Addressing Social Determinants of Health in Dufferin County

A public health perspective on local health, policy and program needs

Wellington-Dufferin-Guelph
Public Health

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Contents

Maps included in the report

SDOH indicator	Map
Household income	Average household income of private households (after tax) in 2005, by neighbourhood, WDG.
Private household LIM	Percentage of low income households (Low Income Measures after tax), by neighbourhood, WDG, 2006.
Children LICO	Percentage of children aged 6 years and under in private households with low income after tax, by neighbourhood, WDG, 2006.
Unemployment rate	Percentage of individuals in the labour force aged 25 to 64 years who were unemployed, by neighbourhood, WDG, 2006.
Low education	Percentage of the population aged 25 to 64 years who did not complete high school education, by neighbourhood, WDG, 2006.
Recent immigrant population	Percentage of the population who immigrated to Canada between 2001 and 2006, by neighbourhood, WDG, 2006.
Lone parent families	Percentage of families that were lone parent families, by neighbourhood, WDG, 2006.
Housing affordability	Percentage of tenant- or owner-households spending 30% or more of total household income on shelter expenses (rent or major payments), by neighbourhood, WDG, 2006.
Early childhood development	Percentage of senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains
Total ED visits	Three-year average emergency department visits (all cause) per 100,000 population, by neighbourhood, 2007-2009.
Cardiovascular-related hospitalizations	Three-year average cardiovascular-related hospitalizations per 100,000 population, by neighbourhood, 2007-2009.
Injury-related hospitalizations	Three-year average injury-related hospitalizations per 100,000 population, by neighbourhood, 2007-2009.
Diabetes-related hospitalizations	Three-year average diabetes-related hospitalizations per 100,000 population, by neighbourhood, 2007-2009.
Lung cancer-related deaths	Three-year average lung cancer-related deaths per 100,000 population, by neighbourhood, 2005-2007.

"Positive health pertains to the capacity to enjoy life and withstand challenges."

- Bouchard, 1994, Determinants of Health and Wellness

Introduction

Social determinants of health are the socio-economic, cultural, and environmental conditions of our lives that impact overall health. A recent publication from the Health Council of Canada, *Stepping it Up: Moving the Focus from Health Care in Canada to a Healthier Canada*, confirms that Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis, and heart disease; to live with a disability; and to be hospitalized for a variety of health problems. They are twice as likely to use health care services as those with the highest incomes.

Serious and pervasive concerns about growing health disparities, the increasing prevalence of chronic conditions, and the need to look at sustainability of the health care system are converging to create a sense of urgency about health promotion and disease prevention in Canada. Since the greatest gains in improving health can be made in vulnerable and marginalized sub-groups of our population, it is important to undertake activities supporting specific efforts in these areas.

Wellington-Dufferin-Guelph (WDG) communities have demonstrated their commitment to improving the health of residents by addressing the social determinants of health. However, many of the existing health initiatives could be strengthened by using a "whole of community" approach, whereby action is taken collectively and results are measured and demonstrated.

This report identifies barriers to health and wellbeing within communities and effective strategies to address these barriers and enable all residents to realize their full potential. The report also considers existing community strengths and assets. In order to create this picture quantitative data collected from the 2006 Census was integrated with community voices. Statistics and real stories will assist in determining the focus of coordinated efforts to address the social determinants of health in Dufferin County.

Much has been written about the impact that social determinants of health can have on a community. We have local data to support the existence of these determinants and we have a beginning inventory of promising practices and policies to begin addressing the health inequities. Now, we need ACTION. It is only by working together that we can truly impact the health of our residents, in a positive way, and ultimately see improvements that will support the future generations of our communities. It is recommended that we work together to:

- Continue working to establish a collaborative, community-wide process to determine the most suitable course of action. This should include a commitment to engage broad membership from the health, education, business and other sectors.
- Strengthen mechanisms that link existing community networks in WDG across the issues in order to strengthen their impact and maximize policy and intervention outcomes.
- Draw further support and commitment by sharing the evidence about the cost effectiveness of investing in early years interventions and poverty reduction.
- Support mechanisms to monitor population health and equity gaps.
- Continue to engage priority areas in the development of optimal solutions that match their needs and unique circumstances.
- Build on the momentum by raising public awareness about the importance of addressing social determinants of health.
- Support intervention research and continue to build on the existing evidence base for promising practices in addressing social determinants of health.

The Call to Action section of this report further describes the action we can take towards addressing the social determinants of health.

Context

An initial report focused on communities within the boundaries of the Waterloo Wellington Local Health Integration Network. The creation of the report involved three health units: the Grey Bruce Health Unit, the Region of Waterloo Public Health Unit and Wellington-Dufferin-Guelph Public Health. Following the completion of this report it was agreed that a presentation of the information by health unit boundaries would be more effective for planning and service provision purposes. The data was reanalyzed to generate rates specific to the Wellington-Dufferin-Guelph area.

This report provides a wealth of data for social determinants of health indicators. It was recognized that these indicators must be further explained and understood in the context of the experience of communities. As a first step, situational assessments were conducted. These assessments revealed existing strengths, assets, capacities, services and supports in each community. The findings and recommendations from this report were then explored and validated through a meaningful community-wide engagement process. Key informant interviews with service providers and community members provided more knowledge about each community and informed a plan to further consult with community members. Focus groups with community members increased the understanding of the experience of community members.

Community members and service providers (key informants) were asked to identify community assets and strengths as well as challenges and barriers within communities. Consultations explored whether the findings reflect an accurate understanding of the communities. Key informants were asked:

- Whether the findings of the initial report resonate with their experience of living in the community
- Whether the recommendations in the initial report are relevant within the context of their community
- To describe their vision for success in pursuing action on this report
- Whether the identified priority communities are communities that should be prioritized for action

Following the release of this report, priority communities will be engaged in the development of optimal solutions that match their needs and unique circumstances.

How to use this report

This report reflects **evidence** from various sources including a review of the literature, a community and provincial environmental scan, and a situational assessment to describe the different perspectives of need, as well as the capacity and actions to address social determinants of health. Five main types of evidence were considered for this report. Those are:

- Evidence from literature, government, and other research and evaluation reports
- Evidence describing the policies and practices in Ontario, and beyond
- Statistical and spatial evidence of hospitalization and other population health data for the Wellington-Dufferin-Guelph area
- Experiential evidence obtained through a facilitated group discussion, where the steering group, working group, and several topic experts from the three health units engaged in a review of the preliminary report and generated recommendations for action
- Experiential information gathered through consultations with community members living in, and service providers working with, priority communities

The evidence throughout this report can be used to make decisions about advocacy, setting priorities, applying for funding, or attaining support for an intervention.

Priority communities were identified through a system of ranking all areas according to eight social determinants of health (SDOH) indicators. These indicators were chosen based on evidence from existing literature and the data examined in the report. All communities were ranked on each of the eight indicators. The indicator ranks were then totalled for every community. Areas appearing in the highest 20% of the overall rank were identified as priority communities. Indicators used to identify priority communities were:

- Percentage of persons in private households with low income after tax
- Percentage of children aged 6 years and under in private households with low income
- Unemployment rate for individuals in the labour force aged 25 years and older
- Percentage of the population aged 25 to 64 years without completed high school education
- Percentage of families that were lone parent families
- Housing affordability (proportion of households that spent 30% or more of income on housing costs)
- Percentage of the population who were recent immigrants
- Percentage of senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains

Information about priority communities can be used to inform planning and service delivery.

Community profiles are provided in Appendix A. The community profiles present an overview of social determinants of health information in each area. Each profile includes a map, quick facts, key findings, a snapshot of social determinants of health and health outcome rates. These profiles can be used to better understand the strengths and challenges of priority areas.

Social determinants of health fact sheets are provided in Appendix B. The fact sheets present background information, some local highlights, recommendations for action, and statistics for municipalities in Wellington-Dufferin-Guelph for select determinants of health:

- Income
- Employment
- Education
- Immigrants
- Lone parent
- Early child development

The fact sheets can be used to better understand the interplay of each social determinant of health in Wellington-Dufferin-Guelph communities.

The final section of this report is a **call to action** to address health inequities that contribute to the healthcare crisis in Ontario. The report offers evidence describing the effectiveness of policy development and promising interventions. This information can be used to assist in determining the focus of coordinated efforts to address the social determinants of health in each community. Clear and specific recommendations are provided.

Dufferin County Geography

Wellington-Dufferin-Guelph Public Health serves a geographic area that encompasses three separate regions: the County of Wellington, the County of Dufferin, and the City of Guelph. As of the 2011 Statistics Canada Census, the population of Wellington-Dufferin-Guelph was estimated to be 265,240.

Dufferin County is made up of three towns and five rural townships. It is about 1,442 square kilometres in size and is located in south-central Ontario, east of Wellington County. As of the 2011 Statistics Canada Census, the population of Dufferin County was approximately 56,880. Over half of the population lives in Orangeville, which is located about 75 kilometres northwest of Toronto. The eight towns and townships in Dufferin County are:

- Amaranth
- East Garafraxa
- East Luther Grand Valley
- Melancthon
- Mono
- Mulmur
- Orangeville
- Shelburne

"If we began viewing poverty as the result of a kind of robbery, think of the different theories and policies that would be created."

Matthew Desmond, Assistant Professor of Sociology, Harvard

Social Determinants of Health

The health and well-being of individuals is determined by a complex set of interactions among a range of social and economic factors, factors in the physical environment, individual behaviours, living conditions, and genetic endowment. This list of factors is often referred to as determinants of health (Ontario Ministry of Health and Long-Term Care [MOHLTC], 2009b). Social determinants of health refer to a specific group of socio-economic factors within the broader determinants of health that relate to an individual's place in society, such as income, education or employment. Social determinants of health are the conditions in which people are born, grow, live, play, work, and age, including the healthcare system. These conditions are shaped by the distribution of power and resources at global, national, and local levels, which are themselves influenced by policy choices (World Health Organization, 2011).

The Final Report of the Senate Subcommittee on Population Health states that about 50% of health outcomes are attributable to socioeconomic factors, another 10% to physical environment factors, 15% to biological factors, and 25% to the health care system (Keon & Pepin, 2009).

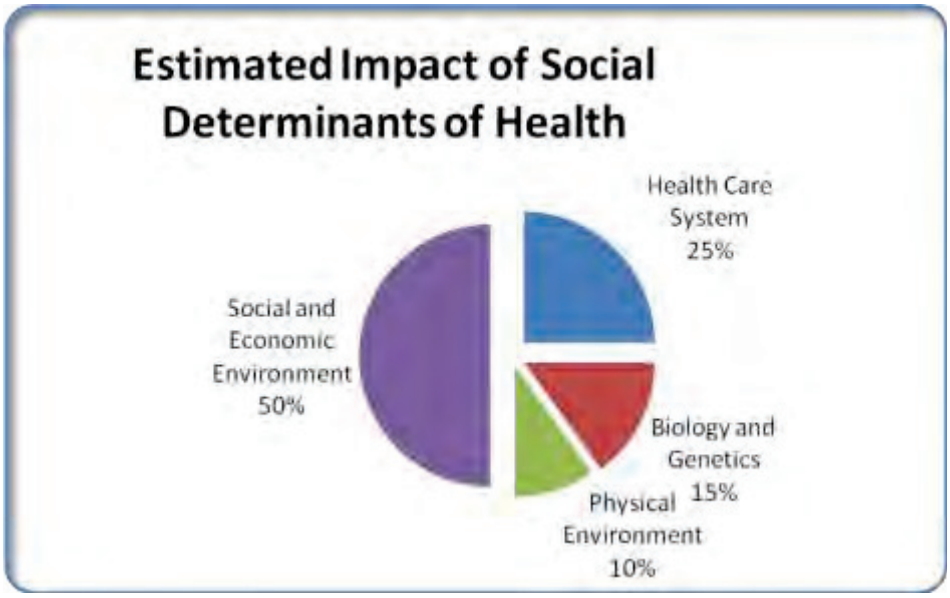


Figure 1 – Graph adapted from *the Health of Canadians - the Federal Role, Volume One: The Story so Far, March 2001,* Standing Senate Committee on Social Affairs, Science and Technology

Similar findings have been reported recently in the United States, where a meta-analysis of all articles published between 1980 and 2007 that report on the relationship between social factors and mortality concluded that the estimated number of deaths attributable to low education, racial segregation, low social support, and various measures of low income in the United States is equal to the total of the combined patho-physiological and behavioural causes (Galea et al., 2011).

One specific list of social determinants of health from a Canadian context includes the following factors:

- Aboriginal status
- Early life
- Education and literacy
- Employment and working conditions
- Unemployment and job security
- Disability
- Food security
- Gender
- Health care services
- Housing
- Race
- Income and its distribution
- Social safety net
- Social exclusion

(Raphael, 2009; Mikonnen & Raphael, 2010)

These social determinants of health are seen as key contributors to the existence of health inequalities and health inequities. While not all health inequalities are avoidable and preventable, such as biological factors, some of them emerge as a result of a different experience in society. Gaps in population health refer to the absolute and relative differences in the health status between the most and least advantaged groups in a population (Canadian Institute for Health Information [CIHI], 2004). Health inequities are systematic differences in one or more aspects of health across socially-, demographically-, or geographically-defined populations or population subgroups. These population health differences are unnecessary, avoidable, and unjust (Whitehead, 1992; Gardner & Ticoll, 2007). Unlike the health gaps that result from biological factors, health inequities are the product of social inequity and disadvantage, and are created in a social context; therefore, they are potentially remediable by policy changes (International Society for Equity in Health, 2011). Generally, policies and practices that can contribute to the reduction of health inequities need to include:

- Actions that aim at the reduction of poverty, marginalization, and exclusion
- Provision of supportive and culturally appropriate social support and health care
- A seamless continuum of services
- A system that is prepared to place the focus on the most disadvantaged individuals and population groups, through the commitment to "upstream"[1] interventions (Gardner & Ticoll, 2007; Sutcliffe et al., 2007)

Braveman suggests expanding this definition of health inequities and acknowledges the cumulative effects of health disparities. He states that health disparities are the types of differences in health in which groups that are disadvantaged have a consistent and systematic experience of increased health risk. Those who are consistently marginalized and disadvantaged—such as people with low incomes, those with lower education, or racial/ethnic minorities—experience poor health outcomes, which in turn put them even further behind those who have a health advantage (Braveman, 2009).

Health Equity and Income Inequality

Many researchers consider income to be the most important and influential SDOH. Income affects health-related behaviours such as diet, level of physical activity, tobacco use, and alcohol and/or substance abuse, and determines the quality of the other SDOH such as ability to secure affordable and adequate housing, food, quality child care etc. (Mikkonen & Raphael, 2010). Low income intersects with a number of other socio-demographic disadvantages, which creates even greater health vulnerability, social exclusion, and additional disadvantages, and often leads to differences in health status experienced by various individuals or groups in societies, known as health inequalities.

Selected Facts on Health Inequities across Ontario:

- In the Ottawa-Gatineau region, there are 1.4 times more low birth weight babies born per 100 live births among mothers with lower socioeconomic status (SES).
- In Hamilton, hospitalization rates for diabetes are 2.6 times higher among people with lower SES.
- In London, hospitalization rates for anxiety disorders are 4.5 times more likely among low SES individuals.

  (Canadian Institute for Health Information, Canadian Population Health Initiative, 2008)
- In Toronto, males in the highest income decile are expected to live 4.5 year longer than males in the lowest income decile.

  (Canadian Institute for Health Information, Canadian Population Health Initiative, 2008)

[1]Upstream interventions are large scale interventions focusing on social determinants and societal influences such as policies that relate to income, social networks, food supply, transportation, or pollution (State Government of Victoria, Australia, Department of Health, 2011).

Richard Wilkinson, a social epidemiologist from the UK, argues that although income is an important and influential factor in determining health, health inequalities are the result of a deeper more important issue, the distribution of wealth within societies. What matters is social status and income in relation to others and the size of the income gap between the poorest individuals and families and the richest. It has been shown that in more unequal societies, where the gap between the poorest and the richest is larger, there is a more significant social gradient in health.

Among affluent countries, Norway and Japan do better than the United States or Switzerland because the income gap between the rich and the poor is smaller. Among less affluent countries, Spain and Greece do better than Portugal because they have less inequality. Wilkinson (2011) has shown that across all the western democracies, and across a wide range of indicators, there is a consistent pattern in which outcomes get worse as levels of inequality increase and income gaps widen. He suggests that in order to address health equity we must address the distribution of wealth and narrow the gap between the rich and the poor.

Looking at families and low income in Ontario:

- Over 478,480 children, or one in every six, live in poverty in Ontario (Maund and Hughes, 2006).
- Almost half (47%) of children in new immigrant families are poor.
- One-third of children in visible minority families in Ontario are poor (MOHLTC, 2009a).
- Over the past ten years the percentage of low income children in families with no employment income has dropped from 47% to 43%,
- The percentage of low income children with parents who have employment income from part-time/part-year work declined from 36% to 18% as more parents have been able to find full-year/full-time work.
- The poverty rate in Ontario remains at 17.4%—an increase from 15.15% in 2001 (Maund and Hughes, 2006).

Understanding Promising Practices

To increase our knowledge and understanding of how to address social determinants of health it is important to look at the successes of broad, universal policies and interventions. It is also beneficial to explore successful interventions with smaller segments of the population. In order to effectively address the social determinants of health, we need to access both quantitative and qualitative evidence to increase our understanding of the effectiveness of interventions. As the notion of credible evidence in this field expands to acknowledge qualitative information, certain approaches repeatedly show up in the reviews and evaluations as providing good results such as peer interventions, high intensity supports, and cross-sectoral collaborations. Different types of evidence were used to identify promising practices, from evidence published in systematic reviews and peer-reviewed journals to

evidence that comes from qualitative evaluations of interventions in the specific context in which the intervention was applied. According to these sources, the key promising interventions for addressing social determinants of health are:

- Multi-sectoral policies, such as employment and income, housing, early years policies, and urban policies
- Comprehensive early years Interventions
- Neighbourhood and peer-based interventions that complement direct and intensive interventions with at risk individuals
- Interventions focusing on at risk groups
- Continuous provision of strong evidence on the impact of social determinants of health and related interventions

"Existing health initiatives could be strengthened by using a 'whole of community' approach, whereby action is taken collectively and results are measured and demonstrated."

Social Determinants of Health in Dufferin County

The rates of each of the social determinants of health listed below are reported for Dufferin County and compared with rates in Wellington-Dufferin-Guelph (WDG) and Ontario. In recognition that there are inequities in determinants of health between and within communities, rates of the following indicators were examined in all of the Dufferin County municipalities:

- low income
- food insecurity
- transportation
- employment
- education
- immigrants
- social supports
- healthy child development

Low Income

Paid employment and benefits contribute to the health and well-being of individuals and their families, reduce the likelihood of physical and mental illness, and increase life expectancy. These contributions also extend to youth and their employment experience (Public Health Agency of Canada [PHAC], 2003).

Using the Low Income Measure (LIM), households are considered low income when they earn less than 50% of the median adjusted household income. The LIM takes family size into consideration and is "adjusted" to reflect the fact that a household's needs increase as the number of members increases (Statistics Canada, 2012). In 2006, a single person in Canada with an income below $15,179 was considered low income, whereas a family with two adults and two children with an income below $30,358 was considered to be living with low income (Zhang, 2009).

People with lower SES use health services more frequently and often are more seriously sick or injured (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004). Low income results in poor health and is attributable to 20% of total health care spending in Canada (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004).

Children who live in low income households are particularly affected. They are more likely to have a range of health problems throughout their life, even if their socioeconomic status (SES) changes later in life (Ontario Physicians Poverty Work Group, 2008).

A large number of reports confirm that low income and low SES at the individual and community levels are associated with a higher prevalence of being overweight or obese, having a poor diet, and inadequate physical activity among children. Moreover, a series of longitudinal studies confirm a consistent inverse relationship between low SES in childhood and being overweight or obese as adults (Ball & Crawford, 2005). The outcomes are more negative for people living in poor neighbourhoods than for those who have a low SES but live in a neighbourhood with higher than average income levels (Braveman, 2009).

Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis, and heart disease, and to live with a disability (Health Council of Canada, 2010). The Wellesley Institute Study *Poverty Is Making Us Sick* offered a comparison between the highest and lowest income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60% more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage (Ontario Physicians Poverty Work Group, 2008).

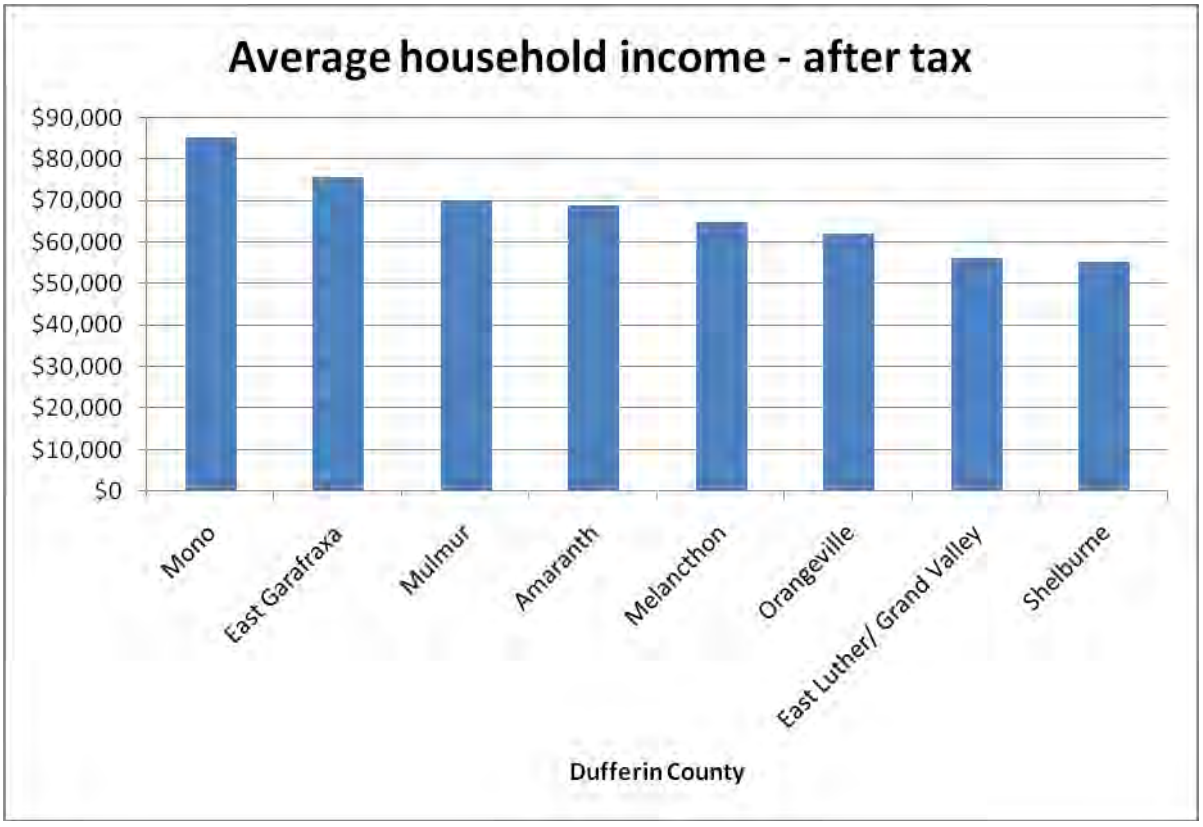
> *"We cannot invite people to assume responsibility for their health and then turn around and fault them for their illnesses and disabilities which are the outcomes of wider social and economic circumstances."*
>
> *The EPP Report, Achieving Health for All: A Framework for Health Promotion, 1986*

Even when controlling for variables such as education, disability, smoking, physical activity, household income and presence of social assistance, income continues to be associated with higher rates of most chronic diseases. The discrepancy is also visible in the uptake of screening services. For example, when comparing low income and high income women over the age of 40, those with low incomes are half as likely to have ever had screening tests such as a Pap test, breast exam, or mammogram (Community Social Planning Council of Toronto, University of Toronto Social Assistance in the New Economy Project & Wellesley Institute, 2009). Despite having a greater need for health care support, social

assistance recipients are less likely to have a stable health care practitioner, tend to see more general practitioners, and have fewer contacts with specialists in comparison to those who are not on social assistance. (Community Social Planning Council of Toronto, University of Toronto Social Assistance in the New Economy Project & Wellesley Institute, 2009)

Low income in Dufferin County

In Ontario the average after tax household income was $63,441; in Dufferin County it was a little higher at $65,756. There is, however a wide range of average income between communities in Dufferin County. The most affluent community had an average income of $85,346 while the most impoverished had an average after tax household income of only $55,331. The difference in average income between these two communities is greater than $30,000. Shelburne and East Luther Grand Valley are the municipalities in Dufferin County with the lowest average income (see map on next page).



Using the Low Income Measure (LIM), 11% of households were low income in Dufferin County. Again, there is a wide range between Dufferin County communities in the rate of low income households – from 7.1% to 13.7%. Amaranth and East Luther Grand Valley are the municipalities in Dufferin County with the highest rate of low income households (see map on next page).

