# Honouring the Voices of Marginalized Communities

A Participatory Research Experience

Community Development Halton

Electronic copies of this report are available from:
Community Development Halton
860 Harrington Court
Burlington, ON
L7N 3N4
Phone: (905) 632-1975
Fax: (905) 632-0778
Email: office@cdhalton.ca
Web: www.cdhalton.ca
A United Way Member Agency

Research Team:
Joey Edwardh, Executive Director
Rishia Burke, Research Associate
Richard Lau, Research Associate

Community Survey Team:
Federica Arroyo
Misty Hobbs
Sherry Carew-Kaiser
Janice Pacheco
Tess Mitchell
Mason Mitchell
Justin Cargill
Hayley Gendron
Joy Bartels
Jennifer Gerrard
Alexandra Schellenberger
Maria Estrada
Kaitlyn Muck
Jill MacVicar

A United Way Member Agency

This project had the financial support of:

- Ontario Ministry of Health Promotion and Sport, and
- Halton Region Health Department Regional Municipality of Halton

**Contents**

**List of Figures**



**List of Tables**



**List of Maps**

## Introduction

"I just want to feel like I belong in this community"

These are words spoken by Lori[1], a young adult living in poverty in Halton commenting on what she wishes could change. This statement is a powerful example of the many comments heard throughout this initiative undertaken by Community Development Halton. Lori has housing, although she feels vulnerable there, living in shared accommodation with strangers, she uses food banks and attends community suppers to feed herself and is trying to finish her education so that she can find a good job. She relies on a network of friends and adopted "family" for support and encouragement, all people also living in low income.

This is a report about Lori and many others; shared voices and opinions from many people living in poverty and isolation in Halton. The purpose of the document is to honour those voices and stories, so that we might truly hear them and then reach back out to engage them and others to make change— at the neighbourhood level, at municipal tables, at Regional tables and beyond to Provincial and Federal policy discussions.

This initiative grew out of a provincial pilot project, developed to engage marginalized communities within the Healthy Communities Partnership[2] planning process taking place in communities throughout the Province of Ontario. That planning process led a Community Development Halton social planner out into the community, to spend time with people living in low income. Time was spent developing relationships and trust and having conversations with people about their experience on the margins of Halton's communities. The initiative also took a

[1] All names in this report have been changed to respect the privacy of the community members who took the time to share their stories with us.

[2] The Healthy Communities Fund (HCF) provides funding to community partnerships to plan and deliver integrated programs that improve the health of Ontarians. The Healthy Communities Fund plays a key role in helping the Ministry achieve its vision of *Healthy Communities working together and Ontarians leading healthy and active lives*. The Healthy Communities Fund provides support through a Grants Project Stream, a Partnership Stream and a Resource Stream. The goals of the Healthy Communities Fund are to:

- Create a culture of health and well-being;
- Build healthy communities through coordinated action;
- Create policies and programs that make it easier for Ontarians to be healthy; and
- Enhance the capacity of community leaders to work together on healthy living.

The Healthy Communities Fund is focused on six risk factors: physical activity, sport and recreation, injury prevention, healthy eating, tobacco use/exposure, substance and alcohol misuse and mental health promotion.

More information is available at http://www.mhp.gov.on.ca/en/healthy-communities/hcf/default.asp

community-based participatory research approach to gather further understanding and information to take forward to service providers about health issues as well as information to take back to community to begin the process of effecting local change.

## Engagement

The initiative was about community engagement. There is a community engagement continuum with low to high levels of involvement. The simplest breakdown that is meaningful within the scope of community-based practice divides the continuum of engagement into four levels: informing, consulting, collaborating and empowerment (McCue, 2011). The focus in this initiative was on involving those who are rarely consulted in meaningful, high level engagement.

Engagement in low income communities has been documented as effective when time is taken to develop leadership among citizens and local organizations, provide training and opportunities for peer learning, provide financial resources, and develop relationships and foster collaboration (Ohmer, 2008). Citizen participation is effective in facilitating an individual and a collective sense of being able to achieve what you sent out to do and a sense of community through collective action. That work is best done when there is a trust-building process and meaningful opportunities to voice ideas and opinions along with engagement in "small-scale projects that build competency and competencies." (Ohmer, 2007, p. 118)

Engagement is linked to social capital[3], network development and relationship building. Through community participation there is potential for: an increased sense of belonging, willingness to contribute, helping others and welcoming strangers (MacKinnon, Stephens et al, 2008).

The key principles used by the social planner were:

- *Relationship building.* This is fundamental to the process of meaningful engagement. This may take time and cannot be rushed.
- Recognition that there is a *continuum of engagement*. We will work at the highest level of engagement possible, striving for meaningful engagement opportunities where there are outcomes associated with empowerment and capacity building.
- We will be *open to hearing* whatever a community has to share, regardless of how it fits into a prefabricated framework of understanding. We will use a social determinant of health framework when we talk about "health".
- We will *respect people's information*, their stories that they will share; we will document with anonymity and a process that brings voice to community.
- We will look for *opportunities for capacity development* to work with particular groups to enhance their own capacity for civic engagement through training and other supports,

[3] Social capital can be thought of in terms of the "features of social life – networks, norms and trust – that enables participants to act together more effectively to pursue shared objectives" (Putnam, 1993).

connecting them where appropriate to the work of networks and broader planning processes.

The engagement approach used drew on a review of the literature developed for the project (Community Development Halton, 2010; Social Planning Council of Cambridge and North Dumfries, 2010). The project began with a relationship building approach with local community organizations and faith groups who are working with marginalized communities in Halton. Those organizations and faith groups then opened doors for the social planner to connect with community members who use those service and community spaces.

The process depicted in Figure 1 details the steps and approach used in the initiative to connect with and meaningfully engage with community. It shows the gathering and empowerment of community leaders through the community-based participatory research process.

The top row of pictures is a visual representation of the process of reaching out, developing relationships and working together towards collective action and community change. Although the social planner started the process by herself, through relationship and trust building community members joined the effort, as researchers and as fellow community developers.

The middle section of Figure 1 details the steps in the project, showing the ebb and flow of going out to community, reflecting and interpreting what was seen and heard and going back out to advance towards community change.

The arrow at the bottom of Figure 1 names the key processes used throughout the project. The goal is to continue to gather community members to work on collective action.

> "If I go alone, I cannot do anything; nobody will take me into account. But if we are a group of partners, they will have to listen to us because we are many."
> (A quote from a female health practitioner in Mexico; Gaventa and Barrett, 2010, p. 29)

**Figure 1- Engagement process used in the initiative**

## Methodology

### Community Soundings

For the first six months of the initiative the social planner spent time in community conducting community soundings[4]. Those soundings took place in a variety of settings across the region in all municipalities/communities[5]. The formats for the soundings were varied with opportunities in more formal settings as well as informal settings, each appropriate for the situation. However, the questions asked in all settings were the same:

- What is going well for you and your family?
- What is your biggest headache?

The two questions asked have proven to be very effective in starting conversations about the social determinants of health.

**Initiative Data Gathering Steps:**

1. Conducted Community Soundings
2. Identification of Leaders through Community Sounding experiences
3. Survey developed by social planner and implemented by Community Survey Team
4. Two Community Conversations conducted by the social planner and some of the Community Survey team to validate and clarify the survey results

In addition to the two questions, the social planner was looking for natural leaders in community, with the end goal of gathering people who might form the beginning of a network of people living in low income in Halton. These are people who are volunteers, who support their neighbours and peers, people with obvious skill to lead, either out front or quietly behind the scenes.

After the survey was completed, two community conversations were held to report back on those results to clarify and validate the findings. In those two cases more specific questions were asked about the survey findings.

### Survey

Community Development Halton was given the opportunity in the late summer of 2010 to contribute to the Halton Region Health Department's Healthy Communities Partnership

[4] A community sounding is a term used to describe conversations with people in community; these might be with professionals, volunteers and/or community members. In some case the soundings have been conducted one-on-one, in others the sounding was done with a group. The format depended on the setting. Soundings were conducted in food banks, at community suppers, community BBQs, and in community programs, all places where those participating felt comfortable.

[5] Halton Region is made up of four Municipalities: Burlington, Halton Hills, Milton and Oakville. The Municipality of Halton Hills is made up of a number of smaller communities, the two largest of which are Georgetown and Acton. The work done through this project documents opinion and experience in those two communities separately.

proposal. Community Development Halton was asked to develop an approach to engaging marginalized community members so that they would have an opportunity to have a voice in the development of the Partnership priorities, which will focus on the Ministry of Health Promotion and Sports six risk factors. In addition the survey would generate information on the social determinants of health so that the results would be presented in the context of the realities of living in poverty, on the margins of Halton's civil society.

The process was designed to build on the work of the community soundings; many of those leaders that were identified during the community soundings were recruited, hired and trained to conduct the survey. This group became the Community Survey Team.

These trusted community leaders went back out to their own social networks to connect with people living in poverty and isolation. They accessed people through many of the same places that the social planner visited earlier. The goal was to implement a community participatory research process that would generate community voice that could be shared with service providers as well as used by community members themselves to create local community change.

The Community Survey Team connected with people in places they felt comfortable. Team members are people that others are comfortable with because of their peer status. This allowed us to reach members of the community with whom we would not otherwise be able to connect as effectively. Surveys were conducted with groups, by individuals as well as in interview styles depending on the best fit for the situation. For all but one of the Community Survey Team members conducting a survey was new to them.

### Survey development and implementation

The purpose of the survey was to gather a broad base of responses on the priority areas from a range of people living in marginalized situations (e.g., adults, youth, newcomers and seniors). The process provides a second tier of information that will help ensure that the Region has tapped into the opinion of marginalized community members not often sought out in planning processes.

The team of community surveyors was recruited and trained to collect survey responses from their peers. Locations such as Halton Fresh Food Box[6] drop-sites, ReFresh/Food for Life[7] locations, community meal locations, local food banks, Halton Region Our Kids HUBS[8],

[6] Good Food Box programs address food access and food insecurity issues. The Halton Good Food Box Steering Committee has established this program in Halton based on the guiding principles of Toronto's FoodShare program. More information is available at http://www.choices4health.org/pages/Projects/Halton+Fresh+Food+Box

[7] ReFresh Food is a food logistics and redistribution program for Halton Region.
It collects surplus perishable (including fresh & frozen) and non-perishable food products for redistribution to local food banks and social service agencies. ReFresh Foods is a Halton collaboration led by Food for Life Canada. Food For Life is a registered charity operating seven days a week collecting surplus food from bakeries, restaurants and, supermarkets for distribution to local charities. More information is available at http://www.refreshfoods.ca/about/ and http://www.foodforlife.ca/

[8] The Halton Region Our Kids Hubs provide a local, neighbourhood based resource and means for families, schools and the community to work together to ensure that all children thrive and reach their full potential. Community

housing co-operatives and other social housing sites were used as collection sites. This Community Survey Team approach has helped to ensure a high response rate with peers talking with peers. In addition, the approach has facilitated community capacity building, raising community awareness of the social determinants of health and health promotion issues. The Community Survey Team members report that being involved also resulted in building communication, advocacy and problem solving skills and their increased understanding of broader community issues.

Although the engagement process has been an information collection process, it has also been about deeper engagement of those community leaders who have participated in the research process. Some of those leaders have become champions for the survey results now empowered by the survey information. Some Community Survey Team members have been back to their communities to talk about what might happen next, or how the data can be used beyond the Healthy Communities Partnership process.

Throughout the process the social planner has been reflecting on what it means to "give voice" to a segment of the population. Survey results can be powerful, and focus groups and soundings provide wonderful context to the issues raised. Going a step beyond with the involvement of local community leaders from marginalized groups helping to take the results back to community for further reflection allows us to ensure that the end results are a true representation of community voice. It has also been an opportunity for capacity development and empowerment for those voices so that they are heard accurately, and hopefully an encouragement to see that they can invoke change for their living situations. A recent publication by the Wellesley Institute on the use of community peer social planners sums up this experience:

> It's always worth the challenge, because … when it works, it's perfect, and when it doesn't work, it's still really something interesting. (Service Provider quote, in Roche, Guta and Flicker, 2010)

The survey was designed to collect three types of information:

1. People's perception of the social determinants of health as it related to them, and their families and their living conditions;
2. Community priorities within the six risk factor focus areas of the Healthy Community Partnership (access to healthy food, access to recreation and physical activities, mental health promotion for youth, smoke free environments, substance misuse and injury prevention); and
3. Demographic profile of survey respondents.

The survey included primarily quantitative responses but also incorporated optional qualitative sections, which many people took the time to complete.

---

stakeholder's work with Local Planning Teams based within each Hub community to identify the gaps and barriers that are preventing the community's young people from developing to their full potential. As gaps are identified, strategies are developed locally to reduce the barriers. More information is available at http://www.ourkidsnetwork.ca/hubs/index.shtml

The survey was pre-tested in the community with people from the "target sample". In addition the Halton Region Health Department staff that is coordinating the Healthy Communities Partnership was consulted to ensure that the information collected would meet the needs of their consultations to build a community picture.

The Community Survey Team conducting the survey included people living in low income, a newcomer, an older adult and youth. In addition to the Community Survey Team, the social planner as well as a Nelson Youth Centres[9] staff meeting with youth receiving Ontario Works also conducted the survey with a limited number of community members. An on-line version of the survey was also developed which allowed us to reach more newcomers with the assistance of Oak Park Neighbourhood Centre[10] which connected us with newcomer groups they have been working with.

Community Survey Team members were located as follows:

- Acton: 3 (2 adults and 1 youth)
- Burlington: 3 (2 adults and 1 youth)
- Georgetown: 2 (1 youth and 1 youth located in a social service agency)
- Milton: 2 (1 adult and 1 youth)
- Oakville: 3 (2 adults and 1 youth)

Significant work was completed to ensure that postal codes were associated with each record and geocoding was done so that the results could be mapped. More specifically work was done to ensure that the results would reflect five communities, separating out Georgetown and Acton (each part of the municipality of Halton Hills). This was done because of the significant difference in survey responses received from those two communities. The data was entered by one of the Community Survey Team members, and the Community Development Halton social planner conducted a quantitative and qualitative analysis of the results.

Once the survey data had been analyzed the social planner and Community Survey Team members invited people living in low income to meet together for supper and a community conversation about the survey findings.[11] Participants were asked to clarify and validate the findings. In both cases the social planner and Community Survey Team members gained insights

[9] Nelson Youth Centres is an accredited children's mental health centre that provides group based treatment programs for Halton's children and youth and their families. Their services target children who are experiencing moderate to severe emotional, social, behavioural or learning problems, which result in difficulties at home, school and the community. See http://www.nelsonyouthcentres.com/ for more information.

[10] A neighbourhood centre located in Oakville for people to meet and support one another.
See http://www.oakparkmomsandtots.cal for more information.

[11] One meeting was held in Burlington and one in Acton. Those locations were chosen because of the response to the survey in each of the communities as well as a desire to receive further feedback from both a south and north Halton perspective. In both cases there were people from other Halton communities present. No service providers were invited, to ensure that the participants felt free to voice their opinion and share experiences.

into the survey results because of people's willingness to share their opinions and experience of living in poverty in Halton.

