Social Determinants of Health & Community Engagement:

Developing a Framework for Public Health

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2008

Masters of Public Health

Lakehead University

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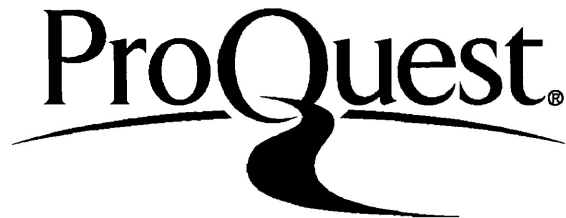
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Acknowledgments:

Introduction

There is a growing understanding within Canada and internationally that our current model of curative medicine is not properly meeting the needs of the population and is unsustainable. The National Health Expenditure Trends 1975–2007 describes how spending on health care in Canada continues to rise (Canadian Institute for Health Information (CIHI, 2007). In 2007, health care spending is expected to be just over $160 billion dollars (which is approximately $4,800 dollars per person) (CIHI, 2007); of which approximately 5% is currently being spent on preventive health measures and health promotion (Shah, 1998). As the rates of chronic diseases within Canada continue to increase (Ontario Prevention Clearinghouse, Ontario Chronic Disease Prevention Alliance and the Canadian Cancer Society, 2007), it is becoming evident that the health of the population is not improving proportional to the amount spent on health care. Clearly, such levels of spending are not feasible for the long term, particularly as it has not led to better health outcomes.

While the biomedical model of health remains to some extent, the dominant model in Canada, greater attention has been paid to the social determinants of health (SDOH) since the release of the Lalonde report (1974). The SDOH typically include: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity (WHO, 1986). This model recognizes the importance of external factors in health, and proposes that reduction of the social inequalities in health (i.e., socially-produced, and therefore potentially avoidable systematic differences in health determined by socioeconomic status; Whitehead, 2007) would lead to better health among Canadians.

There are several advantages to the SDOH approach as it: (1) connects and highlights the need for both social and technical techniques, (2) focuses on both individual and population-based approaches, and (3) addresses the structural conditions that determine health (Marmot, 2007). In doing so, the SDOH approach offers sustainable solutions and equitable outcomes, social justice, and equity (Marmot, 2007).

In particular, income – or poverty, has emerged as one of, if not the most important SDOH. The most recent numbers indicate that 10.8% or 3.5 million Canadians are impoverished, living below the low-income-cut-off (LICO) (Ligaya, 2007). Internationally, it is estimated that over 1.1 billion people live on a dollar a day (Sachs, 2005). Such levels of poverty are not sustainable for individuals, or for communities and economies. Additionally, the gap between the rich and the poor is growing. According to Statistics Canada, in 2005 the gap between the highest income category and the lowest income category was $105,400, while it was $83,000 twenty five years ago (Ligaya, 2007). It is well known that health care disproportionately serves lower income populations (Rapheal, Bryant, & Rioux, 2006), therefore, as rates of poverty continue to rise, so will the need for health care services and health care spending.

This paper will describe the current knowledge and understanding of the SDOH from a public health practice perspective; where relevant, the example of poverty as a SDOH will be used to illustrate points being made. The search strategy employed to review the pertinent literature is described in Appendix A. This paper will also describe the role public health has in implementing a SDOH approach within Ontario, highlighting the work of the Sudbury & District Health Unit. A description of the community engagement model developed by the North East Local Health Integration Network (NE-LHIN) as a means of understanding community priorities follows.

Next, a framework that incorporates both the SDOH approach and community engagement model will be presented. Finally, the implications for implementing this framework for public health education, research, policy development and public health practice are discussed.

Part 1: Current Understanding of the SDOH & the Population Health Approach

The SDOH are comprised of the social, political and economic forces that affect the health of individuals and populations, likely more substantially than personal lifestyles or health care systems (Bryant, Raphael, & Travers, 2007). There is considerable debate within the field of public health about the appropriate terms to be used to express specific ideas that is essential to understand, as terminology often drives both understanding and action. Given the importance of using the correct terminology, a glossary of SDOH-related concepts and terms is provided in Appendix B.

Two terms often used interchangeably, perhaps inappropriately so, are 'health determinants' and 'health inequality determinants'. Graham (2004) summarizes both of these terms, and highlights how confusing them leads to the misunderstanding that policies that affect the SDOH will eliminate the inequalities themselves. While much of the literature discusses factor that contribute to or cause health (or poor health), it is the distribution of these causal factors that has true policy implications (Graham, 2004). This means that policies that target inequalities in health will affect different populations (e.g., advantaged and disadvantaged populations) in different ways (Graham, 2004). Using the right terminology helps ensure that policies affect the desired population in the desired way. While it is recognized that the focus needs to be on the determinants of health disparities, rather than simply on the determinants of health (Frohlich,

Ross & Richmond, 2006), the term SDOH will be used throughout this paper to reflect common practice within the literature.

The use of income as a SDOH may also pose some difficulty for our understanding of social factors that affect health status. This issue is best highlighted in the differences between a resource-oriented theory such as that of Rawls (1999) and a capability/outcome theory such as Sen (1999). Traditionally, a resource-oriented theory has been used which proposes that the various SDOH are resources that individuals and populations can use when they have access to them in improve their health (Rawls, 1999). However, Sen (1999) argues that income has no intrinsic value, and that it is instead the opportunities income provides that is its true value. Sen (2005) further argues that rather than thinking in terms of resources, a more accurate description would be to conceptualize freedoms or capabilities. Therefore, a community with very low levels of income but high levels of freedom would be healthier than a community with high levels of income but low levels of freedom. A capabilities approach recognizes the influence social and political structures have on one's ability not only to access but also to make use of their resources such as income. In using a capabilities approach as suggested by Sen, strategies related to empowerment, community engagement, and multifaceted interventions that involve all levels of policy become the priority (Ruger, 2004).

While debates on the appropriate terminology and most accurate approaches can increase the level of confusion surrounding an already complex issue, it demonstrates that the SDOH approach is still evolving. Addressing the barriers and debates not only strengthens the SDOH approach, it furthers understanding of the social factors that influence the health of populations.

Social Determinants of Health (SDOH) – What are they? How do they affect health?

