OROMOCTO and Surrounding Area

Community Health and Well-Being Needs Assessment

Executive Summary

June 2011

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Oromocto And Surrounding Area Health And Well-Being Needs Assessment, 2011

Prepared For The

Oromocto And Surrounding Area Health Care Advisory Committee

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"Volunteering, interestingly, in addition to all the good work we may do, is associated with better health for the volunteer as well. Why? Health is more than merely the absence of disease or the presence of physical well-being. It is about having those basic, solid foundations for life and society in place, and ensuring we have community, connections, friendship, control over our lives and influence over our destinies. ……Our health is influenced by the type of society we choose to create. We all have a role to play in creating the physical, economic, social and cultural conditions that are the foundation of good health. And what we do, even in small ways, can make a difference."[1]

Dr. David Butler-Jones, Canada's Chief Public Health Officer, 2008

"The major risk factors for chronic disease are an unhealthy diet, physical inactivity, and tobacco use."[2]

"If the major risk factors for chronic disease were eliminated, at least 80% of heart disease, stroke and type 2 diabetes would be prevented; and 40% of cancer would be prevented."[3]

World Health Organization, Ten Facts About Chronic Disease, 2005

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EXECUTIVE SUMMARY

Introduction

Oromocto and Surrounding Area (O&SA) is comprised of the Town of Oromocto, Oromocto First Nation (OFN), Canadian Forces Base (CFB) Gagetown, and a number of small rural villages and crossroads. According to the Canadian Census 2006, the total population of O&SA, including military personnel, is 30,020. The geographic area for the needs assessment extended as far north as Youngs Cove, east to Codys, south to Wirral, and west to Beaverdam. There are 18 governance jurisdictions in O&SA serving approximately 45 communities.

In 2009, the Director of the Community Health Program, Horizon Health Network, Fredericton and surrounding area, worked with the broader health care community to establish a Health Care Advisory Committee representative of O&SA. This stakeholder group was tasked with overseeing a participatory, community-based health and well-being needs assessment.

The needs assessment had three complementary objectives: 1. identify O&SA's health and well-being priorities; 2. develop strategies for realizing O&SA's health and well-being priorities in keeping with its needs and resources; and 3. align the provision of health services with O&SA's resources and health and well-being concerns. From the onset, the Advisory Committee understood that their modus operandi was to find efficiencies and leverage resources through inter-sectoral collaboration with community and institutional partners.

Background

Three conceptual underpinnings endorsed by the Word Health Organization (WHO), Health Canada and the Public Health Agency of Canada (PHAC) informed the needs assessment process, namely: population health; determinants of health; and health disparities. Their use effected a shift away from a sole focus on Health Services and back to what David Butler-Jones refers to as "a whole of society response" wherein "Canadians' health is a shared responsibility and individuals, communities, public, private and not-for-profit sectors all have a role to play."[4] Implicit throughout the course of the needs assessment was the understanding that any new or additional health care services would have to benefit the population of O&SA as a whole.

Methodology

The needs assessment followed a mixed quantitative and qualitative design. PHAC's 12 Determinants of Health Framework was used to structure the needs assessment process, the data collection and the writing of the report. There was one town hall meeting, six focus groups and 20 key informant interviews. Relevant cycles of the Canadian Community Health Survey (CCHS) and a customized, extended O&SA Canadian Census 2006 profile were obtained from Statistics Canada. Complementary systems-level data were acquired from Health Services, the NB Cancer Registry, the Population Health – Office of the Chief Medical Officer of Health, Elections Canada, the New Brunswick Liquor Corporation, Atlantic Lottery Corporation (ALC) and CFB Gagetown. Qualitative and quantitative data were analyzed for health disparities across O&SA and amongst seven communities within the area identified (Town of Oromocto; Burton Parish (Greater Geary Area); Village of Cambridge Narrows; OFN; Village of Gagetown; Village of Fredericton Junction and CFB Gagetown's military spouses and dependants). Where appropriate, O&SA data were compared to Fredericton and surrounding area and the province of NB as a whole.

There were a number of limitations. As evidenced in the methodology chapter, local data collection and analysis posed many challenges as most standardized data collection tools are designed for regional rather than small area collection and analysis. The Community Health Program's decision not to include a survey component meant there was no self-reported data and emergent themes or perceived barriers to health and well-being could not be quantified.

Findings according to the numbers

The comparative data analysis of O&SA, Fredericton and surrounding area, and the province as a whole, indicated that O&SA is doing better than the comparison groups. According to the 2007-2008 Canadian Community Health Survey (CCHS) and 2006 Statistics Canada Census, the New Brunswick Cancer Registry, the Office of the Chief Medical Officer of Health, Elections New Brunswick, and Elections Canada, citizens in O&SA enjoy higher median incomes, with a lower percentage of the population living below the Low Income Cut Off (LICO). They spend less disposable income on rent and are more likely to own their own homes. O&SA has fewer children living in poverty. Fewer senior citizens live alone, and there are fewer lone parent families. More O&SA citizens voted in the last election. More citizens received their influenza immunization, are more likely to have a doctor, while, interestingly, males have lower rates of cancer than their Fredericton and surrounding area and provincial cohorts. There are fewer accidental deaths. And, O&SA has a greater proportion of the population "from away" who have settled in the area.