### *Limitations to the work and our learning through the process*

Although the methodology has been effective in reaching the target group, the success in each individual community has been impacted by the networks of the survey team members and the access allowed to them by community social service agencies. The project has been limited by the short time frame in which the work had to be completed. The survey development occurred in late October and the survey responses were collected in November. The Community Survey Team took the initial results back to the community in early February for feedback.

We found that certain communities felt "more ready" than others to participate in the survey. In some communities, finding people to join the survey team was a challenge. Once in place some Community Survey Team members had a more challenging time getting people to respond, specifically in Georgetown and Milton, which is reflective in the survey response for those areas. This may have been due to their relationship with those they were asking to complete the survey, their access or the sense, that some expressed, that it wouldn't make a difference if they completed the survey. Further relationship building with community members and other service providers may resolve those issues for future work.

Personal challenges, such as physical and mental health issues, present hurdles for some Community Survey Team members (often part of the reason they themselves are marginalized). Overcoming "public speaking" fear was an issue for one member. The challenges the team experienced were recognized as just part of the learning process of the work and heightened the need for support throughout the project. One Community Survey Team member who received training disappeared from the project. This is an individual who is living with cancer. After receiving the training she no longer responded to calls to check in and did not attend the meeting that had been pre-set to pick up results. An agency that she is affiliated with was contacted to alert them to the fact that Community Development Halton was concerned about this person so that they could follow up on her well-being.

The role of the social planner in this type of initiative is to routinely check in with surveyors to see if they require any additional supports or encouragement. It was the hope to maintain a close relationship with each of the survey team members after the data collection process, but soon after some of their phones, not to mention e-mail, no longer worked or they were, for whatever reason, unreachable, possibly because of other life stresses. Others are focused on school or finding work. A core of the team however, has remained involved as volunteers, attending public meetings and helping to present the results to their own communities and to service providers.

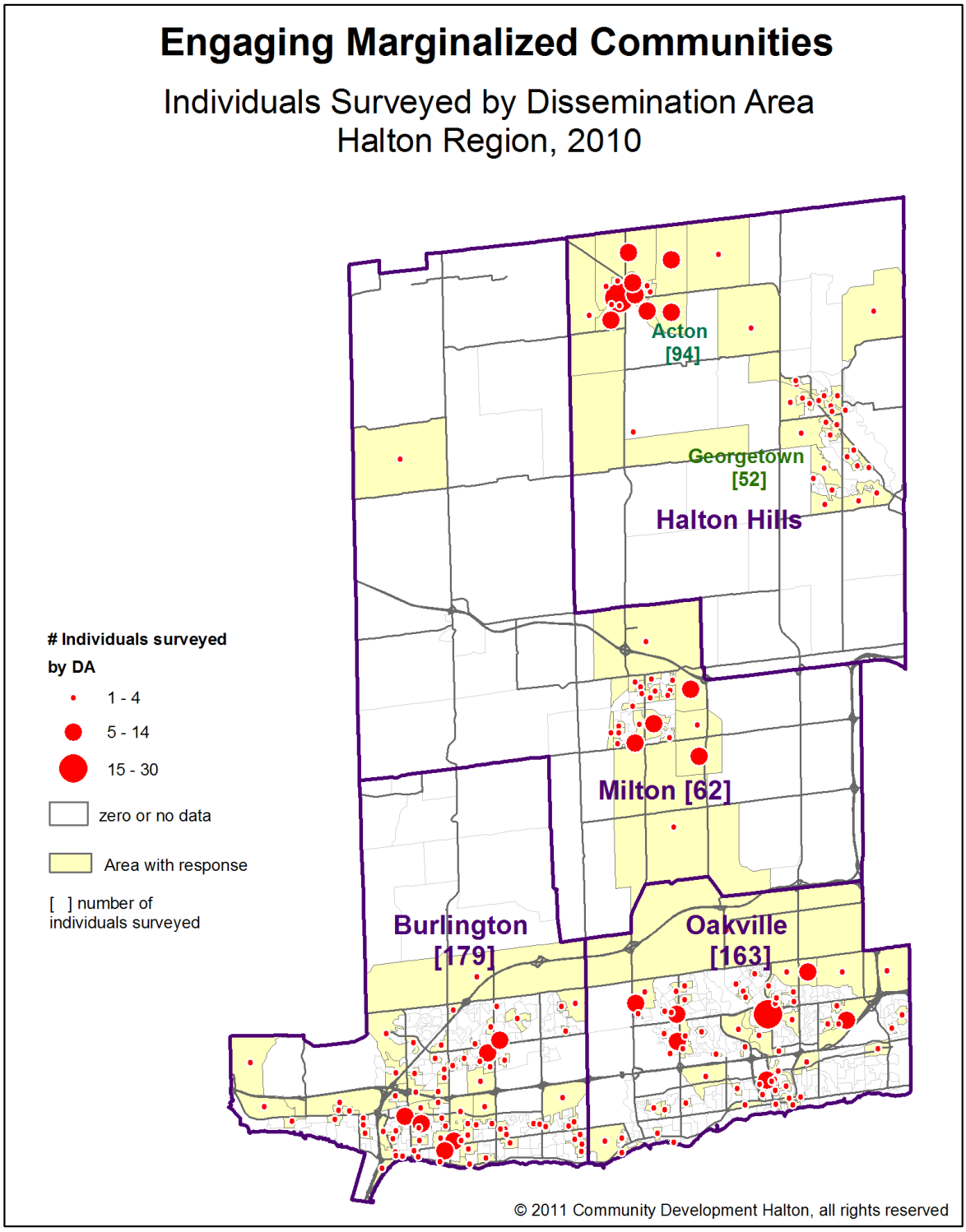
## Who did we talk to?

During the first six months of the initiative the social planner spoke with close to 100 people and spent time with and observed social networks of dozens of others in many different settings across Halton. There were 559[12] people who took the time to complete the survey. Map 1 illustrates the locations[13] of survey respondents in each municipality.

[12] The total number of people responding to the survey was 559 (N= 559), however because not every survey respondent provided a postal code there are some responses that have not been mapped and thus are not included in the municipal/community totals. In other cases the response to a question is less than 559 because survey respondents have chosen not to respond to that particular question.

[13] Postal codes were used to determine the dissemination area in which the participant lives. A dissemination area is, "*a small, relatively stable geographic unit composed of one or more blocks. It is the smallest standard geographic area for which all census data are disseminated*."
Statistics Canada, http://www12.statcan.ca/English/census01/products/reference/dict/geo021.htm

Map 1- Survey Responses



As indicated in Figure 2 the survey respondents are primarily females, shown below broken down by municipality/community.

**Figure 2 - Survey Responses by Gender**

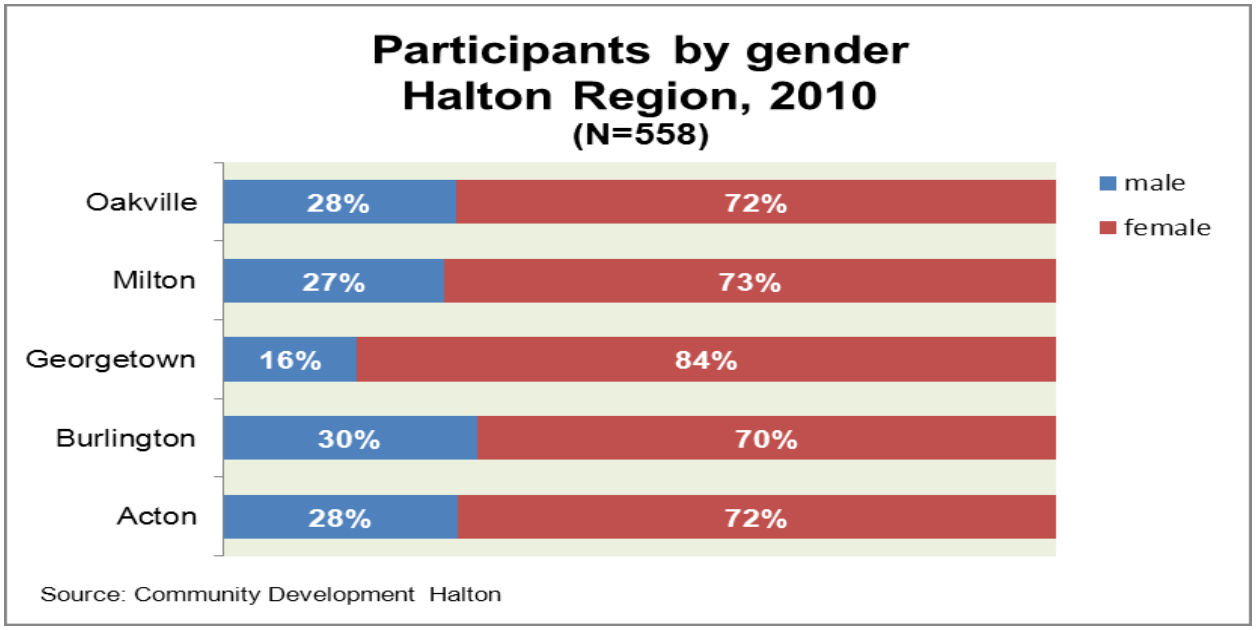



**Figure 3 - Responses by Age Groups**

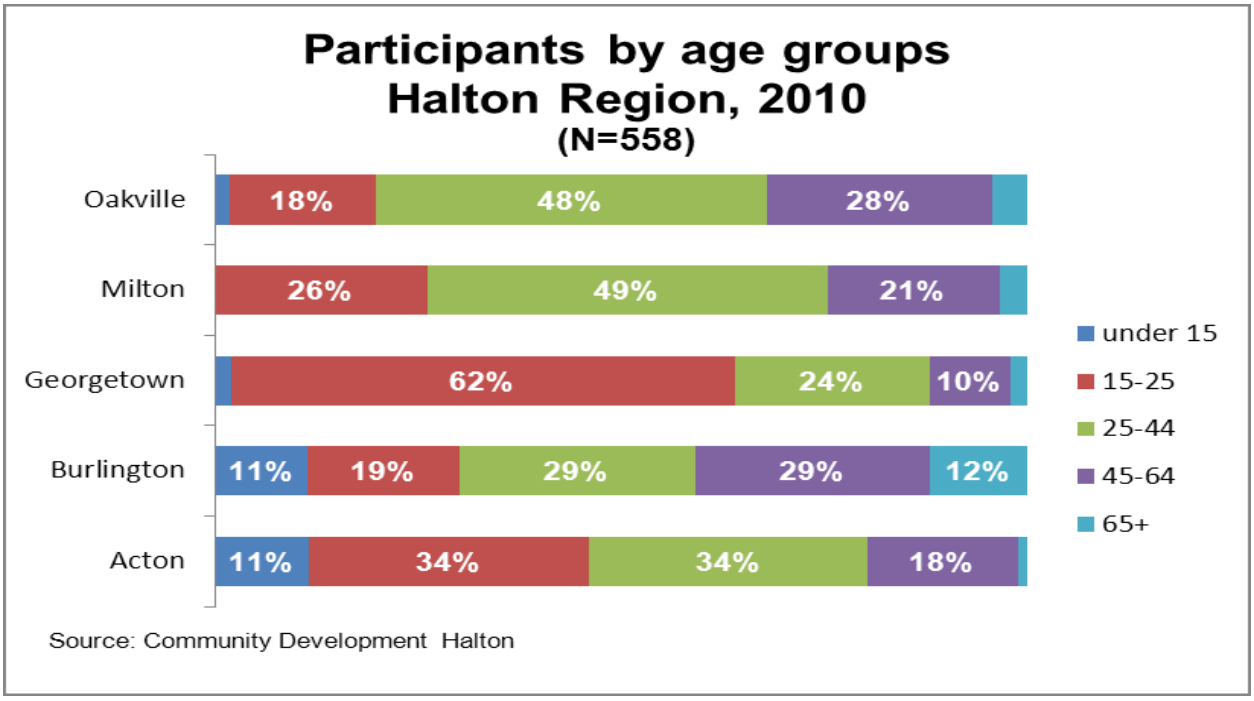



Figure 3 shows the survey response by age group. There are responses from youth, adults and seniors in each community/municipality. The large number of youth responding in Georgetown

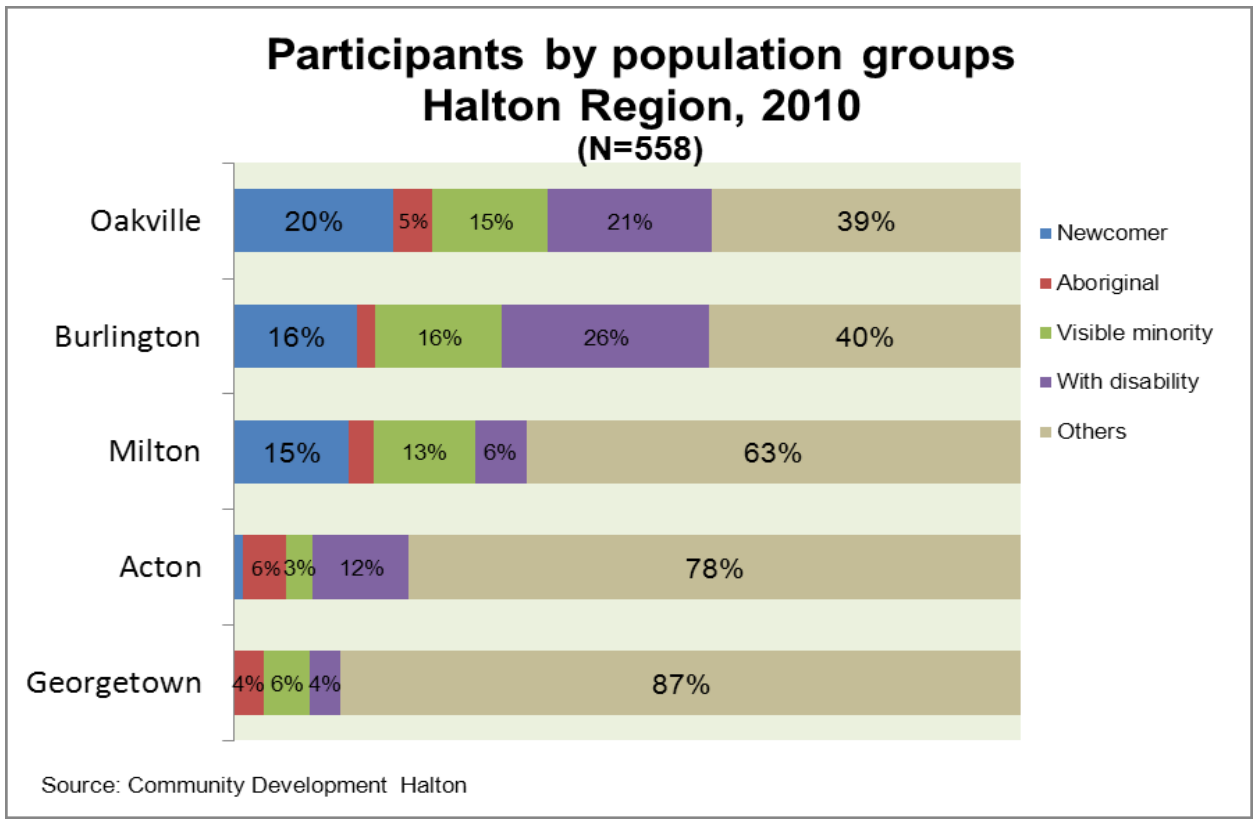
is a demonstration of the limitation to the methodology noted above; in that community many of the adults approached to complete the survey were unwilling to participate.