The link between health and income has been known for some time. In fact, it was this link that led to the development of public health (Poland et al., 1998) and has been the focus of much public health research, though not without controversy. One of the first accounts of the use of epidemiological methods and purposeful study of public health was conducted by John Snow, who completed an investigation of a cholera outbreak in a poor neighbourhood on Broad Street in London in 1849 (Friis & Sellers, 2004). Snow found that those who received water from the Broad Street pump were far more susceptible to the diseases than those who received water from another competing company. Therefore, even before the discipline of public health was officially established, there was awareness of the impact of the distribution of resources on the health of the community. Some have suggested that it is the concern with the distribution of resources that has lead to the lack of support for public health as a medical discipline relative to other curative disciplines of medicine (Poland et al., 1998). Briefly, curative medicine is favoured not because of its virtues, but because it does not challenge social structures or the current system and mechanism by which resources are distributed.

Our understanding of the connection between health and income has developed significantly since the time of John Snow. Epidemiological data is now refining what we know about the effects of wealth on the health of population, and has demonstrated that it is not the absolute wealth of a nation (often measured in terms of Gross Domestic Product, or GDP) that predicts population health, but how that wealth is distributed within the nation (Wilkinson, 2005) – which is typically measured using the Gini Coefficient, which is a measure of income distribution (Kawachi, Subramanian, & Almeida-Filho, 2002). Generally speaking, the more equitability that income is distributed within a society, the better the overall health status of the population

(Raphael, 2000). The gains in population health resulting from national economic prosperity tend to level off at about $3000 - $6000 GDP per capital; after which income equity is a more salient predictor of national population health (Wilkinson, 2005).

Kerala, one of the poorest states in India, provides an interesting illustration of the impact of the distribution of wealth on health. Though Kerala has an average state income of approximately $300 ($US) per year, the average life expectancy is approximately 70 years, which is almost equivalent that in the United States, despite the latter having a much greater average income (Sen, 1999). The success of Kerala (in terms of health) has been attributed to structural changes that have taken place since India obtained independence (e.g., increased literacy, political participation, access to health care services, more women in the labour force, equal incomes, and a general expansion of the social safety net) (Sen, 1999). The state of Kerala exemplifies how social arrangements, particularly equal access to resources, can better the health of the population.

What started as a general awareness of the relationship of health and income has developed into a much deeper understanding of that relationship (i.e., that how income is distributed within a population most greatly influences health). As such, the social and political context within a country or region (e.g., welfare system) and how they impact the ability to redistribute income are key considerations not only for public health, but also at the policy level for improving population health.

Social and Political Context of the Social Determinants of Health

The unequal distribution of resources that has fuelled development of the SDOH is not itself rooted in inadequacies of individuals or groups; rather it is the way which societies are organized that determines the distribution and access to resources (Wilkinson, 2005). This organization is determined by public policies developed and enacted by governments at the federal, provincial and municipal level (Wilkinson, 2005). The work of Raphael and Bryant (2004) and others have highlighted how the arrangement of a nation in terms of its redistribution of resources influences the health of its citizens. The works of Esping-Andersen and Raphael in comparing countries along the political spectrum have been particularly influential in this area (Navarro, et al., 2006). Welfare states are grouped into three distinct categories: social democratic, liberal and conservative (Raphael & Bryant 2004). Social democratic countries (e.g., Nordic countries) place importance on universal access to benefits and have more extensive programs for the redistribution of resources (Raphael & Bryant, 2004). Liberal countries (e.g., United States, United Kingdom) are at the other end of the continuum and only provide benefits when the market system fails to do so (Raphael & Bryant, 2004). Conservative countries (e.g., Italy and Germany) are more traditional and offer benefits based on employment (Raphael & Bryant, 2004). The manor in which the welfare state is structured influences the health of the population particularly on such outcomes as income mortality and life expectancy at birth (Navarro et al., 2006). For example, there is greater income inequality in liberal states compared to social democratic states. Therefore, it is not enough to simply examine the relationship between health and income and the redistribution of benefits when examining population health. It is vital that the socio-political context in which these inequalities occur is also considered when developing public health practice and policy.

Barriers/Challenges to Addressing the SDOH

While there is considerable evidence that supports the effectiveness of policies and programs aimed at addressing the SDOH (Eyles, Stoddard, Lavis, Pranger, Molyneaux-Smith & McMullan, 2001; Frankish, et al. 2007), there are relatively few examples of specific policies and programs in Ontario. This may be attributed to the many barriers and challenges to implementing this type of policy work. In this section, barriers related to lack of knowledge and policies are briefly addressed.

Knowledge

In spite of the general awareness of the SDOH, there remains a lack of knowledge regarding the importance of social factors in determining the health of the population, even among health and social service providers. For example, Collins, Abelson & Eyles (2007) found that a group of social workers in Hamilton Ontario had little knowledge of the SDOH framework. This is a surprising finding, as this was a population that one would expect to have an understanding of the framework, and values that support practice and policy actions based on the SDOH. Because policy makers are highly influenced by public opinion, it is also vital to increase knowledge of the SDOH in the general public in order to eventually build support for equitable distribution of resources. However, this is becoming increasingly more challenging as we live in an era dominated by individualism, materialism and neo-liberalism ideology (McMichael & Butler, 2006). As a result, it is more difficult to promote policies based on values of social justice, collective good and sustainability.

Policy

Generally, there is a lack of policy based on the understanding of the SDOH, partially because research in the area is not always conducted in a way that is relevant to policy makers (Frohlich, Ross & Richmond, 2006). It is vital that policy makers and researchers work together so that policies can build on evidence and research can contribute to policy development. The Canadian Health Service Research Foundation (CHSRF) is providing leadership in this area, as all grants applications must involve decision makers and researchers working together on the project (CHSRF, 2007).

Given the many barriers associated with SDOH-related knowledge and policies, education is sorely needed at all levels (e.g., individual, community, population, policy, etc) not only to increase awareness of the SDOH, but also to facilitate and enhance public health practice.

The Role of Public Health

The field of public health, through its multidisciplinary workforce and understanding of population health and the socio-political context in which it occurs, is the ideal body to provide leadership in the understanding of the SDOH (Whiteside, 2004). Public health professionals have a clear understanding of the differences between public health, population health, health promotion, and the more traditional curative medical model. However, in spite of its broad view of health, the field of public health is, perhaps unfortunately, viewed as being within the folds health care system.