Children (birth to 13 years of age) account for about 21% of the Dufferin County population. This amounts to over 11,000 children. A smaller percent of children under the age of six years in Dufferin County were living in households with low income (7.1%) compared with the province of Ontario (14.8%). The Dufferin County areas with the highest rate of children under the age of six years in households with low income were Orangeville (9.8%) and Shelburne (9.3%) (see map on next page).

What can be done?

It is important to cultivate accessible, culturally appropriate, and meaningful interventions. This could include developing and/or supporting policies to enable sustainable livelihoods and optimal living conditions for all individuals and families.

In 2008, Headwaters Communities in Action facilitated a series of focus groups. Participants raised concerns about the lack of public awareness of the issues faced by the most vulnerable in the community. Key areas of concern were access to basic needs such as housing and food, affordability of higher education, and access to public transportation and recreation.

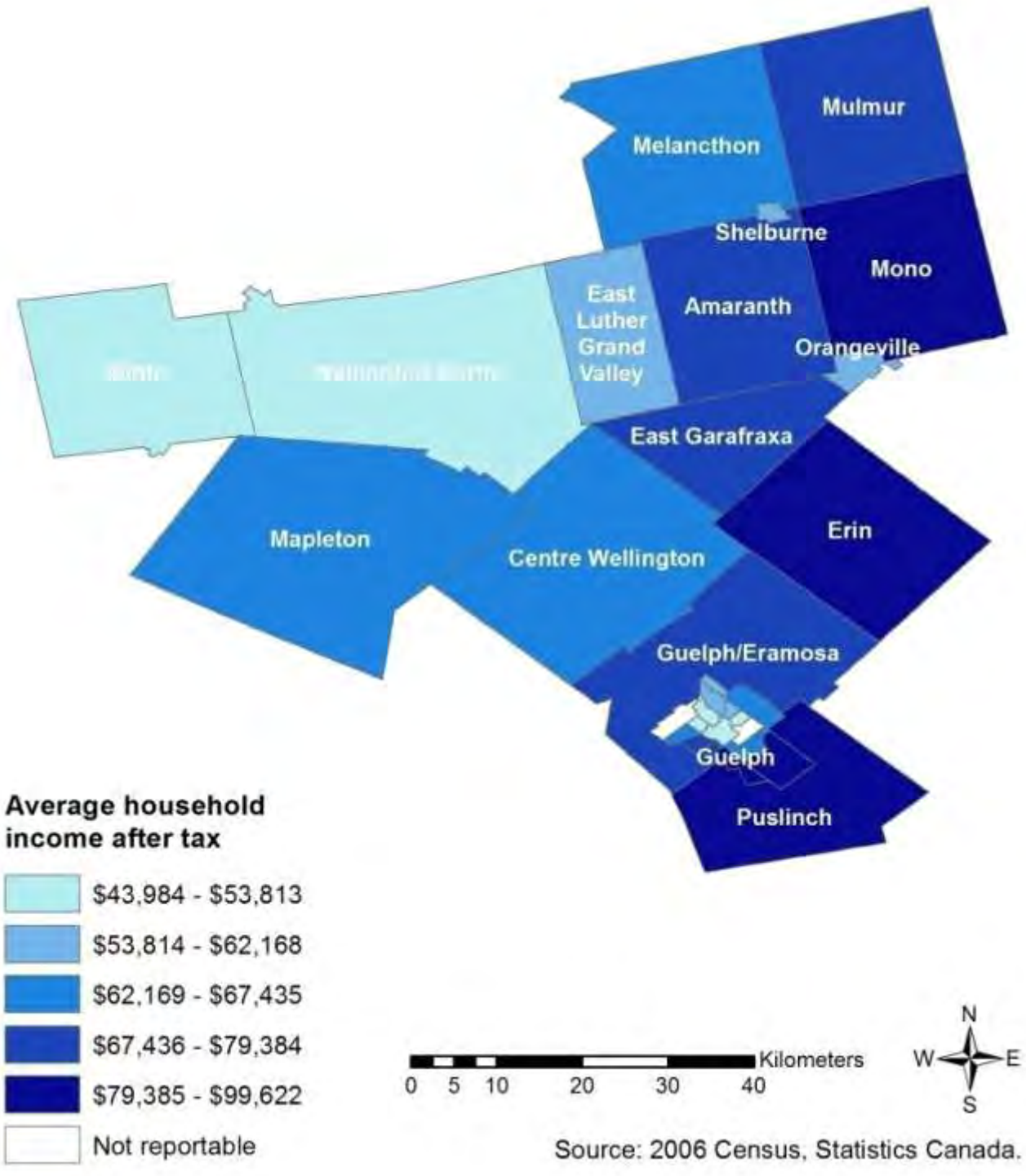
Bridges Out of Poverty is a powerful model for economic and social change, sustainability, and stability. It inspires innovative solutions in those looking to counter poverty and its impact at all levels in a community. This approach helps employers, higher education, community organizations, social service agencies, hospitals, individuals, and others to address poverty in a comprehensive way. People from all economic classes come together to improve job retention rates, build resources, improve outcomes, and support those who are moving out of poverty. In WDG three public health employees have completed an extensive *Bridges Out of Poverty* train-the-trainer course. They are now qualified to provide community-wide training in WDG.

Getting Ahead is a workshop that focuses on helping individuals transition out of poverty. Participants examine the impact of poverty on themselves and their communities. By the end of the three week session participants have developed a plan to transition out of poverty. The County of Wellington, Ontario Works has taken a lead role in offering *Getting Ahead* workshops in Guelph and Wellington County.

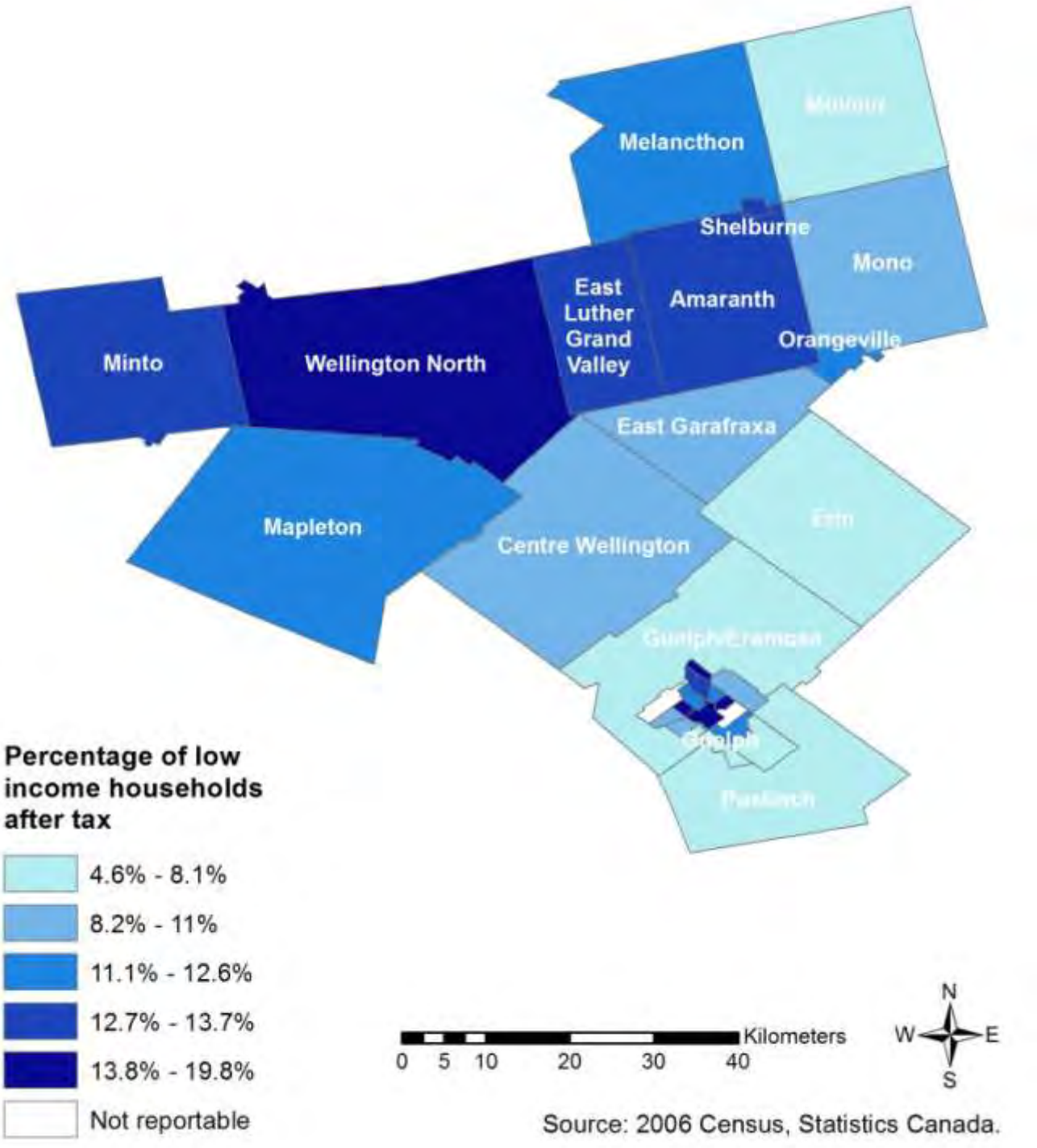
Circles is a supportive, intentional, reciprocal, befriending relationship made up of one Circle Leader who is living in poverty and two to five Circle Allies who are from the middle class. A Circle Leader is responsible for their Circle; convening, leading, and receiving support to work on their dreams, plans, and goals. They will work with the Allies to complete the plan developed in the *Getting Ahead* group. Circle Leaders and Allies explore the implications of poverty, economic

class, race, and community prosperity. They develop relationships of mutual respect. WDG Public Health has taken a lead role in offering *Circles*.

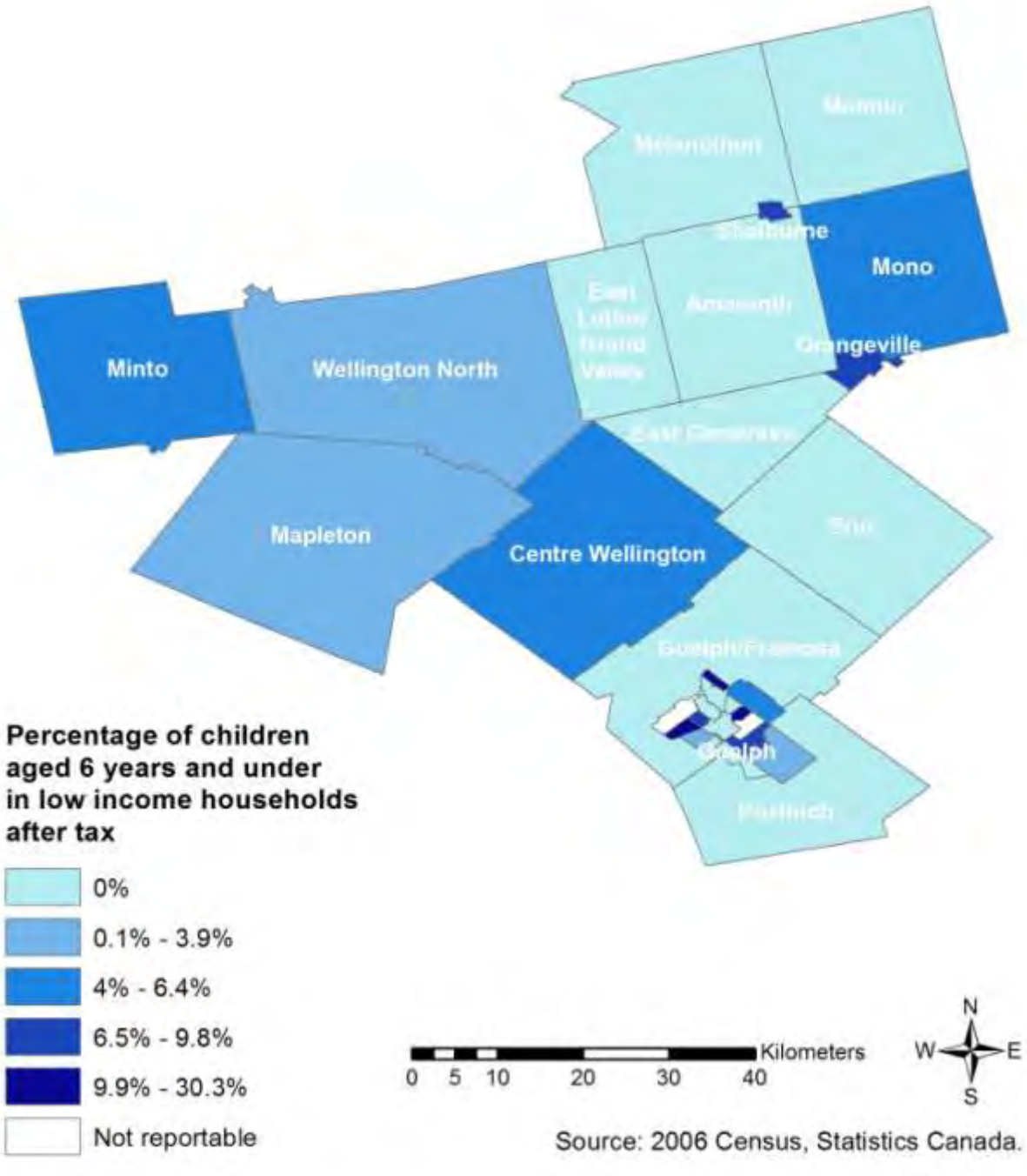
Average household income of private households (after tax) in 2005
Wellington-Dufferin-Guelph, 2006



Percentage of low income households (Low Income Measures after tax)
Wellington-Dufferin-Guelph, 2006



Percentage of children aged 6 years and under in private households with low income after tax
Wellington-Dufferin-Guelph, 2006



Food Insecurity

Food insecurity affects families in many ways. Children are of primary concern when families experience food shortages. Children who experience food shortages often experience a myriad of issues related to growth and development. They often have increased behavioural and learning problems and a lesser understanding of the importance of nutrition for good health (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). Children and youth make up 38% of those helped by Canadian food banks even though they account for only 21% of the population (Food Banks Canada, 2012). Local research found that 29% of food bank users in Guelph-Wellington were children between the ages of 0 to 14 years (Ontario Association of Food Banks, 2008).

"The community really likes 'collective kitchens' the term used for community kitchens because they feel it sounds less like charity. Everyone in the community who goes to the kitchen decides the recipes they want to cook and they will all work together, either making muffins or soup or a meat dish. Recipes are low cost and some families are subsidized and it really helps them to stretch their food dollars. It's been an amazing resource."

Each year Wellington-Dufferin-Guelph Public Health calculates the cost of basic healthy eating according to current nutrition recommendations and average food purchasing patterns. The calculation is completed by conducting a comprehensive survey of local grocery stores using the *Nutritious Food Basket* (NFB) tool. The survey monitors affordability and accessibility of foods by relating the cost of the food basket to individual/family incomes. In 2012, an average family of four living in WDG needed to spend $191.29 a week to buy the quantity of basic foods in the NFB, to meet minimum nutrition recommendations. The cost of a nutritious food basket for a reference family of four has increased 14.5% from 2009 until 2012.

What can be done?

There are several community efforts in place in WDG to address the issue of food insecurity. Food banks and community pantries are located in various neighbourhoods to provide food to individuals and families experiencing food shortages. A big challenge faced by emergency food providers, identified though community consultations, is the ability to keep a variety of quality nutritious foods on hand. Relying on donations and limited by storage facilities, much of what they

are able to provide consists of pre-packaged, boxed and canned foods rather than fresh produce and milk.

The *Garden Fresh Box* program is one answer to the lack of fresh produce. The Garden Fresh Box is a non-profit, service that aims to increase access to local produce. The community is supportive of this program and many organizations offer subsidies for low-income individuals and families. The concern shared by many service providers is that often the fruits and vegetables in the boxes are unfamiliar to people and often families are unaware of the method of preparation.

Programs exist that help families to expand food choices such as community kitchens, community gardens, food pantries and church collective kitchens. These programs help to increase neighbourhood resources that build engagement and help reduce barriers such as the stigma surrounding low income, food security and accessing food programs. Programs such as community kitchens allow individuals to retain their dignity while providing nutritious food to their families.

Several communities focus on providing a variety of in-school food programs. Some schools have a breakfast program or offer lunch, while others provide a snack during the day. Almost half (46%) of the schools in Dufferin County offer in-school food programs (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). Other initiatives include the community gardens that help children feel connected to what they are eating and a 'cooking club' as a way to get children excited about trying something new and encouraging them to cook it at home for their parents.

A community resource guide has been developed and distributed to help residents in communities access food programs and services more easily. The guide provides information about emergency food pantries, meal programs, collective kitchens, community nutrition programs, community gardens and eligibility criteria. The guide was prepared and released by the Guelph & Wellington Task Force for Poverty Elimination in partnership with other community groups and agencies.

While there is a perception that food banks – as well as programs like school and community meal programs, community gardens and kitchens – are providing the needed response to food needs, Canadian research challenges this notion. HungerCount 2012 (Food Banks Canada, 2012) reports that food assistance programs in Canada are showing an increase of 2.4% over 2011. The reliance on these programs is 31% higher than before the recession began in 2008.

Transportation

Individuals with low income cannot afford the costs of reliable transportation such as vehicle payments, insurance, fuel or taxi fare. This has considerable impact on other important determinants of health. It becomes a barrier to daily functions including the ability to access programs and services including medical appointments. The rural nature of Dufferin County intensifies transportation issues. Residents who can't afford the expenses of a car or the rising costs of fuel are isolated.

> *"When you come to a neighbourhood where people don't have cars because there just isn't enough money, you ask how do parents take kids to appointments, how do they get groceries?"*

In Orangeville there is public transportation. The cost of riding the bus can be a barrier for many low income individuals. This makes securing employment, accessing a grocery store or food bank more challenging, and limits access to programs and services. This is a strong example of the intersectionality of low income with the other social determinants of health. In 2010 the Guelph & Wellington Task Force for Poverty Elimination collaborated with the University of Guelph Research Shop to produce a report that investigated the impact of a lack of affordable transit on individuals and families facing economic hardships. The report provided an overview of affordable public transit programs in other communities and provided possible options for a similar program in Guelph (Ellery & Peters, 2010).

What can be done?

Many groups and individuals have identified the need to prioritize the enhancement of transportation options in Dufferin County. As a result a group has been convened to address the issue of transportation. Headwaters Communities in Action has partnered with the County of Dufferin to bring together a small group of community leaders from various sectors to form The *Dufferin Rural Transportation Learning Group* to explore possible solutions. The Learning Group will develop a shared understanding of the current transportation options that exist in Dufferin County, learn about possible models and options for addressing transportation issues, and establish a group of local champions to develop recommendations to enhance transportation options in Dufferin County. The goal of the *Dufferin Rural Transportation Learning Group* is to develop specific recommendations on how the county can enhance the capacity of its alternative transportation system. Group members will conduct interviews with key community stakeholders to assist in better understanding this issue from various perspectives (Headwaters Communities in Action, 2013).

Employment

Unemployment, underemployment and stressful or unsafe work conditions are associated with poor health. Paid employment and benefits contribute to the health and well-being of individuals and their families, reduced likelihood of physical and mental illness, and increased life expectancy. Employment and job security have a great impact on one's physical and mental health, providing both financial and non-financial benefits (Mikkonen & Raphael, 2010). Not only does paid work provide money, it also provides a sense of identity, purpose and social contacts. Unemployment can be very stressful and negatively impact an individual's self-esteem, increasing the likelihood of turning to unhealthy coping behaviours such as tobacco use, problem drinking, and substance abuse (Mikkonen & Raphael, 2010).

People who are unemployed or not seeking jobs have the highest mortality rates and suffer more health problems than people who have a job (PHAC, 2003). People who have greater control over their employment situation and fewer stress related demands in their jobs are healthier than people with little control and higher stress (PHAC, 2003).

On average, those who immigrated to Canada have more formal education compared to those who were born in Canada, but the unemployment rate for the immigrant population is twice as high (Population Health Promotion Expert Group: Working Group on Population Health, 2009).

The impact of employment on income is clear. The main theme that emerged around employment through community consultation was the need to provide opportunities for skill building, both for youth and adults. Opportunities to become involved and volunteer within the community help build and develop skills that can be transferred into the workplace and can assist individuals to secure employment later on.

Community youth are open to developing skills and gaining experience, but they do not necessarily have the means to cover the costs of enrolling in organized leisure and recreation activities even if they are available. Service providers explained that when youth do not have the financial means to participate in team sports or go to summer camp, they are often at a disadvantage when looking for jobs because they haven't had the opportunity to develop leadership skills.

Service providers also commented on the barriers to employment, such as the costs of transportation and childcare, which are not accessible to everyone. The process of finding and

securing employment in itself can be a challenging and overwhelming process: filling out job applications, writing resumes, and getting to and from interviews. It can require a lot of appointments and for some it can be quite difficult to get through the entire process without giving up.

Employment in Dufferin County

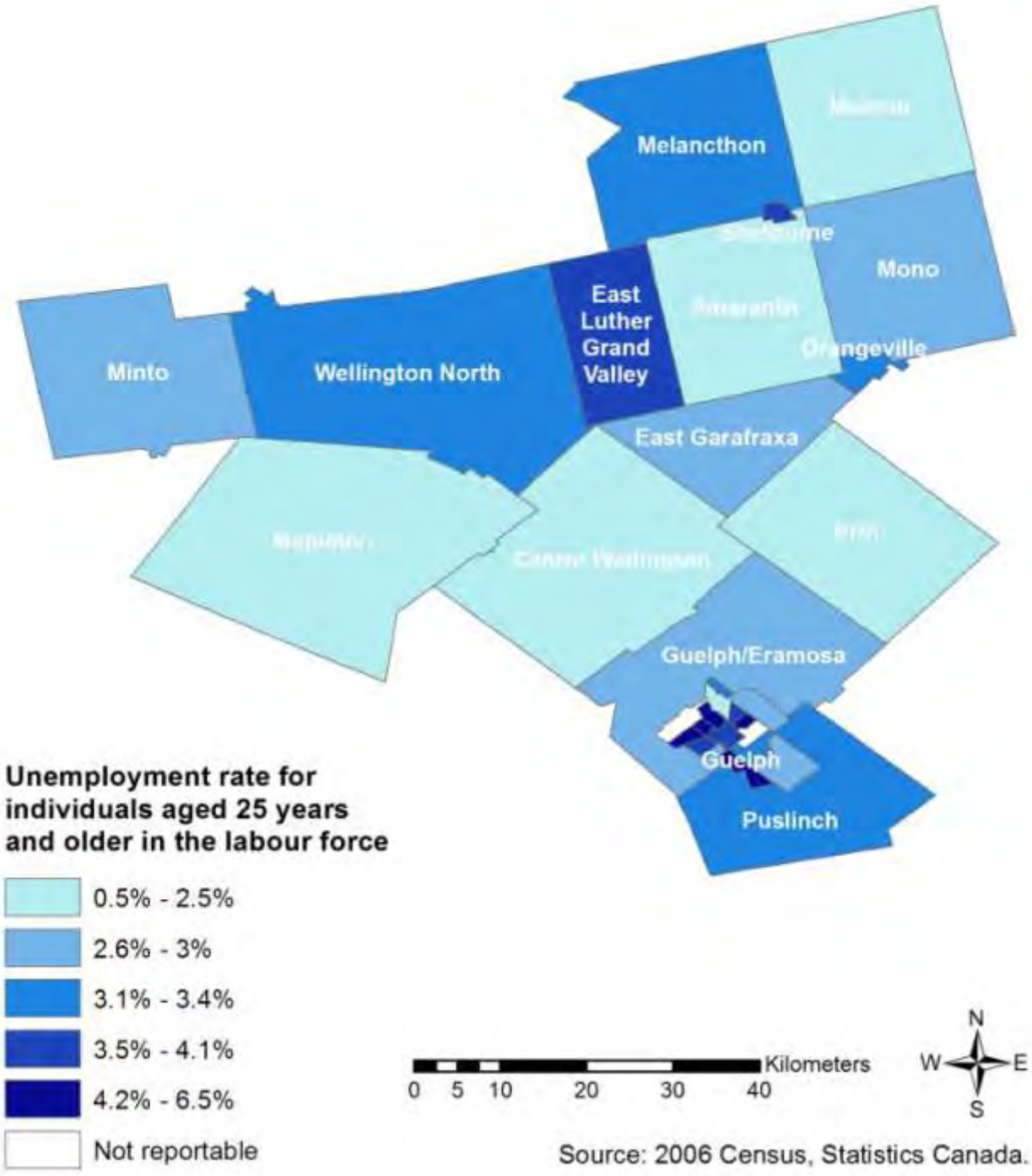
The unemployment rate in Dufferin County (2.9%) is lower than the rate in Ontario (4.9%) and WDG (3.2%). There is a similar trend with youth unemployment - the rate in Dufferin County (12.8%) is lower than the rate in Ontario (14.5%) but slightly higher than the rate in WDG (10.7%). The Dufferin County area with the highest rate of unemployment is Shelburne (4.1%) (see map on next page).

What can be done?

Closing the Gap in a Generation, a report issued by the World Health Organization's Commission on Social Determinants of Health calls for "urgent and sustained action, globally, nationally and locally" to eliminate health inequities. The Commission acknowledges the critical role of civil society and local movements that "both provide immediate help and push governments to change." The report provides three key recommendations to address health inequities. Supporting fair employment and working conditions is one of the key recommendations, along with improving daily living conditions of people who are impacted by health inequities, and placing health in the centre of governance and planning.

