

Access and Equity:

Region of Waterloo Public Health

**Final Report on the Access and Equity Review findings based on
the Equal Access Standard of the Mandatory Health Programs
and Services Guidelines**

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SUMMARY

The Region of Waterloo Public Health (RWPH) Access and Equity review was conducted in the spring of 2002. One hundred and forty-three activities of the twenty-two programs were assessed for their compliance with the Equal Access Standard of the Mandatory Public Health Services Guidelines. The results were considered with respect to three areas: outreach to vulnerable populations, nature and type of activities undertaken, and needs and resources relevant to access and equity.

The majority of RWPH programs have been making attempts to improve access and equity in their services. Across various programs the most common activities reported include: translations and interpretation activities, improved physical accessibility, age and gender-specific work, and to some extent outreach to rural population. A small number of programs reported more substantial access and equity work, such as work on poverty reduction, work with vulnerable groups in the community, or through hiring of staff of diverse backgrounds. However, almost three quarters of all responses to specific actions relevant to vulnerable groups indicate either **no** action taken (45%) or lack of perceived relevance to their activity (28%).

Two staff discussions informed recommendations for further action. Some of the key recommendations included: awareness and strategy development training; maximizing community input, more off-site work, cross-programming and policy development work.

INTRODUCTION

This report outlines the process and findings of the Access and Equity Review that took place at Region of Waterloo Public Health. The review was carried out by the Planning and Evaluation Team of the Health Determinants Planning and Evaluation Division, and guided by a departmental advisory group. The review was implemented in response to the Department Leadership Team's direction to "*facilitate a systematic access and equity review within all programs within the next two years.*" (1).

This direction was grounded in the findings and recommendations of *The Access and Equity: A framework for Action* report (2), a task report prepared in 2000.

The purpose of this project was to conduct a systematic review of the degree of compliance of the PH activities with the Equal Access Standard of the Mandatory Health Programs and Services Guidelines (MHPSG) (Appendix A).

The Equal Access Standard demands that each Board of Health comply with the following goal and objective:

- Goal: To ensure that all Ontarians have access to public health programs*
Objective: To reduce educational, social and environmental barriers to accessing mandatory public health programs.

Specific Requirements include:

- 1. The board of health shall provide mandatory public health programs and services, whenever practical and appropriate, which are accessible to people in special groups for whom barriers¹ exist. Broadening access may require adjusting existing programs, promoting accessibility and developing special programs including special educational materials, tailored service delivery and active outreach.*
- 2. When planning to use facilities and sites for mandatory public health programs, the board of health shall select those which are barrier-free and have suitable access for special groups.*
- 3. The board of health shall establish ongoing community processes to identify needs, recommend approaches and monitor progress toward achieving access to the mandatory public health programs and services (Appendix A)*

¹ *Barriers can include, but are not limited to: literacy level, language, culture, geography, social factors, education, economic circumstance, and mental and physical ability.*

The key objectives of the review were to:

- Collect baseline information on the current CHD status with respect to the Equal Access Standard,
- Identify opportunities and barriers to implementation, and
- Provide recommendations for desired interventions

UNDERSTANDING THE CONTEXT

Access and equity issues have been acknowledged for a long time as one of the critical measures of excellence in public health practice. Consequently a number of public health departments across Ontario have indicated increased interest in promoting accessible and equitable services (9). The range of strategies considered in public health includes:

- Improvements in communication with various groups;
- Attempts to introduce institutional changes and policy development;
- Engaging in activities that promote community participation; or
- Various evaluation activities.

The more comprehensive the access and equity strategies within public health departments are, the more research, planning and time went into their development. Toronto Public Health for example, asserts that *“a successful integration of access and equity into practice requires a comprehensive groundwork, including organizational assessment, analysis and policy development”* (10)

Background Report: *The Access and Equity: A framework for Action* report of the Region of Waterloo Public Health (2) provided the groundwork for this review by offering some important information, including:

- Groundwork based on three main frameworks: theoretical, legislative and organizational;
- An overview of the community context with respect to diversity;
- Information on the initiatives within the Region of Waterloo and its individual departments with respect to this issue, and
- Information on the initiatives taken by other public health departments within Ontario.

The report also generated a number of recommendations for action on access and equity.

- A. Legislative Context: The report asserted that *“from the Supreme Law of Canada to the Region of Waterloo's vision, there is a set of legislation and guidelines at the federal, provincial and local level that provide the legal foundations to ensure the access to service and equal treatment of all those who are associated with an organization”*(2) (Appendix B).

The focus of the Access and Equity review however was clearly on only one aspect of the legislative framework- the Ontario Ministry of Health and Long Term Care's Mandatory Health Programs and Services Guidelines (MHPSG) and its Equal Access Standard (3) as they pertain to the Health Promotion and Protection Act (4).

- B. Organizational Context: The organizational context relevant to the equal access issue is defined by both Regional and Public Health mission statements. The Regional Municipality of Waterloo's (RMW) vision statement asserts that *“The residents of the*

Region of Waterloo will enjoy the highest possible quality of life and equal opportunity “(5). In accordance with this statement, the RMW has recently initiated the Integrated Service Delivery project which has re-emphasized its commitment to improving access to its services by the citizens (6). Region of Waterloo Public Health (RWPH) also acknowledges access and equity by stating in its mission statement that it is “*working in partnership, to build a healthy, safe and supportive Region with opportunities for all to reach their highest level of health*” (7). In addition, the Ottawa Charter for Health Promotion, operational planning framework of RWPH states that “*basic conditions and resources for health are peace, housing, education, food, income, a stable and safe environment, sustainable resources, social justice and equity*” (8).

Operationalizing the Equal Access Standard

In order to be translated into a measuring tool, the standard needed to be operationalized. Since this type of work has not been formally done before², the first task of the project was to ensure that we developed an accurate, relevant and comprehensive interpretation of the standard. Accurate, meant ensuring that we respected the scope of the standard to include all potential indicators as they pertain to the requirements. Those included aspects such as: accessibility issues, groups who experience barriers, modifications and new program developments; active outreach; and community processes relevant to planning and program evaluation. Relevancy meant understanding our community and organizational context (defining vulnerable groups and programming units to assess). Finally, comprehensiveness was reflected in ensuring that all aspects of programming in the RWPH were included in the review and that there were sufficient opportunities for the expression of a variety of activities in all aspects of the review.

Vulnerable Populations: The work of Toronto Public Health and the most recent statistics for the Waterloo Region (2) served as primary sources of information for developing our list of vulnerable groups.

The list of vulnerable groups had been developed through a consultation process with all divisions and with input from various programs. At the end of this process, the Access and Equity Review Advisory Group determined that as many vulnerable groups as we have determined to exist should be considered, regardless of their numbers or prevalence in the community. The groups identified in the tool include: **immigrant newcomers, refugees, ethno-cultural groups, gay/lesbian/bisexual/transgendered, age vulnerable (youth and elderly), low literacy, rural communities, impoverished/working poor, differently-abled, and aboriginal people**. The Appendix C offers working definitions for each of the groups. The definitions were developed in consultation with the Advisory Group and the staff who has experience working with respective groups. These definitions were shared with the tool at the time of the review.

² Recently, the Ontario Public Health Association designated a group to engage in the development of the indicators for the standards, which are to be proposed to the Ministry of Health and Long-term Care.

Research Approach and Process

Participation: This project was limited to the internal, organizational collection of information, and did not include external groups who have the stake in the issues of access and equity. However, internally, the project ensured that opportunities for staff input were maximized, as well as that the key messages relevant to the access and equity issues in public health were clearly conveyed. Several sets of specific activities contributed to this:

1. The selection of the Advisory Group.
2. Publicizing of the review in Health in Action (Department newsletter to the community).
3. The communication campaign “Think Access, Think Equity” in Good Morning Community Health (electronic newsletter) and a three-week long poster/audio/video display with the same title.
4. The General Staff Meeting (GSM) “Opening New Doors: One step at the time” where staff had an opportunity to hear about examples of actions of others; a public health organization and several people in the community, as well as to provide direct recommendations for action at the RWPH
5. The data gathering process was flexible and adaptable to the needs of programs/activities.

Advisory Group: Upon the approval of the Department Leadership team an advisory group was formed to guide the entire review process. Several reasons motivated the decision to recruit this group: a) to increase the sense of ownership and responsibility for understanding the issue; b) to obtain assistance in operationalizing the Equal Access Standard; c) to obtain input into interpreting and acting upon the results of the review; and d) to strengthen the communication process during the review. Two individuals, a management and a staff representative were recruited from each of the divisions to assist in this role.

During the course of the preparations and the review, the following tasks were completed by this group:

1. Reviewing and finalization of the review tool.
2. Determining the process for gathering information.
3. Communicating with the divisions.
4. Assisting and support of data gathering.
5. Support to the communication campaign and organizing of the GSM with the Access and Equity theme.
6. Generating recommendations based on the preliminary findings.

Project management tools and techniques were used to guide the process and actions of the Advisory Group.

The review plan was approved and initiated in November 2001. Data gathering took place between March and June of 2002. The staff of the Planning and Evaluation team supported all divisions in the process of data gathering. Multiple hard copies of the tool were accompanied with a letter of introduction (Appendix D) and distributed to all program managers via Advisory Group members.

Communication Campaign: The data gathering process was launched and publicized via multiple communication venues: through Good Morning Community Health; divisional representatives on the Advisory Group; and direct communication to all staff via e-mail. The following actions contributed to the “Think Access, Think Equity” campaign:

- Ten weekly contributions to the RWPH electronic newsletter “Good Morning Community Health”, written by the staff who have expertise working with vulnerable groups;
- Ten e-mail messages with similar information, including some of the most recent statistical information and articles relevant to access and equity;
- A multimedia display, which lasted for two weeks and covered a variety of access and equity issues and actions taken internally, and in the community; and,
- A General Staff meeting entitled “Opening New Doors, One Step at a Time”

The General Staff meeting held in June 2002 was a culmination point in the communication campaign. In it, the RWPH staff had an opportunity to hear what some of the leading community advocates think and do to address access and equity. Toronto Public Health staff had a presentation on how they had developed and implemented access and equity policy guidelines. Finally, the staff had an opportunity to provide their input into the generation of recommendations for future RWPH actions, which are included in this report.

Data Gathering Tools

Three data gathering methods were used to collect information on the compliance with the Equal Access Standard, and to obtain recommendations for action.

1) The Access and Equity Review Tool

The Peel Region Health Department has created an assessment tool for a similar review process. We used this tool as a starting point in the development of our review form. The Planning and Evaluation team made initial modifications and offered it as a draft document for further input from the Advisory Group. In the process of finalizing the key variables, the Advisory Group considered the following key questions:

- what kind of information is useful to gather;
- what is the desired level of detail;
- how will the information be used
- what is the role of staff during the data collection process and beyond; and
- what is the time frame for each of the stages

Several versions of the tool were tested with various programs and the final one was piloted with six program/activity areas. The final version of the review questionnaire consisted of three distinct segments of data collection : program information, activity information and needs and capacities (Appendix E):

a. Program Information. The intent with this section was to gather summative information specific needs and capacities that existed within the programs which could guide the future action steps. This part of the questionnaire collected basic information from 22 program areas

within the department. These areas for the most part match the existing administrative units. Minor modifications were made by raising some activities to the program level in order to allow them to provide more detailed information on their activities. This was, for example, the case for the volunteer/student placements of the Central Resources Division, which is normally considered an activity, but due to its equal access relevance we considered it at a program level. This section of the questionnaire also a) identified core activities within divisions and programs, b) offered a summative view of the population that the program is dealing with, and c) asked for basic information on outreach to specific vulnerable groups. This form was completed by the managers of respective programs.

b. Activity Information. This part of the questionnaire referred to all of the core activities that are identified in first section. Question 2.1. was repeated as many times as there were activities identified in Part 1. The remaining questions of this section ask for more details related to the codes that are assigned in question 2.1, and contain space for brief explanations and example of specific activities undertaken. Core activities from each of the programs were assessed by looking at two key variables: vulnerable groups and stages of program delivery. The stages were defined according to the common program development phases: needs assessment, program planning, implementation and evaluation. Each activity was then assessed to learn in what stage, if any, the program has been addressing the needs of specific vulnerable groups. The section dealing with specific interventions was developed in such a manner that several aspects from the standard were respected:

- physical aspects of the access to facilities and programs
- socio-cultural aspects of the access, and
- opportunities for participation and contribution in the decision making process about programs

A number of specific access and equity concerns, some of which are applicable only to certain groups (e.g. hearing aids) were listed in this section, in order to provide respondents with an opportunity to elaborate on the interventions that they have been using.