The affiliation of public health with the health care system has made it vulnerable to spending cuts (Poland et al., 1998) as it competes for limited resources. In fact, because public health

typically works 'behind the scenes' in the healthcare system (e.g., focus on education and prevention), the public is often not aware of the work being done, and therefore are not as likely to be outraged when public health funding is cut (Raphael, 2003). Furthermore, the burden of illness that is decreased as a result of the work of public health professionals does not appear immediately, and the lag between service and outcome is often longer than most politicians' terms in office. Therefore, there is less political risk in cutting public health programs and services compared to cuts in acute curative health care services (Raphael, 2003). Given its mandate to improve health by addressing the SDOH, the field of public health must better advocate for itself to avoid further budget cuts.

In the past, public health has focused on a 'lifestyle' approach to promoting health (Freudenberg, 2007). An inherent assumption in this approach is that individuals can change – otherwise, promotion of healthy living (e.g., eating healthy, active living, smoking cessation) would be futile. The various successes and failures of this approach have led to greater realization of the importance of the socio-political context in the amount of lifestyle change that is possible. For example if appropriate infrastructures that enable exercise such as safe, accessible walking trails and paths are not provided, it is difficult for individuals to be physically active.

Much like individuals, the political and economic contexts that influence health can change. Through political pressure, advocacy and community mobilization, economic and social policies can be modified to positively influence the health of populations. The manner in which resources are distributed in a given society affects the degree of social cohesion and social trust, and subsequently the policy directives that will be supported (Navarro, & Muntaner, 2006). The greater the social cohesion within a society, the more likely members of that society will believe

they are able to affect change. Within Canada, and particularly in Ontario, public health is situated within the political landscape in such a way that is can work to address the distribution of resources that affect health. Public health units in Ontario receive core funding from both the provincial and municipal governments. Therefore, they are situated both inside and outside the health care system, accessible to local community groups, responsive to community needs, and are able to advocate for change at multiple levels of government. This is important because it allows individual communities to be involved in all aspects of public health practice, including identifying, prioritizing, and addressing the local SDOH (Baker, Metzler, & Galea, 2005).

Not only does the field of public health have the historical knowledge and political position to work to address the SDOH inequities, it also has the skill set. There are two types of public health skill sets – expert/evidence and leader/development, both of which contribute to and are needed to equalize the distribution of health determinants (Connelly & Emmel, 2003). The expert/evidence skills represent the technical medical and epidemiological knowledge used to examine patterns of disease and their causes, while the leader/development skills are those related to knowledge translation, leadership in evidence-based policy development, and community engagement. In fact, the community engagement work done in the public health sector is a focus of this paper.

One of the many challenges currently facing the public health sector is related to the translation of emerging scientific data about the SDOH into innovative practices (Potvin, Gendron, Bilodeau & Chabot, 2005). One way of resolving the inconsistency between evidence and practice is to establish a theoretical foundation for practice that is built on the evidence (Ansari, Carson, Ackland, Vaughan & Serraglio, 2003). The field of public health has attempted to do just that in

creating the Population Health Approach (Potvin, Gendron, Bilodeau, & Chabot, 2005), which is described below.

Population Health Approach

Currently in Canada there is a move towards integrating a population health approach into public health practice. The assumption is that this approach will result not only in a healthier population, but also to better use of limited public health resources (Evans, Barer, & Marmot, 1994).

The Population Health Approach was developed by the Canadian Institute for Advanced Research, and more specifically by Evan and Stoddard (1990), and it is founded on the principle that the health of populations is influenced by many economic, social, and political factors. Health Canada defines the population health approach as one that "aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health, (Health Canada, 2001, p1)." There are eight key elements to a population health approach, including: (1) focus on the health of populations (i.e., not on individuals); (2) addressing the determinants of health and their interactions; (3) evidence-based decision-making;(4) increasing upstream investments; (5): application of multiple strategies; (6) collaboration across all health sectors and levels of government; (7) Employment of mechanisms to enable/increase public involvement; and (8) demonstrating accountability for health outcomes (Health Canada, 2001).

However, there is some debate regarding the value of the population health approach. In particular, while many have recognized the value of population health approach, they have also

noted that theoretical underpinnings of the approach need to be more explicit (Coburn et al., 2003; Frohlich, Mykhalovski, Miller, & Daniel, 2004; Rapheal & Bryant, 2002). For example, while all eight elements are valued equally, the value of equity is not clearly explained. The population health approach is also very broad, and there is concern that it is trying to be all things to all people, thereby becoming nothing in the end. Therefore, Poland et al. (1998) argue that though the population health is important, and while it is currently the model of choice in Canada, public health practitioners need to be careful that it is not used to justify the status quo.

Applying a Population Health Approach and the SDOH in Practices: Example of the Sudbury & District Health Unit

The Sudbury & District Health Unit (SDHU) is one of 36 health units that make up local public health practice in Ontario. Within and outside of the province, the SDHU is seen as a leader in applying both the population health approach and the social determinants of health to public health practice and research. The work being done at the SDHU has resulted in a number of advocacy initiatives and discussion papers. For example, "A Framework to Integrate Social and Economic Determinants of Health into the Ontario Public Health Mandate: A Discussion Paper" describes a vision of public health that incorporates the SDOH into its mandate (SDHU, 2006), while "Social Inequities in Health and Ontario Public Health: A Discussion Paper" (SDHU, 2007) provides rational as to why public health needs to be involved with the social determinants of health.

To assist providers in the application of the SDOH to public health practice, the SDHU has adopted a model that is becoming the foundation for program planning and evaluation throughout their health unit. The model employed was developed by Dahlgren and Whitehead (1993), and

incorporates the various layers that affect the health of populations (see Figure 1) (Dahlgren & Whitehead, 2007). Although the layers are depicted as separate entities, in practice their boundaries are not as clear and well defined (Dahlgren & Whitehead, 2007).

