU and community partners improve the current needle and syringe recovery strategy to destigmatize injection drug use, PWID, and harm reduction services?

### **KEYWORDS**

Harm reduction; needle recovery; needle exchange programs; wrap-around care; PWID; HIV prevention; injection drug use; structural violence; social determinants of health.



## CASE 11

# Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan

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“Canada is committed to leading global action in support of sexual and reproductive health rights for women and girls. Women's rights begin with the right for all women and adolescents to be in control of their bodies and make their own decisions.”

– Marie-Claude Bibeau, Minister of International Development and La Francophonie

### BACKGROUND

Aamir Khan, senior program manager at Daud Foundation Canada (DFC)—an international non-profit organization—was faced with the pressing issue of incorporating sexual and reproductive health (SRH) services into DFC's health programming. As the senior program manager at DFC, his responsibilities included reviewing and ensuring that all of DFC's health projects in developing countries were approved by Global Affairs Canada (GAC), through which DFC obtained most of their program funding.

Aamir briefed his team about GAC's mandate of applying a feminist lens and adopting a human rights-based approach to address persistent gender inequalities, which negatively impact women and girls globally. GAC had advised that international programming should play a leadership role in protecting sexual and reproductive health rights of women and girls. GAC mandated that all programming should focus on promoting and providing a full range of sexual and reproductive services, including contraception, family planning, and comprehensive sexual education, in order to advance Canada's aid effectiveness agenda and to sharpen the focus of international assistance.

Aamir was aware that, moving forward, all future project health programming proposals within DFC would need to align with GAC's requirements, and that DFC would also need to shift the focus of their current programming from solely providing maternal, newborn, and child health (MNCH) services to promoting SRH services in their development programs in Asia. Specifically, one project, The Pakistani Maternal Newborn Health Initiative (PAMNHI), had consumed Aamir's thoughts for weeks as he contemplated how his team would weave SRH services into this project. This project was being implemented in Pakistan, where sexual and reproductive health rights (SRHR) are a very sensitive issue. He knew that achieving gender equality in Pakistan was a very complex issue due to many competing factors, such as the predominantly patriarchal structure of society and the lack of support from governing bodies. He was worried how Daud Foundation Pakistan (DFP) and local civil society organizations (CSO) would advocate for SRH services in a country where women face multiple forms of oppression—both in the privacy of their homes and in public.



## **Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan**

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### **DAUD FOUNDATION INTERNATIONAL**

The Daud Foundation International (DFI) is a global leader in striving towards the sustainable development goal of eradicating poverty worldwide. DFI is active in more than 10 countries, including Canada and Pakistan, and consists of a number of development agencies with individual mandates that collectively aim to address context driven social, economic, and cultural dimensions of development. The underlying goal of DFI is to improve the quality of life for vulnerable populations in Asia. All affiliated agencies within DFI strive to improve the living conditions of impoverished individuals across the world, regardless of their faith, origin, or gender.

The DFI's annual budget for non-profit development activities is approximately \$500 million USD, and a considerable portion of the funding comes from national governments, multilateral institutions, and private partnerships. Approximately 45,000 people are employed internationally and, with most individuals residing in developing countries, DFI is committed to achieving sustainable results in underdeveloped communities. Through ongoing research and project implementation, the DFI strives to tackle challenges in three key areas: civil society, health, and rural development. Furthermore, the DFI works with both civil society and local governments and represents the shared interests of local communities and their specific needs. The organization primarily functions through the continued support of interdisciplinary teams which include individuals from local communities, volunteers, and healthcare professionals. With the inception of any project, DFI thrives to work towards its ultimate goal of promoting a higher standard of living for underserved communities.

### **DAUD FOUNDATION CANADA**

Daud Foundation Canada (DFC) is a prominent non-profit organization within DFI and was established in 2000 with the sole purpose of supporting vulnerable populations residing in developing nations by utilizing Canadian resources and through evidence-based research, education, healthcare, and advocacy. Since its inception, DFC has built a strong relationship with Global Affairs Canada (GAC), the department of international development and humanitarian assistance within the Canadian government. With the continued support of GAC, DFC has provided financial and resource assistance to numerous initiatives in both Africa and Asia.

DFC has been recognized as one of the most avid supporters of international programming within DFI. By engaging in public and private sector partnerships, DFC has supported a multitude of projects on health systems strengthening and rural development in developing nations such as Pakistan. DFC works with the underlying mandate of providing lasting and sustainable change in the communities where it works. DFC recognizes the importance of adapting each initiative to the specific context of each region, hence local communities are an integral component of every initiative. Communities are engaged in each phase of projects—from design to implementation and evaluation.

### **DAUD FOUNDATION PAKISTAN**

Daud Foundation Pakistan (DFP) is an agency within DFI, which seeks sustainable solutions to systemic problems of poverty, illiteracy, and ill-health with a strong focus on the needs of rural communities within Pakistan. With the continued support of donor organizations within DFI, such as DFC, DFP can implement various projects that aim to improve the health and well-being of vulnerable populations in Pakistan.

## **Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan**

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### **PAKISTANI MATERNAL NEWBORN HEALTH INITIATIVE (PAMNHI)**

In 2016, Transparency International, a global organization that strives to overcome abuse of power and bribery, ranked Pakistan 116<sup>th</sup> out of 175 countries in corruption (Transparency International, 2016). The public sector's ability to plan and manage health service delivery in Pakistan is low. Health indicators in the Northern regions of Pakistan are behind the rest of the country and have failed to meet the Millennium Development Goals (MDGs), specifically MDG4 and MDG5: reducing child mortality and improving maternal health, respectively (World Health Organization, 2017).

Aamir was aware that the mountainous geography of the northern regions of Pakistan limits access to appropriate health services. The local government health system's outreach is very limited, and most existing primary healthcare facilities lack the basic infrastructure and trained clinical staff to effectively deliver a full range of pre- and post-partum health services (National Institute of Population Studies, 2013). Additionally, there are a limited number of birth attendants at the community level and knowledge regarding healthy practices for mothers and infants is low (National Institute of Population Studies, 2013).

Aamir and the health team had planned PAMNHI as a three-year project. PAMNHI began in 2014 and aimed to reduce maternal, neonatal, and child mortality in women of reproductive age and children under five years of age in the northern, underdeveloped regions of Pakistan.

In Pakistan, Aamir had hoped that agencies within DFI would collaborate with local health departments and community organizations would deliver context-specific activities that would address the main causes of low maternal and neonatal health outcomes. Additionally, through DFP, Aamir and his team aimed to actively engage women's rights organizations to advocate for the health rights of women and to influence community perceptions. In the three-year PAMNHI project, Aamir and his team sought to improve the provision and utilization of MNCH and neonatal services by targeting 32 primary health care facilities within the project areas.

In order to address low community participation in public affairs and governance, he hoped that PAMNHI would strengthen health system capacity by training government staff and providing proper equipment and renovations to improve the overall delivery of MNCH services. Additionally, by utilizing existing capacities within DFI, along with public-private partnerships for health service delivery in the project areas, PAMNHI aimed to assist in local capacity building of public sector health professionals for planning and managing health services.

Additionally, Aamir had hoped the project would increase community participation and build local capacity by creating health facility governance committees, village health communities, district management teams, and local support organizations (i.e. women's rights organizations). Over the three years of project implementation, he hoped PAMNHI would improve overall knowledge and behaviours surrounding MNCH in communities and engage more women in health system decision-making. Moreover, the health team sought to train health workers in providing community-based MNCH services (i.e., community midwives) with a strong focus on provisioning low-cost effective postnatal interventions.

The PAMNHI project would address geographical barriers by conducting outreach activities at various outlets, including mobile clinics, to deliver MNCH care and health education for individuals who are not able to access services at health facilities. Furthermore, PAMNHI would engage community champions, with both male and female representatives, to increase awareness and overcome barriers in adopting positive health behaviours, especially regarding pregnancy and newborn care.

## **Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan**

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Since its inception in 2014, the PAMNHI project has strived to engage the local governments in the target project areas and has conducted an in-depth training-needs assessment to determine the current knowledge of healthcare workers and gaps in healthcare delivery. By engaging community members and the regional council during the first year of implementation, the project identified potential community health worker candidates to receive training. However, limited activities were conducted in the first year of implementation, as the PAMNHI project team encountered delays and challenges in effectively engaging major stakeholders (i.e., local governments) and retaining staff members in target project areas.

However, moving forward, as per GAC's recent mandate on international programming, Aamir contemplated how PAMNHI would shift its focus from solely providing MNCH services to providing a comprehensive range of SRH services starting from the second year of project implementation. Given the current socio-political climate of Pakistan and the persisting gender inequalities, he was aware that implementing a full range of SRH services would be a challenging task for the PAMNHI project team.

### **GLOBAL AFFAIRS CANADA'S MANDATE**

Global Affairs Canada (GAC) is an integral branch of the Canadian government which manages Canada's diplomatic and consular relations, promotes international trade, and is primarily responsible for leading Canada's international development and humanitarian relief services (Global Affairs Canada, 2017). GAC continually strives to achieve international peace and security through leadership and international engagement, reinforces Canada's relationship with international partners, and contributes to achieving a more inclusive and sustainable world (Global Affairs Canada, 2017).

In honour of International Women's Day 2017, the Honourable Marie-Claude Bibeau, Minister of International Development and la Francophonie, along with Justin Trudeau, the Canadian Prime Minister, announced Canada's strong commitment to promoting gender equality and applying a feminist lens to all international programming (Global Affairs Canada, 2017). During several consultations and written submissions, GAC highlighted the importance of adopting a human rights-based approach to address persistent gender inequalities, such as gender-based discrimination, which negatively impact women and girls globally. GAC recommended that all international programming should play an avid leadership role in protecting the SRHR of women and girls. GAC mandated that all programs should have a strong focus on promoting and providing a full range of sexual and reproductive services, including contraception, family planning, and comprehensive sexual education, in order to advance Canada's aid effectiveness agenda and to sharpen the focus of international assistance (Global Affairs Canada, 2017). Programs that align with this mandate will help prevent and respond to sexual- and gender-based violence, (i.e., child early and forced marriage), to support the right to choose safe and legal abortion practices, and to provide access to post-abortion care. On the issue of gender equality, GAC stated that, by promoting safe abortion practices, international organizations are working to address important gaps in maternal and newborn health and gender inequalities (Global Affairs Canada, 2017).

Therefore, in order to align PAMNHI with GAC's requirements, Aamir deliberated how the project's focus would shift towards promoting SRH services as opposed to solely MNCH services. PAMNHI would need to advocate for the sexual reproductive health rights of women and girls under all circumstances by providing access to family planning services, contraception, comprehensive sexual education, and a full range of pre- and post-abortion services.

## **Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan**

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### **GENDER DISPARITIES IN PAKISTAN**

In order to weave SRH services within PAMNHI, the team had to understand the existing gender disparities within Pakistan, along with the efforts that had been made to date in an attempt to overcome these persisting inequalities. Abiding by GAC's mandate on international programming was problematic in Pakistan, as gender inequalities have persisted for multiple generations and have been entrenched in social, cultural, and religious systems. The Constitution of Pakistan clearly outlines the principles of equal rights and treatment of both men and women; however, women continue to be victims of discrimination on the basis of gender and/or social identity (National Assembly of Pakistan, 1982). Achieving gender equality in Pakistan was a very complex issue due to multiple competing factors, such as the predominantly patriarchal structure of society.

In 2012, the National Commission for Human Rights Act was passed by the Pakistani parliament to promote the social, economic, and political rights of women, as originally outlined in the Constitution of Pakistan. In the Northern regions of Pakistan, such as Gilgit Baltistan, activists have been striving for the minimum age of marriage to be 18 for both boys and girls; however, the inherent patriarchal structure of society has made it difficult to achieve their goal.

A recent survey conducted in Pakistan, known as the Pakistan Demographic and Health Survey (2013), indicated that knowledge surrounding contraception was widespread, as approximately 98% of the women in the project area had prior knowledge about contraceptives. Even though women had existing knowledge surrounding family planning services, the uptake of contraceptives was relatively low, as misinformation surrounding contraceptive use prevailed, specifically among the rural and uneducated demographic. The survey demonstrated that approximately 33% women use contraceptives in Pakistan (PDHS, 2013). Barriers that prevent women from utilizing SRH services include perceived negative effects of contraceptives, religious and cultural norms, and lack of decision making power (Azmat et al., 2012). Widespread misinformation and myths prevail, such as the inability to conceive after contraceptive use, excessive bleeding, infections, and irregular menstruation (Azmat et al., 2012).

Multiple factors prevent the uptake of health services, including poor quality of services, geographical barriers, affordability, religious beliefs, low awareness, and societal norms (Shaikh & Hatcher, 2005). Cultural norms are often determined by men, as they are usually the sole wage earners and make decisions regarding the women of their households. Women are often unable to demand improved access to healthcare services due to their subservient status in society, limited education, and restricted mobility (Azmat et al., 2012; Shaikh & Hatcher, 2005). Only 20% of women receive postnatal care, as most women who are dependent on their husbands are unable to access health services without spousal consent (Azmat et al., 2012).

Additionally, religion has been referenced as an important determinant in reproductive health (Ali & Ushijima, 2005). Pakistan is a predominantly Muslim country, and most of its laws are governed according to Islam. In rural regions, where the majority of the population is illiterate, religious leaders are viewed as strong influencers. A cross-sectional survey conducted in 2000 with 180 male participants on the perceptions of men on reproductive health in twelve rural districts of Pakistan indicated that "the involvement of religious leaders in reproductive health programs is essential for the programs in rural areas" (Ali & Ushijima, 2005).

The societal perception of women as being dependents is continually reinforced by traditional practices the existing laws of Pakistan, which are among the underlying barriers to gender equality (NIPS, 2013). Other barriers, such as the limited availability of sex-disaggregated data,

## **Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan**

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high prevalence of domestic violence, negative attitudes towards gender equality, and low education rate, collectively deny women opportunities and access to health services (Azmat et al., 2012).

The collection of accurate sex-disaggregated information in Pakistan is a challenging issue, as negative attitudes towards discussing private matters publicly results in underreporting (NIPS, 2013). The perception of women and girls being owned by their patriarchs leads to high rates of violence, and there is usually lack of support from the husband's family when women experience emotional and physical abuse. Approximately 39% of married women aged 15-49 reported experiencing physical or emotional violence from their spouse, and around 52% of women who were victims of violence never sought help (NIPS, 2013). Additionally, assistance from community leaders (i.e., religious leaders) and health service providers is limited, as negative perceptions regarding gender equality and women's empowerment persist (NIPS, 2013). Furthermore, girls' education is a low priority in Pakistan (NIPS, 2013). Even though women are entitled to inherit wealth from their fathers, mothers, husbands, or children, their share is usually smaller than the share allotted to men. Although women have the right to access bank loans and other forms of credit, their access is limited by their inability to provide the required financial collateral.

Overall, women in the project areas are mainly limited to household activities, including raising children and taking care of elders in their households and performing other domestic duties (Azmat et al., 2012). Although they have legal rights to freedom of movement, cultural norms, such as male ownership, bound their ability to exercise their rights. Additionally, lack of financial resources, misinformation, inadequate infrastructure along with cultural practices place constraints on women's mobility and ability to access health resources, specifically SRH services (Azmat et al., 2012; Shaikh & Hatcher, 2005).

### **CONCLUSION**

Aamir was convinced that the PAMNHI project would have to employ a multipronged approach to address the systemic gender inequalities in Pakistan. After much deliberation and research, Aamir discussed with his team that, as a first step, the involvement of key stakeholders would be crucial in addressing gaps in gender disparities and in responding to the local needs of the population. Key stakeholders would have the ability to support and promote the integration of SRH services throughout PAMNHI in order to address gendered barriers and advance equitable outcomes and benefits from project interventions for women in Northern Pakistan.

Aamir knew that stakeholder engagement is an integral component for the implementation and sustainability of health programming in developing countries. He informed his team that stakeholders who affiliated with the project have the ability to directly influence the integration of SRH services in target project areas. In order to tackle the complex issue of gender inequality, the health team conducted an in-depth stakeholder analysis to identify and discuss the specific roles, interests, and impacts of potential stakeholders, including CSOs, religious leaders, local government, women's rights organizations, and community health workers—all which have the potential to influence the perceptions of communities on SRHR.

## Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan

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## INSTRUCTOR GUIDANCE

### Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan

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#### BACKGROUND

The Pakistani Maternal Newborn Health Initiative (PAMNHI) project needs to shift its focus from providing solely maternal, neonatal, and child (MNCH) services in Pakistan to incorporating sexual and reproductive health (SRH) services in order to be approved by Global Affairs Canada (GAC). Aamir Khan, senior program manager at Daud Foundation Canada (DFA), and his team must weave SRH services into this project, which is being implemented in Pakistan, where sexual and reproductive health rights are a very sensitive issue. Aamir knows that achieving gender equality in Pakistan is a very complex issue due to many competing factors, such as the predominantly patriarchal structure of society and the lack of support from governing bodies.

Aamir knew that, moving forward, the involvement of key stakeholders would be crucial in addressing gaps in gender disparities and responding to the local needs of the population. Key stakeholders have the ability to support and promote the integration of SRH services throughout PAMNHI in order to address gendered barriers and advance equitable outcomes and benefits from project interventions for women in Northern Pakistan.

The goal is to identify key stakeholders who have the potential to influence the perceptions of communities in order to successfully promote SRH in Pakistan and align the project's focus with GAC's mandate of addressing sexual and reproductive health rights (SRHR). Also, Aamir and his team must discuss the roles, interest, and influence of each potential stakeholder (i.e., religious leaders and community partners) in helping to strengthen the project's focus and achieve the underlying goal of decreasing gender disparities in Pakistan.

#### OBJECTIVES

1. Explore the extent of gender disparities that exist in developing countries like Pakistan.
2. Understand Canada's mandate on international programming; gain insight on how various organizations (i.e., DFC and GAC) must work together to address sensitive topics such as SRHR in developing nations.
3. Discuss the importance of stakeholder engagement for the success of projects by identifying key stakeholders and creating an engagement plan.

## **Improving Sexual and Reproductive Health Rights: A Key Step in Achieving Gender Equality in Pakistan**

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### **DISCUSSION QUESTIONS**

1. What are the key health and gender issues facing women and adolescent girls in these regions of Pakistan?
2. How do you think community leaders, health service providers, and other influencers feel about gender equality, specifically sexual and reproductive health?
3. What are the main actions needed to address barriers to accessing sexual and reproductive health services for women?
4. How can nonprofit organizations engage both men and boys and change the attitudes and behaviours towards the sexual and reproductive health rights of women?
5. What are the most effective ways to increase women's participation in decision making around their sexual health and reproductive rights at the household and community levels?

### **KEYWORDS**

Gender equality; women and adolescent girls; sexual and reproductive health; community engagement; stakeholder relationships; global health; Global Affairs Canada; Pakistan.





## CASE 12

### Housing and Health: A Human Rights Approach to Wellbeing

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Health Justice Initiative, St. Michael's Hospital Academic Family Health Team)*  
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Julia checks her watch; she has five minutes to prep before her next client meeting begins. It has been a busy day for Julia between client appointments, stakeholder meetings, and a looming court date to prepare for. But Julia knows that her work is incredibly important for her clients. Without her services, some of the clients would not be able to afford legal assistance for their health matters. Julia opens the file to see Dawn's case, who has come with a human rights issue regarding poor health stemming from poor housing conditions. Anticipating this case, Julia prepares to draw on the *Human Rights Code*, *Residential Tenancies Act*, and community support and advocacy groups to mitigate this situation.

#### HEALTH JUSTICE INITIATIVE

The social determinants of health can greatly impact the social, economic, and environmental factors involved in primary care, well beyond medical diagnoses. In order to address the need for a holistic method of primary care services that encompass multiple determinants of health, the Health Justice Initiative was created. The Health Justice Initiative is a medical-legal partnership between the St. Michael's Hospital Family Health Team and community legal aid clinics in Ontario (Macdonald, 2017).

The Health Justice Initiative improves client access to justice and addresses the social determinants of health and health equity in the Toronto community through direct services, legal education, and systemic advocacy. The Health Justice Initiative also engages in community research and performs evaluations to assess the success of project goals. The Initiative provides legal information, advice, and brief services to clients who are low-income and have legal issues affecting their wellbeing. These issues include experiences of discrimination and personal safety and problems with employment, housing, and other issues.

Julia is a staff lawyer at the Health Justice Initiative. With the support of her clerk and several physicians from St. Michael's, she is running the Health Justice Initiative's direct services and advocacy work. Julia has experience with a plethora of social housing cases and commits herself to framing her work through a human rights lens. Julia recognizes that Dawn's case is complex, as there are a number of conditions that contribute to a human rights violation, but Julia is determined to find a solution.

#### DAWN'S STORY

Dawn arrives at her appointment ten minutes early; she anxiously waits to receive advice that could potentially change her life. Dawn is in search of legal advice for a persistent issue where she feels she has been discriminated against. For some time now, the landlord of her apartment building has been unwilling to accommodate Dawn's physical needs and makes derogatory comments towards her physical disability, impacting both her physical and mental health. In a

considerably complex situation, Dawn has gathered evidence against her landlord that could help her win a human rights claim. Now she has the opportunity to win back her rights and the health that she once had.

Dawn has lived in social housing in Toronto her entire life. Her childhood was troubled; her parents separated when she was young, and, as a result, she was constantly moving between poor quality social housing units. Her poor housing conditions impacted her health, and she was often too sick to attend high school, staying home for respiratory tract infections and colds. Dawn eventually finished high school but was not able to pursue post-secondary education due to her financial situation. Dawn worked as both a server and a dog walker part-time, always making sure she had the funds to pay her rent on time every month. But working two jobs eventually took a toll on Dawn, and combined with her poor housing conditions, Dawn started to have symptoms of depression and anxiety.

Dawn had her daughter, Rosa, at age 29. The father was not present for Rosa's upbringing, and Dawn again had to take on more work to pay the bills. During her pregnancy, Dawn discovered that she had a hereditary heart condition. Nevertheless, Rosa grew up to be a healthy child and later had her own son at the age of 24. Meanwhile, Dawn's mental health continued to deteriorate over the years, due to constantly working, singlehandedly raising Rosa, and worrying about the heart condition that had killed her mother five years before Rosa was born.

Now at 67, Dawn lives in a two-bedroom apartment with her daughter and her 14-year-old grandson, Jeffery. They live on the 13<sup>th</sup> floor of a social housing apartment in the west end of Toronto. Dawn is becoming too weak to take the stairs as she ages, and her heart condition makes the thirteen flights of stairs a serious risk to her health. Dawn is afraid to use the apartment's elevator due to its disrepair. Furthermore, there have been incidences of violence and aggression in the elevators that Dawn has experienced and been warned of, which creates fear and anxiety that prevents her from using them.

Dawn's concern with the elevator disrepair is not unfounded. The physical conditions of her apartment building are extremely poor. There is often garbage in the elevators and lobby and sometimes feces lining the walls and ceilings. Not a week goes by without some level of problem occurring in the building or in Dawn's unit. This usually consists of an electrical malfunction, appliance breakdown, or deteriorating paint on the walls and ceilings. In addition to the physical conditions, some of the tenants' behaviours are negatively affecting other neighbours. This includes drug use, production, and dealing; harassment; partying; mental health-related behaviours, like screaming and excessive noise; inappropriate sexual behaviours; violence; firearms possession; and housing unit takeovers. Dawn fears that she is an easy target of harassment, especially late at night, and that being in a confined elevator will prevent her from escaping any aggressive or inappropriate situations. Her anxiety skyrockets when she is forced to take the elevator, and she describes the feeling as her chest compressing and heart racing—two symptoms that exacerbate her heart condition.

Dawn's family doctor at St. Michael's Hospital referred her to the Health Justice Initiative in order to address all of the compounding issues affecting Dawn's health. Her doctor believes that Dawn's human rights have been violated, and that her health is becoming increasingly rundown because of her situation. The doctor sends Dawn to the Health Justice Initiative with a list of questions: To what extent does housing act as a determinant of health? Does the landlord have a duty to help Dawn? How can Dawn's health team and legal team work together to mitigate her negative situation? These questions felt bigger than Dawn's situation, but she was ready to get

some answers, through legal services and intermediate levels of community action, to help her situation and to prevent the same occurring to Rosa, Jeffrey and others.

