Addressing Social Determinants of Health in the City of Guelph

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

Wellington-Dufferin-Guelph
Public Health

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For more information, please contact:

Health Promotion and Health Analytics
Wellington-Dufferin-Guelph Public Health
503 Imperial Rd N
Guelph, ON N1H 6T9

T: 519-846-2715 or 1-800-265-7293

info@wdgpublichealth.ca
www.wdgpublichealth.ca

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Acknowledgements

Authors

Daniela Seskar-Hencic
Laura Campbell, Health Promotion Specialist, Wellington-Dufferin-Guelph Public Health
Keira Rainville, Masters of Public Health student, University of Guelph
Louise Brooks, Health Promotion Specialist, Wellington-Dufferin-Guelph Public Health

Primary Contributors

Jennifer MacLeod, Program Manager, Health Analytics, Wellington-Dufferin-Guelph Public Health
Wing Chan, Health Data Analyst, Wellington-Dufferin-Guelph Public Health
Andrea Roberts, Director, Child & Family Health, Wellington-Dufferin-Guelph Public Health
Sharlene Sedgwick Walsh, Director, Healthy Living, Planning & Promotion, Region of Waterloo Public Health

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 from Dufferin communities 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.

City of Guelph 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.

The city of Guelph lies in the southern part of Wellington County but is a separate municipality about 87 square kilometres in size. As of the 2011 Statistics Canada Census, the population of Guelph was 121,685. Due to low counts, some Guelph neighbourhoods were combined for the purposes of this report, resulting in 13 city of Guelph areas used in data analysis. The City of Guelph neighbourhoods are:

- Brant
- Downtown/ Sunny Acres/ Old University
- Exhibition Park
- Grange Hill East
- Hanlon Creek/ Hales Barton
- Kortright Hills
- Onward Willow
- Parkwood Gardens
- Pine Ridge/ Clairfields/ Westminster Woods
- St. George's Park
- Two Rivers
- Waverley
- West Willow Woods

"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).

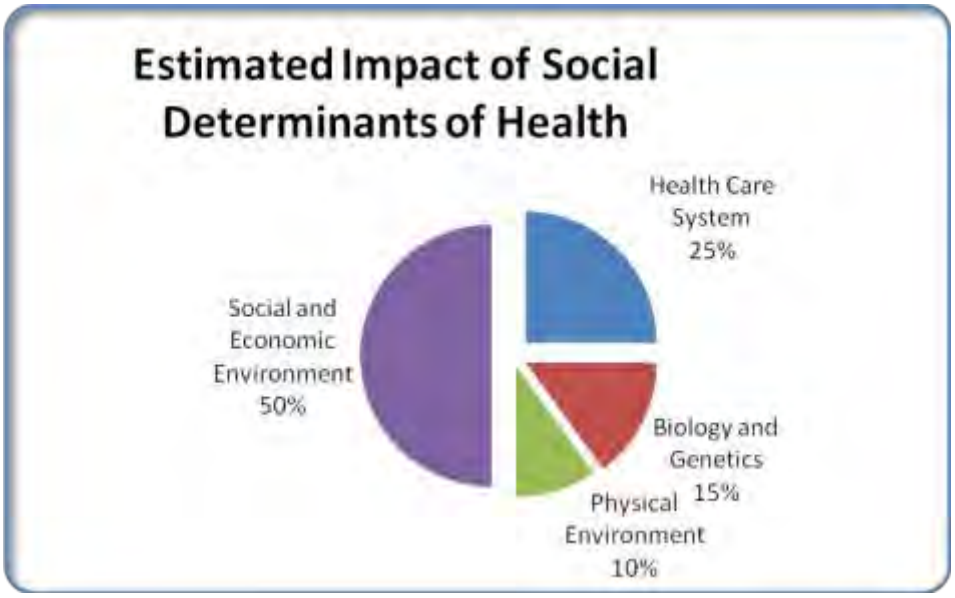


Figure 1 – Graph adapted from *the Health of Canadians - the Federal Role, Volume One: The Story so Far, March 2001,* Standing Senate Committee on Social Affairs, Science and Technology

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 the City of Guelph

The rates of each of the social determinants of health listed below are reported for Guelph and compared with rates in Ontario. In recognition that there are inequities in determinants of health between and within communities, rates of the following indicators were examined for all of the neighbourhoods in Guelph:

- 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).

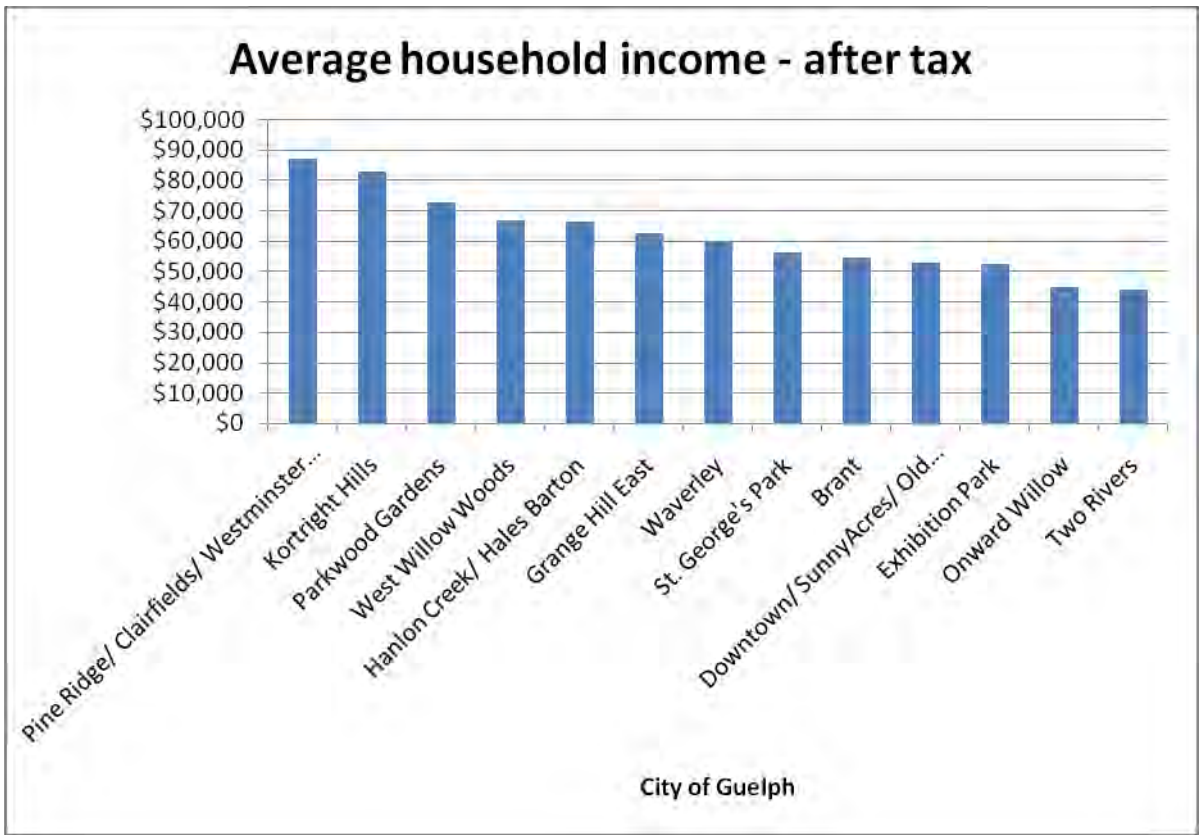
> *"We cannot invite people to assume responsibility for their health and then turn around and fault them for their illnesses and disabilities which are the outcomes of wider social and economic circumstances."*
>
> *The EPP Report, Achieving Health for All: A Framework for Health Promotion, 1986*

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 Wellington-Dufferin-Guelph

In Ontario (2006) the average after tax household income was $63,441; in Guelph it was a little lower at $62,269. However, there is a wide range of average income between neighbourhoods in Guelph. The most affluent community had an average income of $87,341 while the most impoverished had an average after tax household income of only $43,984. The difference in average income between these two communities is greater than $43,000.



Using the after tax Low Income Measure (LIM), 12.4% of households were low income in Guelph. Again, there is a wide range between Guelph neighbourhoods in the rate of low income households – from 4.6% (Pine Ridge/ Clairfields/ Westminster Woods) to 19.8% (Two Rivers) (see map on next page).

Children (birth to thirteen years of age) account for almost 19% of the Guelph population. This amounts to over 21,000 children. A smaller percent of children under the age of six years in Guelph were living in households with low income (9.7%) compared with the province of Ontario (14.8%). The Guelph neighbourhood with the highest rate of children under the age of six years in households with low income was Brant (30.3%) (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.

The Guelph & Wellington Poverty Task Force for Poverty Elimination is a community coalition composed of concerned and affected residents, organizations, businesses, government, the research community and others working together to move poverty reduction issues such as food security forward. The task force is made up of a steering committee, working groups (Research and Policy, Community Voices) and action groups (Guelph Wellington Food Round Table, Wellington-Guelph Housing Committee, Income Security Action Group, Guelph *in motion*). Service providers and community members can support poverty reduction initiatives by becoming involved with the task force action groups.

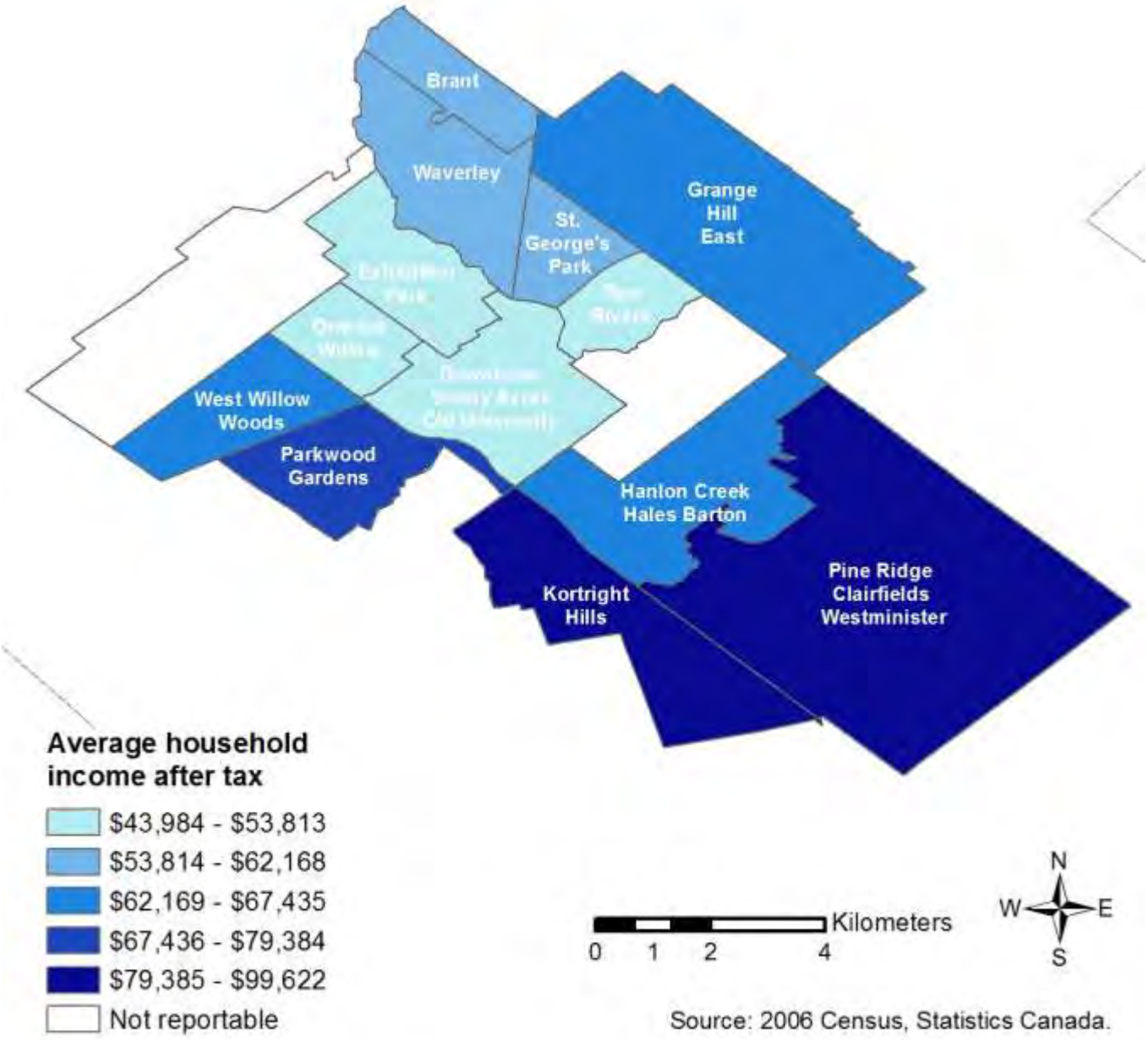
Bridges Out of Poverty is a powerful model for economic and social change, sustainability, and stability. It inspires innovative solutions in those looking to counter poverty and its impact at all levels in a community. This approach helps employers, higher education, community organizations, social 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.

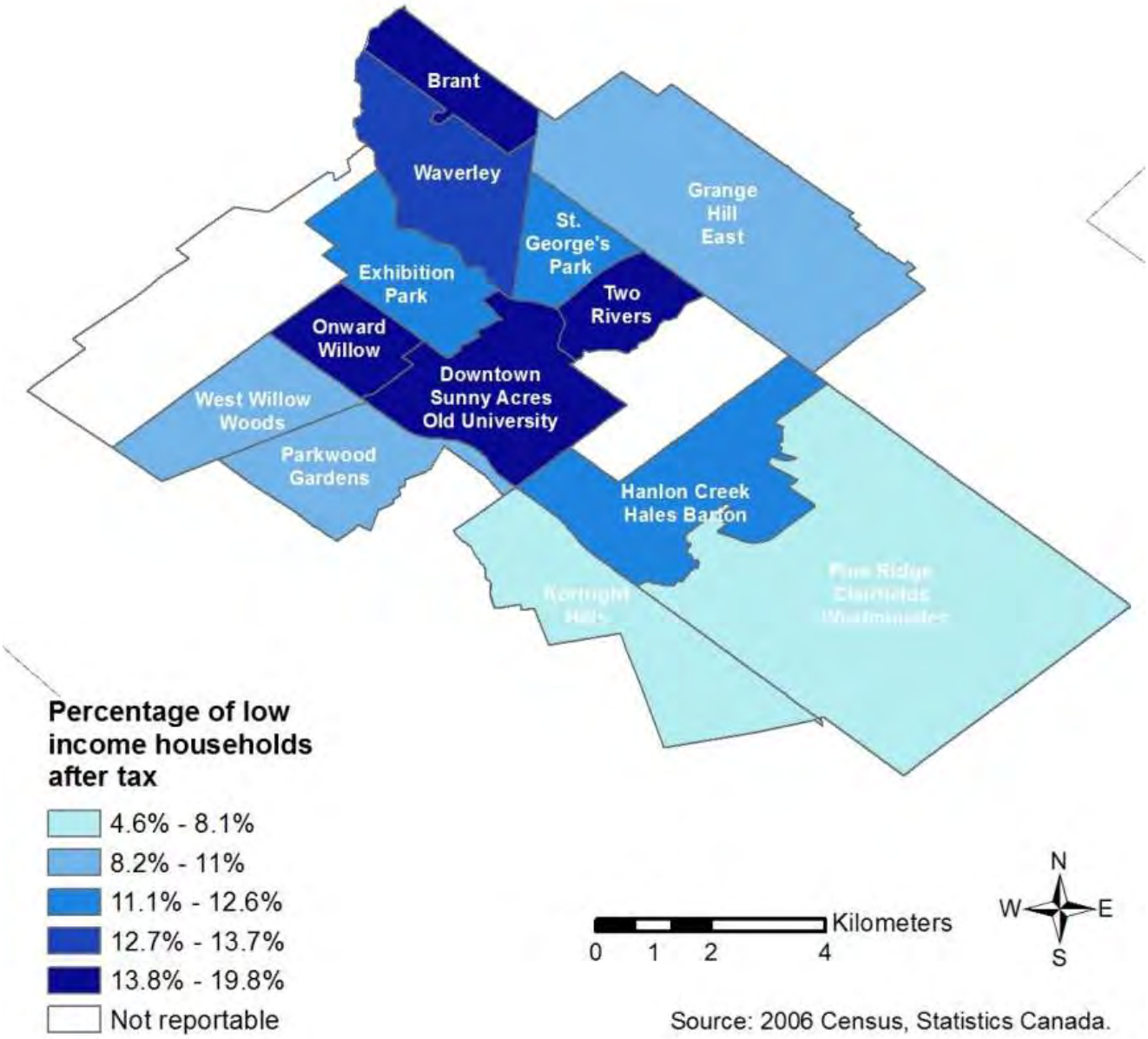
Circles is a supportive, intentional, reciprocal, befriending relationship made up of one Circle Leader who is living in poverty and two to five Circle Allies who are from the middle class. A Circle Leader is responsible for their Circle; convening, leading, and receiving support to work on their

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*.