Figure 1. Dahlgren and Whitehead's (1993) model
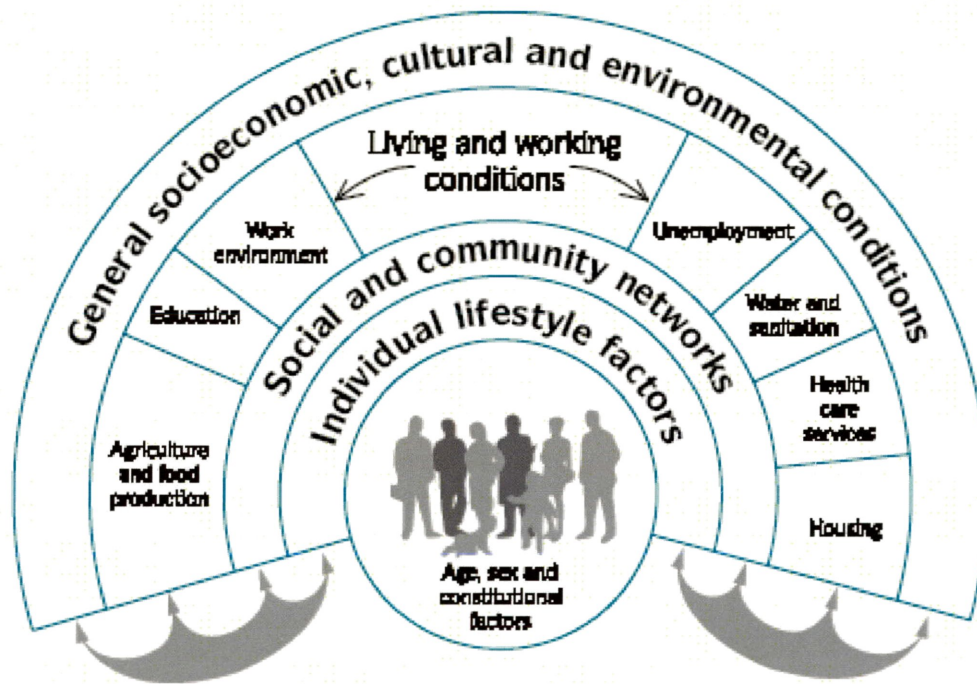
Source: Dahlgren and Whitehead, 1993

This model highlights how the SDOH are conceptualized at the SDHU. Public health programs are located within the model to help guide work to address the SDOH in the community and the province. In the middle are those individual characteristics that are largely pre-determined (i.e., age, sex, and constitutional factors). The next layer is composed of individual lifestyle factors, including personal behaviours such as nutrition and physical activity. The third layer consists of the immediate social networks that influence lifestyle factors, while the fourth layer represents the settings that inhibit or facilitate health (e.g., living and working conditions, access to

resources). Finally, the outer layer is made up of the cultural, socio-economic, and environmental circumstances that influence the health of the population and the individual (Dahlgren & Whitehead, 1993). While layers are depicted as separate and distinct from one another, in reality each layer is embedded in the surrounding layers and is interdependent (Dahlgren & Whitehead, 2007). For example, lifestyles are rooted in social networks and norms and community conditions, which are embedded in cultural and socio-economic circumstances (Dahlgren & Whitehead, 2007).

In this paper, Dahlgren and Whitehead's model will be combined with a model for community development (described below) to form a new framework within the population health approach for addressing the SDOH through community engagement.

Part 2: Community Engagement

"Public policy influences the ways in which society and governments respond to and think about issues that impact the health and well-being of communities. It is essential, therefore, that communities learn to understand the policy-making process. It is also critical that policy makers learn how to work with communities and to tap into the wealth of knowledge, experience and diversity that can help create better public policy."
(Devon Dodd & Hebert Boyd, 2000, p.5).

Emerging evidence is demonstrating that the meaningful participation of citizens and community groups in health increases the positive health outcomes of the community as well as individuals, (Winnipeg Regional Health Authority (WRHA), 2004). This process of encouraging citizens and community groups to participate in governance, policy development and decision-making is called community engagement. Community engagement refers to a process of involving citizens, community groups and/or local organization based on respect, honesty, open communication and a common understanding of the purpose (Ktpatzer consulting, 2006). Strategies such as open houses, focus groups and community advisory panels are often used to accomplish this (Smith, 2003).

In order for successful community participation to occur there are several principals that need to be adhered to, including transparency in the purpose, goals and expectations, appropriate level and method of engagement, earliest possible initiation of engagement, provision of additional supports to engage hard-to-reach populations, and evaluation of the engagement process (Hariri, 2003). As these principals are being put into practice, the many advantages of participatory models of governance and decision-making are being recognized, including increased: (1) coverage (e.g., it involves more people than non-participatory projects); (2) efficiency (e.g., it promotes better co-ordination of resources); (3) effectiveness (e.g., the goals and strategies are more relevant as a result of participation); (4) equity (e.g., it promotes the notion of providing for

those in greatest need); (5) self-reliance (it increases people's control over their own lives); (6) fiscal responsibility (e.g., it establishes priorities and helps to identify funding partners); (7) legal and policy requirements (e.g., through national and international agreements, provincial and federal legislation and regulation, special rights of Aboriginal people); (8) public knowledge, understanding, and awareness; (9) stakeholder agreement (e.g., it addresses and reduces conflict); and (10) health of the population (Bandesha & Litva, 2005; Smith, 2003; WRHA, 2004). Further, this process also represents a means by which communities can share their knowledge and experience with policy makers, and by which policy makers can share their intentions with the community (Dodd & Boyd, 2000). The exchange of ideas helps establish a link that can be used to discuss complex social and health issues in the community, such as the SDOH.

In spite of its many advantages, community engagement is a long and challenging process. Inappropriate funding strategies, the multi-disciplinarity of the work, and simultaneous involvement of many people from many areas and at multiple levels represent only some of the difficulties (Syme, 2004). However, the benefits of community engagement far outweigh its challenges.

Community engagement is an active process that requires a commitment from both the community (citizens and community organizations) and governments (including government organizations such as health units) for it to be initiated and sustained (WRHA, 2004). This approach requires that governments involve the public in determining priorities and decision-making in a respectful and transparent manor (Health Council of Canada, 2006). Engaging community members in health related concerns not only increases the health of the community, it

also increases efficiency of the health programs by increasing sustainability and program uptake from the community (Ktpatzer consulting, 2006).

Putting the Public Back in Public Health

As part of the overall health care system overseen by the provincial government, public health practice must concern itself with the values of its community and the types of public policy those values will support. Further, community engagement is deemed to be such an important aspect of public health work that it figures prominently in the evaluation of public health practice (i.e., is part of the balance scorecard for public health developed by the Institute for Clinical Evaluative Sciences) (Woodward, Manuel, & Goel, 2004). In particular, the key aspects of community engagement examined include: individual client satisfaction, population and organization level satisfaction, the level of support and knowledge within the community for public health, and public policy decision makers responsiveness to public health issues.

