RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Salisbury, Havelock, Elgin, Petitcodiac and surrounding communities

Community Health Needs Assessment – Fall 2024

Table of contents

Acknowledgements:

We acknowledge that the land on which we gathered to facilitate the Salisbury, Havelock, Elgin, and Petitcodiac CHNA is on the traditional unceded and unsurrendered Wabanaki territory. We are grateful to be able to come together and do this important work on the land where Indigenous people have been living and working from time immemorial.

This report is produced by Horizon Health Network's (Horizon's) CHNA Team and would like to extend gratitude to all the community organizations, service providers, and community members who took part in the CHNA process.

1.0 Executive summary

People living in New Brunswick want to thrive and be healthy. One's individual health and wellbeing is influenced and impacted by many factors, including the people, places, and things that surround them. A Community Health Needs Assessment (CHNA) is a systematic approach used by health service providers to better understand the broader health needs of the populations they serve (Wright & Williams, 1998).

Through community engagement, a CHNA can define an area's strengths and needs leading to the identification of local priorities that, when acted upon, can improve the health and wellbeing experienced by individuals and population groups. The CHNA process provides the community an opportunity to voice their health needs, concerns, and community assets, which is integral to the improvement of the community's health and wellbeing as well as its empowerment.

This CHNA focuses on the Salisbury, Havelock, Elgin, Petitcodiac (SHEP)[1] and surrounding communities. This region in Southeast New Brunswick has one of the smaller population bases, is more sub-rural, and contains many families with young children and yet, has higher than average chronic health conditions, higher rates of tobacco and alcohol consumption, and reports of feeling less connection to community (NBHC, 2022).

The SHEP community CHNA planning committee identified 16 populations of focus; population groups in the community who are more likely to experience barriers to health and social system access and more likely to experience poorer physical and mental health outcomes. Engagement consultations with these 16 populations of focus set the foundation for the data collection work.

From April to June 2024, 34 interviews and 8 focus groups were held in the SHEP area, this represents hearing from 116 individual community members. Through these learning engagements, seven health need themes were captured (in no particular order):

- Access to health services
- Accessibility in community
- Income and food security
- Mental health services
- Non-emergency same day health clinic
- Transportation and infrastructure
- Youth, child, and family services

Each health theme is further explained within the report as well as possible solutions suggested from community members to address those health needs. A CHNA captures where a community is at a certain point in time, but where that community goes into the future is unlimited. The CHNA lays the foundation for the good work that lies ahead.

This report is further supported by a technical document found at HorizonNB.ca/CHNA.

[1]The SHEP name was chosen by the community to be representative of the area under assessment.

2.0 Community Health Needs Assessment

A CHNA is a "dynamic ongoing process undertaken to identify the strengths and needs of a community, enable the community wide establishment of priorities, and facilitate collaborative action planning directed at improving community health status and quality of life" (Government of Manitoba, 2019). Since inception, CHNAs have supported Horizon in fulfilling its legislated responsibility to determine the health needs and prioritize health care for the population that it serves (Government of New Brunswick, 2011). CHNAs at Horizon began in 2010 and the process was amended in 2022 to better reflect and incorporate best practices in the areas of community engagement, population health, and health equity.

When a CHNA process is initiated in a community, it is co-created with community members to ensure the process responds to the unique engagement needs of the community and the populations who live within it. At Horizon, a key component of the CHNAs is the dedicated effort to engage populations within communities who are more likely to experience health inequities.

This collaborative exchange supports developing and strengthening local relationships between service providers and community members and the regional relationship between communities and Horizon as a health authority within the province. Engaging citizens to share in determining their own community health needs is valuable to informing overall health system change.

To ensure that the CHNA process offers a meaningful engagement process for all those involved, CHNAs are guided by the Community Engagement Principles as outlined in Horizon's Health Care Engagement Framework (Horizon, 2021) which are available on the Horizon website.

The CHNA guiding principles

CHNAs at Horizon are best understood and implemented using a population health approach through a health equity lens. Health equity occurs when everyone has a fair opportunity to attain their optimal level of health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other social factors (Public Health Ontario, 2024).

> ***Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups. –*** *(Braveman, P., Arkin, E., Orleans, T., Proctor, D and Plough, A, 2017)*

A population health approach aims to improve the health of the entire population and to reduce the health inequities that may exist among population groups. This means that the CHNA process is designed to actively engage population groups who have unique health challenges and have historically had poorer health outcomes.

2.0 Community Health Needs Assessment

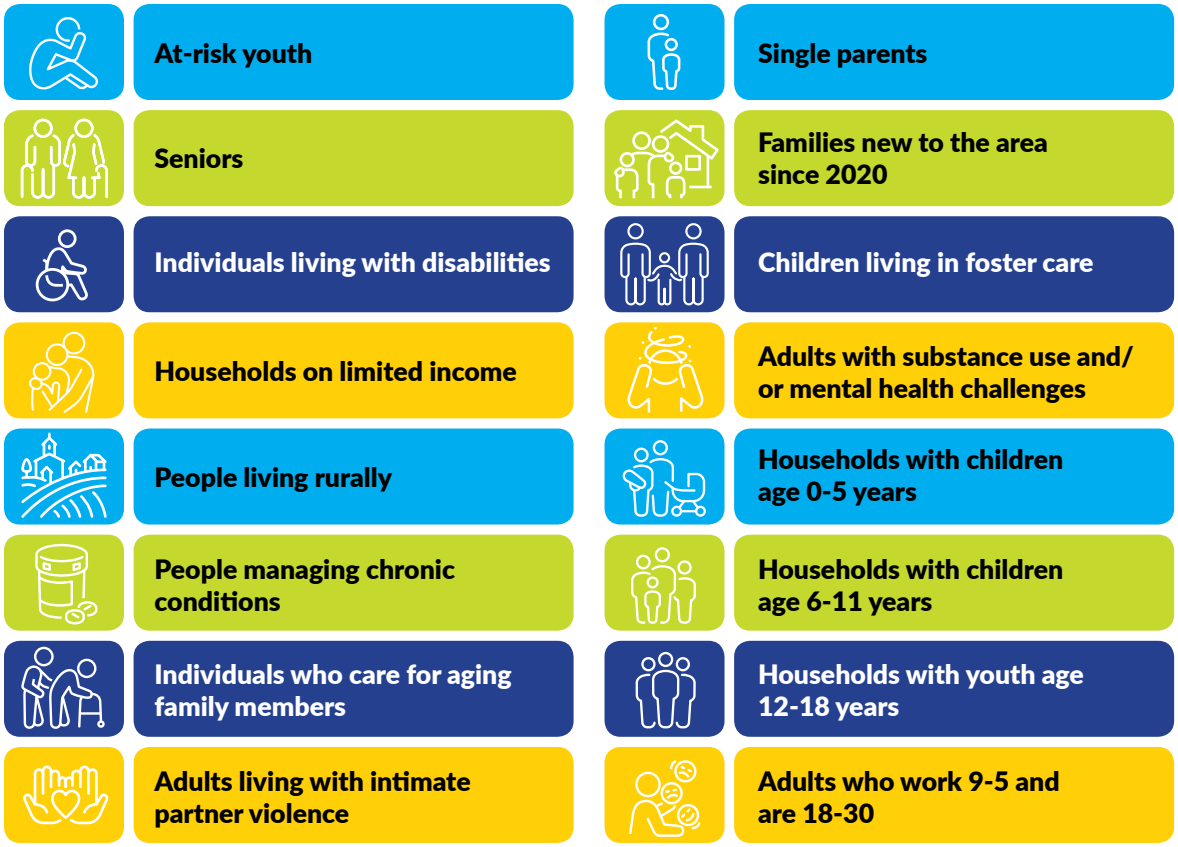
Actively engaging with populations who experience health inequities is operationalized through the key partners involved in planning the CHNA, the types of data collected, the methods used for engagements, and the way the final report is communicated amongst others. The CHNA process prioritizes hearing and learning from these populations of focus. This is important because listening to and learning from these populations of focus can improve the accessibility and usability of health care systems for all.