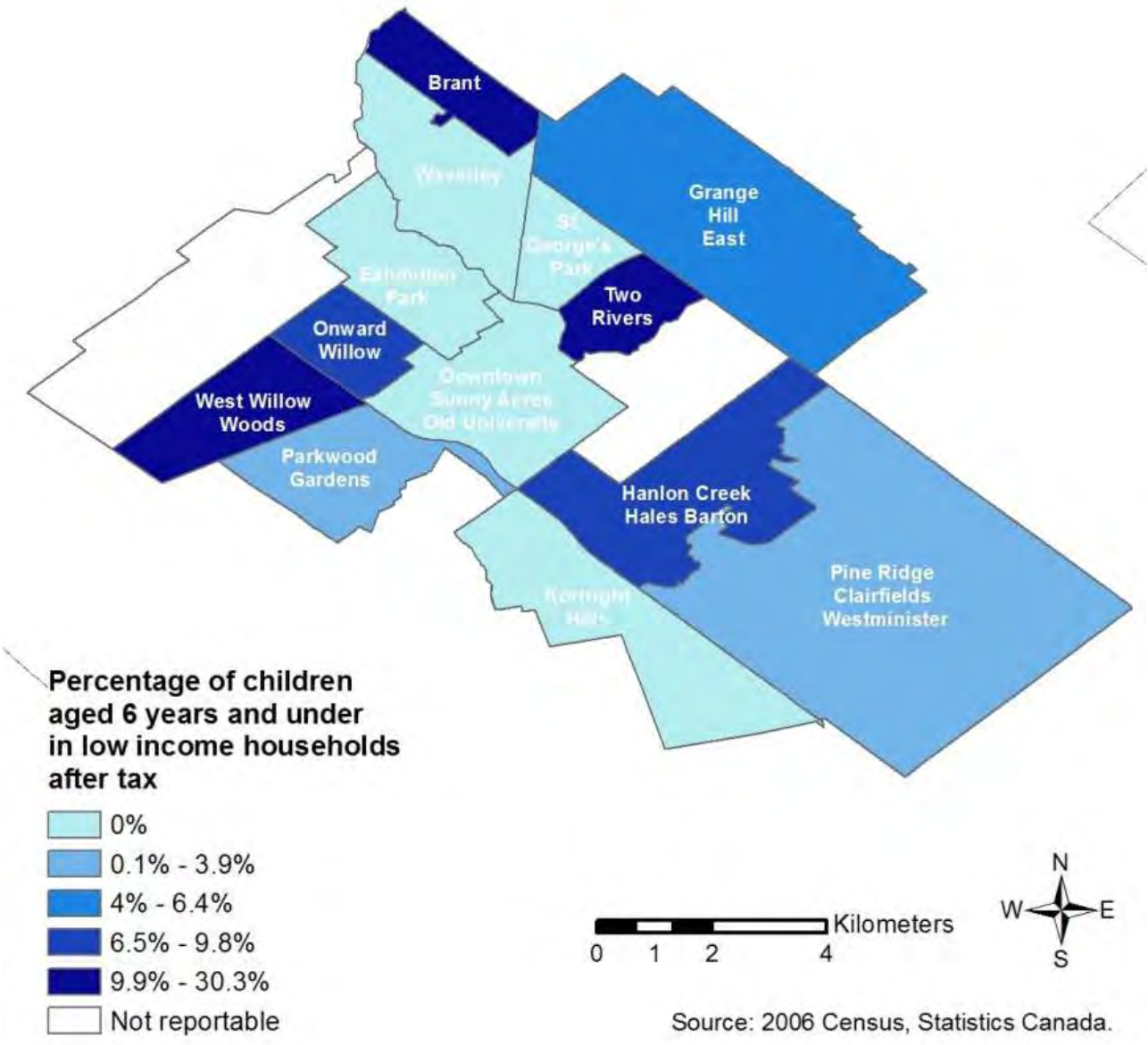
Average household income of private households (after tax) in 2005
Guelph, 2006



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



Percentage of children aged 6 years and under in private households with low income after tax
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 Guelph 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 neighbourhoods 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. 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 neighbourhoods 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 reliable transportation. This alone 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.

> *"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 Guelph, one of the main transportation issues raised by communities was about the location of bus stops and the cost of riding the bus. For many low income individuals this makes securing employment more challenging, accessing a grocery store or food bank difficult, 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?

Progress can be made through the provision of seamless services and systems-based approaches that build on existing strengths and capacities within communities. One example of this was the Implementation of an affordable bus pass pilot program in the City of Guelph in July 2012. The Guelph & Wellington Poverty Elimination Task Force (PTF) worked with the Research Shop to conduct research on the impact on transit fees on low-income community members. In early 2011 the research results were presented to City Council by a delegation. As a result the City of Guelph committed to work with the PTF to develop an affordable transit pass program. A PTF ad-hoc transit committee worked with City of Guelph Community & Social Services staff to create the Affordable Bus Pass Pilot Program over the course of the year. The two-year pilot program was approved by Council in late 2011. The program allows people living in low income households to purchase a transit pass at a reduced rate (50% of the regular bus pass price).

Another solution is to provide programs and services at community hubs that are centrally located in priority neighbourhoods. Emergency food banks, community health centres and other government support services have to reach the people who need support and resources the most.

Other initiatives include investing in peer-based programs proven to assist people in gaining information and building skills. Peer-based programs, such as the *Better Beginnings Better Futures* program in Guelph, *Nurturing Neighbourhoods, Triple P Positive Parenting* and the proposed implementation of the *Bridges Out of Poverty* program in 2013 will assist people in gaining access to information, and build skills in a non-threatening way while keeping their unique needs in mind. More importantly, they encourage self sufficiency and encourage future goals.

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 Guelph

The unemployment rate for individuals aged 25 years and older was 3.8% in Guelph in 2006, which was lower than the provincial rate of 4.9%. The three neighbourhoods in Guelph with the highest rates of unemployment were Onward Willow, Two Rivers and West Willow Woods (see map on next page).

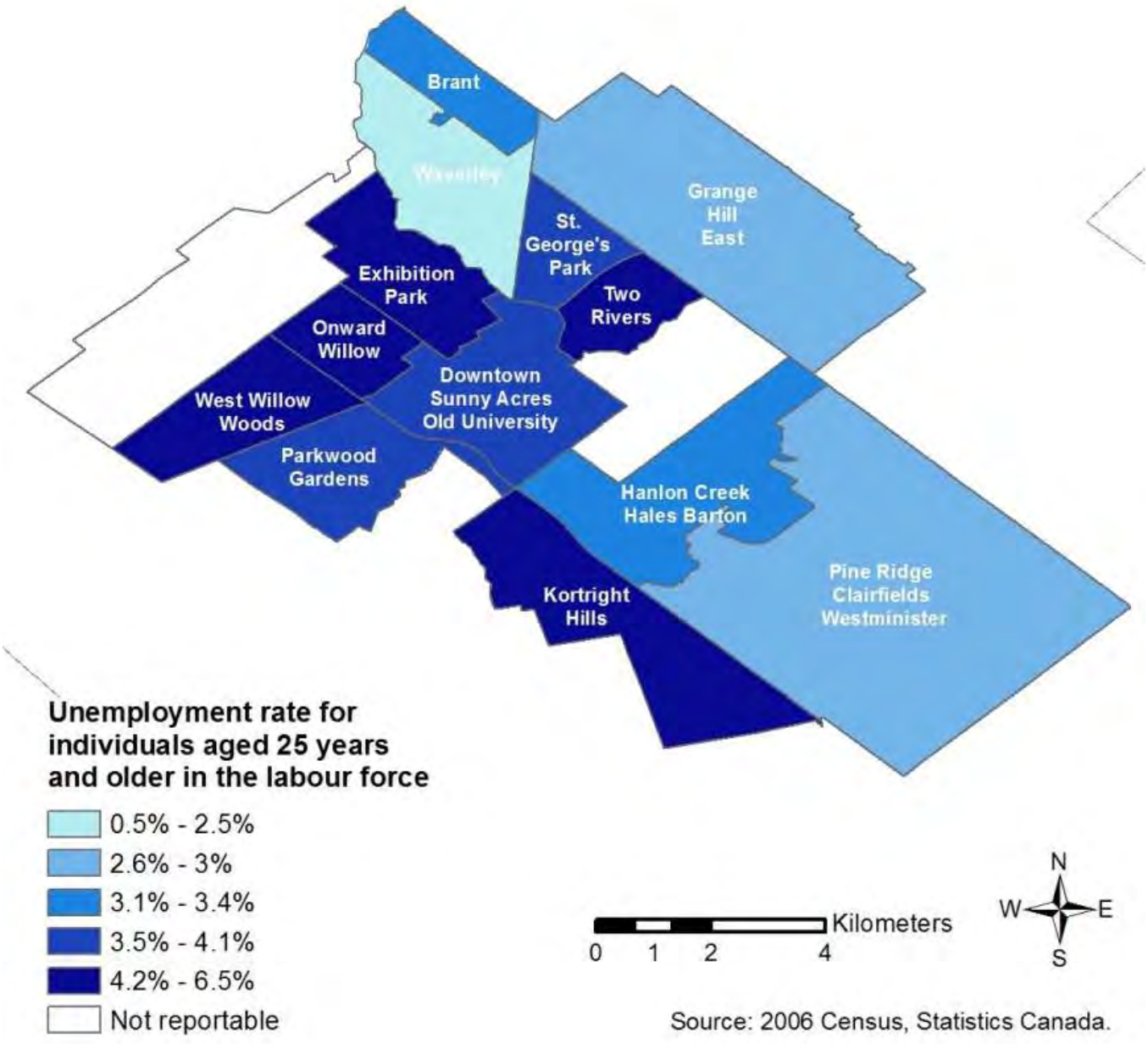
What can be done?

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

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.

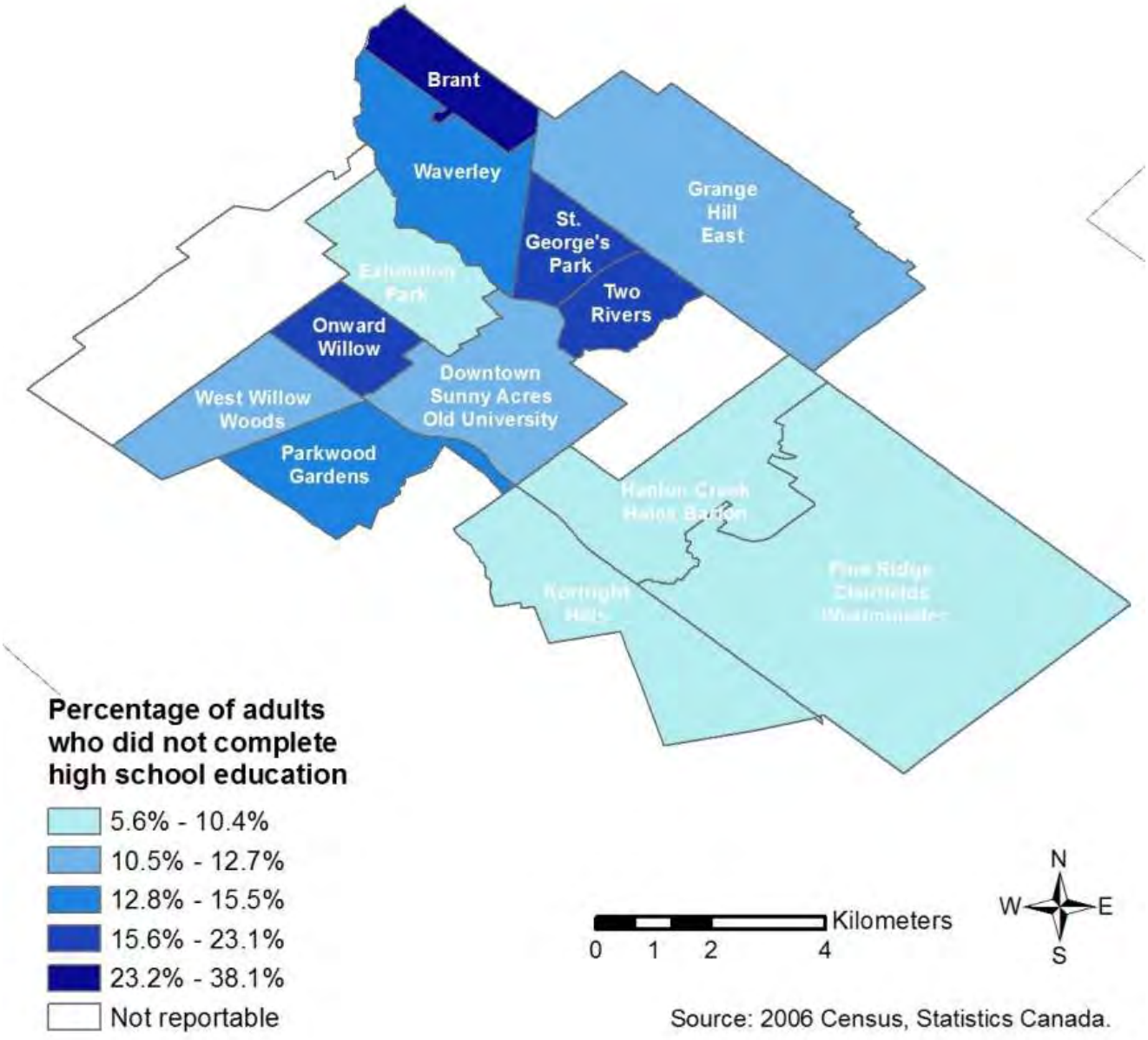
Education in Guelph

In the city of Guelph 12% of adults between 25 and 64 years of age did not complete high school (Statistics Canada 2006 Census). This is lower than the Ontario rate of low education (13.6%). The Guelph neighbourhood with the highest rate of low education was Brant (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 socioeconomic 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
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 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

[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)

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.

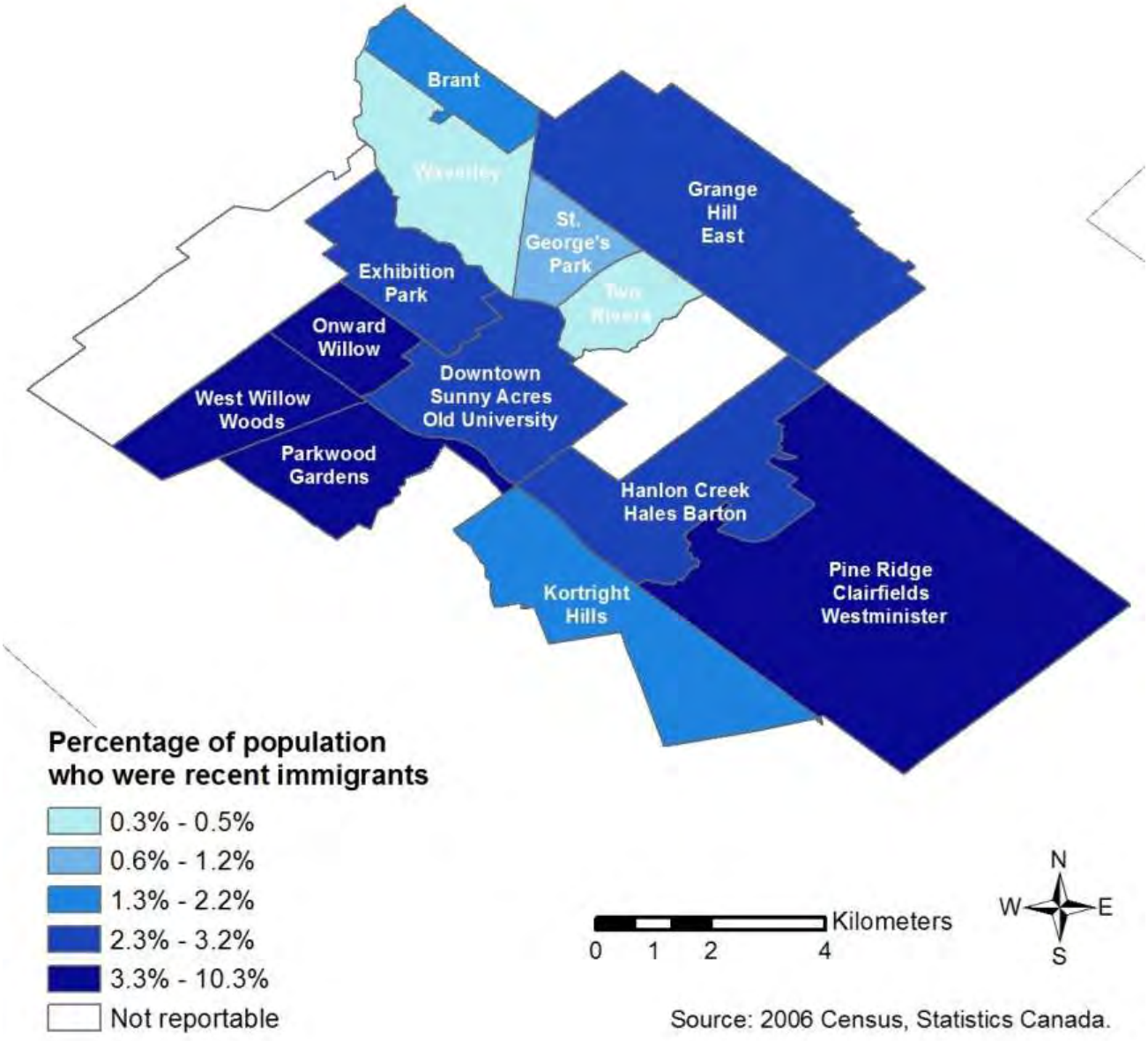
Immigrants in Guelph

In 2006, 21.2% of Guelph residents were immigrants, which is lower than the Ontario rate (28.3%). The rates of recent immigrant (3.3%) and visible minority populations (13.8%) in Guelph were also lower than the provincial rates (4.8%, 22.8%). The neighbourhoods with the highest rates of immigrants and recent immigrants were Parkwood Gardens, West Willow Woods and Onward Willow (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
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.