Figure 4 illustrates the responses to the statement:
*Please check if any of the following describes you: (check all that apply)*

- *I am a newcomer to Canada (last 5 years)*
- *I am Aboriginal*
- *I am a member of a minority group*
- *I have a disability*

The largest response in relation to identification with population groups is with a disability, followed by newcomers. The 3.8% (regional average) of people who self identify as Aboriginal was a surprise with Statistics Canada reporting less than 1% of Halton residents indicating an Aboriginal identity.[14]

**Figure 4 - Responses by Population Groups**




Survey participants also provided information about whom they live with. There were 537 people who responded to this question and the results show a variety of living arrangements,

[14] Statistics Canada (2006). Aboriginal Population Profile. http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-594/Index.cfm?Lang=E

including more traditional family arrangements and other arrangements that bring together people, relatives and friends. The social planner heard through community soundings that it is often necessary to bring a variety of people together as roommates to pay the rent, having arrangements range from:

- Family
- With my children (single parents)
- Alone
- Family with children
- With spouse and/or children and parents or other family
- Friends
- Grandparents or grandchildren
- Roommates
- Adult children
- Employers
- Host home

Those who indicated that they live with their employers are people from the Philippines who are employed as nannies and those in host homes were newcomers.

Also, respondents were asked if they would indicate their income sources. Table 1 shows that the majority of those who responded report that they were working either full time or part time.

**Table 1- Responses by Income Sources**

| Income Source | # responding | % |
|---|---|---|
| **Full Time work** | 150 | 26.9 |
| **Part Time work** | 128 | 22.9 |
| **Ontario Disability Support Program** | 71 | 12.7 |
| **Ontario Works** | 59 | 10.6 |
| **Old Age Security Pension** | 36 | 6.5 |
| **Other (e.g. self-employed)** | 31 | 5.6 |
| **Retirement Income** | 17 | 3.0 |
| **Employment Insurance** | 15 | 2.7 |
| **Student Loan** | 12 | 2.1 |

# Themes from the Findings

## Social Determinants of Health

> Everyone has the right to a standard of living adequate for the health and well-being of himself [herself] and of his [her] family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [her] control. (Article 25, Universal Declaration of Human Rights, United Nations, 1948)

The survey began by asking people about those factors that impact their health, which are fundamental for an adequate standard of living and are also referred to as basic human rights and/or the social determinants of health.

> The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health. (Mikkonen and Raphael, 2010, p.7)

The Health Council of Canada (2010) notes that 35 years of knowledge development about health promotion in Canada shows that "taking action on the broad conditions that affect people's lives offer the greatest improvement in the health of the population." (p. 4). However, it is evident that this knowledge has not made an impact on action, with Canada falling behind other industrialized countries in the alleviation of poverty, and with increasing levels of inequality.

Figure 5, reflects the social determinants of health challenges that the survey respondents report.[15]

The top five challenges are:

- Not having enough money,
- Not being able to afford healthy food,
- Difficulty in finding and in keeping a good job,
- Not having enough education to get a good job, and

[15] Those who indicated "does not apply" to a question may have done so because of their age or family situation or other life circumstances. For example, some younger youth felt that they couldn't respond about whether or not they had enough money, those who infrequently use social services did not respond to the statement: *I have access to social service supports that I can turn to for help when I need it. (e.g. social worker, food bank, recreation subsidies)*. Those without children did not respond to the statement: *My children are happy, healthy and doing well.*

- Not being able to cope with the stress in their lives.

**Figure 5 - Social Determinant of Health Challenges**


Maps 2-6 reveal the geographic distribution pattern of participants experiencing these challenges. It is evident that those individuals are not evenly or randomly located throughout the community. There are geographic clusters of participants for each of the challenges. It is interesting to note that each challenge has its own geographic distribution pattern. Closer examination of the clusters may reveal underlying causes. For example, participants experiencing the challenge of "cannot afford healthy food" may not have easy access to a grocery store, or healthy food is not available in the neighbourhood corner store or they do not have enough money to purchase food.

## Income

"Not having enough money" was an issue for all ages of those responding to the survey. Map 2 provides geographic distribution of those results. During community soundings people talked about the impact of not having enough money, for example making monthly decisions between housing and food, how they are not able to afford school and community programs for their children, some spoke about not having warm enough clothing for the winter.

> "Income is a determinant of health in itself, but it is also a determinant of the quality of early life, education, employment and working conditions, and food security. Income is also a determinant of the quality of housing, the need for a social safety net, the experience of social exclusion, and the experience of unemployment and employment insecurity across the lifespan. (Raphael, 2009, in Health Council of Canada, 2010, p. 10)"

Mikkonen and Raphael (2010) note that there is increasing income inequality in Canada.

> "…with significant increases from 1980-2005 in the percentages of Canadian families who are now poor or very rich. The percentage of Canadian families who earned middle-level incomes declined from 1980 to 2005 while the percentage of very wealthy Canadians increased as did those near the bottom of the income distribution." (p.13)

In recent work by Wilkinson and Picket (2010), they look at statistical evidence that points to the importance of inequality and positioning within equality within a society. They found that ill-health and social problems were found much less frequently in societies where there is more equality, or a smaller divide between the rich and the poor. We know that those who live in the lowest income situations in a given society bear the most ill-health, but the burden of that ill-health is higher in unequal societies. One speculation to explain the trend is the tendency to compare oneself to the "norms" of one's society, so that if there is a huge gap between rich and poor, there is significant stress in not having what is perceived to be "normal".

The Do the Math survey[16] team found that when 21 Members of Provincial Parliament completed the survey they felt a single person would in fact require $1,301 a month or $15, 612 a year to live decently, which is the equivalent of 84% of LIM[17] in 2008. In fact in the Ontario context we know that a single adult receiving Ontario Works receives $592 per month or $7,104 a year. (Novick, 2011)

Poverty Free Halton's[18] video entitled, *Being Poor on Halton*[19] highlights the situation of a family of four, with two parents- one working full time full year and the other part time, both at minimum wage in Halton.

---

[16] An on-line version of the Do the Math survey is available at http://dothemath.thestop.org/. The project is sponsored by the Stop Community Food centre and the Social Planning Network of Ontario.

[17] The LIM is defined as half the median family income (income is adjusted for the family size). LIMs are the most frequently used measure internationally, particularly when making comparisons between countries. http://www.statcan.gc.ca/pub/75f0002m/75f0002m2004011-eng.pdf

[18] Poverty Free Halton is a citizen advocacy group focused on poverty reduction in Halton Region.

[19] See the video being Poor in Halton at http://www.cdhalton.ca/

In Halton, a family of four (1 child in school and 1 child requiring childcare) with one parent working full-time and another working part time both at minimum wage would have an after-tax income of $33,034 (including a Child Tax benefit of $6,698).

- To rent a 3 bedroom apartment in Halton would cost about $14,250, which accounts for 43% of the after-tax income.
- To feed a family of four in Halton would cost about $8,400, representing 25% of the after-tax income.
- To get to and from work, to the grocery store and to childcare would cost about $5,800; including owning and maintaining one used car and a bus pass for another adult in the family. The transportation cost accounts for 17% of income.
- To place the two children in subsidized early childhood education and before and after school programs would cost another $3,750.

Based on the annual Survey of Household Spending conducted by Statistics Canada, it would cost $1,283 to provide clothing for the families in all seasons.

In order to pay for all the daily basics and necessities, the family of four would need an extra $3,740. They would either be forced into debt or have to give up some of the essentials. How would that family handle unexpected costs or emergencies? How would they send their children to school activities and trips? (Community Development Halton, 2011a)

As reported in various issues of Community Development Halton's Community Lens publications, in, 2005 there were over 8,000 families and 37,000 individuals living in poverty in Halton. About 6.7% of all families lived in poverty. Between 2000 and 2005, the number of low income families has jumped by 40%; this increase has outpaced the growth of all types of families by 2.5 times. Families headed by single mothers, seniors, recent immigrants and visible minority persons fared worse than families in general. (Community Development Halton, 2011a)

The incidence of low income tells only part of the story: it counts the number of families living below the poverty line (LICO threshold[20]) but does not capture the depth of poverty. Many families live far below the poverty line. Special tabulations from Statistics Canada group low income families into three categories by percentages below the LICO thresholds. The three groups are:

1. less than 50% of LICO

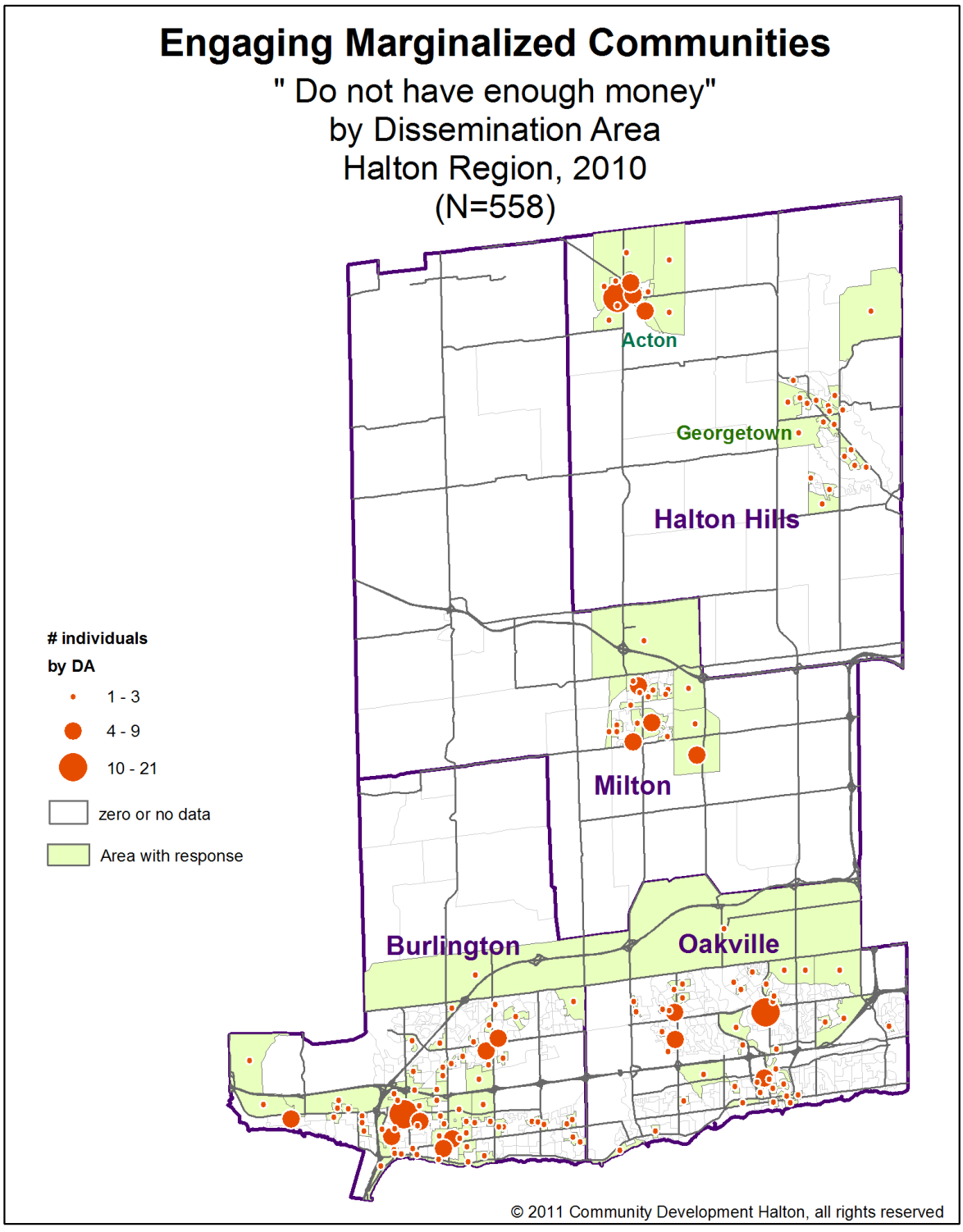
[20] The Low Income Cut-Off (LICO) established by Statistics Canada is a widely recognized approach to estimating the low income threshold below which a family or an individual will likely spend 20% or more than the average on food, shelter and clothing. Although Statistics Canada maintains that LICO thresholds do not necessarily imply poverty, they have been generally accepted as measures of economic hardship faced by families and individuals. (source: Community Development Halton, Community Lens #27, 2009)

2. 50% to 74% of LICO
3. 75% to 99% of LICO.

Families in the “less than 50% of LICO” can be considered as having extreme low income or living in deep poverty.

In 2005, over one in three (36%) low income families were living in deep poverty. For a family of four, it means that they have to survive with an annual total income of less than $20,000 (the LICO threshold is $38,610). (Community Development Halton, 2011b)

### Map 2 - Do not have enough money



## Employment and Education for Employment

Map 3 shows those who indicate that they are not able to "find and keep a good job". In 2004, 60% of parents and single adults in Ontario were employed but with insufficient earnings to live above poverty (Novick, 2011), as noted above in the example of the family living on minimum wages in Halton. In 2008, one third of all Ontario children living in poverty were families with full-time, full-year hours of work (Novick, 2011).

"Not being able to keep a good job" is an issue for a significant number (50%) of those aged 25-64 compared to approximately 33% of youth (24 and under) and 25% of seniors (those aged 65 years or more). During community soundings the issue of seniors needing to work well past retirement age to make ends meet was a discussion point.