The CHNA team connected with people from these communities: Salisbury, Havelock, Elgin, Petitcodiac, River Glade, The Glades, Cornhill, Anagance, Portage Vale, Goshen, Parkindale, Killams Mills, Colpitts Settlement, Prosser Brook, and Pleasant Vale.

2.0 Community Health Needs Assessment

The health and wellbeing experienced by communities depends on a broad range of interconnected factors and conditions often referred to as the social determinants of health and can contribute to inequitable differences in health outcomes (Raphael, 2016).

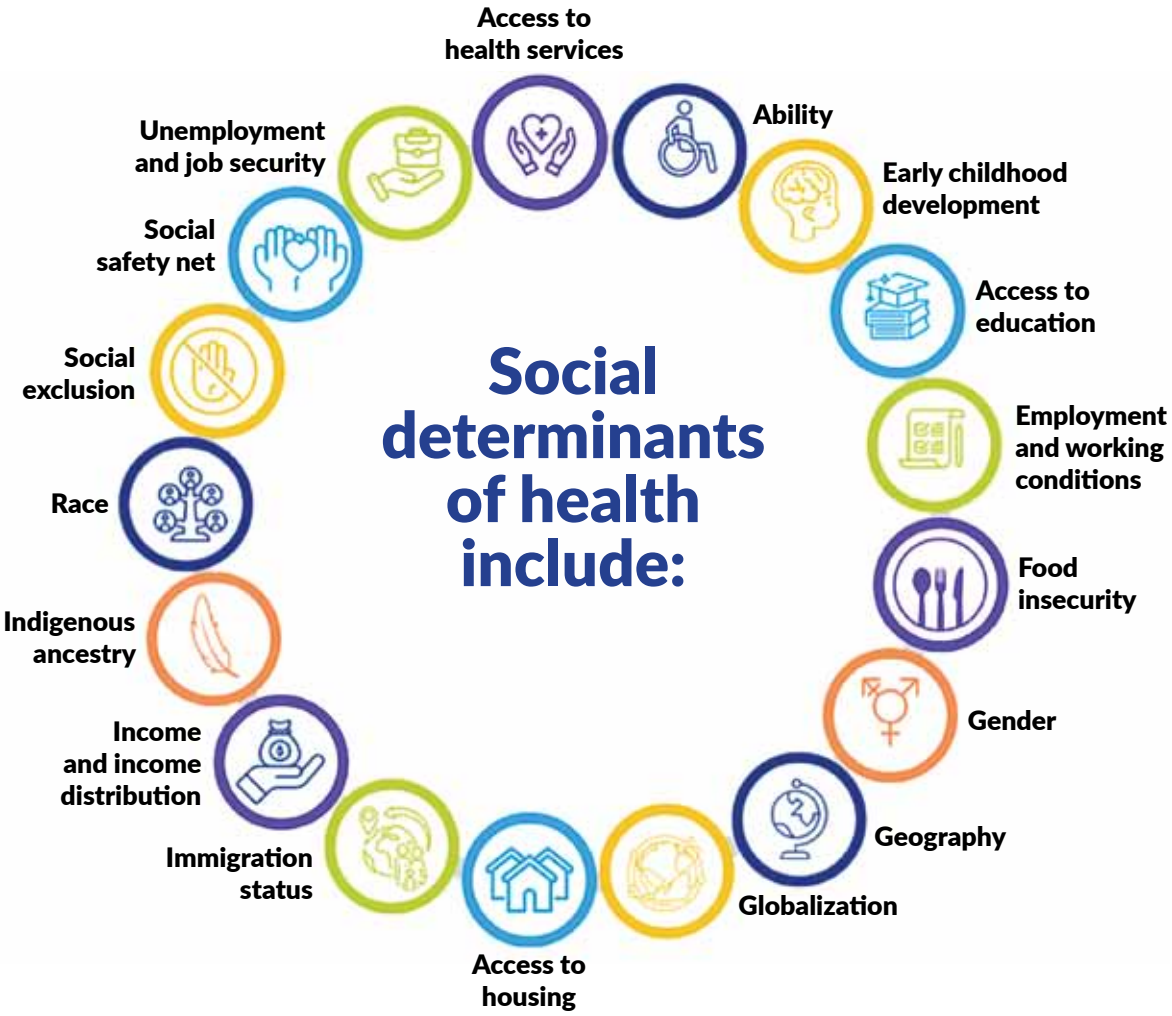
Within the SHEP area, the following 16 populations of focus were identified by the community members involved in planning the local CHNA:



Thus, CHNAs were created to level out those differences and to implement a population health approach to act upon the social determinants of health, as these factors and conditions have a strong influence on overall health and wellbeing (Raphael, 2016).

2.0 Community Health Needs Assessment

The social determinants of health (Raphael, 2016) include, but are not limited to:



The social determinants of health have been shown to have strong effects upon the health of populations, and in some cases are much stronger than the ones associated with typical health behaviours such as diet and physical activity (Raphael, D., Bryant, Mikkonen, and Raphael, A., 2020).

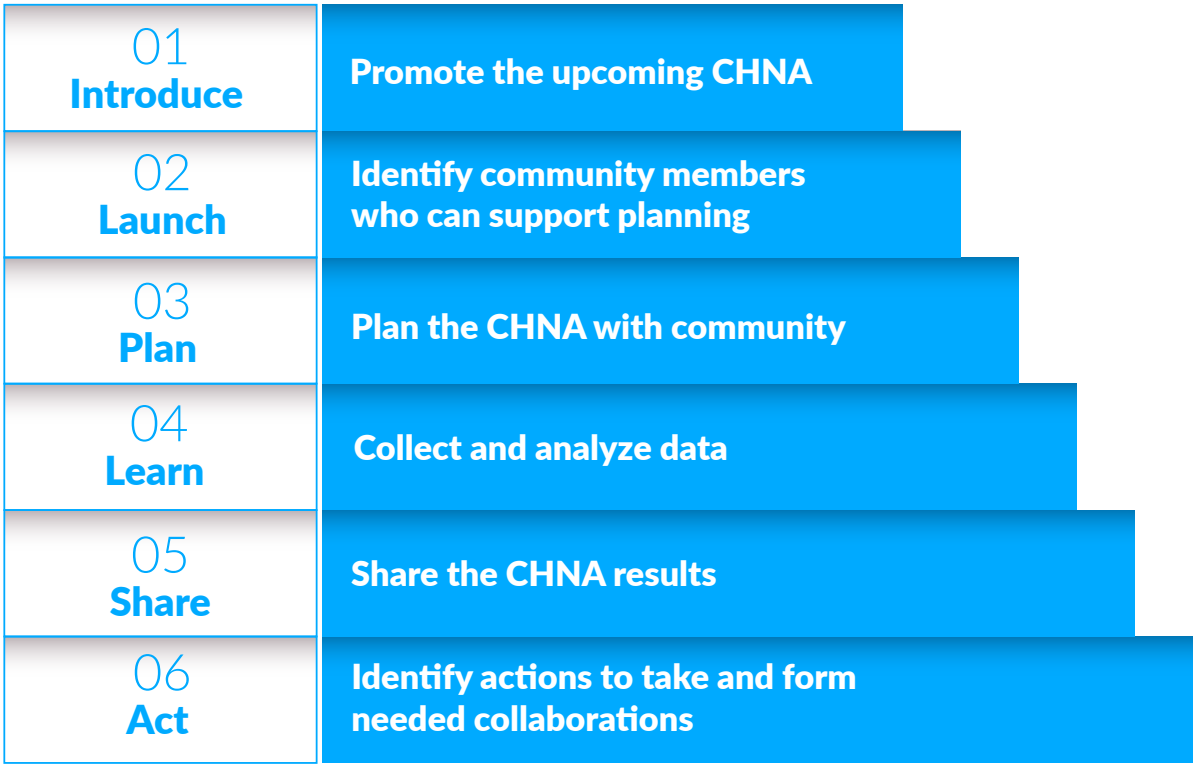
Certain social determinants have a stronger influence on health than others and can contribute to health inequities between population groups that are unfair. Therefore, a population health perspective, viewed through a health equity lens, looks at different groups of people living in an area (for example, those living in isolated areas, or those living with a low income) to assess how different social determinants impact health outcomes. This information can then be used to identify needed changes to the health care system.