Several neighbourhoods in Guelph have created community gardens. The gardens have been a good way for neighbourhoods to create a natural hub where community members feel welcomed. Many neighbourhoods where the gardens have been really successful are hoping to build on the momentum and further community development and engagement activities in their neighbourhoods.

Community Development Workers (CDW) work collectively with communities to bring about social change and improve quality of life. They work with individuals, families or whole communities to empower them to:

- identify their needs, opportunities, rights and responsibilities
- plan what they want to achieve and take appropriate action
- develop activities and services to improve their lives

Community Development Workers (CDWs) often act as a link between communities, local government and other statutory bodies. They are frequently involved in addressing inequality, and projects often target communities perceived to be culturally, economically or geographically disadvantaged.

Consistently, in community consultations, people discussed the enriching role that the CDWs played in communities. The CDWs were able to work one on one with people and facilitate respectful communications, early intervention, service provision and referrals. CDWs were responsive to community needs and acted as the connection between the community and the services that were available, helping people to navigate the system. They provided the constant support that some individuals need in their lives.

"Going places and having a feeling of belonging ...knowing you're welcome, I think that is the most important thing."

Losing the CDWs has been a big setback for neighbourhoods. Staff turnover is also a big issue. Developing trust with a community can take months or years and is crucial to success. When a staff person leaves and a new person comes in, that process has to happen all over again.

Social and Community Support in Guelph

In 2006, 12% of families were lone parent families in Guelph. The percentage of lone parent families in Guelph is lower than the Ontario average of 15.8%. Provincially, 81.6% of lone parent families are female-headed.

What can be done?

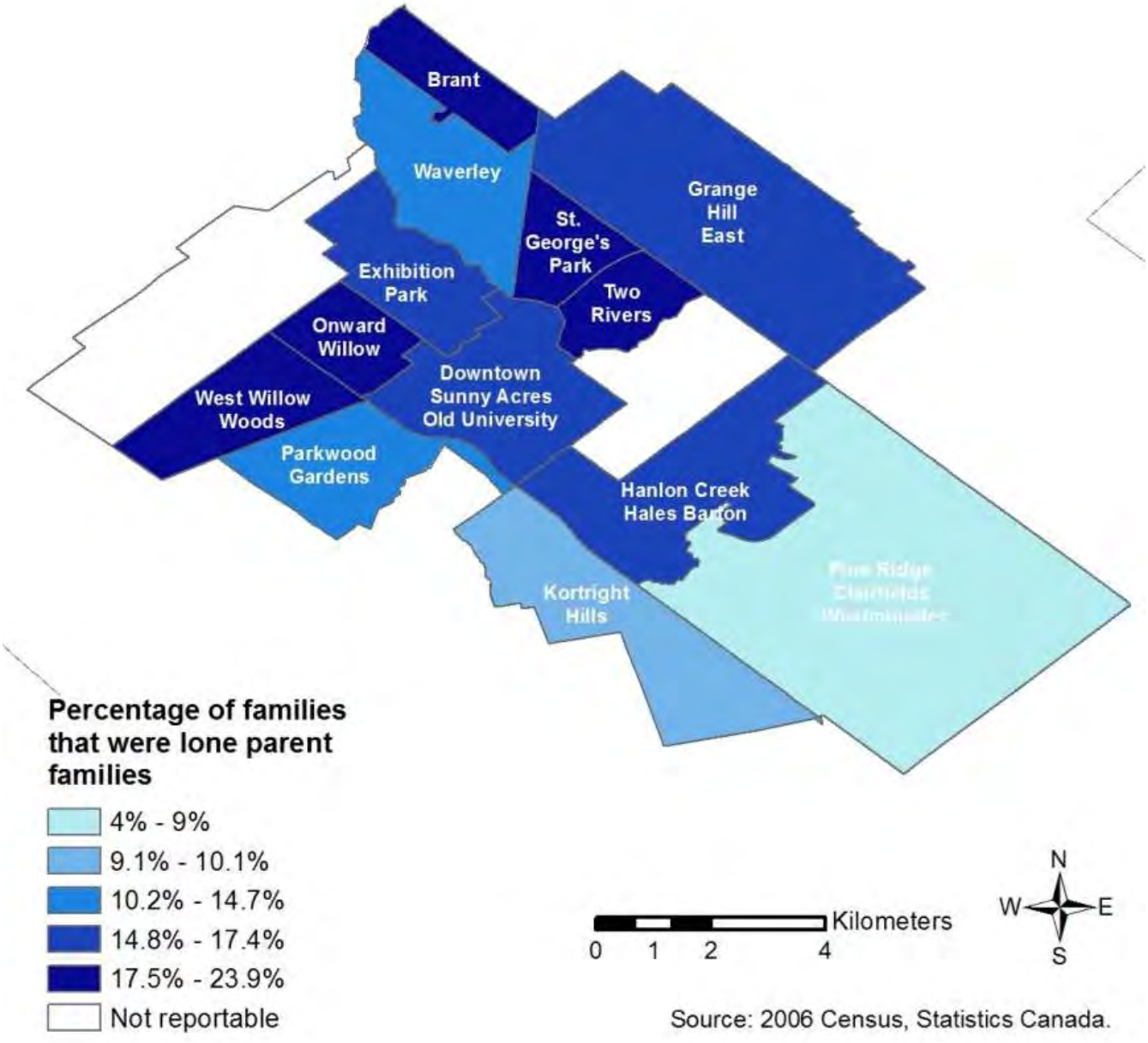
Neighbourhood-based interventions have been acknowledged for a long time as an effective way of reaching out to vulnerable populations. This work needs to start with the reliable identification and prioritization of the neighbourhoods and the populations within them (Nelson, Pancer, Hayward, & Kelly, 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 neighbourhoods 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.

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 funds or inconsistent pilot funds.

Percentage of families that were lone parent families
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 Guelph

In 2006, just over 25% of owners and tenants were spending 30% or more of their income on housing in Guelph. The percentage of owners and tenants spending 30% or more of their income on housing ranged from 18.2% in the most affluent neighbourhood to 33.7% in the most impoverished neighbourhood. The percentage of owners and tenants spending 30% or more of their income on housing in Guelph is lower than the Ontario average of 27.6%. The Guelph neighbourhood with the highest rates of residents spending 30% or more of their income on housing was Two Rivers (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.

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

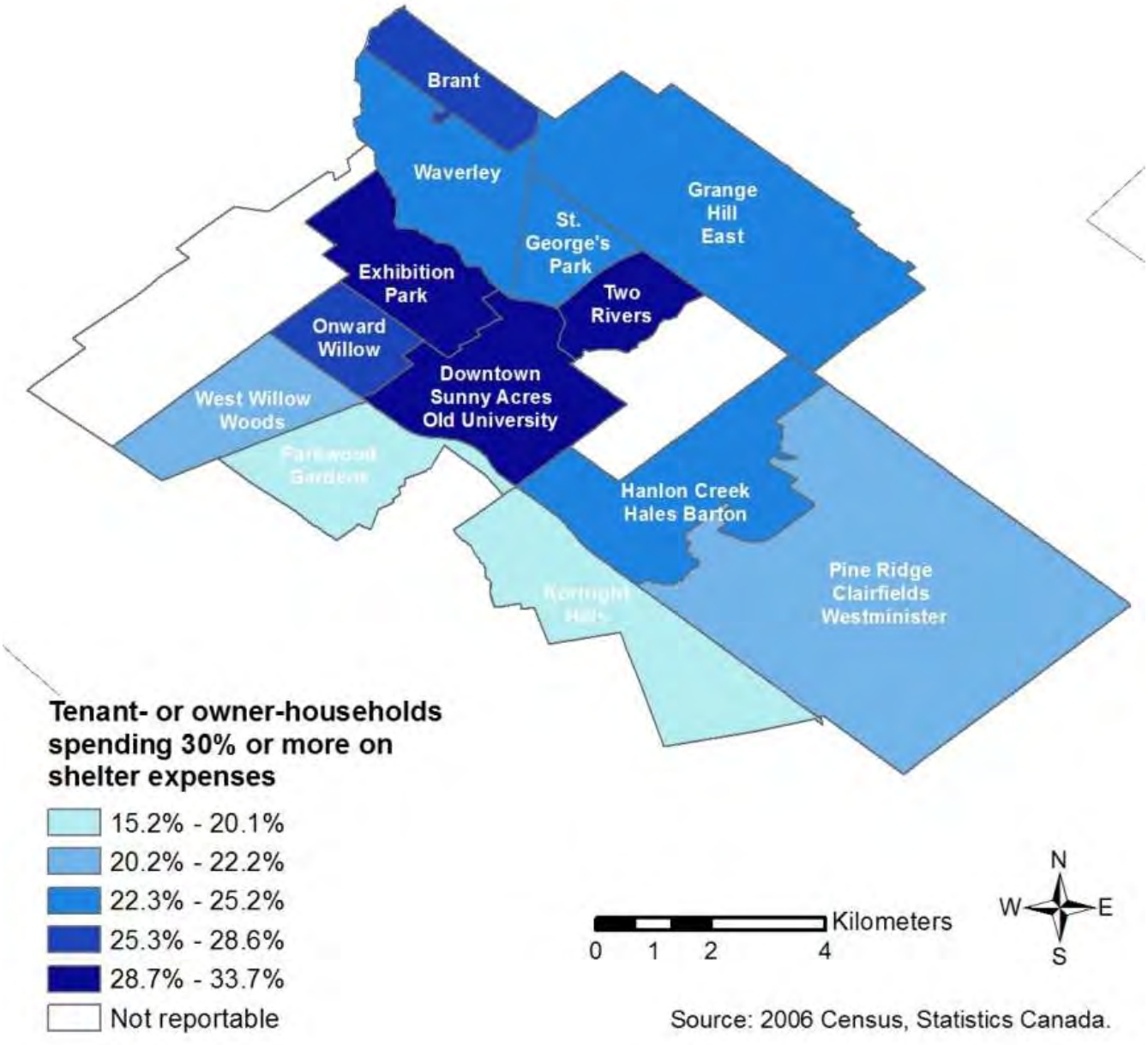
proposal would add an affordable housing component to the anticipated provincial Poverty Reduction Strategy. The Wellington-Guelph Housing Committee has recently formed a working group around this issue and engaged with the Daily Bread Food Bank to develop a public education and awareness campaign.

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)
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).

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.

> *"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."*

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 Wellington County are eligible for fee subsidies to provide financial assistance for the cost child care. As of May 31, 2010, there were a total of 81 children on the waitlist for fee subsidy – 10 children living in Wellington, and 71 children living in the city of Guelph. Most child care spaces on the wait list (69%) support low income, working families. From January to March 2010 (inclusive), 857 children and 685 families in Guelph-Wellington were

supported by a full or partial fee subsidy. A little less than one quarter of children (23%) accessing child care subsidy live in the County of Wellington (cited in May 2010). Over half of the families receiving fee subsidy (57%) were earning under $20,000 per year (County of Wellington, 2010).

Early Child Development in Guelph

In 2006, 13.5% of SK children in Guelph were considered to be vulnerable on two or more domains of the Early Development Instrument (EDI). In Ontario the proportion of vulnerable SK children was 13.8%. The Guelph neighbourhood with the highest rate of vulnerable children was Onward Willow (see map on next page). From 2006 to 2009 in Guelph, there was a statistically significant increase in the percentage of children vulnerable in two or more domains. The proportion of vulnerable SK children in 2009 was 14.3% in the city of Guelph (Bestari, 2010).

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).

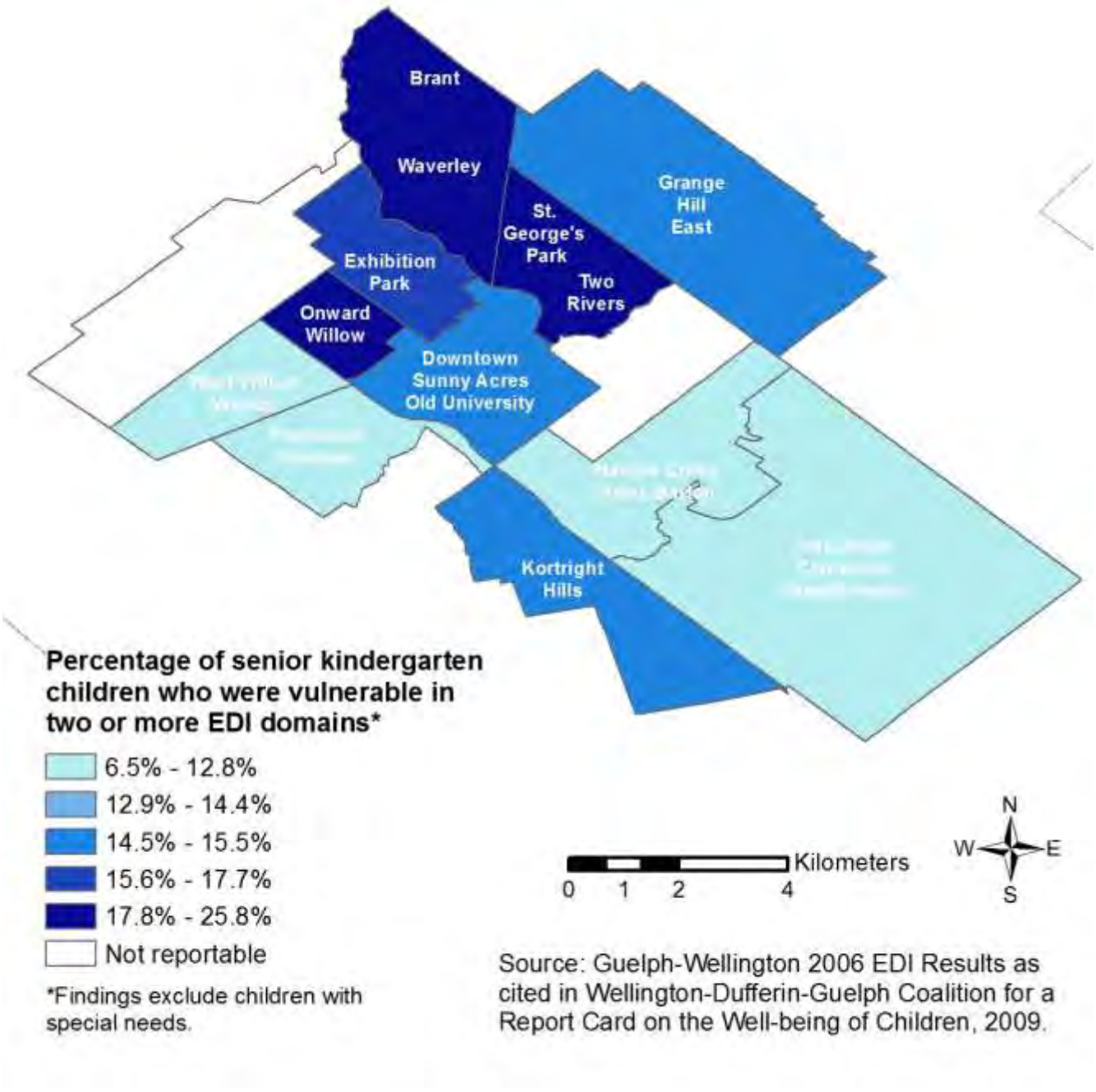
The Triple P (Positive Parenting Program) is an example of an evidence-based parenting and family support strategy focused on preventing behavioural, emotional, and developmental problems in

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

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

The Guelph neighbourhood with the highest rate of mortality due to lung cancer was Two Rivers. The neighbourhoods with the highest rate of emergency department visits were Brant, Onward Willow and Two Rivers.

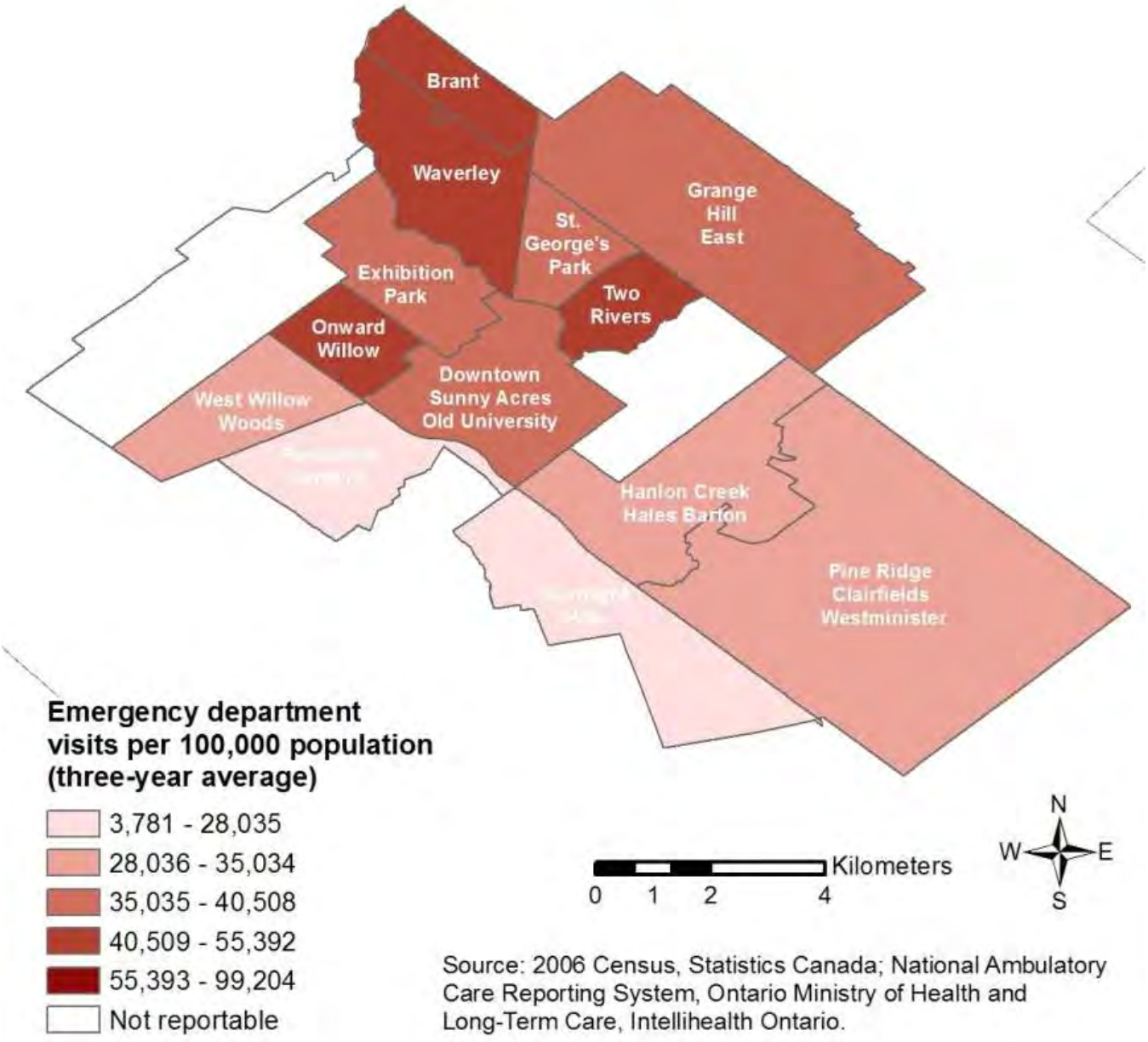
Exhibition Park had the highest rate of hospitalizations due to cardiovascular disease, injury and diabetes. The Exhibition Park neighbourhood also has the highest rate of residents who are 65 years of age and older (21.7%).