Community engagement is also important to public health practices as it is becoming increasingly clear that without adequate levels of input from the community, action taken to address the SDOH will not be successful (Yassi, Fernandez, Fernandez, Bonet, Tate & Spiegel, 2003). Community engagement at the local level is an effective means to learn about and address the needs of marginalized populations, whose needs have not traditionally been met (Hariri, 2003; Wallerstein, 2006).

As public health continues to focus more attention and energy on addressing the SDOH, community engagement will become an increasingly valuable strategy to ensure that public health practice responds to the needs of the community (Yassi, Fernandez, Fernandez, Bonet,

Tate & Spiegel, 2003). However, one must take into consideration various community characteristics that may affect how people interact with one another, and the types of policy decisions they are likely to support (e.g., level of social cohesion or the distribution of resources within the community) (Baum, 2007; Coburn, 2004). In reality, the process of engaging with any community to address the SDOH is essentially about changing power relations within the community (Williams & Labonte, 2003). The literature describes three main types of power: power-with (i.e., ability of individuals to exercise power), power-over (i.e., power accessed through collaboration with others), and power-within (i.e., power of the institution to force something on individuals) (Whiteside, 2004; Williams & Labonte, 2003). It is also important to note that change in the power relations within a community does not always result in positive changes for that community (Williams & Labonte, 2003). The negative consequences of an attempted power shift are a particular concern for disadvantaged persons within communities (e.g., older adults, Aboriginals, or persons with cognitive impairment) and it is often necessary to incorporate capacity building into the initial stages of the process so that these community members can participate in the community engagement process as equals (Yassi, Fernandez, Fernandez, Bonet, Tate & Spiegel, 2003). If power differentials are not adequately recognized and addressed at the initial stages of the community development process, work to address the SDOH may not be effective (Ktpatzer consulting, 2006; Wallerstein, 2006).

North East Local Health Integration Network – Community Engagement

Until very recently, Ontario was the only province in Canada not to have a regional system of health care delivery or management. In 2006, the Ontario government established 14 local health integration networks (LHINs) in the province to allocate funds and manage health care delivery within their region (Moloughney, 2007). While there are many health care services that are now

the responsibility of the LHIN, public health is not one of them – though there is debate and speculation to whether this will change in the future (Moloughney, 2007). Regardless of public health's current autonomy from the LHINs, the overlap between the mandates of both organizations is substantial as both aim to improve the health of the community. In order to accomplish this, the LHINs have recognized the necessity of community engagement, and as mandated in the Local Health Systems Integration Act, have developed strategies to encourage citizens to participate in the decision-making process. In particular, the community engagement strategy developed by the North East LHIN (NE-LHIN) will be discussed here.
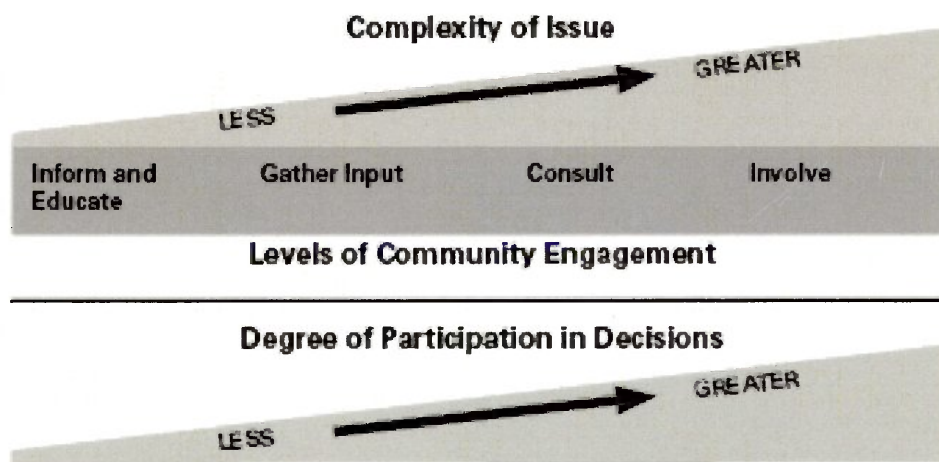
The NE-LHIN has defined community engagement as the "broad array of approaches to generate two-way interaction between NE-LHIN and the community" (NE-LHIN, 2006, p.4), and has outlined eight principles to guide their community engagement strategy (i.e., transparency, timeliness, inclusiveness, appropriateness, accessibility, balance, equitability, and accountability). Similar to other models of community engagement (Health Canada, 2000, WRHA, 2004; Hariri, 2003), the NE-LHIN has embraced a model that encompasses a range of activities from sharing information, to seeking feedback, to jointly planning and making decision, (Hariri, 2003).

The NE-LHIN's model specifies four distinct levels of community engagement that are achieved using various strategies (Smith, 2003) (see Figure 2):

- *Inform and Educate* – Provision of accurate, timely, relevant, and easy to understand information to citizens and stakeholder groups (e.g., open houses, meetings, discussion papers, publications, informal discussions);
- *Gather Input* – Seeking input on health issues from citizens and stakeholder groups (e.g., surveys, meetings, informal discussions, focus groups, open space technology);

- *Consult* – Seeking the views of citizens and stakeholders on the policies, programs, and services that affect them directly, or in which they may have a significant interest (e.g., advisory boards, meetings, task groups, focus groups, workshops, public hearings, appreciative inquiry, call for briefs); and

- *Involve* – Working directly with citizens and stakeholders on strategic directions and implementations opportunities (e.g., delegation, legislated authority, responsibility and accountability, local boards, co-management, partnerships, formal agreements).