2.0 Community Health Needs Assessment

The CHNA process

Horizon's CHNA process follows six stages to meaningfully engage with communities during a CHNA, as referred to in Figure # 1. These stages provide the structure to the process while offering flexibility to shift and adjust to distinct local circumstances. During each stage of the CHNA process, community representatives are engaged in key decision making including the identification of local populations of focus, determining the community geographical boundaries, and reviewing and confirming local health needs. For details about the process used to conduct a CHNA, see the Horizon CHNA Technical Document available at HorizonNB.ca/CHNA.

This report highlights the first four stages in the process and subsequent reports will capture the information from the remaining two stages.



2.0 Community Health Needs Assessment

INTRODUCE

Purpose of stage	Within SHEP
• Promote the upcoming CHNA in the community through community partners, advertising, and with Horizon Community Developers. • Hold information sessions (in person and virtual events) to educate people about CHNAs. • Distribute an online community engagement capacity survey via email.	• An email communication about the upcoming CHNA was sent to 149 community representatives including regional and internal staff in the area. • Two virtual info sessions were held for interested community members. One was offered during a daytime lunch hour and the other in the evening. 19 community members signed up for the sessions. • A community-wide survey was distributed with a 40% response rate.

LAUNCH

• The CHNA team works with local Horizon Community Developers to identify interested community members for the work in this stage. • Existing local quantitative data is reviewed. • The boundaries of the CHNA are determined in collaboration with community. • Results of the CHNA Community Engagement Capacity Survey are reviewed. • Identification of additional community members who could help to support CHNA planning work is initiated.	• Five community representatives participated in the Launch stage over two meetings. • Discussions took place around timelines, boundaries, roles, and past actions resulting from the previous CHNA. • Recommendations for members to join the planning team were discussed.

PLAN

• Finalize the CHNA community boundaries. • Discuss what population health and health equity are, and importance to the CHNA process. • Discuss issues of concern that impact the health of the community to facilitate the identification of populations of focus for CHNA engagement. • Identify and confirm the populations of focus who will be engaged during the Learn stage. • Identify community assets that support health. • Identify communication methods that would best serve the community throughout the CHNA process.	• 11 community representatives participated in the planning stage over three meetings. • Discussions and activities took place to determine issues affecting the health and wellbeing of local populations. • Collaborative discussion and collection of community assets were shared. • Members reviewed the health service profile and listed populations of focus in the community. • Engagement methods were confirmed. • Formation of the Community Learning Committee (CLC) took place.

LEARN

• Establish a CLC. • The CLC is comprised of 10 to 25 community members who have knowledge of and relationships with populations of focus. • CLC members advise the CHNA engagement team on how to engage with members of the local populations of focus, so that appropriate qualitative data gathering engagements can be organized. • Qualitative data is gathered within the community to learn about the health and wellbeing needs of population groups living in the area. • Engage in discussion to determine if the health needs identified during data collection and analysis are supported as needs within the community and provide feedback. • Inform a communication plan to share the results of the CHNA.	• 15 community representatives formed the CLC. • Determined populations of focus for CHNA. • Methods of engagement were discussed and confirmed. • 82 community members participated in eight focus groups. • One-on-one interviews were held with 34 community representatives. • 11 communities were involved. • Communication material was customized for each engagement and distributed within the communities.

3.0 Data collection and analysis

The data that support the community health needs assessments are a combination of quantitative and qualitative data. Qualitative data helps to contextualize the quantitative data and other commonly held assumptions about the community. Pulling from multiple data sources and capturing the lived experiences of community members as they negotiate their lives, and the operation of the health care system thereby providing key insights as to what is working well and what is not.

For the SHEP area, the qualitative data was collected from April to June 2024 and was analyzed from June to August 2024. During this time, eight focus groups with 82 participants were conducted along with 32 semi-structured one-on-one interviews with community members and two semi-structured interviews with service providers. Thirty-two of the one-on-one interviews were conducted over the phone while one interview was held on Microsoft Teams and one in-person interview was held. In total, 116 community members contributed to the data collection.

Interview participants were recruited using a multi-pronged approach, including social media posts, physical posters in central locatio ns, snowball sampling technique[2] , as well as word of mouth. A goal-directed sampling technique was used to recruit participants to the focus groups; in other words, participants from each of the populations of focus were recruited to participate in specific conversations; for example, one focus group was for seniors, another for at-risk youth, another for people who live rurally or sub-rurally, etc.

This was achieved through the recommendations of service providers in the area, local community experts, and Horizon's Community Developers. The focus group meetings were scheduled based on participants' availability and for their greatest convenience. For example, the focus group meeting with at-risk youth was conducted during the school day at a time and location where they already met as a group. The senior's focus groups were held at locations and times when the groups were already meeting, and the focus group for those with disabilities was held in an accessible central location.

All focus group meetings were held in person and all focus groups and interviews were audio recorded and transcribed verbatim. The written transcripts were then upload to Nvivo Qualitative Analysis software and analyzed thematically using emergent codes. These codes were merged to create emerging health need themes. A theme refers to a specific pattern of meaning found in the data.

Thematic analysis is a method for identifying and analyzing patterns of meaning in a dataset (Braun & Clarke, 2006), in this case, the dataset is the transcripts from the focus groups, interviews, and field observations. Thematic analysis illustrates which themes are important in that dataset and highlights the most salient meanings (Daly et al., 1997). Themes are thus patterns of explicit and implicit content. For example, some participants spoke explicitly about not having a cell phone because the cellular service was so poor in their community, while others were more implicit about the perceived personal usefulness of having a cell phone. Together this data speaks to the lack of cellular infrastructure in the community and thus, falls under the theme (or health need) of transportation and infrastructure in this report. Thematic analysis draws on both explicit and implicit content. First analysis of the data for SHEP garnered 34 themes. Second analysis narrowed it to 16 themes with the final analysis bringing the themes to seven.

[2]Snowball sampling technique is a nonprobability sampling method where the current participants in a study are asked to recommend other participants to the study. Within SHEP, participants and community partners were asked to recommend others who self-identified with the populations of focus to join in the engagement process.

3.0 Data collection and analysis

To triangulate the data collection, both unstructured and structured observational research techniques were employed. Field observations can be structured, unstructured, or a combination of both (Fetters & Rubinstein, 2019). Structured observations use a template or a previously created worksheet to record specific observations.

For SHEP, field notes were used for the focus group interactions to record the unspoken body language, social interactions among participants, etc., as well as counting the gender breakdown of participants. Unstructured observational data uses the researcher's words for thick description of phenomena or events (Fetters & Rubinstein, 2019). These words and observations emerge through the researcher's experience in the field. In SHEP, the researcher drove through the communities experiencing the roads, parks, trails, stores, shops, health clinics, pharmacies, chatted with locals, and experienced the communities in the area.

Emerging health need themes

> ***I don't think we need to build up our communities because rural communities should stay rural, but rural residents still deserve all the same services. We're not going to get a heart surgeon here, but we should have family medicine practitioners.*** *– (interview participant)*[3]

Emerging health need themes are a result of many voices coming together speaking on similar issues and are captured from the qualitative data to represent what the community members have identified as their priorities for health and wellbeing. Seven broad health themes were captured from these data in SHEP.

Within each health need theme is a more detailed table that outlines specific needs within that theme and in some cases solutions or suggestions to addressing that need are provided.