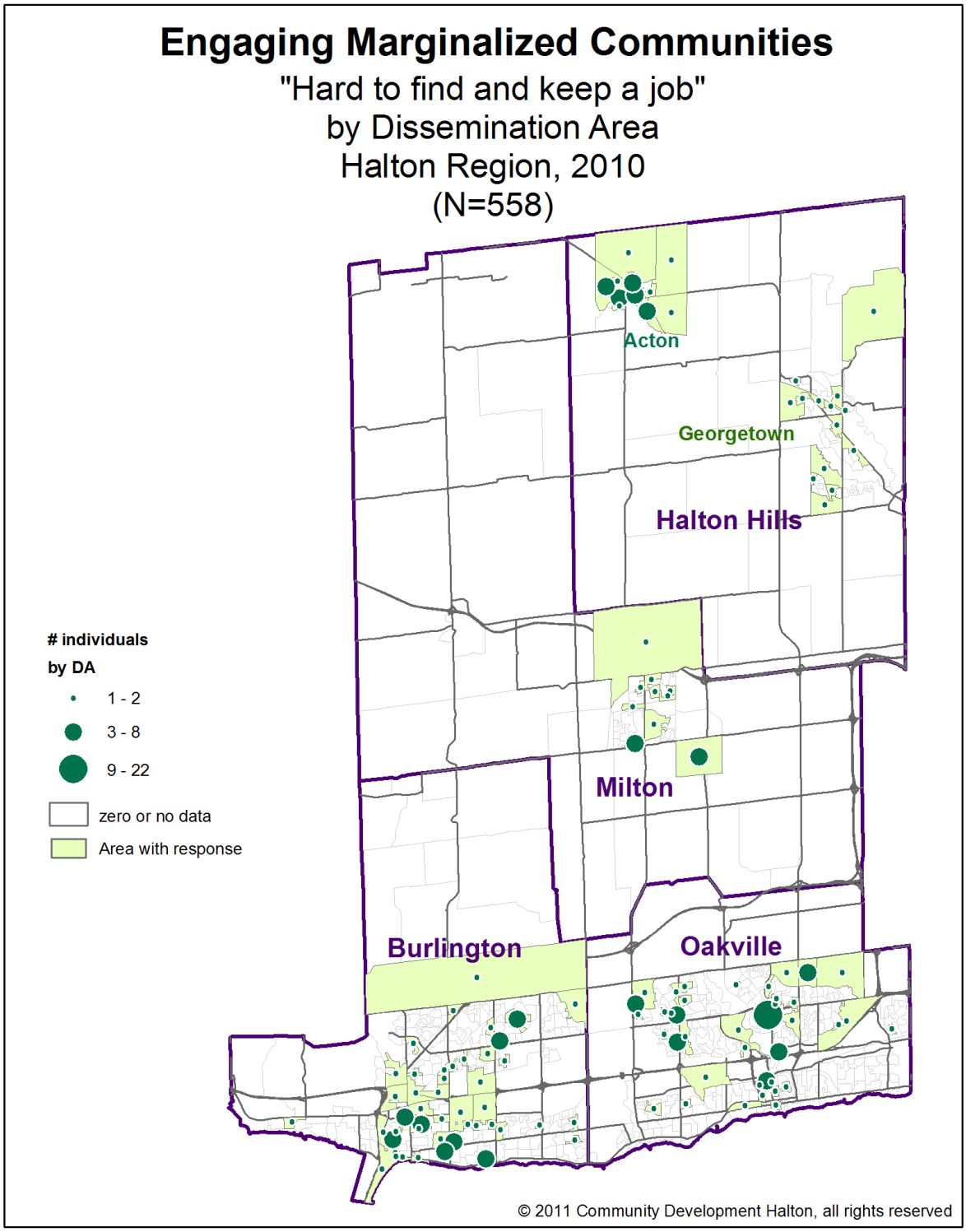
> There was a senior at the supper who talked about having to work at the local Wal-Mart to try and pay the bills despite her ill health. She said that within a few months she would be broke, despite her efforts.
>
> - Excerpt from Community Conversation notes

In addition, the social planner heard that for some the challenge to find a good job is tied up with their community's limited inter and intra municipal transportation system or the lack of a transportation system in the community or into another community. For others, health issues made keeping a job a challenge. Others also talked about not having enough education to get a good job. This perception was backed up by survey results, as displayed in Map 4.

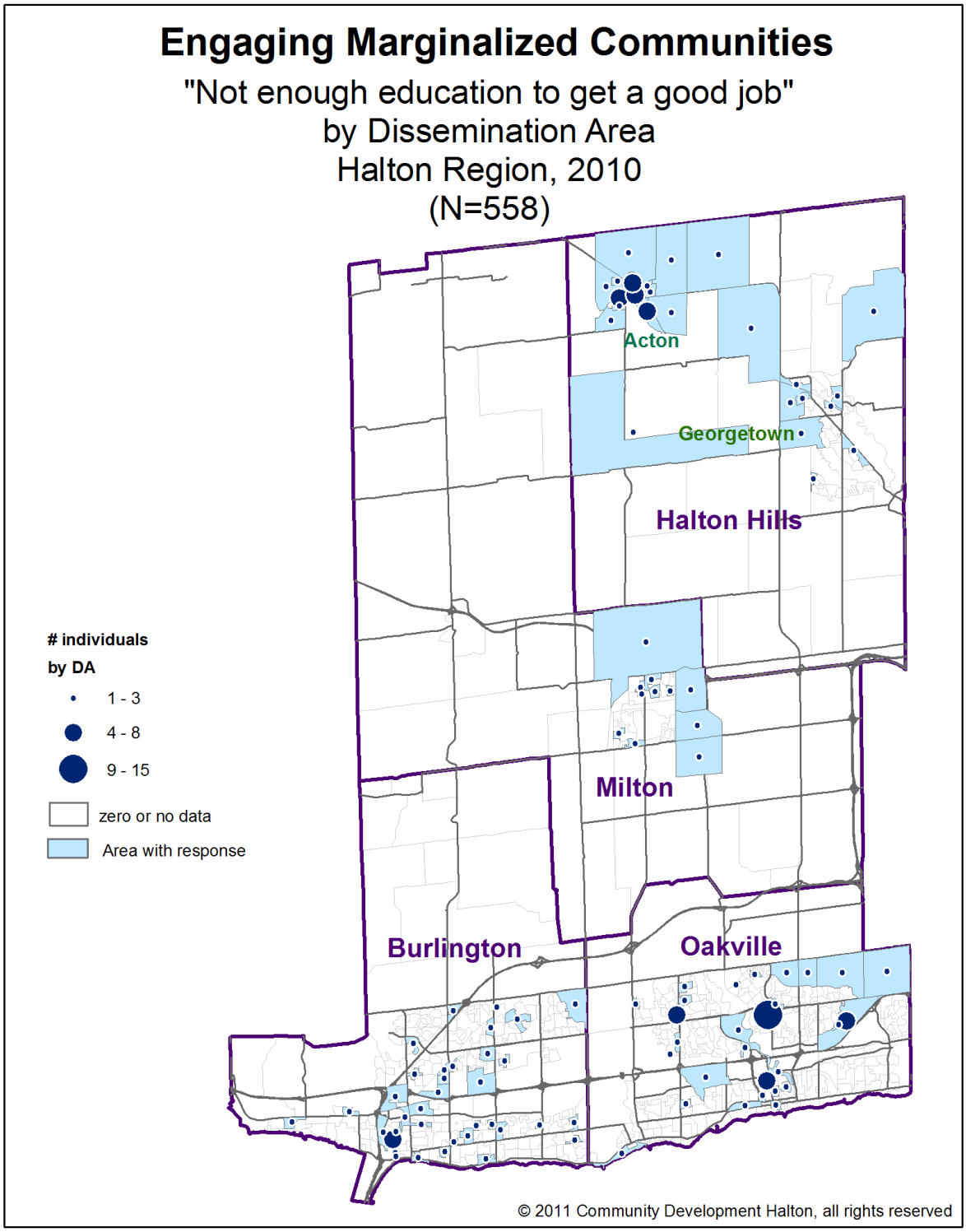
Novick (2011) points out that although education has value, it is not always the pathway out of poverty, quoting the following statistics:

- 80% of low income parents in Canada had completed high school (2004)
- 50% had some post secondary education studies, and
- 45% of the unemployed in Canada had completed a post-secondary education (October 2010)

### Map 3 - Hard to find and keep a good job



### Map 4 - Not enough education to get a good job



## Mental Health

The compounded stress of living in poverty and its impact on mental health emerged as an overriding theme in the community soundings.

This cumulative stress has a variety of starting points that then speak to the intersection of the social determinants of health; they are hard to pull part. It is the stress of feeling as if you do not belong that you can't access the same things as others, or that everything you have is poor quality; knowing that your children don't have the same opportunities as the other children at school.

The social planner spoke with many people dealing with the stress of living with a chronic mental health issue in addition to poverty. The stigma of their illness along with that of poverty creates anxiety and stress in their lives.

> I was at a drop-in group for people with mental health issues today. A number of the people in attendance were from a local group home. One of the things that they talked about was the stigma of their illness. One woman spoke about how the local children will not come to their group home at Halloween because "that's where all the crazy people live." I have heard in their particular community that those folks who live in the group home are often seen walking up and down the street with very little to do; based on conversations with others in the community this adds to the stigma.
>
> - Excerpt from Community Sounding notes

The survey contained three statements related to mental health, with which respondents could indicate their level of agreement or disagreement.

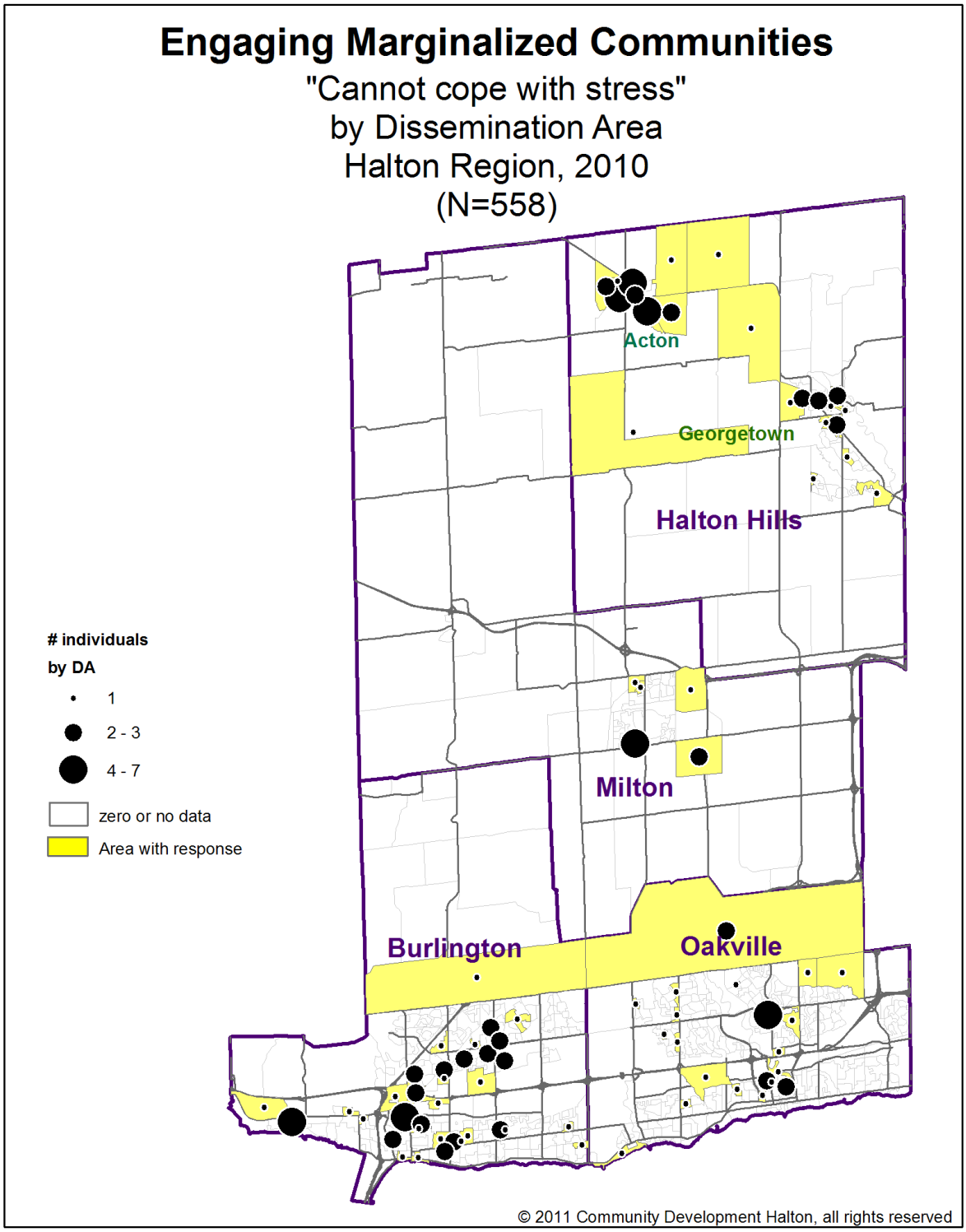
- I can cope with the stress in my life right now,
- I feel good about myself, and
- I feel like I belong to my community.

Looking back to Figure 5 (p.20), 27% of respondents disagreed that they were coping with their stress, 23% indicated that they did not feel good about themselves, and 22% indicated that they did not agree that they belonged to their community. Map 5 shows the responses to the coping variable, which was the fifth highest challenge for those who responded to the survey.

Not coping with their stress was reported as an issue by

- 33% of those aged 45-64;
- 30% of those aged 15-24;
- 26% of those aged 25-44;
- less than 10% of youth under 15 and less than 20% of seniors said coping was an issue.

### Map 5 - Cannot cope with stress



## Housing

The survey results indicate that 17% of respondents "did not feel good about their housing." Housing was, however, the number one theme emerging from the qualitative comments raised by respondents including:

- the lack of housing for those with disabilities,
- housing management,
- long waiting lists for subsidized housing,
- long waiting list for long-term care spaces,
- the lack of independence for those living in group housing, and
- the lack of shelters for youth.

During community conversations held at the end of the initiative people told the social planner and the Community Survey Team that they feel good about their housing, because the housing is "nice", but that many cannot afford their housing. In fact, housing was a key theme in many of the conversations the social planner had with people living in poverty. People talked about the cost of housing, the lack of affordable housing and the waiting lists for affordable housing. Housing is the cause of significant stress for people.

> I sat and chatted to some of the older ladies that I have seen over the past two visits. Housing is an issue for these community members. I heard this a few times from people. There was one lady looking for a new space for herself, working to get away from an abusive situation.
>
> - Excerpt from Community Sounding notes

> I got out to the BBQ at a social housing complex. It was a pretty busy spot with lots of kids. I took my son with me to get supper and chat with people. He got invited by some of the kids we were eating with to go and play a game at the playground. The BBQ organizer directed me to a young lady to talk to. She told me her story right away. She is a young widow with three children. She lives off the baby bonus and a small widow's pension. At the end of the month she has $400 to pay for food, clothes and extras for the kids. She said "I just need to get out of here, I need a job. She told me she used to have a nice little bungalow, "How did I end up here?" I asked what "here" was like. She said that there is lots of violence. The police are there all the time and they come to her to ask what happened. She is often out cleaning up after the fights.
>
> - Excerpt from Community Sounding notes

## Access to Healthy Food

The issue of food goes well beyond nutrition. Access to food is about human dignity, it is the effect of the scrutiny that many report at food banks, the way that food bank operators make one feel. One service provider recently noted, "I am are not sure how we got to the place where we second guess people for coming to a food bank to get expired food twice in one month." Community sounding results indicate that people only access food banks out of necessity, not because it is their preference as a food source.

Not being able to afford healthy food, or any food for that matter, was for some another key theme in community soundings as well as in the survey results. This was a challenge reported by 59% of survey respondents (see Figure 5, p. 20). Breaking down the survey data further reveals that it is a problem reported by 41% of those aged 25-44 and those aged 65+; and 38% of those under 15 and those aged 45-64. The responses for this critical health issue are found in Map 6.