The concept of a living wage has been introduced as a way to improve the quality of life of the working poor. It is meant to result in a rate of pay high enough to allow families to afford a decent and dignified life. Over 100 municipalities in the US have adopted living wage policies. Many leading companies and public sector employers in Britain have signed living wage agreements and the results of the new policy have demonstrated its success. Some jurisdictions in Canada have taken important steps toward the adoption of a living wage. Two municipalities in British Columbia pay living wage rates to city employees and city contractors. Furthermore, many private sector employers in BC have become official living wage employers (Cabal Garces, 2011). The development of policies to support sustainable employment and living wage are important elements of a strategy to reduce health inequities. Interest in policy advocacy exists in WDG and can be further expanded by supporting and improving the connections with local coalitions and groups that are spearheading employment strategies.

Percentage of unemployed individuals aged 25 to 64 years
Wellington-Dufferin-Guelph, 2006



"Poverty must not be a bar to learning and learning must offer an escape from poverty."

Lynden B. Johnson

Education

Level of education is a strong predictor of health. The higher and the more successful the education experience is for children and adults, the better their health will be (PHAC, 2003). This finding also applies to youth. Youth with post-secondary education are more likely to be employed than those without, and employment contributes to better health (Canadian Council on Social Development [CCSD], 2006).

When compared with post-secondary graduates, Canadians who did not complete high school are almost twice as likely to report fair or poor health (PHAC, 2003). The highest mortality rates in Canada are found among people who did not complete secondary school, those who are unemployed or who are not seeking jobs, and those who have unskilled jobs and are consequently living on low incomes (Population Health Promotion Expert Group: Working Group on Population Health, 2009).

Due to the impact that individual educational attainment has on determining further schooling, employment, health, and social outcomes, the Ministry of Children and Youth Services has identified the mandate `Every Young Person Graduates from Secondary School' as one of its five strategic goals. Quality early learning and child development services provide children with the skills, capabilities and knowledge required for success in school (Ontario Ministry of Children and Youth Services, 2008).

"I think that's probably one of the keys to success, if anything, is the relationship and the rapport the kids build with their teacher."

In making the transition to school, and throughout their educational pathways, many children require more than just academic support to succeed. Services such as mental health and specialized support are crucial to helping many young people achieve success in the classroom (Ontario Ministry of Children and Youth Services, 2008). Children and youth involved with the youth justice services and child protection systems can face significant

challenges in school and often require additional support beyond that provided by the education system.

During community consultations many parents discussed having had poor experiences in school which made them hesitant to become involved in their children's education. Research shows that parental involvement has a significant impact on children's academic achievement. Differences in involvement are not only associated with social class or poverty, differences are also associated with parents' values, school memories, or feelings of self-confidence. Some parents simply do not view involvement in their children's education as part of their role (Desforges & Abouchaar, 2003). Some parents are reluctant to come into the school space. When parents are not actively involved in their children's education it is less likely that the children will value it and understand the opportunities education can provide for them. The need for consistent attention and support from an adult who cares, was identified through community consultation as a key success factor for youth achievement in school.

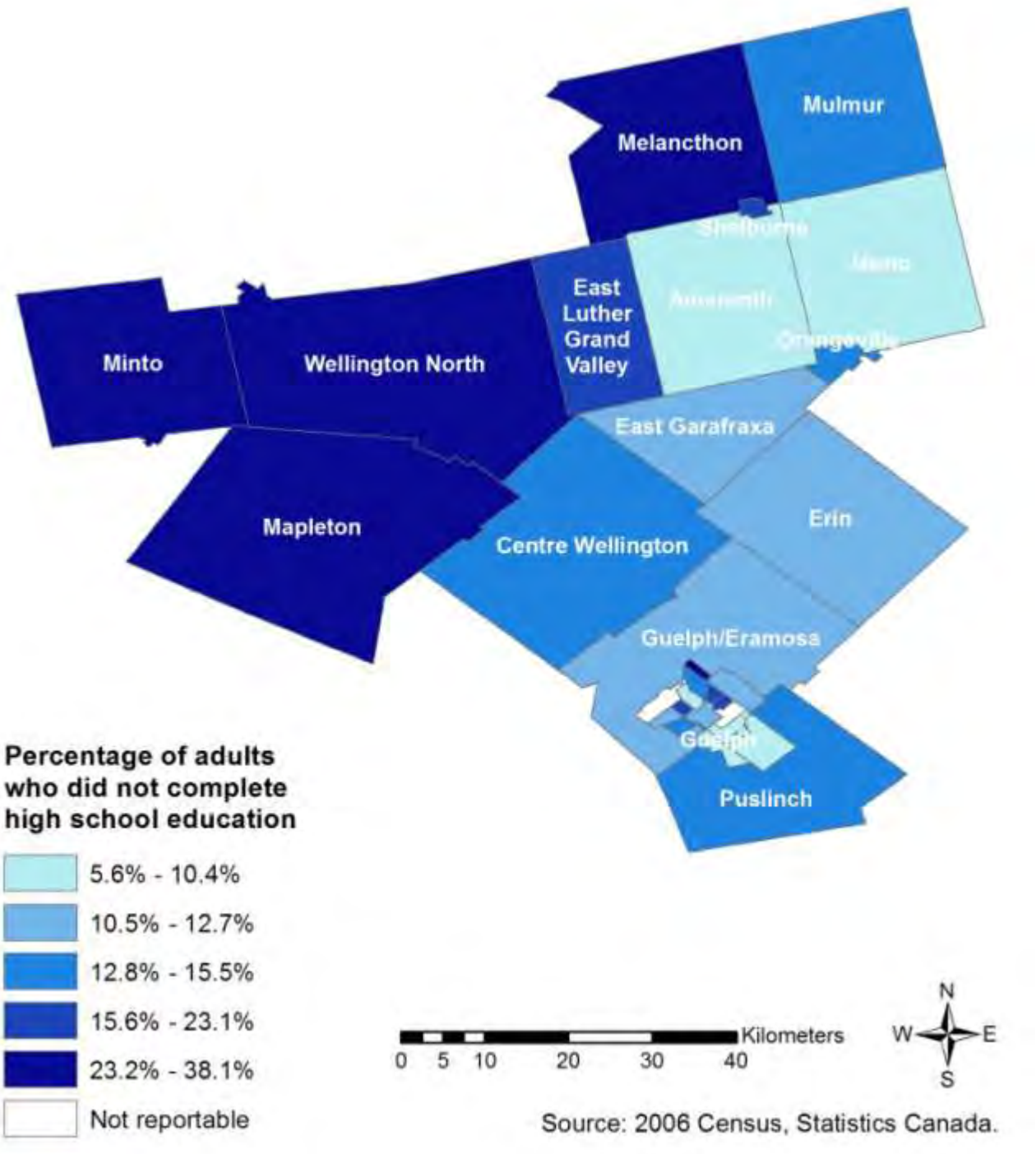
Education in Dufferin County

In Dufferin County a high proportion of the population aged 25 to 64 years does not have a completed high school education (14.7%) compared Ontario (13.6%). Inversely, a lower proportion of the Dufferin County population has a post-secondary degree (42.4%) than the populations of WDG (47.8%) and Ontario (52.7%). The Dufferin County area with the highest rate of low education is Melancthon (23.6%) (see map on next page).

What can be done?

Interventions providing focus on specific priority populations and local issues have proven to have a strong and positive impact in closing equity gaps. An example of this type of program is the *Pathways to Education* program (*Pathways*). *Pathways* aims to address the issues of youth school attendance, academic achievement, and credit accumulation by partnering with parents, community agencies, volunteers, local school boards, and secondary schools to develop intense, multi-faceted, and long-term support for high-school students. This program is a proven social and health investment that reduces high school drop-out rates by 70 percent by addressing the four pillars of academic, social, advocacy and financial supports. *Pathways* delivers a $24 return for every $1 invested (The Boston Consulting Group, 2011). *Pathways* demonstrates that youth from low income communities can achieve as well as, or better than, their wealthier peers (Boston Consulting Group, 2011; Pathways to Education, 2011). Staying in school and educational achievement lead to improvement in socio-economic conditions and as a result minimizes or remove barriers to health.

Percentage of the population aged 25 to 64 years who did not complete high school education
Wellington-Dufferin-Guelph, 2006



"Dare to dream, but also dare to act. Don't let things just happen to you. Go out there and 'happen' to things."

Wendy Yuan, Entrepreneur and RBC's Canadian Immigrant 2012's Top 25 Winner

Immigrants

New immigrant families and their children have been identified in many studies as a priority population. New immigrants often experience barriers that are related to their capacity to understand and speak English, and may face additional barriers related to cultural discrimination and racism (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). A study of the experiences of new Canadians living in Wellington and Guelph communities found that they tend to have more difficulty gaining sufficient employment that matches their qualifications, more difficulty finding affordable and stable housing, and more difficulty accessing child care (Guelph Inclusiveness Alliance, 2008).

> "Language is a barrier for new immigrants… how can they give back? How can they feel value? You build on people's skills and values and find that connection."

The poverty rate among new immigrants is 19%, the second highest rate after lone parent families (26%) (Butler-Jones, 2008). For recent immigrants who have been in Canada for less than 5 years, the poverty rate based on the Low Income Cut Off measure[2] is three times higher (30.2% compared to 10.2%) than the Canadian-born population (Region of Waterloo Public Health, 2010). According to the 2006 Census, the unemployment rate of new immigrants is double the rate for Canadian-born persons and established immigrants (11% vs. 5%). This finding is of particular concern given that in 2006, 70% of recent immigrants had a bachelor's degree or higher, compared to 40% among established immigrants and 27% among non-immigrant populations. In

[2] "Low income cut-offs (LICOs) are established using data from the Survey of Household Spending. They convey the income level at which a family may be in straitened circumstances because it has to spend a greater proportion of its income on necessities than the average family of similar size. Specifically, the threshold is defined as the income below which a family is likely to spend 20 percentage points more of its income on food, shelter and clothing than the average family. There are separate cut-offs for seven sizes of family - from unattached individuals to families of seven or more persons - and for five community sizes - from rural areas to urban areas with a population of more than 500,000." (Statistics Canada, 2010)

addition, recent immigrants who have less than a bachelor's degree have a 41% lower income than their counterparts who are Canadian-born, and those with bachelor's degrees earn 45% less than their Canadian-born counterparts (Workforce Planning Board of Waterloo, Wellington and Dufferin, 2009).

Most of the demographic growth for Canada overall and its provinces and territories is predicted to come from visible minority populations, where one in five Canadians will be part of a visible minority group by 2017 (Statistics Canada, 2005). Currently people within these visible minority groups are experiencing poverty at a much higher rate than the rest of the population. In Toronto, the poverty rate among people considered visible minorities is double the poverty rate of the rest of the population (40.7% vs. 19.8%) (Reitz, 2005). Almost half (47%) of children in new immigrant families in Canada are poor (Campaign 2000, 2010). In Ontario, one-third of children in visible minority families are poor (MOHLTC, 2009). Even though the poverty that many immigrants experience is transitory in nature, the effects are long lasting. Visible minority immigrants are twice as likely as Canadian-born individuals to report deterioration in health over an eight-year period, even though they arrived in Canada with a health advantage over the Canadian-born population (*CIHI*, 2004).

Immigrants and especially recent immigrants, face a whole new set of challenges when they arrive in Canada. The primary issue voiced during community consultations for immigrants in WDG is overcoming the language barrier that many immigrants struggle with when they come to Canada. According to 2006 Census data, 1,980 individuals in WDG spoke neither English nor French, representing about 1% of the population. In WDG, Guelph has the highest percentage of people whose mother tongue is a language other than English or French at 20% of the population, followed by Dufferin at 12% and Wellington at 8%. Language barriers can significantly limit a person's ability to obtain employment and as a result directly affects income.

Being unable to communicate with those around you can also be isolating. It is vitally important that immigrants have the ability to get involved in their community, access services and programs, and feel like they belong. Many of the people that are new to Canada are highly educated and skilled. On average, those who immigrated to Canada have more formal education compared to those who were born in Canada,yet the unemployment rate for the immigrant population is twice as high (Population Health Promotion Expert Group: Working Group on Population Health, 2009). Service providers in the community believe in the importance of finding ways for people to get involved, give back, grow, and feel valued that do not require them to be able to speak English. It is important to tap into the capacity that each person can offer.

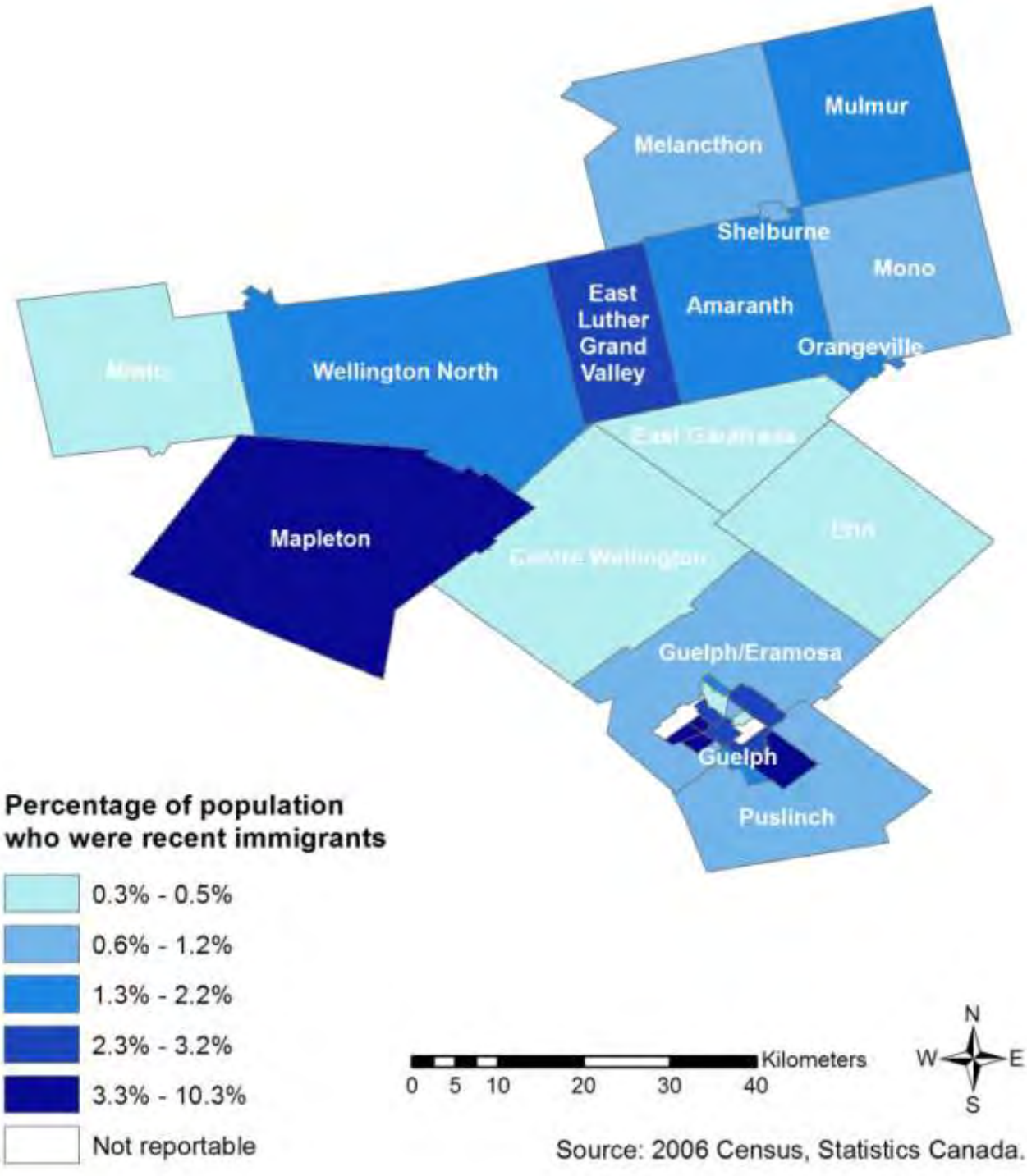
Immigrants in Dufferin County

The proportion of immigrants in Dufferin County is low (12.8%) compared with the rate in WDG (16.1%) and Ontario (28.3%). Dufferin County also has lower rates of recent immigrants (1.2%), residents who identify as visible minorities (3.8%), and people with no knowledge of French or English (0.2%) than both WDG and Ontario. The Dufferin County municipality with the highest rate of immigrants is Mono (15.7%); the municipality with the highest rate of recent immigrants is East Luther Grand Valley (2.3%) (see map on next page).

What can be done?

To address cultural barriers, accessibility, and low income, investing in peer-based programs such as the *Community Development Neighbourhood* programs in Guelph has proven to assist people in gaining access to information and build skills in a non-threatening way while keeping their unique needs in mind. Peer-based support has been indicated in many evaluation studies as a promising approach that complements broad-based interventions and provides culturally appropriate, accessible, and convenient high intensity service to people who deal with multiple and intersecting barriers. In priority populations including new immigrant families these interventions reduce social isolation, improve adoption of healthy living practices, and improve parenting skills (including reducing the need for intervention related to child protection), nutrition, and physical activity. Guelph-Wellington is also engaged in the *Guelph Wellington Local Immigration Partnership*; a planning process with the goal of developing a comprehensive and well integrated system of immigrant settlement support. This system includes improved access to, and benefits from, the health care system. In addition to this process, Guelph Wellington Local Immigration Partnership also offers direct services and supports through Immigrant Services Guelph-Wellington.

Percentage of the population who immigrated to Canada between 2001 and 2006
Wellington-Dufferin-Guelph, 2006



Social and Community Support

People supported by their family, friends, and communities experience better health (PHAC, 2003). Barriers to health may include the experience of discrimination, stigmatization, marginalization, and a lack of culturally appropriate resources and services. Lack of social connectedness and low income also affect Canadian rural communities. The more remote the community, the more likely it is that the residents experience a variety of barriers—such as lack of transportation, suitable housing, and social connectedness—and are less healthy overall (Standing Senate Committee on Agriculture and Forestry, 2008).

"People want accessible services…so programs have shifted to after hours in the schools …there isn't anyone watching where you are coming to the school from. You could be there for any type of activity, not just because you need help."

New immigrant children and their families are also faced with multiple cultural, social, and economic challenges including language barriers (CCSD, 2006; Health Council of Canada, 2006).

Research has shown that children's success in school and later on in life is increased by parenting support programs, and that parents who get support may be better able to cope with the many challenges of raising their child(ren) (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). All parents need support, whether it comes from family and friends and/or a formal service provider. There are a wide range of parental supports available in most communities; some provide access to peer-social support with other parents and aim to reduce isolation (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). Other types of supports may involve direct instruction on how to deal with particular issues, like sleep, toileting, discipline, and nutrition, while others may involve more intensive therapeutic services (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009).

Lone parent families have one parent responsible for taking care of the child(ren). The poverty rate among lone parent families is 26%, the highest among other priority populations, and much higher than the overall poverty rate of 11% in the general population (Butler-Jones, 2008). The Chief Public Health Officer of Canada states that children who live in lone parent families are one of the priority populations and need to be the focus of poverty reduction policies and other interventions (Butler-Jones, 2008). Lone parent families may require more social and community support than two parent families.

Building strong connections to ensure neighbourhood residents experience a sense of belonging is important. Social connectedness ensures people have the support they need during various life changes that can affect their health, changes such as having and raising children, attaining education or employment training, looking for housing, entering the job market, and retiring (Mikkonen & Raphael, 2010). However, social service agencies and programs can be very difficult to navigate so even though a lot of help is available, it may not be accessible to those who would benefit from it the most.

One of the most important themes identified through community consultations was the importance of collaboration. Frustrations about the waste of resources resulting from siloed efforts were repeatedly expressed. The most successful programs are collaborations where resources are shared to address identified community concerns.

Accessibility and potential barriers to accessing programs and services must be explored in an ongoing way throughout program development, implementation and evaluation. For example the location of programs and services can be a factor in determining their success. However, a challenge for service providers is the lack of available and appropriate space. Many programs use space in schools and for some it is an ideal neutral space because to a certain extent individuals feel anonymity as there are several reasons for entering a school. However, some people who have had negative school experiences as children are hesitant about coming back into the school again as adults. It may also be challenging to ensure those who are not involved in schools, such as people without children or seniors are aware of the programs and services that are available.

Social and Community Support in Dufferin County

There is a lower rate of lone parent families in Dufferin County (13.9%) than there is in Ontario (15.8%). There is also a lower rate of seniors living alone in Dufferin County (22.5%) than there is in WDG (23.7%) and Ontario (25.7%). The Dufferin County municipality with the highest rate of lone parent families (17.4%) is Orangeville (see map on next page). The Dufferin County municipality with the highest rate of seniors living alone (33.3%) is Shelburne.

What can be done?

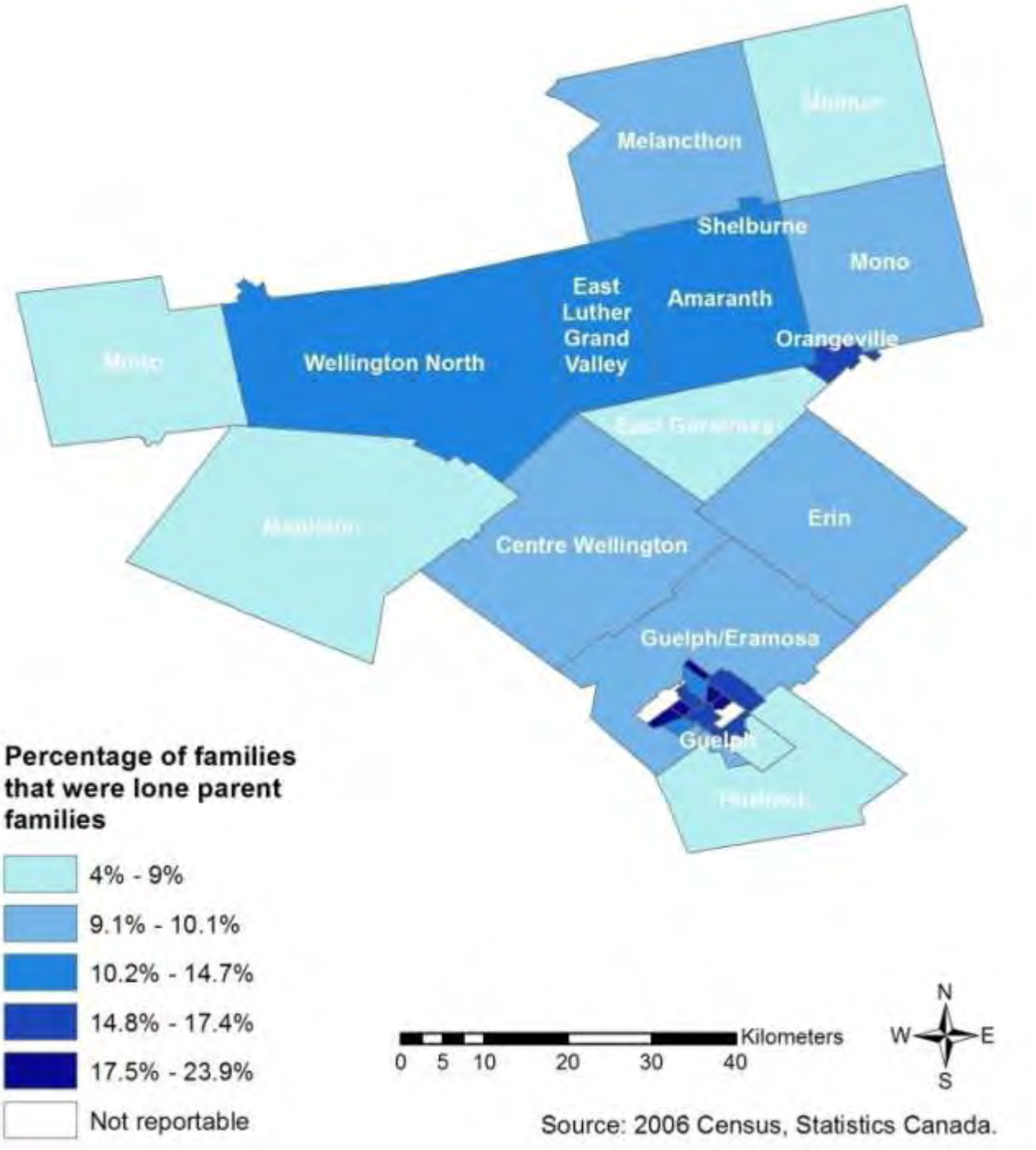
Community-based interventions have been acknowledged for a long time as an effective way of reaching out to vulnerable populations. This work needs to start with the reliable identification and prioritization of the neighbourhoods and the populations within them (Nelson, Pancer, Hayward, & Kelly, 2004; Ontario Ministry of Health and Long-Term Care, 2008; Ontario Ministry of Health and Long-Term Care, 2009a; Ontario Public Health Association, n.d.; Public Interest

Strategy and Communications Inc., 2011; Region of Waterloo Public Health, 2009; Glazier et al., 2007).