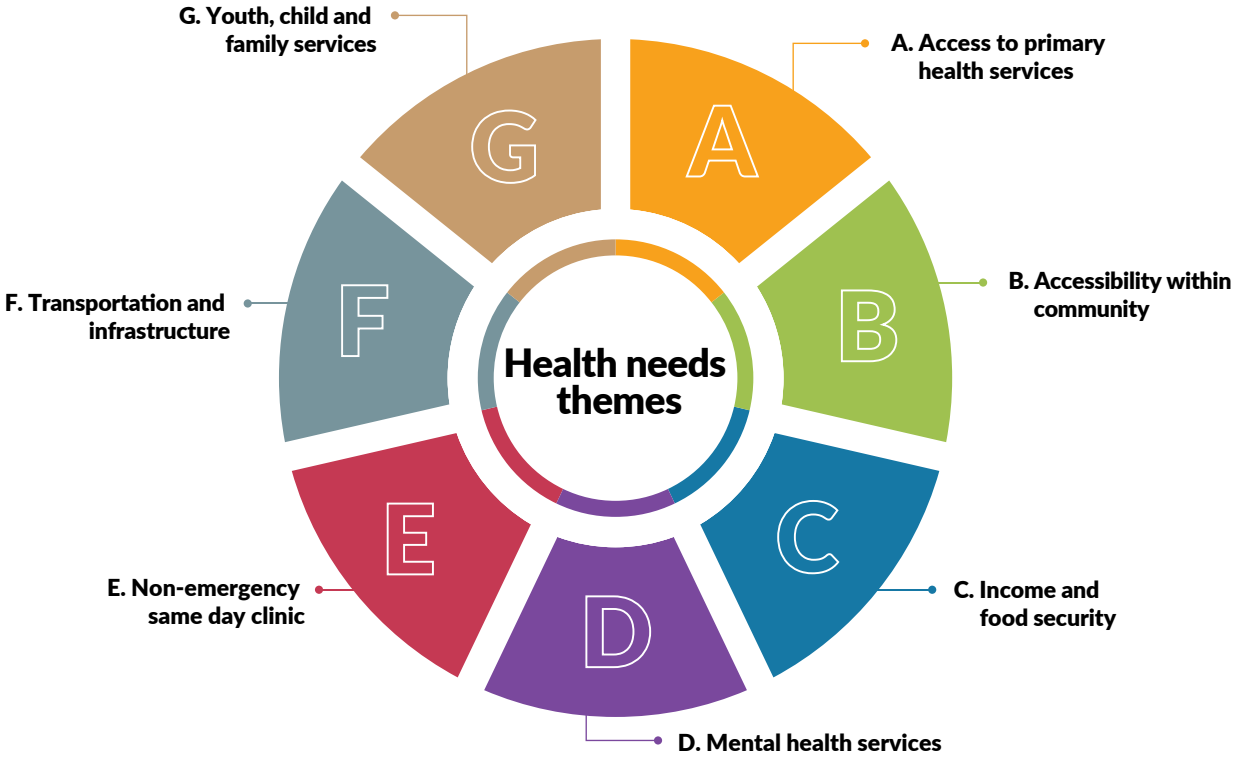
Note: The solutions or suggestions provided are from the participating community members and not from the report's authors. The emerging health needs have been listed alphabetically and are not listed by any ranking or prioritization.

The seven health themes identified are:

- Access to health services
- Accessibility in community
- Income and food security
- Mental health services
- Non-emergency same day health clinic
- Transportation and infrastructure
- Youth, child, and family services

[3]Some quotes from the participants in the CHNA have been edited for grammar, length, and clarity to improve readability. Every effort has been made to ensure that the original meaning and intent are preserved.

3.0 Data collection and analysis



A. Access to primary health services

> ***The issue is access to health services. The services aren't there for us, and we suffer in silence. And that's a horrible, horrible way to feel.*** *– (interview participant)*

Having timely access to high quality health care services is not only a social determinant of health, but also a basic human right (Raphael, 2016). Unfortunately, over the past few decades, access to primary health services in New Brunswick, and the rest of Canada, has been increasingly challenging. Recruiting family physicians and other health practitioners has been exceptionally more difficult in the rural and sub-rural areas.

> ***Most people around here are pretty resigned to not having enough medical services.***
> *– (interview participant)*

Others in the community focus group meetings determined that it was not the quality of care, but rather the lack of access that made staying healthy difficult. Most troubling was the conversation from the disability focus group, where those with disabilities and limited access to health care were becoming more desperate.

> ***I don't see that we have a lack of quality care. I think it's the more the accessibility.***
> *– (seniors focus group participant)*
>
> ***And now with MAID (Medical Assistance in Dying) being out there, there are people with disabilities who can't get health care, who can't get income. They're applying for MAID.***
> *– (disability focus group participant)*

Within this health need, access to primary health services encompasses not just physical access to see a physician or primary care provider, but also access to specialized services, and long wait times.

Access to family doctors

A recurring theme from multiple focus group meetings and individual interviews was how difficult it was to book an appointment with family doctors. The difficulty of trying to reach family doctors by telephone to book an appointment was expressed by those who use Horizon practitioners and those who have private practice physicians. A request for longer phone hours and different methods to book appointments was requested.

> ***Mainly that the phone answering hours are stupid. Like that is the biggest barrier to health care – making an appointment. Here is something so, so simple is just answer the phones for more hours. That would make the biggest difference because that's the point of first contact. And if you have to jump through so many hoops to get that first contact, let alone the year you're going to spend on the waiting list, then you very quickly become discouraged with seeking any kind of help at all.***
> *– (interview participant)*

A. Access to primary health services

> ***The phone hours are absolutely ridiculous. You can't call before work because they don't start till 9 or 930. You can't call after work because they stop answering at 330 and you can't call over lunch because they don't answer between 12 and 130. So you end up not going to the doctor because you have to book time off work to even make the appointment, let alone go to the actual appointment.*** *– (interview participant)*

Expressing frustration of the limited number of hours during the day that phones were answered to book appointments, made it incredibly difficult to work around people's work schedules that do not have flexibility during the day to book appointments.

> ***I've sat here and went through the entire two hours in the morning and redial and not gotten through. And there was 15 minutes left in the afternoon and got an appointment booked for a month and a half later. What good is that?*** *– (interview participant)*
>
> ***To try and book an appointment, they do take calls two days a week for two hours in the morning, two hours in the afternoon and you're just hitting redial after redial after redial after redial because the phone is so busy, people trying to get in to see the doctor because we're so short on doctors.*** *– (interview participant)*
>
> ***I'm sure there are a lot of people with issues they're ignoring because they don't want to go through the hassle of trying to get an appointment.*** *– (at-risk youth focus group participant)*

The challenge of access does not end after an appointment is booked; it continues with the time and distance to travel to the appointment and then feelings of being rushed once inside the office.

> ***I only go to see my family physician if I absolutely have to. Most of the time I just suffer in silence because it's an hour-long drive.*** *– (interview participant)*
>
> ***When you finally get to see your family physician you can only come to them with one issue, and you feel so rushed and you only have a few minutes, and you have to remember all of the things. And then you as soon as you leave, you forgot to say the one thing. You're a person. I don't know anybody who has one issue ever. That's not reasonable.*** *– (senior focus group participant)*
>
> ***Having a family physician with so many patients, it's hard to be able to discuss my concerns with my health or my kid's health.*** *– (interview participant)*

Expressed in the above two quotes is the anxiety people feel once they book the appointment and feel that they only have limited time in which to address their health concerns.

A. Access to primary health services

Long wait times

The long wait times to see either a primary care provider or a specialist is increasingly frustrating for the community members of SHEP.

> ***Long wait lists and difficulty making calls and arranging things are the things that make health care a challenge.*** – *(interview participant)*
>
> ***The wait times are excruciating. It's just not right. People suffer for so long because they can't get diagnosed and they can't get treated until they're diagnosed.*** – *(interview participant)*
>
> ***How is it that in this society, in a first world nation, I have to wait two years as a minimum to get diagnosed?*** – *(interview participant)*
>
> ***I mean, it's one thing to wait when you know what's going to happen eventually. But it's another thing when you're just waiting and you don't even know who the doctor you're going to see is... It's just you never know who [what specialist] you're waiting to see.*** – *(interview participant)*

During a senior's focus group meeting and an individual interview, the possibility of a 'check-in' was requested when someone is referred to a specialist. Often, the patient is not notified of which specialist they were referred to by their family doctor and it is not uncommon for people wait four to eight months before being contacted by the specialist to then set up an appointment which then requires further waiting. It was requested that once the referral is made to the specialist, that the patient be notified that they are referred to that specific specialist and how long the time until appointment might be. The option for check-ins during that time was also requested incase the patient's health issues change.