If neighbourhoods with more than 15% of residents who are 65 years of age and older are eliminated the Guelph neighbourhoods with the highest rate of hospitalizations due to cardiovascular disease, injury and diabetes were Two Rivers, Brant and Onward Willow.

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:

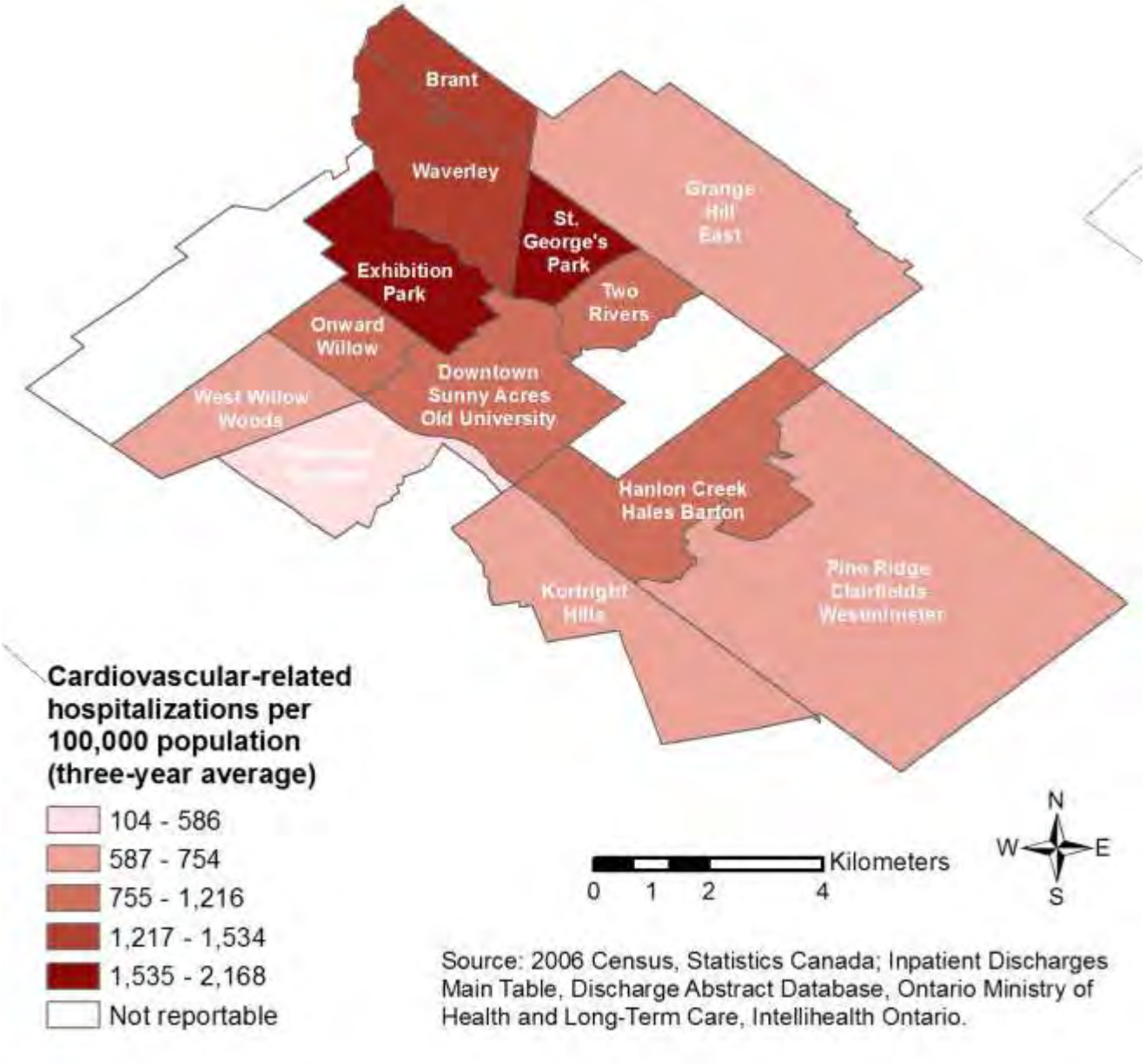
- ED visit – Ambulatory Visits Main Table form the National Ambulatory Care Reporting System.
- Inpatient hospitalization – Inpatient Discharges Main Table from the Discharge Abstract Database.
- Mortality – Deaths Main Table from the Vital Statistics Mortality Database.

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



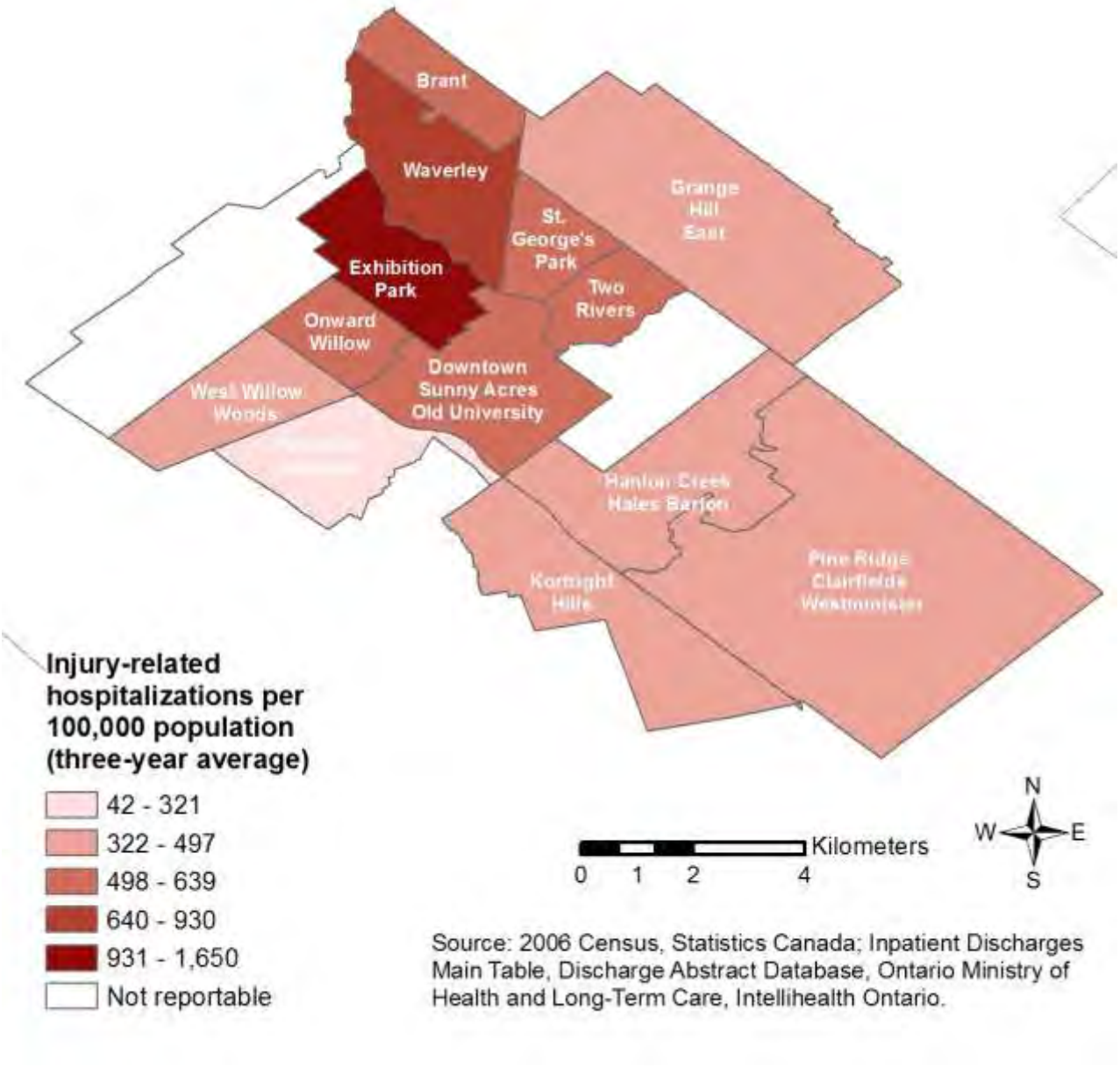
Source: 2006 Census, Statistics Canada; National Ambulatory Care Reporting System, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

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



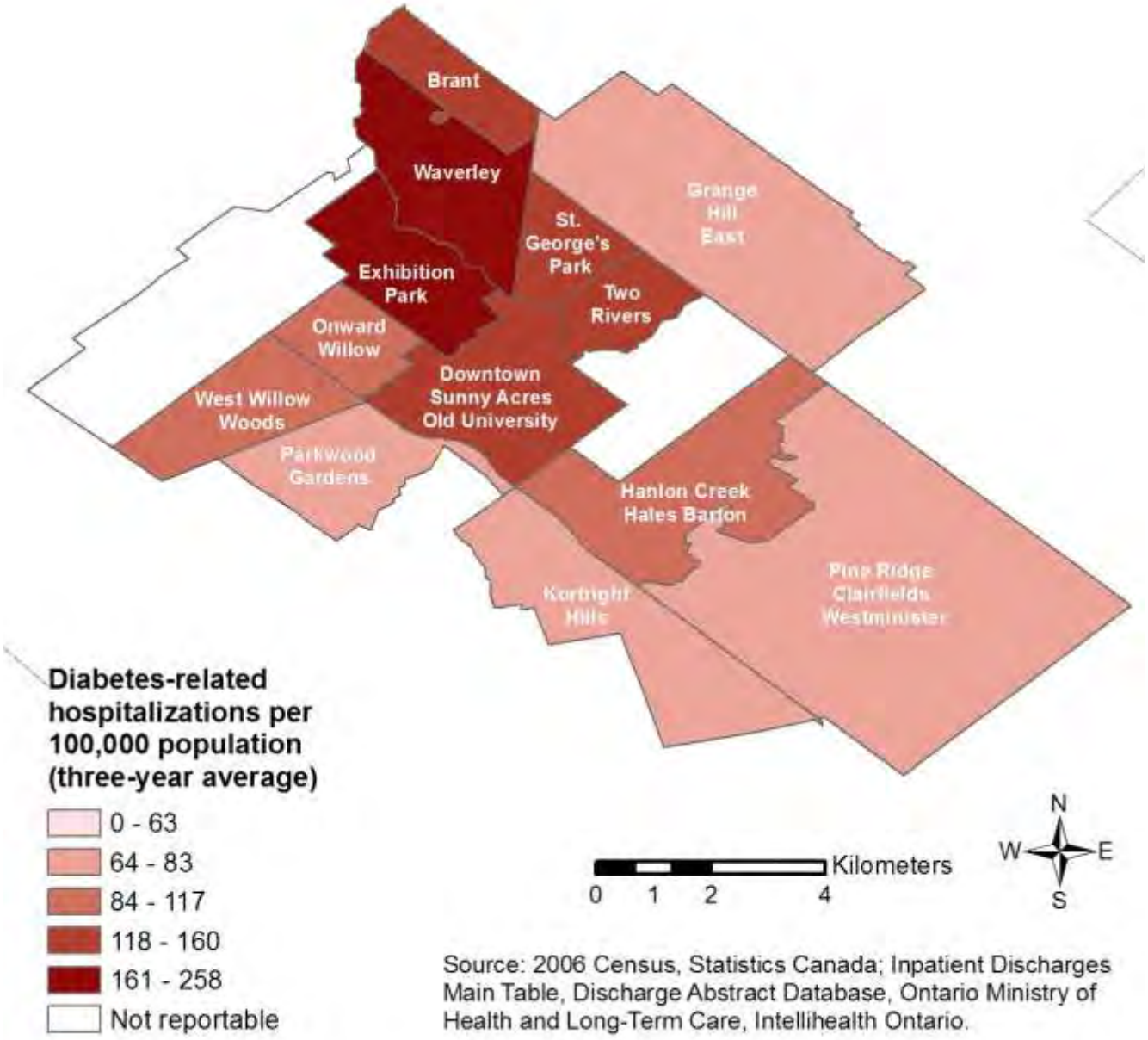
Source: 2006 Census, Statistics Canada; Inpatient Discharges Main Table, Discharge Abstract Database, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

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



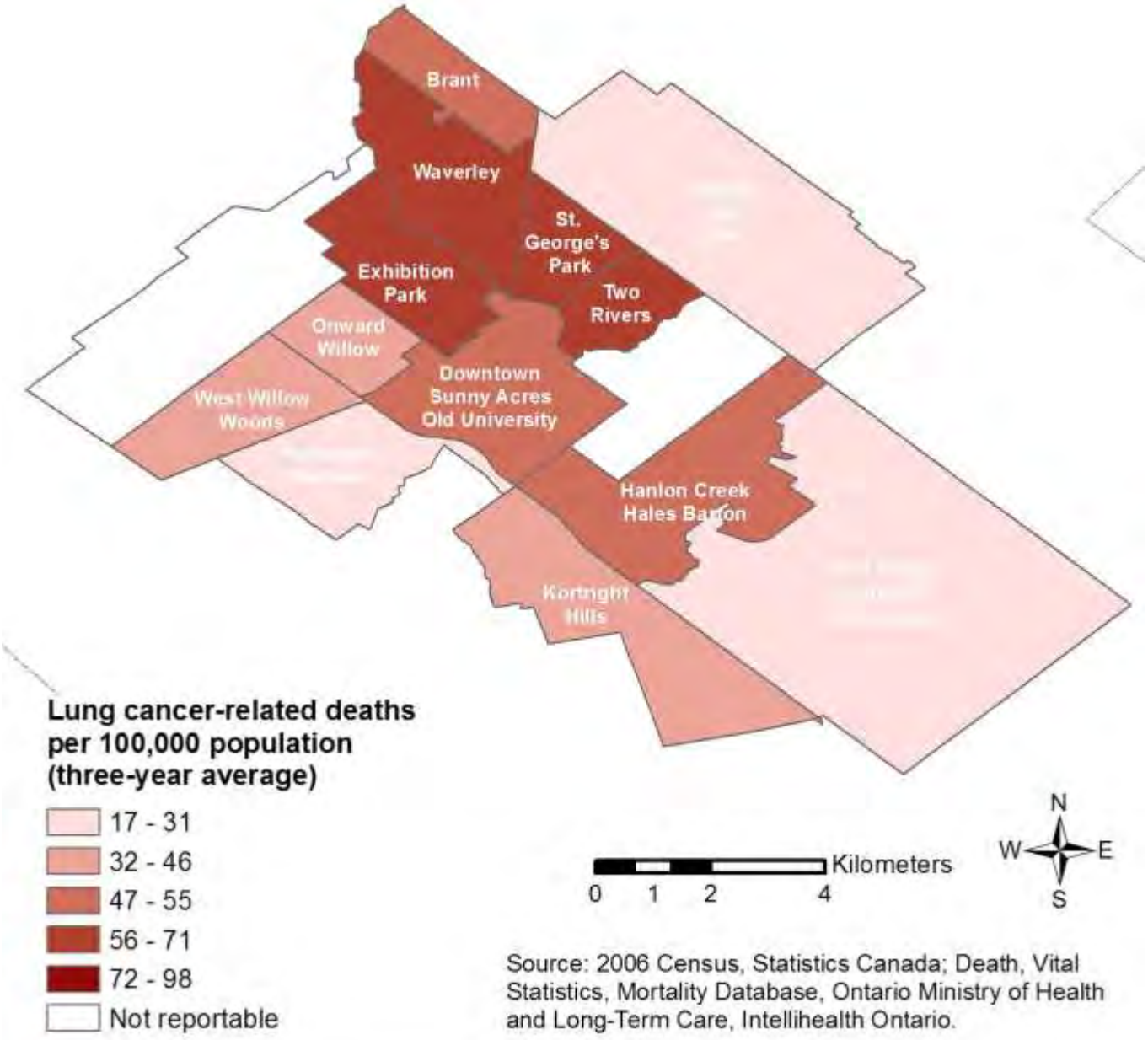
Source: 2006 Census, Statistics Canada; Inpatient Discharges Main Table, Discharge Abstract Database, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.