Figure 2: Levels of Community Engagement

(Adapted from: Community Engagement: A Commitment to Participatory Decision-Making, 2006, p.14)

As most community engagement models, the NE-LHIN's model depicts community engagement as occurring along a spectrum of different levels of power sharing and participation. At the lower end of the continuum, community engagement strategies generally involve government organizations (such as health units or LHINs) sharing information with citizens and local community groups. At the other end of the continuum, citizens and community groups are empowered with decision-making responsibilities that can affect the health of their community

(Ktpatzer consulting, 2006). Similar to how the Dahlgren & Whitehead model (described in Part 1 of this paper) guides SDHU's conceptualization of the SDOH, the NE-LHINs model outlines their understanding of the community engagement process and spectrum. These two models will be incorporated together to develop a framework that could be used by public health organization to guide them in their work of addressing the SDOH through community engagement.

Part 3: Proposed Framework for Addressing SDOH through Community Engagement

This paper has explored the relationship between the SDOH and community engagement, and now aims to develop a framework that is applicable to public health that combines these two important concepts. Public health practice is extremely diverse both in terms of the issues covered (e.g., chronic diseases, human development, environmental contaminants) and in the methods used to address these diverse issues (e.g., contact tracing, public education, inspections, one-on-one counseling). A framework for public health must, therefore, be applicable to all aspects of public health practice. The value in having such a framework is that it provides a consistent understanding of community engagement and SDOH as well as consistent terminology. The use of such a framework also has implications at the provincial, organizational, and community levels.

Provincial

For action on the social determinants of health to be successful, large amounts of various types of knowledge must be applied to practice in a manor that facilitates continual learning and knowledge development (Measurement and Evidence Knowledge Network (MEKN, Kelly & Bonnefoy, 2007). The use of a common framework within public health practice facilitates this in a systematic manner while supporting the development of best practices. Best practices cannot be established without a common understanding of how community engagement can facilitate work to address the SDOH. Additionally, the continuous nature of the community engagement gradient allows practitioners to build evidence on the requirements for moving from one level to the next (MEKN, Kelly & Bonnefoy, 2007). As evaluations based on this framework are conducted, an evidence base will emerge that can be used to identify best practices for community engagement strategies to address the SDOH. This evidence base can then be used to

assess the quality of individual health unit's work and to compare strategies and their outcomes across the province.

Organizational

Within individual health units, this framework will allow practitioner to speak in a unified voice using consistent terminology (NE-LHIN, 2006). This framework will lead to continuous quality improvement within the health unit as evaluations are conducted, lessons learned are shared and community engagement practices are established. The improved public health practice of individual health units can then be disseminated to the larger public health community in a systematic fashion. The use of a consistent framework will help different programs and departments within health units communicate and establish similar community engagement practices. Having similar practices across the health unit will not only help internal processes but will increase the health unit's credibility within the community.

Community

Community members and local organizations will be involved in community engagement processes; therefore it is important that the proposed framework be presented to them as well. Sharing the framework with the community will facilitate the engagement process as both health units and those they seek to engage will have a similar understanding of what is being asked and what is required. For example, if a community group understands that they are beings asked for feedback at the level of '*gathering input*' and not at the level of '*involve*' they will be able to provide the appropriate information without getting frustrated by unmet expectations of being involved. Alternatively, the community group could use the framework to advocate for higher levels of engagement. As mentioned previously, using a consistent framework and

communicating that framework to all involved in community engagement processes decreases frustrations, outlines expectations and provides a common understanding of the engagement. In light of fairly recent public health events that have received lots of public attention (i.e. Walkerton, SARS) community might now be more interested in becoming engaged in the work of public health.

Proposed Framework

The proposed framework (see Figure 3) combines the concepts of the SDOH and community engagement expressed in Dahlgren and Whitehead's and the NE-LHINs model respectively, and aims to enhance the ability of district health units to engage communities in addressing the SDOH. In Ontario, all health units engage in an annual program planning exercise in which programs, services and initiatives for the coming year(s) are identified and incorporated into an organizational or team workplan, though the program planning process is different for each health unit. For this reason, the framework is broad enough to be applicable to all program planning processes, yet sufficiently detailed to help guide program development.

Similar to the SDOH (Figure 1), this framework has individual factors embedded with the social and political contexts. While Dahlgren and Whitehead's model (1993) primarily focuses on how each of these layers can be mediated by policy, the proposed framework is concerned with how each layer can be affected through community engagement. The goal or the outcome is the same for both of these models; however, the proposed community engagement framework focuses on the *process* to achieve the goal. For example, both Dahlgren and Whitehead's model (1993) and the proposed framework support increasing social assistance rates as an action to increase the health of the population. However, the proposed framework outlines *how* this can be achieved

through community engagement. This model also recognizes that there are many levels or degrees of community engagement – the proposed model moves from left to right as the level or degree of community engagement increases.

Figure 3: SDOH & Community Engagement
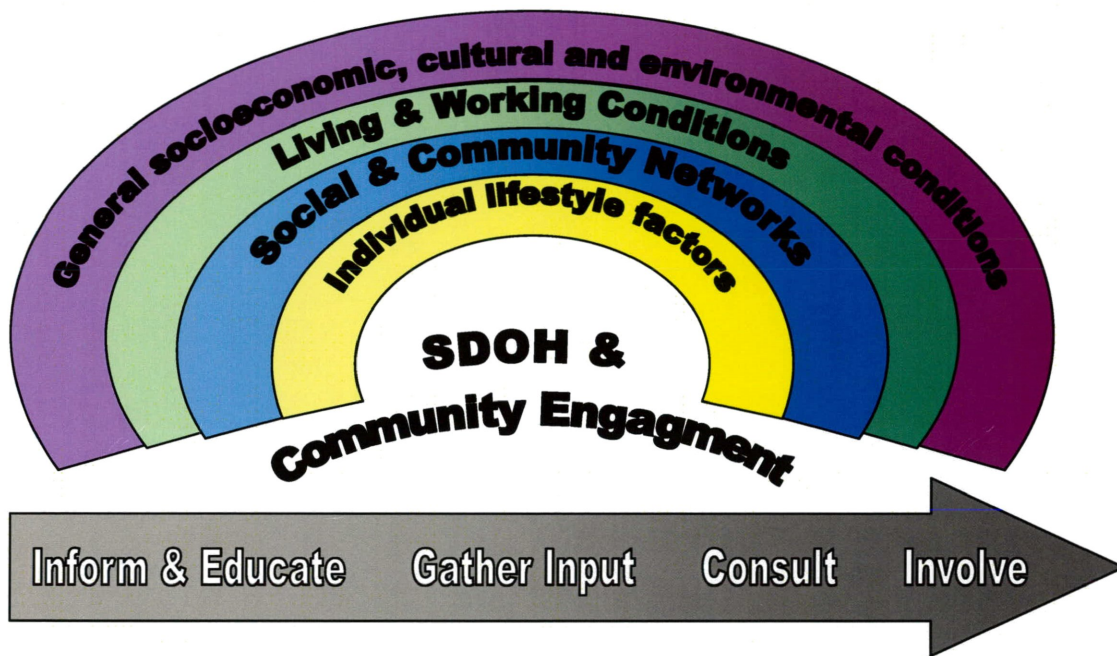
To further illustrate the proposed model, Table 1 provides concrete examples of how different levels of community engagement can be use to address poverty as a SDOH at each level within the SDOH model. These are just a number of many possible actions that could be taken to address the poverty as a SDOH through community engagement.