### HOUSING AND HEALTH

The primary factors that influence the health of Canadians are not medical treatments, but the living conditions that they experience (Mikkonen & Raphael, 2010), i.e., the social determinants of health. Only 15% of what makes Canadians sick is because of their biology; the other 85% comes from factors such as lifestyle, access to healthcare, and the environment (Exhibit 1) (Canadian Medical Association, 2017). There are 14 social determinants of health considered in the Canadian context: income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, aboriginal status, gender, race, and disability (Exhibit 2) (Mikkonen & Raphael, 2010). Canada spends a tremendous amount of money on healthcare: in 2016, total health expenditure reached \$228 billion or 11% of Canada's GDP (CIHI, 2017). Once individuals leave healthcare facilities, they often return to conditions that made them sick in the first place. Health and illness occur on a social gradient, where a lower socioeconomic position leads to worse health. The social determinants of health expose the inequities in Canadian society and bring light to the complex and challenging problem that is healthcare.

Poor quality housing and homelessness are two crucial factors to the health of Canadians; without safe, affordable, and secure housing, health problems are a serious risk (Goering et al, 2014). Overcrowding, lack of clean water, lead and mould, pests, high costs, poor heating, inadequate ventilation, and vermin are all determinants of adverse health outcomes due to poor housing quality. Not only do these poor conditions affect health, but the stress that accompanies poor housing conditions can create negative mental health outcomes and coping mechanisms, as exemplified in Dawn's case. Furthermore, children who grow up in poor quality housing are at a greater risk of poor health throughout their lives (Mikkonen & Raphael, 2010). This is a concern for Dawn, as she grew up in social housing with compromised health, and also for her grandson Jeffrey's health. Living in inadequate housing leads children and youth to a number of negative outcomes, including aggressive behaviours, diminished school performance, asthma symptoms, and exposure to health hazards (Waterston, Grueger, & Samson, 2015).

It is difficult to link negative health effects exclusively to housing, since poverty, poor housing, and pre-existing illness are interrelated; however, it has been shown that housing on its own can cause adverse health effects. The impacts of housing on personal health and the healthcare system are evident, and, despite the apparent housing needs, Canada remains the only G8 country without a national housing strategy (Waterston, Grueger, & Samson, 2015). One in three Canadian households are in substandard housing conditions or in housing need (Waterston, Grueger, & Samson, 2015). The Canada Mortgage Housing Corporation (CMHC) helps Canadians meet their housing needs through access and affordability and has developed minimal housing standards to determine if housing is in "core need". Housing is considered to

be in “core need” (CMHC, 2017a) when it fails to meet one or more of the standards of adequacy<sup>1</sup>, affordability<sup>2</sup>, accessibility<sup>3</sup>, or suitability<sup>4</sup> (Paradis, Wilson, & Logan, 2014).

Adequate housing is lacking for low-income families, individuals with mental illness and disabilities, seniors, Indigenous people, and recent immigrants and refugees (Dean, 2016). Social disadvantages such as social exclusion, poor education, and food insecurity are correlated with inadequate housing. These social disadvantages limit social integration and a sense of community among individuals and, ultimately, reduce their quality of life. Being a part of a community is a precursor to social, economic, and health benefits.

### INTERNATIONAL HUMAN RIGHTS LAW

To have one’s own personal habitat, with peace, security, and dignity is not a privilege, but a necessity to ensure personal security, privacy, health, safety, and protection from the elements (United Nations Human Settlements Programme & Office of the High Commissioner for Human Rights, 2002). This necessity requires the international community to recognize adequate housing as a basic and fundamental human right. Since the Universal Declaration for Human Rights was adopted in 1948, the right to adequate housing has been explicitly recognized as a component of the right to an adequate standard of living in international human rights law. The strongest references to international legal rights for adequate housing are found in the Universal Declaration for Human Rights (UN Declaration) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Article 25(1) of the UN Declaration states that, “Everyone has the right to a standard of living adequate for health and wellbeing of [themselves] and [their] family, including food, clothing, housing...” (United Nations Universal Declaration of Human Rights, 1948). The right to adequate housing enshrined in the UN Declaration applies to all member states of the United Nations.

Article 11(1) of the ICESCR reads, “The States parties to the present Covenant recognize the right of everyone to an adequate standard of living for [themselves] and [their] family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States parties will take appropriate steps to ensure the realization of this right...” (United Nations International Covenant on Economic, Social, and Cultural Rights, 1976).

International pressure from the Commission on Human Rights (Human Rights Council) on the right to adequate housing resulted in the mandate of “Special Rapporteur on adequate housing” in 2002 to help clarify the scope and content for the right to adequate housing (United Nations Human Settlements Programme & Office of the High Commissioner for Human Rights, 2002). International law creates legal duties for housing rights, and any state that deprives individuals of adequate housing can be considered *prima facie* failing to perform its obligations to adequate

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<sup>1</sup> “Adequate” housing is affordable, equally accessible, habitable, and culturally adequate, with protection against threats to health (Bill C-400, 2012; United Nations High Commissioner for Human Rights, 2009). Adequate entails households that are in good state of repair, with the availability of services, materials, and infrastructure (CERA, 2006). It implies safe and secure communities (CWP, 2017) as well as security of tenure (UN CESCR, 1992).

<sup>2</sup> “Affordable” housing means that housing costs do not impede an individual’s ability to meet other basic needs (food, access to healthcare services, education, etc.) (Bill C-400, 2012). A common measure of 30% of an individual’s or household’s income before tax is used to determine if housing is considered to be affordable.

<sup>3</sup> “Accessible” housing means barrier-free accommodations for the needs of individuals who have a disability (mental or physical disability, disadvantaged by age, medical condition, visible minority, or natural disaster) in order to eliminate inequities (Bill C-400, 2012; CERA, 2006).

<sup>4</sup> Included in adequate housing is “suitable” housing, referring to National Occupancy Standards regarding the amount of space and bedrooms for the make-up of the household (CMHC, 2014).

housing under the Covenant according to the United Nations Committee on Economic, Social and Cultural Rights (“the UN committee”).

### CANADIAN LAW

Canada and all of its provinces and territories have agreed to international law supporting the right to adequate housing in the ICESCR. Yet, there are no laws at the federal level translating these Covenants into Canadian law. The Canadian *Charter of Rights and Freedoms* does not enshrine housing rights, although one might consider the right to adequate housing protected under section 7 of the Charter: right to life, liberty, and security of the person, and under section 15: right to equality (Porter, 2003; Canada Without Poverty, 2017). Furthermore, the *Canadian Human Rights Act* provides individuals equal opportunity to have their needs accommodated without discrimination or adverse differentiation, and such discrimination is applicable to the denial of residential accommodation (c.33, s.6.) (Canadian Human Rights Act, 1985).

The UN committee performs periodic reviews on the implementation of the ICESCR. The March 2016 review of Canada showed concern at the failure of the Canadian government to fulfill the progressive realization of the right to housing (Committee on Economic, Social and Cultural Rights, 2016). Concerns included the absence of a national housing strategy, insufficient funding for housing, and shortage of social housing units. The Committee urged Canada to develop and effectively implement a national strategy on housing by increasing federal and provincial resources.

### THE ONTARIO HUMAN RIGHTS CODE AND RESIDENTIAL TENANCIES ACT

For tenants like Dawn, accommodation is required in order to fulfill a happy and safe living arrangement. It is thus the landlord’s duty to accommodate these needs for Dawn and tenants, alike. Under the Ontario *Human Rights Code*, housing providers have a duty to accommodate certain needs of their tenants and to remove existing barriers to ensure the fulfillment of access to human rights (Human Rights Code, 1990; Ontario Human Rights Commission, n.d.). The duty to accommodate includes disabilities that “may be the result of a physical limitation, an ailment, a perceived limitation, or a combination of all these factors” (Centre for Equality Rights in Accommodation, 2017). The duty to accommodate includes three principles: respect for dignity, individualization, and integration and full participation. Failure of a landlord to provide accommodation in a timely manner can result in discrimination against a tenant, whether it is intended or not. For example, in Dawn’s case, her landlord should acknowledge her physical disability with the accommodation of improved elevator access to her apartment or relocation to a better-suited apartment, and above all, without discrimination.

The 2006 *Residential Tenancies Act* (RTA) provides protection to tenants from unlawful activities like evictions and provides a framework for the regulation of landlord and tenant rights and responsibilities (Residential Tenancies Act, 2017). The RTA states that “a landlord is responsible for providing and maintaining a residential complex, including the rental units in it, in a good state of repair and fit for habitation and for complying with health, safety, housing and maintenance standards” (RTA, 2006, s 20). Additionally, “a landlord shall not harass, obstruct, coerce, threaten or interfere with a tenant” (RTA, 2006, c. 17, s. 23).

Both the *Human Rights Code* and the *Residential Tenancies Act* can be emphasized in advocacy arguments for individuals’ rights. Many groups and organizations fighting to maintain and realize their right to housing hone in on Acts, such as these, to use legislation and policy to win tenancy arguments against positions of power, like landlords or housing corporations. Through leveraging the Code and Act, tenants like Dawn can use advocacy to make positive impacts on their physical and mental health.

### FEDERAL BILLS ON HOUSING

There have been failed attempts in the past to develop explicit housing rights in Canadian legislation. Canadian politicians have brought forth private members' Bills seeking to ensure secure, adequate, accessible, and affordable housing for Canadians (Parliament of Canada, 2010). For examples, Bill C-304 was defeated in 2011 and Bill C-400 in 2013. The Bills set out requirements to establish a national housing strategy that would respect, protect, promote, and fulfil the right to adequate housing, and its accessibility to individuals with disabilities and vulnerable groups, as it is guaranteed under international human rights treaties that Canada has ratified.

### CANADA MORTGAGE AND HOUSING CORPORATION

The government of Canada, through CMHC, works to improve access to affordable housing through federal funding. CMHC is governed by a board of directors and is accountable to Parliament through the Minister of Families, Children and Social Development (CMHC, 2017b). The Minister works with the Minister of Infrastructure and Communities to develop a national strategy for the Federal Government in supporting affordable housing. The legislative framework governing CMHC consists primarily of three Acts: the *Canada Mortgage and Housing Corporation Act* (1985), the *National Housing Act* (1985), and the *Financial Administration Act* (1985).

CMHC, on behalf of the Government of Canada, invests around \$2 billion annually for housing need in Canada (CMHC, 2017a). As part of the \$2 billion investment, CMHC provides federal funding for housing to provinces and territories under the Investment in Affordable Housing (IAH). IAH funding aims to increase the supply of affordable housing across Canada, improve and preserve its quality, and improve housing affordability for vulnerable Canadians.

### TORONTO COMMUNITY HOUSING CORPORATION (TCHC)

TCHC is Canada's largest public housing agency (Toronto Star, 2011). TCHC is an agency of the City of Toronto and is funded by Toronto and the Government of Ontario. The administration of housing in Canada is the responsibility of municipalities, leaving TCHC to administer all public housing units within the City of Toronto. TCHC has over 58,000 units and 164,000 tenants across Toronto. These tenants are split up into 2,100 buildings, including high-, mid-, and low-rise apartments, townhouses, and homes (Toronto Community Housing Corporation, 2017a). The tenants have various payment methods, including rent geared to income, market-level rents, and subsidized rates.

The large size of TCHC makes it difficult to respond adequately to tenant needs. It is estimated that 5,000 units is an appropriate size for a public housing agency; however, TCHC consists of 58,000 units (Ridgway, 2016; Mayor's Task Force on Toronto Community Housing, 2016). Ever since the formation of TCHC in 2002, there has been a backlog of necessary housing repairs in the buildings (Côté & Tam, 2013). In order to meet the high price tag of the needed repairs, TCHC started selling off units and assets in 2011. Between 2013 and the end of 2016, TCHC spent \$911 million on repairs (Pagliaro, 2017a). This money was mainly the result of refinancing both TCHC mortgages and city loans and not funding from the city (Exhibit 3).

In 2017, the funding crisis only got worse. Premier Kathleen Wynne's provincial government cancelled \$150 million in annual funds. Although Prime Minister Justin Trudeau's federal government has committed to reinvesting in social planning, details of how the money will flow are still unknown. The uncertainty of funding has led TCHC to consider closing 1,000 units by the end of the year, which would relocate families and add to the already long waitlist of 181,000 people looking for affordable housing. If funding fails to materialize within the next five years,

half of TCHC buildings will be in “critical” condition, based on their standard ranking scale (Exhibit 4) (Pagliaro, 2017b). The Facility Condition Index (FCI) is a percentage of the cost for repairs versus the cost to replace buildings (TCHC Board Meeting, 2015). An FCI of 5% is good condition, between 11% and 30% is poor, and over 30% is critical. Poor to critical FCI indicates the building’s condition has a negative impact on the residents’ quality of life. Over 3,000 individuals live in “critical” units, and, out of 364 developments, 222 of them are in “poor” condition (Pagliaro, 2017b). TCHC has \$438 million worth of repairs to do in the next year in order to stay on target of the \$2.6 billion 10-year plan (Exhibit 4) set out by the city in 2013 to improve affordable housing. Currently, TCHC is \$350 million short.

The required repairs in TCHC properties are much more than fixing broken fridges and chipped paint (Exhibit 5); the foundations of buildings are crumbling, plumbing has failed, and roofs are leaking so much so that tenants require umbrellas indoors in order to walk up the stairs to their units. As exemplified in Dawn’s case, the poor living conditions ultimately take a toll on an individual’s mental and physical health.

Moreover, a lesser-publicized, but very serious harm to TCHC and social housing tenants are Housing Unit Takeovers (HUTs). HUTs threaten housing stability as unwanted parties commandeer tenant units (Weissman, 2016). 86% of HUTs occur in public housing and supportive housing, affecting the most vulnerable tenants: for example, individuals with physical or mental illnesses or addiction, single working mothers, and elderly and low-income individuals. Housing predators manipulate tenants physically and/or emotionally, sometimes by offering economic support, and take over a unit for drug trafficking, violence and sex, and other uses. Nearly two thirds of the time, predators are acquaintances of the tenant (Butera, 2013). Part of the reason HUTs are so common in public housing is due to the disrepair existing in TCHC units. Predators can easily enter ground floor units through damaged windows or enter high-level apartment units due to a lack of security or landlord response to tenant concerns. HUTs often go unreported due to fear of stigma or violence from neighbours and predators and a lack of education or awareness. It is imperative to advocate for the support for vulnerable tenants to make services and aid available. Advocacy groups, such as The Dream Team, perform research and education on supportive housing and HUTs. Their efforts have initiated projects like Safe at Home, where the community is involved in crime prevention and advisory support at an impactful intermediate level in supportive housing research (Weissman, 2017).

### **DAWN’S DECISION**

Dawn has been living in unacceptable conditions for several years, and these conditions have caused negative health effects. Unsure of how to improve her situation, she has come to Julia at the Health Justice Initiative for help. Julia discusses Dawn’s options on how to proceed.

Dawn has the option to make arguments about her human rights at the Ontario Human Rights Tribunal or at the Landlord and Tenant Board. Dawn needs evidence to prove that she has experienced discrimination. Julia believes that Dawn has a valid human rights argument that could either hold at a hearing, or at the very least, bring awareness and give a voice to Dawn. How would she argue the urgency for Dawn’s deteriorating physical and mental health? Julia does note that the tribunal process has the potential to cause anxiety for Dawn, and with her already fragile mental health state, would this route be the best option for Dawn?

Dawn’s health is the top priority in the case at hand, and her housing is adversely affecting this. Since housing is such an important determinant of health, how should Dawn go about improving her health during this process? How can Dawn’s physician be involved in this case?



### **ALTERNATIVE: ADVOCACY**

Although Julia is going to work to achieve a legal remedy for Dawn, she also suggests that Dawn join a tenant advocacy group. Affordable social housing struggles for government funding; there is not enough funding to build new units, and hardly any is given to updating and improving existing TCHC units. Due to funding shortages, alternative solutions to money are necessary for tenants to receive a remedy for their unliveable situations. Advocacy is one such route to improve the conditions for TCHC tenants. Systemic advocacy seeks to influence government policy and community attitudes through advocates sharing information and experiences. One such organization, the Advocacy Centre for Tenants Ontario (ACTO), works to improve the housing situation of Ontario residents, including low-income tenants (ACTO, 2017).

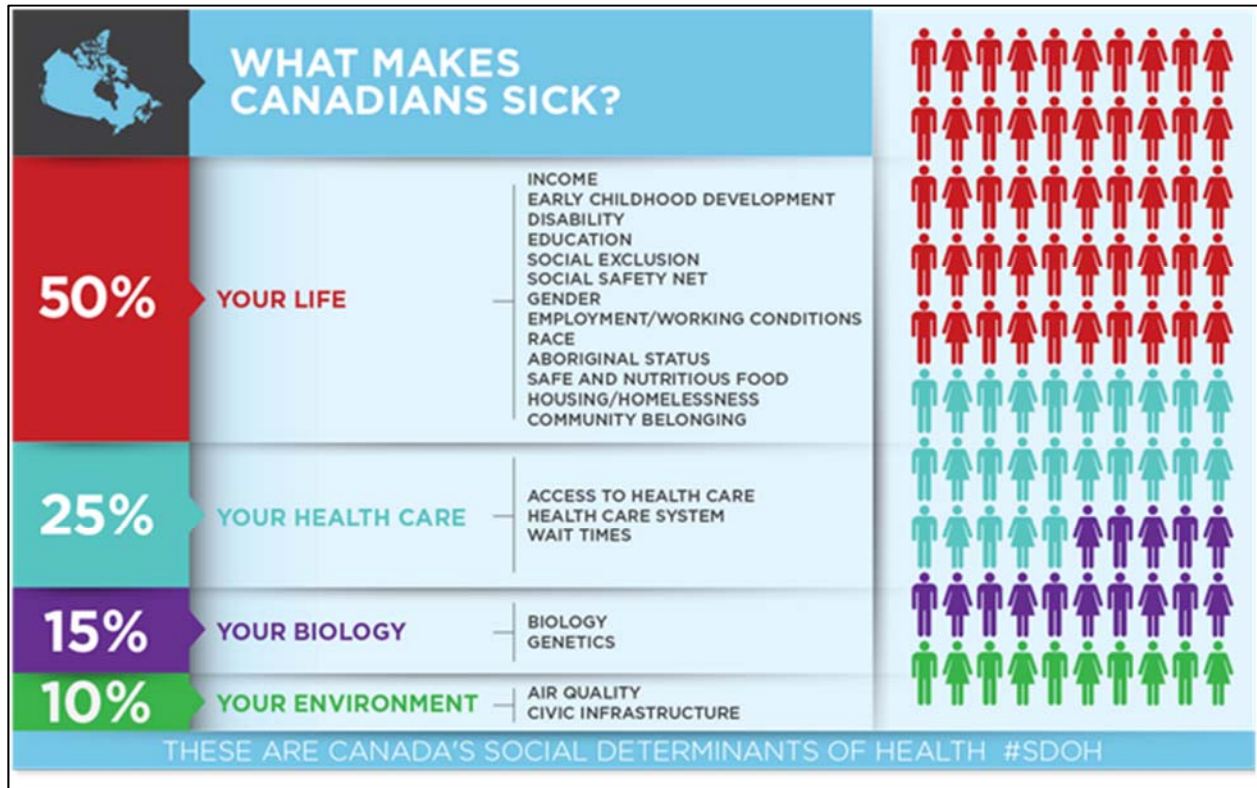
By creating partnerships with different interest groups and stakeholders, advocacy has the ability to make systematic change, at all levels, for housing rights. Julia has a list of tenant advocacy groups and Toronto housing organizations that participate in advocacy. How can Dawn get involved in these groups to successfully bring her voice to the table in order to create change? What can tenants do to advocate for change to TCHC housing conditions?

### **CONCLUSION**

If Dawn continues to live in her current situation, her physical and mental health will continue to deteriorate. Julia is going to try to bring awareness to the situation and remedy Dawn's housing case. It is clear that such a complex case for Dawn's housing, health, and human rights will not be an easy fix. If her housing doesn't improve, Dawn and Julia know that Dawn's health will suffer. How can they effectively use the medical-legal partnership for Dawn's situation?

Dawn and Julia want to get this solved as soon as possible and aim for an end-of-the-year deadline. So with the start of the appointment, Dawn and Julia begin their uphill battle to fight for human rights.

EXHIBIT 1  
What makes Canadians sick?



Source: Canadian Medical Association, 2017. Reprinted from Health equity and the social determinants of health, Canadian Medical Association Journal. © Canadian Medical Association 2017. This work is protected by copyright and the making of this copy was with the permission of the Canadian Medical Association Journal ([www.cmaj.ca](http://www.cmaj.ca)) and Access Copyright. Any alteration of its content or further copying in any form whatsoever is strictly prohibited unless otherwise permitted by law.

EXHIBIT 2  
The Social Determinants of Health

Figure 1.1 A Model of the Determinants of Health

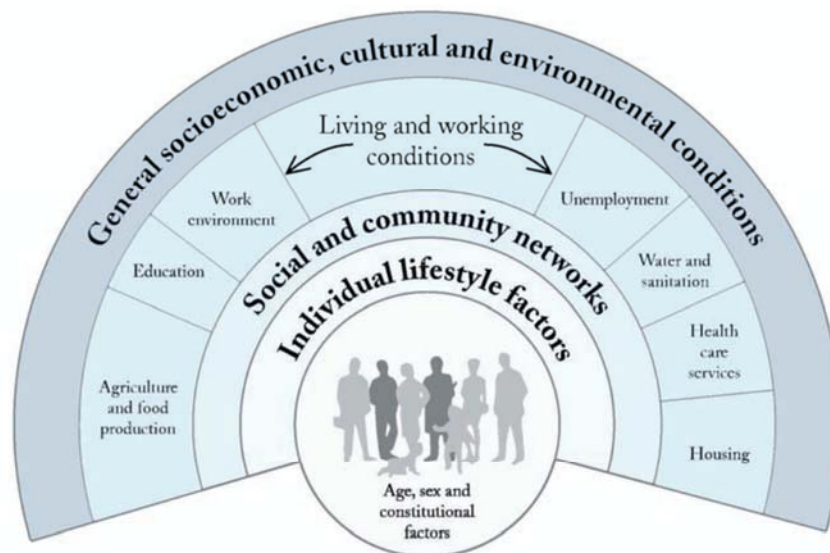
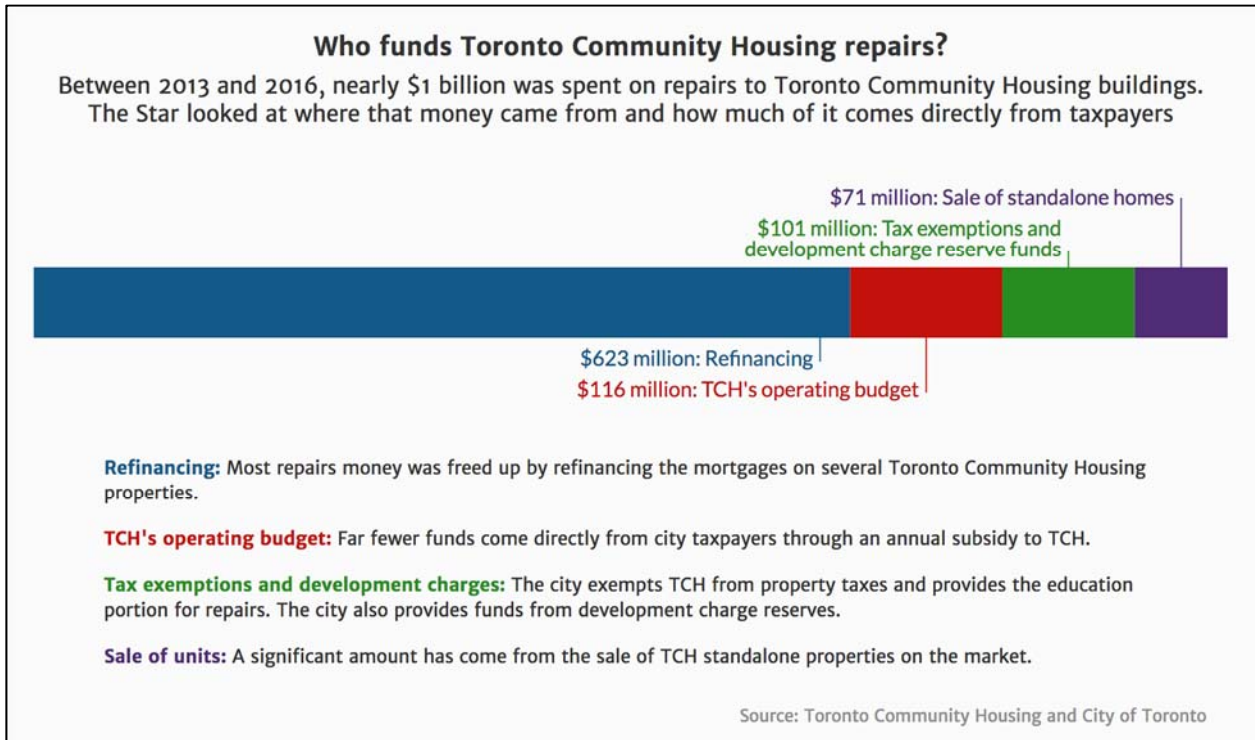


Figure shows one influential model of the determinants of health that illustrates how various health-influencing factors are embedded within broader aspects of society.