Three-year average diabetes-related hospitalizations per 100,000 population 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 lung cancer-related deaths
per 100,000 population
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 Neighbourhoods

Wellington-Dufferin-Guelph is home to citizens who sustain this resourceful, supportive and dynamic community. WDG 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, WDG appears to fare relatively well for many of the social determinants of health indicators. However, by examining the community a little more closely, 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. In order to create this picture quantitative data collected from the Census will be superimposed with community voices describing real stories in the community.

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 neighbourhoods were identified through a system of ranking. Eight social determinants of health indicators were used to rank all neighbourhoods and 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 WDG were ranked on each of the eight indicators. The indicator ranks were then totalled for every area. Areas appearing in the highest 20% of the overall rank were identified as priority neighbourhoods.

In the City of Guelph four neighbourhoods were identified as priority areas based on the eight indicators that were chosen.

- Brant
- Onward Willow
- Two Rivers
- West Willow Woods

Although these areas have many strengths, they are all experiencing challenges such as high rates of unemployment, low income, 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 Neighbourhoods in the City of Guelph

Onward Willow

Geography and Demographics

Onward Willow is a neighbourhood located in the northwest part of the city of Guelph. It is home to 7,280 people as of the 2006 Statistics Canada Census. This neighbourhood accounts for 2.9% of the Wellington-Dufferin-Guelph population. Seniors comprise 11% of the population and the neighbourhood is home to 2, 030 families. Children under 14 years of age make up 18.1% of the population of Onward Willow and child well-being is a core value to many members of this community.

Through conversations in this neighbourhood, one of the first things that stood out was how united this community is in their commitment to children. Parents of young children, along with service providers, volunteers and older children from the community invest a significant amount of community time and resources into programming and creating opportunities for children to get involved. In fact, because children are so involved and integrated into many of the community activities, more parents are getting involved.

> *"It's having that connectivity, of where you belong, where you are not always seen as a client of somebody's service. That's really important."*

Many of these activities occur at the Shelldale Centre which is one of eight *Better Beginnings Better Futures* (BBBF) sites in Ontario. The *Better Beginnings Better Future* (BBBF) program was launched in 1991 in low income communities across Ontario with the idea that every child has a right to develop and grow to reach their full potential. (The Onward Willow BBBF services and programs provide parent and family support.) A combination of community volunteering and agency support are the main factors for its strength and success. The three goals of *Better Beginnings, Better Futures* are to:

- Prevent emotional and behavioural problems in children
- Promote the optimal emotional, behavioural, social, physical and cognitive development in children
- Strengthen the ability of communities to respond effectively to the social and economic needs of children and their families

(Peters, 2004).

Other important assets that were identified in this community were the Onward Willow Neighbourhood Group, the Neighbourhood Support Worker and the connectedness between community members.

Poverty is identified as a major challenge in the community. There are two unique factors that contribute to the social issues in this community. Onward Willow is often the first area in Guelph in which landed immigrants settle and the turnover is constant. Once immigrants become established, find employment and gain better financial status they move out of the neighbourhood. The second factor is that the highest concentration of social housing in the city of Guelph is located in this neighbourhood.

> *"You have to break apart the world that's falling apart, and stay on top of just a little part; put your focus and energy into the small pieces."*

Income and Employment

Income, which is known to be the most influential determinant of health, was one of the indicators that supported the identification of Onward Willow as a priority neighbourhood in Guelph. In Onward Willow, 19% of households fall below the Low Income Measure after tax and 7% of children ages six and under are living in low income households. Onward Willow has the highest overall unemployment rate in WDG for adults aged 25 and over (6.5%) and one of the highest percentages of low income households.

In Onward Willow, nearly 40% of jobs for neighbourhood residents are in the manufacturing industry. The manufacturing industry was particularly hard hit during the 2008 international recession and has not yet made a complete recovery.

Since the recession, many people have lost their jobs and the number of Ontario Works and Employment Insurance beneficiaries increased in this neighbourhood and across the city of Guelph. Many members of this community are part of the Ontario Disability Support Program which provides a meagre income for individuals living with a disability. Some community members have paid employment but work in jobs that pay low wages and don't provide health benefits. Demand for resources from Onward Willow has continued to be high but so has the determination of the staff to be supportive and consistent in helping to provide what is needed.

In Onward Willow 24% of families are lone-parent families of which 81% are lead by females. This percentage of lone-parent families is high relative to the rest of the neighbourhoods and municipalities in the WDG area (top quintile). Experiences of poverty are amplified for single

parents who shared stories about trying to juggle child care, school and work. In many cases, wages are so low, and benefits either absent or minimal that individuals cannot afford to work. The cost of childcare, dental and eye care and prescription drug programs would no longer be available through social assistance and a job paying minimum wage would not compensate for this loss. This experience was one of many shared with the province during the social assistance review and a recommendation was made to provide benefits to all people with low income regardless of whether or not they were collecting social assistance.

Education

Of the adults living in Onward Willow, 23.1% have not completed their high school education and 34% completed high school but have no further post secondary education. Compared to other neighbourhoods and municipalities in WDG, Onward Willow has a high rate of adults who have not completed high school and adults who have completed high school but not post secondary school. Low educational attainment presents challenges in circumstances of high unemployment where specific skills help with employability. Of those that have university degrees, 31% were obtained outside of Canada.

> *"How can you go to school if you don't have food for lunches or even pair of shoes...future goals are in the back of your head."*

One new program at the Onward Willow Centre aims to increase school readiness. This program provides preschool children with the opportunity to visit the local elementary school before they start school to increase familiarity and comfort during the transition from preschool into school. There are programs in place to support children once they enter elementary school, such as breakfast and lunch programs that provide nutritious food, and after school programs to provide recreation and childcare. One gap that was noted during community consultations was a lack of programming for children on weekends. The types of programs needed are those that address adolescent issues. Currently, a teen drop-in is offered and is filled to capacity.

One barrier that was identified for youth completing their high school education is a lack of role models. Other barriers identified were youth having to work which makes it difficult for them to attend traditional school hours, or youth having children of their own and not having access to affordable childcare. In order to create circumstances that would allow youth experiencing these challenges to continue to work towards graduating from high school, an alternate program, called *Young Parents Education Program* was developed so that youth could continue to work, parent and finish school at the same time. Attendance was good and youth were coming on a regular

basis. As a result, another session was added for young women with babies to come and study and receive child care at the school.

The Onward Willow BBBF program has been operating for 21 years, and the staff at the Shelldale Centre are now observing some of the long-term benefits. Many of the children who have been involved in programming from a young age are now completing high school and going off to college and university. Some adults return to the neighbourhood to help out and others return because they feel connected to and supportive of the neighbourhood they left.

> *"There are successes. It's the stuff that gives you hope and makes you say, yes it's all worth it , let's keep going even though this is hard right now."*

Immigrant and Visible Minority Populations

Onward Willow has a high proportion of immigrants compared to the rest of WDG neighbourhoods and municipalities with 27.5% of the population describing themselves as immigrants. Recent immigrants (those who were living outside Canada five years ago) make up 10% of the neighbourhood and nearly 2% of the neighbourhood population came to Canada as recently as one year ago. In this community, 23.5% of individuals would describe themselves as a visible minority. Compared to the rest of WDG neighbourhoods and municipalities, Onward Willow is in the top quintile for percentage of immigrants, recent immigrants and visible minorities.

> *"New immigrants face different challenges, as many new immigrants are educated, healthy and motivated to work, but cannot get jobs right away."*

Nearly 22% of people in Onward Willow speak a language other than English most often at home indicating language barriers to accessing programs and services. Over 3% of people living in the Onward Willow neighbourhood do not speak English or French at all. In Onward Willow, other than English, the most common languages spoken at home are Vietnamese, Chinese, Italian and Punjabi.

Community Social Support

Parenting support groups are available at the Shelldale Centre. Some programs are for a specific group such as Vietnamese moms and others are mixed groups with people of other cultures and English speaking moms together. The program lead hopes to increase informal support for new mothers and gives moms of new babies the opportunity to see that many of the issues they face are the same.

In spite of the challenges facing Onward Willow, the neighbourhood has many parents (135) who volunteer at the Onward Willow Centre (Onward Willow Partner Summit 2012). Families have access to a large number of supports. Children's involvement in community programming is an indication of a well connected informal service network in operation. In 2012, there were 210 children registered for children's programs at the Onward Willow Centre (Onward Willow Partner Summit 2012).

The *Peer Parent Program* at Onward Willow is a great example of neighbours helping neighbours and the incredible support that members of this community offer to one another. Onward Willow volunteers connect with people in the community to see how they are managing and help link them to programs that are offered. The program's purpose is to gain parenting skills, meet other parents, and learn about child development. Fostering relationships, building friendships, and trusting the community are goals the program leaders hope to achieve through this program. Other programs in the community such as Baby Day and Women's Group also promote inclusion. Programs that address adolescent issues were identified as a need. Currently, a teen drop-in is offered and is "filled to capacity" with 180 youth registered (Onward Willow Partner Summit 2012).

Food security is a major issue in this community. In response to this issue being identified by individuals living in the neighbourhood, a community food cupboard was started at the neighbourhood group for people who are in need. Much of this food insecurity stems from lack of adequate income to afford nutritious food, but is also influenced by lack of transportation which makes it difficult to access healthy food.

Housing

Onward Willow is a community of small, rental high-rise apartments. Well over half (57%) of people rent and 36% of homes are located in high-rise buildings. Growth in the community has slowed down with only 0.5% of homes being constructed between 2001 and 2006. As a consequence of the high rates of low income in this neighbourhood, 27% of tenant or owner households spend 30% or more on rent or housing payments. This measure was used as an indicator to select priority neighbourhoods. One measure of social risk for a neighbourhood is the number of people who are moving in any given year. In this neighbourhood, 20.4% of people moved in the last year which is high and indicates a neighbourhood that is at risk of social issues (Report Card, 2009).

A significant portion of social housing in Guelph is located in the Onward Willow neighbourhood. The majority of social housing units in Onward Willow are single units and all types of social housing have long wait lists. It is estimated that for any unit (no specifications) the wait is about three years, and to get into one of the more desirable units (in a particular neighbourhood, or specific type of housing) it can be up to nine years.

> *"This is a neighbourhood where poor people can live, where housing is somewhat available and affordable."*

Because of the huge demand for housing, matching families to an appropriately sized house is important but can contribute to the frequent circulation of people in and out of different units to match the landlord and tenant needs. For example, when a child grows up and decides to move out on their own, the remaining family members are often required to relocate to a smaller unit, which is disruptive to the family but necessary to maximize the number of people who can be housed.

Healthy Child Development

Of children in senior kindergarten in Onward Willow in 2009, 29.7% were vulnerable in two or more Early Development Instrument domains. This is high compared to other areas in the city and higher than the rate in 2006 at 18.6%. A significant percentage of children in this neighbourhood struggle on all five domains; however, despite this a good percentage are doing very well especially in emotional maturity and social competence (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009). The results indicate that some educational issues in the neighbourhood persist and that there is more work to be done in preparing children to become ready for school. Children's health is also the lowest in the city of Guelph with only 73% of parents reporting children's health to be excellent or very good (Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children, 2009).

One community worker remarked on the importance of accessible programs for optimal child development, "What builds the good sportsmanship and relationship and building with others, start from kids in childcare to share toys, to go play soccer in the soccer fields, with team mates. We shouldn't take this away from kids because they don't have enough money."

> *"One of the most important things you can give children is a dream, believing in them enough that whatever they want to do is possible."*

The strength of the Onward Willow community continues to be the support system of the people who live in the community and volunteer to give back to the neighbourhood.

Brant

Geography and Demographics

The Brant neighbourhood is located in the north east area of Guelph. In total, Brant is 2.3 square kilometres in area. Brant has a population of 3,015 including 895 families, many of which are young families. This neighbourhood has many lone-parent families (23.5%). Brant has one of the highest proportions of seniors compared to the rest of the neighbourhoods and municipalities in WDG at 10.1%. Children under the age of 14 years make up 21.1% of the neighbourhood's population. Despite the high numbers of children in the neighbourhood there is low child care availability in the area. Brant has the highest rate of unpaid child care demands in the city (10.6% of people do more than 60 hours of this work a week).

Brant has a strong and active Neighbourhood Group which was one of the first established in Guelph. The location of the group is not ideal. Stigma associated with the street discourages people from accessing services because they are afraid of being watched or judged. The community is hoping to move the program into Brant Avenue Public School which is a more neutral location and this will make the space more accessible for everyone. Brant has come together as a neighbourhood to engage in some long-term community planning. Through this process the community recognized that having the neighbourhood group located at the school has really helped the community build on its assets.

Brant is located on the periphery of Guelph and residents of this neighbourhood identified transportation as an issue as many families do not own cars and bus service is limited. It is also cut off geographically by Victoria Road which is a high traffic artery in the city. The neighbourhood does not have any grocery stores or recreational facilities within easy walking distance. These deficiencies are felt by the community members who would like programs, services and amenities to be closer in order to better serve the community.

> *"A lot of people don't have access to vehicles and so often you will see people riding bikes across town to go to a grocery store with their kids, and that's difficult."*

People in this community want locally accessible services because so much else in the city is not accessible due to the cost of bus fare, limited child care or other barriers. There are single parent families with low income and sometimes parents are very consumed with the demands of day to day basic needs, so having both locally based service and access to other opportunities such as recreation and leisure would benefit the community. It was specifically identified that families and children prefer drop-in programs without forms to fill out or fees to pay.

This community experiences a high rotation of people in and out of the neighbourhood. Feedback received through consultation with community members and service providers in the area indicated a lack of social unity in the neighbourhood due to continuous transition. Despite this, the community has come together on a number of occasions to work on creating a vision for the future and a strategy roadmap, outlining some goals and priorities for the neighbourhood.

> *"I think the neighbourhood group is undivided in their vision, they really want to build bridges; they really want to build on their assets but that physical location really limits them."*

Income and Employment

The Low Income Measure after tax is an indicator of low income that was used to identify neighbourhoods where poverty is a significant social issue. Brant is among the neighbourhoods and municipalities in WDG with the highest rates of low income with 17.0% of households falling below the LIM. It is also the neighbourhood with the largest percentage of children under six years old living in low income homes at 30.3%. The median household income in Brant is about $55,000 which reflects a mix of incomes in the neighbourhood with some families living comfortably and others who are struggling to make ends meet. The unemployment rate in Brant, as of the 2006 Census, was 3.2% which is lower than the rate for Ontario (5%).

There is a lot of subsidized housing and low cost housing in the Brant neighbourhood. Things that some families may take for granted such as winter coats, winter boots, running shoes and school lunches are not something that all children in this neighbourhood can afford. A former teacher at Brant Public School describes building resources in the community to help the children, "We were probably one of the first schools to start a breakfast club and we did that totally through fundraising and teachers volunteering time to supervise in the morning before breakfast and food programs became more mainstream and better supported."

Now an emergency food pantry is available and a church in the neighbourhood has a community kitchen that is popular among members of the neighbourhood who enjoy cooking meals together. New Life Church also provides a food pantry so people have access to food and they also have fresh food boxes available. At the community kitchen, community members choose a recipe they want to cook and then everyone works together to prepare it. Food is then divided up to take home. The recipes are low cost and can also be subsidized for people who can't afford it; this helps stretch food dollars and it also ensures a nutritious meal.

Education

Educational attainment in Brant is the lowest in the city with 25.9% of adults and youth without a high school education. This is particularly an area for concern if people are laid off from their jobs in a time of economic recession and have fewer qualifications than other employment seekers. In Brant, 21% of those with post secondary degrees received their degree outside of Canada.

> *"There certainly are parents who are very involved and very supportive of the school and we do have quite an active volunteer program that tries to recruit parents."*

Brant Public School is located in the Brant neighbourhood and has approximately 180 students. One theme that emerged during consultation with teachers and service providers was a lack of support for school from parents who had bad experiences when they were in school. For some parents, school brings back bad memories. Principal Linda Beale says, "We're certainly trying to overcome that feeling that people are afraid of the schools." To address this barrier the school often holds events such as 'Take your parent to school day.' These events usually include breakfast with several children and families in the neighbourhood attending. The event provides an opportunity for parents to see where their children spend much of their time and to see the classroom as a supportive environment.

The *Family and Schools Together* (FAST) program addresses issues around parenting. This program has been successful in the community. The program teaches family strategies and gives parents a chance to talk to other parents. The program supervisor describes the types of behaviours that are reinforced in the program, "One of the powerful things about FAST at the end and throughout is that we give affirmations about them as parents, and that they do have ability, and that they are doing good things for their children." In order for parents to give more to their children they have to have more themselves. Many parents describe feeling beaten down, feeling hopeless, that they don't have capacity, are looked down on, are unappreciated. This program aims to empower parents to make good choices for their families.

Another support in the community is the after school program which is offered at the neighbourhood group. This program runs four days a week for young children and two days a week for youth.