Table 1: Examples of Community Engagement strategies to address poverty as SDOH

SDOH	Community Engagement Strategies			
	Inform & Educate	**Gather Input**	**Consult**	**Involve**
General Socio-economic, cultural and environmental conditions	Paid advertising to raise awareness of the effects of poverty on health	Community needs assessments to identify health issue priorities	Public Meetings to develop community action plan to address poverty	Collaborate with poverty advocates on issues that affect health, invite anti-poverty organizations to attend/present at BOH meetings
Living and Working Conditions	Website to promote workplace health promotion	Establish mechanisms to seek input from hard to reach populations such as homeless youth	Develop task group of local businesses to develop a skills development program for youth	Develop local poverty action community committee to advise council
Social and Community networks	Provide workshops on community development for local coalition leaders	Focus groups in low income neighbourhood to explore neighbourhood assets	Online consultations for development of community center	Work with a group of Ontario Works recipients to form an advocacy group to raise levels of assistance
Individual lifestyle factors	Social Marketing campaign to promote affordable healthy meals	Survey to identify needs of low income families in the community	Seek input from clients about financial barriers to health unit programs	Develop advisory committee to review program plans

Though community engagement is often a long process, it is hoped that this model will help health units identify some easy first steps they can take to initiate the engagement process in their community. This framework will also serve as a tool for discussion to assess current knowledge, attitudes and readiness to use community engagement strategies to address the SDOH within the health unit and the community. As individual teams, departments and programs identify current community engagement initiatives; the health unit, as an organization, will be in a position to recognize where its strengths and weaknesses lie. This recognition can lead to organizational and systematic changes in practice. For example, if a health unit recognizes that it does not have any initiatives as the level of 'involve' they may be able to change their policies and practices to enable engagement at this level (i.e. create community oversight committee, community members on internal ethic review boards, develop a youth peer-to-peer health promotion team). By identifying where in the framework programs are and where they would like be, health units will be able to help move their program to a higher level of engagement. Such questions might

include: What internal policies and/or processes need to be in place to facilitate more community engagement? What skills could be developed to support increased community engagement? Are there specific populations that are not being engaged and what can be done to facilitate their engagement?

Community engagement is already an essential component of public health practice. Local health units educate, inform, consult and involve their local community in a number of ways. Developing a framework onto which health units can map their current community engagement practices will help acknowledge this in a concrete, consistent manor. As health units begin to understand the number of ways they already engage their community, it is anticipated that they will continue to move to higher levels of community engagement by building on their current successes. For example, if a health unit currently develops and conducts educational campaigns targeting youth, perhaps this framework will encourage them to consult or involve youth in the development and implementations of those campaigns.

Finally, the framework can also be use as the basis to inform and guide the evaluation of public health unit's community engagement initiatives to address the SDOH. The field of community engagement evaluation is slowly developing as best practices, indicators and evaluation standards are continually developed (Abelson, Forest, Eyles, Smith, Martin & Gauvin, 2002). Public health, with its close relationship to the community and its value of evidence-based practices, is in an ideal position to contribute to this developing area of evaluation. Again, the proposed framework could provide a consistent and common basis for evaluating community engagement initiatives.

Evaluating the Framework

For the proposed framework to be truly valuable to the field of public health, it must be validated. This could be accomplished via focus groups with public health practitioners at the local and provincial levels. This would help ensure that the framework has face validity, and is applicable and relevant to public health practice. However, as many of the SDOH lie outside the sphere of public health (Baum, 2007), it would be beneficial to seek the input of stakeholders in other sectors (education, transportation, housing etc.) to determine how this framework could also apply to their practices. It would be particularly important to seek the input from health care professionals working in the area of primary care as its delivery incorporates aspects of public health, such as health promotion and disease prevention.

The proposed framework could also be evaluated by incorporating it into the program planning process at a health unit or team to determine its impact. For example this could be accomplished by presenting the framework to the program planning team and having the teamwork through an exercise of identifying where in the framework each of their programs best fits. Once all of their programs have been placed in the framework the team could then identify which programs and/or participants would benefit a higher level of engagement. After a few programs that could benefit form more engagement are identified the team can work to make that higher level of engagement possible. Through this processes team members would be asked to evaluate the proposed framework to determine if and how it facilitated or inhibited the planning process and if it helped the team see their programs in a different way.

Once the validity of the framework has been established, it should be widely disseminated. This could be accomplished in many ways including through professional networks and conferences,

publications, and presentations. It is also important to share this framework with the general public, as it will provide a common understanding of the role of public health and public health units, as well as educate on the importance of the SDOH, a need that has been identified in the literature (Lavis, Ross, Stoddard, Hohenadel, McLeod & Evans, 2003).

Part 4: Implications of the Proposed Model and the Effect on Public Health Practice

"Th[e] shift toward a more collaborative, horizontal approach to policy making encourages all parties to reflect and learn. It promotes a focus on common ground and recognizes that citizens and communities have important knowledge and experience to add to the debate."
(Dodds & Boyd, 2000)

Solidly based on well-established public health theory, the overall goal of the proposed framework is to improve the health of Ontarians. In order for this to be accomplished, the proposed framework must be incorporated into the field of public health. The implications of implementation are briefly discussed in terms of public health practice, education, research, and policy development.

As local public health units engage in planning and priority setting, the framework could be used as a means to ensure they are adequately engaging their community. By identifying where public health programs are located in the framework, practitioners may recognise gaps in their programming and skill sets. For example a health unit or specific program may be able to identify that they engage families at the level of *Inform and Educate* but they do not engage families in *Consultation*, or, the health unit as an organization may identify that staff require additional skills and training so they can effectively engage the community to address the SDOH.