> ***There's very little recognition for the times between when somebody makes an appointment and when they have the appointment, there's no check-ins to see what's changed, or confirmation that I'm still on the list.*** – *(seniors focus group participant)*

Repeatedly the call for allied health services and specialists was requested to supplement existing health care services. Some allied health services are needed for preventative measures, others for maintenance of good health. Specifically, the request for midwifery, physiotherapy, and dietitian services was requested.

> ***My main wish would be that we have access to midwives around here because as much as I would like to have a home birth, for instance, I can't because I'm an hour from a hospital.*** – *(interview participant)*
>
> ***In rural areas, there is absolutely no access to physiotherapy. That is a big barrier, not only to older people who have had knee replacements or hip replacements, but to young children who need it. There is a void in the community because most seniors will not travel to Moncton and deal with parking at the hospital There's just nothing available here.*** – *(interview participant)*
>
> ***The general access just isn't there, and it's really unacceptable to have to wait eight months to speak to a dietician or I've got an appointment with an endocrinologist that was a year in the making.*** – *(interview participant)*

A. Access to primary health services

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Access to primary care providers	
• Lack of family physicians, nurse practitioners, and primary care providers in rural communities. • Long wait times to see primary care providers and most Horizon services. • Lack of ways for patients to book an appointment to see a primary care provider. • Phones are not answered for enough hours during the day to book appointments for people without flexibility in their schedule. • Lack of access to primary care providers who can renew prescriptions for people without a family physician. • Lack of communication to the patient when someone is referred to a specialist.	• Establish a non-emergency same day clinic in Petitcodiac or Salisbury with quick access to a RN, NP, or physician depending on the medical issue. • Allow for online booking of appointments at Horizon's Petitcodiac Health Centre. • Allow people to leave messages for booking medical appointments at Petitcodiac Health Centre and other physician offices. • Increase the number of hours available for telephone booking at Petitcodiac Health Centre and other physician offices. • Have a check-in protocol for people to see where they are on a waiting list for specialists. • Provide more 'dashboards' of wait times for specialists, ER waits, etc.
Access to allied health services	
• Lack of access, availability, and knowledge of midwifery care in rural areas. • Limited access to physiotherapy services in rural areas.	• Offer midwifery care in rural areas. • Offer physiotherapy services, specifically for post operative care and youth rehabilitation, rurally.

B. Accessibility within community

> ***It just seems counterintuitive that as we age, we need more assistance to get around. We're all aging. We're all going this way. If you make it accessible, it's accessible for everybody.***
> *– (disability focus group participant)*

Concern for access to not only to health-related services and facilities but also general private businesses was often raised in discussions. Accessibility within the community, in this context means a spectrum of things including supports for healthy aging, ongoing supports for adults with disabilities, increased assisted living supports, increased housing stock available for seniors and those with limited mobility.

These needs were raised by several populations of focus, including seniors, individuals with disabilities, households living on limited income, people with young children, people who live rurally and sub-rurally, people who take care of elderly family members, and those managing chronic conditions. They spoke of their desire to continue living in the SHEP area and to age in community. However, there is a real fear that people will not be able to do that without improved access which considers their physical limitations and disabilities.

> ***My senior mother is very nervous about me inquiring for any government help. She's afraid that government representatives are going to come and tell her she can't stay in her own home. This is a fear shared by many seniors.*** *– (interview participant)*
>
> ***It's not that people don't want to help, our infrastructure is just old. Years ago, we didn't require that much because people who had mobility issues just didn't leave the house.***
> *– (disability focus group participant)*

Older adults living in the SHEP area spoke about their desire to not only age in their home community, but specifically to age in their own homes. In order to age at home, more senior and limited mobility housing options needs to be available within community and in the interim, greater access to home support was requested.

> ***Having a home care service where somebody comes into your home two or three days per week would be very helpful. There are some of those agencies around, but it's more difficult to get people to work in a rural area than in the city because there's more driving involved.***
> *– (interview participant)*

It was suggested that aging in community would benefit from mobile health services being provided at consistent scheduled times and locations in rural communities. The service should include tracking, testing, and diagnosis as well as the ability to treat minor ailments, i.e., strep throat, skin irritations, etc. as needed. Mobile health services need to be located in a centralized area with easy access.

> ***If you are an older people person who can no longer drive, your access to anything is severely limited. Once you are unable to drive, the ability to stay in your own home is limited. You need family around who can support. It really limits the ability of people to stay in their own home and not be forced into some sort of nursing home care or assisted living care.***
> *– (senior focus group participant)*

B. Accessibility within community

Interest was expressed for quarterly (or semi-annual) workshops for health information and education. These sessions would address such topics as fighting cold and flu season, general nutrition advice, diabetes education, wound care, how and where to access Horizon health programs and services, amongst other health and wellness topics decided by the community.

> ***I feel like having a person in each community that you can go to with any kind of health-related question and they're going to direct you to a resource that is within your reach and within your ability to actually connect with would be really important.*** – *(interview participant)*

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Additional in-home care services	
• Excessive turnover in home care/disability support staff due to lack of desire to travel to rural areas. • Not enough communication or information on what supports are available in community to age at home. • Not enough communication or dissemination on the government's priorities on aging in place. • More help needed for seniors to place online grocery orders for delivery. • Inadequate contact system for seniors and other people who are isolated.	• Increase the pay for those who provide home care supports in rural areas. Offer greater financial incentives for those who service rural communities. • Provide group workshops or one-on-one help with online grocery orders for seniors who live near grocery stores that deliver. • Offer 'wellness check-ins' for people who are isolated, and a drop-in service to people's homes to see how they are managing.
Increase disability supports and subsidization	
• Inconsistent amounts of subsidization for medical equipment, people must pay upfront and wait for reimbursement for medical equipment. • Inconsistent and a lack of specialized programs and services for people with special needs (adults with intellectual disabilities, etc.) – specifically around assisted living supports and independent living support. • Lack of assisted living homes and communities where people can age in place with some support or adults with disabilities (physical and intellectual) can live with some support.	• Provide free medical equipment for those in need, or a method where people do not have to pay out of pocket for the equipment they need and then get reimbursed. Many people cannot afford the large upfront cost. • Provide specialized programs and services for people with special needs (adults with intellectual disabilities, etc.) – specifically around assisted living supports and independent living support. • Build assisted living homes and communities where people can age in place with some support or adults with disabilities (physical and intellectual) can live with some support.

C. Income and food security

> ***So I know dealing with poverty isn't in your [Horizon] area to deal with, but I think adding that as a consideration in every single activity that you [Horizon] do would make a big difference.*** *– (interview participant)*

Income is perhaps the most important social determinant of health. The level of income a household has shapes the overall living conditions, impacts psychological functioning, and influences health-related behaviours (Sawchuk, 2019).

> ***We have to commit fraud to get things we need.*** *– (focus group participant)*
>
> ***I live here because my parents live here and I can't afford rent anywhere else.*** *– (interview participant)*

When people from SHEP talked about income, focus groups and interviewees, referenced to the underground economy. In this case, the underground economy refers to people working for cash, and using the barter system.

> ***You're definitely not getting rich off of cash jobs. You're just trying to make ends meet or a little bit extra to do something nice with your kids.*** *– (interview participant)*

These methods of obtaining money were normalized and deemed necessary to survive in the community.

> ***This area [SHEP] has a lot of what we would consider lower income folk, but folks who don't necessarily consider themselves low income because this is always what it's been and that's what all the neighbors are as well. Its average income, it just happens to be that the average income is low, like poverty level low.*** *– (interview participant)*

Participants talked about how government subsidies and local food banks although helpful, were not enough to sustain them.