Immigrant and Visible Minority Populations

The immigrant population in Brant neighbourhood is 18.7% which is lower than the rate of immigrants in the city of Guelph as a whole at 21%. The population of recent immigrants is 2.2% of the total population of the neighbourhood. Even with a low percentage of immigrants, Brant is

in the top quintile for its population of individuals who have no knowledge of English or French (1.5%). In total, 10.6% of Brant residents describe themselves as being a visible minority. Often new immigrants will stay only for specific period of time before moving on as their economic situation improves.

Community Social Support

As previously mentioned, Brant neighbourhood is located on the edge of the city of Guelph and transportation has been identified as an issue for many residents. In addition to this, many of the essential programs, services, shops and recreation facilities are located outside of the neighbourhood. Despite this, the neighbourhood group and involved residents have brought a number of programs to the neighbourhood such as Zumba, yoga, babysitting training courses, community garden and a Mother Goose program for young children, which have all been successful in the neighbourhood.

"Community gardens are about more than growing fresh local food; they bring people together, build community, engage youth, and provide an opportunity for education and cultural exchange and a collaborative effort."

A community garden at Brant Public School has been a success in the neighbourhood. A former community development worker says the program is successful because it's a collaborative effort, "We started with the children's community garden because the kids were really driving it, then adults would join, and soon we saw a lot of positive results from those kids who had been involved." Participants in the garden report very little vandalism and a huge sense of pride from children and families that participate. New Life Church was identified as a huge asset in this community. They also provide programs where a family can go and cook at a collective kitchen or get food for a very small cost.

A challenge identified by both staff and residents of this community was staff turnover and trust. The lack of a consistent support person has created challenges for consistent programming and for families trying to access formal social support. Another challenge that was identified was the lack of community space. The community finds the lack of appropriate space frustrating and feels it's because they live in this neighbourhood that they are provided with less than adequate spaces. As one service provider states, "They [the community] are expected to go into a room that is really horrible and make do. It's not even designed with children in mind."

Many people from the community recognize that being located at the school has really helped the community build on its assets. They feel it is a neutral space and can be compared to a hub. Brant, for a long time, has hoped to be able to build a community hub similar to the Onward

Willow model. As much as possible it's a priority to build the hub through a community process, rather than have it led by one agency or organization. In order to do so, there needs to be a process designed that supports community participation so all voices tell their stories in ways that gives them something back**.**

Housing

Brant is a diverse community and has experienced a lot of change in the last generation. New housing developments are emerging north of Woodlawn and over 6.3% of homes in the community were built between 2001 and 2006. Nearly half (45.5%) of homes in Brant are rental dwellings and a number of Wellington County housing projects are located in the community. Among all households, 27% spend 30% or more of their income on rent or house payments. In this neighbourhood, 14.4% of residents moved in the last year, an indicator of social risk for the neighbourhood (Report Card, 2009).

> *"There are two types of housing communities: neighbourhoods that have buildings without elevator access, usually 3 or 4 stories high, very noisy; and then there are housing units that people don't want to leave, with front and back yards and garages. No one is living on top of each other, so this produces a real community where turnover is very slow."*

The high rotation of people through the neighbourhood was discussed in community consultations, and a trend identified was that as families start to do better financially, they move out of the neighbourhood because they don't want to pay market rent for a housing unit. Another reason for outward rotation from the neighbourhood is due to children growing up and leaving home which results in the remaining family members having to downsize according to social housing rules. This cycle was described by a community member, "You'll have this boom of a lot of younger children and families moving into the housing units. They'll grow up and move out. So there's the one cycle that is people getting into better financial situation and then moving out. Then there's the other cycle, the family life cycle of being moved out."

Healthy Child Development

In the Brant neighbourhood, data for EDI is not available on its own due to the small number of senior kindergarten children. EDI data for the Brant and Waverly neighbourhoods are combined in order to maintain confidentiality of individuals and to maintain the validity and reliability of the data.

In Brant/Waverly, 25.7% of senior kindergarten children are vulnerable in two or more domains of the Early Development Instrument. This is an increase from 2006 when the rate was 18.1%. Of the four priority neighbourhoods in Guelph, the highest rate of children vulnerable in the social competence domain is in Brant/Waverly (29.7%). A high percentage of children are also vulnerable in the domain of physical health and well-being at 27.0%. The specific sub-areas from the EDI in which some children from these neighbourhoods struggle are communication skills and aggressive, hyper-active and inattentive behaviours.

> *"Give the children something to do...If we can encourage people to dream and stay in school and become educated in something they like to do ...then we can somehow break the cycle of going around and around."*

Children in Brant should have access to increased supports and services that will provide them with the same opportunities as other children in the city of Guelph.

Two Rivers

Geography and Demographics

The Two Rivers neighbourhood in Guelph is a smaller neighbourhood, at 2 square kilometres in area. It has a population of 3,780. Two Rivers is a neighbourhood of older families with over 63% of the population being adults ages 25 to 64. There are 1,005 families living in the Two Rivers neighbourhood of which 22.9% are lone parent families; belonging to the highest quintile in the WDG area. Seniors 65 and older make up 11.8% and children under 14 years old make up 15.5% of the neighbourhood population which is in the lowest quintile for the city of Guelph.

The Two Rivers neighbourhood, with a history rooted in immigration from Italy and Ireland, has the lowest current immigration rate in the city with only 0.5% of residents new to Canada in the past 5 years. Other than English, Italian and Polish are the two most common languages spoken most often at home. It is a close knit community as a member of the community describes, "A lot of people know each other, especially if they have kids."

The unique culture in this neighbourhood is one many residents are proud of, as one person stated, "If Guelph is the granola capital of the world, the ward is the granola capital of Guelph." This community is home to many artists, and it's not uncommon to see chickens roaming in backyards with big gardens. The community is set up in such a way that old homes with small front yards that are close together help contribute to the sense of community that people feel and enjoy.

Income and Employment

In the Two Rivers neighbourhood, 19.8% of all households are considered to be low income according to the Low Income Measure after tax. This is the neighbourhood with the highest rate of low income households in the City of Guelph. The percentage of children who are under 6 years of age growing up in low income homes is also high at 11.6%. The unemployment rate in this neighbourhood is the second highest in the city at 5.8%.

For families living in the Two Rivers neighbourhood, there can be many social, physical, financial and other barriers to pursuing a life with the highest level of health. Poverty is a huge issue in the neighbourhood which can cause other challenges for families. Despite these challenges, consultations with the community revealed stories about neighbours helping neighbours; informal childcare arrangements, food sharing and neighbours helping each other out with transportation.

> *"The economy is on the decline in this neighbourhood as businesses are up for sale and moving out."*

The economic landscape has changed. In the past this neighbourhood prospered. A member of the community described the neighbourhood as one that used to have it all with access to recreation, industry and retail.

Education

In the Two Rivers neighbourhood 19.4% of adults have not completed their high school education and 22% of adults have completed high school as their highest level of education. However 47% of adults in this neighbourhood have gone on to complete post secondary education. The 2007 needs assessment conducted in Two Rivers highlighted that low educational attainment levels in the neighbourhood are leading people to take low or minimum wage jobs in the fast food industry outside of the neighbourhood (SNEF, 2010). In this neighbourhood, 3.5% of the total population aged 25 to 64 years with post-secondary education graduated outside of Canada.

> *"The kids need consistency from caring adults. Free programs would help...having someone plugged into something structured and not just hanging out."*

EDI scores for Two Rivers are combined with St. George's Park for validity and confidentiality reasons. In this area, 28.1% of senior kindergarten children are vulnerable in two or more EDI domains. This is an increase from 2006 when the rate was 22.2%. In the domain of physical health and well-being, 29.8% of children are vulnerable, again an increase from 23.6% in 2006. Sub-domains among SK children that showed elevated percentages

include: gross and fine motor skills, physical independence, pro-social and helping behaviour, aggressive and hyper-active behaviour communication skills, and all sub-domains of language and cognition.

Immigrant and Visible Minority Populations

The history of the Two Rivers neighbourhood is rooted in immigration from Italy and the United Kingdom. Current immigration and recent immigration rates in Two Rivers are low at 12.3% and 0.5% respectively. Eight of nine immigrants that live in the neighbourhood came to Canada over 20 years ago (SNEF, 2010). In this neighbourhood, 5% of people describe themselves as a visible minority while less than 1% of the population has no knowledge of English or French.

Community Social Support

The neighbourhood groups offer support and strength to community members with food cupboards and clothing closets. Camps and after school programs for children are offered at different schools. Service providers believe the structure of the neighbourhood affects what programs are offered as the neighbourhood is well established with a large senior population. Other strengths include a school within walking distance but this school is scheduled to close in another year. Another concern is that there is not an assigned high school in the neighbourhood.

> *There are not many options when finances are a problem, there is housing that is geared to income... but there are not a lot of supports or resources really targeted to the neighbourhood."*

Housing

The percentage of rental dwellings in the Two Rivers neighbourhood is the highest in the city at 87%. It also has the highest percentage of the population paying more than 30% of their income on housing at 34%. In the Two Rivers neighbourhood 20% of residents moved within the last year. This may be partly due to the many university students that live in the area. Low incomes in the neighbourhood are driven by the high proportion of single-parent families and low education levels.

West Willow Woods

Geography and Demographics

The West Willow Woods neighbourhood is located in the north-west part of Guelph. It is 3.6 square kilometres in area and has a population of 9,715, which is 3.8% of the total population of Wellington-Dufferin-Guelph. West Willow Woods is home to 2,815 families and has one of the lowest proportions of seniors compared to other neighbourhoods and municipalities in WDG. The percentage of lone parent families is 19.4%, which is higher than in the city of Guelph (16.0%). Children under the age of 14 make up 21.9% of the neighbourhood's population.

West Willow Woods is a diverse community in terms of language, race, culture, ethnicity, religion, and income. It is located west of the busy Hanlon expressway which means that spatially, the Hanlon creates an island and physically isolates the neighbourhood from the rest of the city. As a result, this community has its own identity often described as living in 'west Guelph'.

> *"It's about neighbours and how do you change that culture...it's about having a need now, a need later and how we can work together through things."*

Substantial effort and resources have been put into increasing engagement and participation in the community. The active neighbourhood group, schools, churches, recreation centres and the active volunteer base in the neighbourhood have created many opportunities. Quarterly community events engage members of the community to participate in visioning and creating social opportunities for families, enabling the community to gage its needs and set priorities.

Income and Employment Status

In the West Willow Woods neighbourhood the unemployment rate is 5.1% which is relatively high compared to other areas in the city of Guelph. The unemployment rate for women in West Willow Woods is 6.2%. In this neighbourhood 10.5% of families are living with low income according to the LIM after tax; this number is close to average for the city of Guelph as a whole. However, more children under 6 years old (13.6%) are living in low income households in the neighbourhood compared to the rest of the city. Many families (19.4%) in the neighbourhood are lone parent families and of these a large percentage are low income according to the LIM after tax (30.6%). This puts the percentage of low income lone parent families in the top quintile for WDG.

Education

Only 11% of adults in West Willow Woods have not completed their high school education and over 50% have obtained a post-secondary education. In this neighbourhood, 22.4% of the total population aged 25 to 64 years with post-secondary qualification received their education outside

Canada. Despite this, the rate of unemployment in the neighbourhood for individuals age 25 and older is in the top quintile for WDG at 5%.

A number of barriers for youth to complete high school were identified by youth, youth workers, parents and teachers in the neighbourhood. Some of these barriers arise early in a child's educational pathway, such as not having a lunch to bring to school. Food and income insecurity that results in children not having a lunch can lead to a phone call home by a teacher which is discouraging for parents who may then decide to keep their kids home from school on days that they don't have food to send to school. A local community member explains, "There are kids in our community that don't go to school because they don't have lunch. If those kids aren't going to school now then they aren't going to have the education they need to have a job and a sustainable life by themselves."

Another identified barrier was that youth don't believe in themselves or their potential. This can be fuelled by a lack of role models in the circle of people that a particular child or youth is surrounded by. A youth worker explains, "What we hear in the stories from the youth is -well my brother dropped out of school and he's going to go work with my mother at Tim Hortons on the night shift doing whatever- and these kids see that as their destination because there is no other alternative." An attitude that is prevalent among some youth in the community is self-deprecating. People working with youth in the community believe that more resources and support for creating opportunities for youth is one of the keys to their success. Additionally, the relationship and the rapport they build with mentors can also make a big difference.

> *…kids in this area don't have access to sports and space is an issue…it's very different socioeconomically...and we need time to develop their skills."*

Immigrants and Visible Minority Populations

West Willow Woods has the second highest rate of immigrants in the city of Guelph at 28.5% and also a high rate of immigrants who have come to Canada in the past 5 years (5.7%). As a result, 17% of people in the neighbourhood speak a language other than English most often at home and 2.2% of the population have no knowledge of English or French. Language barriers are evident in schools where some children first come to school unable to speak English. West Willow Woods is also potentially an emerging entrance community for new Canadians with an above average number of people moving to the neighbourhood from outside of Canada in the last year (1.3%). West Willow Woods is also home to one of the biggest visible minority populations in the city of Guelph (26.1%).

Community Social Support

The West Willow Woods neighbourhood is one of neighbourhoods with the highest rates of young people in the city of Guelph but programs and opportunities for this group are in short supply. Structured and unstructured youth programs with activities like cooking, discussions and sports were identified needs in the community. Residents here report challenges with having consistent staff, building trust, and rapport with youth. In trying to develop a sense of community among youth, one youth leader explains that social cohesion is limited by the fact that "all of the kids go to different high schools. There is not even a high school here in the area that the kids go to, to gain a certain friend base. Your friends can be scattered from all over." Another challenge is the limited connection to green space. A lack of bike paths, walking trails, community space and transportation is an issue that has been identified by the community.

As in many other neighbourhoods in Guelph, a lack of community space is a challenge in West Willow Woods. A neighbourhood support worker emphasized "space is a big huge need." Agencies looking to provide programming in this neighbourhood also have trouble finding space.

This community strongly values its partnerships and recognizes that partnerships allow them to make programs and services accessible. Excellent partnerships exist between the local church, schools and neighbourhood group. Compassionate, engaged community leaders and employees of social service organizations allow for strong social support networks. Continuous efforts are made to apply to various funding opportunities including community grants, that if accepted, will allow the neighbourhood group children to access summer camps and activities such as swimming, baseball and basketball.

Housing

Nearly one-third of homes in West Willow Woods are rental dwellings and 21% of residents spend 30% or more of their income on housing. Of all residents in this community, 17% have moved in the past year, which is an indicator of social risk. In the West Willow Woods neighbourhood, 9.8% of homes were built between 2001 and 2006.

In the neighbourhood, there is a mixture of families and seniors living in social or subsidized housing. Guelph non-profit housing is mostly for families, with only one building available for seniors. There is a slightly higher than average number of homes in high rise apartments (15.6%) (SNEF, 2010).

> *"The relationship with public housing is a strength, a positive relationship in bringing services to those housing complexes."*

Some of the challenges faced by people who live in social housing are recognized by staff at the organization. Buildings are often four storey walk-ups without access to an elevator. Families with children living on upper floors face inconveniences. There are also obstacles to getting to bus stops and grocery stores.

Healthy Child Development

EDI scores for senior kindergarten show that 16% of children in 2009 were vulnerable in two or more domains, up from 11% in 2006. EDI scores in West Willow Woods indicate significant vulnerabilities with 16% of children receiving low physical health and well-being scores. West Willow Woods has a slightly elevated percentage of children exhibiting hyper-active and inattentive behaviours.

Youth workers in the neighbourhood agree that providing programs, activities and leadership opportunities for youth is very important because they help build experience and confidence in youth, and also help them to develop their abilities, interests and identities. A youth worker observes that if children are involved in an activity that brings them confidence and self-esteem, children are less likely to access poor habits such as smoking as they perceive smoking as a threat to their success in that particular activity.

The neighbourhood group believes that planning is an area that needs more development and stated that 'synergies' would be an added bonus so everyone could work together to put a plan in place that will be goal-oriented and sustainable.