**Source:** Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

Source: Mikkonen & Raphael, 2010.


EXHIBIT 3  
TCHC Funding




Source: Pagliaro, 2017a.

**EXHIBIT 4**  
**TCHC 10-year Capital Plan**


TCHC by the Numbers




**2154**  
**Total number of buildings owned by Toronto Community Housing.**  
841 single family homes, 86 multi-units homes and 1227 apartment and townhome buildings.



**42 years**  
**Average age of Toronto Community Housing buildings.**  
More than 1000 buildings are over 50 years old, while only 2 per cent (23 buildings) were built within the past 10 years.



**\$2.6 billion**  
**Total amount needed for capital repairs over 10 years.**  
To date, Toronto Community Housing and the City of Toronto have secured just over one-third of this funding, \$919 million.



**\$1.73 billion**  
**Funding shortfall for capital repairs.**  
We are working with the City of Toronto to call upon the Provincial and Federal governments to invest in our vital housing infrastructure.

Secured Funding (unaudited June 2017)

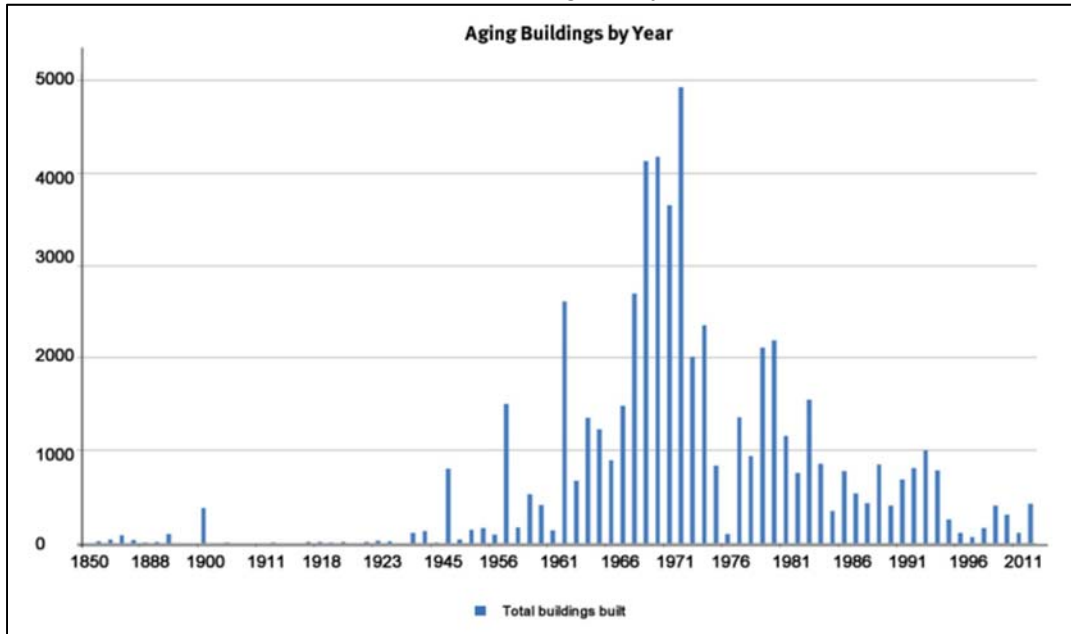
	Annual Capital Repair Funding Over 10 Years (Operating Budget)	\$296-million
	Property Tax Exemption Over 10 years	\$90-million
	Development Charge Reserve Allocation	\$10-million
	Sale of Stand Alone Units	\$78-million
	City loans refinancing	\$33-million
	Mortgage Refinancing	\$786-million
<b>TOTAL:</b>		<b>\$1.239-billion*</b>

EXHIBIT 4 (cont'd)

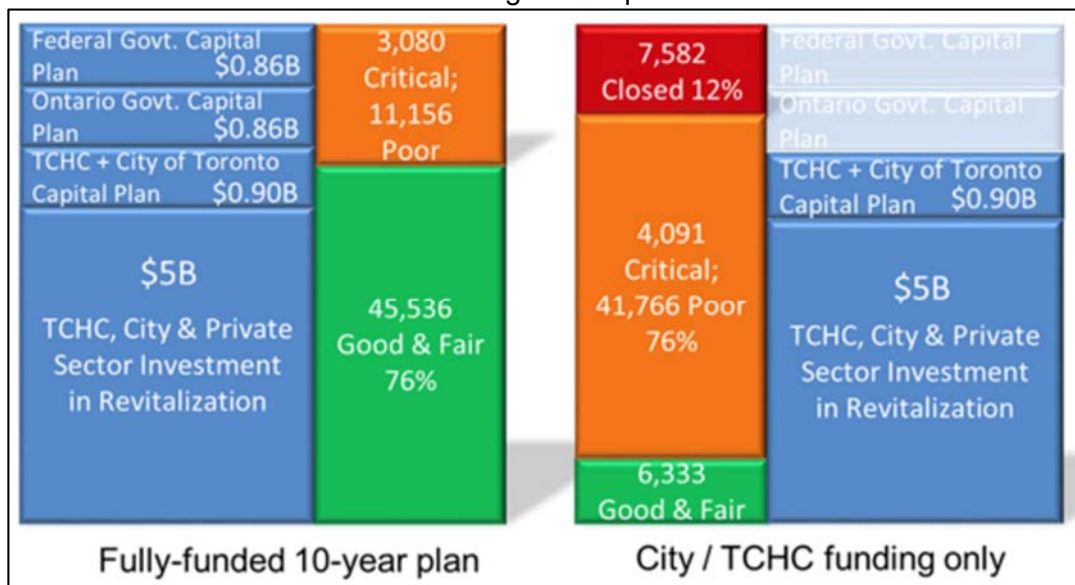
Missing Funding

● Government of Canada	\$864-million
● Government of Ontario	\$864-million
<b>SUB-TOTAL: \$1.728 billion</b>	

TCHC Building Lifecycle



No Funding Consequences



Source: Toronto Community Housing Corporation, 2017b.

**EXHIBIT 5**  
**Toronto Community Housing Disrepair Photographs**

“Toronto Community Housing: Thousands of units could close due to lack of cash for repairs”



EXHIBIT 5 (cont'd)



Source: Cheung, 2016.

“Task force recommends shakeup at Toronto Community Housing”



Source: Torstar News Service, 2016.



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## INSTRUCTOR GUIDANCE

### Housing and Health: A Human Rights Approach to Wellbeing

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#### BACKGROUND

The Health Justice Initiative medical-legal partnership serves clients experiencing human rights violations, especially related to housing. Through the provision of legal services, education, and systemic advocacy, it aims to improve clients' care, health, and wellbeing. The current case revolves around a client and her many health struggles, amplified by her unliveable Toronto Community Housing Corporation (TCHC) unit. Like many TCHC units, it is in extreme disrepair and unlikely to change due to TCHC's funding shortage. The client is physically unable to take the stairs to her apartment due to a heart condition and mentally unable to take the elevator due to anxiety. It is necessary to transfer her to a low-rise building imminently, as her mental and physical health is deteriorating in her current situation. In efforts to restore the situation, a family physician refers the client to the Health Justice Initiative to explore the legal remedies available and to learn how the health team and legal team will work together to mitigate the situation. By applying knowledge of the social determinants of health, human rights, and housing law, a solution can be established to improve the client's health.

#### OBJECTIVES

1. Discuss the importance of housing as a social determinant of health and create definitions for adequate, accessible, and affordable housing.
2. Identify advocacy and policy windows to create change in the TCHC housing crisis.
3. Understand the usability of international housing law and the Human Rights Code to develop a human rights argument for TCHC tenant cases.
4. Understand the implications of international human rights treaties on Canadian federal legislation and the Canadian *Charter* in relation to housing and human rights.
5. Discuss the roles of a medical-legal partnership in public health and what other stakeholders are necessary to partner with in health and housing.

#### DISCUSSION QUESTIONS

1. Why is housing important to health? What are implications of poor social housing conditions?
2. Can economic, social, and cultural rights be litigated in court for housing policy? How do international and national treaties bind their parties?
3. Why is a national housing strategy important?
4. Develop a list of stakeholders necessary to create adequate, accessible, and affordable housing.
5. Brainstorm the ways in which housing policy and public health policy could be linked.
6. How can a medical-legal partnership leverage health-related policies?

#### KEYWORDS

Human rights; housing rights; social determinants of health; social housing; law.



## CASE 13

### The Abokobi Open Dump

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*Matthew Tersigni, HBSc, MPH (MPH Class of 2017)*

*Reginald Quansah, PhD (Assistant Professor, School of Public Health, University of Ghana)*

*Amardeep Thind, MD, PhD (Professor, Western University)*

Luca Parente got off the plane in Accra, the capital city of Ghana. His coworker, Charles, picked him up and gave him a tour of the city. Besides the overwhelming heat, Luca was struck by the amount of waste in the street. Accra utilized an open gutter system, meaning that everything from rain water to plastic bags and spoiled food collected in the gutters. Charles explained to Luca that the gutters sometimes clogged during the rainfall season due to the plastics that were dumped in the gutter. This resulted in the flooding of the surrounding area. In the hot sun, the smell of the gutters was unpleasant, and he felt grateful for the sewer systems in Ontario.

#### THE BURDEN OF WASTE

The World Bank approximates that every year humans produce roughly 1.3 billion tonnes of municipal solid waste (MSW), or roughly 1.2kg per person, per day. MSW includes the everyday garbage that comes from used items that are then thrown away, such as packaging, batteries, paint, paper, etc. However, excrement, air pollution, waste water, and other similar byproducts are not included. The World Bank predicts that each consecutive year we produce more waste than the one before, at a rate where the total amount of global waste production per year will double by 2025 (World Bank, 2012). Such an estimate means that the average amount of waste produced by each person, each day will grow to 1.42kg. These trends are the result of an increasing global population and standard of living.

Generally, waste production is dependent on economic development, degree of industrialization, societal habits, and the local climate of a nation. Some of these factors have more influence than others. Specifically, as a population transitions from low income to middle income to high income, the amount of waste produced is expected to increase. High and upper middle income individuals generate roughly 65% of global waste, while only composing 16% of the global population (Kochhar, 2015; World Bank, 2012). Conversely, low and lower middle income individuals produce 35% of global waste, while composing 84% of the global population (Kochhar, 2015; World Bank, 2012). Therefore, as countries continue to develop and populations move away from rural to urban communities, the amount of waste that is generated is expected to increase.

To respond to the growing amount of waste, countries must employ waste management systems to collect, segregate, dump, and recycle waste. The rate of waste production has outpaced the implementation of waste management systems in many developing countries, leaving roughly 2 billion people worldwide without adequate waste collection services (International Solid Waste Association, 2012).

In 2012, the United Nations estimated that societies who inappropriately manage their waste could expect to spend roughly five to ten times more than if an appropriate waste management system were put in place. Many of these costs come in the form of health care, lost productivity,

## The Abokobi Open Dump

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and damages to local businesses. For example, uncollected waste is a significant public health hazard, shown to result in respiratory (e.g. pneumonia) and gastrointestinal infections (e.g. cholera and E.coli), which significantly increases the use of health care services (International Solid Waste Association, 2012). From an environmental perspective, unmanaged waste produces biological toxins resulting in the contamination of land, seawater, groundwater, and freshwater. Many communities in developing countries resort to the open burning of waste to manage the quantity and smell. Such practices contribute to local air pollution, discourage tourism, and hurt local businesses (International Solid Waste Association, 2012).

Many African countries have a linear economy. This means that products are produced, consumed, and then dumped. A circular economy, like those of many countries within the Organization for Economic Co-operation and Development (OECD), ties the ends of production and dumping together with recycling. To move towards a circular economy, significant investments must be made by governments to incentivize the recycling of particular materials, especially scrap metal and plastics.

Ghana's waste management services are unable to keep up with a growing economy, where citizens are transitioning from low income to middle income lifestyles. While the majority of waste produced in Ghana is organic, production of plastic waste is significantly increasing (Yoada, Chirawurah, & Adongo, 2014). In Ghana, large scale recycling remains an uncommon practice, with only a few composting and recycling companies operating in some of the nation's major cities. Much of the recycling in Ghana occurs at a community level by informal waste workers. These waste workers, or scavengers, collect plastics and metals from dumps and then sell it to independent organizations for below market price.

### WASTE MANAGEMENT SYSTEM IN ACCRA

Luca, a recent Master of Public Health (MPH) graduate, was looking forward to starting his new job at an environmental advocacy group in Ghana called Treesus. Treesus promotes environmental protection and lobbies governments and organizations to prioritize environmentally conscious projects, while still encouraging local economic development. Particularly, Treesus excels at bringing together multiple stakeholders and developing meaningful relationships with decision-makers and investors. The organization's goals were aligned with Luca's own goals, which involved bettering the environment. Luca had extensive experience working in the Solid Waste Management sector in Southern Ontario and had completed his undergraduate degree in civil engineering at the University of Toronto. Luca took the job in Accra, because he believed it was a good opportunity to make an impact while gaining international experience and an opportunity to travel.

Accra is the capital city of Ghana, a small West African country bordered by Togo and Cote d'Ivoire. Ghana's population totals roughly 27 million people, yet has a landmass of 238,535 square kilometers, making it one of the denser African countries. In 2011, Ghana had a GDP equivalent to \$39.15 billion USD, a third of which comes from agriculture (Quansah et al., 2016). Accra is part of the Greater Accra Region with a population of roughly 4 million and a GDP per capita of about \$1,695 USD, making it one of the most financially successful regions in Ghana (Jones Lang LaSalle, 2016; Ghana Statistical Services, 2012).

Ghana had updated its environmental sanitation policies in 2010, hoping to accelerate its progress towards achieving the Millennium Development Goals (MDGs). Specifically, for MSW, Ghana utilized a 'polluter-pay' principal, meaning those who created waste had to pay for it. While this intended to create an equal playing field, many individuals could not afford to pay for waste collection or simply opted not to. Estimates found that roughly 76% of households in

## The Abokobi Open Dump

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Ghana utilized improper waste disposal methods such as open dumping or burning. Only about 5% of homes had their waste collected by a formal waste management organization (Government of Ghana, 2012). Part of the problem was that the 5% of homes, who were generally middle to upper class, set the prices of collection for an entire area, resulting in fees too high for the adjacent, lower income households.

Accra also faced an insufficient number of treatment and disposal sites. This exacerbated the problem of implementing house-to-house collection, as waste management companies had to pay elevated prices at disposal sites. Treatment facilities, such as composting or recycling sites, were scarce and high in demand. The recycling companies that did operate bought recyclable material from waste collection companies. This provided a two-fold benefit to waste management companies, since they received a small profit for providing their recyclables and reduced the fees paid to disposal sites since fewer materials needed to be dumped. However, most recycling is still done informally through scavenging. Scavengers in Accra are self-employed individuals who enter open dumps in search of material that can be resold to private organizations. Most commonly, scavengers gather scrap metal for local smelting companies. They also collect and sell plastics.

Overall, the performance of Accra's waste management system is poor. Most individuals cannot afford proper waste collection and are forced to indiscriminately dispose of their waste. Others use common dumping places or open burning. Waste on roadsides is very common, with plastics accounting for a large proportion. The accumulation of plastics in gutters leads to clogging and consequent flooding, resulting in damage to infrastructure and pools of water for vector-borne diseases (Government of Ghana, 2012).

### WASTE MANAGEMENT IN CANADA

Luca was very familiar with the waste management system in Canada, after working as a sanitation engineer for a drainage and sewage company and as an engineer for the municipal government for 3 years before completing his MPH degree. As of 2006, roughly 93% of households in Canada had access to one form of recycling program, and about 97% of these homes used at least one program (Statistics Canada, 2007). Theoretically, this means that household waste is being transported away from the home and is separated from recyclable material. While Luca was aware that Canada performed better than Ghana in this regard, he knew the Canadian waste management system had several flaws.

Canada ranks at the bottom (17<sup>th</sup> out of 17) when comparing its waste generation to other OECD countries (Exhibit 1). Canada produced approximately 25 million tonnes of waste in 2010, costing about \$2.9 billion to adequately manage it (about 9% of Ghana's GDP in 2010) (Giroux Environmental Consulting, 2014). The fact that only 27% of waste in Canada is diverted from a landfill to either a recycling plant or a compost facility reduces Canada's waste score significantly (Statistics Canada, 2007). Recycling only a quarter of waste is considerably low, especially compared to European states such as Sweden, which recycles 50% of its waste, or Germany, which recycles 65% (OECD, 2015).

### THE ABOKOBI OPEN DUMP

The focal point of Luca's work in Accra is the Abokobi open dump (Exhibit 2) and its environs, which began operation in 2003. As it was described to him, the Abokobi dump site is a large open dump roughly one kilometer in diameter. Open dumping is very primitive and unscientific, although it is easy and economical in the short term. The dump resides in the Abokobi community, which is on the border between the Ga East Region and the Accra Metropolis (Exhibit 3) and receives over 8,150 tonnes of waste per month. As with many of the open



## The Abokobi Open Dump

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dumps in Accra, they are not properly engineered to prevent contamination and leachate runoff. Leachate runoff is dangerous to the surrounding environment, often polluting the surrounding land and making its way into adjacent aquifers (Majumdar et al., 2014). While Luca was not aware of the full extent of the dump's pollution, he knew that people in the surrounding area gathered water from nearby wells or bore holes. He wondered how he could estimate this data and determine if, or how many of, the local water sources were polluted.

To exacerbate the problem, the dump was intended to be temporary and was not initially projected to handle so much waste. Luca learned from talking with workers that the dump site was initially a large hole, despite it being over 60m tall now. To ensure there is adequate room, condensers run day and night compacting waste. Waste is burned to help eliminate many of the odours, but burning creates toxic fumes that blow into the surrounding community for several weeks at a time.

As Luca walked around the dump, he could feel his lungs get heavy as he breathed in. He noticed many of the workers only had a thin cloth over their mouths to filter the smoke. Many of the workers did not look like they were wearing any protective equipment besides gloves or overalls. He also noticed scavengers who wore almost no protective equipment and displayed cuts around their legs and wrists; some even wore open-toed shoes and shorts. The material they collect and sell to private companies is often sharp or jagged, such as tin cans, scrap metal, and broken plastic containers.

### HEALTH HAZARDS OF LIVING BESIDE AN OPEN DUMP

Luca wondered what the health effects were of living beside the Abokobi open dump. He began a literature scan and found that the evidence of the public health consequences of living adjacent to an open dump site was limited; the main reason was a lack of consistency concerning what constitutes an open dump, regarding its size and the type of waste dumped there (WHO, 2000). Despite this fact, there are negative health outcomes, especially in children, such as increased respiratory stress and chronic diarrhea, that have been observed and replicated in scientific literature. Many of these effects are amplified due to dumps being placed in poor or marginalized communities (Palmiotto et al., 2014). Often these communities have lower levels of access to medical services as well as decreased education and health literacy (Wilson, Velis, & Cheeseman, 2006).

Many of the chemicals found in the air surrounding a dump or released during open burning are hazardous to an extent. Volatile Organic Compounds (VOCs) are present in fumes, and many are carcinogens or capable of producing other serious health effects. While no study showed a definitive causal link between living beside an open dump and increased cancer rates, the levels of VOCs in the air were often above an accepted threshold (Majumdar et al., 2014). Other chemicals found in dumps result in the formation of a tropospheric ozone that when inhaled, even in low amounts, can cause chest pains or respiratory stress (Majumdar et al., 2014). Heavy metals are also present in most MSW, often in the form of plastics. Determining the levels of cadmium in fumes is important, especially considering its role as an immunosuppressant (Schoeters et al., 2006).

Luca was very worried about the impact of such a cocktail of chemicals on children. He found evidence of congenital abnormalities, low birthweights, and chromosomal abnormalities in communities living close to dump sites (Porta, Milani, Lazzarino, Perucci, & Forastiere, 2009). Children living close to high concentrations of waste had almost three times the incidence of diarrhea – one of the major killers of children under five (Shibata et al., 2015). Chronic exposure

## The Abokobi Open Dump

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to odors, especially beginning at a young age, is also associated with anxiety, dermatological problems, and increased rates of asthma (Palmiotto et al., 2014; Porta et al., 2009).

Luca wondered what to make of this data. While much of it was inadequate to make definitive scientific conclusions, he felt that there was enough evidence to support the fact that the Abokobi dump may affect the community's health. He also wondered whether the lack of data was because of a lack of research. He noted that many of the communities living beside open dumps were in lower income areas with few research institutions.

### THE GA EAST MUNICIPAL ASSEMBLY

Luca knew that the decisions pertaining to the dump, and future matters involving waste, were determined by the local municipal assembly in the Ga East district of the Greater Accra Area. Like municipal governments in Canada, divisions of the municipal assembly manage water, sanitation, and other environmental concerns (Government of Ghana, 2012). The municipal assembly is also responsible for responding to public inquiries and complaints.

The municipal assembly responsible for the Abokobi dump was much more disorganized than what Luca encountered back in Toronto. Luca had planned a meeting with members of the local government, but waited several hours before discussing the dump with any official. Most of his time was spent shaking hands and introducing himself. Once Luca began describing the work he was trying to do, he was quickly referred to another office in the government building. Eventually Luca ran into Mr. Spong, an assistant to the Assemblyman of Environmental Health in the Ga East district. Mr. Spong was first introduced to Luca by Charles, who was a longtime friend. A frustrated Luca asked why no one cared to listen to his story.

Mr. Spong explained to Luca that no one in the municipal assembly trusted Luca and his intentions. "You can't just come in here and start asking difficult questions that can get people fired. No one and everyone is to blame for the dump. We all let it happen, but no one wants to take responsibility. Once someone starts answering your questions and explaining the process to you, they start taking responsibility, and no one wants that. No one is going to risk a good government job for someone they don't know, especially a foreigner."

Luca tried to explain to Mr. Spong that the longer this problem went on the worse it was going to get. He explained the literature he found and the negative health consequences that come from living beside an open dump. Despite his sincere petitions, Mr. Spong revealed another layer of complexity. "You think we don't know that? We get calls every day from people complaining, but even if someone was willing to help, you couldn't just change it. Half the people here are making money from the dump, either because they get to make big contracts with waste management companies, or they are paid by those companies to let things slide. The waste management companies always pay on time, and treat everyone here very well. You don't get that treatment every day."

Luca left the municipal assembly less optimistic than when he entered. It seemed that the local government was very much at the behest of the large waste management companies.

### THE ABOKOBI COMMUNITY

The surrounding Abokobi community is a heterogeneous population. Luca noticed that most of the homes were small wooden structures with only a few brick houses with power lines running to them. It was difficult for Luca to make any further assertions about the community without talking to some of the members.

## The Abokobi Open Dump

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Mr. Quacoe, one of the local community leaders, explained that many of the citizens were employed but had limited access to electricity. Moreover, while most children were in school, many of the parents and grandparents had little education past elementary school. There was a general feeling in the community that they were being taken advantage of by the waste management companies using the dumpsite. Mr. Quacoe recalled one of the discussions he had with a nearby resident: “It’s making us sick, we have to live every day beside the dump breathing in the toxic air, meanwhile the people who own the dump get rich. They get everything, and we get nothing.” Individuals felt that waste management was also the responsibility of local governments, and that Assembly Members (the legislative officials in Ghana) were not doing their best to put the interests of the community first. Mr. Quacoe explained how this opinion was not uncommon, but it was not the only perception of the dump either.

Father Solomon, a pastor at the local Presbyterian church, was an influential member of the community and had his finger on the pulse of the community. “Many people are angry, but many people are happy too. The dump has employed many people and has brought business to the surrounding shops. The government has even started repairing nearby roads so that the dump trucks break down less frequently.” Father Solomon explained that individuals wanted support to make sure that they would be healthy and that their children would grow to live long lives.