The review of best practices offers information that home visiting delivered in communities and through various forms of peer support provides positive outcomes for children's mental health, mental development, and physical growth. This approach is also beneficial for reducing maternal depression, improving mothers' employment, education, nutrition and various other health habits. Some evidence for government cost saving is mentioned as well in the context of these interventions (Public Health Agency of Canada, 2011). Home visiting programs, such as the *Nurse Family Partnership*, build on family strengths, help with early identification of risks associated with developmental difficulties, and work with families to support healthy child development (Ontario Ministry of Health and Long-Term Care, Ministry of Community, and Family and Children's Services, 2003; Krysik & Lecroy, 2007). The *Nurse Family Partnership* home visiting program focuses on working with mothers who are teens, first time moms, live with low income, and are single parents, providing them with information on healthy child development, education around positive parenting practices, self-care practices, and referrals to other community supports as needed (Headwaters Communities in Action, 2013).

The *Community Neighbourhood Development* programs in Guelph have proven to be able to assist people in gaining access to information and build skills in a non-threatening way while keeping their unique needs in mind. Despite the proven benefits and being cost effective, some of these programs operate on limited, modest funds or inconsistent, pilot funds. This model could be customized for priority communities in Dufferin County.

Percentage of families that were lone parent families
Wellington-Dufferin-Guelph, 2006



"Shelter is a basic human need - in our climate a matter of life and death. In more prosaic terms, adequate and secure housing is a fundamental requirement for acceptable levels of health and comfort, for normal family life."

Habitation New Brunswick, Moncton, New Brunswick

Housing

One measure of economic well-being is the proportion of income spent on the cost of shelter. Affordable and acceptable housing (housing that costs less than 30% of the household's before tax income) is a critical social determinant of health. Affordability of suitable housing is directly related to income. In order to be able to obtain employment and provide a supportive home for raising healthy children, stable affordable housing is widely considered to be essential (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). Housing costs affect disposable income, access to jobs, health status, and general inclusion in society (Carter & Polevychock, 2004).

Consequences related to the inability to afford a suitable housing situation include food deprivation or substandard housing conditions, where either or both have direct negative health consequences (PHAC, 2003). According to the 2008 Chief Public Health Officer's Report, 13.7% of Canadians live in an unaffordable and/or unacceptable housing situation. Inadequate housing impacts health by contributing to the inability to afford other basic necessities in life and by being exposed to unhealthy conditions, such as substandard and harmful environmental conditions and overcrowding.

Homelessness is both a product and contributor of poor health (Butler-Jones, 2008). A Toronto survey found that homeless individuals had an increased risk for many chronic conditions, including respiratory diseases, arthritis, rheumatism, high blood pressure, asthma, epilepsy and diabetes when compared with the general population, and frequently homeless populations do not receive the health care services they need (Ambrosio et al., 1992).

Certain population indicators have been strongly associated with social risks such as child health outcomes at the family, neighbourhood and community level (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). A shortage of affordable housing leaves very few options for families who cannot afford to pay market rent. Crowded living conditions create a stressful environment for families to live in which is compounded by the worry of losing even substandard housing and homelessness. Many families in our community find themselves having to move around from house to house and neighbourhood to neighbourhood. The percent age of people moving into or out of the neighbourhood is an indicator of social risk for a neighbourhood (Report Card, 2009). This cycle was a common theme identified through community consultation. Typically there was a focus on two distinct cycles of transition.

Some families move because they improve their financial situation. Other families are obliged to move into smaller housing units once their children have left home. The stream of people moving up the income ladder can be seen as an indicator of the success of programs and services being offered in the community. However, for the staff running the programs it can be exhausting and feel as though they are constantly starting over. From first glance it would appear as though data from the neighbourhood is stagnant and as though nothing is changing; however, closer examination reveals that although many of the statistics are the same, they are not reflecting the same population due to the rotation of people into and out of the neighbourhoods.

> *"I think as they start to do better financially they will naturally graduate out of the neighbourhood."*

The Wellington-Guelph Housing Committee advocates effectively for a population that needs support. Community members and service providers have expressed concern over the shortage of affordable housing. According to housing experts a healthy market should have a minimum vacancy rate of 3% for rental properties; however in the Guelph CMA [3], the vacancy rate has dropped from 1.9% in 2011 to 1.0% in 2012 (The Guelph & Wellington Task Force for Poverty Elimination, 2012). This shortage of vacant rental properties means increased wait times for affordable housing and less competitive rental costs. Between 2007 and 2010 in Wellington County, including the city of Guelph, there has been a 71% increase in the number of individuals and families on wait lists for affordable housing, whereas Dufferin has seen a 25% decrease in its waitlist size (Ontario Non-profit Housing Association [ONPHA], 2010). Depending on the size, type and location of housing, individuals or families looking for affordable housing face a wait time in

[3] CMA – Census metropolitan area is formed by one or more adjacent municipalities centred on a large urban area.

WDG of 2 to 9 years (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009).

Housing in Dufferin County

More than one quarter of households (27.5%) in Dufferin County spend 30% or more of their income on housing. It is clear that this is a significant number of households that are facing financial stress. This rate is similar to the proportion of the Ontario population (27.6%) spending 30% or more of their income on housing. There is also a lower rate residents living in rental dwellings in Dufferin County (15.1%) than there is in WDG (22.4%) and Ontario (28.8%). The Dufferin County municipality with the highest proportion of the population spending 30% or more of their income on housing was East Garafraxa (32.4%) (see map); Shelburne was the municipality with the highest rate of rental dwellings (21.1%).

What can be done?

It is important to cultivate accessible, culturally appropriate, and meaningful interventions. This could include developing and/or supporting policies to enable sustainable livelihoods and optimal living conditions for all individuals and families.

The *Housing Benefit Working Group* is a coalition lead by the Daily Bread Food Bank. The group of private sector and front line agencies is advocating for an Ontario Housing Benefit which would help low income individuals and families cover their rent and other housing expenses through a monthly payment paid directly to the recipient (Garces & Ellery, 2012). For social assistance recipients, the housing benefit would cover 75% of the difference between their shelter allowance and the actual rent cost, while for working families and individuals, the housing benefit would cover 75% of the gap between their actual rent and 30% of their income (Garces & Ellery, 2012). The Ontario Housing Benefit, as it is being proposed, would be paid directly to the recipient, unlike traditional rent supplements which are delivered to the landlord. This strategy aims to maintain fair and competitive rental prices from landlords, while empowering low income individuals and families. A similar model called *RentAid* in Manitoba provides low income individuals and families who are living in the private rental market with up to $210 a month to help cover housing expenses (Manitoba Family Services and Labour, n.d.). Manitoba, like Ontario, is experiencing low vacancy rates and long wait lists for social housing (Campaign 2000, 2008). The Manitoba shelter benefit (*RentAid*) allows low income individuals and families who may otherwise only be able to afford to live in social housing to be able to rent from the private market.

A coalition of industry and community organizations, including the Daily Food Bank, has submitted a proposal to the Government of Ontario to implement a housing benefit. The new benefit would

help low-income renters with high shelter-to-income burdens in communities across Ontario. The proposal would add an affordable housing component to the anticipated provincial Poverty Reduction Strategy. The Wellington-Guelph Housing Committee has recently formed a working group around this issue and engaged with the Daily Bread Food Bank to develop a public education and awareness campaign.

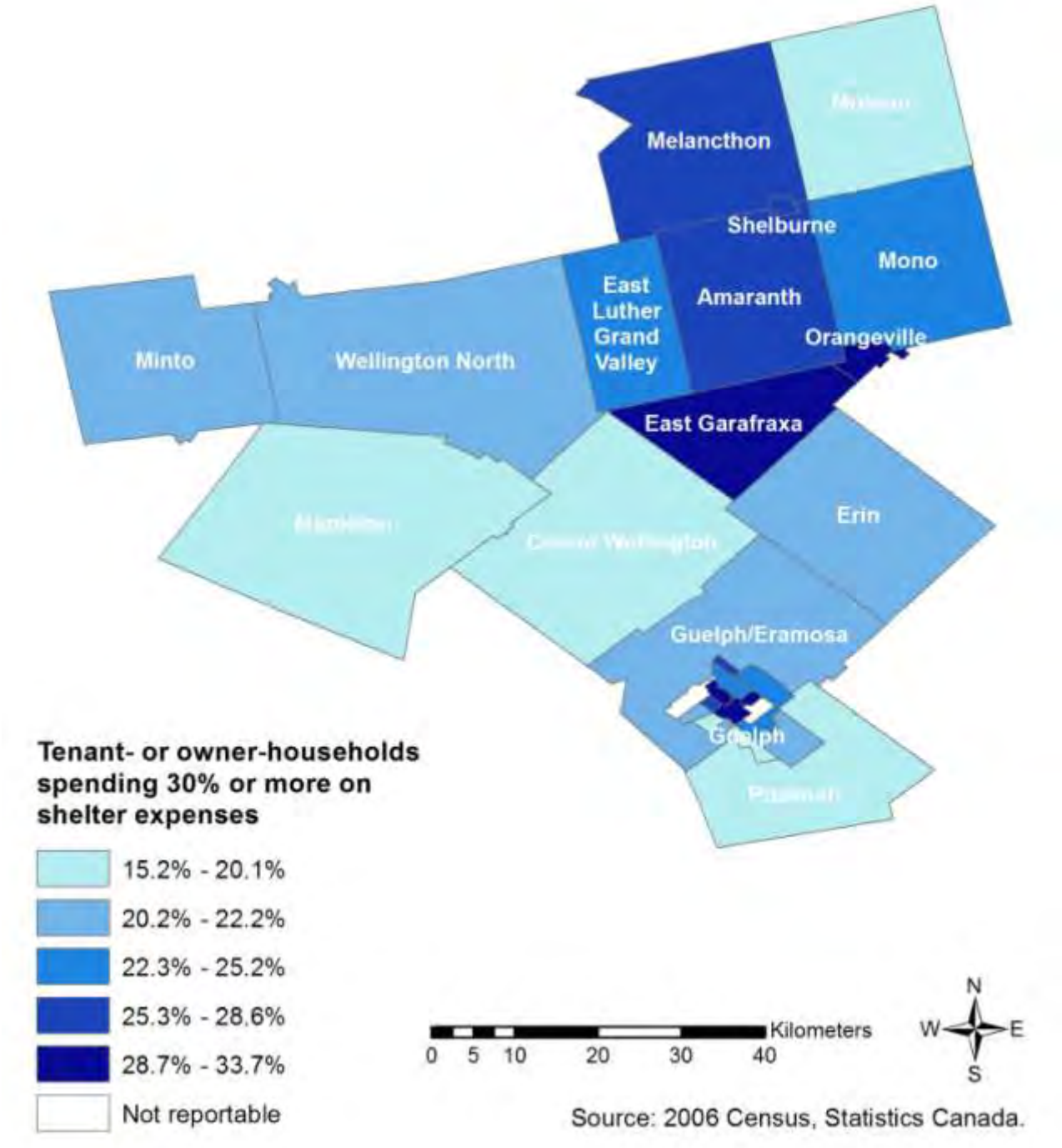
Current federal funding is either short-term or diminishing; as a result the area of social and affordable housing is suffering. The future of housing depends on adequate, sustained funding, which is why, in accordance with the recommendations in the Drummond Report (2012), Ontario should negotiate with the federal government to commit to a housing framework for Canada that includes long-term federal funding and encourages its housing partners, including municipal governments, to work with the federal government to secure this commitment.

The Ontario Ministry of Municipal Affairs and Housing recently released Ontario's Long-term Affordable Housing Strategy. One component of the strategy is simplifying the current rent-geared-to-income calculation process to reduce the administrative burden of the process on tenants and housing providers (Ontario Ministry of Municipal Affairs and Housing, 2012). This easier method of calculating rent for rent-geared-to-income housing would also provide a fair, equitable, and consistent calculation for use province-wide, to address the inconsistencies in practices. Currently the province, municipalities, tenants and housing organizations are collaborating to review and analyze potential changes, before establishing new rules for calculating rent for rent-geared-to-income housing (Ontario Ministry of Municipal Affairs and Housing, 2012).

A research profile produced by the Guelph & Wellington Task Force for Poverty Elimination (2011) produced a report with describing energy policy and outlining recommendations for addressing it. Ensuring that those who need it have access to affordable and energy efficient homes, increasing social assistance rates, and providing a living wage to the working poor can all contribute to the elimination of energy poverty. In the absence of such initiatives, the research proposes three possible ways to move vulnerable households out of energy poverty:

1. Increase income by means of programs that provide financial assistance to households experiencing energy poverty.
2. Regulate energy pricing.
3. Reduce home energy usage through programs such as the *Canadian Mortgage and Housing Corporation's Homeowner Residential Rehabilitation Assistance Program*. This program (which ended in March 2011) offered financial assistance to low-income homeowners for mandatory home repairs that preserved the quality of affordable housing.

Percentage of tenant- or owner-households spending 30% or more of total household income on shelter expenses (rent or major payments)
Wellington-Dufferin-Guelph, 2006



A child's early experiences and the environments in which they spend their time have an important and measurable effect on their later life path of health and well-being.

~The Human Early Learning Partnership (HELP)

Early Child Development

Research shows that parenting and family relationships have the greatest impact on children's healthy development and well-being; however, high quality early learning programs and child care can also play a significant role in a child's overall development. Access to and utilization of high quality programs can vary widely among families depending on their income, where they live, and their knowledge about the importance of these programs and how to access them (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009).
Early childhood development is negatively impacted by growing up in an unsupportive and neglectful social environment, which creates problems in social adaptation, school success, and numerous health problems in later life, including various chronic diseases, heart disease, substance abuse, and mental health difficulties (Heisz, 2007). Children need a safe, supportive environment, as well as a warm, nurturing relationship with their primary caregivers, to be able to meet their full potential; growing up in a neglectful, unsafe, or abusive environment can negatively affect brain development (Hon. McCain, Mustard & Shanker, 2007). Environmental conditions can subsequently impact social, emotional, physical, cognitive, and/or behavioural development. Parents also need supportive neighbourhoods and communities to help them fulfill their critical role as parents (Hon. McCain, Mustard & Shanker, 2007).

The association between SES and health outcomes begins before birth and continues throughout life. Teen pregnancy rate is a predictor of poor health outcomes for both pregnant teens and their children (MOHLTC, 2009). For teenage women, it is a predictor of various social, educational and employment barriers; for babies of teen mothers, there is an increased risk of low birth weight and pre-term birth, which leads to health and developmental challenges (MOHLTC, 2009). In Ontario, the pregnancy rate for women aged 15 to 19 years is 25.7 in 1,000 females (MOHLTC, 2009).

The Canadian Council on Social Development used the *National Longitudinal Survey of Children and Youth* to examine the negative effects that poverty has on children and youth. The findings include the following:

- "Children in low-income families are twice as likely to be living in poorly functioning families as are children in high-income families."
- "Nearly 35 % of children in low-income families live in substandard housing, compared to 15 % of children in high-income families."
- "More than one-quarter of children in low-income families live in problem neighbourhoods, compared to one-tenth of children in high-income families."
- "Nearly 40 % of children living in low-income families demonstrate high levels of indirect aggression (such as starting fights with their peers or family members), compared to 29 per cent of children in families with incomes of $30,000 or more."
- "Children in low-income families are over two and a half times more likely than children in high-income families to have a problem with one or more basic abilities such as vision, hearing, speech or mobility."
- "More than 35 per cent of children in low-income families exhibit delayed vocabulary development, compared to around 10 per cent of children in higher-income families."
- "Almost three-quarters of children in low-income families rarely participate in organized sports, compared to one-quarter of children in high-income families."
  (Ross & Roberts, 2011).

Access to basic necessities, including food, quality housing, and other resources such as child care and recreational opportunities, contributes to healthy child development. Children who live in low income families are deprived of many of these aspects, and the effects remain throughout their lifetime (MOHLTC, 2009a). Vulnerable children in poor families begin life in stressful households and may have fewer opportunities for nurturing, early stimulation, a healthy diet, safe housing, and other conditions needed for successful development (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004).

According to Campaign 2000, a public education movement focusing on poverty, one in 10 children in Canada lives in poverty. One in three of these children living with low income have families in which at least one parent has full-time employment. Babies who are born and grow up in low income families are more likely to be pre-term, have low birth weights, experience unintentional injury in childhood, and experience or witness abuse or neglect (Telford, 2011).

Early Development Instrument (EDI)

The EDI is a population-based tool used for measuring children's readiness to learn and is completed by senior kindergarten (SK) teachers for each child in their class every three years. The EDI measures how "ready" children are to learn at school using five domains of development, including physical health and well-being, social competence, emotional maturity, language and cognitive skills, and communication and general knowledge (Tardiff, 2009; Wellington-Dufferin-Guelph Coalition for a Report Card on the Well-Being of Children, 2011). Children who score low on one or more domains are considered to be vulnerable and may benefit from supports to assist them in catching up with their classmates. Children who score low on two or more domains have been shown to be likely to continue to struggle throughout their school years, in the absence of intervention (Wellington-Dufferin-Guelph Coalition for a Report Card on the Well-Being of Children, 2011).

"Many of our neighbourhood children are already leaders, they are born leaders and they have the skills, they just need opportunity to build on them."

The early experiences of children influence the course of childhood development. Children's environments and experiences shape their brain development and impact their behaviours. Communities, learning environments, and families can enhance children's early experiences to increase the likelihood of healthy child development.

Through community consultation it became clear that children are a priority for many communities within WDG. Children are the future of the community and for residents and service providers alike, children are the primary focus. Programs are offered in order to support children and provide the opportunities and experiences necessary for healthy child development.

Access to affordable quality childcare was identified by parents as a challenge. Quality daycare or preschool can provide opportunities to develop strong skills in all five EDI domains. However, the high cost of child care means it is not always accessible for people and informal childcare was identified as the norm in many communities. Moms help each other out, trading child care for each other's children. Informal child care often lacks the structure of a more formal setting and cannot provide access to the same types of resources such as space, toys, activities, etc. Some low income families in Dufferin County are eligible for fee subsidies to provide financial assistance for the cost child care. Eligibility for the Child Care Fee Subsidy is based on both income and eligible hours of care.

Early Child Development in Dufferin County

In 2006, 12.1% of SK children in Dufferin County were considered to be vulnerable on two or more domains of the Early Development Instrument (EDI). This rate was lower than the rates of vulnerable children in WDG (15.6%) and Ontario (13.8%). In 2006 the Dufferin County area with the highest rate of vulnerable children was Orangeville (see map on next page).

In 2009 the rate of vulnerable children in Dufferin County decreased to 10.3%. This is lower than the rates of vulnerable children in the city of Guelph (14.3%) and Wellington County (12.8%). In 2012 the rate of vulnerable children in Dufferin County was 10.8%.

What can be done?

There are several reports and studies that provide persuasive arguments that early child development interventions are a sound long term social investment. Evidence shows that children benefit from early interventions both cognitively and socially, which is visible in reduced crime rates, school retention, and a decrease in teen pregnancy. The study also states that the economic returns on these early investments are high but may progressively decrease as the intervention is offered later into adolescent years (Cunha & Heckman, 2006).

The *15 by 15 report: A Comprehensive Policy Framework for Early Human Capital Investment* in British Columbia states that any rate in child vulnerability above 10%, which is genetically and biologically expected, is unnecessary, avoidable, and potentially costly should interventions not be put in place to prevent such outcomes. The authors go further in providing an economic analysis which states that the cost of dealing with the consequences of the current 29% of vulnerable children may account for as much as 20% of the gross domestic product over the next 60 years, claiming that the total sum of this loss is equal to 10 times the total BC provincial debt (Kershaw et al., 2009).

Meta-analyses and systematic reviews have demonstrated that early childhood development programs that are comprehensive and community-based have a protective role in a child's development, prevent developmental delays, and are effective in narrowing the gap between the children from low income families and those from higher income families (Anderson et al., 2003; Public Health Agency of Canada, 2011).

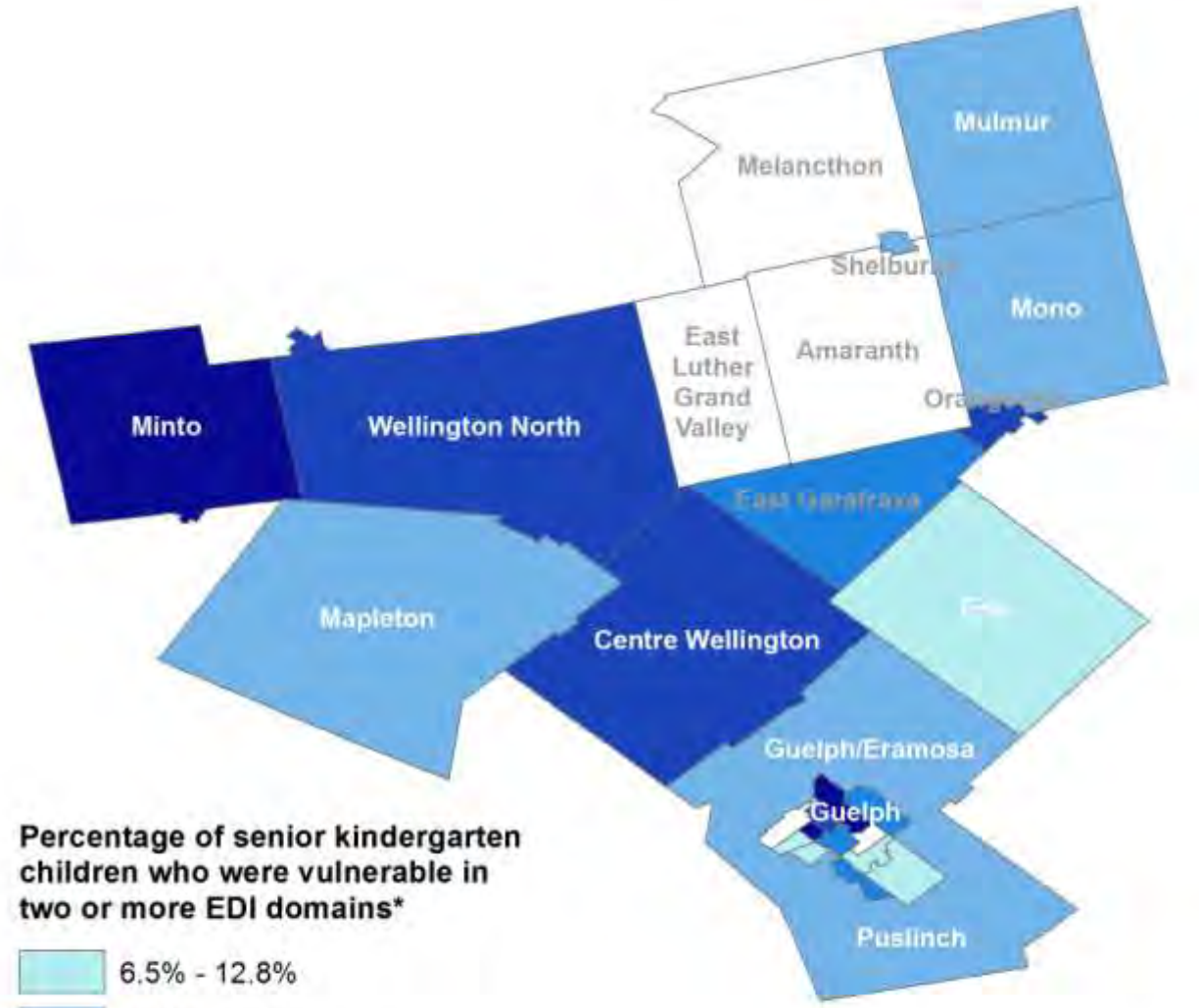
The Triple P (Positive Parenting Program) is an example of an evidence-based parenting and family support strategy focused on preventing behavioural, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of their parents. It provides a

common framework for service providers and consistent messages for parents. A flexible curriculum supports parents with children birth to age 18 from all strata of society regardless of the composition of the family. *The Triple P* model assumes that parents have different needs and require various levels of support: from offering general information for all parents, to mid-range guidance (e.g., tip sheets, parenting advice, workshops), to offering more advanced clinical help for parents who are experiencing significant behavioural issues with their children. *Triple P* is one of the most extensively evaluated interventions and has consistently shown positive effects on observed and parent-reported child behaviour problems, parenting practices, prevention of child maltreatment and parents' adjustment across sites, investigators, family characteristics, cultures, and countries (Prinz, Sanders, Shapiro, & Lutzker, 2009; Sanders, 2008). Improvements in children's behaviour are sustained over time. The universal nature of the program also decreases the risk of stigma associated with some organization-specific parent education programs.

The Quebec model of childcare is an example of how governments can help parents to access quality childcare and balance their family and work responsibilities. In Quebec, there are various types of childcare for parents to choose from for children aged 0 to 4, and for school aged children under 12 daycare services are also provided in schools. Subsidies offset the cost to parents; some parents pay only part of the cost, while others pay nothing at all. Fees for an average family are $7 per child per day (Gouvernement du Québec, 2010). For $7 a day the child receives up to 10 consecutive hours of childcare, one meal and two snacks, educational programming, and materials (Gouvernement du Québec, 2011).

Percentage of senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains

Wellington-Dufferin-Guelph, 2006



Source: Guelph-Wellington 2006 EDI Results as cited in Wellington-Dufferin-Guelph Coalition for a Report Card on the Well-being of Children, 2009.