> ***And we're trying not to lose our house like everybody else. Using the food bank. And it's not enough. And friends are helping us.*** *– (disability focus group participant)*
>
> ***I find even welfare is not providing enough support for someone to manage their lifestyle.*** *– (interview participant)*

Food insecurity, which means having limited or uncertain access to adequate food, is associated with poorer health outcomes and higher odds of chronic illness (NAMI, 2024). A person's lack of access to healthy food can negatively impact physical, mental, and social health, and can also be costly to the health care system. For example, people who don't have access to healthy foods are less likely to have good nutrition. Poor diet raises people's risk of developing diet-related chronic diseases such as heart disease, Type 2 diabetes, obesity, and certain types of cancers, all which can lower the quality of life and life expectancy of individuals.

> ***A good life for me is being able to afford groceries.*** *– (interview participant)*
>
> ***We are trying to eat good, which can be hard. That can be a challenge, to have groceries.*** *– (interview participant)*

C. Income and food security

> ***The pricing of food at our local grocery, it's skyrocketed through the roof.*** *– (interview participant)*
>
> ***We don't have access to healthy food. We go to the foodbank, so we get some fruit that way, or sometimes if it's on sale, we'll pick it up.*** *– (interview participant)*

Food banks, community pantries, church organizations, and perhaps other individuals and organizations provide food for people in need within the community. However, having to rely on those sources for food often creates a feeling of stigma and shame for those who utilize the services.

> ***Being in a small community, you wonder like if somebody is going to see you [using the foodbank] and then the whole town hears about it, and then you're all of a sudden not a good mom anymore because you have to reach out for help. And you wonder about those little things.***
> *– (interview participant)*

One interview participant talked about bringing food security into the schools and starting there: suggesting daily food programs to all students and making food security a part of the school curriculum.

> ***If we could focus on feeding kids and teaching them how to feed themselves, we would eliminate a lot of chronic health issues long term. It's pretty basic, start with food.*** *– (interview participant)*

Poverty and inequality are underlying causes of food insecurity and malnutrition. Poverty negatively impacts on the nutritional quality of diets. Income inequality in particular increases the likelihood of food insecurity – especially for socially excluded and marginalized groups.

> ***We don't do anything but survive.*** *– (disability focus group participant)*

C. Income and food security

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Income security	
• To be able to afford the basic needs for families with kids. • Lack of a guaranteed income program, where people get a base amount of money from the government to cover all their living (housing, food, medical) needs.	• Increase the amount allocated for families using social assistance. • Increase the amount of money people can earn while on social assistance.
Food security	
• Food banks do not provide enough fresh fruit and vegetables. • Food banks do not provide enough kid friendly and school friendly snacks. • People do not know how to cook or have the resources (pots, pans) to cook their own food	• Create a food security program in local schools that provide breakfast and lunch to all students. Ensure this food is wholesome food. • Use local farm produce in food programs. • Implement a training program in high schools that connect students with locally produced food. • Teach courses in high school on sustainable farming. • During the school year, increase the amount of school safe snacks to families using the foodbank. • Host workshops on healthy low-cost cooking. • Host more community dinners that are no or low cost.

D. Mental health services

Good mental health is integral to human health and wellbeing (WHO, 2014). Mental health is often used as a broad term to envelop many things, but at the root lies the ways in which people are able to cope with life's challenges and opportunities. A person's mental health including many common mental disorders is shaped by various social, economic, and physical environments operating at different stages of life (WHO, 2014).

> ***I mean I just need help and I don't know where to get it.*** – *(interview participant)*

Taking action and providing wrap around support to improve the conditions of daily life from before birth, during early childhood, at school age, during family building, working ages, and at older ages provides opportunities both to improve population mental health and to reduce the risk of those mental disorders that are associated with social inequalities (WHO, 2014).

> ***I am on long term disability, obviously, because I can't function very well. And so I panic and stuff easily and get overwhelmed. I do attend an online peer support group with other folks with mental illness, so that has helped because then I don't have to travel because I do get tired. It is exhausting.*** – *(interview participant)*

During the consultation process mental health was addressed in two distinct ways: either directly and specifically or indirectly and in a dismissive manner. Issues surrounding mental health services were discussed openly during interviews; however, the occurrence of mental health issues in the community specifically was seldom mentioned in the focus groups and never within senior populations. The inability to identify mental health struggles within a group setting suggests mental health stigma may still exist with the community and there may be opportunities to foster community awareness and acceptance.

> ***A mental health support group that meets even once a week just to make a connection to people, so I don't feel so isolated.*** – *(interview participant)*

When mental health was spoken about openly within the individual interviews, the request from participants was for more mental health supports in community, more mental health workers in community and in schools, more group therapy, more publicly funded therapy, and more community workshops.

> ***I don't feel that support [mental health and social connection] from my oncology team, unfortunately, other than on the medical side they put priorities on actually treating the physical, not necessarily the emotional. I just don't feel like the human part is there anymore. I need a team that cares a little bit more.*** – *(interview participant)*
>
> ***At the hospital in Moncton I don't find that there is really much available in terms of connecting with people that are going through stuff. I don't find there is much for people struggling with a terminal illness and there's nothing that's available to me.*** – *(interview participant)*

When mental health issues emerged in more nuanced ways in the focus groups it was when seniors talked about the possibility of having to move closer to health services and leave their homes and communities where they have lived for over 40 years. Anxiety and uncertainty were expressed when people in rural areas talked about the level of radon in their homes and their inability to pay for remediation to fix the issues.

D. Mental health services

Further, stress and anxiety around the conditions of the roads, making it difficult for ambulance services to get to them should they be in need or the lack of cell phone coverage to even reach emergency services; this is when mental health emerged as a health theme.

> ***There are no signs that say that the bridge is out, just that it's a detour. I talked to the lady that lives in the house right there. If she ever had a heart attack or her husband had a heart attack or needed anything, they're going to die before an ambulance finds them because now they [emergency services] have to go around [a lengthy detour].*** – *(rural focus group participant)*

Also, mental health concerns around fear and uncertainty arose when parents of children with disabilities talked about themselves getting older and dying and not knowing who would take care of their special needs children. The indirect way that seniors talked about no longer having a family doctor precisely when one was needed the most.

> ***Right now I'm without a doctor and I could use some medical advice.*** – *(interview participant)*

A source of stress for one mother was when she could no longer afford the private therapy sessions for her child. These are everyday concerns that the citizens of SHEP have as their daily stressors but have limited to no mental health supports available in community.

> ***Money is the barrier for my son seeking mental health services.*** – *(interview participant)*

As with mental health, the topic of addictions did not openly surface in many interviews other than in the at-risk-youth focus group, suggesting addictions is not prevalent in SHEP; however, statistical data collected from the New Brunswick Health Council (2022) captured that SHEP has higher than provincial rates in, smoking, vaping, heavy drinking, and cannabis use.

> ***I would say addiction services could always be more present because I think there's a lot of people who experience poverty and food insecurity that still need to cope. There's a lot of people coping in unhealthy ways…But if we're not addressing root causes, then I would say teach people how to cope.*** – *(interview participant)*

D. Mental health services

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Availability and access to mental health services	
• Lack of free mental health support groups, resources, and programs. • Not enough free or reduced cost access to mental health counselors. • No timely access or availability to psychologists and psychiatrists; long wait times for an appointment. • Lack of access and availability to child mental health counselors, psychologists; long wait times for an appointment. • Lack of access to timely and funded autism, ADD, ADHD, diagnosis and testing.	• Increase the amount of in person and online mental health support groups in the region. • Offer different mental health support groups (e.g., those for youth, those with disabilities, those dealing with grief and loss, those who are new parents, those with anxiety and depression, etc.) • Have the support groups or mental health sessions facilitated by a trained mental health counselor. • Offer mental health supports at regular intervals (e.g, a support group that meets every Tuesday at 2 p.m.) so people know when it's available and can drop in.
Available community spaces to gather	
• Lack of available safe, non-faith-based spaces to gather.	• Creation of non-faith-based community spaces to gather. • Reinstate the Petitcodiac Public Library.
Community based addiction services	
• Lack of in community addiction programs, services, and resources.	• Support groups or workshops on coping skills, resiliency, etc.