### WASTE MANAGEMENT COMPANIES

Various organizations operate in Accra’s lucrative waste management sector. Waste management companies often fill a large gap in services, since municipal assemblies lack the capacity to manage waste on their own. However, upon entering the waste management market, many new companies face significant taxation and require large amounts of capital investment. To operate in a municipality, waste management companies must also pay monthly fees. These conditions require companies to prioritize profit, rather than quality service, from the outset if they wish to operate. As a result, it is common for waste companies to ignore poor neighbourhoods, since most individuals cannot afford the price of collection. Waste managers provide high income neighbourhoods with higher quality services, but these neighbourhoods still suffer from inconsistent collection due to problems such as a shortage of garbage trucks.

More established, financially stable waste management companies, such as those operating the Abokobi dump, find themselves in a different predicament. Some have adopted a strong sense of corporate social responsibility, since it buys them significant favour with the local municipal assemblies. Established organizations will fund think tanks or provide significant financial aid to support community health interventions. While this practice is uncommon, bribery is common. Other larger waste management companies in Accra often pay politicians or municipal assemblies sizeable amounts of money to operate in wealthier neighborhoods or avoid penalties for not adhering to their contracts. Either case makes it difficult to adequately regulate and enforce policies. Luca wondered how he could work with organizations that generally did as they pleased.

### IMPORTANT MEETING

At the end of the week, Treesus will hold a workshop in the Accra Metropolis district and invite the Municipal Assemblymen who are responsible for environmental health and sanitation in Accra. Treesus also invited several of the major solid waste management companies. Three of the waste management companies – Waste Giant, Meko, and Speedy Waste – all use the Abokobi open dump and had confirmed their attendance. Luca will give a presentation at the workshop to describe some of the strategies Canada and other countries use to manage and reduce the amount of solid waste they produced. Luca knows this is a good opportunity to

## The Abokobi Open Dump

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describe the economic and health benefits of implementing an effective waste management system, such as transitioning Accra from a linear to closed-loop economy.

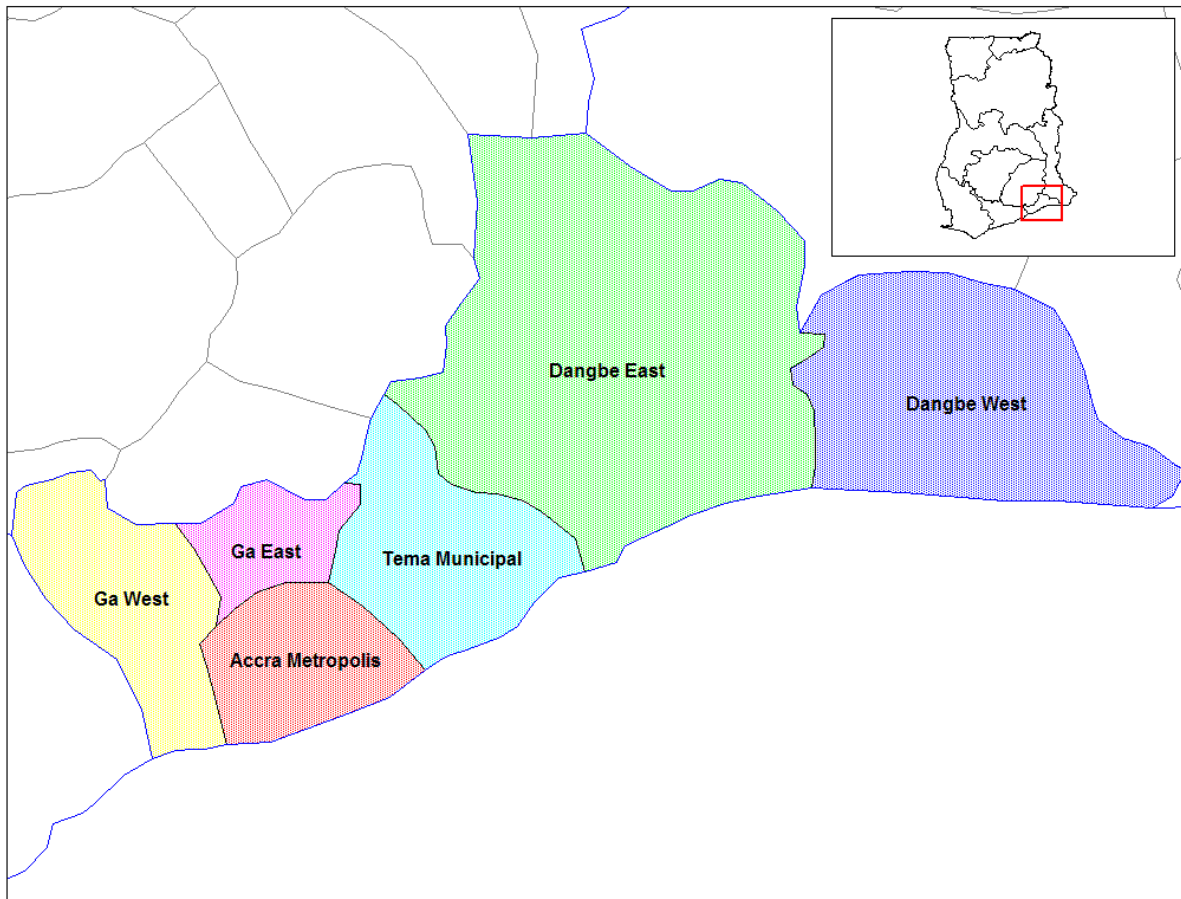
Luca debates what is a more productive presentation. He wonders how much stakeholders know about other waste management systems in other parts of the world? He even wonders if Treesus knew how poorly Canada's waste management systems ranks compared to other countries in the OECD. Luca has a couple of days to prepare his presentation but is unsure how much knowledge or what biases his audience will have.

Luca considers presenting the waste management system in Canada while also presenting its shortcomings. Providing the whole picture will allow Accra to learn from some of Canada's mistakes. Transitioning to a more advanced waste management system is also appealing, especially considering that he knew Ghana's desire to achieve the Millennium Development Goals. However, Luca wonders if a waste management system that relies heavily on landfills is an attractive option in Accra. Would he convince the government and corporate officials that more landfills, despite their costs, are still a better option compared to open dumping? How aware of this are they already? Furthermore, much of Canada's recycling stream relies heavily on households segregating their waste from recyclable materials, a non-existent practice in Accra. Would officials interpret the presentation as an achievable ideal or would they find it unrealistic in a resource restrained country?

Alternatively, Luca thinks about giving a strengths-based presentation. While households in Accra do not separate their recyclable materials, there is a large population of informal waste workers who do. By augmenting or formalizing the existing forms of waste separation, Accra could utilize existing methods to close the ends of its linear economy. Would officials consider this strategy as moving away from the Millennium Development Goals? Would waste management companies feel comfortable with a formalized waste scavenger system operating in their dumps? Could Luca create a convincing strengths-based presentation, while still promoting some of the beneficial waste practices Canada performs? Would Treesus be comfortable with a presentation that strays from its original purpose? Should Luca just present what is expected of him? What are the pros and cons of each of his presentations, and what option should Luca present at the workshop?

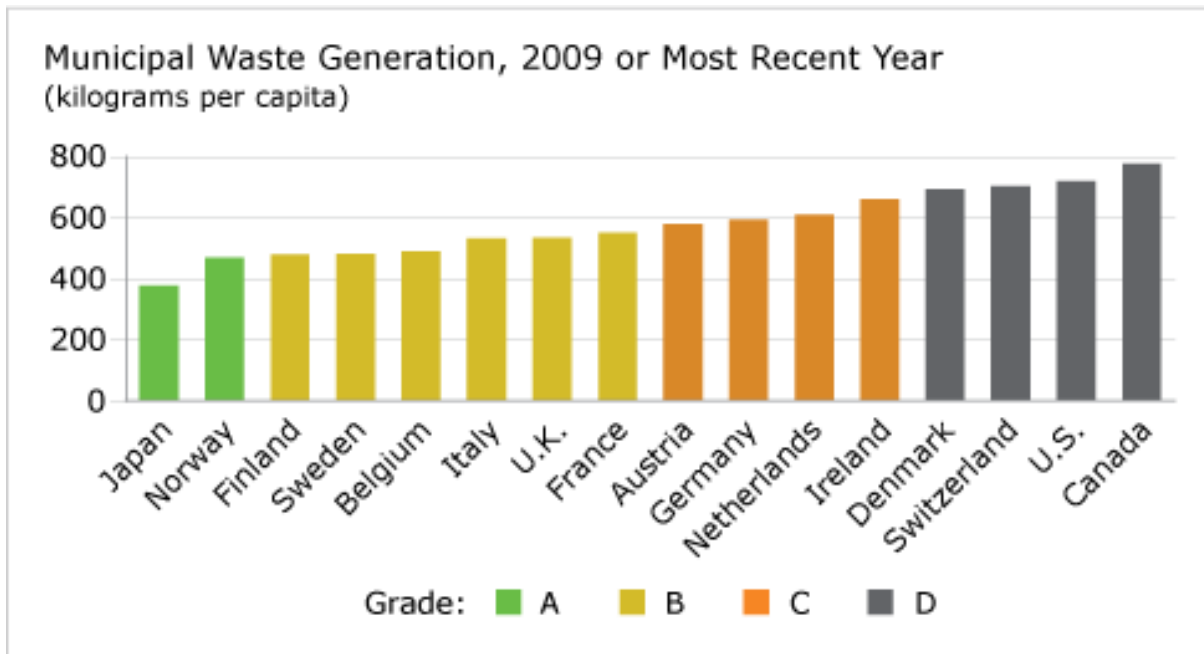
# The Abokobi Open Dump

## EXHIBIT 1 Municipal Districts of Accra



Source: Rarelibra, 2006.

**EXHIBIT 2**  
**Municipal Waste Generation Rankings Among OECD Countries (2009)**



Source: Conference Board of Canada, 2013.

## The Abokobi Open Dump

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### EXHIBIT 3 The Abokobi Open Dump



Source: Captured by author.

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## INSTRUCTOR GUIDANCE

### The Abokobi Open Dump

*Matthew Tersigni, HBSc, MPH (MPH Class of 2017)*

*Reginald Quansah, PhD (Assistant Professor, School of Public Health, University of Ghana)*

*Amardeep Thind, MD, PhD (Professor, Western University)*

#### BACKGROUND

Treesus, an environmental advocacy group in Accra, Ghana, recently hired Luca Parente. Like many West African countries, Ghana has a linear economy, meaning that it dumps rather than recycles most of its municipal solid waste. Luca explores the Abokobi open dump site, a large open dump in the middle of the Abokobi community. Luca recognizes the hazards of living beside an open dump and learns that it may increase the rate of communicable diseases and the exposure to toxic heavy metals. The Abokobi community is divided on their perceptions of the dump. Some see scavenging at the dump as an opportunity to provide income for their families while others view the dump as a significant health hazard. Scavenging is one of the only forms of recycling present in Accra. Luca is expected to present on what he believes to be the best direction for waste management in Accra. Will Luca conclude that Accra should follow the footsteps of countries with more developed waste management systems? Or will Luca find a way to augment existing structures?

#### OBJECTIVES

1. Understand the magnitude of waste and the challenges that arise when societies transition from low income to middle income countries.
2. Identify the similarities and differences in waste management systems between Canada and a developing country such as Ghana.
3. Apply the HDI and I = PAT to municipal solid waste management and determine how they impact decision making.
4. Perform a SWOT analysis of the waste management system in Accra to guide the decision-making process outlined in the case.
5. Analyze the consequences to the environment, economy, and human health that result from inadequate waste management.
6. Evaluate the evidence surrounding the health effects of living beside an open dump to determine whether or not the evidence is conclusive.

#### DISCUSSION QUESTIONS

1. What are some innovative ways countries are managing their waste?
2. What steps can Accra take on a household level to promote recycling? What about at a government level?
3. Is scavenging at the Abokobi open dump a practice that should be prohibited because of the health effects to workers or promoted because of the economic and environmental benefits?
4. What are the challenges to implementing a strengths-based approach at a community level? How about at an international level?
5. What consequences could have been avoided had the Abokobi dump been engineered to protect the surrounding environment?

## The Abokobi Open Dump

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6. What evidence does Luca need to reach a conclusion regarding the health effects of the Abokobi dump?
7. How will the 'Next 3 Billion' effect the global production of waste?

### **KEYWORDS**

Waste management; municipal solid waste; stakeholder engagement; recycle.

## CASE 14

### Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

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*Stanley Ing, MPH, CPHI(c) (Epidemiologist, Chatham-Kent Public Health Unit)*  
*Laura Zettler, MSc (Epidemiologist/Program Manager, Chatham-Kent Public Health Unit)*  
*Gerald McKinley, PhD (Assistant Professor, Western University)*

Today's generation is likely the first to be less healthy and die sooner than their parents' generation (Heart & Stroke, 2017). This statement should activate the critical and analytical parts of one's thinking to ask: "Are certain populations more affected than others?"; "What are the social, ethical, medical, and economical implications?"; and ultimately; "Why?" To evaluate a population's health requires an understanding of the population itself. These factors are contemplated daily by public health epidemiologists and professionals alike, including Nancy Del, Chatham-Kent Public Health Epidemiologist.

Nancy has been tasked with evaluating the wellbeing of Chatham-Kent residents with respect to the burden of chronic disease. Specifically, her research is to focus on the implications that rural residence places upon a population's health. To do this, she decides to use an epidemiological approach to demonstrate and highlight the disparities experienced by the region of Chatham-Kent. The generated information will then be presented to the Board of Health for approval and subsequently used to help teams within the Health Unit prioritize, plan, and implement programs and services.

#### BACKGROUND

Using an epidemiological approach to answer some of public health's most relevant problems is essential. Place of residence is an integral determinant to one's health. Research demonstrates that rural<sup>1</sup> areas experience higher prevalence and incidences of chronic diseases and higher proportions of chronic disease-related risk factors than their urban counterparts (Hartley, 2004). Chronic diseases commonly prevalent in rural areas include cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes (Eberhardt & Pamuk, 2004). Chronic disease-related risk factors commonly prevalent in rural areas include smoking, overweight and obesity, low fruit and vegetable consumption, and physical inactivity (Caldwell, Kraehling, Kaptur, & Huff, 2015).

Hypothesizing that rural areas experience disproportionate health disparities, compared to the rest of Ontario, requires a mechanism of evidence. Based on previous findings of health disparities in rural populations, the epidemiological approach provides this mechanism. Through quantifying chronic diseases, chronic disease-related burdens, and chronic disease-related risk factors, and comparing rates among different populations, program planning aimed at improving the health of rural residents can be effectively informed.

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<sup>1</sup> Although varying definitions exist to describe rural residence, the most consistent definition states that any region with less than a population of 1000 or a density of 400/km<sup>2</sup> is considered a rural area (Statistics Canada, 2015).

## Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

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### CHATHAM-KENT

The municipality of Chatham-Kent has Ontario's highest per capita mortality rate from heart attacks (Aaron, 2017). Cardiovascular disease was one of the leading causes of mortality for Chatham-Kent, second to cancer (PHO, 2014). To understand why cardiovascular disease-related deaths are so high, Nancy needs to establish a description of the community and conduct geographic comparisons of cardiovascular disease and chronic disease-related risk factors.

The Municipality of Chatham-Kent is located in Southwestern Ontario between Lakes St. Clair and Erie and has select major city centres including Chatham, Wallaceburg, and Tilbury (see Exhibit 1). Established in 1998 with the amalgamation of 23 separate communities, the Municipality of Chatham-Kent is a single-tiered municipality (Association of Municipalities Ontario, 2017). This implies that the municipality is responsible for all public services to their residents and for all communities within the municipality (Association of Municipalities Ontario, 2017). The estimated population in 2016 was 102,042, down 2% from 2011 (Statistics Canada, 2017a). Just over half of Chatham-Kent's population resides within the three stated urban centres, with the remaining residing in surrounding rural communities (Francis, 2015). When compared to Ontario, Chatham-Kent had a 28% lower median household total income for 2015 [Chatham-Kent (\$58,185), Ontario (\$74,287)] and a 7% lower labour force participation rate for 2016 [Chatham-Kent (60.2%), Ontario (64.7%)] (Statistics Canada, 2017b; Statistics Canada, 2017c).

Under the Canadian Census, there are established peer groups that allow for health units (in the case of Ontario) to be compared based on geographic and demographic characteristics. Chatham-Kent is a part of Public Health Ontario's "Mainly Rural" peer group, which maps to Statistics Canada's peer groups D and E (see Exhibit 2) (PHO, 2016a).

Utilizing the epidemiological approach, Nancy needs to compare cardiovascular disease-related mortality between populations by using age standardized rates to assess the wellbeing of Chatham-Kent residents. She is provided with raw data outlining the number of deaths and total population of different regions by age. To begin, she compares Chatham-Kent to Ontario as a whole, then Lambton County to Ontario, and lastly Chatham-Kent to Haldimand-Norfolk.

### CHATHAM-KENT CARDIOVASCULAR DISEASE MORTALITY

Nancy needed help from a colleague on her team. She asked Jack to create a report addressing the following:

Calculate the appropriate rates outlined in **Worksheet 1** and answer the following questions:

1. What is Chatham-Kent's crude mortality rate for cardiovascular disease?
  - a. Provide an interpretation for the rate.
  - b. Can the rate be directly compared to Ontario's crude mortality rate? Why or why not?
2. What is Chatham-Kent's age standardized mortality rate for cardiovascular disease?
  - a. How does Chatham-Kent's age standardized rate compare to that of Ontario's?
  - b. What conclusions can be made based on the results?

### LAMBTON COUNTY CARDIOVASCULAR DISEASE MORTALITY

Nancy was also interested in Lambton County, a neighbouring region to Chatham-Kent. Once again she asked Jack to calculate and interpret mortality rates, the summary of which is displayed in the following statement:

The crude cardiovascular disease mortality rate for Lambton County during 2011 was 299.2 deaths per 100,000 population. Accounting for different age structures through the

## Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

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direct age standardization method, Lambton County recorded an age standardized, cardiovascular disease mortality rate of 240 deaths per 100,000 population, while Ontario recorded a rate of 185 deaths per 100,000 population during 2011.

### HALDIMAND-NORFOLK CARDIOVASCULAR DISEASE MORTALITY

The Haldimand-Norfolk Public Health Unit is a part of the same peer group as the Chatham-Kent Public Health Unit: Mainly Rural. The purpose of the peer groups is to highlight regional similarities that may be overshadowed when grouped together with dissimilar regions (e.g. comparing Southern Ontario to Ontario as a whole where each group contains differently structured populations). In this case, the rurality of communities is the common similarity expressed by the Mainly Rural peer group. Comparing similar regions allows one to see if the differences seen against Ontario are unique to that region or are characteristic of rural areas in general. In this case, if cardiovascular disease mortality rates seen in Chatham-Kent are similar to Haldimand-Norfolk, it infers a rural connection to higher rates. If they are uniquely higher than both Haldimand-Norfolk and Ontario, the rural connection may still be present, however, it indicates that other factors are at play.

To round out the report Nancy asked Jack to provide the following information:

Calculate the appropriate rates outlined in **Worksheet 2** and answer the following questions:

1. What is Chatham-Kent's age standardized mortality rate for cardiovascular disease?
  - a. How does Chatham-Kent's age standardized rate compare to that of Haldimand-Norfolk's?
  - b. What conclusions can be made based on this result?

### CONCLUSION

During 2014, Chatham-Kent was ranked seventh in the province for adult smoking rates (28% of the adult population were recorded as daily or occasional smokers) and fifth in combined overweight and obesity rankings (61% of the population were either overweight or obese) (PHO, 2016b; PHO, 2016c). Knowing that these are major contributors to cardiovascular disease, and based on the rates calculated for cardiovascular disease mortality, Nancy was faced with the following questions:

1. Does Chatham-Kent, as a rural community, experience greater health disparities? Is there additional information needed to answer this question and how would she go about finding it?
2. Ultimately, how best should she present her findings to the Board of Health?

With these questions in hand, Nancy prepared for her upcoming Board meeting, ready to present on the wellbeing of her rural community and help inform future programming and service delivery.

# Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

## EXHIBIT 1 Municipality of Chatham-Kent Map



Source: New Staff Orientation PowerPoint: Chatham-Kent Public Health, 2017.

## Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

### EXHIBIT 2

#### Public Health Ontario (PHO) Peer Groups and Statistics Canada 2015 Peer Groups

Peer Group	Public Health Unit
<ul style="list-style-type: none"> <li>• PHO: Population centres with high population density and rural mix</li> <li>• Statistics Canada peer group A</li> </ul>	Brant County Health Unit City of Hamilton Health Unit Middlesex-London Health Unit Niagara Regional Area Health Unit Windsor-Essex County Health Unit
<ul style="list-style-type: none"> <li>• PHO: Population centres with moderate population density</li> <li>• Statistics Canada peer group B</li> </ul>	City of Ottawa Health Unit Durham Regional Health Unit Halton Regional Health Unit Simcoe Muskoka District Health Unit Waterloo Health Unit Wellington-Dufferin-Guelph Health Unit
<ul style="list-style-type: none"> <li>• PHO: Population centres and rural mix</li> <li>• Statistics Canada peer group C</li> </ul>	Elgin-St. Thomas Health Unit Hastings and Prince Edward Counties Health Unit Kingston, Frontenac and Lennox and Addington Health Unit Lambton Health Unit North Bay Parry Sound District Health Unit Northwestern Health Unit Peterborough County-City Health Unit Porcupine Health Unit Sudbury and District Health Unit Thunder Bay District Health Unit Timiskaming Health Unit
<ul style="list-style-type: none"> <li>• PHO: Mainly rural</li> <li>• Statistics Canada peer groups D &amp; E</li> </ul>	<b>Chatham-Kent Health Unit</b> District of Algoma Health Unit Eastern Ontario Health Unit Grey Bruce Health Unit Haldimand-Norfolk Health Unit Haliburton, Kawartha, Pine Ridge District Health Unit Huron County Health Unit Leeds, Grenville and Lanark District Health Unit Oxford County Health Unit Perth District Health Unit Renfrew County and District Health Unit
<ul style="list-style-type: none"> <li>• PHO: Largest population centres with high population density</li> <li>• Statistics Canada peer groups G &amp; H</li> </ul>	City of Toronto Health Unit Peel Regional Health Unit York Regional Health Unit

Source: Public Health Ontario (PHO), 2016a.



**Rural Residence and Associated Health Disparities:  
The Case of Chatham-Kent**

**WORKSHEET 1**

**Cardiovascular Disease Mortality Rates: Chatham-Kent and Ontario**

<b>2011</b>	<b>Chatham-Kent</b>			<b>Ontario</b>		
<b>Age Group</b>	<b>No. Deaths</b>	<b>2011 Population</b>	<b>Age-Specific Rate</b>	<b>No. Deaths</b>	<b>2011 Population</b>	<b>Age-Specific Rate</b>
0-19	0	25,099		29	3,103,210	
20-44	7	30,564		341	4,512,766	
45-64	40	32,334		3054	3,760,476	
65-74	45	9904		3423	1,012,644	
75+	234	8781		17677	874,448	
<b>Total</b>						

Direct Age Standardization

<b>2011</b>	<b>Chatham-Kent</b>			<b>Ontario</b>	
<b>Age Group</b>	<b>2011 Composite Population</b>	<b>Age-Specific Rate</b>	<b>Expected Deaths</b>	<b>Age-Specific Rate</b>	<b>Expected Deaths</b>
0-19					
20-44					
45-64					
65-74					
75+					
<b>Total</b>					

Age Standardized Rate: Chatham-Kent

Age Standardized Rate: Ontario

Notes:

1. All age-specific and age standardized rates are per 100,000 population.
2. All values calculated should be done so to three decimal places.
3. All reported values should be done so to one decimal place.

Source: Created by author.