Health Outcome Indicators

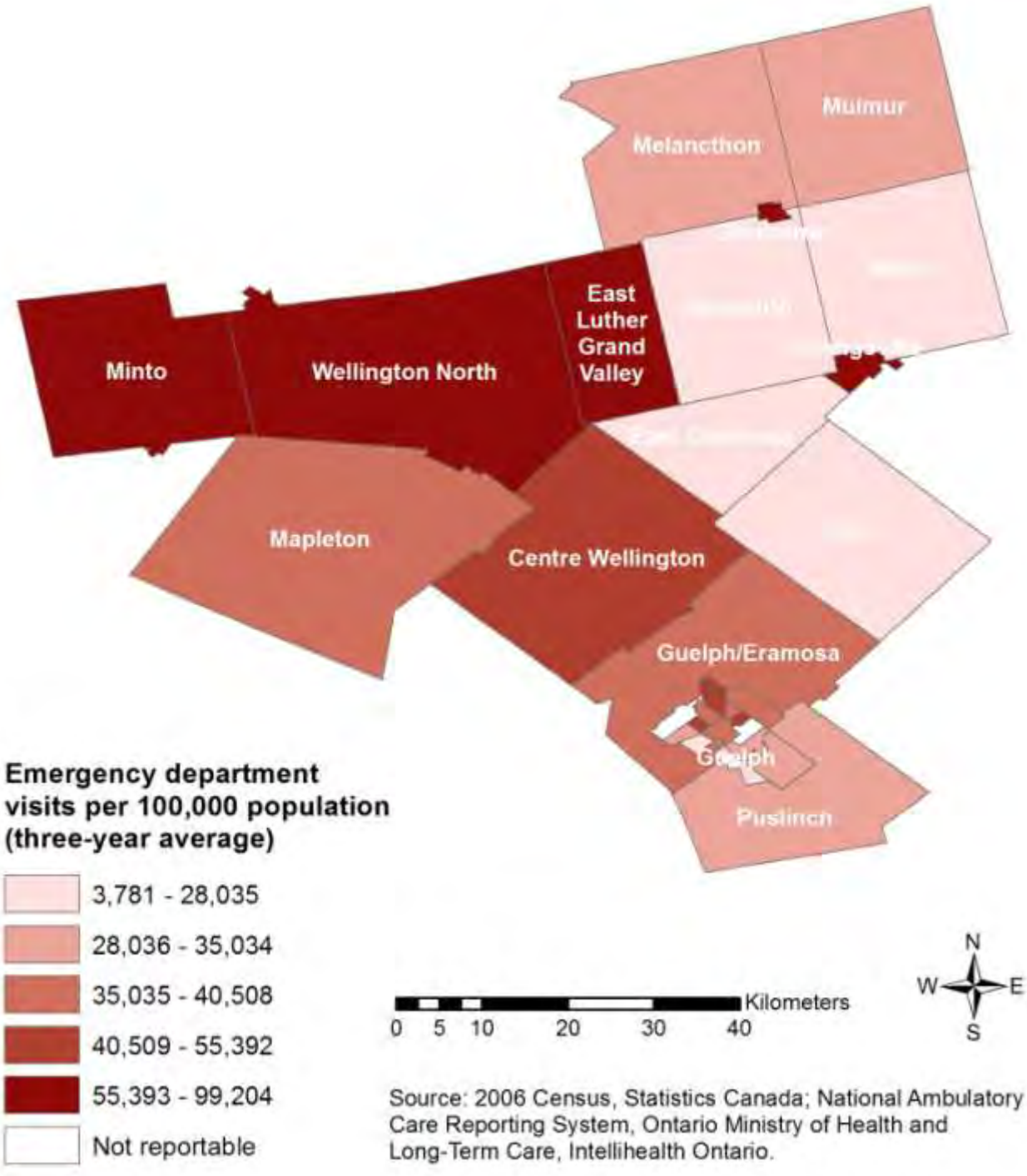
Four health outcomes that are known to be associated with social determinants of health were examined:

- Cardiovascular disease
- Injury (external cause)
- Diabetes
- Lung cancer

Unscheduled Emergency Department (ED) visit data, inpatient hospitalization data, and mortality data were obtained from the Ministry of Health and Long-term Care (MOHLTC). The original data sources were as follows:

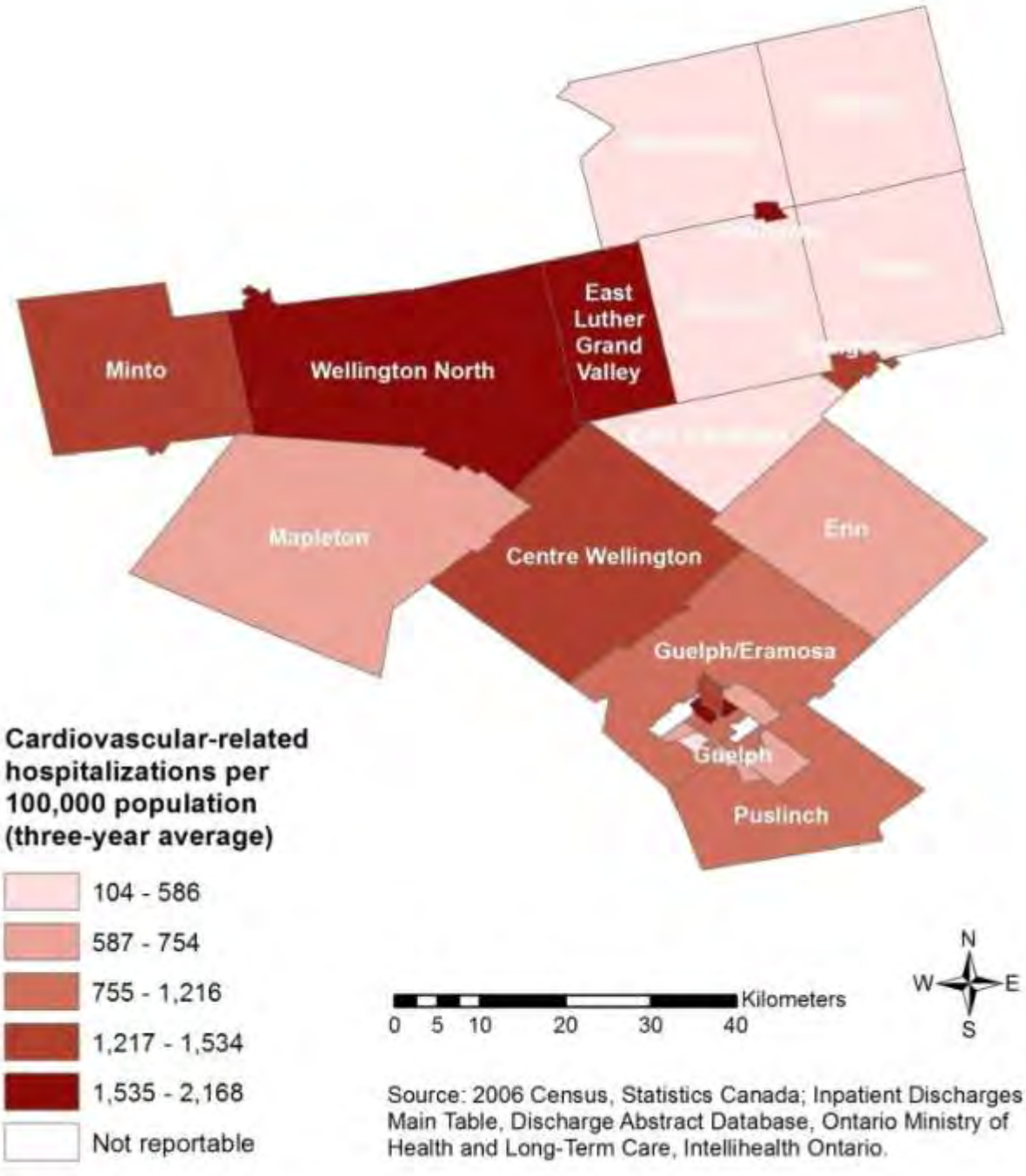
- ED visit – Ambulatory Visits Main Table form the National Ambulatory Care Reporting System.
- Inpatient hospitalization – Inpatient Discharges Main Table from the Discharge Abstract Database.
- Mortality – Deaths Main Table from the Vital Statistics Mortality Database.

Three-year average emergency department visits (all cause)
per 100,000 population
Wellington-Dufferin-Guelph 2007-2009

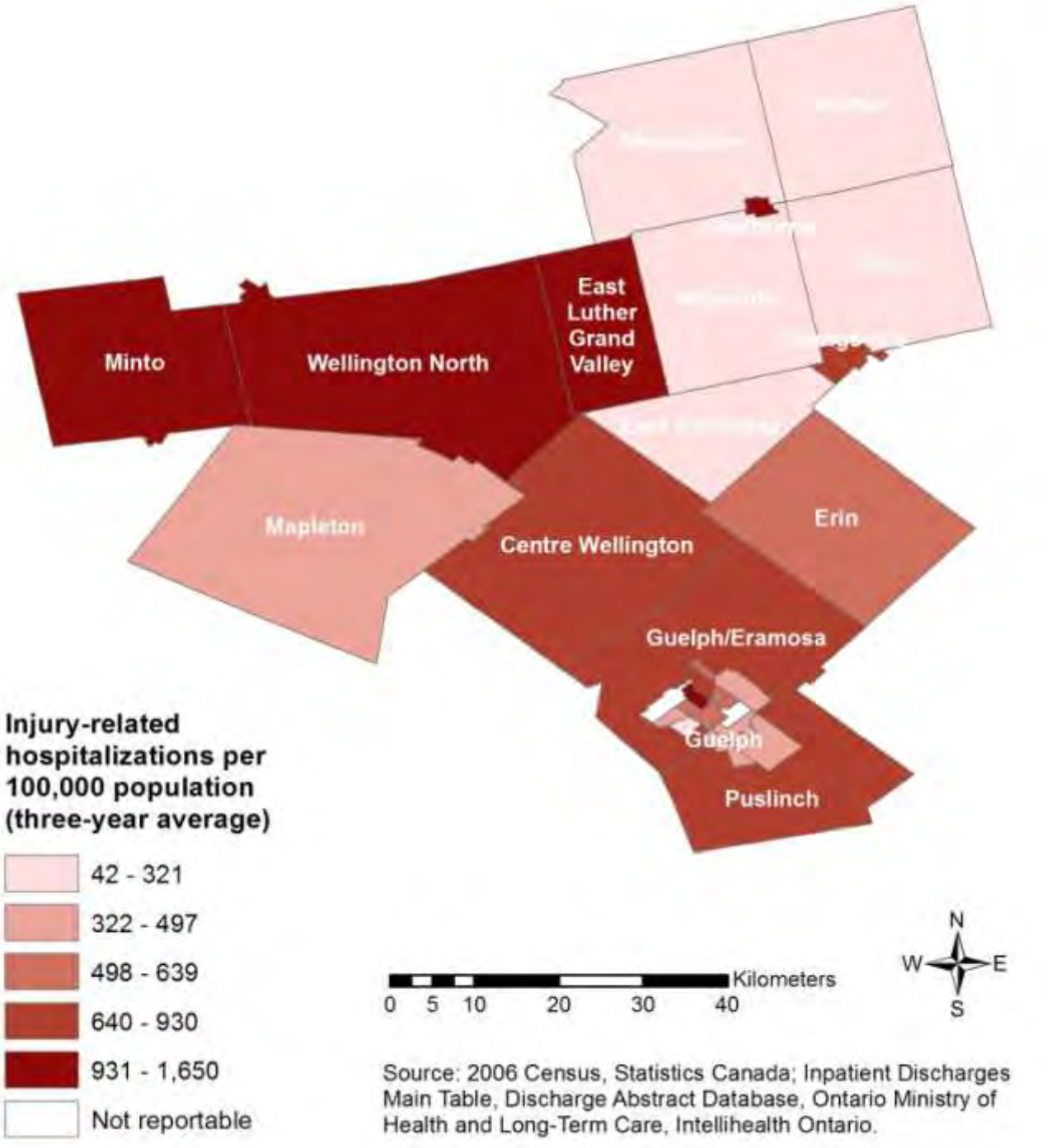


Source: 2006 Census, Statistics Canada; National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Three-year average cardiovascular-related hospitalizations per 100,000 population Wellington-Dufferin-Guelph 2007-2009

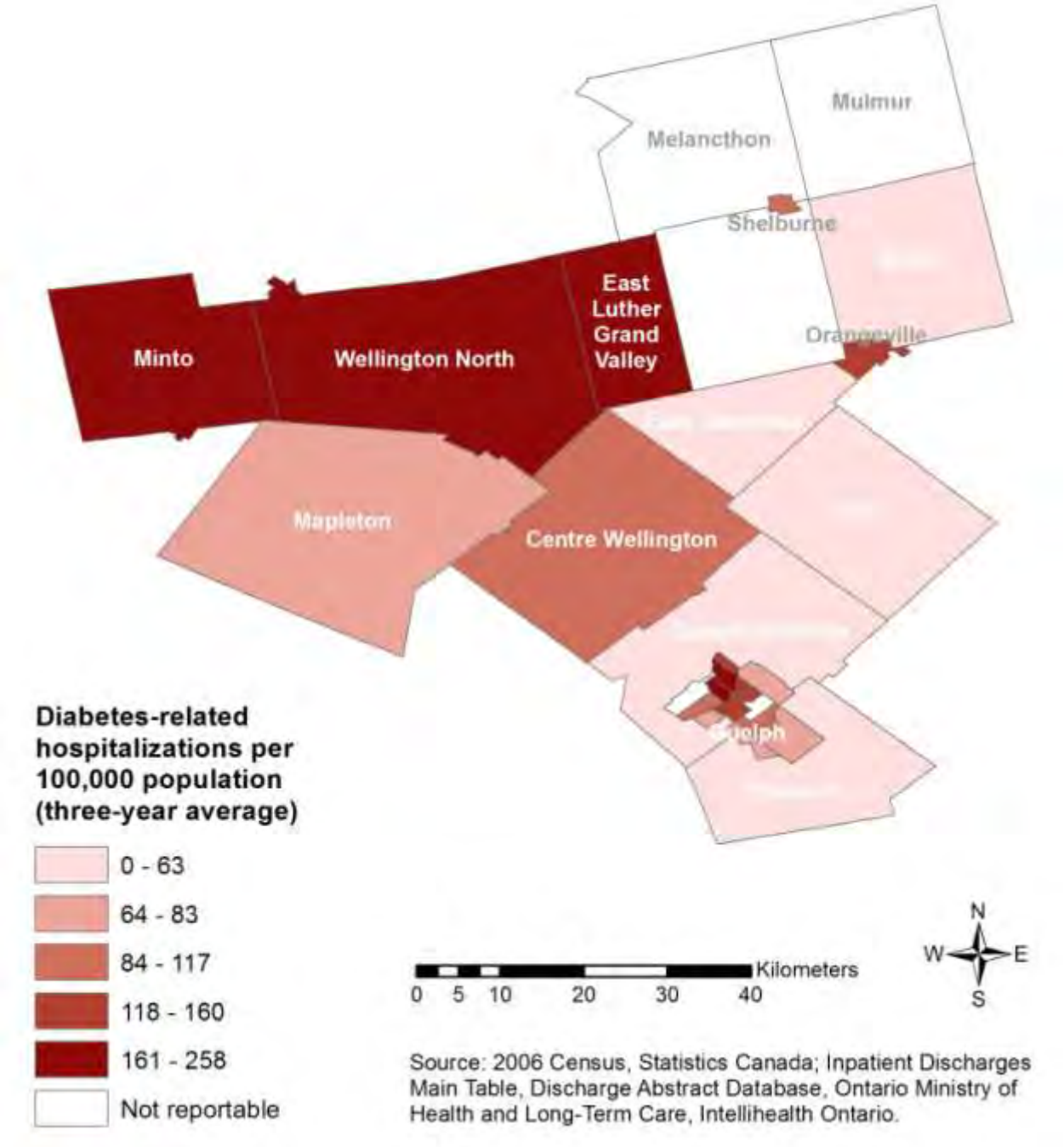


Three-year average injury-related hospitalizations per 100,000 population Wellington-Dufferin-Guelph 2007-2009

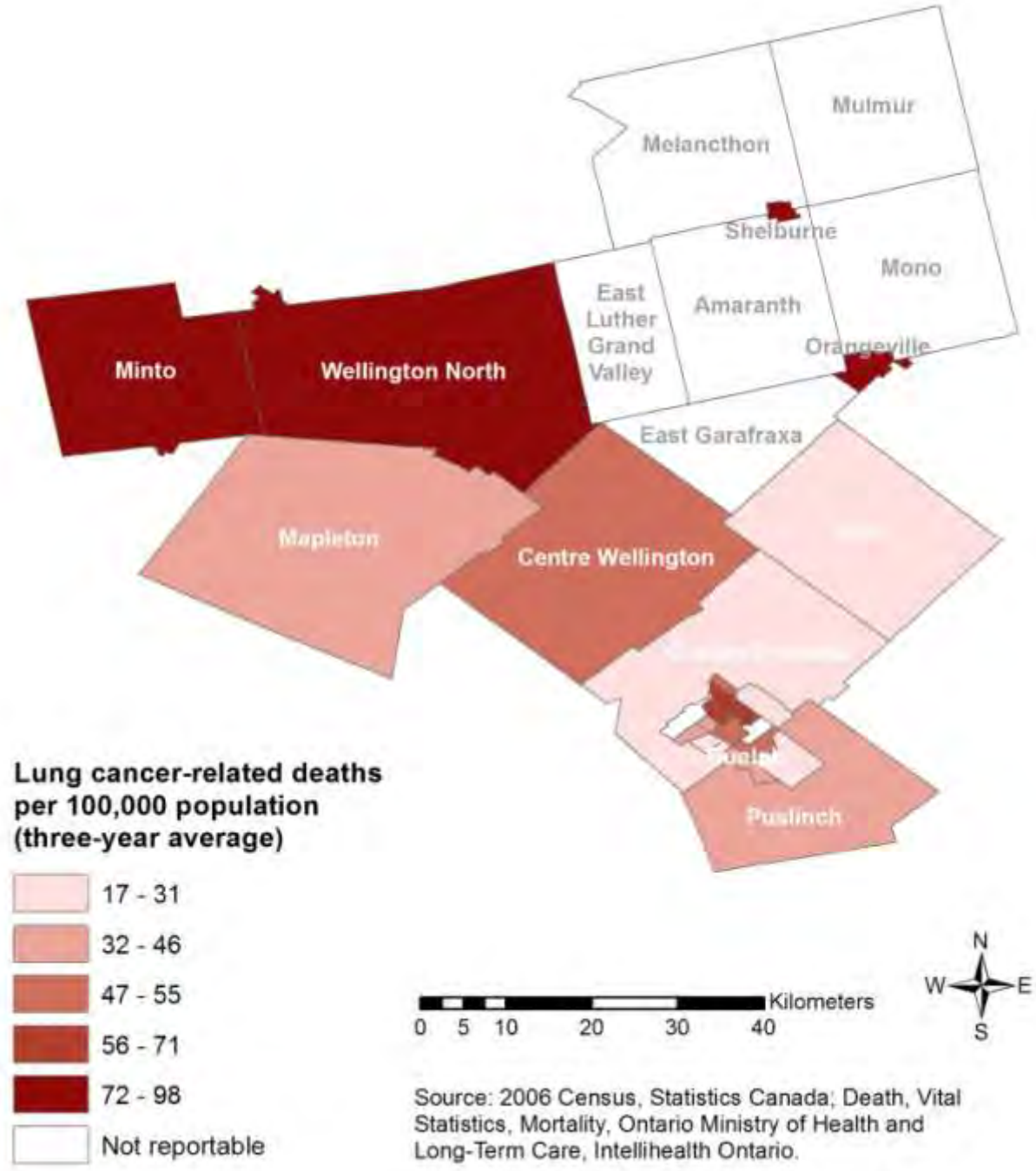


Source: 2006 Census, Statistics Canada; Inpatient Discharges Main Table, Discharge Abstract Database, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Three-year average diabetes-related hospitalizations per 100,000 population Wellington-Dufferin-Guelph 2007-2009



Three-year average lung cancer-related deaths
per 100,000 population
Wellington-Dufferin-Guelph 2005-2007



"Why worry about poor neighbourhoods? … We are concerned about the profound human cost of poverty on individuals and families who struggle not only to survive, but to participate fully as citizens."

-The United Way

Priority Communities

Dufferin County is home to citizens who sustain this resourceful, supportive and dynamic community. Dufferin County is made up of communities that are caring and innovative. Community members and service providers work together to create and deliver programs, services, public policy, advocacy and education to ensure everyone achieves the highest level of health. In comparison with other regions in Ontario, Dufferin County appears to fare relatively well for many of the social determinants of health indicators. However, it is clear that there are significant health and social inequities which exist between groups and must be addressed. It is the purpose of this report to identify community strengths and assets as well as barriers that get in the way of communities being healthy. The report recommends strategies to address these barriers and reduce health inequities.

Recognizing and raising awareness about the inequities that exist is an important step in addressing them. It is not done lightly; it is with much consideration, respect and commitment that this matter is brought forward. Many local groups, organizations and agencies are dedicated to working together to address inequities and are determined to create a community where everyone can prosper. It is our intention to use all the tools available to us: evidence, literature, our partners and each other to find strategies that will work in our local context. In a time of austerity, resources are scarce and we must work as efficiently as possible together to reduce overlap, set priorities and respond to the call to action.

The purpose of this report is not to single out or to stigmatize any individual community; rather it is to recognize that some communities are struggling despite the strengths of the community and the successes that have been achieved by individuals, volunteers, service providers and agencies. In order to make progress towards a more equal society local solutions must be used that build on the strengths and needs of each unique community.

Priority areas were identified through a system of ranking. Eight social determinants of health indicators were used to rank all areas. The results are highlighted in Table 1. These indicators

were chosen based on evidence from existing literature and the data examined in this report. All areas in Dufferin County were ranked on each of the eight indicators. The indicator ranks were then summed for every area. Areas appearing in the highest 20% of the overall rank were identified as priority areas.

Orangeville and Shelburne were the two areas in Dufferin County that were identified as priority areas based on the eight indicators. Although these areas have many strengths, they are experiencing challenges such as high rates of low income, unemployment, and vulnerable children.

Social Determinant of Health Indicators

When exploring the social determinants of health, indicators play an important role in quantifying or measuring determinants that cannot themselves be directly measured. This allows the relevant information to be available for decision-makers and the public by providing a synthesized view of existing conditions and trends (World Health Organization, 2002). Table 1 shows a list of indicators (middle column) that can be used to measure status of each corresponding determinant. Bolded indicators in Table 1 were used to rank and identify priority neighbourhoods.

> *"Indicators are a way of seeing the big picture by looking at a small piece of it."*
>
> *(Plan Canada, 1999)*

Table 1 – Indicators used in overall ranking of neighbourhoods

SDOH Indicators		Impact
Income	• Child <6 in low income households • Unemployment rates 25+ • Private households LIM after tax • Average household income after tax • Private households LIM before tax • Lone parent households LIM before tax • Lone parent households LIM after tax	• People with lower socio-economic status use health services more and are more often and more seriously sick or injured (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security,2004). • Children who live in low income households are more likely to have a range of health problems throughout their life, even if their socioeconomic status changes later in life (Ontario Physicians Poverty Work Group, 2008).
Education level	• Low education (no diploma/degree/certificate) • High school only • Post-secondary education (University/college)	• The higher and the more successful the education experience is for children and adults, the better their health will be (PHAC, 2003). • The highest mortality rates in Canada are identified among people who do not have secondary school, those who are unemployed, or who are not seeking jobs, and those who have unskilled jobs and are consequently living on low incomes (Population Health Promotion Expert Group: Working Group on Population Health, 2009).
Social and community support	• Lone parent families • Female headed lone parent families • Seniors living alone • Some unpaid care for seniors	• People supported by their family, friends, and communities experience better health (PHAC, 2003).
Housing	• Housing affordability • Owner & tenant spending >30% on housing • Owner spending >30% on housing	• Affordability of suitable housing is directly related to income and the consequences of an inability to afford suitable housing leads to either food deprivation or substandard housing conditions, where either or both have direct negative health consequences (PHAC, 2003).
Immigration	• Recent immigrants • Immigrants • No knowledge of English or French • Visible minority	• The poverty rate among new immigrants is second highest after the lone parent families (Butler-Jones, 2008). • New immigrants on average have more formal education than Canadian-born persons, yet the unemployment of immigrants is double the rate of Canadian-born persons.
Early childhood development	• EDI vulnerable on 2+ domains	• Growing up in a neglectful, unsafe, or abusive environment can negatively affect brain development. Environmental conditions can subsequently impact social, emotional, physical, cognitive, and/or behavioural development.