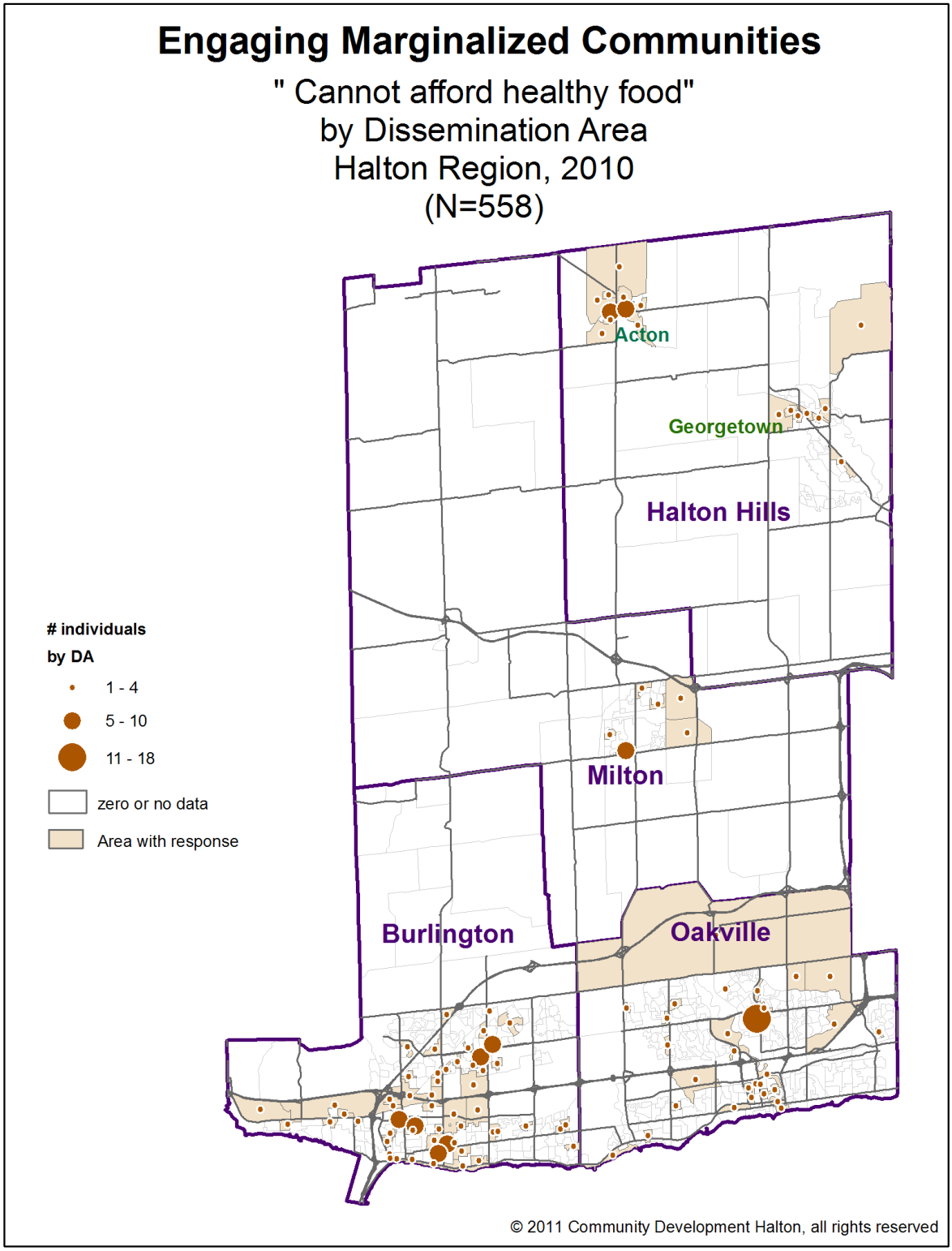
One single mom reported during a community sounding that while working a minimum wage job she has absolutely no money left to grocery shop, she is completely dependent on food programs to feed her family.

> Access to healthy food was a real hot button issue during the community sounding. The room was full of frustration at the mention of a particular food bank. They said their approach takes away any shred of dignity and they are really the only consistent source of milk, eggs and meat. They were positive about some other food banks. They all know about the Fresh Food Box, Refresh Foods and community dinners. Really there was little that I could tell these folks about community resources to meet basic needs. They were all experts out of necessity.
>
> - Excerpt from Community Sounding notes

Comments from the survey also included the connection between housing and food.

> "Can't afford where I live. I find it hard to keep healthy fresh food in my house for a whole month."
>
> "Do I have to choose every month between shelter and food?"
>
> - Survey Response Quotes

### Map 6 - Cannot afford healthy food



The housing challenges people face often mean that they are required to use food banks and food programs to feed themselves and their families. When people live in low income without subsidized housing they often spend up to 50% or more of their income on rent leaving them nothing for food (Recession Relief Coalition, 2011).

During a community sounding, a community member explained that her life is in crisis because she can't pay the rent and is about to be evicted. As a result she uses food banks so that she can put as much towards housing as possible, but when she goes into food banks she is made to feel awful about herself, being scolded because she needs help more than once a month. This further exacerbates her mental health issues, which is the reason she is not able to work and not able to pay her rent in the first place.

We know from research that the purchasing patterns of people living in low income tend towards high fat, high carbohydrate, and high sodium foods, which are least expensive. In fact, this is often the typical offerings though local food banks as well. Poor diet, part of the cost of poverty, is closely associated with obesity and chronic disease (Health Council of Canada, 2010; Milway, Chan, Stapleton, and Cook, 2010)

During the community soundings the social planner heard that the food that is available at food banks is limited. Fresh fruit and vegetables, meat and dairy are not available universally and where they are only available in limited amounts. During one community sounding, a community member stood up and said:

> "Look at us, we are all fat. All we eat is beans and pasta from the food bank."
>
> - Excerpt from Community Sounding notes

Food choices are connected to affordability and, in some cases, the location of grocery stores, with many low income areas located in food deserts.[21] During community soundings many people indicated that grocery stores are not places they can afford and that discount grocery stores are not close by and are hard for them to get to by public transit. Although there has not been a study of food deserts in Halton, community members living in low income point to a number of locations in the region where access to grocery stores is limited and/or where there is limited access to discount grocery stores, where those living in low income can afford healthy food. This is an example of the intersection of access to healthy food and transportation.

Scharf, Levkoe and Saul (2010) provide the following commonly accepted definition of food security:

[21] Food desert is a term used to refer to those neighbourhoods where access to food stores with unprocessed and fresh fruit and vegetables are limited. (Milway, Chan, Stapleton, and Cook, 2010)

> "…a situation in which all community residents obtain a safe, culturally acceptable, nutritionally adequate diet through a sustainable food system that maximizes self-reliance and social justice." (p. 17)

In writing about a model of a community food centre, these authors refer to the food security continuum developed by MacRae. This continuum moves from measures to address emergencies or immediate food needs, followed by innovations and new practices that build capacity and then to measures to re-frame social problems and responsibilities such as incomes for social assistance recipients, minimum wage rates, urban agriculture and food system education. They note that solutions are not necessarily in cheaper food but increased incomes to ensure that everyone can access food at its real cost.

Finally, these authors note something that may be at the heart of why access to healthy food is such a strong theme in conversations and survey findings: food is universal.

> "Food unlike other commodities, engages individuals in a fundamental way, since we depend on it for our very survival…food has a special potential as a politicizing tool for inspiring collective action – both as a way to draw people together and as a focus for activism to gain access to it. Understanding food can help us understand the social and political systems that affect us at the individual and community level." (Scharf, Levkoe and Saul, 2010. p. 14)

We all eat, we all need to eat, and when we bring people together to eat we find potential for community and can build social capital[22]. This potential is seen at local community suppers in Halton. However, when the food connection is made in crisis or as part of one's daily survival, for example through food banks, often we do not take time to build relationships in those settings, thus, we lose the opportunity to build social capital.

## Prioritizing Ministry of Health Promotion and Sport Priorities

The second section of the survey that the Community Survey Team took out to the community deals with the six risk factors that are the focus of the healthy Communities Framework of the Ministry of Health Promotion and Sport. Figure 6 shows the survey response to the question:

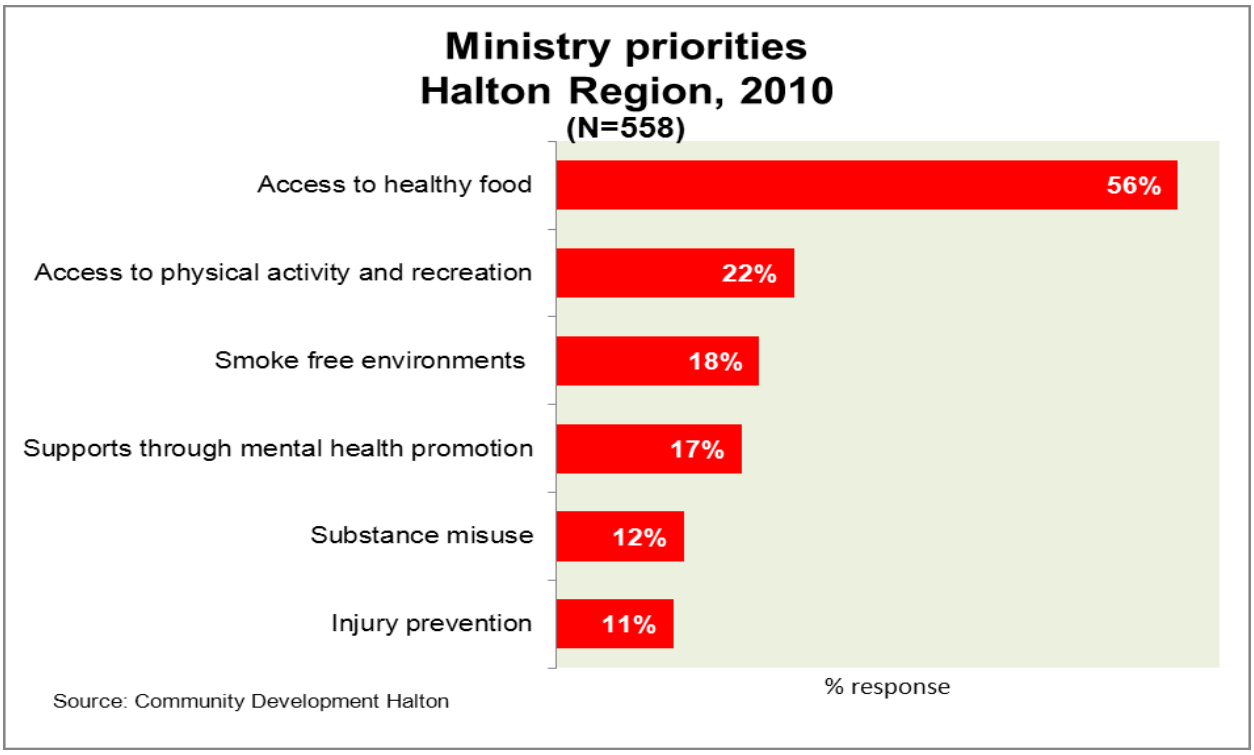
*The Ontario Ministry of Health Promotion and Sport is asking communities to set priorities within some areas that can have an impact on a healthy community. Which of the following areas do you think we should focus on first? Please rank in the order of importance to you. For example 1= most important; 6 =least important.*

[22] Social capital can be thought of in terms of the "features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives." Putnum, R. (1993, Spring).

Given the other survey responses about the challenges to afford healthy food and the community sounding discussions about access to affordable healthy food, it is not surprising to see that access to healthy food is the number one priority that survey respondents would like to see addressed through the Healthy Community Partnership. Access to physical activity and recreation followed as a second priority overall for the region.

> "I feel that having more access to healthy food and increased access to physical activities and recreation are the most important because it creates a healthier person and increases self-confidence."
>
> - Survey Response Quote

**Figure 6 - Survey Response to the Ministry of Health Promotion and Sport Priority Areas**




Map 7 provides a bar chart for each of the municipalities/communities, indicating how each of the six Ministry risk factors compare as priorities for those completing the survey. Higher bars indicate that more survey respondents felt that particular factor was a priority. Map 7 shows that access to healthy food is a priority for all of the communities/municipalities in the region.

Map 7- Responses to the Ministry of Health Promotion and Sport Priority Areas by Community