The activity information part of the questionnaire was completed in several ways. In some cases the questionnaires were completed by either individual staff or teams working on a particular activity. In others, either a supervisor, or a manager completed the form.

c. Needs and Capacities. This was a third part of the questionnaire which dealt with the program needs and resources as they pertain to the access and equity issues. This part was completed by either managers, or by staff in the program team meetings.

In order to assist the programs with the terminology used in the questionnaire, and for consistency reasons, a list of brief definitions of the vulnerable groups was provided. More detailed explanations and definitions were offered through the existing Glossary of the Access and Equity Terms. The review focused on the current status of activities as they pertain to the access and equity issues. Participants were also invited to separately share information on past initiatives, but to clearly delineate those from the present ones.

The questionnaires were originally meant to be administered electronically, but due to technical difficulties, only hard copies were available for completion.

The staff of the Planning and Evaluation program, and the Advisory Group representatives were available throughout the review to assist with questions and concerns.

2) Advisory Group Focus Group Discussion

In order to generate recommendations in response to the review, a focus group session was held with the Advisory Group. At the last Advisory Group meeting, the 12 participants were provided with an overview of the preliminary findings and asked to provide their input into the recommendations for action. Specifically, the participants shared their perceptions of the promoting and hindering factors with respect to the next steps, and generated recommendations for action on Access and Equity.

3) Small Group Discussions

The third data gathering tool was used at the General Staff Meeting which was devoted to the issue of Access and Equity. Brief round table discussions were organized after the staff had had an opportunity to hear about the examples of equal access action in other health departments as well as from the community. Seventeen tables with eight to ten staff at each, participated in the discussions where staff responded to the question:

“Based on what you have heard today, what do you think we should do about improving access and equity at the Region of Waterloo Public Health? Consider suggestions that both relate to your professional/employment role, and role as a citizen of this community.”

Review Findings

The review process and focus group discussions generated a wealth of information. The information was analyzed in two ways. The primary review results were addressed with a combination of descriptive statistics and a summary of qualitative information, while the focus groups discussions were analyzed by using content analysis.

The review findings are provided under the following headings:

- \$ Overview of the Access and Equity Initiatives at the Region of Waterloo Public Health(RWPH)
- \$ Divisional Profiles with both Program and activity information, and
- \$ Summary of Learnings with Recommendations

OVERVIEW OF THE ACCESS AND EQUITY INITIATIVES AT REGION OF WATERLOO PUBLIC HEALTH

Twenty two program areas were identified as relevant to the Access and Equity Standard compliance review. These areas for the most part correspond to the administrative and operational structure. However, some, due to their potentially high relevance to access and equity issues, were extracted as specific areas to respond. This was primarily the case in Central Resources, where some activities, such as volunteer management/ student placements and the Resource Centre were purposefully given the status of program areas as they have greater relevance to the work with the public.

The following table outlines the number of activities assessed, per division and per program. A detailed list of activities assessed is provided in **Appendix F**

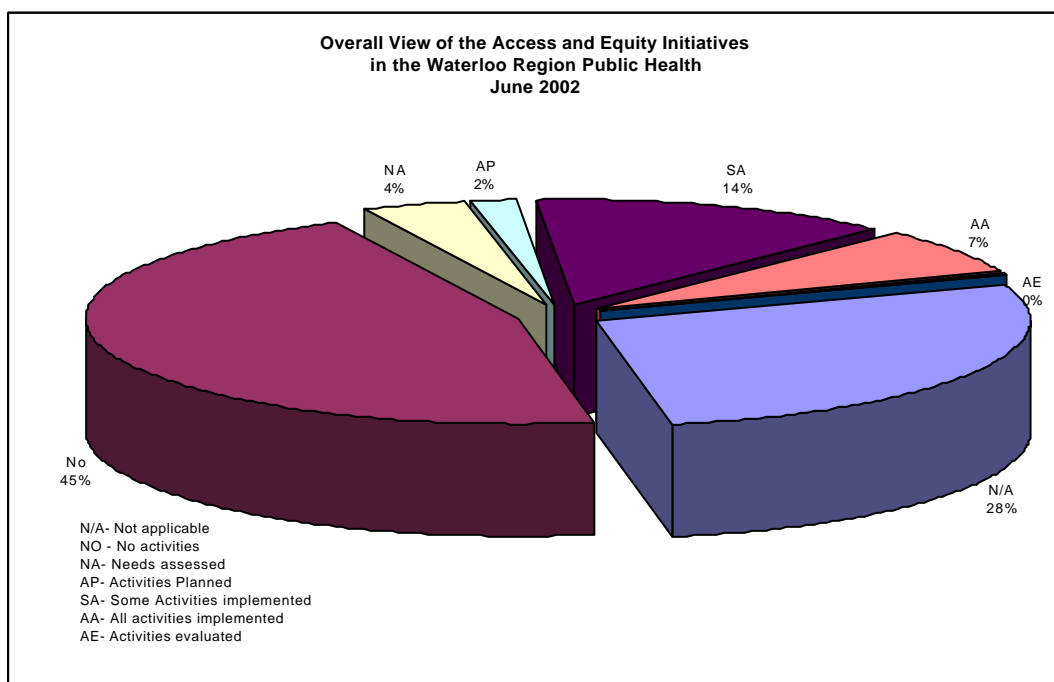
DIVISION/PROGRAM	Number of Activities Assessed
COMMUNICABLE DISEASE/DENTAL/SEXUALITY RESOURCES	
Dental Health	4
AIDS/STD	5
Immunization	6
Sexual Health	6
Reproductive Health	7
Control of Infectious Diseases	5
Tuberculosis Control	4
	Total: 37
CENTRAL RESOURCES	
Administration	8
Resource Centre	7
Marketing/Communications	2
Volunteer/Student Placements	3
	Total: 20
EMERGENCY SERVICES	Total: 4

FAMILY AND COMMUNITY RESOURCES	
Family Health	14
Youth Health	7
	Total: 21
ENVIRONMENTAL HEALTH AND LIFESTYLE RESOURCES	
Heart Health and Cancer Prevention	10
Safe Water	6
West Nile Virus	5
Tobacco Enforcement	8
Environmental Health	4
Injury Prevention	7
Food Safety	8
	Total: 48
HEALTH DETERMINANTS PLANNING AND EVALUATION	
Healthy Communities and Policy	5
Planning and Evaluation	5
Epidemiology	3
	Total: 13

The following overview captures only the basic descriptive statistics on the responses gathered. Figures 1, 2 and 3 offer various perspectives to the distribution of responses to the Question 2.1. that assesses to what extent an activity considers all vulnerable groups. As mentioned earlier in the description of the tool, the level of engagement of any of the activities assessed was reviewed in the context of the potential stages of program development and implementation. The stages spread out on a scale which covers a spectrum of options, from “not applicable”, through assessing the needs of a group, planning, implementing, and finally, evaluating the activities that address identified needs. The respondents looked at the scale (N/A to AE) and had to assign one of the codes to each of the vulnerable groups listed in the table. The primary intention of this question was to determine whether or not, and at which stage the interventions had been implemented, not the number or nature of interventions (question 2.2).

Figure 1 shows that 45% of the responses indicate **no** strategies addressing access and equity issues of various vulnerable groups. In addition, 28% feel that access and equity actions do not apply to them. While it is reasonable to assume that not all vulnerable groups have relevance to all programming activities, the fact that in 28% of the cases this relevance is questioned, may indicate several other possible reasons. For example, during the review, the facilitators (Advisory Group members and Planning and Evaluation staff) observed a tendency to choose this response when an activity is geared to “general population”. So possibly, some respondents assumed that if they are addressing general population there is no need to address the specific groups, or that if they are dealing with a specific group, the issues

Figure 1: Overall view of the responses to access and equity activities with respect to various vulnerable groups



of other vulnerable groups would not apply to that activity. This issue had been acknowledged during the pilot phase and the Advisory Group responded by suggesting two strategies to minimize this bias. First, to remove from the list of activities, all of those that clearly had no relevance to working with public (e.g. “distribution of publicly-funded vaccines and reinforcement of storage”), and secondly, to ensure that both Advisory Group members and the Planning and Evaluation team take an active role in assisting programs and clarifying this and other issues during the course of the data gathering. Given the relatively high percentage that persisted despite these interventions, we may need to assume that some “not applicable” responses were still wrongly interpreted or, that the respondents persisted in not perceiving any access and equity relevance to their activities. Finally, some activities clearly had little to no relevance to some, or all of the groups. For example, food safety has no relevance to gender issues, and therefore we have to acknowledge that at least to some extent, the high “N/A” percentage of responses, reflects those cases as well.

Among the activities addressing the needs of vulnerable populations, 4% were identified as either currently undergoing a needs assessment, or having completed a needs assessment without follow up actions. Twenty one percent of the responses reported that some, or all of the activities that they had intended to do have been implemented. Only one third of those have been fully implemented. Evaluation activities have been recorded in only three cases (age, gender, and poverty –related activity, Figure 3).

Figure 2: Frequency of indicated activities relevant to vulnerable groups (“SA” and “AA” combined)

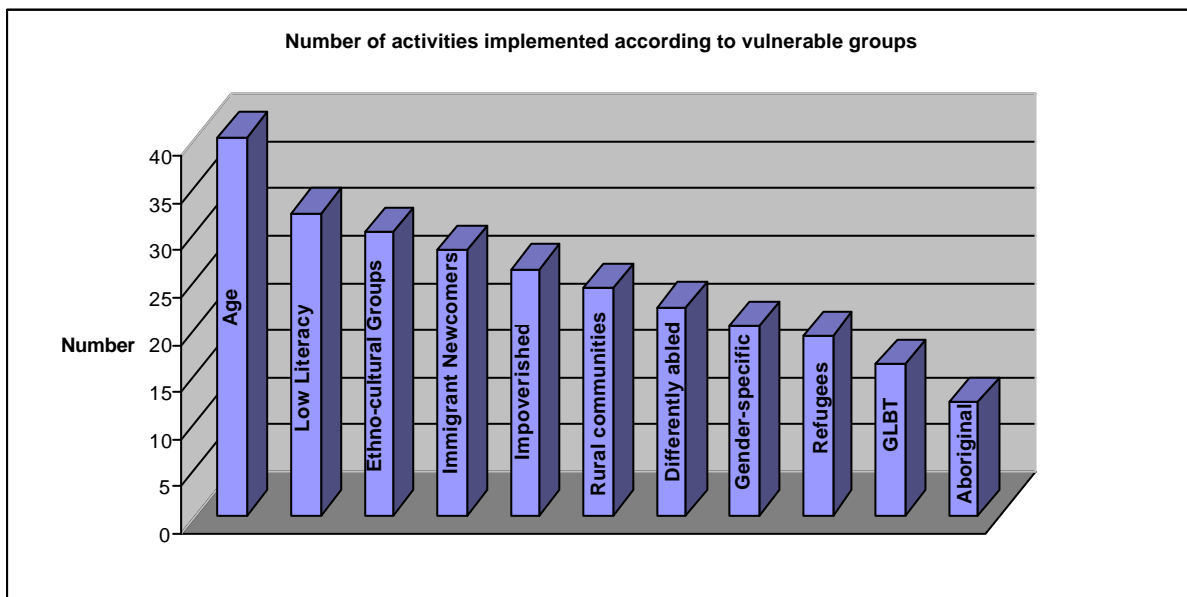
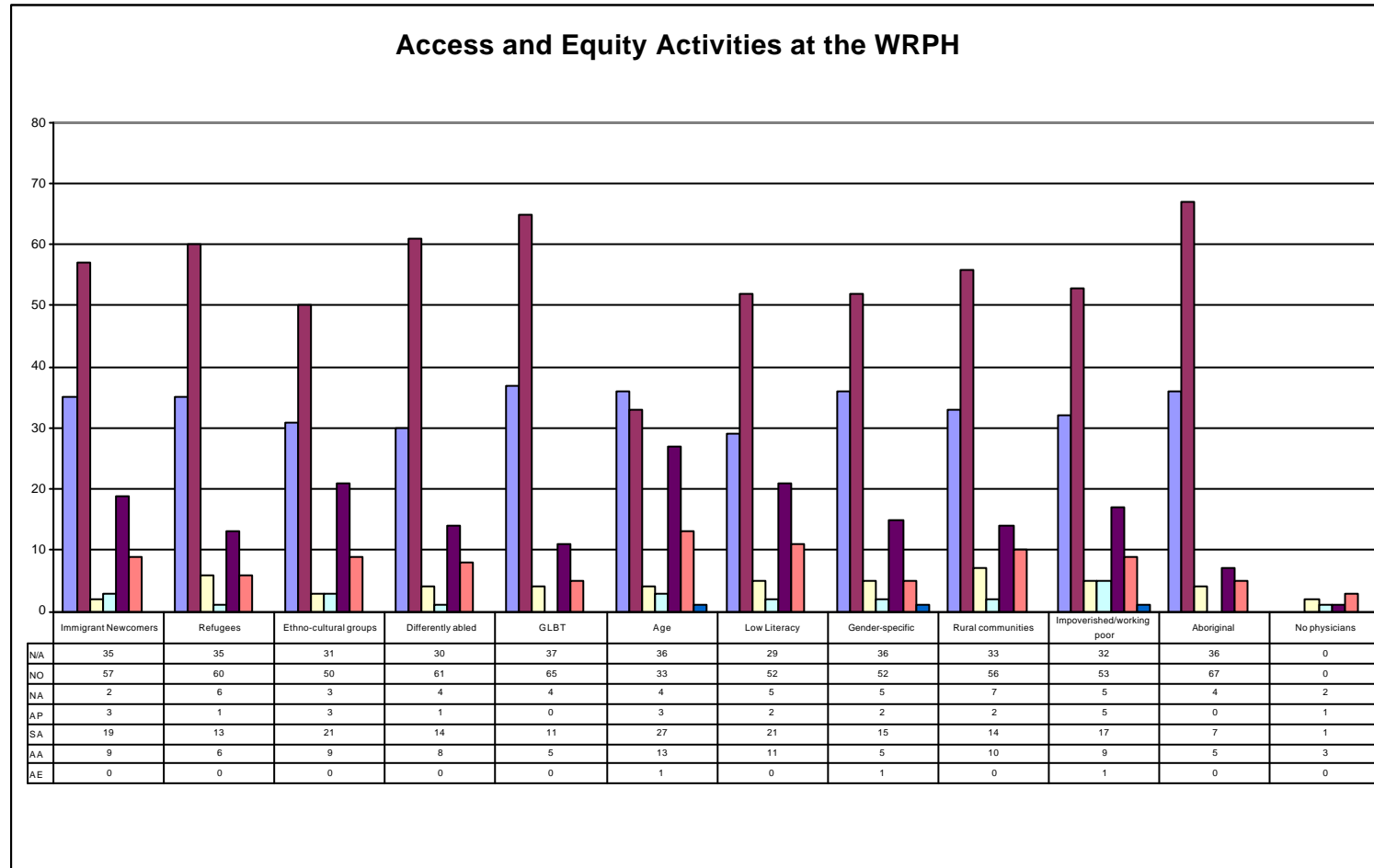