E. Non-emergency same day clinic

> ***I wish there would be somebody that you could go to if you got something in an emergency – but not like you were going to die, but something urgent that needed medical attention that day, so you don't have to go to emerge.*** *– (senior focus group participant)*

Data supplied by the New Brunswick Health Council (2020) indicate, perhaps surprisingly, that 97% of SHEP residents had a family doctor in 2020; however, that number has likely decreased since that statistic was collected. Through the community engagements, it was learned that many primary care providers have either retired or left the area.

Although SHEP has among the largest number of people who reported having a family doctor, strangely the community ranks below the provincial average in terms of access to those family doctors (NBHC, 2020). Just over one in two seniors (53%) and two in five adults (43%) reported being able to get an appointment with their family doctor within five days (NBHC, 2020). Throughout the consultations, community members continually asked for access to a non-emergency same day clinic service within their community.

> ***Having some sort of small rural clinics that could deal with all the routine stuff and you only have to go to the hospital or the bigger centre for other things would be very helpful.***
> *– (interview participant)*
>
> ***I think everybody's trying to look for another option because Moncton [hospital] is overwhelmed.***
> *– (rural focus group participant)*

Community members of SHEP also talked about the wonderful Petitcodiac Health Centre; however, the physicians and services offered there are for patients of that clinic only, leaving those without a family doctor attached to that clinic unable to access any services provided there, even though the facilities exist.

> ***My doctor in Sussex gave me a requisition for blood work, but I can't go to that clinic in Petitcodiac and get it right... I have to either go to the Sussex Hospital or the Moncton Hospital or some other private blood work clinics. It seems kind of a shame to have a clinic in Petitcodiac that has the facilities, but they're only available to the patients of that clinic.*** *– (interview participant)*

When conversations addressed remote, non in person access to health care, the Maple App was considered to be the most popular. The Maple App is an online platform to connect patients with primary care providers either virtually or over the phone. Unfortunately, many community members within SHEP do not have reliable internet or cell service. In addition, the population tends to be older and may not have a computer or not be computer literate. Consequently, the Maple App and similar are not helpful to all residents in SHEP.

> ***There are certain things [health services] on the table that is fantastic if you know about it [the Maple App] and if you have [internet] access and are computer savvy. Because some people are not [computer literate] and they're really stressed out. They've lost their doctor.*** *– (rural focus group participant)*

Still other community members questioned why they could not see a doctor in person if they were available via the Maple App.

E. Non-emergency same day clinic

> *It's an excellent supplement service [the Maple App], but it doesn't do many, many things. So I'm happy that we have it. And it's great for some folks and it's good. But if I can do it [talk to a primary care provider] online, why can't you [primary care providers] be in a physical building and see people?* – *(disability focus group participant)*

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Access to same day non-emergency clinic	
• Lack of timely access to health care services in community.	• Provide a same day non-emergency clinic that is open to all residents staffed by RNs, NPs, and a physician (among other health care providers) that can treat urgent, but nonlife threatening issues.

F. Transportation and infrastructure

> ***Because unfortunately, the people making these decisions to put health and other government services online, are generally in Fredericton or Moncton or in the Miramichi and have no idea that people in SHEP don't have cell service.*** *– (rural focus group participant)*

Transportation is a critical social determinant of health that can have a significant impact on the physical and mental health, and overall wellbeing of individuals and communities. Transportation affects nearly every other aspect of one's health and wellbeing (CPH, 2022). The lack of reliable and safe transportation options in the SHEP area limits people's ability to meet their basic needs and hinders access to needed services, whether it be a doctor's appointment, trip to the grocery store, places to recreate, or where someone is able to find housing. The inadequacy of transportation and infrastructure is often more significant in rural communities.

> ***Well a lot of it is that isolation. You have to go into Moncton to get any health services. And to do that you have to have a car which I don't have, which is also a big barrier for a lot of seniors who don't drive. And yeah, for a lot of people with various disabilities who can't drive safely, it means you're even more isolated because there's no way to access any services. There's no way to get anywhere. So you're just left with whatever your friends and family are kind enough to provide you, you are very dependent on other people.*** *– (interview participant)*

Within SHEP, issues surrounding the quality of the roads have been an ongoing issue for decades. In rural areas where people must drive for every service they require, inadequate and unsafe roads is a major source of stress. Notably, one focus group of rural participants, the conversation was dominated by the quality of the roads and the impact that has for emergency services workers in their community.

> ***And I know that with ambulance drivers, sometimes somebody can't make it to the shift in [town]. So they have somebody else come from [another town]. They don't know the roads or the detours, where the potholes are so it takes that much longer [to get an ambulance in an emergency].*** *– (rural focus group participant)*

Even the ability to receive quality home care health services was a source of stress for one participant. She was concerned for the physical condition of the car belonging to her home health care nurse.

> ***Then I came home [from the hospital] and a really nice extramural nurse came. But every time she came to my house, she was risking breaking her car on the broken road.*** *– (rural focus group participant)*

Lack of transportation can negatively impact access to health care, and solutions to transportation barriers are often overlooked when health care reform is discussed.

> ***One of my biggest concerns here is that we don't have good ambulance service or cell service.*** *– (rural focus group participant)*

In order to fully support rural communities and people's desire to age in place, restructuring needs to occur that addresses transportation challenges. Addressing the transportation should be concurrent to the provision of reliable cell service in the area.

> ***And be able to afford Internet access and have decent internet access to get. It's so expensive and so unreliable. I mean cell phone service is even worse.*** *– (disability focus group participant)*

F. Transportation and infrastructure

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Infrastructure	
Roads • Lack of clear and accurate information on road maintenance. • No timely notice and information on road closures, detours, and reopening. • Not using a multipronged approach to notify community members of road work, closures, and detours. • Lack of a communicated plan on how and when the road networks will be fixed. • No meaningful communication between road crews and community members. • Road construction is not completed in a timely manner, it is lasting years. **Buildings** • Not enough accessible parking in rural towns. • Lack of enforcement for buildings that have accessible doors that don't work. • Lack of enforcement to businesses to adhere to accessibility legislation. **Home** • Not enough free or reduced cost well water testing in rural areas. • Not enough free or reduced cost radon testing services in rural areas.	• Notify community members of upcoming road work and completion dates by mail, and online. • Notify community members of road closures, detours and roads reopening by mail and online. • Ensure all new builds and infrastructure updates meet accessibility legislation and requirements. • Provide free well water testing kits and service to rural users. • Provide free radon testing kits and services and programs for subsidized remediation of homes found with high levels of radon.
Public transportation options	
• Lack of ongoing funded public transportation. • There is no public transportation option to Moncton from the SHEP region. • Lack of options for transportation in rural areas. • No accessibility of a system or program to get people to their appointments in more urban areas that are affordable or free. • Not enough local health clinics. • More Extra-Mural nurses, case workers, support workers, home care providers, etc. to service rural areas.	• Secure ongoing, multi-year funding for the Rural Rides program, increase amount available to compensate volunteers. • Revisit the possibility of providing public transit from rural communities to larger cities. • Provide a shuttle to Moncton twice a week. • Establish a travelling clinic that makes stops at designated dates and times in specific rural towns. These clinics could offer a variety of health-related services. • Increase pay and provide financial incentive for Extra-Mural nurses, case workers, support workers, home care providers etc. who need to travel rurally to provide care and services.
Internet and cellular service	
• The need for better, more reliable cellular coverage – some areas have no cellular service. • The need for faster and reliable internet service. • The cost of existing internet and cellular service is too expense for most residents.	• Provide reliable, affordable internet services to all rural areas in SHEP. • Provide financial rebates for internet and cell service in rural areas in SHEP.