Priority Areas in Dufferin County

Shelburne

Shelburne has a population of 5,150 with 1,390 families (Statistics Canada, 2006). It covers an area of 4.7 square kilometres. Children aged 14 years and under account for 21.8% of the population and seniors aged 65 years and over account for 15.3% of the population. The average household income (after tax) is low at $55,331. Compared with other areas in WDG, Shelburne has a high percentage of adults who did not complete high school education and children living in low income households. Shelburne had high rates of lung cancer-related deaths and the highest rates in all WDG of:

- Emergency department visits
- Cardiovascular-related hospitalizations
- Injury-related hospitalizations

Orangeville

Orangeville has a population of 26,925 with 7,635 families (Statistics Canada, 2006). It covers an area of 16 square kilometres. Seniors aged 65 years and over account for 10.1% of the population. Orangeville has a high percentage of children aged 14 years and under (22.4% of the population). The average household income (after tax) is $62,168. Compared with other areas in WDG, Orangeville has a high percentage of children aged six years and under in private households with low income, lone parent families, children who were scored as vulnerable on the Early Development Instrument (EDI), and adults who completed high school as the highest education. Orangeville had high rates of poor health outcomes in two of four of the health related indicators that were examined:

- Emergency department visits
- Lung cancer-related deaths

A Call to Action

This report includes a call to action to address health inequities that contribute to the healthcare crisis in Ontario. It provides evidence that factors such as income, education and child development have a profound impact on health outcomes. The report offers evidence describing the effectiveness of policy development and promising interventions. This information will be used to assist in determining the focus of our coordinated efforts to address the social determinants of health in Wellington-Dufferin-Guelph communities. Clear and specific recommendations are provided as a starting point and to provide some guidance based on best or promising practices from the literature.

Information about specific communities will allow stakeholders to ensure that community members have an opportunity to clearly identify assets and challenges within their respective communities and that assumptions or decisions are avoided which could negatively impact identified communities.

"If you live in a world of silos then you see **low income**, **poor health** and **high medical costs** as three different problems... But once you start connecting the dots, you see that they are all parts of a vicious cycle. **We have to find innovative and sustainable solutions that confront root problems."**

WDG communities have demonstrated their commitment to improving the health of our residents by addressing the factors that determine health. However, many of the existing health initiatives could be strengthened by using a "whole of community" approach, whereby action is taken collectively with concerned citizens, the private sector, business, faith communities and other service providers and results are measured and demonstrated. Addressing the social determinants of health is all of our responsibility. It is not a "health" problem to be addressed by professionals in the "health" business.

Priority neighbourhoods will be engaged in the development of optimal solutions that match their needs and unique circumstances. Communities will be given an opportunity to review the suggested recommendations in the report and to assess their relevance and compatibility within the context of their current programming and other activities.

This report summarizes our current knowledge of how social conditions influence people's health and outlines what we currently know about promising policies and interventions to improve these conditions and decrease the burden on the health care system. Here are some principles and suggestions that may support collaboration to pursue action steps:

1. **WDG communities need to introduce a collaborative, community-wide process to further explore the findings and recommendations from this report and determine the most suitable course of action. This should include a commitment to engage broad membership from the health, education, business and other sectors.**

   Suggestions for next steps:

   - Present the findings and recommendations of this report
   - Begin a discussion to define a process and structure that will address social determinants of health in a collaborative, action-oriented way
   - Plan a course of action which will include identifying:
     - Specific interventions (programs, services or resources)
     - Timelines; a multi-year plan in which interventions build on each other
     - Stakeholders from the broader community to be part of this process
     - A lead agency to take responsibility for facilitating the identified process and lead agencies for each intervention
     - A plan for evaluation and population health monitoring
     - A plan to provide funding and resources for the identified interventions, including in-kind resources

   The creation of public policies and programs must avoid widening health disparities and action on reducing them needs to be collective, coordinated and integrated (Health Council of Canada, 2010). We need to improve understanding of these principles across the sectors (public, private and non-profit).

2. **Introduce mechanisms that link existing community networks in WDG across the issues (e.g., linking early years and poverty reduction networks) in order to strengthen their impact and maximize policy and intervention outcomes.**

   Suggestions for next steps:

   WDG communities have many strong networks that are built to support specific issues such as poverty, early years, education, chronic disease, etc. This is a call to action to avoid duplication and build on these existing networks. WDG communities are encouraged to seek optimal and efficient solutions to advance multi-sectoral action. Engaging decision makers is critical to this action but that does not mean the addition of another network with regular meetings that are often time consuming and hard to sustain. Instead, this action may mobilize

a flexible, but committed and supportive network or alliance of individuals and organizations. Such groups can act as champions for action and add a strong voice in key stages of policy advocacy, or support resources needed to pursue promising interventions. Networks can be linked using strategies such as:

- Presentations to each network to raise awareness of the social determinants of health
- Identifying a person on each network or planning table to liaise with the social determinants of health group
- Developing a system of knowledge exchange using vehicles such as e-bulletins, reports, and sharing of evidence.

3. Sharing the evidence about the cost effectiveness of population health policies and interventions with private, public, business and other sectors and inviting them to invest in early years interventions and poverty reduction.

Suggestions for next steps:

Stakeholders in the social, education and health sectors have been working together to address social determinants of health. In order to strengthen multi-sectoral support for this action:

- Identify stakeholders from a broader range of sectors to join this call for action
- Develop a comprehensive plan to engage the identified stakeholders
- Structure the plan such that it clearly describes the role stakeholders will play in addressing the social determinants of health

4. Developing mechanisms to monitor population health of the residents of WDG and the progress in narrowing down the health equity gaps in identified areas.

Suggestions for next steps:

Establish a system to monitor the progress of action over time. Continuous reporting on social conditions and their relationship to health will increase the understanding of how community interventions and policy decisions influence changes in this relationship. A surveillance system with this type of data at the community level may serve multiple purposes, from recording the community's progress, to continuously informing the community, to identifying new and emerging needs to address.

- Work collaboratively to identify population indicators using a Results-Based Accountability (RBA) framework
- Formalize a plan to monitor the chosen indicators over time
    - Identify a lead agency
    - Establish a timeline
    - Determine a reporting structure
    - Plan how to resource and fund the monitoring of population health

- Exploit existing resources such as data available through the WDG Community Data Consortium and data from population health reports such as:
    - The WDG Report Cards on the Well-Being of Children
    - Health status reports released by WDG Public Health

5. **Priority areas, communities, and service providers need to be engaged in the development of optimal solutions that match their needs and unique circumstances. It is important to ensure that no further harm or stigmatization occurs in this process.**

Suggestions for next steps:

WDG Public health explored and validated the findings of this report through a meaningful community-wide engagement process. Community members and service providers were asked:

- Whether the findings of the initial report resonate with their experience of living in the community
- Whether the recommendations in the initial report are relevant within the context of their community
- To describe their vision for success in pursuing action on this report
- Whether the identified priority communities are communities that should be prioritized for action.

Service providers should provide further opportunities for communities to review the suggested recommendations in the report and to assess their relevance and compatibility with the context of their current programming and other activities. As we begin to plan interventions communities should be engaged in an ongoing way in order to ensure that solutions build on the strengths and needs of each unique community.

6. **Raise public awareness about the importance of addressing social determinants of health. It will be essential to find a way to present the social determinants of health in a way that people will understand and that is meaningful to them.**

Suggestions for next steps:

Key messages to clearly convey the idea of social determinants of health have been developed. These messages have been designed to resonate with community members, whose attitudes they ultimately have to shape or reflect. Resources to share these messages have been developed. These resources have been packaged in a tool kit which includes a video with a guide, fact sheets, a presentation, a game and key literature.

- Establish a process to share the messages and resources widely with agencies and community leaders.
- Encourage agencies and community leaders to use the resources to share key messages broadly. Key messages could be shared with:

- Stakeholders who haven't traditionally been involved in collaborative efforts, including business and political sectors
- The general public
- Neighbourhood groups
- Students

7. Support intervention research and continue to build on the existing evidence base for promising practices in addressing social determinants of health.

Suggestions for next steps:

The suggested interventions in this report have been evaluated and have proven to deliver substantial positive outcomes. Interventions that are implemented across our communities must be examined for their contribution to reducing health equity gaps and improving the overall health of the communities. Evaluation research that provides evidence on the outcome of these interventions is a valuable source for learning how to overcome the adverse effects of social inequities. This research will assist with increasing our collective knowledge of what interventions prove to be most successful in reducing health inequities.

- Seek opportunities to engage academia and other sectors in evaluation research
- Formalize a plan to evaluate interventions
  - Choose evaluation indicators
  - Identify a lead agency
  - Establish a timeline
  - Determine a reporting structure
  - Plan how to resource and fund evaluation research

Conclusion

Much has been written about the impact that social determinants of health can have on a community. We have local data to support the existence of these determinants and we have a beginning inventory of promising practice and policies to begin addressing the health inequities. Now, we need ACTION. It is only by working together across the entire geographic area that makes up Dufferin County that we can truly impact the health of our residents, in a positive way, and ultimately see improvements that will support the future generations of our communities.

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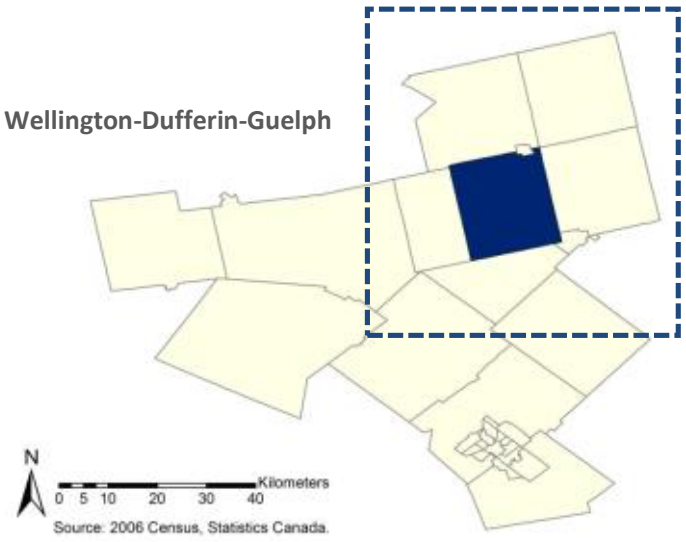
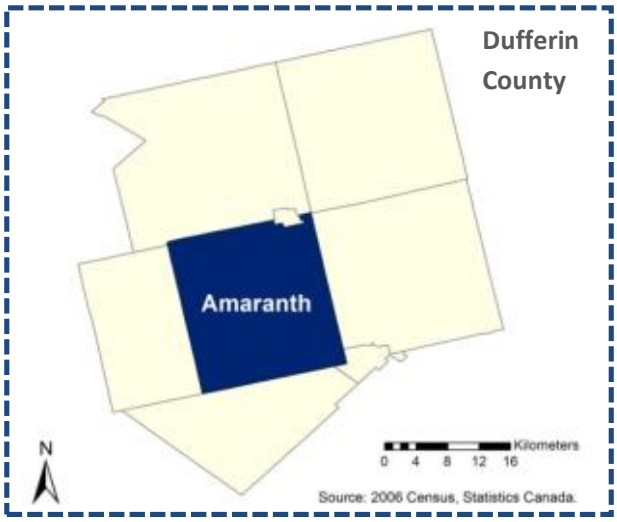
Appendix A: Neighbourhood Profiles

The neighbourhood profiles provide an overview of social determinants of health information about each community. Each profile includes a map, quick facts, key findings, a snapshot of social determinants of health and health outcome rates. These profiles can be used to better understand the strengths and challenges of priority areas.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Amaranth





Quick Facts about Amaranth

- Population: 3,845
- Percentage of total population of Wellington-Dufferin-Guelph: 1.5%
- Area: 265 km^2
- Located: In Dufferin County
- Number of families: 1,140
- Children aged 14 years and under: 20.7%
- Seniors aged 65 years and over: 10.0%
- Population living at a different address one year ago: 10.8%
- Average household income (after tax): $69,016

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in Amaranth

- Compared with other areas in WDG, Amaranth has a high percentage of:
  - Low income households (Low Income Measures after tax)
  - Low income lone parent households
  - Adults who completed high school as the highest education
  - Tenant- or owner-households spending 30% or more on rent/payments
- Compared with other areas in WDG, Amaranth has a low percentage of:
  - Emergency department visits, cardiovascular- and injury-related hospitalizations

Snapshot of Social Determinants of Health in Amaranth

Low income families

- Low income households (Low Income Measures before tax) : 14.1%
- Low income households (Low Income Measures after tax): 13.7% Highest
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 10.1%
- Female-headed lone parent families among lone parent families: 56.5% Lowest
- Low income lone parent households (Low Income Measures before tax): 46.7% Highest
- Low income lone parent households (Low Income Measures after tax): 40.0% Highest

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): Not reportable
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 6.2%

Education

- Adults who did not complete high school education: 10.4% Lowest
- Adults who completed high school as the highest education: 35.8% Highest
- Adults who obtained post-secondary education: 38.7%
- Post-secondary education obtained outside of Canada: 12.7%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 0.5% Lowest

Immigrant and Visible minority populations

- Immigrant population: 15.2%
- Recent immigrant population: 1.6% (or 10.3% among immigrant population)
- Visible minority population: 2.0%

Language

- Population with no knowledge of English or French: 0.3%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 28.6% Highest
- Rental dwellings: 7.7% Lowest

Seniors

- Seniors living alone: 9.2% Lowest
- Population 15 years and over providing unpaid care or assistance to seniors: 19.5%

Health outcome indicators*

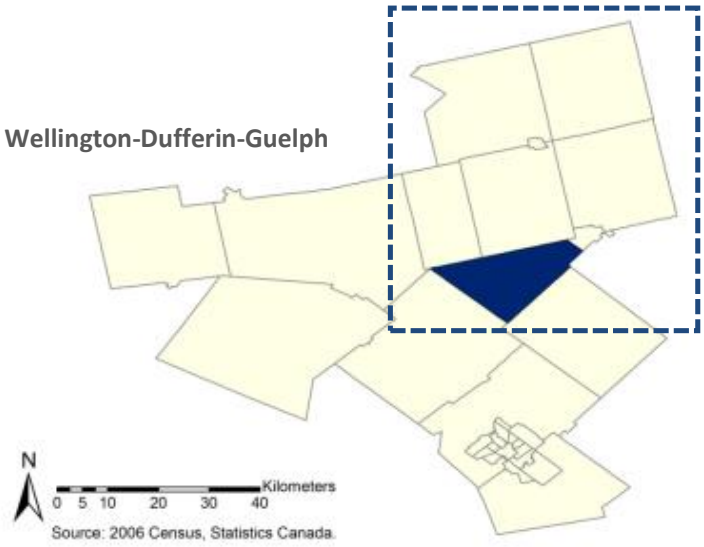
- Emergency department visits (all cause): 6,329 per 100,000 population Lowest
- Cardiovascular-related hospitalizations: 191 per 100,000 population Lowest
- Injury-related hospitalizations: 69 per 100,000 population Lowest
- Diabetes-related hospitalizations: Not reportable due to small counts
- Lung cancer-related deaths: Not reportable due to small counts

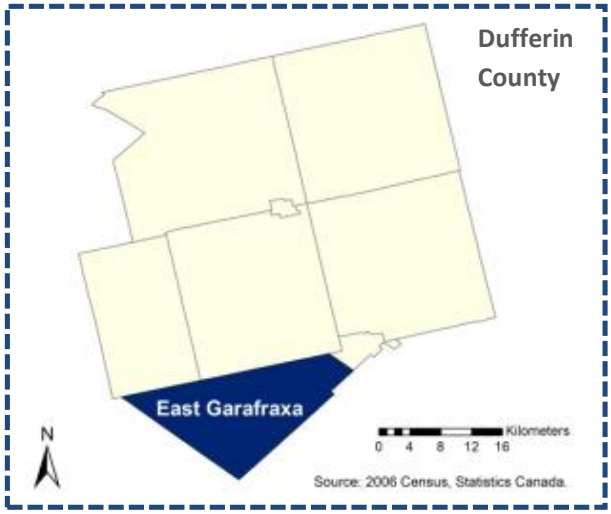
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

East Garafraxa





Quick Facts about East Garafraxa

- Population: 2,390
- Percentage of total population of Wellington-Dufferin-Guelph: 0.9% Lowest
- Area: 167 km^2
- Located: In Dufferin County
- Number of families: 680
- Children aged 14 years and under: 20.4%
- Seniors aged 65 years and over: 10.1%
- Population living at a different address one year ago: 12.4%
- Average household income (after tax): $75,887

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in East Garafraxa

- Compared with other areas in WDG, East Garafraxa has a high percentage of:
  - Population 15 years and over providing more than 60 hours of unpaid childcare a week
  - Tenant- or owner-households spending 30% or more on rent/payments
- Compared with other areas in WDG, East Garafraxa has a low percentage of:
  - Lone parent families
  - Immigrant population
  - Emergency department visits, cardiovascular-, injury-, diabetes-related hospitalizations

Snapshot of Social Determinants of Health in East Garafraxa

Low income families

- Low income households (Low Income Measures before tax) : 12.9%
- Low income households (Low Income Measures after tax): 11.0%
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 6.6% Lowest
- Female-headed lone parent families among lone parent families: 66.7% Lowest
- Low income lone parent households (Low Income Measures before tax): 22.2%
- Low income lone parent households (Low Income Measures after tax): 0.0% Lowest

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): 15.5%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 9.1% Highest

Education

- Adults who did not complete high school education: 10.8%
- Adults who completed high school as the highest education: 30.9%
- Adults who obtained post-secondary education: 39.8%
- Post-secondary education obtained outside of Canada: 9.3%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 2.9%

Immigrant and Visible minority populations

- Immigrant population: 11.7% Lowest
- Recent immigrant population: 0.4% (or 3.6% among immigrant population) Lowest
- Visible minority population: 5.4%

Language

- Population with no knowledge of English or French: 0.8%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 32.4% Highest
- Rental dwellings: 5.2% Lowest

Seniors

- Seniors living alone: 20.4%
- Population 15 years and over providing unpaid care or assistance to seniors: 22.5% Highest

Health outcome indicators*

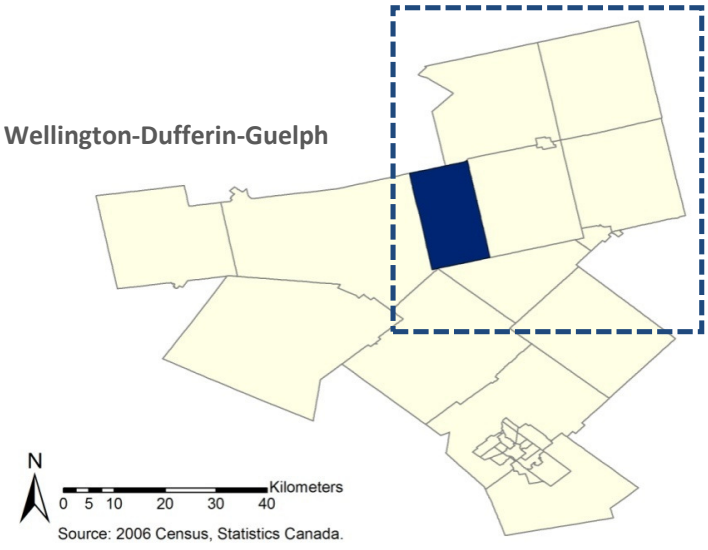
- Emergency department visits (all cause): 23,305 per 100,000 population Lowest
- Cardiovascular-related hospitalizations: 586 per 100,000 population Lowest
- Injury-related hospitalizations: 321 per 100,000 population Lowest
- Diabetes-related hospitalizations: 0 per 100,000 population Lowest
- Lung cancer-related deaths: Not reportable due to small counts

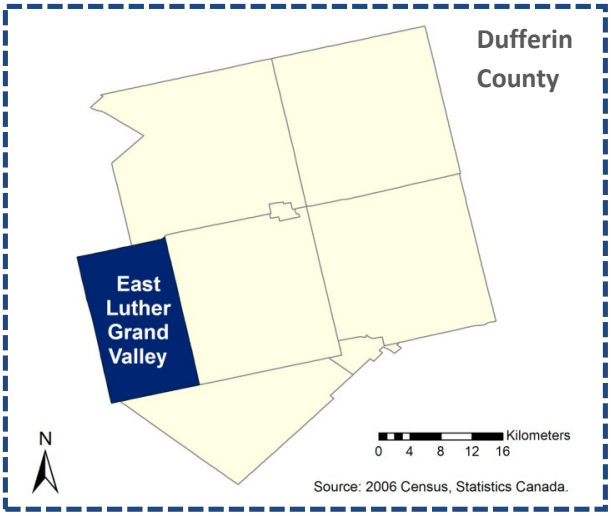
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

East Luther Grand Valley





Quick Facts about East Luther Grand Valley

- Population: 2,840
- Percentage of total population of Wellington-Dufferin-Guelph: 1.1% Lowest
- Area: 163 km^2
- Located: In Dufferin County
- Number of families: 815
- Children aged 14 years and under: 22.4% Highest
- Seniors aged 65 years and over: 8.0% Lowest
- Population living at a different address one year ago: 10.6%
- Average household income (after tax): $56,423

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in East Luther Grand Valley

- Compared with other areas in WDG, East Luther Grand Valley has a high percentage of:
  - Adults who completed high school as the highest education
  - Population 15 years and over providing more than 60 hours of unpaid childcare a week
  - Seniors living alone
  - Population 15 years and over providing unpaid care or assistance to seniors
  - Emergency department visits, cardiovascular-, injury-, diabetes-related hospitalizations

Snapshot of Social Determinants of Health in East Luther Grand Valley

Low income families

- Low income households (Low Income Measures before tax) : 16.9%
- Low income households (Low Income Measures after tax): 13.2%
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 12.3%
- Female-headed lone parent families among lone parent families: 70.0%
- Low income lone parent households (Low Income Measures before tax): 40.0% Highest
- Low income lone parent households (Low Income Measures after tax): 10.0%

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): Not reportable
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 11.5% Highest

Education

- Adults who did not complete high school education: 17.9%
- Adults who completed high school as the highest education: 37.1% Highest
- Adults who obtained post-secondary education: 30.5% Lowest
- Post-secondary education obtained outside of Canada: 8.3%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.8%

Immigrant and Visible minority populations

- Immigrant population: 11.8%
- Recent immigrant population: 2.3% (or 19.4% among immigrant population Highest)
- Visible minority population: 1.1% Lowest

Language

- Population with no knowledge of English or French: 0.4%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 25.0%
- Rental dwellings: 16.4%

Seniors

- Seniors living alone: 29.0% Highest
- Population 15 years and over providing unpaid care or assistance to seniors: 22.7% Highest

Health outcome indicators*

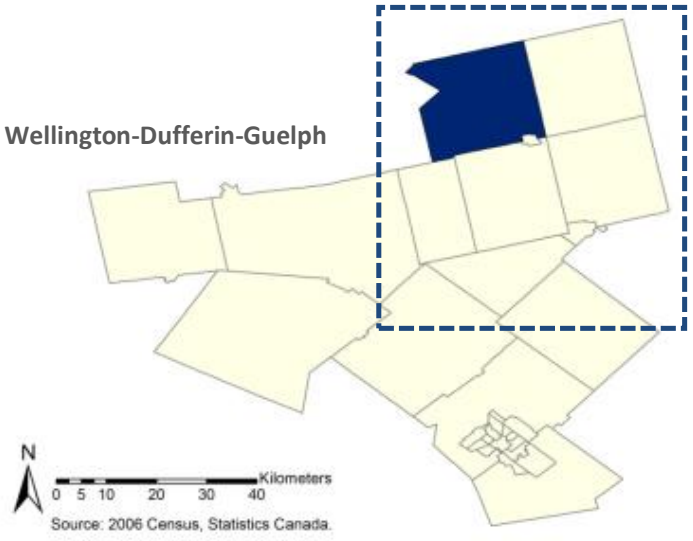
- Emergency department visits (all cause): 66,655 per 100,000 population Highest
- Cardiovascular-related hospitalizations: 1,561 per 100,000 population Highest
- Injury-related hospitalizations: 974 per 100,000 population Highest
- Diabetes-related hospitalizations: 258 per 100,000 population Highest
- Lung cancer-related deaths: Not reportable due to small counts

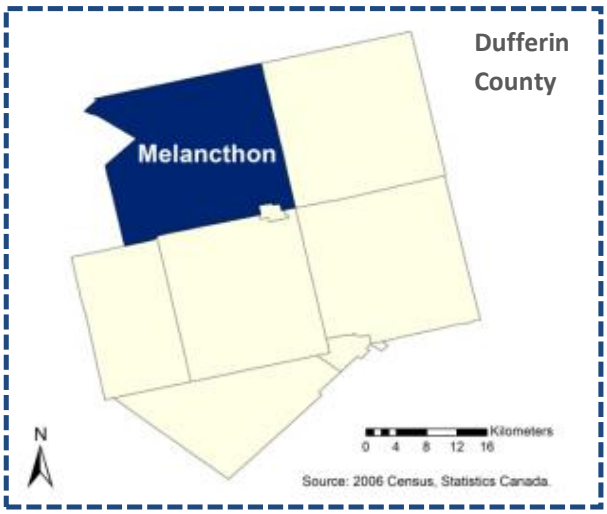
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Melancthon





Quick Facts about Melancthon

- Population: 2,895
- Percentage of total population of Wellington-Dufferin-Guelph: 1.1% Lowest
- Area: 313 km^2
- Located: In Dufferin County
- Number of families: 870
- Children aged 14 years and under: 19.8%
- Seniors aged 65 years and over: 10.2%
- Population living at a different address one year ago: 11.1%
- Average household income (after tax): $64,802