On the negative side of the balance sheet, when compared with Fredericton and surrounding area and the province as a whole, O&SA citizens are: less likely to have a university certificate or degree; less likely to have a sense of community belonging; less likely to have lived in the province one year ago or five years ago; less likely to have participated in the 2006 provincial election; more likely to be exposed to second-hand smoke both at home and in vehicles; less likely to have had a routine pap smear; more likely to report "quite a lot of stress"; less likely to be "moderately active" or "active" in their leisure time; much less likely to speak both official languages and more likely to have an overweight or obese Body Mass Index (BMI). **According to the 2007-2008 CCHS, in O&SA 72.0% of adults over age 18 (excluding pregnant females) self-reported an overweight or obese BMI compared with 60.8% in Fredericton and surrounding area and 61.0% in the province as a whole. As well, 20.6% of the O&SA population age 12 and over has high blood pressure.**[5]

Although O&SA's overall picture was positive, except for extant gender disparities, the subsequent comparative data analysis of the seven representative O&SA communities revealed significant health disparities in terms of income, social status, aboriginal identity, and geography. Moreover, there was compelling evidence of poor social cohesion, social exclusion, marginalization, and pockets of marked child poverty. These disparities were found both within and between the seven representative O&SA communities profiled.

Findings according to the people

Working with the qualitative data from the focus groups and key informant interviews, the top ten health and well-being priority areas for action that emerged are:

• ***Access to public transportation:*** Fear of liability has virtually shut down the volunteer driver sector, which in the past enabled urban and in particular rural seniors, youth and young families to socialize, carry out activities of daily living and get to medical appointments.

• ***Increased access to services for mental health and addiction:*** Priority populations include youth, rural communities and OFN.

• ***Primary care and prevention to be delivered in the communities:*** Orphan patients, and in particular transient military dependants, can be found throughout O&SA. There is great interest in using Nurse Practitioners as primary care providers particularly in rural areas, and in evolving a new model of primary care practice generally.

• ***Ready access to recreational facilities accommodating all ages:*** Communities recognize the need to embrace physical fitness, active living and healthy eating. Making all schools fully accessible community schools and complementing them with local infrastructure (ball fields, rinks, recreation centres, and so on), is key.

• ***Dramatic change in culture around obesity:*** Obesity in O&SA is an epidemic and the health care system, in its current configuration, cannot address it alone. Successfully tackling obesity rates in O&SA requires a "whole of society/government response". Communities and citizens need to become engaged.

• ***Empowering governance structures and community infrastructure:*** As noted by Canada's Chief Public Health Officer, self-determination and control are foundational to a community's motivation to address the determinants of health and advance health equity.[6] A robust, community-based communication infrastructure is a pre-requisite.

• ***Appropriate and enabling housing:*** An aging population and concentration of seniors in rural communities makes "healthy aging in place" a priority.

• ***Sustainable income, inclusion and health equity:*** O&SA is a highly varied constellation of approximately 45 communities with widely variant median incomes, backgrounds and cultures. Strengthening tolerance, inclusion and social cohesion within and between communities is a priority. These 'healthy community' characteristics go hand in hand with community capacity and resiliency. Access to reliable local data is foundational to addressing health inequities.

• ***Inter-sectoral collaboration:*** Addressing the broad determinants of health requires inter-sectoral collaboration. Health in All Policy (HiAP) and Health Impact Assessments (HIA) need to be taken up by all government departments and local governance structures.

• ***Volunteers:*** These often unsung heroes are reported to be a dying breed. Volunteering needs to be revived and securely embedded in the culture of NB.

Community Resources

The seven communities profiled in Chapter 7 bring a wealth of skills, experience and leadership to the table including: experience with HiAP; an ability to engage and mobilize communities and successfully lobby government; a proven ability to leverage partnerships and existing resources; an ability to develop strong connections between people; an ability to leverage the expertise of outside partners like UNB; experience with integrated learning and childcare and taking up of the NB Curriculum Framework - English; expertise providing

community-based mental health and addiction services; extensive experience with Nurses and Nurse Practitioners as primary care providers; an ability to create recreation facilities; expertise in physical fitness; and finally, an ability to attract and retain volunteers and in the process build social cohesion. Presently however, these community-based resources remain largely untapped and only exist in isolated pockets across O&SA.

Recommendations

The 61 recommendations are congruent with Canada's Chief Public Health Officer's priority areas for action to address health inequalities, namely: social investment, community capacity, inter-sectoral action, knowledge infrastructure and leadership.[6] Recommendations are grouped under O&SA's espoused Top 10 Health Priority Areas For Action and are designed for implementation at the systems level, in communities and by citizens and households.

Inter-sectoral collaboration and partnerships with local schools, associations, municipal councils, provincial government departments (Health Services, Social Development, Education, Justice, Transportation and Local Government) and other outside partners such as University of New Brunswick, CFB Gagetown, Service NB and the NB Health Council - are foundational to the successful implementation of the report's recommendations.

The out-going Advisory Committee expects that the in-coming, elected Advisory Board will form working groups around the recommendations -- most importantly around: transportation; mental health and addictions; primary care access; obesity; and inter-sectoral collaboration.

Conclusion

This community-based, participatory health and well-being needs assessment has accomplished what it set out to do. The Advisory Committee has clearly identified priority areas for action namely, obesity, inactivity, inclusion, intersectoral collaboration, the integration of Nurse Practitioners as primary care providers and finally, increased access to services for mental health and addictions. Moreover, the Advisory Committee has identified doable strategies for addressing these priority areas that are in keeping both with O&SA's capacity and, for the most part, Health Services' existing resources. There is a significant body of work ahead but working together, Health Services, its inter-sectoral peers and the communities that make up O&SA can do much to ameliorate the health inequities in their communities – leading to a better and more equitable quality of life for all.

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