Figure 3: Distribution of access and equity activities across program stages and according to vulnerable groups



N/A Not applicable
 NO No activities
 NA Needs assessed

AP Activities planned
 SA Some activities implemented
 AA All activities implemented

AE Activities evaluated

Figures 2 and 3. provide more detailed views of how individual vulnerable groups scored regarding various stages of access and equity interventions (question 2.1. Appendix E). Here it is visible that all of the categories of answers are relatively evenly spread across various vulnerable groups. When looking at the level of activity implementation, clearly the majority of activities are declared to be “some activities implemented”, indicating a perception that the work has been either insufficient or partially completed.

Addressing age dominates the activities. This is clearly work with youth that is present in almost all divisions. Apart from that, immigrant and ethno-cultural groups, literacy, and rural populations and to some extent, poverty-related interventions, have been somewhat more addressed than other groups and issues, such as refugees, gender, gay/ lesbian/ bisexual/ transgendered (GLBT) or aboriginals (Figures 2 and 3). However, the results stemming from this question (Q.2.1 Appendix E) may not be sufficiently reliable to warrant these conclusions. A pattern was noted during the analysis, that many respondents had not identified some of their strategies while responding to this question, but did so later on when they had more specific probes to respond to. A more detailed and accurate view of the nature and content of the activities implemented is provided in the Divisional Profiles.

Some inconsistencies in responding to this question in relation to other questions were noted.

1. With some groups there is a possibility that respondents provided multiple answers for the same activity (e.g. for immigrants, ethno-cultural groups and refugees).
2. Overall, the number of concrete strategies reported in this question is lower than in the next one (Q.2.2.) where respondents had specific examples to relate to. Therefore, the next question, which is discussed in detail in the divisional profiles, provides a much more accurate picture of what specifically the programs have been doing in response to the needs of the vulnerable groups.

DIVISIONAL PROFILES

The following results capture the assessment findings as they pertain to:

- The RWPH programs: population they work with, outreach to vulnerable groups and their perceived resources and needs
- The activities within the programs and their work relevant to the vulnerable groups designated.

Emergency Medical Services (EMS)

(4 activities assessed)

Population and Outreach: The EMS reports working with general population, and on special occasions with several community groups (special events and the training advisory work at the Conestoga College). Currently, the EMS division and its programs are making active plans for outreach to the rural population.

Capacities relevant to access and equity:

- Training capacity (aphasia, non-violent crisis intervention, elder abuse)
- Partnering with Waterloo Regional Police, Hospital Emergency Room staff and Family and Children Services to deal with issues of abuse

Access and Equity Support Needs:

- No budgeted funds for Equal Access needs in 2001
- No internal partnerships identified
- No comments regarding information, resources, awareness raising and other training needs

Access and Equity Activity Information

The core activities that EMS engages in do not appear to address many access and equity issues. Seventy three percent of their responses indicated that they have no specific strategies or activities that refer to the vulnerable groups. They do have some activities implemented with both elders and youth, and to a lesser extent, rural populations, and differently-abled.

Activities, as they pertain to specific vulnerable groups

Rural

Assessments reveal that rural response times are much longer than urban – which should be improved upon with a rural response unit in 2003-2004, and staff increases for Elmira. A public information session in Elmira will allow for community voices to be heard,

but community input is only planned to come through Regional Council. EMS provides programs at community-based locations with their stand-by ambulance service at the Elmira Maple Syrup Festival.

Elderly

Video training for staff on Elder Abuse is planned, and pharmacists will be distributing a fridge magnet for medical history information, which they may get design feedback on from a senior citizens group. Other opportunity for community input will be through partnership with Community Care Access Centre and Victorian Order of Nurses.

Youth

EMS is promoted to create awareness of the profession in high schools, and to increase understanding and decrease fear in elementary schools, and at the Children's Safety Village. External partnerships exist with high school placement officers, and with youth through participation in the paramedic advisory committee at Conestoga College. There are procedures in place to address suspected child abuse, such as reporting to Family and Children's Services.

Differently-abled

Non-verbal communication training for staff is provided for interaction with people with aphasia.

Environmental Health and Lifestyle Resources (EHLR)

(8 programs and 48 activities assessed)

Population and Outreach: This division provides services to general public, staff, community groups/agencies, health care professionals, as well as some specific target groups such as: food handlers, children 0-6 and their families and youth, through the injury prevention work. Outreach to vulnerable groups includes: addressing low literacy concerns in Food Safety and Infection Control program; and ethno-cultural groups, youth, women, impoverished and elderly, in Heart Health and Cancer Prevention. Six other programs stated that there are no outreach strategies for any of the vulnerable groups.

Capacities relevant to Access and Equity:

- Ability to search for translations that are done by other health units or provincial sector
- Information from the 1996 census on the ethnic origin of the local population
- Literature review on best practices and barriers to health care for multicultural communities
- Literature review related to communication with some vulnerable groups
- Knowledge of who the advocates for vulnerable groups are and that the focus has been mostly on multicultural groups, not other vulnerable groups
- Some internal partnerships include Youth Health and Reproductive Health

Access and Equity Support Needs:

- Translations and translators for printed materials and presentations
- Training: Awareness raising training in general and on the health issues that vulnerable groups identify; training on strategies for addressing access and equity, such as: literacy and language issues and how to address them, best practices (access, settings and messaging) for various vulnerable groups, and to hear stories from other CHD staff on working with vulnerable groups
- Understanding better who the advocates for vulnerable groups are
- Higher priority given by the DLT on improvement in access and equity strategies
- Budget available for translations, but also to understand whether it is better to have info in simple English versus translations; who has printing resources among community groups; a separate budget account is needed
- A coordinator is needed to get information and work on the above issues and organize the work as well as to maintain a database containing which communities have been reached and health issues these groups identify.
- Time to focus more on access and equity
- Information: Overview and up-to-date information on different groups of K-W Immigrants; Health Info-risk factor rates among various immigrant groups and other vulnerable groups
- Information on different types of Low German-speaking groups

A. Heart Health and Cancer Prevention/Cancer Screening

Heart health and cancer prevention for the most part does not have specific strategies that refer to the vulnerable groups. A number of responses reveal that the staff does not believe that the issues of specific vulnerable groups apply to their programs (81%). At the same time, there are some activities that are planned for immigrant newcomers, youth and seniors, women, and impoverished/working poor. Some or all of the planned activities are implemented for youth and seniors, and most or all activities are implemented for people with low-literacy skills and women.

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomer:

Interpreters have been used for cancer prevention presentations, and other partnerships include English as a Second Language (ESL) adult educators, church leaders, multi-cultural group leaders, YMCA and immigration and settlement programs.

Youth

High school tobacco intervention is a current program that is seeking approval from Waterloo Region District School Board (WRDSB) to have a needs assessment done of schools' smoking profiles. This assessment has been conducted at 9 separate schools in the region where interventions are being planned. Community voice and input will be possible through meeting with the schools' various committees. "TV Turnoff Week" is another youth program that receives community input from a parent survey and follow-up questionnaire. "Kick Butt for Two" is a program for pregnant and parenting youth that is offered at community based locations, which are physically accessible and bus tickets are provided. Both external and internal partnerships are important factors to the success of the program. Improved promotion of the program is planned for the future.

Senior Women and Women:

Community input is obtained through focus testing of resources for breast cancer screening, and information from Ontario Breast Screening Program ensures community voices are incorporated. The Central West media campaign was paid for by the Waterloo Breast Health Network and South West Cancer Care Ontario Region, in which a literature review of mass media helped to determine a successful strategy. Breast health presentations are offered at community-based locations, such as workplaces, ESL classrooms, community centers and churches, and information is being gathered on Mennonite women to assess whether breast screening awareness will be a focus for this group. There are plans for workplace initiatives to improve access to programs. Another focus has been with smoking cessation initiatives for pregnant women, in partnership with Program Training and Consultation Centre, Grand River Hospital and Centre for Addictions and Mental Health.

Activities assessed:

1. communications/resources/distribution (professionals)
2. community mass media (ongoing)
3. continuing education events/training (professionals)
4. programs
5. telephone advice line/internet
6. coalitions/networks
7. consultation/assistance/support
8. community events
9. policy development/establish guidelines
10. community wide education campaign

Impoverished/Working Poor:

” Take 5” program has received community input from a focus group and an evaluation is being planned. This program is offered at community-based locations, at sites that are physically accessible, with bus tickets provided. Cancer Care Ontario coordinates the program provincially. Locally, Community Nutrition Workers groups, YWCA – KW help promote and facilitate implementation.

Low-literacy:

The telephone advice line is delivered in a way that is clear and understandable. Media is used particularly for cancer prevention screening for women. Low literacy, language-specific resources were created for 12 languages for cancer screening information.

B. Safe Water

Practically all of the programs for safe water are categorized as not applicable to the access and equity issues (99%). The only vulnerable group that has been considered with some activities is the rural population.

Activities assessed:

1. monitor water sample results
2. issue boil water advisory
3. inspect public pools
4. inspect public bathing beaches
5. establish protocols for adverse samples
6. education to the public

Activities, as they pertain to specific vulnerable groups

Rural

‘How well is your well’ is offered at community-based locations at rural schools, and displays are set up at events such as the Children’s Groundwater Festival. Woolwich Community Health Centre staff, farm community groups, and the environmental farm plan are all important partnerships. There are plans to work with the school board to have programs incorporated into the curriculum.

C. Food Safety and Infection Control – West Nile Virus

West Nile Virus responded to all access and equity items as not applying or not having specific strategies (100%).

Activities, as they pertain to specific vulnerable groups

No information provided.

Activities assessed:

1. establish surveillance for WNV
2. establish WNV contingency plan
3. establish WNV committee
4. establish protocols for reporting dead birds
5. WNV education to the public

D. Tobacco Enforcement (Tobacco Control Act)

Tobacco Enforcement responded to all access and equity items as not applying, or not having specific strategies (100%).

- 1. routine annual inspections
- 2. compliance checks and enforcement checks
- 3. surveillance
- 4. education to the public
- 5. support smoke free places
- 6. third party supply

Activities, as they pertain to specific vulnerable groups

No information provided

E. Environmental Health

Environmental Health responded to all access and equity items as not applying, or not having specific strategies (100%).