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in Melancthon

- Compared with other areas in WDG, Melancthon has a high percentage of:
  - Low income lone parent households (Low Income Measures before tax)
  - Adults who did not complete high school education
- Compared with other areas in WDG, Melancthon has a low percentage of:
  - Female-headed lone parent families among lone parent families
  - Cardiovascular- and injury-related hospitalizations

Snapshot of Social Determinants of Health in Melancthon

Low income families

- Low income households (Low Income Measures before tax) : 17.0%
- Low income households (Low Income Measures after tax): 12.6%
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 9.8%
- Female-headed lone parent families among lone parent families: 58.8% Lowest
- Low income lone parent households (Low Income Measures before tax): 44.4% Highest
- Low income lone parent households (Low Income Measures after tax): 22.2%

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): Not reportable
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 8.5%

Education

- Adults who did not complete high school education: 23.6% Highest
- Adults who completed high school as the highest education: 29.2
- Adults who obtained post-secondary education: 35.1%
- Post-secondary education obtained outside of Canada: 7.5% Lowest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.4%

Immigrant and Visible minority populations

- Immigrant population: 11.7%
- Recent immigrant population: 0.9% (or 7.4% among immigrant population)
- Visible minority population: 2.2%

Language

- Population with no knowledge of English or French: 0.3%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 27.2%
- Rental dwellings: 9.0%

Seniors

- Seniors living alone: 13.6% Lowest
- Population 15 years and over providing unpaid care or assistance to seniors: 14.6% Lowest

Health outcome indicators*

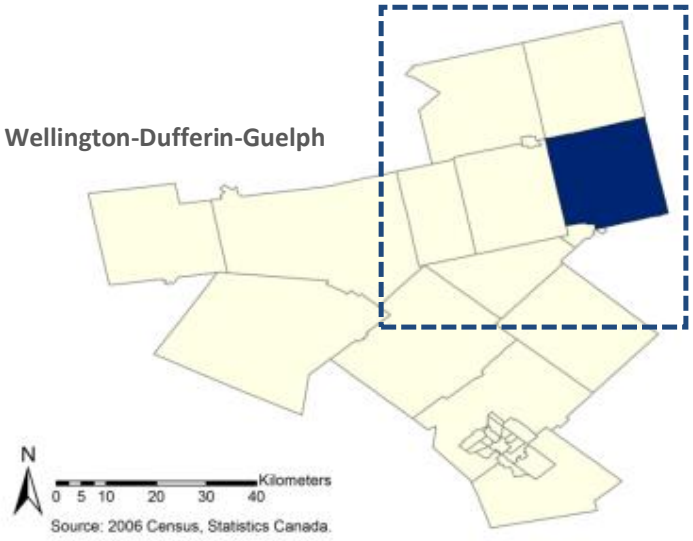
- Emergency department visits (all cause): 34,542 per 100,000 population
- Cardiovascular-related hospitalizations: 495 per 100,000 population Lowest
- Injury-related hospitalizations: 311 per 100,000 population Lowest
- Diabetes-related hospitalizations: Not reportable due to small counts
- Lung cancer-related deaths: Not reportable due to small counts

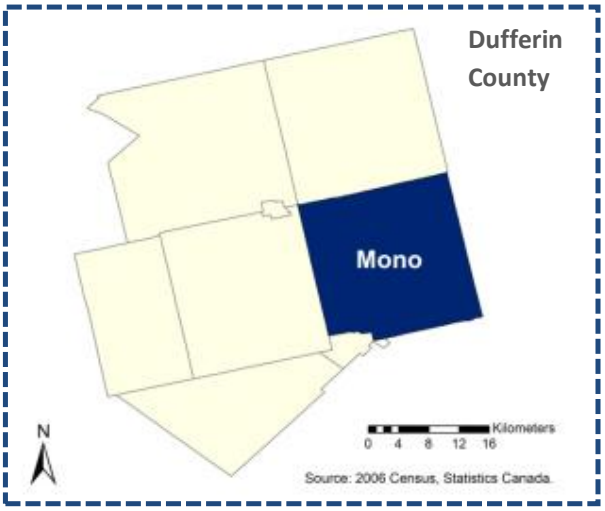
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Mono





Quick Facts about Mono

- Population: 7,070
- Percentage of total population of Wellington-Dufferin-Guelph: 2.8%
- Area: 280 km^2
- Located: In Dufferin County
- Number of families: 2,140
- Children aged 14 years and under: 18.8%
- Seniors aged 65 years and over: 11.8%
- Population living at a different address one year ago: 10.0% Lowest
- Average household income (after tax): $85,346 Highest

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in Mono

- Compared with other areas in WDG, Mono has a high:
  - Average household income
  - Percentage of adults who obtained post-secondary education
- Compared with other areas in WDG, Mono has a low percentage of:
  - Adults who obtained post-secondary education
  - Recent immigrant population and population with no knowledge of English or French
  - Emergency department visits, cardiovascular-, injury-, diabetes-related hospitalizaitons

Snapshot of Social Determinants of Health in Mono

Low income families

- Low income households (Low Income Measures before tax) : 10.0% Lowest
- Low income households (Low Income Measures after tax): 8.3%
- Children aged 6 years and under in private households with low income after tax: 6.1%

Lone parent families

- Lone parent families: 9.6%
- Female-headed lone parent families among lone parent families: 68.3%
- Low income lone parent households (Low Income Measures before tax): 14.7% Lowest
- Low income lone parent households (Low Income Measures after tax): 11.8%

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): 14.3%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 6.9%

Education

- Adults who did not complete high school education: 9.9% Lowest
- Adults who completed high school as the highest education: 27.9%
- Adults who obtained post-secondary education: 53.7% Highest
- Post-secondary education obtained outside of Canada: 10.7%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.0%

Immigrant and Visible minority populations

- Immigrant population: 15.7%
- Recent immigrant population: 0.6% (or 3.6% among immigrant population Lowest)
- Visible minority population: 3.2%

Language

- Population with no knowledge of English or French: 0.0% Lowest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 23.6%
- Rental dwellings: 4.9% Lowest

Seniors

- Seniors living alone: 8.5% Lowest
- Population 15 years and over providing unpaid care or assistance to seniors: 21.6% Highest

Health outcome indicators*

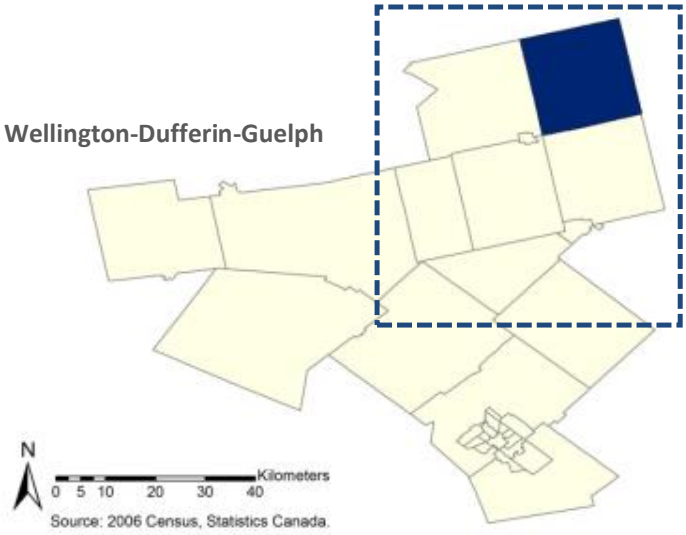
- Emergency department visits (all cause): 3,781 per 100,000 population Lowest
- Cardiovascular-related hospitalizations: 104 per 100,000 population Lowest
- Injury-related hospitalizations: 42 per 100,000 population Lowest
- Diabetes-related hospitalizations: 24 per 100,000 population Lowest
- Lung cancer-related deaths: Not reportable due to small counts

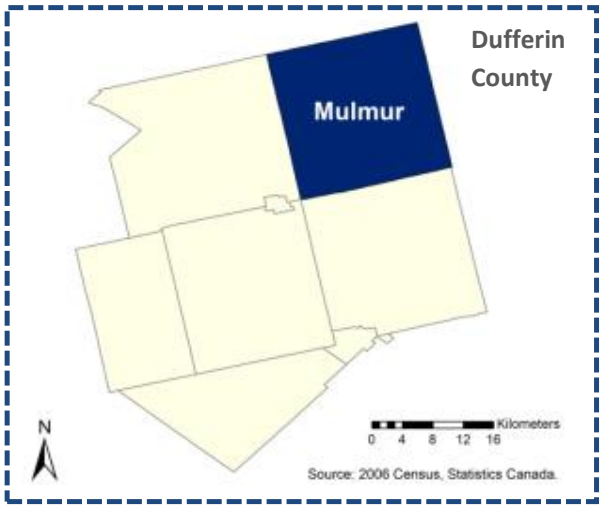
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Mulmur





Quick Facts about Mulmur

- Population: 3,320
- Percentage of total population of Wellington-Dufferin-Guelph: 1.3% Lowest
- Area: 288 km^2
- Located: In Dufferin County
- Number of families: 1,000
- Children aged 14 years and under: 18.5%
- Seniors aged 65 years and over: 12.5%
- Population living at a different address one year ago: 5.4% Lowest
- Average household income (after tax): $70,063

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in Mulmur

- Compared with other areas in WDG, Mulmur has a low percentage of:
  - Lone parent families
  - Low income lone parent households
  - Unemployment rate for individuals aged 25 years and older in the labour force
  - Immigrant and visible minority populations, population with no knowledge of English or French
  - Cardiovascular- and injury-related hospitalizations

Snapshot of Social Determinants of Health in Mulmur

Low income families

- Low income households (Low Income Measures before tax) : 10.5%
- Low income households (Low Income Measures after tax): 7.1% Lowest
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 9.0% Lowest
- Female-headed lone parent families among lone parent families: 72.2%
- Low income lone parent households (Low Income Measures before tax): 0.0% Lowest
- Low income lone parent households (Low Income Measures after tax): 0.0% Lowest

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): 14.3%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 8.1%

Education

- Adults who did not complete high school education: 13.3%
- Adults who completed high school as the highest education: 25.4%
- Adults who obtained post-secondary education: 50.0%
- Post-secondary education obtained outside of Canada: 9.3%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 1.2% Lowest

Immigrant and Visible minority populations

- Immigrant population: 10.9% Lowest
- Recent immigrant population: 1.4% (or 12.5% among immigrant population)
- Visible minority population: 0.5% Lowest

Language

- Population with no knowledge of English or French: 0.0% Lowest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 20.1% Lowest
- Rental dwellings: 5.9% Lowest

Seniors

- Seniors living alone: 13.5% Lowest
- Population 15 years and over providing unpaid care or assistance to seniors: 18.1%

Health outcome indicators*

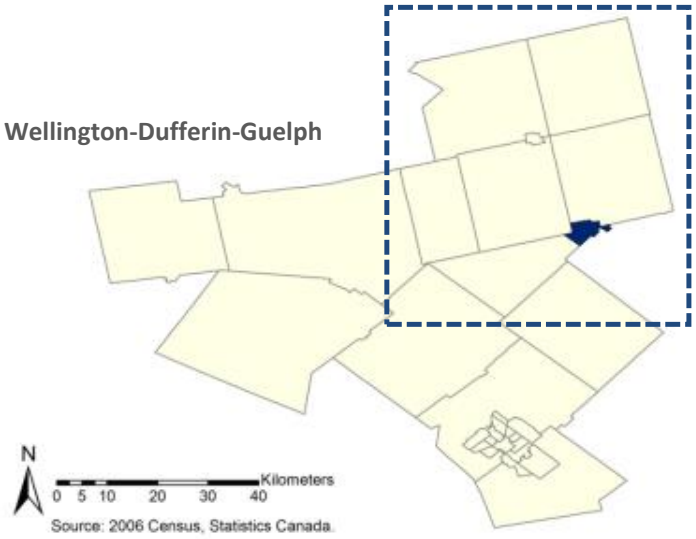
- Emergency department visits (all cause): 29,789 per 100,000 population
- Cardiovascular-related hospitalizations: 452 per 100,000 population Lowest
- Injury-related hospitalizations: 291 per 100,000 population Lowest
- Diabetes-related hospitalizations: Not reportable due to small counts
- Lung cancer-related deaths: Not reportable due to small counts

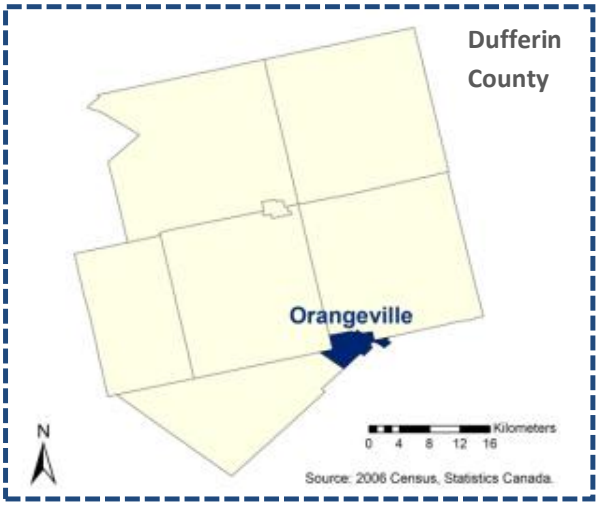
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Orangeville





Quick Facts about Orangeville

- Population: 26,925
- Percentage of total population of Wellington-Dufferin-Guelph: 10.6% Highest
- Area: 16 km^2
- Located: In Dufferin County
- Number of families: 7,635
- Children aged 14 years and under: 22.4% Highest
- Seniors aged 65 years and over: 10.1%
- Population living at a different address one year ago: 11.7%
- Average household income (after tax): $62,168

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in Orangeville

- Compared with other areas in WDG, Orangeville has a high percentage of:
  - Children aged 6 years and under in private households with low income
  - Lone parent families
  - Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs)
  - Adults who completed high school as the highest education
  - Emergency department visits, injury-related hospitalizations, lung cancer-related deaths

Snapshot of Social Determinants of Health in Orangeville

Low income families

- Low income households (Low Income Measures before tax) : 13.7%
- Low income households (Low Income Measures after tax): 11.0%
- Children aged 6 years and under in private households with low income after tax: 9.8% Highest

Lone parent families

- Lone parent families: 17.4% Highest
- Female-headed lone parent families among lone parent families: 75.9%
- Low income lone parent households (Low Income Measures before tax): 28.3%
- Low income lone parent households (Low Income Measures after tax): 24.5%

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): 17.7% Highest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 9.7% Highest

Education

- Adults who did not complete high school education: 14.3%
- Adults who completed high school as the highest education: 34.5% Highest
- Adults who obtained post-secondary education: 43.4%
- Post-secondary education obtained outside of Canada: 8.4%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.1%

Immigrant and Visible minority populations

- Immigrant population: 12.9%
- Recent immigrant population: 1.3% (or 10.5% among immigrant population)
- Visible minority population: 5.2%

Language

- Population with no knowledge of English or French: 0.2% Lowest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 29.4% Highest
- Rental dwellings: 20.0%

Seniors

- Seniors living alone: 29.3% Highest
- Population 15 years and over providing unpaid care or assistance to seniors: 15.5% Lowest

Health outcome indicators*

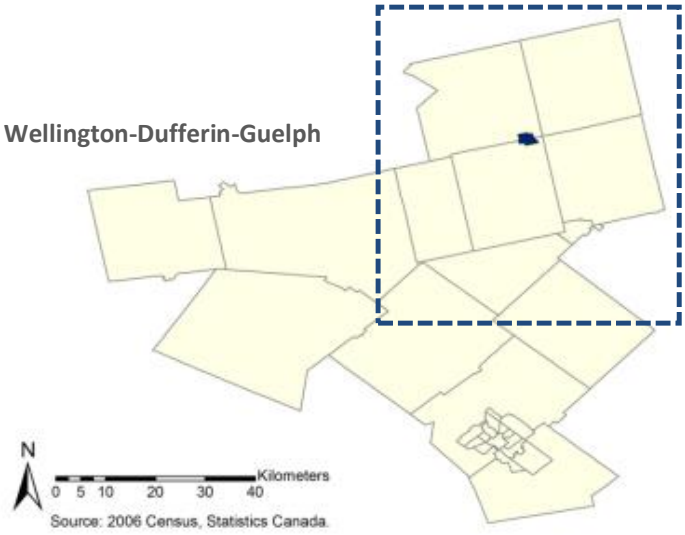
- Emergency department visits (all cause): 66,892 per 100,000 population Highest
- Cardiovascular-related hospitalizations: 1,446 per 100,000 population
- Injury-related hospitalizations: 930 per 100,000 population Highest
- Diabetes-related hospitalizations: 140 per 100,000 population
- Lung cancer-related deaths: 74 per 100,000 population Highest

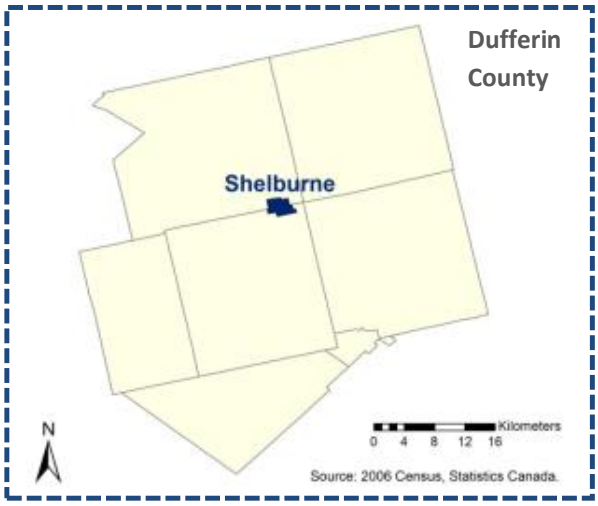
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Shelburne





Quick Facts about Shelburne

- Population: 5,150
- Percentage of total population of Wellington-Dufferin-Guelph: 2.0%
- Area: 5 km^2
- Located: In Dufferin County
- Number of families: 1,390
- Children aged 14 years and under: 22.0%
- Seniors aged 65 years and over: 15.4%
- Population living at a different address one year ago: 18.7% Highest
- Average household income (after tax): $55,331

Legend

Highest = highest quintile

Lowest = lowest quintile

Highest/lowest quintile represents the highest/lowest 20% of all areas in WDG

Key Findings of Social Determinants of Health in Shelburne

- Compared with other areas in WDG, Shelburne has a high percentage of:
  - Children aged 6 years and under in private households with low income
  - Female-headed lone parent families among lone parent families
  - Adults who completed high school as the highest education
  - Unemployment rate for individuals aged 25 years and older in the labour force
  - Emergency department visits, cardiovascular- and injury-related hospitalizations

Snapshot of Social Determinants of Health in Shelburne

Low income families

- Low income households (Low Income Measures before tax) : 15.9%
- Low income households (Low Income Measures after tax): 12.9%
- Children aged 6 years and under in private households with low income after tax: 9.3% Highest

Lone parent families

- Lone parent families: 14.7%
- Female-headed lone parent families among lone parent families: 80.5% Highest
- Low income lone parent households (Low Income Measures before tax): 23.1%
- Low income lone parent households (Low Income Measures after tax): 20.5%

Early child development and child care

- Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs): 14.3%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 12.0% Highest

Education

- Adults who did not complete high school education: 22.9%
- Adults who completed high school as the highest education: 33.5% Highest
- Adults who obtained post-secondary education: 31.6% Lowest
- Post-secondary education obtained outside of Canada: 8.0% Lowest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 4.1% Highest

Immigrant and Visible minority populations

- Immigrant population: 9.8% Lowest
- Recent immigrant population: 1.2% (or 12.5% among immigrant population)
- Visible minority population: 2.8%

Language

- Population with no knowledge of English or French: 0.3%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 26.2%
- Rental dwellings: 21.1%

Seniors

- Seniors living alone: 33.3% Highest
- Population 15 years and over providing unpaid care or assistance to seniors: 17.3%

Health outcome indicators*

- Emergency department visits (all cause): 99,204 per 100,000 population Highest
- Cardiovascular-related hospitalizations: 2,168 per 100,000 population Highest
- Injury-related hospitalizations: 1,650 per 100,000 population Highest
- Diabetes-related hospitalizations: 117 per 100,000 population
- Lung cancer-related deaths: 71 per 100,000 population Highest

**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

Source: 2006 Census, Statistics Canada; Death, Vital Statistics, Mortality Database, Inpatient Discharges Main Table, Discharge Abstract Database, Ambulatory Visits Main Table, National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Appendix B: Social Determinants of Health Fact Sheets

The fact sheets provide background, some local highlights, recommendations for action, and statistics for municipalities and neighbourhoods in Wellington-Dufferin-Guelph for select determinants of health:

- Income
- Employment
- Education
- Immigrants
- Lone parent
- Early Child Development

The fact sheets can be used to better understand the interplay of each social determinant of health in Wellington-Dufferin-Guelph communities.

Income Level in Wellington-Dufferin-Guelph

Income Level and Health

- Income is one of the most important social determinants of health that affects your health.
- Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis, and heart disease, and to live with a disability (Health Council of Canada, 2010).
- People in the lowest quintile (lowest 20%) of income groups use health care services approximately twice as much as those in the highest quintile (Public Health Agency of Canada, 2004).
- Children who live in low income households are more likely to have a range of health problems throughout their life, even if their socioeconomic status changes later in life (Ontario Physicians Poverty Work Group, 2008).

Local Picture in Wellington-Dufferin-Guelph

- Low income families accounted for 11.4% of families in Wellington-Dufferin-Guelph (WDG) in 2006.
- 6.8% of children aged 6 years and under lived in households with low income in 2006; this translates to over 1,500 children. This figure is much lower than the provincial rate at 14.8%.
- There were more children living in households with low income in the City of Guelph (9.7%), compared to Dufferin County (7.1%) and Wellington County not including Guelph (3.2%).
- The average household income in 2005 was lower in the City of Guelph ($62,269), compared to Dufferin County ($65,756) and Wellington County not including Guelph ($69,427), and also to Ontario ($63,441).

Closer Look at the Neighbourhoods

- The highest percentages of low income families were found in Two Rivers, Onward Willow, and Downtown Sunny Acres Old University at 19.8%, 19.1% and 18.3%, respectively.
- 30.3% of children aged 6 years and under were living in households with low income in Brant, which is close to ten times higher than the WDG average (3.2%).
- The lowest average after tax household income was found in Two Rivers ($43,984).

What can be done?

- It is important to remember that low income also intersects with a number of other socio-demographic disadvantages, which creates even greater health vulnerability and additional disadvantages for individuals with low income or living in households with low income.
- To address low income, it is important to invest in peer-based programs such as the Community Development Neighbourhood programs in Guelph that have proven to assist people in gaining access to information, and build skills in a non-threatening way while keeping their unique needs in mind.
- These interventions reduce social isolation in at risk populations including new immigrant families; improve adoption of healthy living practices; and improve parenting skills (including reducing the need for intervention related to child protection), nutrition, and physical activity.
- Despite the proven benefits and being very cost effective, some of these programs operate on limited, very modest funds or inconsistent, pilot funds.
- In the case of the neighbourhood programs supported by community development workers in Guelph, the program has recently been discontinued due to funding despite wide based support of health and social service partners.

Table 1 – Income level in Wellington-Dufferin-Guelph by neighbourhood

	Low income households (Low Income Measures after tax)	Children aged 6 years and under in private households with low income (after tax)	Average household income (after tax)
Ontario	**N/A**	**14.8%**	**$63,441**
WDG Health Region	**11.4%**	**6.8%**	**$65,284**
Wellington County (excluding Guelph)	**10.0%**	**3.2%**	**$69,427**
Centre Wellington	8.7%	4.8%	$67,435
Erin	8.1%	0.0%	$79,759
Guelph/Eramosa	7.5%	0.0%	$79,384
Mapleton	12.6%	3.3%	$64,351
Minto	12.8%	6.4%	$53,194
Puslinch	6.9%	0.0%	$99,622
Wellington North	14.9%	3.9%	$53,813
Dufferin County	**11.0%**	**7.1%**	**$65,756**
Amaranth	13.7%	0.0%	$69,016
East Garafraxa	11.0%	0.0%	$75,887
East Luther Grand Valley	13.2%	0.0%	$56,423
Melancthon	12.6%	0.0%	$64,802
Mono	8.3%	6.1%	$85,346
Mulmur	7.1%	0.0%	$70,063
Orangeville	11.0%	9.8%	$62,168
Shelburne	12.9%	9.3%	$55,331
City of Guelph	**12.4%**	**9.7%**	**$62,269**
Brant	17.0%	30.3%	$54,753
Downtown Sunny Acres Old University	18.3%	0.0%	$52,838
Exhibition Park	12.4%	0.0%	$52,633
Grange Hill East	9.7%	6.1%	$62,697
Hanlon Creek Hales Barton	12.1%	8.9%	$66,591
Kortright Hills	6.9%	0.0%	$82,928
Onward Willow	19.1%	7.0%	$44,846
Parkwood Gardens	8.7%	3.4%	$72,910
Pine Ridge Clairfields Westminster Woods	4.6%	1.8%	$87,341
St George's Park	11.8%	0.0%	$56,222
Two Rivers	19.8%	11.6%	$43,984
Waverley	13.3	0.0%	$59,752
West Willow Woods	10.5%	13.6%	$67,009

(Source: 2006 Census, Statistics Canada)

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Employment inWellington-Dufferin-Guelph

Employment and Health

- Employment and job security has a great impact on one's physical and mental health. Not only does paid work provide money, it also provides a sense of identity and purpose and social contacts.
- People who are unemployed or not seeking jobs have the highest mortality ratesand suffer more health problems than people who have a job (Public Health Agency of Canada, 2008).
- On average, people who immigrate to Canada have more formal education compared those who were born in Canada, but the unemployment rate for the immigrant population is twice as high (Population Health Promotion Expert Group: Working Group on Population Health, 2009).