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 Wellington, Dufferin and Guelph 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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Brant

Quick Facts about Brant

- Population: 3,010
- Percentage of total population of Wellington-Dufferin-Guelph: 1.2% Lowest
- Area: 2.3 km^2
- Located: In the City of Guelph
- Number of families: 895
- Children aged 14 years and under: 21.4%
- Seniors aged 65 years and over: 10.3%
- Population living at a different address one year ago: 21.7% Highest
- Average household income (after tax): $54,753

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 Brant

- Compared with other areas in WDG, Brant has a high percentage of:
  - Low income households
  - Lone parent families
  - Adults who did not complete high school education
  - Population with no knowledge of English or French
  - Rental dwellings

Snapshot of Social Determinants of Health in Brant

Low income families

- Low income households (Low Income Measures before tax) : 20.6% Highest
- Low income households (Low Income Measures after tax): 17.0% Highest
- Children aged 6 years and under in private households with low income after tax: 30.3% Highest

Lone parent families

- Lone parent families: 23.5% Highest
- Female-headed lone parent families among lone parent families: 76.2%
- Low income lone parent households (Low Income Measures before tax): 39.5% Highest
- Low income lone parent households (Low Income Measures after tax): 34.2% 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): 19.8% Highest
  (This statistic includes both Brant and Waverley)
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 10.6% Highest

Education

- Adults who did not complete high school education: 25.9% Highest
- Adults who completed high school as the highest education: 29.7%
- Adults who obtained post-secondary education: 32.6% Lowest
- Post-secondary education obtained outside of Canada: 20.9% Highest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.2%

Immigrant and Visible minority populations

- Immigrant population: 18.7%
- Recent immigrant population: 2.2% (or 11.6% among immigrant population)
- Visible minority population: 10.6%

Language

- Population with no knowledge of English or French: 1.5% Highest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 27.5%
- Rental dwellings: 45.5% Highest

Seniors

- Seniors living alone: 27.9%
- Population 15 years and over providing unpaid care or assistance to seniors: 18.2%

Health outcome indicators*

- Emergency department visits (all cause): 47,418 per 100,000 population
- Cardiovascular-related hospitalizations: 1,282 per 100,000 population
- Injury-related hospitalizations: 542 per 100,000 population
- Diabetes-related hospitalizations: 144 per 100,000 population
- Lung cancer-related deaths: 55 per 100,000 population

**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, Intelihealth Ontario.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Downtown/ Sunny Acres/ Old University

Quick Facts about Downtown Sunny Acres Old University

- Population: 11,500
- Percentage of total population of Wellington-Dufferin-Guelph: 4.5% Highest
- Area: 5.5 km^2
- Located: In the City of Guelph
- Number of families: 2,990
- Children aged 14 years and under: 10.5% Lowest
- Seniors aged 65 years and over: 15.6% Highest
- Population living at a different address one year ago: 21.9% Highest
- Average household income (after tax): $52,838 Lowest

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 Downtown Sunny Acres Old University

- Compared with other areas in WDG, Downtown Sunny Acres Old University has a high percentage of:
  - Low income households
  - Adults who obtained post-secondary education
  - Rental dwellings
  - Tenant- or owner-households spending 30% or more on rent/payments
  - Seniors aged 65 years and over and seniors living alone

Snapshot of Social Determinants of Health in Downtown Sunny Acres Old University

Low income families

- Low income households (Low Income Measures before tax) : 22.0% Highest
- Low income households (Low Income Measures after tax): 18.3% Highest
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 15.7%
- Female-headed lone parent families among lone parent families: 67.0% Lowest
- Low income lone parent households (Low Income Measures before tax): 22.4%
- Low income lone parent households (Low Income Measures after tax): 24.7%

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): 14.9%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 4.2% Lowest

Education

- Adults who did not complete high school education: 10.7%
- Adults who completed high school as the highest education: 20.1% Lowest
- Adults who obtained post-secondary education: 62.8% Highest
- Post-secondary education obtained outside of Canada: 15.4%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 4.0%

Immigrant and Visible minority populations

- Immigrant population: 16.9%
- Recent immigrant population: 2.6% (or 15.7% among immigrant population Highest)
- Visible minority population: 9.1%

Language

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

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 31.3% Highest
- Rental dwellings: 53.4% Highest

Seniors

- Seniors living alone: 30.2% Highest
- Population 15 years and over providing unpaid care or assistance to seniors: 17.6%

Health outcome indicators*

- Emergency department visits (all cause): 37,885 per 100,000 population
- Cardiovascular-related hospitalizations: 1,022 per 100,000 population
- Injury-related hospitalizations: 639 per 100,000 population
- Diabetes-related hospitalizations: 135 per 100,000 population
- Lung cancer-related deaths: 47 per 100,000 population

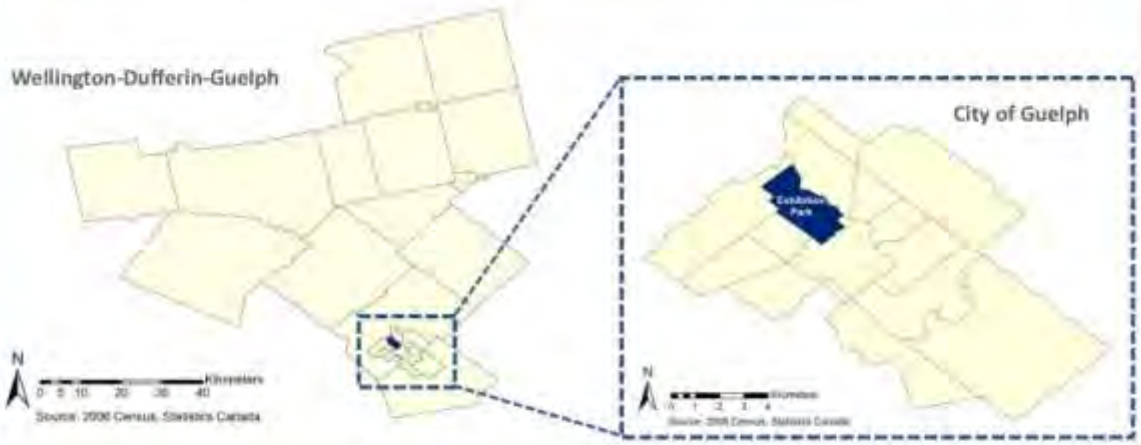
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Exhibition Park



Quick Facts about Exhibition Park

- Population: 10,645
- Percentage of total population of Wellington-Dufferin-Guelph: 4.2%
- Area: 3.7 km^2
- Located: In the City of Guelph
- Number of families: 2,915
- Children aged 14 years and under: 15.4% Lowest
- Seniors aged 65 years and over: 21.7% Highest
- Population living at a different address one year ago: 16.1%
- Average household income (after tax): $52,633 Lowest

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 Exhibition Park

- Compared with other areas in WDG, Exhibition Park has a high percentage of:
  - Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains (excluding children with special needs)
  - Adults who obtained post-secondary education
  - Unemployment rate for individuals aged 25 years and older in the labour force
  - Tenant- or owner-households spending 30% or more on rent/payments
  - Cardiovascular-, injury-, diabetes-related hospitalizations and lung cancer-related deaths

Snapshot of Social Determinants of Health in Exhibition Park

Low income families

- Low income households (Low Income Measures before tax) : 16.1%
- Low income households (Low Income Measures after tax): 12.4%
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 15.3%
- Female-headed lone parent families among lone parent families: 76.4%
- Low income lone parent households (Low Income Measures before tax): 24.7%
- Low income lone parent households (Low Income Measures after tax): 21.3%

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): 17.3% Highest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 6.7%

Education

- Adults who did not complete high school education: 10.4% Lowest
- Adults who completed high school as the highest education: 25.8%
- Adults who obtained post-secondary education: 56.8% Highest
- Post-secondary education obtained outside of Canada: 10.1%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 4.4% Highest

Immigrant and Visible minority populations

- Immigrant population: 17.2%
- Recent immigrant population: 2.2% (or 12.8% among immigrant population)
- Visible minority population: 5.6%

Language

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

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 29.5% Highest
- Rental dwellings: 41.8% Highest

Seniors

- Seniors living alone: 37.3% Highest
- Population 15 years and over providing unpaid care or assistance to seniors: 18.9%

Health outcome indicators*

- Emergency department visits (all cause): 40,508 per 100,000 population
- Cardiovascular-related hospitalizations: 1,628 per 100,000 population Highest
- Injury-related hospitalizations: 1,035 per 100,000 population Highest
- Diabetes-related hospitalizations: 191 per 100,000 population Highest
- Lung cancer-related deaths: 66 per 100,000 population Highest

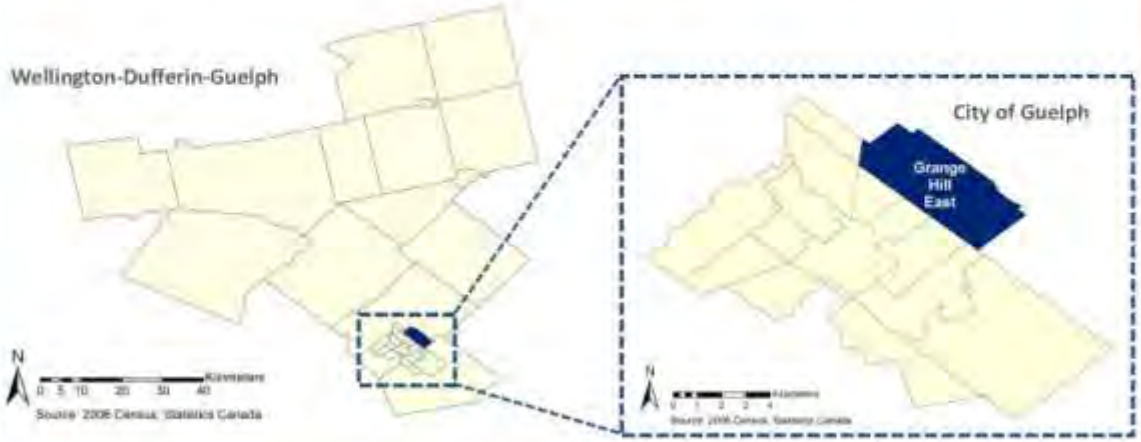
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Grange Hill East



Quick Facts about Grange Hill East

- Population: 10,875
- Percentage of total population of Wellington-Dufferin-Guelph: 4.3%
- Area: 12.1 km^2
- Located: In the City of Guelph
- Number of families: 3,175
- Children aged 14 years and under: 23.6% Highest
- Seniors aged 65 years and over: 6.5% Lowest
- Population living at a different address one year ago: 16.3%
- Average household income (after tax): $62,697

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 Grange Hill East

- Compared with other areas in WDG, Grant Hill East has a high percentage of:
  - Children aged 14 years and under
  - Female-headed lone parent families among lone parent families
  - Population 15 years and over providing more than 60 hours of unpaid childcare a week
- Compared with other areas in WDG, Grant Hill East has a low percentage of:
  - Seniors aged 65 years and over
  - Lung cancer-related deaths

Snapshot of Social Determinants of Health in Grange Hill East

Low income families

- Low income households (Low Income Measures before tax) : 10.7%
- Low income households (Low Income Measures after tax): 9.7%
- Children aged 6 years and under in private households with low income after tax: 6.1%

Lone parent families

- Lone parent families: 16.5%
- Female-headed lone parent families among lone parent families: 86.7% Highest
- Low income lone parent households (Low Income Measures before tax): 26.1%
- Low income lone parent households (Low Income Measures after tax): 22.8%

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): 14.8%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 10.6% Highest

Education

- Adults who did not complete high school education: 12.3%
- Adults who completed high school as the highest education: 29.4%
- Adults who obtained post-secondary education: 48.1%
- Post-secondary education obtained outside of Canada: 12.8%

Employment

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

Immigrant and Visible minority populations

- Immigrant population: 18.5%
- Recent immigrant population: 2.3% (or 12.4% among immigrant population)
- Visible minority population: 9.9%

Language

- Population with no knowledge of English or French: 0.7%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 23.3%
- Rental dwellings: 11.7%

Seniors

- Seniors living alone: 25.4%
- Population 15 years and over providing unpaid care or assistance to seniors: 17.1%

Health outcome indicators*

- Emergency department visits (all cause): 39,408 per 100,000 population
- Cardiovascular-related hospitalizations: 638 per 100,000 population
- Injury-related hospitalizations: 414 per 100,000 population
- Diabetes-related hospitalizations: 83 per 100,000 population
- Lung cancer-related deaths: 21 per 100,000 population Lowest

**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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Hanlon Creek/ Hales Barton

Quick Facts about Hanlon Creek Hales Barton

- Population: 14,020
- Percentage of total population of Wellington-Dufferin-Guelph: 5.5% Highest
- Area: 6.7 km^2
- Located: In the City of Guelph
- Number of families: 3,915
- Children aged 14 years and under: 16.7% Lowest
- Seniors aged 65 years and over: 12.8%
- Population living at a different address one year ago: 14.8%
- Average household income (after tax): $66,591

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 Hanlon Creek Hales Barton

- Compared with other areas in WDG, Hanlon Creek Hales Barton has a high percentage of:
  - Children aged 6 years and under in private households with low income
  - Low income lone parent households
  - Adults who obtained post-secondary education
  - Post-secondary education obtained outside of Canada
  - Immigrant and visible minority populations

Snapshot of Social Determinants of Health in Hanlon Creek Hales Barton

Low income families

- Low income households (Low Income Measures before tax) : 14.1%
- Low income households (Low Income Measures after tax): 12.1%
- Children aged 6 years and under in private households with low income after tax: 8.9% Highest

Lone parent families

- Lone parent families: 15.1%
- Female-headed lone parent families among lone parent families: 88.1% Highest
- Low income lone parent households (Low Income Measures before tax): 38.5% Highest
- Low income lone parent households (Low Income Measures after tax): 34.9% 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): 10.0% Lowest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 5.1% Lowest

Education

- Adults who did not complete high school education: 7.0% Lowest
- Adults who completed high school as the highest education: 21.8% Lowest
- Adults who obtained post-secondary education: 64.1% Highest
- Post-secondary education obtained outside of Canada: 17.1% Highest

Employment

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

Immigrant and Visible minority populations

- Immigrant population: 21.5% Highest
- Recent immigrant population: 3.2% Highest (or 15% among immigrant population)
- Visible minority population: 14.9% Highest

Language

- Population with no knowledge of English or French: 0.7%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 25.2%
- Rental dwellings: 25.1%

Seniors

- Seniors living alone: 21.4%
- Population 15 years and over providing unpaid care or assistance to seniors: 17.6%

Health outcome indicators*

- Emergency department visits (all cause): 33,121 per 100,000 population
- Cardiovascular-related hospitalizations: 969 per 100,000 population
- Injury-related hospitalizations: 492 per 100,000 population
- Diabetes-related hospitalizations: 84 per 100,000 population
- Lung cancer-related deaths: 48 per 100,000 population

**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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Kortright Hills

Quick Facts about Kortright Hills

- Population: 7,060
- Percentage of total population of Wellington-Dufferin-Guelph: 2.8%
- Area: 6.7 km^2
- Located: In the City of Guelph
- Number of families: 2,015
- Children aged 14 years and under: 19.2%
- Seniors aged 65 years and over: 7.9% Lowest
- Population living at a different address one year ago: 10.1% Lowest
- Average household income (after tax): $82,928 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 Kortright Hills

- Compared with other areas in WDG, Kortright Hills has a high percentage of:
  - Immigrant and visible minority populations
  - Unemployment rate for individuals aged 25 years and older in the labour force
- Compared with other areas in WDG, Kortright Hills has a low percentage of:
  - Low income households
  - Adults who did not complete high school education or completed high school only

Snapshot of Social Determinants of Health in Kortright Hills

Low income families

- Low income households (Low Income Measures before tax) : 9.0% Lowest
- Low income households (Low Income Measures after tax): 6.9% Lowest
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 9.9%
- Female-headed lone parent families among lone parent families: 77.5%
- Low income lone parent households (Low Income Measures before tax): 5.6% Lowest
- Low income lone parent households (Low Income Measures after tax): 5.6% 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): 15.4%
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 5.8% Lowest

Education

- Adults who did not complete high school education: 6.3% Lowest
- Adults who completed high school as the highest education: 18.7% Lowest
- Adults who obtained post-secondary education: 68.6% Highest
- Post-secondary education obtained outside of Canada: 15.5%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 4.5% Highest

Immigrant and Visible minority populations

- Immigrant population: 24.1% Highest
- Recent immigrant population: 2.1% (or 8.5% among immigrant population)
- Visible minority population: 14.2% Highest

Language

- Population with no knowledge of English or French: 1.0%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 18.2% Lowest
- Rental dwellings: 11.7%

Seniors

- Seniors living alone: 9.6% Lowest
- Population 15 years and over providing unpaid care or assistance to seniors: 21.5% Highest

Health outcome indicators*

- Emergency department visits (all cause): 26,714 per 100,000 population Lowest
- Cardiovascular-related hospitalizations: 629 per 100,000 population
- Injury-related hospitalizations: 358 per 100,000 population
- Diabetes-related hospitalizations: 67 per 100,000 population Lowest
- Lung cancer-related deaths: 38 per 100,000 population

**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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Onward Willow

Quick Facts about Onward Willow

- Population: 7,280
- Percentage of total population of Wellington-Dufferin-Guelph: 2.9%
- Area: 2.1 km^2
- Located: In the City of Guelph
- Number of families: 2,030
- Children aged 14 years and under: 18.2%
- Seniors aged 65 years and over: 10.8%
- Population living at a different address one year ago: 20.5% Highest
- Average household income (after tax): $44,846 Lowest

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 Onward Willow

- Compared with other areas in WDG, Onward Willow has a high percentage of:
  - Low income households and lone parent families
  - Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains
  - Unemployment rate for individuals in the labour force aged 25 years and older
  - Immigrant and visible minority populations

Snapshot of Social Determinants of Health in Onward Willow

Low income families

- Low income households (Low Income Measures before tax): 22.6% Highest
- Low income households (Low Income Measures after tax): 19.1% Highest
- Children aged 6 years and under in private households with low income after tax: 7.0%

Lone parent families

- Lone parent families: 23.9% Highest
- Female-headed lone parent families among lone parent families: 81.4% Highest
- Low income lone parent households (Low Income Measures before tax): 36.8% Highest
- Low income lone parent households (Low Income Measures after tax): 33.7% 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): 20.0% Highest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 7.0%

Education

- Adults who did not complete high school education: 23.1% Highest
- Adults who completed high school as the highest education: 33.7% Highest
- Adults who obtained post-secondary education: 35.1%
- Post-secondary education obtained outside of Canada: 30.6% Highest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 6.5% Highest

Immigrant and Visible minority populations

- Immigrant population: 27.5% Highest
- Recent immigrant population: 10.3% (or 37.4% among immigrant population) Highest
- Visible minority population: 23.5% Highest

Language

- Population with no knowledge of English or French: 3.3% Highest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 26.9%
- Rental dwellings: 57.1% Highest

Seniors

- Seniors living alone: 28.2%
- Population 15 years and over providing unpaid care or assistance to seniors: 13.7% Lowest

Health outcome indicators*

- Emergency department visits (all cause): 46,354 per 100,000 population
- Cardiovascular-related hospitalizations: 887 per 100,000 population
- Injury-related hospitalizations: 552 per 100,000 population
- Diabetes-related hospitalizations: 110 per 100,000 population
- Lung cancer-related deaths: 46 per 100,000 population