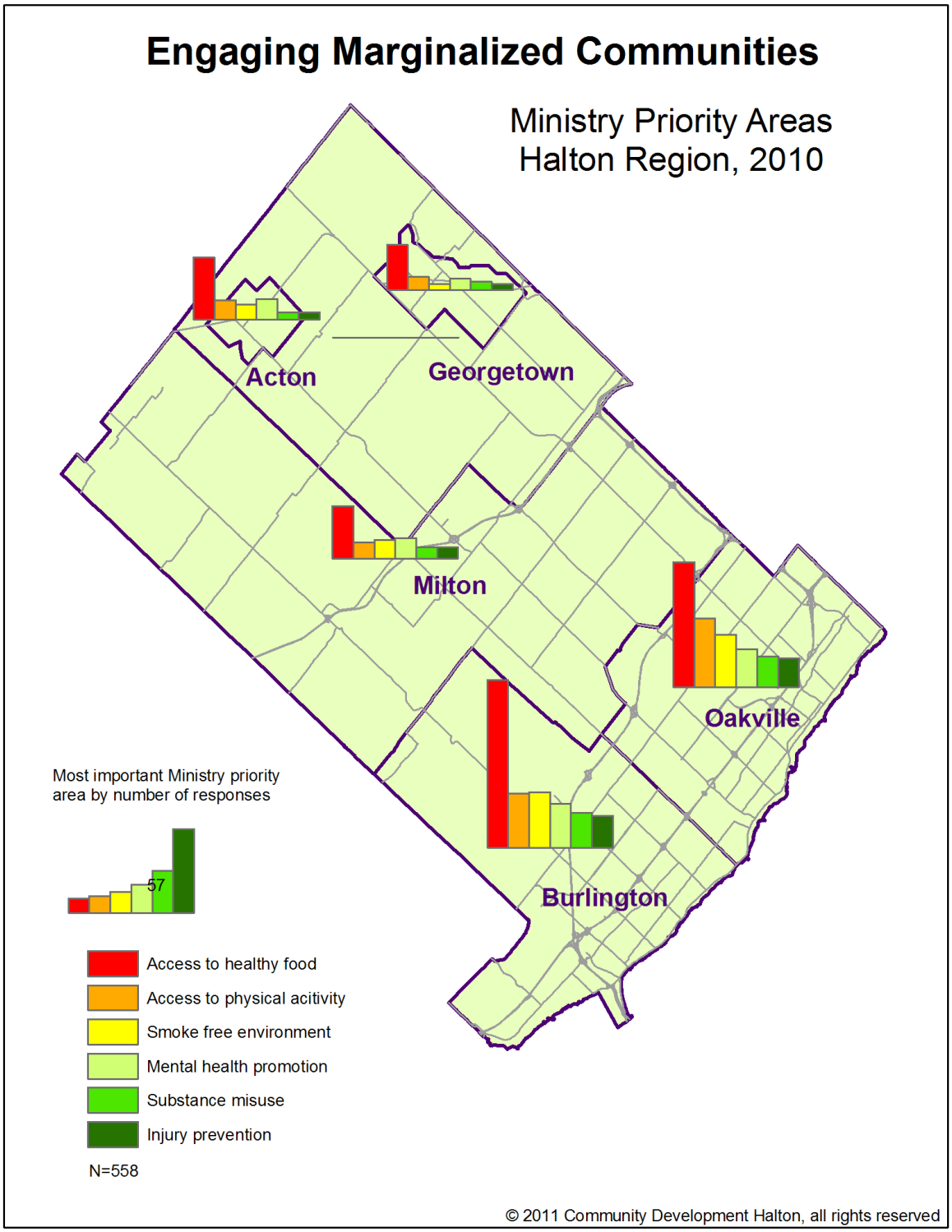
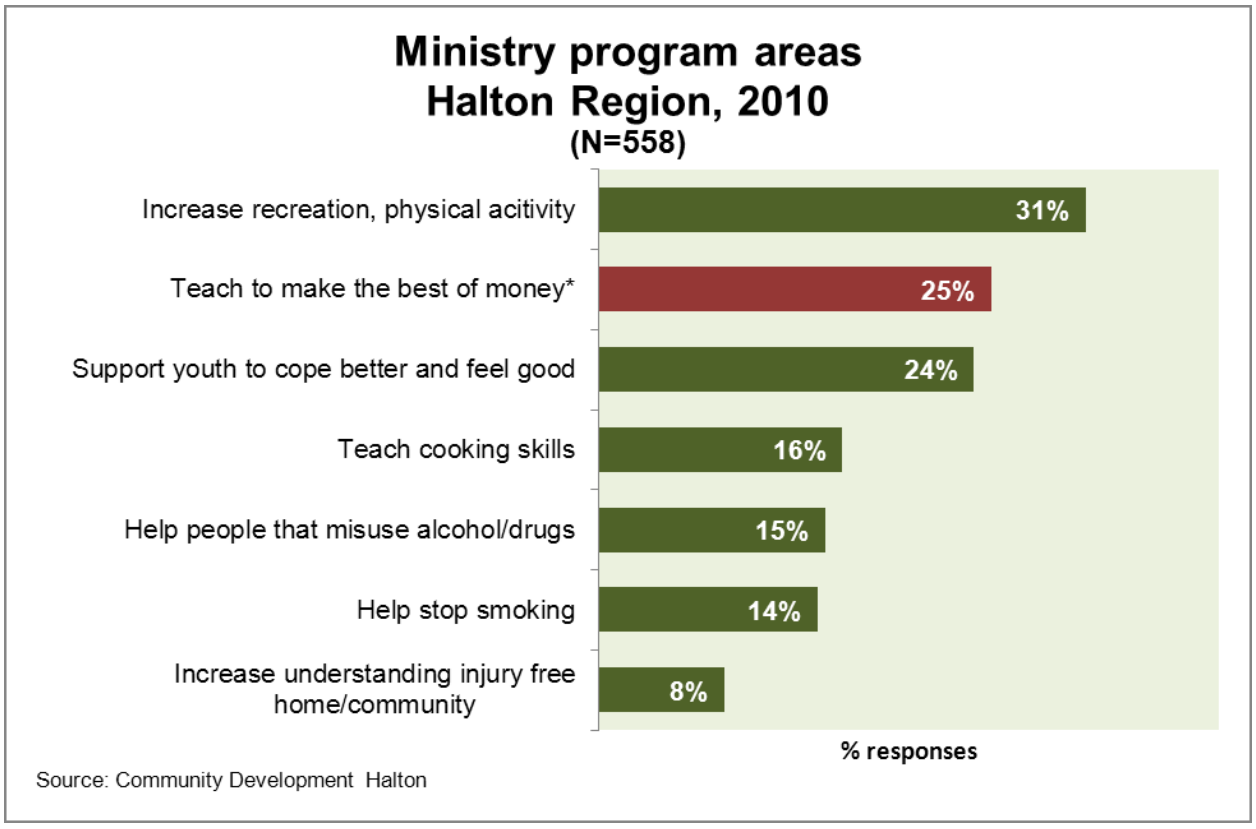


**Figure 7 - Survey Response to the Ministry of Health Promotion and Sport Program Areas**




Survey respondents were also asked to indicate their priorities within a set of Ministry of Health Promotion and Sport program suggestions, associated with the six risk factors[23].

[23] The Ministry of Health Promotion and Sport's Healthy Community Framework proposes a variety of "programs" or recommended action areas related to the six risk factors. Survey respondents were asked the following question: *Which of the following would you like to see offered as a program for you and/or your family? Please rank in the order of importance to you. For example 1= most important; 7=least important*

- *programs and that teach cooking skills,*
- *programs that increase opportunities for recreation, physical activity, walking and bike riding,*
- *programs to help you stop smoking,*
- *programs to support youth to cope better and feel good about themselves,*
- *programs to help people that misuse alcohol and/or drugs, and*
- *programs that increase our understanding of how to have an injury free home and community.*

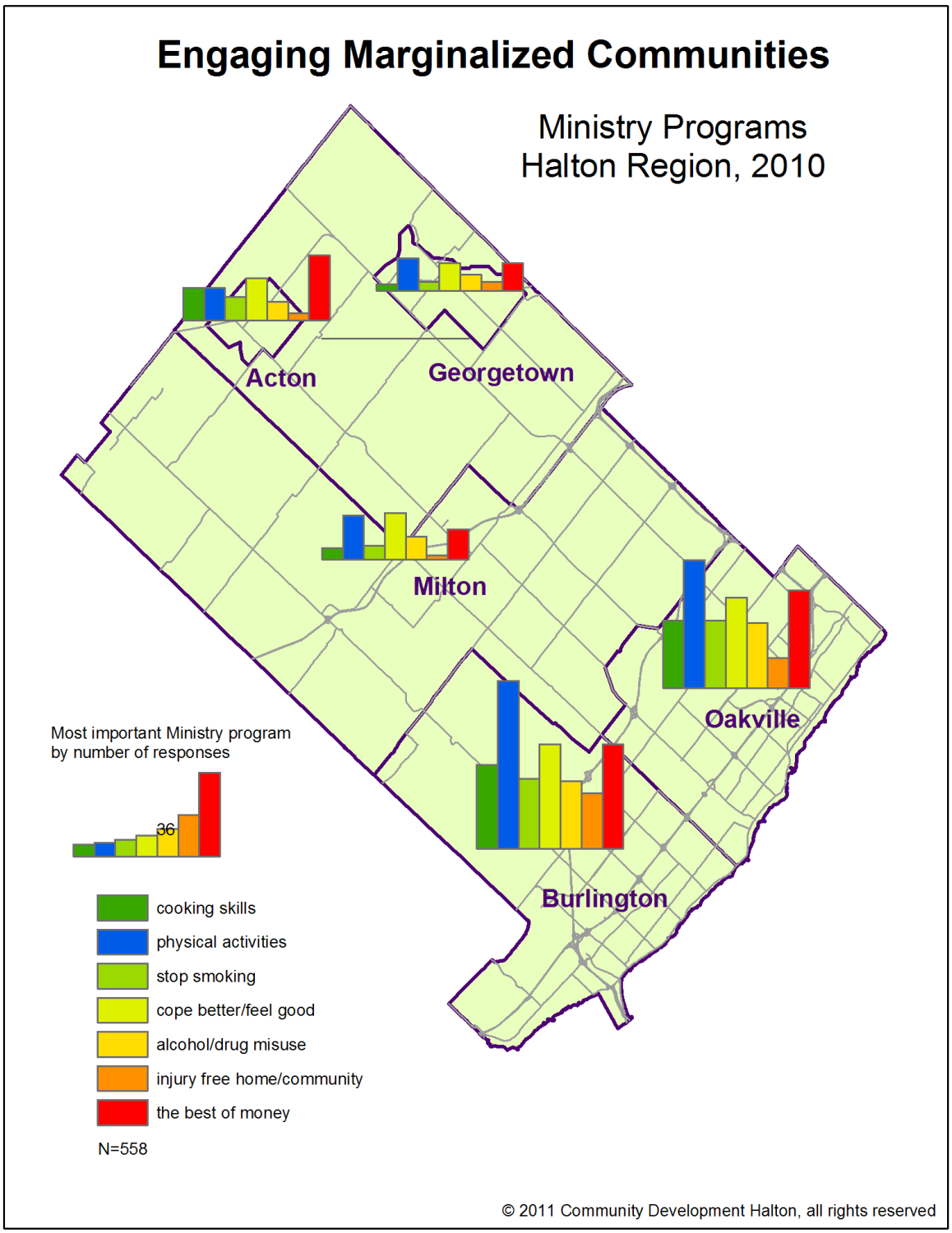
In addition, survey respondents were also asked about how they might prioritize the community taking action to provide

- *programs that teach me how to make the best of my money*

As illustrated in Figure 7, increased recreation and physical activity opportunities is the first priority, not developing cooking skills. The food related program was third, despite the strong emphasis placed on access to healthy food, with just 16% support as a priority. When probed about this at the follow up community conversations, community members differentiated between access to food and cooking skills. They need access to healthy food; however, "being taught how to cook with beans and pasta" (the typical food available at the food bank) is not a priority rather a reflection that the dynamics of poverty and its impact on living conditions is not understood. It shows a disconnect in thinking, with the program response which simply does not address the issue. There were some qualitative comments about cooking skills in the survey response; they all came from newcomers looking to understand more about the produce that is available in Canadian markets.

Map 8 shows the breakdown of the level of interest in Ministry program areas by municipality/community. The map demonstrates local differences and consequently the need to plan for and meet needs locally.

Map 8 - Survey response to Ministry of Health Promotion and Sport Program Areas by Community



## Access to Recreation

Figures 6 (p. 35) and 7 (p. 37) indicate that of the Ministry focus areas, access to recreation and physical activity are identified as a priority by those living in low income in Halton. This is also true in community soundings with many people talking about the need for more access to recreation opportunities for children as well as adults. Those to whom we spoke understand the chronic disease prevention benefits of physical activity but also, want more access so that they might feel part of community: participation is about social inclusion. Community sounding discussions on this topic focused on the role of recreation in increasing confidence, self-esteem and a sense of belonging.

A report from the Federation of Canadian Municipalities indicates that for individuals to be able to participate in the community, sustain good health, form a stable base, and access adequate food and shelter, it is important to have an adequate income. An individual's poor access to community resources and low participation in community often result from their low income, and leads to their isolation from the community (Arundel, 2003).

> "Social inclusion is about making sure that all children and adults are able to participate as valued, respected and contributing members of society. It is, therefore, a normative (value based) concept - a way of raising the bar and understanding where we want to be and how to get there. Social inclusion reflects a proactive, human development approach to social wellbeing that calls for more than the removal of barriers or risks. It requires investments and action to bring about the conditions for inclusion, as the population health and international human development movements have taught us." (Donnelly and Coakly, 2002)

Inclusive Cities Canada: A Cross Canada Civic Initiative studied the following dimensions of social inclusion: recognition of diversity, opportunities for human development, cohesiveness of living conditions, adequacy of community services and quality of civic engagement (O'Hara, 2006). Part of the Cross Canada Civic initiative took place in The City of Burlington. Comments from that Civic Panel in 2005 mirror those from community soundings in regards to recreation and inclusivity.

> "Participants value the large number of community centres and parks, and the wide variety of activities the City and community organizations seek to provide for residents, including youth, seniors and those with special needs. They also recognize the efforts made by the City and organizations to try to ensure that these activities are affordable for all members of the community. The Sound of Music Festival is raised in numerous areas of inquiry as an event that provides a free opportunity for all members of the community to gather together."(Maxwell, Edwardh and Salole, 2005)

There are a variety of barriers to recreation noted in the literature. A study by Frisby, Alexander, Taylor, Tirone, Watson, Harvey and Laplante (2005) found that there are numerous barriers to recreation participation for low income families and their children, which include:

- costly program fees and equipment,
- program locations and a lack of transportation to get there,
- time constraints and "inflexible and uninviting program structures and schedules",
- a lack of awareness of programs and the subsidy policies or process,
- difficult subsidy processes and stigma associated with asking for financial help,
- experiences with racism,
- negative attitudes and stereotyping towards youth,
- little meaningful consultation,
- lack of structured, skill building programs that focus on the development of self-esteem,
- lack of facilities that can be used for recreation, and
- transportation barriers and/or cost of transportation to get to programs.

During community soundings people talked about not being able to afford transportation costs, preventing them from participating within community life and recreational activities. They also mention the "dignity cost" of asking for a subsidy to be able to participate. Yet when they are able to participate and even contribute as volunteers they feel like they belong.

> "…wouldn't be able to get my kids in if I wasn't on Ontario Works" (This parent was referring to the fact that being clients of Ontario Works more easily identified their family as needing a subsidy and sometimes subsidies were offered up automatically to those receiving Ontario Works).
>
> Another person spoke up and said that "…feel like you have to tell them that you won't abuse the system to get a subsidy for your kids."
>
> - Excerpts from Community Sounding notes

An older adult shared their experience of saving up to be able to pay for a membership to the local seniors' centre, only to find out that many of the activities were trips that would have additional costs that they could not afford; as a result they have not been back.

During community soundings there were many discussions about what free activities people access for their families. They talked about how free community events are opportunities to feel connected to their local communities.

## Transportation

Transportation is a continuous problem affecting the living conditions of low income people. The intensity of the transportation challenge varies by community. It was noted by 26% of the survey respondents as a current challenge for them. When there is a lack of transportation the results are decreased access to programs, services and supports and, for some, food and access to employment. The transportation challenge is a result of not having enough accessible transit, transit that is not affordable, a system with limited routes and time frames, and transit systems that do not connect to other communities.

## Other Issues Raised in Community Soundings and Survey Responses

### *Health Care Expenses*

Additional health care expenses are also concerns for people living in low income. Items not covered by health care plans, such as orthotics, over the counter drugs and medications that fall outside of Ontario Drug Benefit Plan are often necessary but out of reach of people with a low income. The working poor rarely have a health care plan to cover any medications. The end result is that people just go without. There are many long-term health implications for those without coverage as well as for the health care system.

### *The Experience with Receiving Services*

Access to medical care and social services when people need it are also reported on very positively. However, in the case of social assistance qualitative comments indicated that people feel degraded when receiving social assistance and social supports.

> Ontario Works causes too much extra stress in my life. Not worth the fight to get so little help.
>
> I have a big problem with the services in town. They have a way of embarrassing you to the point that I have gone without food instead of facing those agencies again.
>
> - Survey Response Quotes

There are a number of people throughout the process who also spoke about the challenges of navigating the health and social service systems. Although navigating systems is not a challenge exclusive to those living in poverty, the social planner heard the frustration from community study participants that many service providers assume that everyone has access to a phone all the time and access to the Internet to access information, when in fact that is not always the case when you live in poverty.

### *Child Care*

The waiting list for subsidized child care spaces and the need for increased supports for children with special needs are also discussion points that came up in a number of soundings as additional stress points for many parents who spoke with the social planner.