Activities, as they pertain to specific vulnerable groups

No information provided.

- Activities assessed:
- 1. health hazard investigation
 - 2. air quality issues – indoor and out
 - 3. contaminated sites

F. Injury Prevention

All but two activities were responded to as does not apply (97%). The exceptions are that some activities are implemented for seniors and youth.

- Activities assessed:
- 1. infant car seat safety
 - 2. product safety
 - 3. recreational safety
 - 4. motor vehicle safety
 - 5. osteoporosis program
 - 6. alcohol abuse in the 18-24 year group
 - 7. playground safety

Activities, as they pertain to specific vulnerable groups

Seniors

Senior Safety and Osteoporosis support groups attempt to meet the needs of seniors in the community. Community input is obtained through formal feedback at presentations and informally at events and fairs. Seniors have screened written material for clear language and the home safety checklist is available in 8 languages. Seniors also participate on fall prevention and osteoporosis planning committees. Collaboration exists with osteoporosis network, which has also participated in advocating to include certain medication to treat osteoporosis in the government drug benefit program. Improved access to programs will hopefully come from plans to provide literature, and education to senior housing units, and community groups.

Youth

'Party in the Right Spirit' is promoted to youth using communication tools that are visually appealing and engaging. Presentations are made at Regional schools, and they are spearheading a province wide medial campaign directed at youth. Partnerships exist both internally with the Youth Team, and externally with Mothers Against Drunk Driving, and the Waterloo Regional Police. There are also attempts to involve youth as community representatives through establishing student groups within high schools, and regional working group. Linking students who have taken internal leadership in their schools with a region-wide network will hopefully improve access to services. Statistical information about alcohol and drug use of youth comes from the universities, and a provincial, grade 7-OAC survey.

G. Food Safety and Infection Control

The majority of activities do not apply to access and equity issues (95%). However, there are some activities implemented around communication, specifically low literacy skills and language.

Activities, as they pertain to specific vulnerable groups**Low Literacy**

Educational material is written at a basic level, and the Food Safety manual in particular has been revised to ensure readability. Some pamphlets have originated from Canadian Institute of Public Health Inspectors (CIPHI).

Activities assessed:

1. inspections of food premises
2. food handler certification
3. food recalls
4. case management of enteric disease
5. outbreak management
6. education (community/public)
7. complaint investigation

Language

Language interpreters are utilized as needed, and courses may be held in a language other than English if necessary. Oral explanations are provided for those with ESL needs.

Communicable Diseases, Dental, Sexual and Reproductive Health (CDDSR)

(7 programs and 37 activities)

The program information varied in the level of information and detail provided. While some programs provided extensive input, others had very little, if anything to add.

Population and Outreach: The division deals with general population, health professionals and educators, CHD staff and a number of specific groups in the AIDS/STD program. Various vulnerable groups are reached out to, including GLBT, youth, women, ethno-cultural groups, immigrants/refugees, differently-abled, impoverished, and rural population (DH)

Capacities relevant to Access and Equity:

- Information: General information on GLBT and sexual health statistics.
- Rural Access and Equity survey done.
- Some resources for staff training
- Program-specific information related to awareness-raising and strategies for addressing access and equity; Have manuals from Health Canada, some of which are translated materials.
- Some budget for bus tickets, taxi vouchers, and some budget for translations (immunization), some funds available through Health Canada and PNP funds.
- Some external and internal partnerships (including agencies dealing with developmentally challenged, Reaching Our Outdoor Friends (ROOF), Aids Committee of Cambridge, Kitchener, Waterloo and the Area (ACCKWA), Kitchener Downtown Community Health Centre (KDCHC), Healthy Children Healthy Babies program, Pregnant and Parenting Youth Network, Prenatal Nutrition Steering Committee.
- Resources related to youth

Access and Equity Support Needs :

- Information on vulnerable groups.
- Resources: materials in different languages.
- Awareness-raising and strategizing training (cultural awareness).
- Assistance in the development of policies and procedures (re: immunizations enforcement activities and different cultures).

A. Dental Health

Dental health has no activities addressing the GLBT community or gender –specific issues, but the majority of their responses indicate some or all activities implemented (77%). Access and Equity issues are being addressed with immigrant newcomers, refugees, ethno-cultural groups, differently-abled, youth, low literacy skills, rural communities, impoverished and aboriginal people.

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural Groups

Fact sheets and information flyers have been developed in different languages, and some clients are reached through ESL classes. To address the language issue further, they have a roster of dentists and staff who speak different languages. YMCA settlement workers are also available and the St. Jacob’s support centre will provide interpreters as well. A group of women from Afghanistan receive dental health through their multicultural group. Also, work has been done with multicultural centre representatives to address dental health issues with a particular ethno cultural group. The program has assessed a need to address the fear and lack of importance felt by many new Canadians regarding dental care as a result of negative or non-existent experiences

1. school-based oral health screening
2. school-based dental health education
3. children’s dental health
4. (CINOT) Children In Need Of Treatment

Differently-Abled

The CHD building is accessible, and they can direct clients to dentists that have wheelchair access if necessary. They have also worked with hearing impaired children in the past.

Youth

Youth are reached directly through the schools, and referred for extra care if there is a need. Partnership cooperation exists with the Youth Health program.

Low Literacy Skills

Brochures written at a lower literacy level have been ordered from other health departments, they tend to use more picture-based information than written. Planned efforts are in place to improve the readability of forms.

Rural

Include rural schools in school-based dental services and education.

Impoverished

Aware that a lot of people cannot take time off of work for dental appointments, so evening hours make services more accessible. There are also plans to open dental clinic services to adults who could not afford service otherwise. Bus tickets are available, and taxi fare can also be provided. In terms of fostering partnerships, integrated planning happens with social services by supplying income to treat some of the adults. Dental health staff is aware of the economic struggles of parents through information gathered on school forms.

B. AIDS/STD Program

All vulnerable groups are incorporated in AIDS/STD access and equity efforts. Although over one third (35%) of responses indicate no specific strategies exist. Otherwise, when activities are mentioned they tend to be classified as ‘some activities implemented’.

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural Groups

Interpretation can be provided through the Multi-cultural centre, but consulting with the client regarding comfort and choice of interpreter is standard. Plans are in place to train interpreters for HIV/AIDS education for ethno-cultural communities. Participation with community committees examines HIV awareness and prevention strategies.

Activities assessed:

1. STD clinical services
2. health promotion activities, including resources
3. STD/HIV case management
4. community partnership – committee work, consultations
5. anonymous HIV clinic

Differently-abled

Sites for health promotion activities are chosen so they are wheelchair accessible.

GLBT

GLBT referrals have been established with ACCKWA, and ongoing links exist with groups such as Rainbow Youth and Gay and Lesbians of Waterloo (University of Waterloo). They continue to select staff that is non-judgmental in their approach to service delivery and have GLB statistics collected from clinic attendance.

Youth

Service integration programming exists with ROOF, and they also incorporate facilitative participation of youth on community committees. In an effort to meet the needs of the community, an off-site clinic location for youth has been established.

Low Literacy Skills

It is an ongoing priority to select pamphlets and resources that are suitable for low literacy levels.

Women

Facilitate participation of women on community committees.

Impoverished

Taxi vouchers and bus tickets are available, and program locations are chosen so they are accessible by public transportation. An off-site clinic location has been established for the homeless. Also, clients are welcome to bring children with them to clinic.

C. Immunization

The clear majority of responses indicate that there are no specific strategies or that access and equity issues do not apply to the program (80%).

However, Immunization mentions many groups that have needs assessed, and while most vulnerable groups have some comments, GLBT, Gender-specific and aboriginal groups are not addressed in terms of access and equity. Immunization has also identified another vulnerable group – people with no family doctor.

Activities assessed:

1. universal influenza program
2. grade 7 Hepatitis B program
3. CHD immunization clinic and consultations
4. enforcement of immunization of school pupils act
5. telephone vaccine info -line
6. immunization promotion

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural groups

Access to Multicultural Centre interpreters is an option, but interpretation has often been performed by family members. Some form materials are available in several languages.

Differently-abled

All clinic locations are physically accessible, and work has been done with teachers of differently-abled children to accommodate their needs. Bell service has also been useful in interacting with hearing impaired clients.

Youth

Education is delivered to youth through a variety of materials, video and overheads. An internal partnership with Healthy Babies, Healthy Children takes a cooperation approach. Also, they have access to some statistics for children in school.

Seniors

Additional resources are invested into education at long-term care facilities. Immunization staff has also worked with long-term care facilities to prevent disease and educate professionals.

Low Literacy

Written material is consciously made or collected with low literacy awareness. One-on-one meeting with clients are an option to ensure comprehension.

Rural

Outreach to rural community discussions is currently being planned. Rural clinics are available in such area as Baden, Ayr, Elmira, and Linwood. Programs are also offered at schools in rural areas.

Impoverished

Clinics have been held at the St. John's Soup Kitchen, and discussions have also taken place around the idea of holding evening clinics for people who cannot take time off of work. Bus tickets are available when needed.

No Family Doctor

Needs assessment has revealed that many people either have a family doctor out of town or no family doctor at all. Efforts are thus made to offer access to service for people who have no doctor.

D. Sexual Health

A fair number of the responses for sexual health indicate that there are no specific strategies or activities regarding the vulnerable groups (52%). However, when there are applicable programs it tends to be categorized as ‘some activities implemented’. Groups that have no activities are immigrant newcomers, refugees and aboriginal.

<p>Activities assessed:</p> <ol style="list-style-type: none"> 1. community outreach/health promotion activities, campaigns 2. sexual health counseling and clinic services 3. resources development

1. community outreach/health promotion activities, campaigns
2. sexual health counseling and clinic services
3. resources development

Activities, as they pertain to specific vulnerable groups***Ethno-cultural Groups***

‘Focus for Ethnic Women’ outreach program uses interpreters. Interpreters have also been used to translate parent resources into several languages.

GLBT

Specific resources are developed for this population, and the clinic is identifiable GLBT positive with rainbow triangles in all clinic rooms.

Youth

Mandatory program standards require that sexual health promotion be directed at youth. Youth complete a sexual health needs assessment from which access and equity issues are identified. Also, STD and abortion statistics indicate a need for targeting youth. Youth conferences and Health fairs are examples of special events held for youth. Youth have also been involved in the creation of content and graphics for resources. Needs assessment has revealed that counseling and clinic services are mainly provided for people 24 and younger. An additional clinic at ROOF hopes to reach street youth, and counseling also takes place in the schools to meet youth at community-based locations. There are few other services available in the community to deal with youth sexual health.

Low Literacy

All materials are at an appropriate/low literacy level.

Gender

Needs assessment has revealed that counseling and clinic services are mainly provided for women

Rural

Taxis from rural areas are provided.

Impoverished

Bus tickets can be provided, and free contraception is available when required.

E	Reproductive Health
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While most of the responses indicate ‘no specific strategy’ or ‘does not apply’ (68%), Reproductive health makes mention of access and equity actions that range from “activities planned” to “activities evaluated”. Vulnerable groups not identified were: immigrant newcomers, refugees, differently-abled, rural and aboriginal.

Activities assessed:

1. reproductive health on-call line
2. resources development
3. pre-birth clinics
4. prenatal health fairs
5. prenatal classes (adolescent, adult)
6. prenatal nutrition program
7. community outreach/health promotion campaigns

Activities, as they pertain to specific vulnerable groups**Ethno-cultural Groups**

Interpreters are available at the hospital, and they also have a contract with the Multicultural Centre to provide interpreters, or family visitors. Additionally, efforts are made to ensure that resources are available in other languages besides English.

GLBT

Some materials have been developed around parenting and reproduction for gay and lesbian couples. Resources are updated for use at the Gay Pride Fair.

Youth

Federal needs assessment identified the need to target the youth community, and a PH needs assessment revealed that youth validate the importance of having adolescent prenatal classes separate from the adult series. Classes were also moved from PH to Cambridge Memorial Hospital for greater access. All resources are youth friendly and there are specific displays at the prenatal health fair for teens. Youth have also been involved in identifying their priorities and the production of some resources.

Low Literacy

All resources are at a low literacy level, incorporating graphics, pictures and interactive activities.

Fathers – Men

Needs assessment reveal the need for more support and education for dads. The prenatal health fair has specific workshops/displays for men, and radio, TV and promotional materials are specifically written to include and recruit fathers. Formal evaluations of workshops are requested from fathers and continuous efforts exist to develop appropriate materials around fathering.

Women

Folic Acid campaign is directed at women in childbearing years.