Local Picture inWellington-Dufferin-Guelph

- The unemployment rate for individuals aged 25 years and older was 3.2% in Wellington-Dufferin-Guelph (WDG) in 2006, which was lower than the provincial rate at 4.9%.
- 55.7% of individuals aged 15 years and over in WDG worked full year, full time, in 2006. This rate was higher than the provincial rate at 52.8%.
- 39% of individuals aged 15 years and over in WDG only worked part of the year or part time in 2006, which is slightly lower than the provincial rate at 40.6%.

Closer Look at the Neighbourhoods

- The highest percentages of unemployment were found in Onward Willow, Two Rivers, Kortright Hills, and Exhibition Park at 6.5%, 5.8%, 4.5%, and 4.4%, respectively.
- The lowest percentages of individuals who worked full year, full time were found in Downtown SunnyAcres Old University, East Garafraxa, and Hanlon Creek Hales Barton at 47.5%, 50.9%, and 51.0% respectively.
- Downtown SunnyAcres Old University had both the lowest percentage of individualswho worked full timefor the full year (47.5%) and the highest percentage of individuals who only worked part of the year or part time (47.7%).

What can be done?

- **"Closing the Gap in a Generation"**– a report issued by the World Health Organization's Commission on Social Determinants of Health, calls for "urgent and sustained action, globally, nationally and locally" to deal with health inequities.
- The Commission acknowledges the critical role of the civil society and local movements that "both provide immediate help and push governments to change".
- The report provides three key recommendations to deal with health inequities. Supporting fair employment and working conditions is one of the key recommendations, along with improving daily living conditions of people who are impacted and placing health in the center of governance and planning.
- **Development of policies to support sustainable employment and living wage** –interest in policy advocacy exists in WDG and could be further expanded by improving the connections with, and supporting local coalitions and groups that are spearheading poverty reduction strategies, new immigrants, and other policy initiatives that are unique to addressing the social determinants of health.

Table 1 – Employment-related statistics in WDG

	Unemployment rate (aged 25 years and older)	Population 15 years and over worked full year, fulltime	Population 15 years and over worked part year or part time
Ontario	**4.9%**	**52.8%**	**40.6%**
WDG Health Region	**3.2%**	**55.7%**	**39.0%**
Wellington County (excluding Guelph)	**2.5%**	**57.0%**	**37.4%**
Centre Wellington	2.5%	56.0%	38.6%
Erin	1.5%	57.5%	36.8%
Guelph/Eramosa	3.0%	58.9%	36.3%
Mapleton	1.7%	56.9%	37.3%
Minto	2.6%	59.7%	34.4%
Puslinch	3.0%	53.1%	40.8%
Wellington North	3.1%	57.1%	36.2%
Dufferin County	**2.9%**	**56.7%**	**38.1%**
Amaranth	0.5%	53.6%	39.5%
East Garafraxa	2.9%	50.9%	44.3%
East Luther Grand Valley	3.8%	61.0%	34.8%
Melancthon	3.4%	57.5%	39.2%
Mono	3.0%	51.2%	42.4%
Mulmur	1.2%	53.6%	40.3%
Orangeville	3.1%	59.4%	35.6%
Shelburne	4.1%	55.2%	40.7%
City of Guelph	**3.8%**	**54.3%**	**40.5%**
Brant	3.2%	52.3%	43.4%
Downtown SunnyAcres Old University	4.0%	47.5%	47.7%
Exhibition Park	4.4%	54.2%	39.8%
Grange Hill East	2.9%	61.1%	35.5%
Hanlon Creek Hales Barton	3.1%	51.0%	42.9%
Kortright Hills	4.5%	51.2%	45.1%
Onward Willow	6.5%	53.0%	41.7%
Parkwood Gardens	3.6%	56.1%	39.1%
Pine Ridge Clairfields Westminster Woods	2.6%	59.0%	35.2%
St. George's Park	3.7%	56.6%	37.0%
Two Rivers	5.8%	53.2%	43.1%
Waverley	2.0%	54.1%	39.6%
West Willow Woods	5.1%	56.1%	38.2%

(Source: 2006 Census, Statistics Canada)

Public Health Agency of Canada. (2008). *What makes Canadians healthy or unhealthy.* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php.

Population Health Promotion Expert Group: Working Group on Population Health. (2009). *Closing the gap: Synthesis of the significant population health reports of 2008.* Pan-Canadian Public Health Network.Retrieved from http://www.phn-rsp.ca/pubs/chg-ceps/pdf/chg-ceps-eng.pdf.

Education Level inWellington-Dufferin-Guelph

Education and Health

- Education is an important social determinant of health. Higher and more successful educational experience for children and adults is related to better health (Public Health Agency of Canada, 2008).
- People who did not complete high school are identified amongst the groups with the highest mortality rates in Canada. These people are also at higher risk of having chronic diseases such as heart disease and lung cancer (Population Health Promotion Expert Group:Working Group on Population Health, 2009).
- To improve outcomes and opportunities for children and youth, one of the five goals of the Ontario Ministry of Children and Youth Services Strategic Framework is that every young person should graduate from high school (Ontario Ministry of Children and Youth Services, 2008).

Local Picture inWellington-Dufferin-Guelph

- 14.8% of adults between 25 and 64 years of age did not complete high school in Wellington-Dufferin-Guelph (WDG) health region in 2006.
- While this percentage is similar in Dufferin County at 14.7%, the rate is much higher in Wellington County (excluding the City of Guelph) at 18.8%, and quite a bit lower in the City of Guelph at 12.0%.
- It is not surprising that the rate is lower in the City of Guelph since there is a university within the city and residents may be university students and staff.
- Overall, the percentage of adults who did not complete high school in WDG health region is higher compared to the Ontario average of 13.6%.

Closer Look at the Neighbourhoods

- High percentages of adults who did not complete their high school education were found inMapleton, Wellington North, and Mintoat38.1%, 26.1%, and 24.3%, respectively.
    - These same neighbourhoods also had low percentages of adults who completed post-secondary education, at 28.4%, 27.8%, and 31.1%, respectively.
- This pattern may be related to the Low German speaking Mennonites that reside in Wellington County.
    - Low German speaking Mennonites tend to have low levels of education, because most children leave school by their fourteenth birthday (WDG Public Health, 2009).

What can be done?

- Invest in a community-based program, such as*Pathways to Education program* (Pathways) in the priority neighbourhoods, to improve high school graduation rates.
- Pathways aims to address the issues of youth school attendance, academic achievement and credit accumulation, by partnering with parents, community agencies, volunteers, local school boards, and secondary schools to develop intense, multi-faceted, and long-term support for high-school students.
- This program is a proven social and health investment that has reduced high school drop-out rates by 70 percent. Pathways delivers a $24 return for every $1 invested (The Boston Consulting Group, 2011).
- Pathways demonstrates that youth from low income communities can achieve as well, or better than, their wealthier peers (Boston Consulting Group, 2011; Pathways to Education, 2011).
- Staying in school and educational achievement lead to improvement in socioeconomic conditions and therefore minimizes or removes barriers to health. Learn more about Pathways to Education at http://www.pathwaystoeducation.ca/

Table 1 – Percentage of the population aged 25 to 64 years by highest education and neighbourhood

	Did not completehigh school	Completed high school as the highest education	Obtained college or university certificate, diploma or degree
Ontario	**13.6%**	**25.0%**	**52.7%**
WDG Health Region	**14.8%**	**27.9%**	**47.8%**
Wellington County (excluding Guelph)	**18.8%**	**28.0%**	**42.1%**
Centre Wellington	15.5%	27.9%	46.0%
Erin	12.7%	29.8%	48.6%
Guelph/Eramosa	10.9%	27.6%	51.6%
Mapleton	38.1%	22.1%	28.4%
Minto	24.3%	31.3%	31.1%
Puslinch	14.5%	24.9%	50.5%
Wellington North	26.1%	30.9%	27.8%
Dufferin County	**14.7%**	**32.8%**	**42.4%**
Amaranth	10.4%	35.8%	38.7%
East Garafraxa	10.8%	30.9%	39.8%
East Luther Grand Valley	17.9%	37.1%	30.5%
Melancthon	23.6%	29.2%	35.1%
Mono	9.9%	27.9%	53.7%
Mulmur	13.3%	25.4%	50.0%
Orangeville	14.3%	34.5%	43.4%
Shelburne	22.9%	33.5%	31.6%
City of Guelph	**12.0%**	**25.5%**	**54.5%**
Brant	25.9%	29.7%	32.6%
Downtown SunnyAcres Old University	10.7%	20.1%	62.8%
Exhibition Park	10.4%	25.8%	56.8%
Grange Hill East	12.3%	29.4%	48.1%
Hanlon Creek Hales Barton	7.0%	21.8%	64.1%
Kortright Hills	6.3%	18.7%	68.6%
Onward Willow	23.1%	33.7%	35.1%
Parkwood Gardens	14.4%	31.3%	47.5%
Pine Ridge Clairfields Westminster Woods	5.6%	19.0%	69.6%
St. George's Park	16.0%	27.2%	48.9%
Two Rivers	19.4%	22.3%	47.3%
Waverley	14.2%	29.7%	45.8%
West Willow Woods	11.0%	28.8%	50.2%

(Source: 2006 Census, Statistics Canada)

Boston Consulting Group.(2011). *BCG assessment of pathways to education, Executive summary* (presentation).Pathways to Education. Retrieved from http://www.pathwaystoeducation.ca/PDF/BCG.pdf

Ontario Ministry of Children and Youth Services. (2008). *Realizing potential: Our children, our youth, our future - strategic framework.* Ministry of Children and Youth Services.Retrieved fromhttp://www.children.gov.on.ca/htdocs/English/documents/about/StrategicFramework.pdf.

Public Health Agency of Canada. (2008). *What makes Canadians healthy or unhealthy.* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php.

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Immigrant and Visible Minority Populations inWellington-Dufferin-Guelph

Health of Immigrant and Visible Minority Populations

- New immigrant families and their children have been identified in many studies as a priority population.
- Almost half (47%) of children in new immigrant families are poor.
- One-third of children in visible minority families in Ontario are poor (Ontario Ministry of Health and Long-Term Care, 2009).
- The unemployment rate of new immigrants is twice as high compared to Canadian-born individuals and established immigrants. This finding is particularly troubling given that 70% of recent immigrants had a bachelor's degree or higher (Workforce Planning Board of Waterloo, Wellington and Dufferin, 2009).
- Even though poverty that many immigrants experience is transitional in nature, it lasts long enough to potentially have a serious impact on their growing children.
- Visible minority immigrants are twice as likely as Canadian-born individuals to report deterioration in health over an eight-year period, even though they arrived in Canada with a health advantage over the Canadian-born population (Canadian Institute for Health Information, 2004).

Local Picture inWellington-Dufferin-Guelph

- 16.1% of the population in Wellington-Dufferin-Guelph were immigrants in 2006, which is quite a bit lower than the Ontario average at 28.3%.
- There were more immigrants who resided in the City of Guelph (21.2%), compared to Dufferin County (12.8%) and Wellington County (excluding the City of Guelph) (11.4%).
- A similar trend was seen for the recent immigrant and visible minority populations, where more recent immigrants and visible minorities resided in the City of Guelph (3.3%, 13.8%), compared to Dufferin County at (1.2%, 3.8%) and Wellington County (excluding the City of Guelph) (1.0%, 1.7%).

Closer Look at the Neighbourhoods

- The highest percentages of immigrant population were found inParkwood Gardens, West Willow Woods, and Onward Willow, at 29.2%, 28.5%, and 27.5%, respectively.
- These threeneighbourhoods also had:
    - The highest percentages of recent immigrant population, at 4.6%, 5.5%, and 10.3%, respectively.
    - The highest percentages of visible minority population, at 26.9%, 26.1%, and 23.5%
        - May imply that many of the immigrants in these neighbourhoods are also visible minorities

What can be done?

- To address low income, accessibility, and cultural barriers, invest in peer-based programs such as the *Community Development Neighbourhood*programs in Guelph that have proven to assist people in gaining access to information, and build skills in a non-threatening way while keeping their unique needs in mind.
- These interventions reduce social isolation in priority populations including new immigrant families, improve adoption of healthy living practices, and improve parenting skills (including reducing the need for intervention related to child protection), nutrition, and physical activity.
- Guelph is also engaged in the *Guelph Wellington Local Immigration Partnership*, a planning process with the goal of developing a comprehensive and well integrated system of immigrant settlement support. This system includes improved access to, and benefits from, the health care system. In addition to this process, Guelph Wellington Local Immigration Partnershipalso offers direct services and supports through Immigrant Services Guelph-Wellington.

Table 1 – Percentage of immigrant, recent immigrant, and visible minority population by neighbourhood

	Immigrant Population	Recent Immigrant Population*	Visible Minority Population
Ontario	**28.3%**	**4.8%**	**22.8%**
WDG Health Region	**16.1%**	**2.1%**	**7.6%**
Wellington County (excluding Guelph)	**11.4%**	**1.0%**	**1.7%**
Centre Wellington	10.3%	0.5%	1.0%
Erin	12.3%	0.5%	1.8%
Guelph/Eramosa	13.8%	0.7%	1.8%
Mapleton	12.5%	3.5%	1.6%
Minto	7.5%	0.5%	0.7%
Puslinch	16.0%	1.1%	3.5%
Wellington North	9.4%	1.3%	2.7%
Dufferin County	**12.8%**	**1.2%**	**3.8%**
Amaranth	15.2%	1.6%	2.0%
East Garafraxa	11.7%	0.4%	5.4%
East Luther Grand Valley	11.8%	2.3%	1.1%
Melancthon	11.7%	0.9%	2.2%
Mono	15.7%	0.6%	3.2%
Mulmur	10.9%	1.4%	0.5%
Orangeville	12.9%	1.3%	5.2%
Shelburne	9.8%	1.2%	2.8%
City of Guelph	**21.1%**	**3.3%**	**13.8%**
Brant	18.7%	2.2%	10.6%
Downtown SunnyAcres Old University	16.9%	2.6%	9.1%
Exhibition Park	17.2%	2.2%	5.6%
Grange Hill East	18.5%	2.3%	9.9%
Hanlon Creek Hales Barton	21.5%	3.2%	14.9%
Kortright Hills	24.1%	2.1%	14.2%
Onward Willow	27.5%	10.3%	23.5%
Parkwood Gardens	29.2%	4.6%	26.9%
Pine Ridge Clairfields Westminster Woods	23.1%	3.7%	17.3%
St. George's Park	14.7%	1.1%	3.0%
Two Rivers	12.3%	0.5%	4.9%
Waverley	15.0%	0.3%	3.3%
West Willow Woods	28.5%	5.5%	26.1%

(Source: 2006 Census, Statistics Canada)

**Recent immigrant population – those who have been in Canada for five years or less in 2006 (i.e. arrived to the area between 2001 and 2006)*

Canadian Institute for Health Information.(2004). *Canadian Population Health Initiative, improving the health of Canadians.*Retrieved from http://dsp-psd.pwgsc.gc.ca/Collection/H118-14-2004-1E.pdf.

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Lone Parent Families in Wellington-Dufferin-Guelph

Lone Parent Families and Health

- Lone parent families are families with one parent responsible for taking care of their child(ren).
- The poverty rate among lone parent families is 26%, the highest among other priority populations, and much higher than the overall poverty rate of 11% in the general population (Butler-Jones, 2008).
- The Chief Public Health Officer of Canada states that children who live in lone parent families are one of the priority populations and need to be the focus of poverty reduction policies and other interventions (Butler-Jones, 2008).
- Lone parent families may require more social and community support compared to two parent families.
- People supported by their family, friends, and communities experience better health (Public Health Agency of Canada, 2008).

Local Picture in Wellington-Dufferin-Guelph

- 12.9% of families were lone parent families in Wellington-Dufferin-Guelph in 2006, where 76.3% of them were female-headed lone parent families.
- While the percentage of lone parent families is higher in the City of Guelph at 15.6%; the rate is lower in Dufferin County at 13.9% and much lower in Wellington County (excluding the City of Guelph) at 8.8%.
- These percentages of lone parent families in Wellington-Dufferin-Guelph are lower compared to the Ontario average of 15.8% of lone parent families (among these lone parent families 81.6% are female-headed).

Closer Look at the Neighbourhoods

- The highest percentages of lone parent families in Wellington-Dufferin-Guelph were found in Onward Willow, Brant, and Two Rivers, at 23.9%, 23.5%, and 22.9%, respectively.
- The highest percentages of female-headed lone parent families were found in Hanlon Creek Hales Barton, Grange Hill East, and Pine Ridge Clairfields Westminster Woods, at 88.1%, 86.7%, and 84.2%, respectively.
- The highest percentages of low income lone parent households (Low Income Measures after tax) were found in Amaranth, Hanlon Creek Hales Barton, Brant, Onward Willow, and Two River, at 40.0%, 34.9%, 34.2%, 33.7%, and 33.3%, respectively.

What can be done?

- In order for lone parents to receive the parenting support they need, it is essential to reinforce the existing work of community agencies by investing in an evidence-based parenting support program such as the *Triple P initiative (Positive Parenting Program)* that has proven to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of their parents.
- Triple P is based on a flexible system of increasing intervention intensity: the Triple P model assumes that parents have different needs and require various levels of support.
- The goal of Triple P is to help parents create a positive and caring relationship with their children.
- Improvements in children's behavior via the Triple P program are sustained over time. The universal nature of the program also decreases the risk of stigma associated with some organization-specific parent education programs.
- Learn more about Triple P at http://www.triple-p.ca/

Table 1 – Lone parent families in Wellington-Dufferin-Guelph by neighbourhood

	Lone parent families	Female-headed lone parent families	Low income lone parent households (Low Income Measures after tax)
Ontario	**15.8%**	**81.6%**	**N/A**
WDG Health Region	**12.9%**	**76.3%**	**22.6%**
Wellington County (excluding Guelph)	**8.8%**	**72.1%**	**18.9%**
Centre Wellington	10.1%	82.5%	20.8%
Erin	9.3%	53.2%	10.5%
Guelph/Eramosa	9.4%	67.2%	17.5%
Mapleton	4.0%	70.0%	0.0%
Minto	8.6%	80.0%	19.5%
Puslinch	5.8%	60.9%	25.0%
Wellington North	10.3%	70.3%	26.7%
Dufferin County	**13.9%**	**73.3%**	**21.1%**
Amaranth	10.1%	56.5%	40.0%
East Garafraxa	6.6%	66.7%	0.0%
East Luther Grand Valley	12.3%	70.0%	10.0%
Melancthon	9.8%	58.8%	22.2%
Mono	9.6%	68.3%	11.8%
Mulmur	9.0%	72.2%	0.0%
Orangeville	17.4%	75.9%	24.5%
Shelburne	14.7%	80.5%	20.5%
City of Guelph	**15.6%**	**79.3%**	**24.9%**
Brant	23.5%	76.2%	34.2%
Downtown Sunny Acres Old University	15.7%	67.0%	24.7%
Exhibition Park	15.3%	76.4%	21.3%
Grange Hill East	16.5%	86.7%	22.8%
Hanlon Creek Hales Barton	15.1%	88.1%	34.9%
Kortright Hills	9.9%	77.5%	5.6%
Onward Willow	23.9%	81.4%	33.7%
Parkwood Gardens	13.1%	78.6%	19.0%
Pine Ridge Clairfields Westminster Woods	8.3%	84.2%	8.3%
St George's Park	18.1%	77.4%	4.0%
Two Rivers	22.9%	76.1%	33.3%
Waverley	14.4%	74.0%	27.0%
West Willow Woods	19.4%	79.8%	30.6%

(Source: 2006 Census, Statistics Canada)

Butler-Jones, D. (2008). *The Chief Public Health Officer's report on the state of public health in Canada.* Retrieved from http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/fr-rc/cphorsphc-respcacsp07d-eng.php.

Public Health Agency of Canada. (2008). *What makes Canadians healthy or unhealthy.* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php.

Early Child Development inWellington-Dufferin-Guelph

Early Child Development and Health

- Children need a safe, supportive environment, as well as a warm, nurturing relationship with their primary caregivers, to be able to meet their full potential.
- Growing up in a unsupportive, neglectful, unsafe, or abusive environment can negatively affect brain development, which creates problems in social adaptation, school success, and numerous health problems in later life, including various chronic diseases, heart disease, substance abuse, and mental health difficulties (Heisz, 2007).

What is Early Development Instrument (EDI)?

- The EDI measures how "ready" children are to learn at school using five domains of development, including (1) physical health and well-being, (2) social competence, (3) emotional maturity, (4) language and cognitive skills, and (5) communication and general knowledge (Wellington-Dufferin-Guelph Coalition for a Report Card on the Well-Being of Children, 2009).
- Children who score below the 10th percentile (i.e. bottom 10%) on one or more of the five EDI domains are at a *higher risk* of negative developmental outcomes in that domain.
- Children scoring below the 10th percentile on two or more domains are considered *vulnerable*.

Local Picture inWellington-Dufferin-Guelph

- 29.8% of Senior Kindergarten (SK) children in Wellington-Dufferin-Guelph (WDG) were at a higher risk of negative developmental outcomes in one or moreEDI domains, and 15.6% were vulnerable.
- On average, more SK children in WDG were at a higher risk for and vulnerable tonegative developmental outcomes in EDI domains when compared to the Ontario averages of 28.3% and 13.8%, respectively.

Closer Look at the Neighbourhoods

- The highest percentages of SK children in WDG who were at a higher risk of negative developmental outcomes in one or moreEDI domains were found in Onward Willow, Two Rivers and St. George's Park, and Minto, at 41.4%, 38.9%, 37.1%, respectively.
- Theseneighbourhoods also had the highest percentages of SK children who were vulnerable tonegative developmental outcomes in two or moreEDI domains, at 20.0%, 22.2%, and 25.8%, respectively.

What can be done?

- The *Growing Great Kids* System of Care builds a coordinated full spectrum of community-based services and supports that are integrated to meet the needs of children prenatal to age six.
- This partnership among different services allows a seamless, integrated, and effective service system for children with a single point of access to all services and supports for children and their families in these communities.
- Through Growing Great Kids, children receive a coordinated assessment and a coordinated service plan that meets the family's and child's needs.
- Families receive accurate information about their child's development and what services are available so that they can make informed choices.Families can get the right service at the right time from the right provider.
- Learn more about Growing Great Kids at http://www.growinggreatkidsguelph-wellington.com/

Table 1 – Early Child Development in Wellington-Dufferin-Guelph by neighbourhood*

	Senior kindergarten children (excluding those with special needs) who were vulnerable in:	
	One or more Early Development Instrument (EDI) domains	**Two or more Early Development Instrument (EDI) domains**
Ontario	**28.3%**	**13.8%**
WDG Health Region	**29.8%**	**15.6%**
Wellington County (excluding Guelph)	**31.0%**	**16.0%**
Centre Wellington	36.1%	16.7%
Erin	26.8%	12.2%
Guelph/Eramosa*	22.6%	14.4%
Mapleton	28.7%	13.1%
Minto	37.1%	25.8%
Puslinch*	22.6%	14.4%
Wellington North	32.7%	16.3%
Dufferin County	**31.4%**	**16.8%**
Amaranth	N/A	N/A
East Garafraxa	N/A	15.5%
East Luther Grand Valley	N/A	N/A
Melancthon	N/A	N/A
Mono*	23.8%	14.3%
Mulmur*	23.8%	14.3%
Orangeville	N/A	17.7%
Shelburne	24.5%	14.3%
City of Guelph	**28.3%**	**14.7%**
Brant*	35.8%	19.8%
Downtown SunnyAcres Old University	23.9%	14.9%
Exhibition Park	29.3%	17.3%
Grange Hill East	26.8%	14.8%
Hanlon Creek Hales Barton	23.0%	10.0%
Kortright Hills	28.8%	15.4%
Onward Willow	41.4%	20.0%
Parkwood Gardens	20.2%	8.8%
Pine Ridge Clairfields Westminster Woods	16.1%	6.5%
St. George's Park*	38.9%	22.2%
Two Rivers*	38.9%	22.2%
Waverley*	35.8%	19.8%
West Willow Woods	32.3%	12.8%

(Source: Wellington-Dufferin-Guelph Coalition for a Report Card on the Well-Being of Children, 2009)

**Note:the percentages presented for Guelph/Eramosa and Puslinch are for both areas combined due to low counts.This also applies to Mono and Mulmur, Brant and Waverley, and St. George's Park and Two Rivers.*

Heisz, A. (2007). Income inequality and redistribution in Canada: 1976-2004. *Catalogue no. 11F0019MIE-no.298.*

Wellington-Dufferin-Guelph Coalition for a Report Card on the Well-Being of Children. (2009). *The well-being of children ages birth to six: A report card for Wellington-Dufferin-Guelph.*