G. Youth, child, and family services

The SHEP and surrounding communities have one of the smallest populations in the South-East region of New Brunswick and it has a high proportion of households with children under the age of 18 (NBHC, 2022). Sadly, the youth in these communities report a lower-than-average quality of life. The relationships youth have with the people in their lives, and with their school, is less favourable than in other communities within New Brunswick (NBHC, 2022).

> ***When I was in [name of school], I tried talking with the guidance counselor. And as soon as I told her something like, I kind of just tested her first, it wasn't even something that I like really cared about. She told my parents. So, I was like, that's the end of that. But you never look back. When I came here [new school]. I trusted them.*** *– (at risk youth focus group participant)*

Crucial services for youth, both recreational and health related are not available, not accessible, nor affordable to some families in the SHEP area. The engagement process identified weaknesses in the wrap around services for children in the foster care system, those children with disabilities, and at-risk youth. The caseloads that social workers currently carry for youth involved in the system make it extremely difficult to tailor programs and services to help those individuals that case workers are assigned to.

G. Youth, child, and family services

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Wrap around support for children in foster care and at-risk youth	
• Lack of support filling out college applications and transitioning to post-secondary school for at risk youth which can include help with locating housing for college or university, moving costs, transportation to new towns and cities, and emotional support for the transition period. • Lack of available mental health programs and services for children in foster care, mental health that is tailored to meet the child where they are at. • Not enough time spent building relationships between social workers, case workers and children (foster, disabilities, etc.) in their care.	• Better collaboration between government departments, school system and those involved with foster and at-risk youth to provide tailored care for kids. • Increase services for at risk youth leaving high school who may need support to transition to post-secondary education and training opportunities, and employment training guidance for a number of years after graduation. • Increase mental health programs for youth that are specifically designed to meet youth where they are. • Decrease the workload on social workers and case workers responsible for foster children and those with disabilities. • Hire more social workers and case workers to look after children in the system.
Available, accessible, and affordable physical activity and recreation options	
• Lack of available, accessible, and affordable recreational opportunities, programs offered for children in Petitcodiac and surrounding areas. • Lack of options for recreation programs in smaller areas. • Need to increase year-round recreational opportunities for youth. • Offer more recreational programs for young families, more than just hockey. • Need an indoor public pool that offers swimming lessons. • Lack of non-denominational spaces for youth to gather and connect (e.g. library, skate parks, public pools, basketball courts). • Lack of non-faith-based recreation activities to socialize. • Gap in opportunities for kids to be active and engaged in the community.	• Build an indoor, four-season recreational facility with walking track, swimming pool, gymnasium, weight room, and multi-purpose community meeting space. • Build more outdoor basketball areas. • Offer more discounts for families who want to play hockey but can't afford it. • Create non-faith-based youth groups. • Create non-faith-based youth spaces to gather. • Reestablish the Petitcodiac Public Library. • Expand the Talk with Me program in SHEP, make offerings on weekends, evenings and later in the day to accommodate working parents. • More free events for families (e.g the Fire Department BBQ in Salisbury).

G. Youth, child, and family services

IDENTIFIED HEALTH NEEDS PROVIDED BY COMMUNITY MEMBERS	POTENTIAL SOLUTIONS PROVIDED BY COMMUNITY MEMBERS
Children's Physical Health Services	
Mother and Newborn Care • Lack of access and availability for routine care for children under the age of five – increase the access to routine checkups (i.e language, growth, development, and other milestones). • Gap in the health programs and services offered to new mothers locally. • Limited to no midwifery care and services in rural areas. • Limited to no access to pediatricians and family physicians in rural areas. • Limited to no access to lactation consultants, programs, and services. **Family centred care** • Lack of programs, services, support groups for families with children with ASD, disabilities, behaviour challenges, etc. • Gap in access to child focused physiotherapy. • Lack of free mental health services for children.	• Provide more midwifery care in rural areas, that includes resources and support for mom and baby for the first year of life. This includes lactation consultants and specialized newborn nurses. • Include child-focused physiotherapy in community health teams and clinics or the ability for publicly funded physiotherapists to travel to rural areas. • Offer free or greatly reduced mental health programs, services, and counsellors for youth. • Offer free workshops and information sessions on a variety of health topics e.g., baby-led weaning, cold and flu season, general health, canning food, food preparation, etc.

The above documented health themes have been a summary of over 50 hours of interview and focus group meetings audio recordings taken from 116 community members in the SHEP area.

To recap, the health themes identified in SHEP were access to primary health services; accessibility within community; income and food security; mental health services; non-emergency same day clinic; transportation and infrastructure; and youth, child, and family services.

4.0 Next steps

As captured in the preceding report, a CHNA is a dynamic, on-going process undertaken to identify the strengths and needs of the community and to enable community-wide establishment of health and wellbeing priorities that improve the health status of the population.

As this process is on-going, over the coming months, this report will come to action with the remaining two stages – share and act – in the CHNA process. The report will be shared widely with Horizon's staff and management, Horizon's Executive Leadership Team, and the Board of Directors, as well as local and regional government departments, local non-profits and service agencies, community members, and other interested parties. Together, action will begin by addressing the needs identified from this report with a collaborative approach being implemented and led by community.

A CHNA captures where a community is at a certain point in time, but where that community goes into the future is unlimited. This CHNA, along with other important work already underway identifies and addresses many of the needs and lays the foundation for the good work that lies ahead.

5.0 References

1. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77-101.
2. Braveman, P., Arkin, E., Orleans, T., Proctor, D and Plough, A. (2017). What Is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation.
3. Centre for Population Health (2022). Transportation as a Social Determinant of Health. Retrieved from: https://www.centerforpophealth.org/2022/05/17/transportation-affects-every-social-determinant-of-health/
4. Daly, J., Kellehear, A., & Gliksman, M. (1997). The public health researcher: A methodological approach. Melbourne, Australia: Oxford University Press.
5. Horizon Health Network (2021). Healthcare engagement framework. Retrieved from: Health-Care-Engagement-Framework-2021.pdf (horizonnb.ca)
6. Fetters, M. D., & Rubinstein, E. B. (2019). The 3 Cs of content, context, and concepts: a practical approach to recording unstructured field observations. The Annals of Family Medicine, 17(6), 554-560.
7. Government of Manitoba (2019). Winnipeg Regional Health Authority: Community Health Assessment. Retrieved from: https://wrha.mb.ca/research/community-health-assessment/
8. Government of New Brunswick (2011). Regional Health Authorities Act. Retrieved from: 2011, c.217 - Regional Health Authorities Act (gnb.ca)
9. National Alliance on Mental Illness (2024). Social Determinants of Health: Food Security. Retrieved from: https://nami.org
10. New Brunswick Health Council (2022), "Population Health Profile 2022 - Salisbury and Petitcodiac." https://nbhc.ca/table/health-profiles?cuts=NBC11%2CNBZ1%2CNB [Online].
11. New Brunswick Health Council (2020), "Population Health Services 2020 – Salisbury and Petitcodiac." https://nbhc.ca/table/health-services?cuts=NBC11%2CNBZ1%2CNB [Online].
12. Public Health Ontario (2024). Health Equity. Retrieved from: https://www.publichealthontario.ca/en/Health-Topics/Health-Equity
13. Raphael, D. (Ed.) (2016). Social Determinants of Health: Canadian Perspectives, 3rd edition. Toronto: Canadian Scholars' Press.
14. Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). Social Determinants of Health: The Canadian Facts. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management.
15. Sawchuk P. (2019). The most powerful social determinant of health. Canadian family physician Medecin de famille canadien, 65(7), 517.
16. World Health Organization and Calouste Gulbenkian Foundation (2014). Social determinants of mental health. Geneva, World Health Organization. Retrieved from: https://iris.who.int/bitstream/handle/10665/112828/9789241506809_eng.pdf
17. Wright, J., Williams, R., 1998. Development and Importance of Health Needs Assessment. The BMJ, 316, 1310.