Impoverished

Bus tickets and food incentives are provided to participants, and there is no charge for classes. Staff has also made referrals to community agencies regarding food access. The RWPH also subsidizes low income clients who wish to attend late prenatal community classes. The Federal government identified through an intensive process the need to target low income communities.

F Control of Infectious Diseases (Communicable Diseases)

This group has a fairly even mix of no specific strategies for vulnerable groups and some activities implemented. All vulnerable groups are included.

- Activities assessed:
1. international travel immunization clinic
 2. case management and outbreak control activities
 3. consultation and information to professional public
 4. emergency plan development for new emerging CD's

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural Groups

When there is no access to interpreters they try to use family members as translators and fact sheets and videos are available in different languages. An outbreak several years ago involved an identified cultural group and they worked closely with leader of this group. There is a recognition that some cultural groups are at a higher risk for communicable diseases.

Differently-abled

Bell Telephone has provided service to interact with hearing impaired clients. As well, seeing eye dogs are permitted in the clinic, which is also wheelchair accessible.

Youth

Staff will provide education sessions for teachers if there is an outbreak. They will advocate on behalf of children with physicians/hospital to get them immunized if their mother is a carrier.

Low Literacy

Fact sheets are simple and clear. They will assist clients with completing forms if there is a need.

Impoverished

Staff is aware that service is a fee for service set-up so this does restrict people who can not afford the service. Plans for equal access include trying to introduce reduced rates. Anecdotally, staff knows that many people cannot afford vaccines so they do not come to the Travel clinic. Bus tokens are also available, or staff can visit people in the hospital.

G Tuberculosis Control

Almost the entire access and equity checklist identifies that some or most activities are implemented. They have added another category of vulnerable people – those with no physicians.

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural Groups

Interpretation is provided by family members, family visitors, or the Multicultural centre. The general information form is available in many languages.

Senior

Presentations have been made at long term care facilities and agencies.

Low Literacy

Staff tries to make fact sheets as simple as possible, by using diagrams for example.

Rural

Staff has provided home visits in rural communities.

Impoverished

The program provides option to pay, or not to pay for service. People will not be turned away if they cannot pay. Bus and taxi passes are available, and home visits are an option.

Activities assessed:

1. consultation and information to professionals and public
2. immigration notification and surveillance
3. case management of active and non-active TB clients
4. TB clinic

Central Resources

(4 programs and 20 activities)

Population and Outreach: The Central Resources division works with three sets of populations: the RWPH staff, general public, and health care professionals. Among specific groups, it also deals with students, and potential/actual volunteers. Several vulnerable groups were indicated as actively being reached out to: women, impoverished, and differently-abled.

Capacities relevant to Access and Equity:

- Financial resources to support training and staff development

Access and Equity Support Needs:

- For information and data relevant to improvements in A&E.
- Telephone line for hearing impaired

During the consultations, one of the coordinators shared her interpretation of the task by claiming that the primary role of their staff is supporting the other divisions and that therefore they typically look for the guidance from other divisions and programs. In response to this comment, the staff was invited to collectively explore other options, perhaps challenge this assumption, and consider their division as having a more active role with respect to Access and Equity. A focus group discussion was suggested to assist the staff in generating potential actions related to this potential shift in role towards leading in the advancement of the access and equity agenda.

A	Student Placement/Volunteer Management
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Although there are a couple of activities implemented for youth, women and the impoverished, the majority of access and equity issue responses indicate that there are no specific strategies (88%).

Activities assessed:

1. recruitment of students/volunteers
2. orientation/training – student placements/volunteer management
3. screening student/volunteers

Activities, as they pertain to specific vulnerable groups:

Youth

Partnerships exist with McMaster University and Conestoga College for student placements. Student placement guidelines are created to encourage managers to provide student opportunities.

Women

Newspaper advertisements and recruitment of volunteers for Teen Esteem is directed at women only.

Impoverished

Volunteers may submit travel expenses for reimbursement, and parking will be paid for.

B Marketing and Communication

Marketing and Communication responded to all access and equity items as not applying, or not having specific strategies (100%).

Activities, as they pertain to specific vulnerable groups

No information provided

- Activities assessed:
1. assist divisions with the development and implementation of media and promotional campaigns
 2. promote programs and activities offered by the department

C Administration

The majority of access and equity responses for administration indicate that their programs do not apply or there are no specific strategies (95%). However, there are some activities implemented for immigrant newcomers, ethno-cultural groups and youth, and activities planned for differently-abled.

Activities, as they pertain to specific vulnerable groups

- Activities assessed:
1. coordination of human resources activities
 2. resolve building and maintenance issues
 3. coordinate furnishings/equipment purchases and space
 4. providing mail and reception duties
 5. providing administrative support to CHD
 6. provide training and orientation to staff of CHD
 7. coordination of records retention activities for CHD

Immigrant Newcomers

Foster partnerships with schools in the community specifically related to new immigrants. Public Health is now member of the Speakers Bureau and plan to give a presentation to an ESL class at St. Louis as a means of improving access.

Ethno-cultural Groups

When recruiting Family Visitors, advertisement indicated the need for a variety of different languages. Family visitors currently speak 15 languages.

Youth

Foster partnerships with schools in the community specifically related to youth.

Differently-abled

Planning for appropriate equipment, or parking for staff with physical challenges or ergonomic needs.

D	Resource Centre
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The most common response for the resource centre was that they have no specific strategies or that access and equity issues do not apply to their program (97%). However, activities are implemented for differently-abled and rural communities.

Activities, as they pertain to specific vulnerable groups***Differently-abled***

Aisles between book stacks are at least 920 mm wide as per National Library Standards.

Rural

The resource centre has an external partnership with the Waterloo Regional Library with an interlibrary loan agreement in place with all rural libraries of the region. They also keep track of the number of times the services has been used.

Activities assessed:

1. respond to requests from CHD staff and community members for information and resources
2. distribute pamphlets for the CHD
3. develop and maintain the resource centre collection of resources
4. order resources as requested by program managers
5. maintain and promote databases that manage information resources
6. provide current awareness services and document delivery to each manager within their area of expertise
7. deliver training to staff

Family and Community Resources

(2 programs and 21 activities)

Family Health

Population and Outreach: The Family Health program is serving specific groups: families with children 0-6, health care professionals, community groups and agencies, and RWPH staff. Active outreach is indicated for immigrant newcomers, refugees, ethno-cultural groups, differently abled, youth, low literacy, women, impoverished, rural population and aboriginal population. In other words, all but Gay, lesbian/bisexual and transgendered populations were indicated for active outreach.

Activities assessed:

1. pre-birth services
2. breastfeeding support
3. hospital liaison
4. training needs and capacity
5. documentation
6. service coordination
7. liaison with HBHC community partners
8. family wellness
9. healthy children info line
10. parent education
11. HBHC marketing and communications
12. HBHC early identification component
13. Short-term home visits and HBHC screening
14. Service integration in the community

Capacities relevant to Access and Equity:

- Resources for work with multicultural families
- Policies and procedures are currently being revised to include strategies to increase access and equity for families
- Actively engaging in community partnership. St. Jacob's Family Support and Woolwich Community Health Centre – serving Low German-speaking Mennonite population; other wellness sites are present in 4 rural townships, St. Monica/Monica Ainsley; Multicultural Centre, Outreach Workers, Family Resource Centres
- Provide training to internal and external partners on cultural awareness, immigration, etc.

Access and Equity Support Needs:

- Training: More information on multicultural groups and more training on cultural health practices and beliefs; training needed to learn strategies to work with vulnerable groups
- To increase links with Reproductive Health
- Limited relationship with hospitals related to access and equity
- Limited educational materials in some languages
- Policies and procedures regarding accessing interpreters – identifies a need for RWPH trained interpreters

Most of the responses for Family Health indicate that they have some access and equity activities implemented (62%). However, no activities are addressing the GLBT community.

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural Group

Interpreters are accessible when need be and plans are in place to use interpreters in conducting information sessions with newcomer immigrants/ethno-cultural groups. There are also plans to order different translations of the developmental screen to be used in screening children. Family visitors accompany Public Health Nurses on home visits – 26 languages are represented. It is anticipated that info sessions will be held with ESL class participants and to promote screening/info events through the medical services. Needs of Mennonites are also a focus. A Low-German speaking nurse and family visitor are available, and any changes or new initiatives at the Mennonite sites go through the elders for community approval. Mexican Mennonites have also assisted through organizing a special clinic.

Differently-abled

There are family visitors trained in sign language. Staff also ensures that the location where service is to be delivered is wheelchair accessible, and they will refer families to sites that are physically accessible.

Low Literacy

Marketing materials are tested for low literacy. Literature is geared to low literacy levels and graphics are predominantly used. Videos have also been used for health teaching.

Women

Input from young women was obtained through piloting HBHC marketing materials.

Rural

Plans are being considered to hold screening event at a rural site. There are also 5 rural, family wellness sites, and “Rural Routes on Wheels”. Staff offered support to proposal for Rural Routes project in rural communities.

Impoverished

There is judicious use of bus/taxi vouchers for those attending parenting programs and HBHC. Child care costs are covered for HBHC advisory members, and they also assist families to access child care subsidies so they can use other supports.

Youth Health

Population and Outreach. The Youth Health program works with designated vulnerable group- youth. No outreach to other vulnerable groups within the target group was identified.

Activities assessed:

1. bullying prevention project
2. youth gambling prevention project
3. teen esteem
4. suicide prevention coalition
5. life-skills training
6. puberty co-teaching/training
7. curriculum support/newsletter

Capacities relevant to Access and Equity

No capacities identified³.

Access and Equity Support Needs

- Statistical data related to youth
- Training, teaching materials, time
- Awareness-raising training, strategies/implementation training, policy/procedures support
- No budget allocations for Equal Access initiatives in 2001

Youth Health responded to all access and equity items as not applying, or not having specific strategies (100%).

Activities, as they pertain to specific vulnerable groups

No information provided

³ However, an assumption could be made that the staff expertise and curriculum resources relevant to youth are present and available.

Health Determinants Planning and Evaluation (HDPE)

(3 programs and 13 activities)

Population and Outreach

The HDPE division provided three program information sheets, which cover a total of 13 specific activity areas. The division deals with a wide range of target groups, including: staff, general population, community groups and organizations, health care professionals, as well as the staff and other departments from the corporation of the Region of Waterloo. The vulnerable groups, that HDPE programs reach out to include all but GLBT populations.

Capacities relevant to Access and Equity

- Internal resources- staff expertise and awareness of the access and equity issues
- Internal partnerships through the Access and Equity Advisory group
- External partnership with settlement services, ESL teachers, Centre for Research and Education in Human Services, Opening New Doors, Downtown Kitchener Community Health Centre
- Access to census data
- Experience supporting other divisions’ projects

Access and Equity Support Needs

- More relevant information and data
- Policies and Procedures, specifically, to create explicit procedures that require consideration of the access and equity in all planning,
- To set guidelines and targets for the RWPH relating to A&E
- Need clearer and stronger partnership guidelines between staff of different programs
- The specific budget does not exist but may be built into projects
- Needs updated demographics re: ethno-cultural groups, low income, elderly, etc.
- Specific budget allocations regarding interpretation, translation, community member travel expenses, etc.

A Healthy Communities and Policy
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Almost half of the responses indicate that some or most activities are implemented (47%). All vulnerable groups are addressed.

Activities, as they pertain to specific vulnerable groups

<p>Activities assessed:</p> <ol style="list-style-type: none"> 1. poverty prevention and reduction 2. healthy food systems policy 3. healthy food systems citizen engagement 4. coordinating peer program 5. healthy communities activities 6. access and equity 7. Regional Housing Advisory Committee
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Immigrant Newcomers/Refuges/Ethno-cultural Groups

Staff went to an ethno-cultural radio station to promote guaranteed income supplement. Community gardens and “Good Food Box” will be promoted for use by ethno-cultural groups. The Community Nutrition Program is also looking for ways of allowing certification without literacy skills. A focus on multicultural aspect of food – including religious beliefs, and pairing Somali women with previously trained Somali-speaking Community Nutrition Workers (CNW) is underway. The Canadian Food Guide is translated into 12 languages other than English. Also, some initial planning work has been done with the Community Coalition on Refuge and Immigrant Concerns. These plans include Refugee World Day celebration, advocacy or promotion and outreach of ethnic groups.

Differently-abled

The office is wheelchair accessible and some meeting locations are wheelchair accessible. Community gardens and Good Food Box will be promoted for use by differently-abled community members.

Youth

They have had focus discussions with homeless youth and at-risk youth, and are developing a video for youth. There are efforts to establish a youth centre in Wilmot.