**Rural Residence and Associated Health Disparities:  
The Case of Chatham-Kent**

**WORKSHEET 2**

**Cardiovascular Disease Mortality Rates: Haldimand-Norfolk and Chatham-Kent**

<b>2011</b>	<b>Haldimand-Norfolk</b>			<b>Chatham-Kent</b>		
<b>Age Group</b>	<b>No. Deaths</b>	<b>2011 Population</b>	<b>Age-Specific Rate</b>	<b>No. Deaths</b>	<b>2011 Population</b>	<b>Age-Specific Rate</b>
0-19	0	25,368		0	25,099	
20-44	3	30,894		7	30,564	
45-64	33	35,166		40	32,334	
65-74	49	10,644		45	9904	
75+	240	8681		234	8781	
<b>Total</b>						

Direct Age Standardization

<b>2011</b>	<b>Haldimand-Norfolk</b>			<b>Chatham-Kent</b>	
<b>Age Group</b>	<b>2011 Composite Population</b>	<b>Age-Specific Rate</b>	<b>Expected Deaths</b>	<b>Age-Specific Rate</b>	<b>Expected Deaths</b>
0-19					
20-44					
45-64					
65-74					
75+					
<b>Total</b>					

Age Standardized Rate: Haldimand-Norfolk

Age Standardized Rate: Ontario

Notes:

1. All age-specific and age standardized rates are per 100 000 population.
2. All values calculated should be done so to three decimal places.
3. All reported values should be done so to one decimal place.

Source: Created by author.

## Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

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## INSTRUCTOR GUIDANCE

### Rural Residence and Associated Health Disparities: The Case of Chatham-Kent

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#### BACKGROUND

Rural populations face notably higher rates of chronic diseases than urban areas, specifically, cardiovascular diseases, chronic respiratory diseases, cancer, and diabetes. This case focuses on Chatham-Kent, a small, rural town in Southwestern Ontario, to illustrate this point. More specifically, the case focuses on an epidemiological approach to provide evidence of the health disparities due to an individual's place of residence. Based on the comparison of age-standardized rates, does the rural community of Chatham-Kent experience greater health disparities?

This case provides the reader with practice in calculating and interpreting crude and age-standardized rates and the ability to disseminate findings about the health status of a given population.

#### OBJECTIVES

1. Understand basic epidemiological terminology, such as crude rates, age-adjusted rates, and epidemiological approach.
2. Apply the mechanisms behind the derivation of crude and age-adjusted rates in analysis of health data.
3. Understand how the epidemiological approach can identify health disparities amongst different populations.
4. Compare the health statuses of different populations accurately with appropriate measures.
5. Effectively communicate the results of a health data analysis to intended audience(s).

#### DISCUSSION QUESTIONS

Most discussion should focus around the Case Analysis questions, although, if discussion dies off, or to initiate conversation, the following could be presented:

1. Are there any personal experiences that could help illustrate the points made by the case (e.g. within previous/current employment, previous/current courses, etc.)?
2. How would the presentation of mortality rates differ when presenting to fellow public health professionals (either with or without an epidemiologic background) or to the general public?
3. Based on the results of the case, what interventions would you suggest, if any?

#### KEYWORDS

Epidemiological approach; age standardized rates; crude rates; mortality; rural health; chronic disease; chronic disease-related risk factors.



## CASE 15

### Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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Christina Peterson was sitting in her office on Wednesday, May 25<sup>th</sup>, 2014 getting her notebook ready for her monthly meeting with the Evidence-Informed Practice Working Group (EIPWG) at Public Health Sudbury & Districts (PHSD). As a Foundational Standards Specialist, Christina provides support and expertise to teams on evidence-informed decision-making, policy and practice in the areas of population health assessment, surveillance, education, research and knowledge exchange, core competency development, program evaluation, professional practice and development, and program planning. She was also the Co-Chair of the EIPWG and was the champion in advocating for various public health issues. EIPWG consisted of 15 to 20 staff members from various occupational backgrounds at PHSD, such as health promoters, foundational standards specialists, epidemiologists, managers, public health nurses, and others. EIPWG meets monthly to discuss new evidence regarding public health issues. The members assess the evidence and use it to inform practices within PHSD and make recommendations for any new programs or changes to existing programs. Generally, EIPWG works through two to three “practice-based questions” every year, which touch on a variety of topics. Examples include: “Does Lyme disease pose enough concern in our catchment area to merit enhanced Public Health intervention strategies?” and “What is the effectiveness of health promotion materials related to distracted driving?” The group then strikes sub-working groups who use various methods to answer the practice-based question and subsequently make recommendations for practice or policy.

Christina was very well-liked and respected within EIPWG and the organization; she brought a breadth of knowledge and experience to the table. She has been working at PHSD for a number of years carrying out research and supporting evidence-informed practice. She came into the public health sphere rather late, having prior experience as a nutritionist in the cardiac rehabilitation centre at Memorial Hospital in Sudbury. She worked specifically with the Diabetes Education team. Christina then moved on to the Manitoulin Health Centre in Little Current on Manitoulin Island—about an hour-and-a-half drive west from Sudbury. She got frustrated in the acute-care setting, because many of her patients in Little Current were unable to access

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<sup>1</sup> The authors acknowledge this case note reflects the retrospective narrative of one main actor and does not present the multiple perspectives of other stakeholders at Public Health Sudbury & Districts nor does it accurately reflect the work to date in this portfolio. Of note: the organization described in this case note has recently changed its name from Sudbury & District Health Unit to Public Health Sudbury & Districts. Names of individuals described in this case note have been changed and are not the actual names of staff employed at the agency.

<sup>2</sup> Special thanks to Joanne Beyers for her assistance as well.

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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adequate transportation to reach a grocery store with healthy food options, let alone purchase nutritious food. Much of her dietary knowledge was rendered useless, as the underlying social determinants of health, such as income and food security, were not being addressed. She questioned how useful she was in the clinical setting, and in 1990, she decided to make the switch into a role that would look at ways to address the social determinants of health for these populations, rather than strictly working with individual patients only.

The EIPWG members had tackled several practice-based questions related to priority populations since its inception. For instance, one of the questions that was being worked on was related to exploring housing inspections involving vulnerable populations. Specifically, they were assessing what was working and what was not working related to housing investigations involving marginalized populations, with an aim to propose solutions for improvement. However, there was one priority population that had yet to be focused on: individuals with a disability. Christina was a real advocate for people with disabilities. She had lived in the disability world for over 20 years, as her son James was born with autism. She had seen first-hand the challenges James faced at school with a curriculum designed for people without a disability. As James transitioned through the different stages of his life, from high school to post-secondary and to the workforce, she wondered whether these environments had the capacity to support his needs. She often worried whether professionals and supervisors were trained to work with individuals who have a disability. These fearful thoughts translated into her workplace environment: does PHSD have the capacity to provide services such as immunizations to individuals like James?

Another reason contributing to her motivation to improve PHSD's services to individuals with a disability was the current Accessibility for Ontarians with Disabilities (AODA) legislation. Established in 2005, it became the first of its kind in the world to provide mandatory accessibility standards for various types of organizations within Ontario. The five standards are: Accessible Customer Service, Accessible Information and Communication Standards, Employment Accessibility, Accessibility of Transportation, and the Design of Public Spaces Standard. The final goal is to have a fully accessible Ontario by 2025. The Government of Ontario and other designated public-sector organizations were required to comply with these standards by January 1<sup>st</sup>, 2010, and non-profit and private sector organizations with at least one employee had to comply by January 1<sup>st</sup>, 2012. The Employment Accessibility, Accessibility of Transportation, and the Design of Public Spaces Standards have not set compliance dates yet, but they will be made in the next few years. Finally, the Design of Public Spaces Standard had just been drafted, and has not been made law (People Access, 2011).

An AODA Task Group was set up at PHSD. It mainly comprised of individuals from the human resources team and others who were responsible for ensuring that the organization was meeting the legislative requirements. Christina knew that AODA had helped in fostering a more inclusive environment for individuals of all abilities. Although AODA had specifically pointed out that "unseen disabilities" are included in the definition of "disability", Christina thought that it did not provide enough guidelines to organizations looking to improve their services to individuals with unseen disabilities. There was a need to go "beyond the wheel chair ramp".

Christina had been Co-Chair of the EIPWG team for around six years alongside Valerie Stoville, a Manager in Knowledge and Strategic Services at PHSD. As Christina entered the meeting, she was greeted by typical smiles and laughter from the EIPWG team. After catching up, Christina and Valerie signalled the start of the meeting. Amy Lapierre and Megan Antonini, two health promoters working within the Health Promotion Division of PHSD, were first to present at the meeting, showing the final results from the previous practice-based question which

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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assessed the best practices in reducing alcohol consumption amongst the post-secondary population. This was followed by John Leblanc, an epidemiologist who shared the availability of new population health data and discussing data gaps with the group. As the three-hour meeting reached its latter stages, Christina's mind had started to wander, going back to her thoughts surrounding the disability access issue. Once the meeting finished, and everybody began packing up, Christina suddenly stood up and exclaimed, "Guys, I really love the work we are doing with our practice-based questions, but I think we are missing a huge issue when it comes to providing the best possible health outcomes for our clients. It is regarding the accessibility of PHSD's services, programs, and infrastructure for both clients and employees."

There was a pause in the room. Everyone was a little startled by Christina's abrupt comment. People looked at one another wondering what to say. Realizing that someone needed to speak, Christina continued, "We have focused our efforts on many priority populations, people living in poverty, Indigenous populations and other vulnerable populations, which I am very proud of as it has brought so much success. However, we have not focussed much attention on people with disabilities. I know we already have a few practice-based questions lined up for the rest of the year, but it is time we should take a further look into this issue." Another pause followed. Christina brought forth a practice-based question to the EIPWG: "How does the PHSD operationally define "people with disabilities", particularly related to unseen or invisible disabilities?"

Rita Devlin, one of the other Foundational Standards Specialists, slowly stood up and said, "Christina, I agree with your comments, it is just that I don't know whether we have the time to pursue this issue right now, we have so much going on. Most of us are already working on other issues and are feeling rather stretched."

Christina responded by saying, "Listen, I know we are all very busy, but this is an important issue. I would like all of you to put yourselves in the shoes of an individual who has a disability and is applying for a job here, utilizing one of our services or accessing one of our sites. Let's give more thought to how our programs, services, infrastructure and policies meet the needs of people living with disabilities and let's bring this back to our next meeting. That is a good note for this meeting to end, right Valerie?" All agreed that further discussion was required.

Valerie agreed, and everyone began to file out of the room, leaving Valerie and Christina in the room. She then said, "Christina, your arguments were extremely valid. I can definitely relate to your plight. One of my son's friends is hard of hearing. I have seen how difficult it is sometimes for him to communicate with others and to hear important information. I will do my best to support you in championing this initiative. Let's connect with your director to see how this might fit in your workplan with support from a select few EIPWG members."

Christina replied, "Thank you for your continued support of my proposed initiatives."

In the following months, Christina gained support from her director to determine the scope of this practice-based question and gathered a small team of EIPWG members to work on the issue. Jim Greault, the Manager of Professional Practice and Development, was inspired by Christina's work and helped the issue to gain momentum. With support from her director, and further discussion and uptake at EIPWG, an EIPWG sub-group, known as the People with Disabilities Group (PWD) was established. With the help of Jim and other EIPWG members the scope of the question was refined: How does the agency operationally define "people with disabilities"? The question focused particularly on unseen/invisible disabilities.



## **Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All**

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This PWD group consisted of Christina, Valerie, Rita, Amy, and Megan. Also joining the team was Chantal, another health promoter, and Jim. Within a few weeks of forming, a PWD logic model was established with the following objectives:

1. Programs and services at PHSD are fully accessible and inclusive particularly for people with disabilities, with an emphasis on unseen disabilities.
2. Staff at PHSD recognize, understand, and apply attitudes and practices that are sensitive to and appropriate for people with disabilities.
3. Staff have the knowledge, attitudes, and skills to ensure our programs and services are fully accessible and inclusive for people with disabilities.

Since PWD formed in early 2015, the group has made steady progress with its work. In 2016, a three-year work plan was established with further planned activities to increase PHSD's inclusivity. With the help of a Public Health and Preventative Medicine Resident from the Northern Ontario School of Medicine, a literature review was completed, which helped develop PHSD's definition of what a disability fully entails, and what the definition of an unseen disability is. Through an online survey, feedback collected from all PHSD staff was considered when developing a definition of disability and a definition of an unseen disability. A second literature review was done to compare the health outcomes of individuals who had a disability and individuals who did not. The research consistently demonstrated that individuals with a disability disproportionately suffered negative health outcomes in various facets.

One of the first steps to achieving Christina's long-term goals regarding PHSD's accessibility was to change the attitudes, beliefs, and knowledge of her fellow staff members. The results from this literature review helped inform the development of a primer for all staff. The primer would be used to educate staff on the various health disparities individuals with disabilities face, how to properly address them in person, and the approach that should be taken when interventions are planned.

From a policy standpoint, the PWD team had successfully managed to reach out to PHSD's Board of Health, who approved a motion for a person-centered language statement. This motion can serve as an avenue for change in how staff interact with a client or fellow employee at PHSD. The agency wanted its staff to use language that put the person before the disability, (i.e. 'people with disabilities' instead of 'disabled') (Public Health Sudbury & Districts, 2017a).

### **BACKGROUND**

Originating in 1956, PHSD is one of the over 30 non-profit provincial public health agencies, evolving from a public health service operated by the City of Sudbury Health Department. Over the years, the agency has grown significantly and now employs over 250 staff who deliver provincially legislated public health programs and services. Its geographic area includes the municipalities of Sudbury, Chapleau, Sudbury East, Espanola, and the entirety of Manitoulin Island – the largest freshwater island in the world. There are three offices within Greater Sudbury and district offices in Chapleau, Espanola, Sudbury East, and Manitoulin Island. These offices serve a population of approximately 200,000 (Public Health Sudbury & Districts, 2016b). Exhibit 1 shows the full geographic area that PHSD serves and the locations of the district offices.

Since 2000, PHSD has been led by Dr. Irene Foster, the Medical Officer of Health and Chief Executive Officer, and more recently, Dr. Victoria Hinkel has joined the organization as an Associate Medical Officer of Health. There are five divisions within the organization: Health Promotion, Environmental Health, Clinical Services, Corporate Services, and Knowledge and

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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Strategic Services. Each division is led by a director, who together with the Medical Officer of Health, Chief Executive Officer and Associate Medical Officer of Health, make up the Senior Management Executive Committee (EC).

### INTRODUCTION TO DISABILITIES

According to the World Health Organization, the term “disability” has a wide-spanning definition and covers three main areas: impairments, activity limitations, and participation restrictions. ‘Impairments’ see the problem of disability from a biological and medical perspective, looking at disability as a problem in the body’s structure and function. ‘Activity limitations’ refer to a disability from a functional perspective, where individuals face difficulties in executing a task or action. The social model is emphasized within the facet of ‘participation restrictions’, where there are barriers faced by individuals in getting involved in everyday life situations (World Health Organization, n.d.). After looking at the results from the survey sent out to all PHSD staff exploring their perceptions of how a disability is defined, the team realized that most of the staff looked at a disability from the perspective of the medical model. This inferred that the staff looked at a disability from the individual-level only, rather than from a system-level perspective. These perceptions would almost always inhibit future action to foster a supportive environment to improve the health outcomes for individuals with disabilities, putting the onus only on the individual to adapt.

Christina wanted the staff and the rest of PHSD to think of disabilities from primarily the social model. She did not disregard the other two perspectives, but she felt that they could target the social model to help improve the outcomes for individuals with disabilities. Across Canada, approximately one in seven Canadians have some type of disability (Statistics Canada, 2013). Within the City of Greater Sudbury, excluding the other areas that PHSD serves, it is estimated that there are 24,000-26,000 citizens with a disability. Of this number, 11,000 are seniors over the age of 65. This is in stark contrast to citizens under the age of 15, where there are only about 1,000 individuals. Additionally, another 1,000 consist of teenagers and young adults (City of Greater Sudbury, n.d.a). Greater Sudbury’s population is approximately 164,500, but this population is rapidly aging (The Canadian Press, 2017; Sudbury Star Staff, 2017). There were around 13,000 people aged 75 years or older in Sudbury, and that number is projected to grow by approximately 38.1% by 2026 (Sudbury Star Staff, 2017). Due to the city’s large reliance on the mining sector, which comprises the bulk of its economy, there are often fluctuations in the job market. Often, young people migrate out of Sudbury in search of employment because of jobs having high turnover rates (MacDonald, 2013). This ageing population trend will likely continue into the future, necessitating PHSD to continue to focus on PWD’s as a priority population.

The health outcomes of people with disabilities is a pressing public health issue, as those with disabilities have poorer health outcomes than those without. This results in health inequities. Research from the United States has shown that people with disabilities suffer higher rates of chronic diseases such as diabetes, high blood pressure, arthritis, chronic pain, and heart disease (AUCD, 2016; CDC, 2013; CDC 2014; Havercamp & Scott, 2015). They also have higher rates of physical inactivity and have bodies that are classified as obese (CDC, 2014; Havercamp & Scott, 2015; NCBDDD, n.d; Ouellette-Kuntz, 2005; Rimmer & Wang, 2005;). Within Ontario, Lunsky, Klein-Geltink, and Yates (2013), showed similar results to the aforementioned studies and also reported that people with disabilities received a poorer quality of healthcare by practitioners at both the acute care and preventative care levels. They spent more time at emergency departments and had a higher probability of being hospitalized, especially for preventable ambulatory care sensitive conditions (ACS). They were also less likely to receive important healthcare screenings for breast, oral, and cervical cancers.

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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An individual's disability can also interact with other determinants of health such as race and gender, resulting in intersectionality. This can affect the diagnosis, treatment, and management of disabilities. Disabilities are often diagnosed from a male perspective, which can lead to disabilities being overlooked in women (Banks & Kashcak, 2003). These overlooked conditions are viewed in a negative connotation, being seen instead as self-inflicted, trivialized, and hysterical (Banks & Kashcak, 2003). Intersectionality regarding disabilities can be seen at multiple levels. Shaw, Chan, & McMahon (2012) found that being older, female, a visible minority, and working in a smaller or larger company, in addition to having a disability, was associated with higher risks of disability harassment. Warner & Brown (2011) and Cramer & Plummer (2009) found similar results showing that multiple interactions can pose as barriers to accessing proper intervention services.

### UNSEEN DISABILITIES

Arguably even more complex than visible disabilities, such as paralysis and Down syndrome, are unseen disabilities. Unseen disabilities capture a wide spectrum of conditions that are not immediately visible to another individual. They can include fibromyalgia (chronic musculoskeletal pain), chronic diseases such as diabetes and kidney conditions, mental health conditions such as schizophrenia and attention deficit and hyperactivity disorder, and auditory and visual impairments when hearing aids or corrective lenses are not used. Unseen disabilities can have varying degrees of severity and can be subjectively perceived in nature, as there is no standardized list (University of Massachusetts, 2015). Approximately 12% of all disabilities in Canada are considered to be unseen, but that number could be underestimated (Mullins & Preyde, 2013). Exhibit 3 shows a more detailed breakdown of disability types and prevalence within Ontario for individuals aged 15-64.

There is limited literature looking specifically at the health outcomes of individuals with unseen disabilities. From what was found, individuals with unseen disabilities face poorer social determinants of health compared to visible and other kinds of disabilities. For instance, 54% of Ontarians suffering from a mental health or addiction disability were not employed. In comparison, 42.9% of individuals with non-mental health or addiction disabilities and 21% of individuals without a disability were unemployed (Ontario Human Rights Commission, 2016). From an income standpoint, Ontarians with mental health and addiction disabilities had a median household income of only \$51,267. Again, in comparison, Ontarians with non-mental health or addiction disabilities made a median household income of \$59,474, and individuals without a disability made a median household income of \$82,631. Finally, Ontarians with mental health and addiction disabilities were also more likely to live alone, have inadequate housing, be divorced, and have lower levels of education than Ontarians with other kinds of disabilities, or Ontarians without a disability (Ontario Human Rights Commission, 2016). Similar results were seen for individuals with a developmental disability (Statistics Canada, 2015).

Individuals with both visible and unseen disabilities feel stigma and discrimination in multiple ways, hindering their social mobility, acceptance, and inclusion into modern society. Individuals with unseen disabilities face unique challenges. Their peers cannot see what they are going through on the surface. Unseen disabilities are often subject to skepticism, and some may think the individual is faking their disability for sympathy or attention. Individuals with unseen disabilities are left with a problematic situation. They can direct attention towards their disability to prove themselves, which could exacerbate and worsen their symptoms. Alternatively, they could act normal and lie about their disability without having to go through the trouble of explaining their disability to peers over and over. However, these feelings of deception can

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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really take a physical and emotional toll on the individual. Many are left to internally struggle, whether they should reveal it or not and seek help (Shaw, 2012).

If this stigma and discrimination continues, people with disabilities will continue to face feelings of learned helplessness, and they will forever feel unwanted and useless to society. Russell, Turner, and Joiner (2009) found that individuals with a physical disability have more than twice the relative risk of suicidal ideation than individuals without a disability, and this was observed across all subgroups except older and married adults. This finding was echoed by Ludi and colleagues (2012), who found in their literature review that children with intellectual disabilities were at risk for suicide.

### HEALTH EQUITY

Northern Ontario has unique challenges in regards to achieving optimal health compared to Southern Ontario and the rest of Canada. The influence of the social determinants of health include access to health services, an employment sector relying heavily on fluctuating resource markets, and a large Indigenous population (Health Quality Ontario, 2017). It illustrates the need for a health equity approach when PHSD develops public health programs, services, infrastructure, and policies for its clients.

Health equity implies that individuals can reach a maximum level of health, regardless of age, gender, ethnicity, race, religion, social class, socioeconomic status or any other socially determined circumstance, which should not pose a barrier (Public Health Sudbury & Districts, 2015). Inequities in health can result between different groups of individuals on a micro-level, such as attitudes, personal beliefs, and knowledge of people with disability. It can also occur on more meso- and macro-levels, which includes the natural and architectural environments, organizational and governmental policies, resource allotment, and much more. The onus to improve one's health should not only be placed on the individual with a disability but rather on fostering an inclusive environment around them. Oftentimes, people develop disabilities out of their control. It is the world's largest minority group, and one of the only ones in which any individual can become a part of at any time (Disabled World, 2017).

PHSD has a long history of working toward improving health equity and addressing social inequities in health. Since 2000, the organization has participated in raising awareness of social determinants of health amongst the staff and community and completing an intervention project outlining ten promising public health practices to reduce social inequities in health at the local level, with the potential to be scaled up to a larger contextual level (Public Health Sudbury & Districts, 2016a). Exhibit 3 displays the full framework of the ten promising public health practices to reduce social inequities in health.

The organization has also produced reports identifying health inequities in the community, supported local policy and strategies to reduce poverty and access to affordable food, and advocated and participated in provincial efforts to address health equity, including incorporating health equity as core work of public health. This dedication to health equity is easily seen in the organization's 2013-2017 strategic plan as it lists championing and leading equitable opportunities for health and supporting community actions that promote health equity as two main priorities (Public Health Sudbury & Districts, 2018).

People with disabilities generally do not benefit from health promotion screening and wellness programs. Healthcare professionals often focus on their disabilities rather than the needs of the whole person (U.S. Department of Health and Human Services, 2005). Public health programs, services, infrastructure, and policies are not designed with people with disabilities in mind

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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(Welner & Temple, 2004). Continual efforts are needed using a health equity lens when PHSD looks to improve the health outcomes of people with disabilities.

To help achieve the previously mentioned objectives of the logic model made by the PWD team, one could try to apply some of the promising public health practices devised by PHSD to this file. The section below proposes three promising practices as a lens for which activities of the PWD team could be viewed.

### **PROMISING PUBLIC HEALTH PRACTICE #1: TO REDUCE SOCIAL INEQUITIES IN HEALTH: TARGETING WITHIN UNIVERSALISM**

Targeting within universalism is the concept of using a universal approach but with slight adjustments to increase the accessibility for certain population groups that may not be routinely served compared to others. This will address inequalities in health outcomes and ensure that those population groups who are at greatest risk of poor health reap the most benefits of the work done by organizations. It is a positive step in achieving the ultimate goal of universal inclusive design. Inclusive design is the ideal goal for society, as no targeting of certain population groups is needed, as accessibility and inclusivity is a guarantee. For the long-term outcomes of the PWD working group's logic model to occur, the principles of inclusive design must be embedded in the organization's infrastructure, policies, customer service, technology, and other facets.

Inclusive design must be flexible, usable, and customizable and take into account one's ability, language, culture, gender, and age. It recognizes that individuals are different, and in daily life, people may perform tasks differently (OCAD University, n.d.). In the past, universal design benefitted higher privileged groups, such as those with the highest income, highest education levels, and the strongest social support networks more significantly. However, this is not the desired outcome. The desired outcome is that PWD and other priority populations receive the largest benefit, whilst improving the overall health of the entire population (Public Health Sudbury & Districts, 2015).