### *Alcohol*

Although alcohol and illegal drugs are not reported by the majority of the respondents, 12.5% did indicate that they were using illegal drugs and 10.2% reported that their health was being affected by drinking alcohol. A negative impact on health from use of alcohol was reported by 23% of youth aged 15- 24 (compared to 6% of those aged 24-44).

### *Tobacco*

Those who indicated they smoke consisted of 26% of those who responded to the survey. When smoking was discussed in a community conversation, the social planners heard that people would like to be able to quit. However, smoking was the way that many people "medicate" themselves to deal with the stress in their lives. It was also noted that the cost of quitting, through the use of the patch or gum is more expense than contraband cigarettes.

### *Specific Issues for those with Disabilities*

The group that identified themselves as having a disability had a much longer list of significant challenges than the others in the survey. Table 2 summarizes their significant challenges as reported through the survey.

**Table 2 - Challenges for Those Reporting a Disability**

| Challenges reported by those with disabilities | % of those with disabilities reporting the challenge |
|---|---|
| Not enough money | 90% |
| Not able to afford healthy food | 79% |
| Not able to find and keep a good job | 60% |
| Do Smoke | 50% |
| Do not have enough education to get a good job | 42% |
| Not able to cope with the stress in my life | 38% |
| Do not feel belonging to community | 33% |
| Do not feel good about themselves | 33% |
| Do not have good access to transportation | 31% |
| Do not feel good about housing | 26% |

### *Specific Issues for Newcomers*

The survey analysis reveals that the key issues reported by newcomers are income and jobs. Throughout the project there were community sounding opportunities with newcomers, who have some challenges similar to others living in poverty and others that are very distinct. The isolation and stress from being so far from family is an obvious struggle for many. Other significant challenges are not being able to find work in their field, navigating systems for help,

being taken advantage of in terms of housing, and working in the underground economy that leave workers as victims; these were just some of the struggles mentioned.

## Defining Access

As noted earlier, when the initial results from the survey were analyzed the social planner went back to the community and presented the results, to clarify and validate the findings. The meetings were held in Burlington and Acton. One of the key issues that required further understanding was how community understands and defines access with a special emphasis on access to food and recreation. Those comments and further reflection based on survey findings and other community sounding data have been brought together to break down access in this way,

- Programs and services that allow for access with ***dignity.*** This was the first thing listed in both community soundings. People should not feel "less" as a result of asking for assistance to meet basic needs or to become part of community. This may also mean that a program or service embraces the contributions of those who are willing to contribute to the program or service.

- Next, people talked about programs and services that provide goods and services that are of "***quality***". Second rate, dented, and expired foods do not reflect quality and they take away from dignity.

- ***Affordability*** is critical and intuitive to access. People would prefer to be able to purchase their own goods and services, making all their own choices within a framework of affordability. That would contribute to dignity.

- Finally ***location*** was listed as essential for access. When income and transportation are challenges, opportunities to access goods and services, meet basic needs and be involved in community need to be close to home.

Reflecting on this further these four access factors have relevance to the way in which we develop engagement opportunities: meaningful participation that respect opinion and gifts or ensure dignity; "quality" experiences that allow people to contribute, that don't waste their time but make a difference they can feel proud of being associated with; the removal of financial barriers to participate such as transportation and child care; and neighbourhood-based spaces for meetings and initiatives that mean transportation is not an issue and action is local.

## An Abundance of Capacity

### What is going well in the Community

The survey generated notable positive responses associated with the discussion of feelings of being safe in homes and in community, support received from family, friends, and happy and healthy children.

Although there were many "headaches" reported throughout the community soundings and part of the project was focused on developing community capacity, it is important to report that much capacity in community already exists. The capacity is found in service providers, programs and, most of all, in those living in low income. The abundance of local leaders, stories of resilience, survival, and solidarity or banding together are inspiring.

In talking with a large group of 30 people at a community breakfast program about what community resources were available, it became clear to the social planner that for the most part the people in the room, those living in poverty, were very knowledgeable about what social and health services are available to them. This finding was constant throughout the duration of the project.

> A large focus of conversation became the fact that they were the best resource...and we talked about the opportunities to participate in a network and give voice to these issues through the Healthy Community Partnership.
>
> - Excerpt from Community Sounding notes

Community Development Halton's social planner has met service providers and volunteers with great compassion for people living in difficult circumstances, and those living in these circumstances were very thankful for those supporters. The following are just a sample of the compassion and dedication of service providers and volunteers in the community working with people in poverty.

- A volunteer who gathered together low income, primarily newcomer children, feeds them and plays with them on a monthly basis. These were children that local service providers had not been able to gain access to. Her informal unfettered approach had drawn these children from the shadows.
- A service provider who is unhindered by the small space that she has to work with. In that space she provides free piano lessons, a food pantry and a small clothing room.
- Volunteers who weekly cook and serve a healthy meal to individuals and families living in local motels.
- A day care that orders extra milk to send home with low income moms to help them get their children through the weekend.

- A community outreach worker who provides practical supports to single parents by helping with paperwork, transporting people to appointments and regularly sitting and listening.

However, many of the unsung heroes in the community are those living in poverty themselves, in formal and informal volunteer roles; peers who have mustered courage and found solutions. Here are just a few:

- A community member who monthly draws together others living with mental health issues and organizes a cooking class; a time of chopping and stirring, eating together and supporting one another.
- A community member who saw an abandoned playground and transformed it into a community garden.
- Volunteers who take the time to meet regularly with isolated seniors, to play cards and lend an ear.
- Many community members who look out for one another, calling around with news of good gas prices, or sales at grocery stores. People just looking to make a difference in their neighbourhood providing social support to those around them.
- Neighbours who provide practical support for others in need by gathering clothing for a family who is struggling.
- Volunteers who work in region-wide food initiatives that distribute food to neighbours.

> I went to a housing development where a local church is helping out. There is an afterschool program and a community garden. When I arrived the truck had just dropped off the food and the volunteers were there to help sort it. The rest of the community will pick it up later that evening. The coordinator is a mom who lives in the development. She is now receiving an honorarium to coordinate the food program. She oversees the food program and its volunteers as well as the community garden. She has been there for about a year. She said that having the programs there has made a difference and the garden is going better than people thought it would. People thought that the kids would wreck it (it is the place where a torched playground used to stand!). But the kids club has a garden plot and the bunnies are staying away!
>
> - Excerpt from Community Sounding notes

## Faith Groups

There are numerous program and services across the region that support those living in low income, but a special note is required to acknowledge the work of local churches and faith groups. They are involved in community gardens, clothing rooms, food banks, community suppers and provide dinners served out of motel rooms for those living there without permanent housing. The staff and volunteers are warm, and welcoming. Although the key means by which they gather people together is often through food, as a response to a basic need, the food is not

the reason people keep going back. It is the community that they create in that environment and the fellowship that the warm environments provide.

> I spoke with another person who talked about how the dinner doesn't help them make ends meet but it is a place to come "out for dinner". She talked about taking her grandkids out to dinner to community suppers because she can't afford a restaurant. It is just that the menu is a surprise!
>
> - Excerpt from Community Sounding notes

## Concluding Comments and Recommendations

There is wisdom in community and there is tremendous capacity in Halton among our marginalized community members. If there were just one lesson from this project it would be that any process designed to develop a healthy community needs to include at the forefront the voice and gifts of those in community. Gaining the trust from community, which is necessary for the privilege of hearing that voice and learning about these gifts, takes time. It has been time well spent and an honour to listen to all those who took the time to share their experience.

The community soundings and survey results together paint a strong picture of the daily struggle faced by those who "live on the margins" of our community, unseen by most in Halton. There are some challenges that are universal for those living in poverty in Halton and others that are specific to communities, neighbourhoods and population groups. There is a need for local level planning and solutions. Developing local solutions and involving and letting local voices lead are important in the process of trust and relationship building if we are striving for increased local capacity.

A community-based participatory research approach has been an effective way to gain access to a broad range of voices from the Community Survey Team's natural network. The process has resulted in a rich source of opinion from those living in poverty and who have dared to share. The approach has also resulted in further development of local leadership, the creation of community champions and has drawn new voices into the conversation.

Access, as defined here, such as access to healthy food and/or opportunities for physical activity and recreation, would go a long way to contributing to mental health promotion in the community, for those living in low income. There are other examples where a clear understanding of the intersection of the various social determinants of health is important in designing policy, programs and services, if we are to move forward to making a difference.

It is also necessary for others in the community to have increased awareness and knowledge about barriers to accessing programs and services from the perspective of someone living in

poverty, and particularly with regard to the issue of dignity. As many talk about the importance of community engagement, action will be empty without an emphasis on dignity.

For those who are ready, there is a clear mandate from community, based on this work, for us to be working together on the complex intersection of issues of income, housing, transportation, mental health, social inclusion and food security. Ensuring that community voices are heard at the planning tables is a critical step in trust building; a misstep in this area will result in deepening the mistrust for "systems" by those who are often not consulted.

There is much more to be done. Those living in poverty need to know their voices have been heard and have made an impact, hopefully laying the foundation for rich and meaningful engagement in the future.

# Appendix

## Pilot Project Summary of Outcomes

### Engaging Marginalized Communities for Better Health Outcomes in Halton

**Introduction**

The Engaging Marginalized Communities Project, sponsored by the Social Planning Network of Ontario (SPNO), worked through four local social planning and community development councils in four regions across the province: Halton, Waterloo, Sudbury and Peterborough.

The purpose of this initiative has been to develop and test a model for engaging the participation of members from high health risk populations at the Healthy Communities Partnerships planning tables in their respective communities. Members of marginalized communities would bring their experience and insights into the planning process influencing service development, prevention strategies and policy development related to the health risk factors of the Healthy Communities Fund (HCF).

**Objectives:**

The stated objectives of this initiative are:

a) to work collaboratively with local Public Health Units (PHUs) and other local partners to plan and implement the Healthy Communities Ontario Policy Framework for Community Action in four communities across Ontario;

b) to reach out, engage and support marginalized persons with high health risks to participate in the planning processes for development and implementation of the Framework for Community Action;

c) to build the on-the-ground capacity for community members, local health practitioners and a broader set of partners (e.g. municipal parks and recreation, public education, nonprofit community services, etc.) to engage and work effectively with members of marginalized communities in the planning and implementation of health promotion strategies to achieve better health outcomes; and

d) to document the process of outreach and engagement of marginalized communities in the planning process as an action planning model for potential use in other communities across the province.

## Community Development Halton (CDH) Project Outcomes Summary

### Partnering with the Public Health Unit

A social planner was hired by CDH to develop and undertake the Engaging Marginalized Communities (EMC) project. That social planner liaised, connected with and met with Public Health Staff from the Chronic Disease Prevention Program, Halton Region Health Department and the project coordinator for the Healthy Communities Partnership. The partnership with the Public Health department throughout the project has been fluid and interactive, with information shared back and forth, and connecting one another with community contacts to strengthen one another's project efforts.

Our collaboration focused on developing an approach to collect survey responses from people living in marginalized communities to contribute to the community picture and priority setting process. This approach was designed and carried out by Community Development Halton and financially supported by the Halton Region Health Department; it was included as part of their proposed engagement strategy to the Ministry of Health Promotion and Sport and funded as such.

Although the survey was designed first and foremost for the Healthy Community Partnership project, to contribute to the community picture development and priority setting process, the results serve other regional and local endeavours related to poverty reduction, health and social service planning.

### Connecting with the Community

To achieve the objective of connecting with the community, the social planner struck out into all corners of Halton Region, first to meet with service providers, church leaders, and key volunteers. These community gatekeepers would be the ones to open doors to the programs and services where Community Development Halton and the social planner could connect with community members themselves.

### Connecting with Service Providers

The social planner, over the course of the project has met with numerous service providers in a variety of sectors throughout the region, all of which have been identified as working with marginalized communities. These groups include faith, child care, child/youth supports, education, neighbourhood, housing, food security, mental health, community living and recreation.

When meeting with a service provider or group of service providers the social planner took the time to talk about the work of Community Development Halton and then listened and learned about the work that they are involved with in community, specifically as it relates to their work with marginalized members of the Halton community. Those service providers were asked about

their own perception of the main issues the people they are working with face as they live in marginalized situations.

Service providers were also asked if there were other agencies or groups that they could connect Community Development Halton with, as well as, whether they could set up opportunities where the research could connect with people living in the community in marginalized circumstances.

The work was a process of developing connections to service providers, their networks and to the communities they serve. The work uncovered the layers of service, commitment and personal and community challenge. The results have found that with each layer there has been another amazing story of collaboration, champions, sorrow, support and survival, gaps and future plans.

### Connecting with Community Members

The connections with service providers opened the door to connections with community members and groups of community members.

Connecting to community was done in the form of community soundings, which meant finding safe spaces, places people were comfortable talking, finding their "turf" and asking for permission to engage there. The social planner spent time and sometimes volunteered at food banks, community suppers, community BBQs, drop-in programs, and coffee shops in order to develop trust.

This work was done formally and informally. In some cases, the social planner was invited to speak to a group about her work and allowed to ask the group questions. In other cases, the soundings were individual conversations. The format needed to fit the situation and the permission granted. The soundings happened in all of Halton's local municipalities and with a variety of populations.

The soundings opened a second door. While in community settings the social planners looked for and asked about leaders, among those who were using the programs and services. That was the door that led to local community leaders. These would be the leaders to engage in further training and empowerment, some of whom would be hired to conduct a survey, all of which are described in later sections.

The majority of the soundings were conducted before the survey (referred to earlier in the appendix on the partnering relationship with the Public Health Unit) was developed, some during the survey implementation time period and two intentionally after the survey results had been analyzed. The two final soundings were formal meetings and were used to gain a deeper understanding of the survey findings from the communities' own perspective.

Many observations were made about the spaces and the informal networks that form to support those living on the edge in our community, those who one community member described as the people "who you drive by too fast". Poverty is hidden in Halton, but it is real.

## Community-Based Participatory Action Research: Building Local Community Capacity

The objective of building local community capacity has been addressed in several ways. The first has already been mentioned, the identification of local leaders. Many of those leaders were trained and hired to collect survey responses from their local communities. For the majority this was a first try at such a task and required them to stretch themselves and/or go outside of their comfort zones. Some have carried on as volunteers participating in community meetings related to the Healthy Communities Partnership and some have spoken at public meetings about the findings.

Staff have also been collaborating with other community initiatives to bring an even larger group of local leaders living in low income together for community development training. A first lunch and share meeting was held with just over 20 community members. During that get together people identified some training focus areas. A formal training day is now scheduled.

Throughout the project staff have connected service providers and community groups working with people living in low income with one another and with the Healthy Communities Partnership planning process. This base has been laid for increased collaboration in the future.

Finally the project has opened the door to speak with several church groups involved with marginalized groups about an assets based approach to their ministry; the acknowledgement of gifts and skills of those that they serve, discussion about how those that received service can be part of service. This has been well received.