Low Literacy

Efforts are made to use clear language, large font and appropriate literacy level in all materials and reports.

Rural

Staff is participating in two Ontario Public Health Association work groups: Food Security Work Group (FSWG) and Food Biotechnology Work Group. Both intend to advocate for policy that protects Canadian farmers and promotes local food systems and sustainable farming methods. Consultations with the rural community determined that this community is accessing programs and statistical information is gathered as well. Food Link consists of representatives from rural community.

Impoverished

Demographic analysis of Region’s population identified which groups are most affected by poverty (e.g. single moms, working poor, new immigrants, and youth). Several open community forums have been held to develop comments on “Opportunities 2000” (community-wide poverty reduction strategy) vision and mission. They also have a community action team that is comprised of low income individuals who provide feedback on all aspects of programming. Bus tickets, taxi vouchers, gas certificates are also available. They are continually updating demographic information related to vulnerable groups and the depth and breadth of their poverty. A new measurement tool is also being developed based on Sustainable Livelihoods Assets approach. FSWG has planning activities for an election-related campaign to advocate for adequate income for healthy food – “Pay the Rent and Feed the Kids”. Regular involvement and communication with low income communities determines that they are accessing the programs, and statistical information is gathered

as well. Community gardens and the Good Food Box will be promoted for use by impoverished/homeless/ working poor. Representatives are involved in Food Link. A community consultation will be taking place with regard to the housing vision statement.

Outreach to pregnant women

CNW training tailored to needs of those CNW's who will be working with prenatal groups.

Outreach to Isolated people

CNW groups aim to reach isolated individuals and make contacts for them and include them in group activities.

B Planning and Evaluation

The majority of responses for planning and evaluation indicate that there are no specific strategies that refer to vulnerable groups (64%). Other responses tend to fall in the 'some activities implemented' category, and the only groups with no initiatives are the GLBT and Aboriginal communities.

Activities assessed:

1. rural health study
2. neighborhood consultations
3. urban poverty consortium
4. child health proposal

Activities, as they pertain to specific vulnerable groups

Immigrant Newcomers/Refuges/Ethno-cultural Groups

The Rural Health study involved speaking with Low-German speaking Mennonites from Mexico and those who work with this community. Also, consultations were held with settlement counselors on the needs, resources, and preferences of newcomer families. Settlement workers and HBHC visitors have also acted as interpreters. Events in the future will be organized at ESL schools.

Differently-abled

Accommodations were made for a visually impaired focus group participant. Physical accessibility at community meeting locations was also ensured.

Youth

Some focus groups and key informant interviews have taken place for the Rural Health study.

Low Literacy

There are attempts to use clear language and basic literacy level, for all materials.

Women

Women who are mothers have contributed to the Rural Health study.

Men

Men who are farmers have contributed to the Rural Health study.

Rural

Staff is making a concerted effort to meet with rural neighborhood groups during the neighborhood consultation. Feed back from two groups relays concern at the lack of access to programs available in city. Staff utilized media for the rural population that targeted each township.

Impoverished

Staff is attempting to learn about poverty issues in rural communities. Urban Poverty consortium sought to examine the extent to which each group in the Region has high vulnerability to poverty and how that poverty relates to other issues – such as school performance.

C	Epidemiology
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While a couple of responses indicate a need to assess access and equity issues, the clear majority indicate no specific strategies or these issues do not apply to the activity (91%).

Activities, as they pertain to specific vulnerable groups***Youth***

Data assessment indicates that children are most negatively affected (physically) by accidents and injuries.

Activities assessed:

1. ad hoc requests
2. child health compendium
3. GIS mapping

Gender-specific

Data is assessed separately for males and females and where differences are large, interventions are suggested.

LEARNINGS FOR ACTION:

What we have learned and where we think this may take us next

What we learned....

In summary, several highlights may be extracted from the wealth of information provided in the review. These highlights will capture three aspects: vulnerable populations, nature and type of activities undertaken and needs and resources relevant to access and equity.

- The majority of Region of Waterloo Public Health programs have made attempts to address access and equity issues
 - translation of promotional materials, use of interpreters, and transportation and child care assistance dominate in various programs.
 - The work with immigrant and ethnocultural groups is almost exclusively focusing on translation and interpretation and rarely reflects collaborative, or culturally-grounded approach to programming (e.g. language adjustments, involvement of cultural groups in pilot testing of materials, program planning, etc.);
 - Gender-specific, and age-specific work with youth, are clearly visible across various divisions (CDDSR, F&CR, EHLR)
 - Rural populations have been receiving significant attention lately (Rural Health Study, Wellness Centres, Safe Water, Immunization, Dental Programs)
 - New efforts are emerging with respect to engaging in community consultation processes (HDPE, EHLR)
 - When developing promotional materials, most of the programs respect the literacy level guidelines

- According to the review findings, the majority of the activities have not been grounded in an evidence-based and/or comprehensive planning, but rather in brief and ad hoc needs assessments.
- The majority of the implemented activities are only partially addressing the issues and needs of the vulnerable groups (“some activities implemented”)
- There is very little evidence on cross-divisional coordination of work with specific vulnerable groups (e.g. women, youth)
- Only three of the implemented activities have been evaluated
- Across the Region of Waterloo Public Health there are:
 - multiple resources that could serve as a starting point in generating collective action on access and equity. (staff knowledge and experience; strategies, curricula, and community contacts), and
 - varied levels of the understanding of the scope and breadth of access and equity issues

... and where to go next: Recommendations

“Work from a vision, not on a program delivery frame of mind. Create an environment that welcomes advocacy. See each other as working toward same goals, not in separate disciplines” (staff comment at the General Staff Meeting)

As mentioned earlier, two groups provided information for these results: the Access and Equity Review Advisory Group, and the Region of Waterloo Public Health staff who participated in small group discussions in response to the presentations on issues and strategies addressing access and equity. The two sets of recommendations are remarkably similar and complement each other. Both identify a number of specific and proactive suggestions. Both also offer a range of strategies, including increasing personal and collective awareness, improving our work environment, engaging in collective action, and working on specific policy-level changes:

Advisory Group Recommendations

The Access and Equity Advisory Group had an opportunity to hear the preliminary results of the review which provided a basis for the focus group discussion that followed. Appendix G outlines the questions that were asked at that occasion.

The group focused on providing input by responding to two questions:

- a/ What are the perceived opportunities and challenges to our further engagement in Access and Equity?
- b/ What are some immediate and long-term steps that we may be taking?

Opportunities and Challenges

The group felt that several factors are supporting the need to address access and equity. Externally, the new Region of Waterloo (ROW) Integrated System Service Delivery initiative, while internally, the diligence in responding to the audit, interest, enthusiasm, and sensitivity to the issue (overwhelmingly positive feedback to the General Staff Meeting devoted to the issue). The group also wanted to stress that we “*should not lose the sight of the value of the process that was implemented during the review*“, and some positive outcomes that it generated. A common observation was that as a department we have a number of existing resources to make use of.

Among concerns, the group felt that some program areas are stretching their programs and investing resources (e.g. in translations) while there may be more appropriate and effective alternatives. There is also a concern that as a mainstream organization we may never be able to give sufficient attention to the issues of minority groups. Some participants felt that the review results may be an overrepresentation of efforts, and that in order to address access and

equity issues, resources, such as time, people and money need to be invested. The group also identified that we need clearer parameters/guidelines on what it means to act on access and equity, and the need to make systemic effort to address it instead of adding resources alone.

The group brainstormed around three levels of potential actions: program, division and department level changes and identified several sets of strategies through their recommendations:

Program and Departmental Level Changes

Awareness raising and promotion

- Train existing and new staff, including training on legislation.
- Include this training in the orientation package/resource binder and continue to address it through Good Morning Public Health
- Develop a small resource binder at the divisional level with resources, contact names, examples and references useful for work on access and equity
- Challenge the perception that Access and Equity belongs HDPE – it belongs to everyone

Establish an environment that is supportive of Access and Equity

- Identify the Access and Equity champion(s) in PH
- Take advantage of internal resources (e.g. organize team discussions, problem solving activities, etc.)
- Explore possibilities for a full stakeholder approach in planning programs, services and campaigns

Concrete steps and tools for planning

- Identify one activity that addresses access and equity in all operational plans ;
- Develop a process for implementation of the OPHA Equal Access Standard indicators
- Create Access and Equity standards to guide all our work;
- Designate a program to do a pilot (Youth Health volunteered) of an access and equity program-wide initiative;
- Develop a tool box with access and equity strategies (consultation, communication and research methods, tips and suggestions)
- Include stakeholders in project management (through advisory and steering committee work)

Long Term Changes

- Incorporate access and equity interventions on regular basis
- Ensure that access and equity work is present throughout the department
- Endorse specific outcomes (targets)
- Start from existing policies and modify them (e.g. communication)
- Look at existing contracts and search for opportunities to support vulnerable groups (e.g. local food producers)
- Ensure that DLT endorses follow-up activities with defined parameters

- Celebrate diversity/heterogeneity (“we are other”)
- Consider the example of Family Visitors - may be one strategy that could be transplanted to the other parts of department

Corporate level

- Modify hiring practices to support access and equity (cultural diversity, sexual orientation, disabilities, etc);
- Involve unions in discussions on how to improve access and equity;
- Contribute these findings to the existing efforts related to employment equity and human rights;
- Check the corporate vision, mission and value statement to see how visible commitment to access is;
- Contact Heritage Canada to seek funding for the work on cultural diversity;
- Continue to seek and use staff input in all aspects of access and equity work;

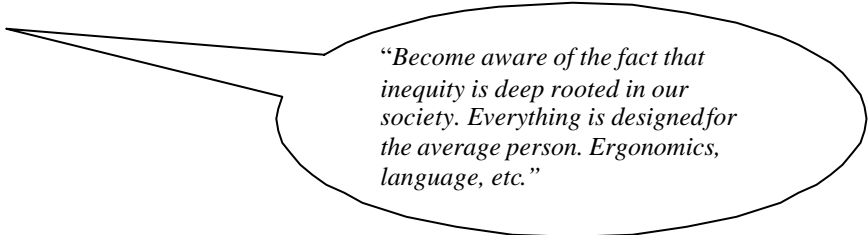
General Staff Meeting

At the General Staff Meeting, which was used as a vehicle for increasing awareness of access and equity issues, the staff (approximately 150 people) had an opportunity to brainstorm about possible strategies for increasing the inclusiveness of our programs and services. The staff responded to a question:

“Based on what you have heard today, what do you think we should do about improving Access and Equity, as Public Health employees and as citizens?”

The list of themes that emerged from this discussion is very similar to the ones generated by the Access and Equity Advisory Group.

Increase Personal and Public Health Awareness and Knowledge



“Become aware of the fact that inequity is deep rooted in our society. Everything is designed for the average person. Ergonomics, language, etc.”

Start with self-awareness: Look at barriers on individual basis (e.g *What do I believe re: this issue, makes it easier to work and advocate, when you figure out barriers it is easier to change*”, “When we don’t understand issues, we are afraid”,, “Volunteer work increases our awareness”)

Promotion of the issues: Publicize community events such as Multicultural Festivals, more Celebrate diversity of Public Health staff

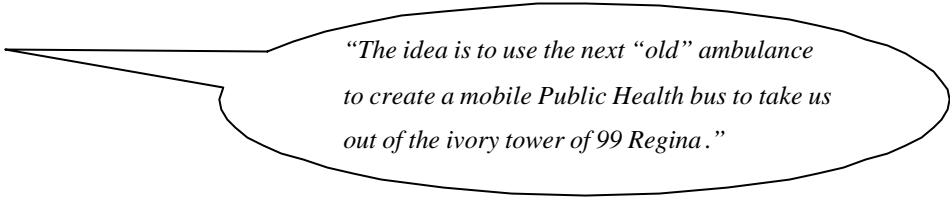
Acquire Tools: Learn how to act sensitively, including learning about the use of sensitive tools, build atmosphere of understanding and tolerance

Need to reach beyond changing ourselves to changing into the community, i.e. organize a forum, or education sessions

Engage personally: *“Talk with youth, address them, connect with them in your own communities”*

Several comments on specific actions to personally support current advocacy efforts (Habitat for Humanity, Group Homes) by voicing personal support

Going out into the Community



“The idea is to use the next “old” ambulance to create a mobile Public Health bus to take us out of the ivory tower of 99 Regina.”