For the anticipated increase in community engagement initiatives as a result of the implementation of the proposed framework to be successful, health units and community partners will have to work to ensure the conditions that facilitate public participation in community engagement are in place. Some conditions might include: a health issue that the community feels is a priority, the political support for community participation, equal power so that social and political culture where community issues can be openly discussed, knowledge and skills in

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community participation, sufficient and appropriate resource allocation and ideally previously successful community participation experiences with in the community (Simonsen-Rehn et al., 2006; Barten, Mitlin, Mulholland, Hardoy & Stern, 2007, Smith, 2003). As community engagement practices emerge, public health practitioners must continue to develop new means by which they can engage various segments of their community, whether that is through partnerships, community coalitions or academic relationships (Selsky & Parker, 2005; Peterson, et al., 2004; Lucey & Maurana, 2007).

Similarly, health units will have to develop different means to engage various segments of their community (e.g. children, homeless, older adults, Aboriginals, persons with intellectual/developmental disabilities etc.). When engaging vulnerable subsets of the population, health units may first have initiate capacity building techniques so that full participation is possible (Yassi, Fernandez, Fernandez, Bonet, Tate & Spiegel, 2003). Different groups in the population will also require different types of support in order to participate in the engagement process. Recognizing the needs, barriers and challenges various groups within the population face in the engagement process will be a vital step for health units.

For health units to increase their organization's skills in community engagement they can train their current staff or hire staff that already possess those community engagement skills the health unit seeks. The later approach could be accomplished by taking a more multidisciplinary approach to the public health workforce. Alternatively, students could be taught community engagement skills in nursing and schools of public health. If community engagement is going to become a larger component of public health practices, schools of public health will need to adjust their curriculum accordingly. This can be accomplished by placing greater emphasis on the

theory, practice and evaluation of community engagement and by offering practical hands-on opportunities for students to be part of a community engagement process. Incorporating practicums into the curriculum of graduate public health programs will require schools of public health to pursue their own community engagement process as they engage community partners to offer community engagement opportunities for students.

Finally, as this framework is used and expanded upon, its relevance to the work of public health in addressing the SDOH will increase. As a result, it will become extremely important to conduct long-term evaluations that determine the effectiveness of community engagement programs and approaches (Stronks & Mackenbach, 2006). In turn, this work could also inform public health best practices.

As the field of public health continues to focus on addressing the SDOH, they will be required to be attentive to the needs of specific communities. It is anticipated that the proposed framework will help guide public health practitioners as they continue to identify ways they can further involve others, through community engagement, in addressing the SDOH.

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Appendix A: Search Terms

The search included published sources and non-published so-called 'grey literature' such as government reports and publications produced by organizations. In the literature database search the following limits were applied to make the number of resources reviewed feasibly given time restrictions and reviewers skills; all resources were in English and published in the last five years. After the initial literature search was complete and relevant resources obtained resources were read and their resources/references scanned to identify any additional references missed in the initial search. In total over 140 resources were reviewed to form the bases of this project.

Search Terms

(limits: past 5 years, English)

- Social Determinants of Health OR Non-medical determinants of health

- Public health OR population health OR community health

- Organization OR department OR centre

- Address OR enhance OR improve OR develop

- Framework OR Outline OR Toolkit

Databases

- PubMed

- CINAHL

- ERIC

- Social Services Abstracts

- Management & Organizational Studies: A Sage Publication

- Public Administration Abstracts

Website Search

Public Health Organizations

- Sudbury & District Health Unit

- Waterloo Public Health

- Canadian Public Health Association

- Ontario Public Health Association

- Association of Local Public Health Agencies

Government Organizations

- CIHI – Institute of Population Health

- Public Health Agency of Canada

- Canadian Institute for Health Research

- Canadian Health Service Research Foundation

Appendix B: Glossary of Terms

Citizen engagement refers to situations where governments have taken the initiative to involve citizens in policy development, including the clarification of values, principles and desired outcomes; "mutual engagement" provides for ongoing deliberation and communication between citizens and policy makers, with each group having input into defining the issues and choosing the action to be taken. (Dodd & Boyd, 2000)

Capacity is the power or ability to use one's own resources to achieve goals. Capacity building is the strengthening of the ability of people, communities and systems to plan, develop, implement and maintain effective health and social approaches. (Dodd & Boyd, 2000)

Collaboration: Two or more individuals or groups working together in such a manner that the agendas and interests of each have equal importance; joint action among two or more parties to produce an outcome that none could produce through their singular efforts. (Dodd & Boyd, 2000)

Community: State of being shared or held in common; organized political, municipal or social body; body of people living in the same locality. (Dodd & Boyd, 2000)

Community Capacity Building: Strengthening the abilities of people, groups and systems to plan, develop, implement and maintain healthy communities. (Dodd & Boyd, 2000).

Community Development: a means to achieve health by living out certain values, employing certain processes, and engaging in certain kinds of work – embodying the kinds of relationships that contribute to health [...] a means of strengthening and building healthy communities. It is an approach to supporting health and well being that can integrate with and complement health service delivery. (Winnipeg Regional Health Authority, 2004)

Inequalities in Health: The virtually universal phenomenon of variation in health indicators especially associated with socioeconomic status. (Last, 2001)

Public Health: Public health is one of the efforts organized by society to protect, promote and restore the people's health. (Last, 2001)

Public consultation: Two-way communication between public/stakeholders and a sponsor through which both become better informed. Public consultation provides participants with the opportunity to influence decision-making. (Dodd & Boyd, 2000)

Public participation: Processes in which individuals, groups, and organizations have the opportunity to participate in making decisions that affect them, or in which they have an interest. (Dodd & Boyd, 2000)

Health promotion: The process of enabling people to increase control over and improve their health. (Last, 2001)

Social Determinates of Health: SDOH are the political, economic and social forces that influence health at the individual, group, community and population level. These factors have as

much if not more impact on health as do traditional medical and behavioural; risk factors. (Bryant, Raphael, & Travers, 2007)

Population Health: The health of the population, measured by health status indicators; it is influenced by physical, biological, social and economic factors in the environment, by personal health behaviours, health care services etc. (Last, 2001).