**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, Intelihealth Ontario.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Parkwood Gardens

Quick Facts about Parkwood Gardens

- Population: 9,830
- Percentage of total population of Wellington-Dufferin-Guelph: 3.9%
- Area: 3.8 km^2
- Located: In the City of Guelph
- Number of families: 2,675
- Children aged 14 years and under: 24.1% Highest
- Seniors aged 65 years and over: 4.3% Lowest
- Population living at a different address one year ago: 11.1%
- Average household income (after tax): $72,910

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 Parkwood Gardens

- Compared with other areas in WDG, Parkwood Gardens has a high percentage of:
  - Immigrant and visible minority populations
  - Population with no knowledge of English or French
- Compared with other areas in WDG, Parkwood Gardens has a low percentage of:
  - Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains
  - Cardiovascular-, injury-, and diabetes-related hospitalizations, lung cancer-related deaths

Snapshot of Social Determinants of Health in Parkwood Gardens

Low income families

- Low income households (Low Income Measures before tax) : 10.0%
- Low income households (Low Income Measures after tax): 8.7%
- Children aged 6 years and under in private households with low income after tax: 3.4%

Lone parent families

- Lone parent families: 13.1%
- Female-headed lone parent families among lone parent families: 78.6%
- Low income lone parent households (Low Income Measures before tax): 32.8%
- Low income lone parent households (Low Income Measures after tax): 19.0%

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): 8.8% Lowest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 7.9%

Education

- Adults who did not complete high school education: 14.4%
- Adults who completed high school as the highest education: 31.3%
- Adults who obtained post-secondary education: 47.5%
- Post-secondary education obtained outside of Canada: 20.6% Highest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.6%

Immigrant and Visible minority populations

- Immigrant population: 29.2% Highest
- Recent immigrant population: 4.6% Highest (or 15.7% among immigrant population)
- Visible minority population: 26.9% Highest

Language

- Population with no knowledge of English or French: 3.0% Highest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 18.2% Lowest
- Rental dwellings: 14.8%

Seniors

- Seniors living alone: 13.3% Lowest
- Population 15 years and over providing unpaid care or assistance to seniors: 16.2% Lowest

Health outcome indicators*

- Emergency department visits (all cause): 28,035 per 100,000 population Lowest
- Cardiovascular-related hospitalizations: 463 per 100,000 population Lowest
- Injury-related hospitalizations: 281 per 100,000 population Lowest
- Diabetes-related hospitalizations: 72 per 100,000 population
- Lung cancer-related deaths: 31 per 100,000 population Lowest

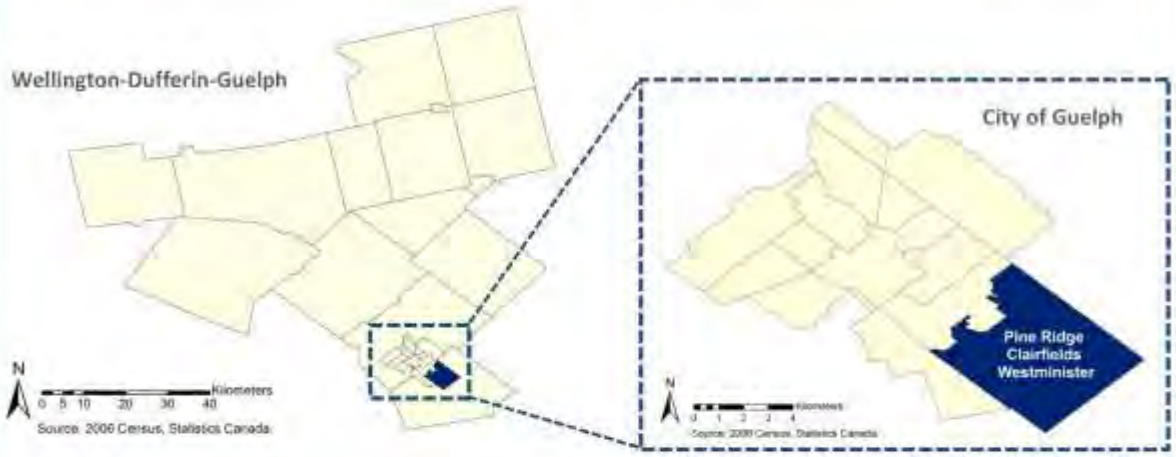
**Average rates over three fiscal years (2007-2009) for emergency department visits and hospitalization rates, and over three calendar years (2005-2007) for mortality rate.*

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, Intelihealth Ontario.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Pine Ridge/ Clairfields/ Westminster Woods



Quick Facts about Pine Ridge Clairfields Westminster Woods

- Population: 11,860
- Percentage of total population of Wellington-Dufferin-Guelph: 4.7% Highest
- Area: 19.9 km^2
- Located: In the City of Guelph
- Number of families: 3,430
- Children aged 14 years and under: 24.2% Highest
- Seniors aged 65 years and over: 8.9%
- Population living at a different address one year ago: 18.7% Highest
- Average household income (after tax): $87,341 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 Pine Ridge Clairfields Westminster Woods

- Compared with other areas in WDG, Pine Ridge Clairfields Westminster Woods has a high percentage of:
  - Immigrant and visible minority populations
  - Population living at a different address one year ago
- Compared with other areas in WDG, Pine Ridge Clairfields Westminster Woods has a low percentage of:
  - Low income households
  - Adults who did not complete high school education or completed high school only

Snapshot of Social Determinants of Health in Pine Ridge Clairfields Westminster Woods

Low income families

- Low income households (Low Income Measures before tax) : 5.3% Lowest
- Low income households (Low Income Measures after tax): 4.6% Lowest
- Children aged 6 years and under in private households with low income after tax: 1.8%

Lone parent families

- Lone parent families: 8.3% Lowest
- Female-headed lone parent families among lone parent families: 84.2% Highest
- Low income lone parent households (Low Income Measures before tax): 10.4% Lowest
- Low income lone parent households (Low Income Measures after tax): 8.3% 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): 6.5% Lowest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 8.9%

Education

- Adults who did not complete high school education: 5.6% Lowest
- Adults who completed high school as the highest education: 19.0% Lowest
- Adults who obtained post-secondary education: 69.6% Highest
- Post-secondary education obtained outside of Canada: 18.6% Highest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 2.6%

Immigrant and Visible minority populations

- Immigrant population: 23.1% Highest
- Recent immigrant population: 3.7% (or 16.1% among immigrant population) Highest
- Visible minority population: 17.3% Highest

Language

- Population with no knowledge of English or French: 0.7%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 20.3%
- Rental dwellings: 6.2% Lowest

Seniors

- Seniors living alone: 14.0%
- Population 15 years and over providing unpaid care or assistance to seniors: 17.1%

Health outcome indicators*

- Emergency department visits (all cause): 32,161 per 100,000 population
- Cardiovascular-related hospitalizations: 668 per 100,000 population
- Injury-related hospitalizations: 432 per 100,000 population
- Diabetes-related hospitalizations: 68 per 100,000 population
- Lung cancer-related deaths: 17 per 100,000 population Lowest

**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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

St. George's Park

Quick Facts about St. George's Park

- Population: 5,000
- Percentage of total population of Wellington-Dufferin-Guelph: 2.0%
- Area: 2 km^2
- Located: In the City of Guelph
- Number of families: 1,465
- Children aged 14 years and under: 15.0% Lowest
- Seniors aged 65 years and over: 20.4% Highest
- Population living at a different address one year ago: 12.1%
- Average household income (after tax): $56,222

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 St. George's Park

- Compared with other areas in WDG, St. George's Park has a high percentage of:
  - Lone parent families
  - Rental dwellings
  - Cardiovascular- and diabetes-related hospitalizations
- Compared with other areas in WDG, St. George's Park has a low percentage of:
  - Lone parent families and low income lone parent households

Snapshot of Social Determinants of Health in St. George's Park

Low income families

- Low income households (Low Income Measures before tax) : 15.6%
- Low income households (Low Income Measures after tax): 11.8%
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 18.1% Highest
- Female-headed lone parent families among lone parent families: 77.4%
- Low income lone parent households (Low Income Measures before tax): 16.0% Lowest
- Low income lone parent households (Low Income Measures after tax): 4.0% 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): 22.2% Highest
  (This statistic includes both St. George's Park and Two Rivers)
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 4.5% Lowest

Education

- Adults who did not complete high school education: 16.0%
- Adults who completed high school as the highest education: 27.2%
- Adults who obtained post-secondary education: 48.9%
- Post-secondary education obtained outside of Canada: 8.7%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 3.7%

Immigrant and Visible minority populations

- Immigrant population: 14.7%
- Recent immigrant population: 1.1% (or 7.5% among immigrant population)
- Visible minority population: 3.0%

Language

- Population with no knowledge of English or French: 0.5%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 22.6%
- Rental dwellings: 58.7% Highest

Seniors

- Seniors living alone: 27.5%
- Population 15 years and over providing unpaid care or assistance to seniors: 21.8% Highest

Health outcome indicators*

- Emergency department visits (all cause): 38,067 per 100,000 population
- Cardiovascular-related hospitalizations: 1,540 per 100,000 population Highest
- Injury-related hospitalizations: 580 per 100,000 population
- Diabetes-related hospitalizations: 160 per 100,000 population Highest
- Lung cancer-related deaths: 60 per 100,000 population

**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

Public Health

Two Rivers

Quick Facts about Two Rivers

- Population: 3,785
- Percentage of total population of Wellington-Dufferin-Guelph: 1.5% Lowest
- Area: 2.0 km^2
- Located: In the City of Guelph
- Number of families: 1,005
- Children aged 14 years and under: 15.5% Lowest
- Seniors aged 65 years and over: 11.8%
- Population living at a different address one year ago: 20.3% Highest
- Average household income (after tax): $43,984 Lowest

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 Two Rivers

- Compared with other areas in WDG, Two Rivers has a high percentage of:
  - Low income households
  - Lone parent families
  - Unemployment rate for individuals aged 25 years and older in the labour force
  - Rental dwellings
  - Tenant- or owner-households spending 30% or more on rent/payments
  - Seniors living alone

Snapshot of Social Determinants of Health in Two Rivers

Low income families

- Low income households (Low Income Measures before tax) : 24.9% Highest
- Low income households (Low Income Measures after tax): 19.8% Highest
- Children aged 6 years and under in private households with low income after tax: 11.6% Highest

Two Rivers

Lone parent families

- Lone parent families: 22.9% Highest
- Female-headed lone parent families among lone parent families: 76.1%
- Low income lone parent households (Low Income Measures before tax): 33.3%
- Low income lone parent households (Low Income Measures after tax): 33.3% 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): 22.2% Highest
  (This statistic includes both Two Rivers and St. George's Park)
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 8.4%

Education

- Adults who did not complete high school education: 19.4%
- Adults who completed high school as the highest education: 22.3% Lowest
- Adults who obtained post-secondary education: 47.3%
- Post-secondary education obtained outside of Canada: 3.5% Lowest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 5.8% Highest

Immigrant and Visible minority populations

- Immigrant population: 12.3%
- Recent immigrant population: 0.5% (or 4.3% among immigrant population) Lowest
- Visible minority population: 4.9%

Language

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

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 33.7% Highest
- Rental dwellings: 86.9% Highest

Seniors

- Seniors living alone: 33.7% Highest
- Population 15 years and over providing unpaid care or assistance to seniors: 16.1% Lowest

Health outcome indicators*

- Emergency department visits (all cause): 43,333 per 100,000 population
- Cardiovascular-related hospitalizations: 1,023 per 100,000 population
- Injury-related hospitalizations: 626 per 100,000 population
- Diabetes-related hospitalizations: 123 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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

Waverley

Quick Facts about Waverley

- Population: 9,010
- Percentage of total population of Wellington-Dufferin-Guelph: 3.6%
- Area: 4.7 km^2
- Located: In the City of Guelph
- Number of families: 2,675
- Children aged 14 years and under: 14.6% Lowest
- Seniors aged 65 years and over: 19.7% Highest
- Population living at a different address one year ago: 12.0%
- Average household income (after tax): $59,752

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 Waverley

- Compared with other areas in WDG, Waverley has a high percentage of:
  - Senior kindergarten children who were vulnerable in two or more Early Development Instrument (EDI) domains
  - Cardiovascular- and diabetes-related hospitalizations
- Compared with other areas in WDG, Waverley has a low percentage of:
  - Recent immigrant populations
  - Unemployment rate for individuals aged 25 years and older in the labour force

Snapshot of Social Determinants of Health in Waverley

Low income families

- Low income households (Low Income Measures before tax) : 17.0%
- Low income households (Low Income Measures after tax): 13.3%
- Children aged 6 years and under in private households with low income after tax: 0.0% Lowest

Lone parent families

- Lone parent families: 14.4%
- Female-headed lone parent families among lone parent families: 74.0%
- Low income lone parent households (Low Income Measures before tax): 25.7%
- Low income lone parent households (Low Income Measures after tax): 27.0%

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): 19.8% Highest
  (This statistic includes both Brant and Waverley)
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 7.9%

Education

- Adults who did not complete high school education: 14.2%
- Adults who completed high school as the highest education: 29.7%
- Adults who obtained post-secondary education: 45.8%
- Post-secondary education obtained outside of Canada: 8.5%

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 2.0% Lowest

Immigrant and Visible minority populations

- Immigrant population: 15.0%
- Recent immigrant population: 0.3% (or 2.2% among immigrant population) Lowest
- Visible minority population: 3.3%

Language

- Population with no knowledge of English or French: 0.7%

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 24.6%
- Rental dwellings: 24.7%

Seniors

- Seniors living alone: 25.6%
- Population 15 years and over providing unpaid care or assistance to seniors: 20.7%

Health outcome indicators*

- Emergency department visits (all cause): 42,906 per 100,000 population
- Cardiovascular-related hospitalizations: 1,534 per 100,000 population Highest
- Injury-related hospitalizations: 873 per 100,000 population
- Diabetes-related hospitalizations: 166 per 100,000 population Highest
- Lung cancer-related deaths: 59 per 100,000 population

**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.

Public Health

Neighbourhood Profiles in Wellington-Dufferin-Guelph

West Willow Woods

Quick Facts about West Willow Woods

- Population: 9,715
- Percentage of total population of Wellington-Dufferin-Guelph: 3.8%
- Area: 3.6 km^2
- Located: In the City of Guelph
- Number of families: 2,815
- Children aged 14 years and under: 22.0%
- Seniors aged 65 years and over: 6.6% Lowest
- Population living at a different address one year ago: 17.3%
- Average household income (after tax): $67,009

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 West Willow Woods

- Compared with other areas in WDG, West Willow Woods has a high percentage of:
  - Children aged 6 years and under in private households with low income
  - Lone parent families
  - Post-secondary education obtained outside of Canada
  - Immigrant and visible minority populations
  - Population with no knowledge of English or French
  - Unemployment rate for individuals aged 25 years and older in the labour force

Snapshot of Social Determinants of Health in West Willow Woods

Low income families

- Low income households (Low Income Measures before tax): 12.9%
- Low income households (Low Income Measures after tax): 10.5%
- Children aged 6 years and under in private households with low income after tax: 13.6% Highest

Lone parent families

- Lone parent families: 19.4% Highest
- Female-headed lone parent families among lone parent families: 79.8%
- Low income lone parent households (Low Income Measures before tax): 32.7%
- Low income lone parent households (Low Income Measures after tax): 30.6% 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): 12.8% Lowest
- Population 15 years and over providing more than 60 hours of unpaid childcare a week: 7.2%

Education

- Adults who did not complete high school education: 11.0%
- Adults who completed high school as the highest education: 28.8%
- Adults who obtained post-secondary education: 50.2%
- Post-secondary education obtained outside of Canada: 22.4% Highest

Employment

- Unemployment rate for individuals aged 25 years and older in the labour force: 5.1% Highest

Immigrant and Visible minority populations

- Immigrant population: 28.5% Highest
- Recent immigrant population: 5.5% (or 19.5% among immigrant population) Highest
- Visible minority population: 26.1% Highest

Language

- Population with no knowledge of English or French: 2.2% Highest

Housing

- Tenant- or owner-households spending 30% or more on rent/payments: 21.2%
- Rental dwellings: 29.7%

Seniors

- Seniors living alone: 18.9%
- Population 15 years and over providing unpaid care or assistance to seniors: 17.0% Lowest

Health outcome indicators*

- Emergency department visits (all cause): 35,034 per 100,000 population
- Cardiovascular-related hospitalizations: 648 per 100,000 population
- Injury-related hospitalizations: 397 per 100,000 population
- Diabetes-related hospitalizations: 103 per 100,000 population
- Lung cancer-related deaths: 34 per 100,000 population

**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)

Health Council of Canada. (2010). *Stepping it up: Moving the focus from health care in Canada to healthier Canada*. Toronto, ON: Health Council of Canada. Retrieved from http://www.healthcouncilcanada.ca/docs/rpts/2010/promo/HCCpromoDec2010.pdf.

Ontario Physicians Poverty Work Group. (2008). Why poverty makes us sick: Physician backgrounder. *Ontario Medical Review*. (This article can be accessed via http://www.stonegatechc.org/assets/files/Povertyandhealth1.pdf)

Public Health Agency of Canada. (2004). *Reducing health disparities: Roles of the health sector, discussion paper*. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/disparities/ddp-eng.php#tab.

Employment inWellington-Dufferin-Guelph

Public Health

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)

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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)

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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)

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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.

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