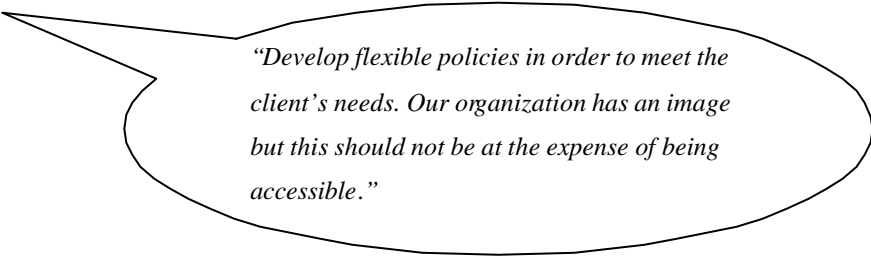
Community locations

“Go to people instead of expecting them to come to us”; “Go into the rural communities”, “Go where people want to go to access services”, “Go to places where different people are or at least make connections with them where you are”; Organize an Open House, More flexibility with clinic hours

Engage in collaboration/partnerships/integration of services:

Create more exchange programs, example is ROOF; Make individual connections with people in the community, establish small groups, learn more about each other; How do we correct the services we have to offer with what certain groups need: perhaps better integration with other agencies who work specifically with certain groups

Develop new and modify the existing policies/guidelines



“Develop flexible policies in order to meet the client’s needs. Our organization has an image but this should not be at the expense of being accessible.”

Hiring/employment policies:

*Ensure hiring policies reflect the diversity of our community
Hire people who reflect the community, who have personal experience; Modify our recruitment. Ask the right questions to get the right people – less education focus – more practical; Ensure equality of treatment in the job (among different unions)*

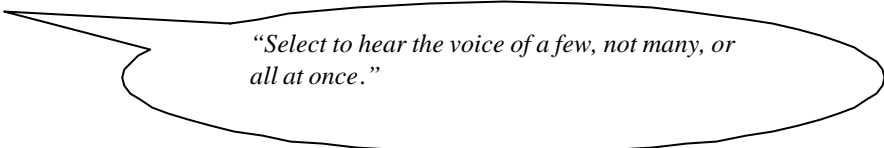
Communication Policy: Advertising, marketing with ethnic radio stations and newspapers;

Inspection policies: Revisit inspection policies and procedures (e.g. *Multicultural festival inspection is in conflict between public health standards and cultural ways- can we follow the same provincial regulations with various cultural practices?*)

New Policies: *Negotiate and establish “new rules”, new policies that will have this renewed sensitivity reflected. We have to appreciate that our tools might be intimidating – focus groups, surveys, etc.; Follow the City of Toronto’s lead and develop Access and Equity policies and implementation strategy.*

Planning and Evaluation Policy: *“Have participants from vulnerable groups as part of input to programs. We have to overcome the barriers as having them as part of the boards, or steering committees”*

Look at priorities

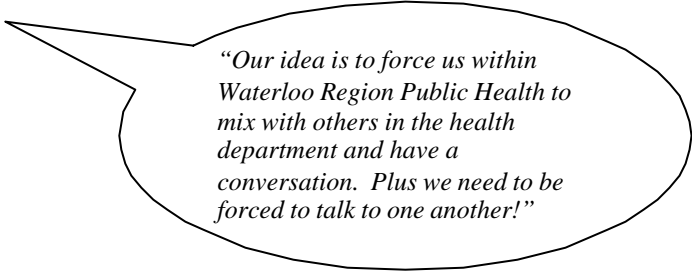


“Select to hear the voice of a few, not many, or all at once.”

“Resources may or may not be an issue, shifting in resources means a shift in priorities”;
“Instead of trying to deal with all, commit to exploring how to support vulnerable groups in accessing funds through grant proposals”

Improve Internal Communication on Access and Equity issues

- *“We go to what’s comfortable and stay with what’s comfortable. To address access and equity we need to become uncomfortable”.*
Have each of programs have a designate to represent A&E issues, and link with the larger planning group
- Work better together
- Recognize the value of the programs that are already addressing this issue, ensure that they stay around or great initiatives may disappear



“Our idea is to force us within Waterloo Region Public Health to mix with others in the health department and have a conversation. Plus we need to be forced to talk to one another!”

CONCLUSION

The findings of the review of the Region of Waterloo Public Health compliance with the Equal Access Standard and the accompanying communication campaign provided a foundation for two discussions on potential improvements, and strategies to achieve them. The two sets of recommendations resemble and complement each other. In summary, those strategies include:

1. Continuous learning about basic issues of access and equity, and strategies to address them. These include training sessions and promotional activities to improve our understanding of who the vulnerable people are how they experience lack of access and equity. It also includes development of resources, strategies, and specific tools to assist the staff in tailoring programs to become more accessible;
2. Increasing the presence in the settings where vulnerable people are. These strategies include more off-site work and consultation in the community, greater collaboration with relevant community partners ;
3. Adoption of a selective, priority-based approach to action. In other words, becoming more informed about best practices relevant to the access and equity work, being able to adapt them in our settings, and developing clear desired outcomes. Such a comprehensive work may require a decision to focus on some vulnerable groups first.
4. Optimizing the existing resources. RWPH already has considerable resources: staff expertise, connections in the community and beyond, creative strategies in some programs, and access to information. Greater integration of these resources and well coordinated cross-divisional work may both facilitate the knowledge transfer and address efficiency of their use.
5. Policy development. Finally, the Region of Waterloo Public Health staff clearly indicated that they are ready to engage in a more systematic work on improving access and equity. This refers to the expressed readiness to engage in a department-wide, and perhaps a corporation-wide policy development around access and equity.

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APPENDIX A: EQUAL ACCESS STANDARD OF THE MANDATORY HEALTH PROGRAMS AND SERVICES GUIDELINES

Equal Access

Goal:

To ensure that all Ontarians have access to public health programs

Objective:

To reduce educational, social and environmental barriers to accessing mandatory public health programs

Requirements and Standards:

1. The board of health shall provide mandatory public health programs and services, whenever practical and appropriate, which are accessible to people in special groups for whom barriers⁴ exist. Broadening access may require adjusting existing programs, promoting accessibility and developing special programs including special educational materials, tailored service delivery and active outreach.
2. When planning to use facilities and sites for mandatory public health programs, the board of health shall select those which are barrier-free and have suitable access for special groups.

The board of health shall establish ongoing community processes to identify needs, recommend approaches and monitor progress toward achieving access to the mandatory public health programs and services.

⁴Barriers can include, but are not limited to: literacy level, language, culture, geography, social factors, education, economic circumstance, and mental and physical ability.

APPENDIX B: FEDERAL AND PROVINCIAL LEGISLATION AND STANDARDS

Canadian Federal Law:

The Canadian Charter of Rights *and Freedom* [Constitution Act, 1982(79) Part I] states:

“Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, mental or physical disability.” [15.(1)]

“Affirmative action programs [Part II, Section 6, (2) Subsection (1)] does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age, mental or physical disability.”

The Canadian Human Rights Act [R.S. 1985, c. H-6, Section 2] states:

“Every individual should have an equal opportunity with other individuals to make for himself or herself the life that he or she is able and wishes to have, consistent with his or her duties and obligations as a member of society.”

Part 1 section 3.(1) prohibits any grounds for discrimination based on race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability and conviction for which a pardon has been granted.

The Employment Equity Act of 1995 states:

“is to achieve equality in the workplace and to correct conditions of disadvantage experienced by certain groups.”

The Canadian Multiculturalism Act of 1988 {R.S., 1985, c.24 (4th Supp.) C-18.7} states:

“The Constitution of Canada provides that every individual is equal before and under the law and has the right to the equal protection and benefit of the law without discrimination and that everyone has the freedom of conscience, religion, thought, belief, opinion, expression, peaceful assembly and association and guarantees those rights and freedoms equally to male and female persons.”

The Multiculturalism Policy of 1988 states:

“3. (1) (c) promote the full and equitable participation of individuals and communities of all origins in the continuing evolution and shaping of all aspects of Canadian society and assist them in the elimination of any barrier to that participation; (e) ensure that all individuals receive equal treatment and equal protection under the law, while respecting and valuing their diversity.”

Ontario Provincial Legislations and Standards:

The Ontario Human Rights Code [R.S.O. 1990, c.H. 19, s. 1;1999, c.6.s.28 (1) (2) states:

“Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, same-sex partnership status, family status or handicap.”

“Every person has a right to equal treatment with respect to the occupancy of accommodation, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age marital status, same-sex partnership status, family status, handicap or the receipt of public assistance.”

The Health Protection and Promotion Act [R.S.O.1990, c.H.7, s.7] gives legal authority to the Mandatory Health Programs and Services Guidelines (Ministry of Health and Long Term Care 1997). The purpose of the Mandatory Health Programs and Services Guidelines[MHPSG] is to

“set out the minimum requirements for fundamental public health programs and services targeted at the prevention of disease, health promotion and health protection.” Section 7 of the Act authorizes the Minister of Health to “develop and publish guidelines that represent minimum standards for these programs and services.”

Equal Access is one of the general standards of the MHPSG. The goal is “to ensure that all Ontarians have access to public health programs” and its objective is “to reduce educational, social and environmental barriers to accessing mandatory public health programs.”

APPENDIX C: VULNERABLE POPULATIONS

Vulnerable Groups - Definitions

Immigrant Newcomers: People who have recently moved to Canada with the intention of settling. The settlement time greatly varies between cultural groups and it may take between 3 and 10 years.

Refugee: A person who by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, has left their country of origin.

Ethno-cultural groups: A social group with a shared cultural heritage which maintains distinctive cultural, linguistic, religious and other traditions while living within a larger (usually multi-cultural) society.

Gay: A man who has feelings of affection and attraction, both emotionally and physically, for men.

Lesbian: A woman who has feelings of affection and attraction, both emotionally and physically, for women.

Bisexual: A woman or man who has feelings of affection and attraction, both emotionally and physically, for both men and women.

Transgendered: The term transgendered is an umbrella term that refers to people who cross gender boundaries and/or do not fit traditional male or female roles and expectations. The transgendered community is very diverse (transsexual, bigender, cross-dressers, drag queens, drag kings, inter-sex, other gender). Definitions and labels are fluid and not mutually exclusive. Some people identify with more than one label, and people's identities can shift over time.

Differently Abled: A person who has a long-term or recurring physical, intellectual, mental, or sensory disability.

Youth Male: Males, 11-29 years of age.

Youth Female: Females, 11-29 years of age.

Low Literacy: (level one - lowest level): Adults at the lowest level of literacy are unable to deal with most of the daily reading and writing activities required at home, work, and in the community. They would likely identify themselves as having difficulties, and they are more likely to depend on T.V. and the radio for information, be under or unemployed, and fall into the lowest economic levels.

Women: Adult females, 29 and over.

Elderly: Usually people 65 years and older. For some Canadians, senior issues may be important at earlier ages (e.g. 55 and over).

Impoverished/Working Poor: Individuals, whose annual income falls below a set poverty line. For example, for a 4 person family income some measures are: Fraser Institute (\$17,542), Statistics Canada (\$31,256), Canadian Council on Social Development (\$32,130).

Rural Population: people living in the 4 townships of Waterloo Region, recognizing that there are different needs and issues among people living in the townships than for people living in the cities.

Aboriginal population: People who belong to indigenous nations of the Americas

APPENDIX D: LETTER OF INTRODUCTION

April 2, 2002

Dear CHD managers:

Enclosed is the Access and Equity Review form that you need to complete by **May 10, 2002**. The primary purpose of the review is to gather information on the status of our programs and services with respect to the Access and Equity standard, and understand our needs and resources. This questionnaire has three parts. Part 1 and Part 3 refer to the programs, while Part 2 deals with core activities within your programs.

Part 1 is asking for basic information on your program: name, core activities, and target groups. It also introduces you to the list of vulnerable groups that we are referring to throughout the form. This part needs to be completed by a program manager or supervisor.

Part 2 of the questionnaire refers to all of the core activities that are identified in Part 1. Question 2.1. should be repeated as many times as there are activities identified in Part 1. The remaining questions of this section ask for more details related to the codes that you assign in question 2.1. Please provide a brief explanation and an example where required.

Part 3 of the questionnaire deals with your program needs and resources with respect to access and equity issues and could be completed either by the program manager or by a team of people.

In order to assist you with the terminology used in the questionnaire, we are providing a list of brief definitions of the vulnerable groups we are referring to. For more detailed information, please refer to the Glossary of the Access and Equity Terms. Your divisional Access and Equity Working Group representatives can provide copies of this document.

We recommend that you review the entire questionnaire first, think about your responses and if possible, consult with your colleagues who may have information, experience or knowledge related to specific questions.

Your responses need to be available electronically, so if you decide to complete the questionnaire manually first, please ensure that you type the information in or ask for your program assistant's support. The electronic version of the questionnaire will be available on the Intranet in the second week of April. Meanwhile, please save your completed questionnaires as usual, in your shared directories. Specific instructions on how to access and use the Intranet version will be provided shortly.