> I spoke with Nancy[24] and another volunteer about the capacity they felt the folks in the room had; did they think that they would be able to talk further about the issues they were facing. Their first thought was that no one could do that. They had way too many things going on in their lives, so many stresses that they couldn't possibly. When I mentioned a couple names of the folks that I had met, they stopped and thought and realized that, in fact, there were several that might be able to do that.
>
> - Excerpt from community sounding notes

## Documenting the Process

The social planner documented the details from meetings with service providers and community members. The material serves as a record of what service agencies, grass roots groups and

[24] All names and locations in this document have been changed to respect the privacy of those who took the time to speak with the social planner.

organizations are working on together and the issues that they are addressing. The information is also a record of the key concerns of those living on the margins and is related to the broader social determinants of health that emerged in the discussions.

The following table is the practice model developed based on a literature review as well emerging knowledge from the field based on discussions by the provincial social planners for the four pilot sites. The practice model guided the day-to-day work of each sites as they engaged with community members and organizations.

### Engaging Marginalized Communities Practice Model[25]

| **Developing Project Practice Model** |
|---|
| a) We must be sensitive to three key sets of relationships in each of our communities and adapt our engagement strategies accordingly:<br><br>• Our own relationship to the marginalized community being approached for engagement.<br>• Our relationships to community agencies and practitioners that facilitate connections for us with members of marginalized communities. New collaborations or existing collaborations that extend into a new area are capacity-building.<br>• Relationship among and within the marginalized communities being approached (either existing or being formed via this Project).<br>• The relationship of members in the marginalized communities to the participants in the larger Healthy Communities Partnership planning process. |
| b) While we are going into the field with a Healthy Community Strategy that emphasizes Ministry of Health Promotion and Sports' six health risk factors, we remain open to the reframing of critical issues from the perspective of marginalized communities in terms of the broader social determinants of health. |
| c) In the continuum of community engagement from: ***Information>>Consultation>>Shared Planning>>Shared Decision-making***, our commitment is to the third and fourth stages of engagement for marginalized communities. Therefore, while our outreach will welcome participation from all members of marginalized communities who show interest in giving any input, we will employ engagement methods that will recruit and support a number of leaders with lived experience from each of our communities who can participate in a regular and continuous way through the Healthy Communities Partnership planning process. Only this approach will |

[25] Source: Peter Clutterbuck, SPNO, June 2010. Central SPNO Support.

ensure moving beyond information and consultation to collaboration and decision-making.

***We recognize that equal and meaningful participation of members of marginalized communities in the planning process may have to take non-traditional forms (i.e. other than meetings and "tables", which professional practitioners typically use). Imaginative and creative ways for their input may have to be designed. Active participation in decision-making presents a real challenge in this regard, calling for imagination and innovation.***

d) We will explore joining our developmental practice roles with a role that supports Project evaluation by introducing early in our engagement with community people a regular practice of "reflection" that will focus on "learnings" and "changes" linked to Project activity.

## Survey and Community Survey Team Training Package

**We want your opinion to be heard....**

Health is not something that we get at the doctor's office. It is something that starts with our families, our schools, our workplaces, our neighbourhoods, our playgrounds and our parks. The more that you see health this way the more you are able to see the ways that you can improve health.

We want your opinion about the things that are going well; the things that impact your health, the things that are getting in your way to having better health, and the things that you think should change. The survey takes about 5 minutes to do and **your responses are all anonymous.**

1. **Please agree or disagree with the following statements. Choose ONE answer per statement.**

| | Strongly Disagree | Disagree | Agree | Strongly Agree | Does not apply |
|---|---|---|---|---|---|
| a. I have enough money. | | | | | |
| b. Finding and keeping a job is easy for me. | | | | | |
| c. I have enough education to get a good job. | | | | | |
| d. I feel safe in my home. | | | | | |
| e. I feel safe in my community. | | | | | |
| f. I have access to good transportation for errands, appointments, to get to social services, recreation and grocery shopping. | | | | | |
| g. I can afford healthy food. | | | | | |
| h. I have good support from friends and family. | | | | | |
| i. I feel like I belong to my community. | | | | | |
| j. I feel good about the housing I live in. | | | | | |
| k. My children are happy, healthy and doing well. | | | | | |
| l. I do **not** use illegal drugs. | | | | | |
| m. My health is not affected by drinking alcohol. | | | | | |
| n. I do **not** smoke. | | | | | |
| o. I feel good about myself. | | | | | |
| p. I can cope with the stress in my life right now. | | | | | |
| q. I have a doctor (nurse practitioner). | | | | | |
| r. I have access to social service supports that I can turn to for help when I need it. (e.g. social worker, food bank, recreation subsidies) | | | | | |

2. Did we miss anything? Are there other things that are going well or "headaches" that we missed above?

_____

_____

3. **The Ontario Ministry of Health Promotion and Sport is asking communities to set priorities within some areas that can have an impact on a healthy community. Which of the follow areas do you think should we focus on first? Please rank in the order of importance to you. For example 1= most important; 6 =least important.**

| | **Your rank (1-6)** |
|---|---|
| **a. Access to healthy food** | |
| **b. Access to physical activity and recreation** | |
| **c. Smoke free environments** | |
| **d. Supports through mental health promotion** | |
| **e. Substance misuse** | |
| **f. Injury prevention** | |

4. **Did we miss anything?** Do you have any comments on the things that you just ranked above?

_____

_____

5. **Which of the following would you like to see offered as a program for you and/or your family? Please rank in the order of importance to you. For example 1= most important; 7=least important**

| | **Your rank (1-7)** |
|---|---|
| a. Programs that teach cooking skills | |
| b. Programs that increase opportunities for recreation, physical activity, walking and bike riding | |
| c. Programs to help you stop smoking | |
| d. Programs to support youth to cope better and feel good about themselves | |
| e. Programs to help people that misuse alcohol and/or drugs | |
| f. Programs that increase our understanding of how to have an injury free home and community | |
| g. Programs that teach me how to make the best of my money | |

6. **Did we miss anything?** Do you have any comments on the things that you ranked above?

_____

_____

**The following information about yourself will help us use answers you have already given us, better.**

7. Please provide us with your postal code so that we can see where you live in Halton: _____ **OR**

   Please provide the intersection/cross streets nearest your home: _____

8. Are you female or male? M F

9. Please check the age range that best describes you:
   - ☐ Under 15
   - ☐ 15-24
   - ☐ 25-44
   - ☐ 45-64
   - ☐ 65+

10. Please check if any of the following describes you: (check all that apply)
    - ☐ I am a new comer to Canada (last 5 years)
    - ☐ I am Aboriginal
    - ☐ I am a member of a minority group
    - ☐ I have a disability

11. My income source(s) is/are: (Please check all that apply)
    - ☐ Part time employment
    - ☐ Full time employment
    - ☐ Student loan
    - ☐ Employment Insurance
    - ☐ Old Age Security Pension
    - ☐ Retirement Income
    - ☐ Ontario Works
    - ☐ Ontario Disability Support program
    - ☐ Self-employed

12. Who do you live with? (For example I live with my partner and children, I live alone…)

**Thank you for taking the time to complete this survey.**
**Please let your surveyor know if you would like to learn about the results of the survey and they will record your name and contact information on a separate sheet of paper.**

**Statement of Confidentiality - Community Survey Team**

**Name of Community Survey Team Member:** (please print)

_____


***In signing below you are indicating that you understand the following:***

- I understand the importance of providing anonymity and confidentiality to community survey respondents.
- I understand that the contents of survey responses are not to be discussed outside of community survey team meetings or with the project lead from Community Development Halton.
- I understand that surveys in my possession needs to be kept in a secure location (e.g., not left unattended so that others have access to them).

**In signing my name below, I agree to the above statements and promise to ensure anonymity and confidentiality for those who agree to complete the survey.**

Signature of the Community Survey Team Member _____

Print Name: _____

Date: _____

**I have fully explained the issues of anonymity and confidentiality to the above Research Assistant.**

Social Planners Signature: _____

Date: _____

**Community Survey Team Training**

***The purpose of the survey*** is to collect community opinion about 6 risk factors that are being proposed as potential focus areas for a Regional Healthy Communities Approach.

The six risk factors have been suggested by the Ministry of Health Promotion and Sport. We want to ensure that a broad range of community opinions go into the priority setting.

The priorities that are set will affect policy decisions and local funding opportunities. We want to ensure that people who are not always consulted are able to have a voice in setting those priorities.

***The survey pieces***
The survey begins by asking people about the factors that make them healthy. We are asking people to think about health "beyond the doctor's office". You may use the introduction of the survey as a script if you are introducing the survey to a group.

The survey asks specifically about the priorities within the six risk factors.

The survey concludes with some demographic information.

There are qualitative sections throughout the survey in case people have other thoughts or comments. Not everyone will take advantage of those sections, but when they do it, it could be very helpful information.

***What will we do with the information?***

We will tabulate the results and by using postal codes and demographic information, map people's responses.

This information will be available to the community. In fact you will have a sheet that allows you to record their names separately in case they would like to be contacted with the results. We will provide some community gatherings to share the results if we can interest people in coming.

The final report will go the Halton Region Healthy Communities Partnership in early January with a presentation and hopefully a short video.

***Important things to remember***

- Survey responses are totally anonymous.
- The survey needs to be done on a voluntary basis. It is not mandatory!

In some cases, people will want to complete the survey on their own. In other case you will sense the need to assist them in completing the survey (e.g. for literacy reasons).

Some questions in the survey are more sensitive than others. We want all the questions filled out if possible for a complete response; however, if you sense someone is not feeling comfortable with a question or they indicate that they are not comfortable answering a particular questions then that question can be skipped.

Here are some tips to help you when asking people the survey questions:

- Put people at ease:
  - Make sure that people know that their response is confidential and anonymous. Their name will not in any way be associated with their answers.
  - Encourage honesty in their responses.
- Be sensitive to literacy issues. Literacy goes beyond whether or not a person can read and write.

Things to remember when conducting the survey:

- ❑ Sensitivity
- ❑ Putting people at ease
- ❑ Good listening
- ❑ Reliable delivery of the questions

- Do not lead people with questions. This means it is important not to suggest the answer that you want to hear with a question either in the way it is written or in the way that it is read (e.g. inflection in voice, body language, facial gestures as they answer)
- Make sure that people understand what the questions are asking them. You may need to repeat the scale (e.g. 1= most important; 6= the least important) or the choices that they can pick from or the way that we have asked them to rate their opinion.
- Other suggestions:

Repeat questions and/or scales where necessary so the respondent is clear about what we are asking them.

_____

_____

_____

_____

_____

_____

If you have questions don't hesitate to call or e-mail me:

Rishia Burke

905.331.6160

rishia@cogeco.ca

rburke@cdhalton.ca

## References


Arundel, C. (2003). Falling Behind: Our Growing Income Gap. Hemson Consulting Ltd. and Federation of Canadian Municipalities. http://www.fcm.ca/english/documents/falling.pdf (Arundel, 2003).

Community Development Halton (2010) Gray Literature Scan on Community Engagement Models. Prepared for the Engagement of Marginalized Communities for Better Health Outcomes Project, 2010 Social Planning Network of Ontario

Community Development Halton. (2011a). Being Poor in Halton. Community Lens #61. February 2011. http://www.cdhalton.ca/

Community Development Halton. (2011b). Depth of Poverty in Halton. Community Lens #62. February 2011. http://www.cdhalton.ca/

Donnelly, P and Coakley, J. (2002). The Role of Recreation in Promoting Social Inclusion. Working paper Series, Perspectives on Social Inclusion. Laidlaw Foundation.

Frisby, W., Alexander, T., Taylor, J., Tirone, S., Watson, C., Harvey, J., & Laplante, D. (2005). Bridging the recreation divide: Listening to youth and parents from low income families across Canada. Prepared for The Canadian Parks and Recreation Association.

Gaventa, J and Barrett, G. (2010). So What Difference Does it make? Mapping the Outcomes of Citizen Engagement Working Paper Volume 2010, Number 347 Institute of Development Studies at the University of Sussex Brighton, UK

Health Council of Canada (2010). Stepping it up: Moving the Focus from Health Care in Canada to a Healthier Canada. Toronto: Health Council of Canada. www.healthcouncilcanada.ca

MacKinnon, S., Stephens, S, Bendell, Brophy, D., Bruyere,R., Champagne, M, Maud,T., Mitchell, E,. Nepinak, L., Seymour,T., Sinclair,C., Thiebaut, S., Thomas, N., Wark,J., & Community Led Organizations United Together (CLOUT) (2008). Is Participation Having an Impact? Measuring Progress in Winnipeg's Inner City through the Voices of Community- Based Program Participants Manitoba: Canadian Centre for Policy Alternatives-Manitoba

Maxwell. G., Edwardh, J. and Salole, A. (2005).*Inclusive Cities: Canada – Burlington. Community Voices, Perspectives and Priorities. Report of the Burlington Civic Panel*. Prepared by Community Development Halton.

McCue, L. (2011). Community Engagement. @ a glance, A Resource of the Healthy Communities Consortium, Winter 2011.

Mikkonen, J., & Raphael, D. (2010). Social Determinants of Health: The Canadian Facts.
Toronto: York University School of Health Policy and Management. http://www.thecanadianfacts.org/

Milway, J. Chan, K. Stapleton, J. and Cook, B (2010) The Poor still pay more: Challenges low income families face in consuming a nutritional diet. Institute for Competitiveness and Prosperity/Open Policy Ontario

Novik, M. (2011). Better Living Conditions for a Poverty Free Ontario. Presentation for Poverty Free Halton (March 2011)

O'Hara, P. (2006). *A Policy and Practice Paper: Social Inclusion Health Indicators: A Framework for Addressing the Social Determinants of Health*. Edmonton Social Planning Council, Inclusive Cities Canada. www.cdhalton.ca

Ohmer, M. (2007). Citizen Participation in Neighbourhood Organizations and Its Relationship to Volunteers' Self- and Collective Efficacy and Sense of Community. *Social Work Research*, Vol. 31, Number 2, June 2007.

Ohmer, M. (2008). The Relationship Between Citizen Participation and Organizational Processes and Outcomes and Benefits of citizen Nieghbourhood Organizations. *Journal of Social Service Research.* Online publication January 2008.

Poverty Free Halton. *Being Poor in Halton* (video). www.cdhalton.org

Putnum, R. (1993, Spring). The prosperous community- Social capital and public life. *The American Prospect*, 27-40

Recession Relief Coalition, (2011). Hunger Crisis: Report of the Hunger Inquiry. www.recessionreleifcoalition.org

Roche, B., Guta, A., Flicker, S. (2010) Peer Research in Action I: Model of Practice, Community Based Research Working Paper Series. The Wellesley Institute.

Scharf, K. Levokoe, C. and Saul, N. (2001). In Every Community a Place for Food: The Role of the Community Food Centre in Building a Local, Sustainable, and Just Food System. Metcalf Food Solutions

Social Planning Council of Cambridge and North Dumfries (2010) Engaging Marginalized Populations: A literature scan of national and international print publications and web Articles Prepared for the Engagement of Marginalized Communities for Better Health Outcomes Project, 2010 Social Planning Network of Ontario

Statistics Canada Income Statistics Division, Low Income Measurement in Canada Published by authority of the Minister responsible for Statistics Canada Minister of Industry, 2004 http://www.statcan.gc.ca/pub/75f0002m/75f0002m2004011-eng.pdf

United Nations (1948) Universal Declaration of Human Rights, Article 25