There are many misconceptions about achieving universal design in the built environment. In the workplace, there are often thoughts that accommodating people with disabilities is very expensive or that accommodation, if provided, is of little value. This is due to the common view that people with disabilities take more sick leave, need more supervision, and will perform the job less effectively than people without a disability. These thoughts are far from the truth, as most accommodations are of little to no cost. In fact, the average one-time accommodation is \$500 (Ability First, n.d.). Research shows that employers have consistently found that employees with disabilities rate average or above-average in attendance. Eight out of ten managers found people with disabilities needed no additional supervision when compared to abled people, and 90% of disabled employees performed their jobs as well or better than employees without a disability (Ability First, n.d.). Despite this evidence, 45% of prospective employees with a disability considered themselves to be disadvantaged in the employment process because of their condition. For those employees with a disability who were hired, 27% noted that their employers were not aware of their limitations (Arim, 2015). Due to the continual stigma, 67% of Canadian adults with disabilities lack the educational, workplace, and home supports needed for daily function (Council of Canadians with Disabilities, 2013).

The vision of the Customer Service Standard within AODA ensures that an organization's customer service actions are accessible for people with disabilities. The training manual provided by AODA provides some pointers for organizations to follow when interacting with customers with various disabilities, including invisible disabilities such as hearing loss, mental

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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health, and intellectual disorders. There is also educational material regarding assistive devices used by some individuals with disabilities such as a teletypewriter (allows those who are deaf or hard of hearing to relay messages) and service animals (e.g., dogs who guide individuals who are blind). In its most recent accessibility plan, PHSD has stated its efforts to train relevant staff on these guidelines, allow the use of support persons and service animals within its buildings, and establish policies, practices, and procedures on providing goods and services to clients of various abilities (Public Health Sudbury & Districts, 2017b).

However, there is very little guidance for developing accessible buildings for organizations, in both exterior and interior design. Information and recommendations are not available for organizations on the design of accessible buildings within AODA's Design of Public Spaces Standard. The Design of Public Spaces Standard focuses on areas such as accessible parking and outdoor play spaces. Currently, the only legislative framework to follow in developing accessible buildings is through the Ontario Building Code. The most recent amendments of Ontario's Building Code in 2015 were geared towards accessibility, primarily focusing on visible disabilities. For instance, it provides recommendations on wider doorways, doors that require a lesser grip or twist to open, and availability of ramps in pool areas and spas. The only real amendment targeting unseen disabilities was mandating visual fire alarms, in addition to audible ones, in public buildings such as multi-unit residential dwellings, theatres, churches, and lecture halls. These requirements would only apply to newly constructed buildings, not existing buildings (Ministry of Municipal Affairs and Ministry of Housing, 2015).

Despite the promising amendments to accessibility under the Ontario Building Code, the PWD group knew there would be a gap in necessary accessibility requirements for people with unseen disabilities. For instance, individuals with autism may experience sensory overload from bright lights in a building, which could trigger a stressful episode (Irlen Institute, n.d.). Guidelines were needed for the building designers at PHSD so they could ensure an inclusive environment for people of all abilities within PHSD's infrastructure. These small changes would provide not only a benefit to individuals with disabilities but also to individuals without a disability.

### **What are some guidelines that could be developed to improve the accessibility of building design at PHSD for people with unseen disabilities such as autism?**

#### **PROMISING PUBLIC HEALTH PRACTICE #8: TO REDUCE SOCIAL INEQUITIES IN HEALTH: CONTRIBUTION TO THE EVIDENCE BASE**

One of the challenges the PWD group anticipated, which could hinder PHSD in facilitating an inclusive design for individuals of all abilities, is a lack of a system in place to routinely collect information regarding any unseen disabilities clients may have. Individuals could be entering the agency at any point in time with an unseen disability and wanting to access services. Although an individual may not visibly show it, he or she may struggle when using a provided service that is not fully accessible.

People with disabilities may feel hesitant in revealing their disability to health services providers. There are a wide variety of reasons for this, such as feelings of unnecessary intrusion or perceptions that they would be treated differently because of their disabilities. Issues such as provider attitudes, communication, physical barriers, and transportation are consistent across the literature for people with disabilities in accessing healthcare and contributing to the aforementioned disparities in health (de Vries McClintock et al., 2016). Studies using focus groups and other qualitative methods have found that people with disabilities perceived marginalization, feelings of incompetency, and a poorer quality of care at both the individual and the systemic levels (de Vries McClintock et al., 2016; Mulumba et al., 2014). The PWD group

## **Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All**

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realized that it would not be easy to collect this valuable information. They would have to organize information from all of PHSD's external visits and from clients visiting PHSD. She would have to somehow build trust with potential clients coming into the organization and let them know that it is a safe place to share this information. Staff would need to be directed to do this extra step of collecting information when working with new clients, adding to their rigorous list of duties.

In the long-term, the PWD group was proposing that there be a system in place where anyone using PHSD's services, either internally within the district offices or externally within the community, could feel comfortable in sharing information regarding a disability he or she may have. This would allow the PWD team and the rest of the PHSD staff to learn more about the various types of disabilities clients may experience. Over time, a database of local information can be built, which can be used to analyze the prevalence of disability types and to see if there are common themes within the PHSD area. The evidence base could help further inform program development and prioritization, adjustment of facilities, and inclusive policies.

**What is the best way PHSD can set up an efficient surveillance system to capture relevant information about a client's possible visible or unseen disability? How can they convince hesitant clients to share this information?**

### **PROMISING PUBLIC HEALTH PRACTICE #9: TO REDUCE SOCIAL INEQUITIES IN HEALTH: COMMUNITY ENGAGEMENT**

To ensure PHSD develops programs, services, infrastructure, and policies that are accessible for people with various kinds of disabilities within its catchment area, community engagement must be undertaken to engage other disability-related organizations that could provide valuable input and expertise. Currently, PHSD has partnerships with some, but not all organizations that work with people with disabilities within their catchment area. Under the Ontario Public Health Standards of 2008, the importance of collaboration with relevant stakeholders such as the voluntary sector and non-governmental organizations in the community is emphasized within each standard. The development of these partnerships has the end goal of fostering a supportive environment, which will help inform the assessment, planning, delivery, service, management, and evaluation of programs and services (Ontario Ministry of Health and Long-Term Care, 2014).

If PHSD continues to build on its relationships with organizations such as the Canadian Hearing Society (CHS), Canadian National Institute for the Blind (CNIB), and reaches out to other local disability-related organizations, the benefits would be numerous. One such example of a local partnership is the Accessibility Advisory Panel. It consists of nine members, many of whom have a disability, and advises City of Greater Sudbury staff members on matters of improving the accessibility of municipal services, municipal programs, and municipal facilities as required by the Ontarians with Disabilities Act (2001) and the newer AODA legislation (2005) (City of Greater Sudbury, n.d.b). Such partnerships could help PHSD refer and direct clients who need information or other forms of assistance that is out of their capacity or scope. These partnerships could be used to better inform programs and services to become more accessible. Valuable education could be shared with PHSD staff and clients to help influence their knowledge, attitudes, and beliefs regarding visible and unseen disabilities.

Some clients may have disabilities and not use any of PHSD's services, but may use the services provided by other organizations. As previously indicated, there is a desire to increase surveillance with those who utilize services of PHSD. If these clients with disabilities are not using the organization's services, this create a gap in any surveillance method used by PHSD when collecting data about people with disabilities in PHSD's encatchment area. Partnerships

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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with other organizations could enhance and make PHSD's information gathering system more comprehensive. From a qualitative standpoint, with the help of other organizations, PHSD could engage clients who use services from other organizations and use that feedback as part of their program planning process. Ongoing evaluation of the organization's programs, services, and infrastructure are essential to demonstrate that the desired impacts are being made with the proposed plans to make PHSD more accessible for all. CHS and CNIB could perform external audits of PHSD within their respective disciplines to mitigate any bias from any internal audits and to have an expert opinion from organizations mandated to improve the lives of people within the community.

However, there may be barriers for the organization in establishing these partnerships. What if the organizations are not interested in collaborating with PHSD? What if they prefer working alone? What if their staff do not have time to participate in meetings? PHSD had already established connections on a province-wide basis, being a part of the Ontario Public Health Association PWD Task Group, alongside Toronto, Lambton Public Health, Simcoe-Muskoka District Health Unit, Ryerson University, and York University, which was established in October of 2016. They were all eager to advance the progress of this issue, through sharing evidence-based practices, professional development, and influencing future policy development. However, Christina and the PWD group also needed to build upon partnerships at the local level.

**How can PHSD engage other disability-related organizations to collaborate in their work? What are some ways that they can get together to share information in a cost and time effective manner?**

### CONCLUSION

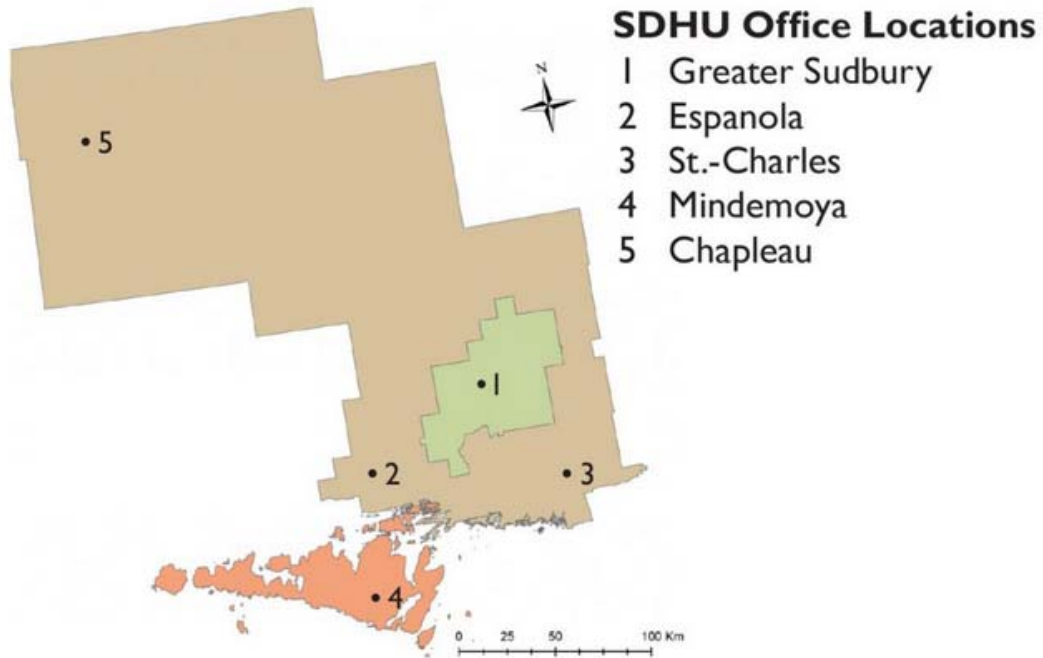
While some of the goals identified by the PWD Working Group have been achieved, there is always more work that can be done to achieve the longer-term goals. Three of the ten promising practices that PHSD has identified to reduce social inequities in health were presented: Targeting within universalism, contribution to the evidence base, and community engagement. With many activities outlined in their PWD plan, there are a lot of initiatives that could continue to be addressed and additional promising practices that could be used as a lens to inform their work. This is an important issue that should continue to be on the radar along with the various other priorities within the continually shifting public health landscape. Fortunately, there are several champions of this work within the organization who could continue to move it forward and integrate it into other initiatives including the health equity work and accessibility work.



## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

### EXHIBIT 1

#### Geographical Representation Depicting the Area Public Health Sudbury & Districts Serves and Location of District Offices



Source: Public Health Sudbury & Districts, 2016b.

Going Beyond the Wheel Chair Ramp: Public Health Sudbury  
& Districts' Plan to Become Accessible to All

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EXHIBIT 2

Prevalence and Types of Disabilities Experienced by Individuals  
Aged 15-64 Within Canada

**Table 1**

**Prevalence of disability by type, Canada, 2012**

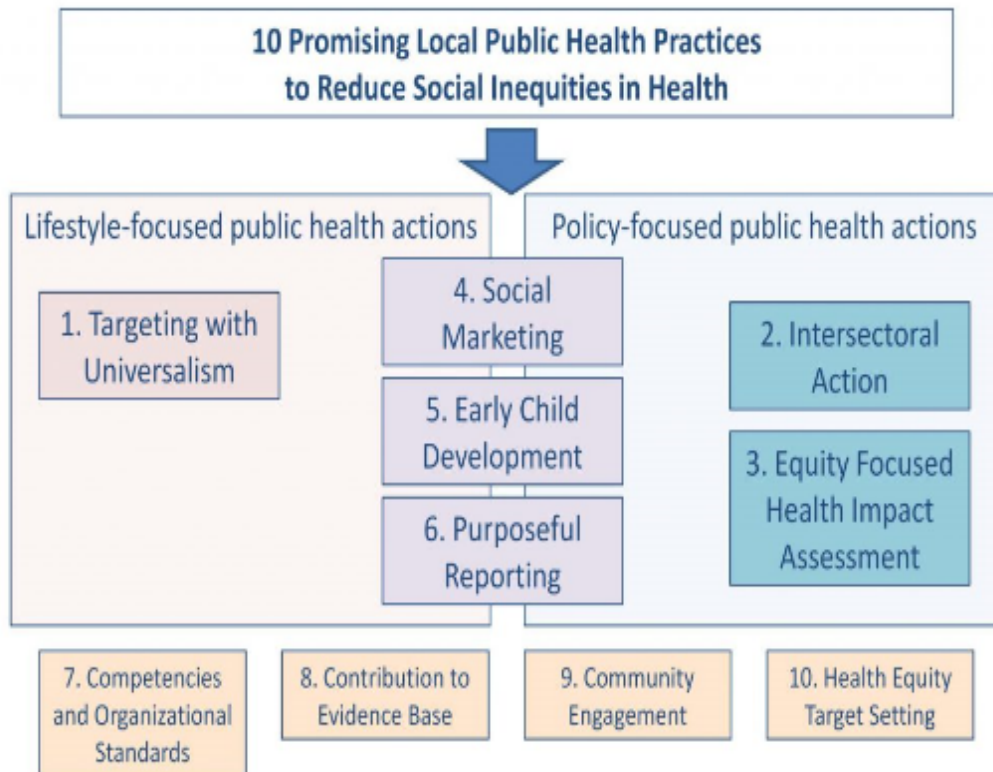
<b>Disability type</b>	<b>%</b>
Pain	9.7
Flexibility	7.6
Mobility	7.2
Mental/psychological	3.9
Dexterity	3.5
Hearing	3.2
Seeing	2.7
Memory	2.3
Learning	2.3
Developmental	0.6
Unknown	0.3

Source: Statistics Canada, 2017.

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

### EXHIBIT 3

#### Public Health Sudbury and District's Framework of 10 Promising Public Health Practices to Reduce Social Inequities in Health



Adapted from: Sudbury & District Health Unit. (2010, May). Implementing local public health practices to reduce social inequities in health. EXTRA [Executive Training for Research Application] Intervention Project: Final report.

Source: Public Health Sudbury & Districts, 2016a.

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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## INSTRUCTOR GUIDANCE

### Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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*Joelle Martel (Health Promoter, Public Health Sudbury & Districts)*

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*Mark Speechley, PhD (Professor, Western University)<sup>1</sup>*

#### BACKGROUND

Following years of advocacy work, Christina Peterson, foundational standards specialist at Public Health Sudbury & Districts (PHSD) and co-chair of the Evidence-Informed Practice Working Group (EIPWG), facilitated the formation of the People with Disabilities Working Group in early 2015. People with disabilities (PWD) faced significant health inequities compared to people without disabilities. The People with Disabilities Working Group had established three long-term outcomes from their logic model:

1. Programs and services at PHSD are fully accessible and inclusive, particularly for people with disabilities (especially for unseen disabilities).
2. Staff at PHSD have the ability to recognize, understand, and apply attitudes and practices that are sensitive to and appropriate for people with disabilities.
3. Staff have the knowledge, attitudes, and skills to ensure programs and services are fully accessible and inclusive for people with disabilities.

Oftentimes, public health programs, services, infrastructure, and policies are not designed with people with disabilities in mind. Healthcare professionals often focus on disabilities alone, rather than the needs of the whole person. PHSD recently developed ten promising local public health practices to reduce social inequities in a health framework. The PWD working group had made some progress towards their long-term goals, such as a board-approved motion for a person-centred language statement within PHSD. However, Christina knew that there was very little done that was based on the health equity framework they had established, especially for those with unseen disabilities. There was a need to go “beyond the wheel chair ramp”.

The goal of this case is for students to understand the definition of health equity and recognize its importance when planning, delivering, and evaluating public health programs, services, infrastructure, and policies within agencies. Based on a modern public health issue, students will have the opportunity to apply promising evidence-based public health practices to reduce social inequities in health and devise other programs when dealing with a marginalized population.

The backdrop of the case, which depicts Christina’s fight to create change within an organization, will highlight the social-ecological model of behaviour change typically applied in health promotion strategies.

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<sup>1</sup> *Special thanks to Joanne Beyers for her assistance as well.*

## Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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### OBJECTIVES

1. Define health equity.
2. Describe the importance of using a health equity framework when planning, implementing, and evaluating programs, services, infrastructure, and policies within public health agencies.
3. Assess various complex, multi-faceted, and common issues in public health related to health equity and devise recommendations for improvement.
4. Define and apply the social-ecological model when advocating for change within an organization.

### DISCUSSION QUESTIONS

1. What were some of the barriers Christina and the PWD team faced in advocating for the health outcomes for people with disabilities?
2. What are some other practices that PHSD can perform, which can reduce the social inequities for people with disabilities?
3. What are some of the benefits of using a health-equity framework when planning, delivering, and evaluating programs within PHSD?
4. Christina was an outstanding leader in this process. What are some of the qualities she possessed that helped create change?

### KEYWORDS

Health equity; people with disabilities; unseen disabilities; universal design; surveillance; community engagement; social-ecological model of behaviour change.





# **FACULTY CASES**



## CASE 16

### Don't Miss the Bus

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*Ava John-Baptiste, MHSc, PhD (Assistant Professor, Western University)*

“Avoid basing decisions on untested but strongly held beliefs, what you have done in the past, or on uncritical ‘benchmarking’ of what winners do.”

–Jeffrey Pfeffer, Thomas D. Dee II Professor  
of Organizational Behavior, Stanford University

#### BACKGROUND

The Canadian Health Measures Survey (CHMS) calculates body mass index based on the height and weight of survey participants. The 2004 CHMS revealed that 22% of Canadian children and youth are overweight and 12.7% are obese. The prevalence of high weight and obesity increased from 17% and 6.3%, respectively, between 1978/1979 and 2004 (Roberts et al., 2012). In 2012, the federal, provincial, and territorial governments of Canada identified reducing childhood obesity as an important area of action for health, stating health ministers “will champion this issue and encourage shared leadership and joint and/or complementary action from government departments and other sectors of Canadian society” (Public Health Agency of Canada, 2012). The province of Ontario accounts for one-third of the approximately 35 million people in Canada. King Region Public Health is one of 36 public health units in Ontario. The Region of King has 1,384,000 residents. It is located northeast of the City of Toronto in the Greater Toronto Area.

#### THE BUS

Philip Singe, the Chief Medical Officer of Health at King Region Public Health (KRPH), was a believer in evidence-based medicine. The belief was inculcated during his days as a medical student and enhanced by his experiences as a public health official. Public health received far fewer resources than medical care. As a public health official, he could not afford to waste time or money on ineffective practices. Philip stopped Vincent Randall, director of the Health Promotion portfolio, in the hall of the KRPH office. “Vince, a friend of mine just sent me a link to the Ottawa Student Transportation Authority website. Ottawa schools are offering a walking school bus program. It looks like they’re in the third year of the program. Twelve schools are operating this September. Ottawa Public Health is a partner” (Ontario Safety Council, 2018).

When hiring for the lead health promotion position last year, Philip had selected Vincent, because he felt Vincent understood the value of considering evidence when formulating health promotion initiatives. Vincent’s resume outlined training in evidence-based public health, and he demonstrated the skills required to identify and appraise evidence. “I’m familiar with the active transport concept, but I don’t have first-hand experience,” Vincent replied. “We have a meeting next week with King Region School Board. Do you want to propose something on active commuting?”

“Maybe.” Philip was intrigued, but his approach to the early phases of any program was to remain equivocal. “Would you be able to take a few days to prepare a briefing document on

active commuting? Focus on elementary school-aged children. Find out what's out there. What are the options? What works?" Philip paused, "I like the idea. I wouldn't be able to convince my teenaged son to walk to school, but maybe we can get to the young ones." He smiled.

"I like the idea too," Vincent responded. "I'll look into it. Would you be able to send me the Ottawa link?"

Vincent began with a search for systematic reviews. Given the short time frame, he wanted to get a handle on the quality and scope of the literature.

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## INSTRUCTOR GUIDANCE

### Don't Miss the Bus

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*Ava John-Baptiste, MHSc, PhD (Assistant Professor, Western University)*

#### BACKGROUND

Dr. Philip Singe is the Chief Medical Officer of Health in the fictional Region of King in Ontario, Canada. Upon learning that Ottawa Public Health is offering a walking school bus program, Dr. Singe asks Vincent Randall to investigate the evidence. In charge of the health promotion portfolio at King Region Public Health (KRPB), Vincent Randall has been asked to apply the principles of evidence-based public health to identify and appraise the evidence on walking school buses. KRPB may suggest a similar initiative to the King Region School Board during an upcoming meeting. Given the short timeframe of one week, Vincent is likely to begin his search by identifying systematic reviews of the literature that are pertinent to the walking school bus program.

The scenario depicted in the case is a common occurrence in public health organizations. In the process of developing new programs, the practices of other organizations and the opinions of leaders in the field can be influential. The case provides students with the opportunity to apply evidence-based practices to program and policy development in order to critically assess program options.

#### OBJECTIVES

1. Understand the importance of using evidence to inform health policy and program development.
2. Distinguish systematic reviews from other types of research and recognize the benefits and challenges of using this type of evidence.
3. Specify best practices in the conduct of systematic reviews and critically appraise the quality of a systematic review.
4. Search for systematic reviews in repositories and journal citation databases.
5. Using information from systematic reviews as a starting point, conduct searches for primary studies to inform public health practices.

#### DISCUSSION QUESTIONS

1. Using the epidemiological framework of population, intervention/exposure, comparison, outcome, and setting, develop a research question pertinent to the walking school bus program.
2. Read the review by Smith and colleagues (Smith, 2015<sup>1</sup>) and appraise the quality according to the criteria found in the Assessing the Methodological Quality of Systematic Reviews (AMSTAR) checklist ([http://amstar.ca/Amstar\\_Checklist.php](http://amstar.ca/Amstar_Checklist.php)).
3. Use the following systematic review repositories to identify additional evidence pertinent to the walking school bus program:
  - a. McMaster University, Health Evidence (<http://www.health-evidence.org/>)

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<sup>1</sup> See references on previous page.

- b. National Collaborating Centre for Methods and Tools  
([http://www.nccmt.ca/public\\_health\\_plus/all/1/list-eng.html](http://www.nccmt.ca/public_health_plus/all/1/list-eng.html))
  - c. Cochrane Database of Systematic Reviews (<http://www.cochrane.org>)
  - d. Cochrane Public Health Group (<http://ph.cochrane.org/>) – The Public Health Group is one of approximately 50 Cochrane Review Groups
  - e. Campbell Collaboration (<http://www.campbellcollaboration.org>)
  - f. Agency for Healthcare Research and Quality  
(<http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/>)
  - g. International prospective register of systematic reviews (PROSPERO)  
(<http://www.crd.york.ac.uk/PROSPERO/>)
4. Develop a search strategy and apply the strategy to search for additional evidence from journal citation indices, including:
    - a. PubMed (<http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed>)
    - b. Embase (<http://www.embase.com>)
    - c. PsycINFO (<http://www.apa.org/psycinfo>)
    - d. Cumulative Index of Nursing and Allied Health Literature (CINAHL)  
(<http://www.ebscohost.com/cinahl>)
  5. Specify an approach to systematically searching for evidence in the grey literature, including reports and guidelines from other public health units and national and international organizations.
  6. What are the appropriate next steps to applying evidence to decision-making? How should Vincent Randall prepare for a meeting with the King Region School Board?

### KEYWORDS

Evidence-based public health; systematic reviews; critical appraisal; health promotion; systematic review repositories; searching for evidence.