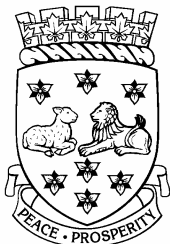
The staff of the Planning and Evaluation program will be available throughout the review to assist with your questions and concerns. Please feel free to contact the staff who work with your division, or call Daniela Seskar-Hencic, at 883-2004, ext. 5317.

Thank you for your support and cooperation.

Planning and Evaluation Team

Please note that while we are collecting information on the present status of our programs and activities, we would also like to hear from you if you have any reliable information on the access and equity strategies and programs that had been in use in the past. Any documentation on this historical information will be helpful too. Please forward those comments directly to Daniela via e-mail.

APPENDIX E: REVIEW TOOL



Waterloo Region Community Health Department Equal Access Initiatives Review



Part One: Basic Program Information

1.1. Name:

1.2. Please indicate which program you are reporting on: Please use this form for reporting on one program only.

- " Environmental Health
- " Injury Prevention
- " Food Safety and Infection Control
- " Heart Health and Cancer Prevention
- " Tobacco Enforcement
- " Cancer Screening
- " Dental Health
- " AIDS/STD
- " Control of Infectious Diseases (Communicable Diseases)
- " Immunization
- " Sexual Health
- " Reproductive Health
- " Family Health
- " Youth Health
- " Resource Centre
- " Administration
- " Marketing/Communications
- " Student Placements/Volunteer Management
- " Healthy Communities and Policy
- " Planning and Evaluation
- " Emergency Medical Services
- " Epidemiology

1.3. Manager/Contact Person:

1.4. Core Activities⁵:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

⁵ Please refer to your operational plans and/or work plans and list your core program activities.

1.5. Please list the target groups that your program is serving:

- " general population
- " community groups/agencies/institutions
- " health care professionals
- " specific target group(s) or stakeholders, Please state the specific target groups 1. _____; 2. _____, 3. _____; 4. _____; 5. _____; 6. _____
- " CHD staff
- " other _____

1.6. Are you presently reaching out to any of the vulnerable groups listed below? YES NO

If yes, please indicate the ones you are working with:

- | | |
|---|---|
| <ul style="list-style-type: none"> " immigrant newcomers; " refugees; " ethno-cultural groups; " differently abled; " gay, lesbian/bisexual/transgendered " youth: male | <ul style="list-style-type: none"> " youth: female " low literacy " women; " impoverished/working poor; " rural population; " aboriginal population; " other, please list: _____ |
|---|---|

2.2. Details on Needs Assessment/Planning/Implementation/Evaluation

In order to respond to this section, please review the previous one and provide more information for each of the identified access and equity actions (Needs Assessed (NA), Activities Planned (AP), Activities Implemented (SA or AA), or Activities Evaluated (AE)).

2.2.1. Needs Assessment: (if indicated that needs assessment done for some vulnerable groups): (NA)

Please share your evidence of the need for improved access/equity: (Which community does it refer to? How did you collect information? What did you find out?)

2.2.2. Planning for Equal Access (if indicated that planning activities have been done for vulnerable groups) (AP)

Please share your planning information related to addressing access and equity issues: (group/community, techniques used, key points, time lines)

2.2.2.1. Does your plan include opportunities for community input?

2.2.2.2. How will you ensure community voices in planning and evaluation of your services in the future?

2.2.3. Implementation (if indicated that specific activities implemented) (SA and AA)

Please answer the following in relation to **all core activities**, by circling the appropriate answer and describing your approach, with examples. Please note that the list of activities below may or may not be detailed enough to capture your actions. At the end of the list, there are three rows marked "other" to allow you to describe those actions.

Type of Activity	Identified Community	Level of Implementation a) Not Applicable b) Partially implemented c) Implemented d) Ensure/facilitate access through community partners e) other Please circle one or more that apply:	Your approach and an example
Using language interpreters		a b c d e	
Improving access for the deaf, deafened, or hard of hearing (e.g. computerized note-taking, real time captioning, sign language interpretation, technical devices)		a b c d e	
Aids for visually impaired (e.g. Braille embossing, audio tapes, large print)		a b c d e	
Ensuring readability: (e.g. translations/literacy levels/clear language/graphics)		a b c d e	

Type of Activity	Identified Community	Level of Implementation a) Not Applicable b) Partially implemented c) Implemented d) Ensure/facilitate access through community partners e) other Please circle one or more that apply:	Your approach and an example
Provision of child care Offering programs at community-based locations (e.g. rural)		a b c d e a b c d e	
Improving physical access for those with different abilities		a b c d e	
Facilitating transportation		a b c d e	

Type of Activity	Identified Community	Level of Implementation a) Not Applicable b) Partially implemented c) Implemented d) Ensure/facilitate access through community partners e) other Please circle one or more that apply:	Your approach and an example
Holding special events for identified groups (e.g. community forum; fair)		a b c d e	
Using media for identified groups (e.g. use of specific radio/tv channels or programs, specially written or produced materials)		a b c d e	
Involving community representatives from identified groups		a b c d e	
Fostering partnerships (CHD) (please identify level:e.g. cooperation, collaboration,		a b c d e	

Type of Activity	Identified Community	Level of Implementation a) Not Applicable b) Partially implemented c) Implemented d) Ensure/facilitate access through community partners e) other Please circle one or more that apply:	Your approach and an example
integrated planning...service integration)			
Fostering external partnerships (please identify level:e.g. cooperation, collaboration, integrated planning...service integration)		a b c d e	
Engaging in community development/organizing		a b c d e	
Stakeholder-based planning/actions		a b c d e	
Advocating on behalf of a group		a b c d e	

Type of Activity	Identified Community	Level of Implementation a) Not Applicable b) Partially implemented c) Implemented d) Ensure/facilitate access through community partners e) other Please circle one or more that apply:	Your approach and an example
Other -----		a b c d e	
Other -----		a b c d e	

2.2.4. Please describe how you determine that these vulnerable groups are accessing your programs/services?

2.2.5. What plans do you have to improve access to your programs/services by the vulnerable groups?

2.2.6. Please describe what statistical information, if any, you are gathering on any of the vulnerable groups:

2.2.7. Evaluation of Equal Access activities (If indicated that evaluation activities have been done)
(AE)

Please share your evaluation information related to addressing access and equity issues: (group/community, techniques used, key learnings, implementation plans)

3.0. Part Three: Needs and Resources

What Needs/Resources does your program have in relation to:	Needs	Resources	Details and comments (e.g. relevance, interest, priorities....)
3.1. Information and data relevant to improved access and equity			
3.2. Resources (e.g. staff training, reading materials, teaching materials, time)			
3.3. Awareness-raising Training			
3.4. Training on strategies for addressing access and equity			
3.5. Policies and Procedures			
3.6. Other			
3.7. Did you have any funds budgeted for Equal Access needs in 2001:			
3.8. Partnerships with internal partners relevant to access and equity :			
3.9. Partnerships with external partners relevant to access and equity			

APPENDIX F: REGION OF WATERLOO PUBLIC HEALTH ACTIVITIES REVIEWED

Family and Community Resources	Gambling Prevention Project
Family Health	Teen Esteem
HBHC Screening	Suicide Prevention Coalition
HBHC Service Coordination	Life Skills Training
Liaison with HBHC Community Partners	Puberty Co-teaching/training
Family Wellness Sites	Curriculum support/ newsletter
Breastfeeding Support	Youth and Homelessness
Healthy Children Information Line	Families and Schools Together
HBHC training/internal and external	Nutrition for Learning
Parent Education	Central Resources
Hospital Liaison	Administration
HBHC Marketing	Resolve building and maintenance issues
HBHC Early Identification	Coordinate furnishing/equipment purchases and space
HBHC ISCIS Quality	Provide mail and reception services
HBHC Prenatal Pre-birth Services	Managing the branch office budget
Short-term home visits	Purchase office supplies for the branch office
Service Integration in the community	Supervise 3 staff
Youth Health	Provide Administrative support to CHD
Bullying Prevention Project	

Coordination of Records Retention Activities for CHD
Coordination of Human Resource Activities for CHD
Provide training and Orientation to staff of CHD
Management of budget and financial report for CHD
Resource Centre
Respond to requests from CHD staff and community members for information and resources
Deliver training to staff
provide current awareness services and document delivery to each manager within their area of professional/academic literature
Maintain and promote databases that manage information resources
Order resources as requested by program managers
Develop and maintain the RC collection of resources
Distribute pamphlets for the CHD
Marketing/Communication
Solicit and promote media coverage of CHD events/activities
Promote the program and activities offered by the department through a variety of venues including: promotional materials and events

Assist divisions with the development and implementation of media and promotional campaigns
Serve as the department's communication liaison and facilitator with both regional and Central West Communication groups
Development and maintenance of department web site
Student Placements/Volunteer Management
recruitment
Screening
Orientation/Training
Evaluation
Communicable Diseases/Dental/ Sexuality Resources
Dental Health
Children's Dental Clinic
CINOT
School-based dental health education
School-based oral health screening
Health promotion activities
AIDS/STD
Health Promotion activities, including resources
STD clinical services

STD/HIV case management
Community Partnerships-committee work, consultations
Anonymous HIV clinic
Immunization
Univerzal Influenza Program
Gr. 7 hepatitis B program
CHD Immunization clinic and confutations
Enforcement of immunization of School Pupils Act
Telephone vaccine info-line
Immunization Promotion
Sexual Health
Sexual health counselling and clinic services at CHD
Sexual health clinical services at ROOF
Girl time program
Resource Development
Community outreach/health promotion activities, campaigns
Sexual health cousselling in high schools
Reproductive Health
Prenatal Nutrition Program
Prenatal classes (adolescent, adult)
Prenatal Health fairs
pre-birth clinics

Reproductive health on-call line
Resources development
community outreach/health promotion campaigns
Control of Infectious Diseases (Communicable Diseases)
International Travel Immunization Clinic
Case Management and outbreak control activities
Consultation and information to professional public
Emergency plan development for new emerging CD's (pandemic, bio terrorism, West Nile virus etc)
TB Control
TB clinic
Case management of active and non-active TB clients
Immigration notification and surveillance
Consultation and information to professionals and public
Environmental Health & Lifestyle Resources Division
Heart Health and Cancer Prevention/Cancer screening
Cancer screening and early detection

Cancer prevention, diabetes prevention, heart disease prevention
Nutrition promotion
Physical activity promotion
Tobacco use prevention
Tobacco enforcement
Tobacco information line
Action on heart health coalition
Tobacco cessation
Safe Water
Monitor water sample results
Issue boil water advisory
Inspect public pools
Inspect public bathing beaches
Establish protocols for adverse samples
Education to the public
Food Safety and Infection Control- West Nile Virus
Establish surveillance for WNV
Establish WNV contingency plan
Establish WNV committee
Establish protocols for reporting of dead birds
Education to the public
Tobacco Enforcement (Tobacco Control Act)
Routine annual inspections

Compliance and enforcement checks
Surveillance
Education to the public
Support smoke free places
Third party supply
Environmental Health
Health hazard investigation
Air quality issues- indoor and out
Contaminated sites
Injury Prevention
Infant car seat safety
Product safety
Recreational safety
Motor vehicle safety
Osteoporosis program
Alcohol abuse in the 18-24 year group
Playground safety issues
Food Safety and Infection Control
Inspections of food premises
Food handler certification
Food recalls
Case management of enteric disease
Outbreak management
Education
Investigation of complaints

Emergency Medical Services Division
Promoting EMS
Participating/Chairing paramedics Advisory Committee - Conestoga College
Responding to service requests
Special events
Health Determinants, Planning and Evaluation
Poverty Reduction
Healthy Food Systems Policy
Healthy Food System Citizen Engagement
Coordinating Peer program
AHealthy Communities@ Activities
Access and Equity
Consultations on Planning and Evaluation
Rural Health Study
Neighbourhood Consultations
Urban Poverty Consortium
Child Health Proposal
Corporate Survey
Child Care Source Book
Responding to data requests

APPENDIX G: FOCUS GROUP QUESTIONS FOR THE ACCESS AND EQUITY ADVISORY GROUP

Access and Equity Review Recommendations Discussion Questions

Given all the information you have heard this morning (preliminary review findings),

1. What excites you about what you have heard?
2. What worries or concerns you about what you have heard?
3. What are some small immediate steps that can be taken to address the findings that take little time and few resources? (consider steps at a program, division, department and corporate level)
4. What are some big bold steps that can be taken to address the findings (consider steps at a program, division, department and corporate level.)