## CASE 17

### Can Hospitals do Health Promotion? Making Hospitals a Place for both Care and Health through Health Promotion

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*Shannon L. Sibbald, PhD (Assistant Professor, Western University)  
J. Ross Graham, MSc, MPA (Manager, Strategic & Quality Initiatives,  
Community Services Department, Regional Municipality of Waterloo)*

Lauren Kitsman, a young nurse with training in health promotion, had recently been promoted by her local hospital to be the new 'Special Programs Manager'. In this new role, she would advise the hospital on how to integrate new and innovative programming into the hospital's daily delivery of care.

A few months had passed since her hiring in July 2017, and she was sitting at her desk in the hospital after a busy day consulting with patients, staff, and families. She reflected on the patterns she had observed so far at the hospital. Despite remaining ill, patients were 'well enough' to be discharged and were heading home into the very environment that had led them to be sick in the first place. They were being discharged from the hospital, yet she had witnessed time and again the same patients coming back, often sicker than when they had left.

External pressures on the hospital were also a concern. Increased prevalence of patients with multiple chronic diseases and mandates to reduce costs impacted nearly all decision-making, from care delivery to senior management practices. In an effort to address these challenges, the Senior Leadership Team struck a working group to look at ways to improve patient care and satisfaction while also achieving cost savings. Lauren was the group chair.

The first meeting happened on a warm fall afternoon. Sitting at the boardroom table were a few of the hospital's senior leaders, directors, and other stakeholders, including a patient representative. As a health promoter, Lauren was able to draw upon a multi-disciplinary base of principles and theories to understand the health issues at the hospital and identified potential areas to inform health promotion action. Lauren initiated the discussion by sharing her thoughts on the current state of care at the hospital, particularly her sentiment that the creation of this working group was a Band-Aid solution to a much bigger systemic issue.

"If our hospital's goal is to improve peoples' health, why are we only focusing on the small amount of time when they are within our four walls?" said Lauren. "Certainly more can be done to help these patients after they leave, to ensure they only come back when they really need to."

The Hospital's Chief Executive Officer (CEO) interrupted, "But what? Our hospital's mandate and funding is for acute episodic care, not for long-term chronic care, nor for upstream prevention or health promotion."

## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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Lauren responded, “But if our patients don’t get the support they need beyond their short length of stay they will be back in hospitals – it’s a terrible revolving door.” The meeting seemed to be at a standstill as the committee was left with more questions than answers. The first meeting ended; it was the beginning of a new journey for Lauren and potentially for the hospital.

Lauren recalled reading about hospitals as settings for health promotion during her education. Lauren began searching the internet and reviewing the literature to better understand if hospitals with health promotion approaches have been effective at improving patient care or reducing service delivery costs. She remembered the all-encompassing health promoting hospitals (HPH) model but knew that transformational implementation at her hospital was unlikely. Even incremental steps towards change would require strong evidence and internal champions. After reviewing the literature, Lauren was confident that hospitals are well-positioned to use health promotion interventions with patients and staff, and to advocate for healthy communities.

#### **BACKGROUND: HEALTH PROMOTION**

In 1986, the World Health Organization (WHO) released The Ottawa Charter for Health Promotion, following the first international conference on health promotion (World Health Organization, 1986). The Charter redefined the concept of ‘health’, highlighted circumstances for improving it, and established a goal to achieve ‘health for all’ by the year 2000. Health should be understood not simply as the absence of illness or disease, but as a state of complete physical and mental wellbeing. The new definition of health challenged the relationship between health and the healthcare sector, as well as the traditional beliefs of how health was distributed and enhanced. This new definition also challenged the traditional role of hospitals as symbols of sickness and instead as potential centers of health promotion. This new view of hospitals suggested that even a small shift in focus within a hospital to support health promotion initiatives could, in time, make for a healthier community. The stage was set for change.

The WHO defined health promotion as “a process of enabling people to increase control over and to improve their health, looking to a wide range of social and environmental interventions”. The Ottawa Charter also established a series of recommendations to encourage and implement health-promoting initiatives. One particular recommendation – “The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative service” – stood out as a call to all healthcare organizations including hospitals. This mandate, according to the Charter, should support the needs of both communities and individuals to improve healthy living and open channels between the health sector and broader social, political, economic, and physical environmental components in an effort to truly achieve health promotion.

Lauren, as a health promoter, believed fully in the process of enabling staff, patients, and families using the hospital’s services to increase control over, and to improve, their health. This belief moved beyond a focus on individual behaviour towards a broad range of environmental and social interventions. However, Lauren’s options to implement even small strategies for health promotion were heavily constrained by the current health system. Understanding the goals of the hospital, to preserve themselves as a community asset by providing care while profiting off services, will be important when she plans to integrate her strategies.

#### **HEALTHCARE IN CANADA**

Any eligible Canadian, regardless of age, health, income, or employment status, is covered by a universal medical care system. The system is publicly-funded and privately-provided. This means that system operating revenues are primarily generated through taxation, and services

## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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are delivered by private nonprofit individuals (such as family physicians) and organizations (mostly hospitals). Non-urgent services, such as vision and dental care and long-term rehabilitation, are most often paid for out-of-pocket by Canadians. Canadian healthcare falls primarily under provincial/territorial jurisdiction. Each of the 10 provinces and three territories has a unique setup for delivery of health services, while maintaining the minimum required services by the *Canada Health Act* (Canada Health Act, 1986).

The fifth action area of the Ottawa Charter for Health Promotion, to 'Reorient Health Services', was created due to the urgent need to improve health in industrialized countries. The objective was to address the social determinants of health (SDOH), which acknowledge that the majority of the population health status is influenced by factors outside medical treatment and lifestyle choice. Unfortunately, little progress has been made to systemically reorient health services since this action area was established 30 years ago. As chronic diseases become more prevalent today, their prevention and management require a comprehensive health promotion approach to influence their SDOH and common, modifiable risk factors (such as unhealthy weight, poor diet, and physical inactivity).

Health promotion initiatives are generally the responsibility of public health and as such, fall into a different organization, funding, and delivery mechanism than hospitals and other healthcare services. The primary mandate of Canadian and Ontario hospitals is acute care and they are funded accordingly. When hospitals wish to engage in health promotion, they struggle to sustain these efforts due to non-existent funding.

Within the Ontario government, the Health Promotion Division is a component of the Ministry of Health and Long-Term Care. The Division's mission is to champion health promotion in Ontario and to inspire individuals, organizations, communities, and governments to create a culture of health and wellbeing. With the goal to make Ontario a leader in health promotion within Canada and internationally, the Division's agenda includes initiatives such as Smoke-Free Ontario, the Healthy Communities Fund, EatRight Ontario, the Northern Fruit and Vegetable Program, active living programs, and disease and injury prevention programs.

The Ontario Hospital Association (OHA) is "the voice of Ontario's public hospitals" (Ontario Hospital Association, 2017). The mission of the OHA is to support the 150 Ontario hospitals by championing innovation and performance improvement, and advancing and influencing health system policy. The OHA's values are health-focused, evidence-based, collaborative, and trusted. The Association is guided by the health needs of the population, uses the best available evidence and experience, works in partnership to influence a high-performing healthcare system, and values trust among members, partners, staff, and consumers of the system.

An example of successful integration of health promotion within acute care exists in Winnipeg, Manitoba. Seven Oaks General Hospital (an acute care community hospital) implemented health promotion approaches throughout the organization. By embedding health education along with chronic disease prevention and management initiatives, this hospital has been the Canadian hallmark of the HPH approach internationally. Perhaps most notable has been Seven Oaks' novel process of connecting hospital and emergency care with follow-up care by family physicians along with support for self-management, all within a single setting (Seven Oaks General Hospital, 2017).

While this information was useful to Lauren, her big question remained the same: "What can and should be done in and by our hospital to provide better care for our patients, and to support improved health in our community?"

## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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She read about how hospitals are considered local 'anchor institutions', meaning that hospitals have a lot of social capital in their communities and they can use this to influence decisions about urban planning, social services, and other factors outside the health system that influence human health. Citizens respect hospital leaders, especially senior clinicians, and care about what hospitals have to say about things outside the health system. Hospitals are also often large employers and purchasers, and they often have large real estate holdings. Lauren also learned that hospitals can be good partners with other organizations, and that these partnerships can influence community health and local prosperity by reducing the economic burden of chronic diseases.

Through partnering with other sectors, such as urban planning and housing, and with local non-profits, such as food banks, the hospital could establish a new way of working in the community to improve health. As an anchor institution, her hospital could speak to the importance of improving local social and economic conditions throughout the community. Similarly, the hospital could focus on increasing primary and secondary prevention services, as well as patient self-management skills, all in a way that gives patients more control over their health. However, could this type of a collective effort work? Would this lead to her hospital becoming a 'health promoting hospital'? What would implementing health promotion initiatives at an acute-care setting even look like? Should similar approaches to Seven Oaks General Hospital be used?

#### **THE INTERNATIONAL NETWORK OF HEALTH PROMOTING HOSPITALS AND HEALTH SERVICES**

The International Network of Health Promoting Hospitals & Health Services (IHPHN) started in the early 1990s as a mechanism for international coordination of action related to the Reorient Health Services action area of the Ottawa Charter. Described as a "network of networks", IHPHN consists of over 40 national and regional HPH networks in 40 countries, as well as individual hospital members located in places without a network. Together, the >1000 member organizations share a goal of using hospitals and healthcare settings as a vehicle to promote health and wellbeing in their communities. HPH networks provide mandates, networking, and best-practice sharing supports to their member hospitals. Networks are guided by a common aim to achieve healthier outcomes, improve healthcare quality, improve relationships between hospitals and other health service providers, and to improve care and health of satisfaction patients and staff.

Rooted in the Ottawa Charter of the WHO, the IHPHN launched its first policy document in 1991: "The Budapest Declaration on Health Promoting Hospitals". This document introduced a call to action for HPH (see Exhibit 1). As a follow-up to this document, the Vienna Recommendations were developed in 1997 to support the growing need for systemic guidance on hospital implementation.

In December 2010, the IHPHN became formally linked with the WHO. This process included development and promotion of international standards to promote effective health promotion practices in hospitals and healthcare settings. The five standards also allow networks to evaluate and compare health promotion developments in member hospitals:

#### Standard 1: Management policy

A health promoting hospital or health service organization must have a written policy for health promotion. Health promotion must be implemented as an integral part of the organization's system and aimed at patients, relatives, and staff. There must be an allocation of resources

## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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towards health promotion, and staff must be competent in the area. The necessary infrastructure, space, and equipment must be available to implement health promotion programs and services.

#### **Standard 2: Patient assessment**

A health promoting hospital or health service organization must support treatment, improve prognosis, and promote the health and wellbeing of patients. A health promotion assessment should be done at the patient's first point of contact with the hospital and should be reviewed and adjusted as necessary. This needs assessment should be done in partnership with the patient and the healthcare provider and be socially and culturally sensitive.

#### **Standard 3: Patient information and intervention**

A health promoting hospital or health service organization must provide patients with information on significant factors concerning their condition. Furthermore, the appropriate health promotion interventions must be established in all patient pathways. All information given to patients must be documented and evaluated and all staff and visitors must have access to general health influencing information.

#### **Standard 4: Promoting a healthy workplace**

The conditions of a health promoting hospital or health service organization must be those of a healthy workplace. A comprehensive human resources strategy must be developed to include the training of health promotion skills. Staff must be involved in the decisions made about their working environment and should be aware of health issues. The healthcare organization should have health promoting activities for its staff and a policy for a healthy and safe workplace.

#### **Standard 5: Continuity and cooperation**

A health promoting hospital or health service organization must have a planned approach to collaborate with other health service institutions and sectors on an ongoing basis. Partnerships should be initiated to optimize the integration of health promotion into the patient pathway. The appropriate documentation and patient information must be communicated to the appropriate partner in patient care or rehabilitation. There should also be cooperation between health care providers within health promoting hospitals and health services and community groups.

Initially a European initiative, the HPH concept has expanded worldwide. As of 2017, there are over 1000 hospital and health service members spanning across 40 countries (see Appendix B).

The HPH concept seemed daunting, but possible in her hospital. Lauren also knew there were specific challenges in the Canadian healthcare system that would need to be considered. The responsibility to advocate for healthier communities remained with public health; however, while chronic disease rates continued to escalate, public health funding in Canada was decreasing. Public health also lacked the community social capital that hospitals have to influence societal beliefs. Lauren also considered the fiscal constraints faced by her hospital. After more research, she came across the Ontario Health Promoting Hospital Network. Perhaps this would provide her with some answers.

### **THE ONTARIO HEALTH PROMOTING HOSPITAL NETWORK (OHPHN)**

Inspired by the work of the International Health Promoting Hospitals & Health Services Network, in 1997, an informal HPH network was started in Ontario, Canada. The network was founded by a few passionate, dedicated healthcare professionals who wanted their hospitals to be more proactive about preventing, not just treating, illness and injury, and more broadly, promoting healthy communities. In the beginning, the excitement and energy around the OHPHN was

## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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small; however, it soon gained organizational support. Originally sponsored by a complex care and rehabilitation hospital in Toronto, OPHPHN joined the International Network in 2008, and became the first official HPH network in Ontario and the second in Canada (the first was Montreal in 2005) (for more information visit: <https://www.hphconferences.org/>).

The OPHPHN committee worked tirelessly to disseminate knowledge around the HPH approach. The committee's aim was to increase support from both individuals and organizations for hospital-based health promotion. Its vision was "to have all health care environments in Ontario committed to the promotion of health and the prevention of disease". The network also worked to increase public awareness about the benefits of health promotion and chronic disease prevention.

#### **OHPHN OBJECTIVES**

OHPHN also created opportunities for open and constructive dialogue around the aims and objectives of healthcare. They wanted to challenge long-held assumptions about the health system, such as: Should 95% of system resources go toward care, when we need to focus on prevention? Is prevention only the responsibility of public health, or should prevention and health promotion be part of care? If patients are given more control over their health, will this reduce healthcare demand and costs? OHPHN leaders wanted to obtain buy-in from all levels of the system and together work toward advancing health promotion. To do this, everyone needed to understand the system level impact of an HPH approach. OHPHN aimed to foster knowledge exchange, partnerships, and shared allocation of resources.

To formalize its approach, the network developed six main objectives:

1. Improve healthcare quality and quality of life for patients, staff, and the community.
2. Encourage experience exchange through network meetings.
3. Enhance organizational policies and practices in health promotion.
4. Explore application of standards and indicators into hospital management systems.
5. Establish a local, national, and international presence.
6. Contribute to the evidence base for health promoting hospitals.

However, Ontario hospitals were in a difficult situation. They had to reduce costs while dealing with increased demand for service. The network saw these challenges as an opportunity to gain leadership and support. Health promotion strategies can be mechanisms to improve system sustainability. Healthier citizens and patients could lead to cost reduction. In 2008, an important relationship formed between the OPHPHN and the OHA. This relationship gave the network increased credibility and presence. Between 2008 and 2012, seven hospitals and health centers became official members of OPHPHN. In addition, over 30 participants from hospitals and healthcare organizations become individual members. Everyone involved seemed passionate about making their hospitals healthier.

Around the same time, another key relationship was established between OPHPHN and the Centre for Addiction and Mental Health (CAMH), Canada's largest mental health and addiction teaching hospital and leading research centre in mental health and addiction. The network supported CAMH in its efforts to include health promotion in its policy, programming, and resources.

OHA, CAMH, and OPHPHN shared concern for a sustainable healthcare system that actually improved the health of patients and the population. OPHPHN brought expertise around primary prevention; OHA understood the key drivers and needs of hospitals; and, CAMH was a perfect setting to test these approaches to change. Together, they would influence health system policy

## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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and increase support for the idea that health promotion ought to be a core function of hospitals. To make the case for health promotion as essential to Ontario's health system more broadly, an official provincial advisory committee was formed between the OHA and OHPHN. The committee's first task was to develop key system-level performance indicators. Typical process measures of length of stay and emergency visits were difficult to associate with improved health promotion – the network needed to be creative (and cautious) in measuring effectiveness. The founding mentors of OHPHN were thrilled with the network's success and the direction it was going. Individual network members were also celebrating the successes of an urban hospital, which disseminated the international health promotion standards throughout their organization and created a framework to support building health promotion policies. One specialty hospital used resources and partnerships to support health promotion through hiring one full-time position for health promotion.

The next goal for OHPHN was to expand and partner with other HPH initiatives across the country (such as Quebec and Manitoba), to propel a nation-wide health promotion movement in Canada. In 2011, leaders and researchers from the Department of Health Administration of the Université de Montréal, the OHPHN, the Quebec HPH network, and an HPH member hospital representative from Manitoba, had a meeting in Ottawa with Accreditation Canada (AC) leadership. They met to discuss shared interests and the alignment of HPH with AC quality goals and standards. AC's accreditation program focuses on the quality and safety of an organization in the health sector to ensure all aspects of the organization's services directly benefit patients, clients, residents, staff, and volunteers.

At local, provincial, and national levels, health promotion was making headway. Aligning with the OHPHN's approach seemed like a perfect solution to the goals Lauren wanted to achieve in her hospital. She continued to learn more about the network and became curious as to why she hadn't heard of this network earlier and what it was doing now.

#### **CHALLENGES**

Challenges arose not long after the increased momentum of the OHPHN in 2009, when leadership changes and champions were relocated within their organizations. A lack of personal contact and less frequent communication amongst OHPHN members caused further challenges. Buy-in declined and resources decreased (time, personnel, funding). The identified priorities of the proposed framework and health promotion activities seemed to have been lost in the transitions.

Strategic partnerships and key relationships also started to break. Leadership at OHA changed and the relationship slowly disintegrated; partnership members were forced to shift their focus elsewhere as new policies and new system restraints arose. Many planned health promotion programs were no longer considered a feasible point of core business. Although dialogue with AC was promising, the lead champion for HPH at AC left his position, and the OHPHN lost institutional support.

The reduction in resources imposed difficulty in assessing performance indicators and reporting on outcomes. This lack of ongoing assessment and implementation capacity for performance in network hospitals was a fatal blow. Without evidence of effectiveness, obtaining new funding, or at the minimum maintaining past resources, was near impossible. With the growing pressure for budget cuts, performance measurements remained an important indicator for policy-makers and administrators to assess opportunity in healthcare initiatives. Without an accurate understanding of impact or outcomes, many OHPHN-led initiatives were difficult to prove effective. System-



## **Can Hospitals do Health Promotion?**

### **Making Hospitals a Place for both Care and Health through Health Promotion**

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level change, while lofty and imperative, is even more difficult to measure. It was impossible for OHPHN members to prove the impact of something that 'just felt right'.

The support from OHA further waned in 2011. The OHPHN moved to a barebones structure, primarily relying on grassroots, self-directed activities to reorient their hospitals towards health promotion. This was challenging when at the same time, healthcare organizations were under increased pressure to deliver and maintain existing services. This strategy proved increasingly difficult, and OHPHN felt it was back to square one. When local hospitals faced cuts and layoffs, the OHPHN struggled to remain active. Demands on Ontario hospitals continued to rise and resources allocated towards health promotion became low priority. There was limited government support for integrating health promotion into acute care. This lack of support was a primary barrier to the implementation and maintenance of HPH activities in Ontario and across the country.

Support had waned, and excitement around the network was not where it needed to be. Given the barriers that prevented the OHPHN from being successful, the network officially disbanded in 2012.

Although the attempt to advance health promotion across all Ontario hospitals was unsuccessful, Lauren remained inspired by the original aims of OHPHN. She believed she still had leadership support to advance health promotion in her setting despite her hospital's challenges, and she believed a health promotion approach was important for improving both patient care and health.

At their next meeting, the CEO informed Lauren that she would receive limited funding to implement a sustainable health promotion and prevention strategy in the hospital. Now she needed to determine what to do with these limited resources, what lessons she would learn from the OHPHN experience, and how she would advance health promotion despite resource constraints and limited system support.

### **CURRENT PERSPECTIVES ON HEALTH PROMOTION IN HOSPITALS**

The concept of health promoting hospitals has changed since its first iteration in 1989. Hospital-based health promotion activities have shown promise and there is an increasing knowledge- and evidence-base showing the benefits of certain HPH interventions (Graham, Boyko, & Sibbald, 2014). Hospitals that employ health promotion strategies with patients, their staff, and the community are viewed as facilitators of change needed to improve healthcare quality, health equity, and population health.

Unlike regular hospitals, a health promoting hospital realizes the full potential of the HPH approach for increasing the health of its patients, staff, and the community through implementing effective health promotion practices. In Quebec, 37 hospitals (members of the provincial Integrated Health and Social Services Centres) have implemented a health promoting hospital approach. In 2005, the Montreal Network of Health Promoting Hospitals became the first regional HPH network created outside of Europe. In 2012, the Montreal network expanded to become the Quebec Network of Health Promoting Institutions. Participating hospitals in the Quebec network embarked on a journey that emphasized health promotion achievements on topics such as health promoting psychiatric health services, and migrant-friendly and culturally-competent healthcare. Knowledge translation processes within the Quebec network have helped reinforce the capacity for hospitals to engage in health promotion and prevention. The Quebec network has produced important HPH research and resources to support its members, including a self-assessment tool that has been used by hospitals to assess and demonstrate

## Can Hospitals do Health Promotion?

### Making Hospitals a Place for both Care and Health through Health Promotion

improved health outcomes, approach effectiveness, and overall performance. Using this tool, network hospitals in Quebec have seen better health outcomes for patients, staff, and the community.

Unsure of the next steps but knowing there were other options that have worked outside of Ontario, Lauren decided her hospital could start by implementing small scale initiatives that are inspired by the health promoting hospitals approach. She remained confident that hospitals can pursue social justice for healthier communities and can be advocates for the pressing need to reorient healthcare resources. However, she worried about her colleagues' questions of the HPH approach, given the opposition that the OPHN faced. Lauren looked to other successes like in Winnipeg, Manitoba where incremental change at the organizational level with the help of individual champions had achieved success. Lauren was anxious to come up with a strategy to advance HPH. The strategy would need to include specific ideas, evaluation metrics, and resource needs so that she could present it and gain approval from the CEO. She needed to get the plan ready for the next executive meeting in two weeks.

**Can Hospitals do Health Promotion?**  
**Making Hospitals a Place for both Care and Health through Health Promotion**

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**EXHIBIT 1**

**Budapest Declaration on Health Promoting Hospitals, 1991**

Note: First policy paper on HPH, which outlines target groups, basic principles and action areas.

*Part 1*

*Content and Aims for Hospitals participating in Health Promoting Hospitals – an International Network*

Beyond the assurance of good quality medical services and health care, a Health Promoting Hospital should:

1. Provide opportunities throughout the hospital to develop health-orientated perspectives, objectives and structures.
2. Develop a common corporate identity within the hospital which embraces the aims of the Health Promoting Hospital.
3. Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and improve the healing process.
4. Encourage an active and participatory role for patients according to their specific health potentials.
5. Encourage participatory, health-gain orientated procedures throughout the hospital.
6. Create healthy working conditions for all hospital staff.
7. Strive to make the Health Promoting Hospital a model for healthy services and workplaces.
8. Maintain and promote collaboration between community based health promotion initiatives and local governments.
9. Improve communication and collaboration with existing social and health services in the community.
10. Improve the range of support given to patients and their relatives by the hospital through community based social and health services and/or volunteer-groups and organisations.
11. Identify and acknowledge specific target groups (e.g. age, duration of illness etc.) within the hospital and their specific health needs.
12. Acknowledge differences in value sets, needs and cultural conditions for individuals and different population groups.
13. Create supportive, humane and stimulating living environments within the hospital especially for long-term and chronic patients.

## Can Hospitals do Health Promotion?

### Making Hospitals a Place for both Care and Health through Health Promotion

14. Improve the health promoting quality and the variety of food services in hospitals for patients and personnel.
15. Enhance the provision and quality of information, communication and educational programmes and skill training for patients and relatives.
16. Enhance the provision and quality of educational programmes and skill training for staff.
17. Develop an epidemiological data base in the hospital specially related to the prevention of illness and injury and communicate this information to public policy makers and to other institutions in the community.

#### *Part 2*

#### *Criteria for Hospitals participating as Pilot Hospitals in Health Promoting Hospitals - an International Network*

#### **Basic Recommendations**

1. Acceptance of the principles declared in the «Ottawa Charter on Health Promotion».
2. Acceptance of the document «Content and Aims for Health Promoting Hospitals».

#### **Specific Recommendations**

Acceptance of the criteria of the European «Healthy Cities» project as they relate to the hospital:

1. Approval to become a Health Promoting Hospital to be sought from the owner, management and personnel of the hospital (including representatives of unions, working council). A written submission will be required.
2. Willingness to cooperate and ensure the funding of programmes with an independent institution in relation to planning, consultation, documentation, monitoring and evaluation.
3. Evaluation to be undertaken annually in order to guide future action.
4. Willingness to develop an appropriate organizational structure and process, supported by project management to realize the aims of the Health Promoting Hospital.
5. Establishment of a Joint Project Committee (with representatives from the Pilot Hospital and institutions of research and/or consultation).
6. Nomination of a project manager by the hospital, who is accountable to the Joint Project Committee.
7. Provision of necessary personnel and financial resources as agreed by the Joint Project Committee.

## Can Hospitals do Health Promotion?

### Making Hospitals a Place for both Care and Health through Health Promotion

8. Readiness to develop at least five innovative health promoting projects related to the hospital, the people who work within it, and the population served, with goals, objectives and targets for each project. Projects should be complementary to health promotion initiatives in primary health care.
9. Public discussion of health promotion issues and possible health promoting activities within the hospital.
10. Provision of evaluation information at least annually to
  - the Joint Project Committee
  - the management
  - the staff
  - the public and to those who provide funding
  - other organizations, both local, national and international including WHO and the Coordinating Centre for the Network.
11. Exchange experience by networking with:
  - other hospitals
  - Health Promoting Hospitals – an International Network (participation in Business Meetings etc.)
  - National Network (group of nominated observers from different institutions with an interest in health).
12. Link the Health Promoting Hospital projects with congruent local health promotion programmes, especially those within the Healthy Cities Network.
13. Prospective running period of the model: 5 years.

This declaration has been issued at the 1st Business Meeting of the International Network of Health Promoting Hospitals.

Source: World Health Organization, 1991.

**Can Hospitals do Health Promotion?**  
**Making Hospitals a Place for both Care and Health through Health Promotion**

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**EXHIBIT 2**  
**WHO Health Promoting Hospitals Members List**

Note: Selected list of hospitals and health services in National/Regional networks registered with WHO. Not a full list of participating members. Any member of the International Network pays an annual membership fee based on the size of an organization and its location. The flat fee for an organization that has ≤ 1000 employees is 250 €. For each additional 1000 staff members, this fee increases by 250 €. A flat fee of 150 € is required for members in lower income countries, and a flat fee of 100 € is required for members in developing countries. Membership fees assist the International Network to maintain and ensure quality, evidence-based standards, and commitment from organizations.

<b>Name</b>	<b>Type</b>	<b>Country</b>	<b>N/R Network</b>
Alfred Health	Health Service	Australia	Australia
Barwon Health	Health Service	Australia	Australia
BreaCan	Hospital	Australia	Australia
Frankston Hospital (Peninsula Health)	Hospital	Australia	Australia
The Peter McCallum Cancer Centre	Health Service	Australia	Australia
The Royal Women's Hospital Melbourne	Hospital	Australia	Australia
A.ö. Krankenhaus der Barmherzigen Brüder - St. Veit	Hospital	Austria	Austria
A.ö. Krankenhaus St. Josef Braunau GmbH der Franziskanerinnen von Vöcklabruck	Hospital	Austria	Austria
A.ö. Landeskrankenhaus - Universitätsklinikum Graz	Hospital	Austria	Austria
A.ö. Landeskrankenhaus Hochsteiermark	Hospital	Austria	Austria
Bezirkskrankenhaus Schwaz Betriebsgesellschaft m.b.H	Hospital	Austria	Austria
Geriatrische Gesundheitszentren der Stadt Graz	Health Service	Austria	Austria
Kardinal Schwarzenberg'sches Klinikum	Hospital	Austria	Austria
Kepler Universitätsklinikum GmbH	Hospital	Austria	Austria
Klinikum am Kurpark Baden	Health Service	Austria	Austria
Klinikum Klagenfurt am Wörthersee (former A.ö. Landeskrankenhaus Klagenfurt)	Hospital	Austria	Austria
Klinikum Wels-Grieskirchen	Hospital	Austria	Austria

**Can Hospitals do Health Promotion?**  
**Making Hospitals a Place for both Care and Health through Health Promotion**

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Krankenanstalt Sanatorium Hera	Hospital	Austria	Austria
Krankenhaus der Barmherzigen Brüder - Wien	Hospital	Austria	Austria
Krankenhaus der Elisabethinen Graz	Hospital	Austria	Austria
Krankenhaus der Stadt Wien Hietzing mit Neurologischem Zentrum Rosenhügel (former Lainz)	Hospital	Austria	Austria
Landeskrankenhaus Graz Süd-West	Hospital	Austria	Austria
Landeskrankenhaus Weiz	Hospital	Austria	Austria
Neurologisches Therapiezentrum Kapfenberg	Health Service	Austria	Austria
Sozialmedizinisches Zentrum Baumgartner Höhe - Otto Wagner Spital mit Pflegezentrum	Hospital	Austria	Austria
Sozialmedizinisches Zentrum Ost - Donaospital	Hospital	Austria	Austria
Sozialmedizinisches Zentrum Süd - Geriatriezentrum Favoriten	Health Service	Austria	Austria
Sozialmedizinisches Zentrum Süd - Kaiser-Franz-Josef-Spital der Stadt Wien	Hospital	Austria	Austria
Wilhelminenspital der Stadt Wien	Hospital	Austria	Austria
Seven Oaks General Hospital	Hospital	Canada	
McGill University Health Centre (MUHC)	Hospital	Canada	
Dalian Kaishi Friendship Hospital	Hospital	China	
Hunan Cancer Hospital / The Affiliated Cancer Hospital of Xiangya School of Medicine, Central South University	Hospital	China	
Hunan Provincial People's Hospital	Hospital	China	
Longgang District Central Hospital of Shenzhen	Hospital	China	
Maternal and Child Health Hospital of Hubei Province	Hospital	China	
Shenzhen Guangming New District People's Hospital	Hospital	China	
Shiyan Taihe Hospital	Hospital	China	

Source: International Health Promotion Network, 2017.

**Can Hospitals do Health Promotion?**  
**Making Hospitals a Place for both Care and Health through Health Promotion**

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## INSTRUCTOR GUIDANCE

### Can Hospitals do Health Promotion? Making Hospitals a Place for both Care and Health through Health Promotion

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*Shannon L. Sibbald, PhD (Assistant Professor, Western University)  
J. Ross Graham, MSc, MPA (Manager, Strategic & Quality Initiatives,  
Community Services Department, Regional Municipality of Waterloo)*

#### BACKGROUND

Lauren Kitsman trained as a health promoter and is now working for a hospital. She has been tasked with implementing a health promotion approach in her hospital and has tried to understand the health issues at the hospital and identified potential areas to inform health promotion action. She turned to the 'health promoting hospitals (HPH) approach' in order to bridge the gap between acute care and health promotion in the hospital setting. As she looked deeper into HPHs in Ontario, she discovered an advocacy network, the Ontario Health Promoting Hospitals Network (OHPHN). While the initiative had largely been unsuccessful in Ontario, Health Promoting Hospital Networks had been successful and continue to have momentum in Europe and around the world. There seemed to be success stories from other provinces (Quebec, in particular). Why is Ontario so different, and what could be done to overcome the barriers to make the work of this network successful? What can Lauren learn from international HPH efforts to apply in her local context? Lauren wants to make changes that are sustainable and in-line with HPH approaches but needs to remain true to the acute mandate of her hospital. She is unsure of next steps.

#### OBJECTIVES

1. Analyze the challenges associated with implementing health promotion in a traditional acute care setting.
2. Explore how to influence patient and health care culture.
3. Develop effective communication strategies to enable a champion in fulfilling health promotion objectives in hospitals and clinical settings.
4. Learn from the historical challenges of managing a health promoting network from multiple settings.

#### DISCUSSION QUESTIONS

1. In order to ensure the highest quality of health promotion amongst network members, the International Network developed five standards to be used to implement and assess health promoting hospitals and health services.
  - a. How may the five standards be integrated into a clinical setting?
  - b. Do the five standards still resonate in today's healthcare climate?
2. What are the goals of health promotion?

## Can Hospitals do Health Promotion?

### Making Hospitals a Place for both Care and Health through Health Promotion

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3. What are the goals of (hospital-based) acute care?
4. How might a hospital integrate health promotion into existing practice?

#### **KEYWORDS**

Health promotion; organizational change; acute care; networks; hospitals; Ottawa Charter.

# **INTEGRATIVE WORKSHOPS**



## INTEGRATIVE WORKSHOPS

As described in the Preface to this Casebook, the MPH Program holds integrative workshops three times a year for its students. These day-long workshops present students with an opportunity to bring the knowledge they have gained in the Program to bear on a topical issue in public health. The following section provides an outline of each workshop held during 2016/17, with a view to sharing examples for others interested in this type of approach to teaching.

### INTEGRATIVE WORKSHOP #1 SYRIAN REFUGEES IN CANADA FALL 2016

#### Faculty Leads

Dr. Mark Speechley, Professor  
Dr. Lloy Wylie, Assistant Professor

#### Speakers

Dr. Sherin Hussein, *Community Capacity Building Coordinator*, Cross Cultural Learner Centre

Hoda Herati, MD, MPH'16

Dr. Mohamed Al-Adeimi, *Director, Newcomer Settlement Services*, South London Neighbourhood Resource Centre

Dr. Sahar Atalla, *Strengthening Families Program Coordinator*, Muslim Resource Centre for Social Support and Integration

Ibrahim Marwa, MD, MPH'16

#### Scenario

On March 15, 2011, an uprising began in Syria. The Syrian regime reacted to this uprising—killing civilians, bombing cities and mass incarcerating protestors—which led to a mass migration and displacement of citizens to other regions of Syria and surrounding countries. Over the past 5 years, more than 7.4 million people have fled Syria to Jordan, Turkey, Lebanon, European countries, and others. Over the last year, Canada has accepted more than 25,000 Syrian refugees. The Canadian government, as well as private sponsors, are responsible to provide basic living requirements, including shelter, salary, education, and other social services to these individuals.

#### Objectives

Learning teams will be provided with one of five case studies that demonstrates some of the struggles faced by Syrian refugees in Canada. Teams will also be assigned with either a research or practice focus, with which they will complete the following objectives.

1. After discussing your case with your Learning Team (LT), create a **Concept Map** on your Team Board from a practice/research perspective (as assigned) that addresses the public health issues as identified from your case study. Teams will divide in half and simultaneously either 1) *present* their own Concept Map to another team (as assigned) or 2)

## Integrative Workshops

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*evaluate and comment on* the Concept Map of another team (as assigned; writing comments directly on the team board). LTs will reconvene in their rooms to complete an online evaluation of their paired team’s Concept Map. Team Board snapshots are also to be uploaded to OWL for evaluation by visiting experts.

2. Learning Teams (LTs) will conduct a **Literature Search**, from a practice/research perspective (as assigned) on the public health issues they identified from their case study. While no formal Literature Review is required, students will take notes of important key findings and will consider how these findings can address other relevant public health issues surrounding the topic of Syrian Refugees. Next, students will actively participate in a large group discussion (in the classroom) where they will present insights from their Literature Search to their classmates and visiting experts. *Note: There will be no written requirement or upload for this Deliverable – participation in the large group discussion will be evaluated.*
3. Learning Teams (LTs) will conduct a 5-minute **Presentation** of research/practice recommendations (as assigned), including concrete recommendations that are within the scope of work conducted by the represented community agencies. LTs are to upload their presentation slide(s) to OWL and feedback from visiting experts will be provided following each presentation.

### Schedule

8:00-8:15	Arrival – tea and coffee
8:15-8:30	Dr. Wylie: Introduction
8:30-8:50	Dr. Sherin Hussein, Community Capacity Building Coordinator, Cross Cultural Learner Centre
8:50-9:05	Dr. Hoda Herati, MD, MPH
9:05-9:25	Dr. Mohamed Al-Adeimi, Director, Newcomer Settlement Services, South London Neighbourhood Resource Centre
9:25-9:30	Instruction and Distribute Deliverable 1
9:30-9:45	Break
9:45-10:15	Prepare Deliverable 1
10:15-10:45	Present & Assess Deliverable 1
10:45-12:00	Return to LT rooms to prepare for Deliverable 2
12:00-12:45	Lunch
12:45-2:00	Dr. Sahar Atalla, Strengthening Families Program Coordinator, Muslim Resource Centre for Social Support and Integration  Deliverable 2
2:00-2:15	Dr. Ibrahim Marwa, MD, MPH
2:15-2:45	Instruction and Prepare Deliverable 3
2:45-3:00	Break
3:00-4:15	Present Deliverable 3
4:15-4:30	Conclusions

**INTEGRATIVE WORKSHOP #2**  
**POLICY MEETS PRACTICE: SUGAR SWEETENED BEVERAGES**  
**WINTER 2017**

**Faculty Leads**

Dr. Jacob Shelley, Assistant Professor  
Dr. Shannon L. Sibbald, Assistant Professor

**Speakers**

Linda Stobo, *Program Manager*, Middlesex-London Health Unit

Dr. Mats Junek, *Global Coordinator*, NCD Free

Joe Belfontaine, *Executive Director (Ontario Mission)*, Heart & Stroke Foundation

Elizabeth Holmes, *Policy Analyst*, Canadian Cancer Society

**Scenario**

Sugar sweetened beverages (SSBs) are classified as any drink that contains added sugar, including soft drinks, such as soda or pop, tea and coffee drinks, sport drinks, fruit juices and energy drinks.[1] SSBs are considered a public health issue due to the alarmingly high rates of obesity and type 2 diabetes associated with the intake of added sugars in sugary drinks and other high calorie foods.[1,2] High rates of obesity and type 2 diabetes in young children and adolescents are of particular concern.[2] Children who consume high intakes of sugar are 55% more likely to develop obesity and type 2 diabetes compared to those who consume low intakes of sugar.[1,3] Moreover, obesity may heighten the risk of developing other chronic diseases.[3]

Given the problem that SSBs pose, many argue that government intervention is required. For example, evidence based studies demonstrate that the implementation of a tax on sugared sweetened beverages may lead to decreases in consumption and improvements in body mass index, specifically in high income countries.[1] An excise tax on sugared beverages would be applied before the point of purchase and is expected to reduce consumption by 13%.[1] It is likely that reductions in consumption would be significant in low income communities where the risk of developing type 2 diabetes is higher.[1] Furthermore, some public health communities have said the revenue from an excise tax could be used to fund anti-hunger, obesity prevention, and other health initiatives.[1]

**References:**

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- [4] BBC News (2016, October 11). Tax on sugary foods and drinks backed by World Health Organization. Retrieved from <http://www.bbc.com/news/health-37620087>



## Integrative Workshops

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### Objectives

The purpose of this workshop is to introduce you to the concepts of policy development, analysis, and implementation. You will be using the skills and knowledge you have gained in the MPH Program to analyze a situation which involves the sugar sweetened beverage industry.

Each Learning Team (LT) will be assigned a specific stakeholder position (**identified below**). Each LT will be provided with some basic information about the stakeholder they have been assigned, and the LT will have an opportunity to familiarize themselves with the stakeholder's interests and views concerning SSBs. The LT will be required to represent the interests of their particular stakeholder before the Standing Committee on Health Promotion.

During the IW, LTs receive a memo stating that the Standing Committee has called a "Town Hall" (round table discussion) to address the issues at hand. Students are given one hour to prepare for the Round Table discussion and must determine which individual from their team will represent their team at the round table discussion.

### Schedule(s)

Initial Schedule (provided to students day before IW):

Time	Activity	Location
8:30-8:45	Introductions & Overview of Workshop Day	Classroom
8:45-10:00	Expert Panel on SSBs 1. Linda Stobo 2. Mats Junek 3. Joe Belfontaine 4. Elizabeth Holmes	Classroom
10:00-10:15	Summary & Instructions Assignment of Stakeholder Positions	Classroom
10:15	Break	Foundation Lounge
10:15-11:00	LT Stakeholder Analysis & Strategic Planning	LT Rooms
11:00-12:00	Concurrent Sessions 1. Linda Stobo – Student Lounge A 2. Mats Junek – Student Lounge B 3. Joe Belfontaine – Boardroom 4. Elizabeth Holmes – Classroom	
12:00-12:45	Lunch	Foundation Lounge
12:45-13:45	LT Preparation for Standing Committee (Policy Brief – max 1 page)	LT Rooms
13:45	Policy Brief Due	OWL
14:00-15:45	Presentations to Standing Committee	Classroom
15:45-16:15	Reflection/Question Period	Classroom
16:15-16:20	Conclusion & Close of Workshop <i>Assignment for MPH 9009 released</i>	Classroom

## Integrative Workshops

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Alternate Schedule (announced to students at IW at 1pm):

Time	Activity	Location
8:30-8:45	Introductions & Overview of Workshop Day	Classroom
8:45-10:00	Expert Panel on SSBs 1. Linda Stobo 2. Mats Junek 3. Joe Belfontaine 4. Elizabeth Holmes	Classroom
10:00-10:15	Summary & Instructions Assignment of Stakeholder Positions	Classroom
10:15	Break	Foundation Lounge
10:15-11:00	LT Stakeholder Analysis & Strategic Planning	LT Rooms
11:00-12:00	Concurrent Sessions 1. Linda Stobo – Student Lounge A 2. Mats Junek – Student Lounge B 3. Joe Belfontaine – Boardroom 4. Elizabeth Holmes – Classroom	Various Rooms
12:00-12:45	Lunch	Foundation Lounge
12:45-13:45	LT Preparation for Standing Committee (Policy Brief – max 1 page)	LT Rooms
<b>13:00</b>	<b>MEMO RELEASED TO LEARNING TEAMS</b>	
13:45	Policy Brief Due	OWL
14:00-16:15	<b>Standing Committee Round Table</b>	<b>1150</b>
16:15-16:20	Conclusion & Close of Workshop <i>Assignment for MPH 9009 released</i>	

**INTEGRATIVE WORKSHOP #3  
“BOTTOMS UP!” DRINKING WATER AND  
THE RISK TO PUBLIC HEALTH  
SPRING 2017**

**Faculty Leads**

Dr. Gerald McKinley, Assistant Professor  
Dr. Charles Trick, Professor

**Speakers**

Mustafa Hurji, *Associate Medical Officer of Health*, Niagara Region Public Health

Bill Hunter, *Manager, Environmental Health*, Niagara Region Public Health

Victoria Colling, *Scientist*, Walkerton Clean Water Centre

**Scenario**

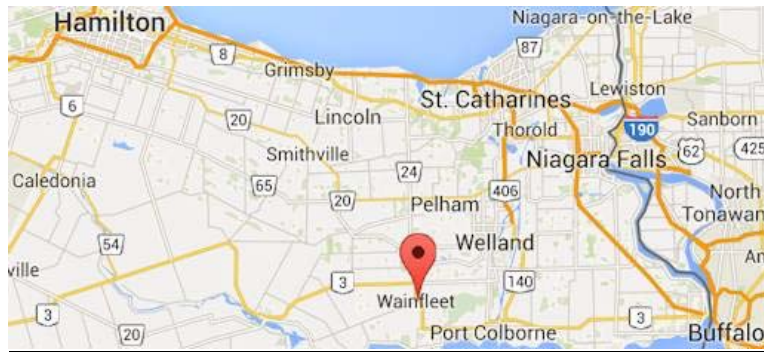
1. The average daily water use for Canadians is ~330 L/day. This is the tap to the drain use in your home (showers, baths, drinking, toilets, washing dishes, etc.). If you were to add the amount of water needed to grow your food or to manufacture goods that you bring into the house, “your true water footprint”, then this number increases 10-fold. So, Canadians are a thirsty bunch. In comparison, citizens in Doha (the capital of Qatar) use an average of 1,200 L/day for home use and if you followed the use of Singaporeans, you would use less than 150 L/day. 330 L? vs 1200 L? vs 150 L? Help me understand the difference? Do Dohaans (I may have made up this word) need excessive liver & kidney flushing? Do Singaporeans have zero-water use toilets and vaporizing showers? What regulates how much water we use? And is there a role of Public Health Professionals in “gatekeeping” water use?
2. Canada is a land of plenty when it comes to water – we are in many ways the most blessed country based on water supply. The Great Lakes contains 18% of the **global** freshwater supply – and there it is on our doorstep. Yet, the facts are an eye-opener. Even here in southern Ontario, we use over 50% of the yearly supply of water from rain and snow. An increase in water use or population will exhaust this surplus quickly (think I=PAT) unless we heavily treat and control our waters. There are great regional differences in the supply of water across Canada and we are presently in one of the areas with the best ratio of supply/need. The prairies are in a nearly constant drought condition. This is a reminder that water use must be related to precipitation and evaporation – this is the supply function.
3. But Public Health responsibilities increase when the concept of “availability” enters the discussion. What separates “supply” from “availability”? Would you drink water from the Medway Creek (that runs under the bridge on the path to main campus/hospital)? What about a glass of water directly from Lake Huron or Lake Erie (London’s drinking water sources)? Or a water fountain at the gym? Or why is there a fancy water supply station in your MPH building? Is it just industrial Brita water? Or why do you buy bottled water? Is surface water “available” or is only well water “available”?

The answer to most of these question is “it depends” and your job as Public Health Professionals is to drink knowledge and ACTIONS into solving “it depends” problems.

## Integrative Workshops

This Integrative Workshop will introduce you to the state of the environment with regards to water and, as the day progresses, variations in the **human water cycle** with regards to Public Health Risk. It is a cycle that involves these terms: drinking water, surface water, potable water, sewage systems, septic systems, catchment, ecological services, “Consider a Spherical Cow,” shopcraft, choice, I=PAT, and risk. Many of these terms you have seen before in a different context.

You will be invited to bring your Public Health skill set into a community-at-risk. The community is Wainfleet, Ontario. Located between Port Colborne, Ontario, near the shores of Lake Erie, this is a very active community of ~6,000 inhabitants (but certainly more in the summertime when the beach attracts visitors). The community (<http://www.wainfleet.ca/>) is composed of about 3500 buildings (2300 are residential).



Members of the Niagara Region Public Health will outline their concern about a water/sewage/health issue. These individuals will serve as a conduit of information from stakeholders to you.

A specialist from the Walkerton Clean Water Center (<https://www.wcwc.ca/>), Ontario’s technical and training center on water and sewage management and risk, will be your mentor on solutions and other technical ideas you may develop. She may introduce this information to you, but just in case: Walkerton was the location of a serious health outbreak of *highly dangerous O157:H7 strain of E. coli* exposure (<http://www.cbc.ca/news/canada/inside-walkerton-canada-s-worst-ever-e-coli-contamination-1.887200>). There were 7 deaths and thousands of illnesses (some very long lasting). The short story is that mismanagement of the water purification system contaminated the drinking water. The *E. coli O157:H7* strain originated in the bovine population.

### Objectives:

1. Show that your Learning Team (LT) can organize an assessment, evaluation, and investigation of a community-at-risk problem **through development of an Influence Diagram, to be presented as a team to the visiting experts.**
2. Show that your Learning Team (LT) can represent your findings to the community in a **Risk/Bowtie Action Plan, to be presented to the larger group as a presentation.**
3. Learning Teams (LTs) will take the gathered information and develop a **Commentary** for a wider audience, educating either the greater public or other Public Health Practitioners of the issues and actions required to reduce the real or perceived risk. **LTs are to upload their Commentaries to OWL for review by visiting experts.**

## Integrative Workshops

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### Schedule

Time	Activity	Location
8:15-8:45	LT meetings to review the purpose and plans for the day.	LT rooms
8:45-9:00	Summary of the day's activities and responsibilities	Classroom
9:00-10:00	Wainfleet Stakeholder presentation	Classroom
10:00-10:15	Walkerton Water Center presentation	Classroom
10:15-10:30	Break	Lounge
10:30-11:45	Stakeholder discussions/mentoring	LT Rooms/Lounge
11:45-12:30	Lunch	
12:30-1:00	Prepare "Goal and <b>Influence Diagram</b> " for presentation	LT Rooms/post at 1:00
1:00-2:00	Stakeholders visit your LT room for 5 min presentation	
2:00-3:00	Prepare <b>Risk/Bow Tie/Action plan</b> – 1 PowerPoint slide	LT Rooms
3:00-4:00	Present PowerPoint Risk/action slide (5 mins max)	Classroom
4:00-5:00	Finish " <b>Commentary</b> " for submission (due at 5:00)	