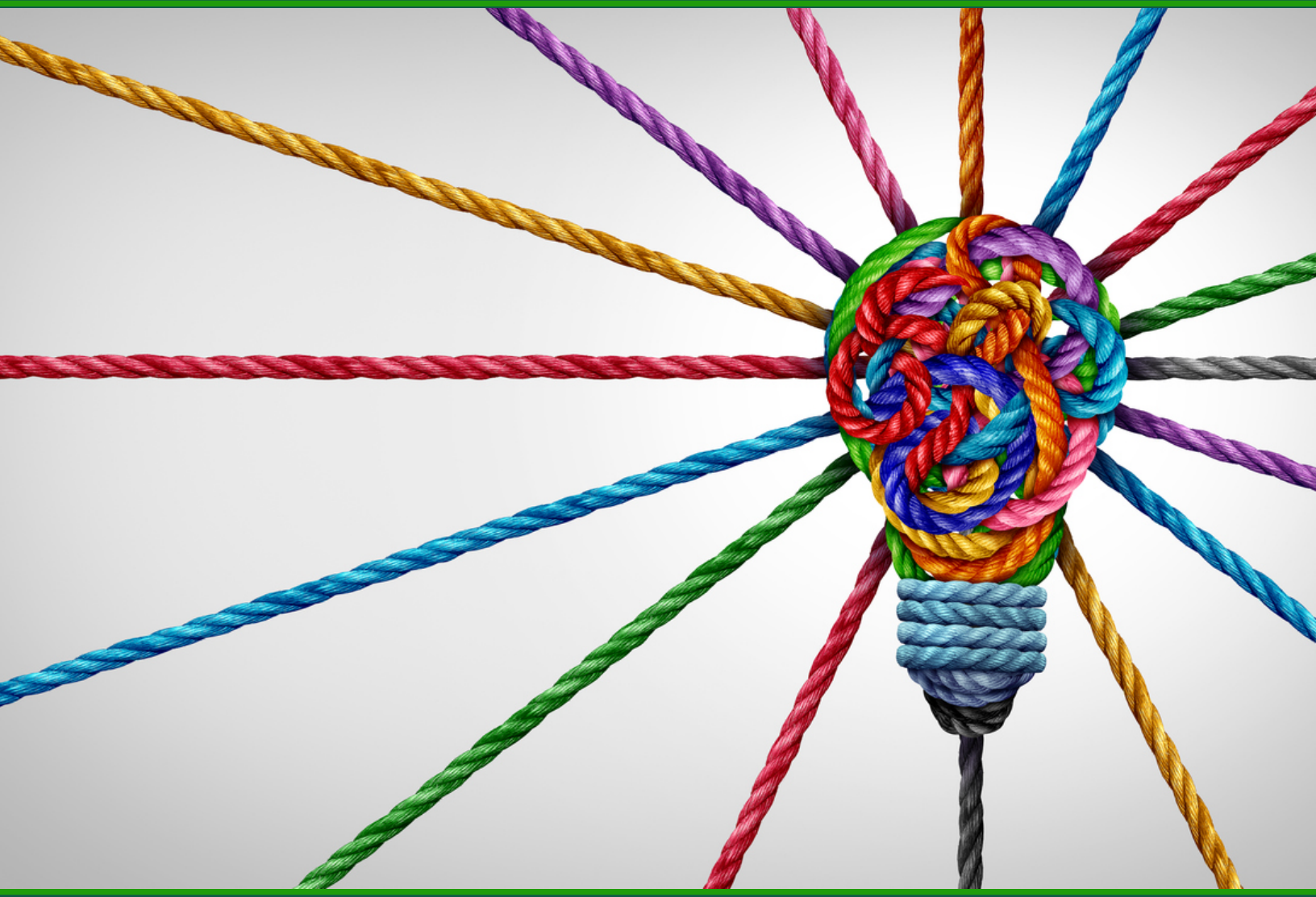
COMMUNITY NEEDS ASSESSMENT REPORT 2022



Health and Social Services
Haldimand and Norfolk

Report of Community Needs Assessment 2022 findings.
Haldimand Norfolk Health and Social Services Division, 2022.
Report prepared by Professional Practice, Quality Assurance, Planning & Evaluation Team.

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Executive Summary

The 2022 Haldimand Norfolk Health and Social Services (HNHSS) Division Community Needs Assessment (CNA) is a follow-up to the HNHSS CNA that was conducted in 2019. The goal of the CNA was to describe the current health and social status of the local community and changes since the 2019 CNA, with the purpose of contributing to future decision-making processes.

The 2022 CNA employed a similar method to the previous assessment, using a multi-pronged approach to data collection and analyses. The CNA was community-based and included both quantitative and qualitative data collection methods, such as a survey, key informant interviews, and focus group discussions. The data for this assessment was analyzed both for numerical trends and thematic trends and cross-validated.

Local community members, partner agencies, and internal staff were highly engaged in the process, resulting in over 1,400 complete survey responses, 80 interviews, and nine focus group sessions. Public engagement also included hundreds of total social media shares and reactions and 11 pop-up survey sites.

The demographic characteristics of the survey participants varied, including participants from across the communities in Haldimand and Norfolk, age brackets, gender identities, and income levels. Experiences related to COVID-19 also varied amongst participants.

Overarching conceptual framing, referred to as frames, to understand the data as it was presented, supported by both quantitative and qualitative information, included “Relationships and Community” and “Health Equity.” These two frames provided insights into the way data themes were interpreted throughout. The five key themes, best understood through the lenses of the two overarching frames, were:

- COVID-Related Changes;
- Barriers to Service;
- Health and Social Services Priority Areas;
- Health and Social Services Systems; and
- Leadership.

The findings contained in this report contribute to ongoing evidence-informed decision-making processes at HNHSS. This report, in conjunction with other critical reports, will serve to support the prioritization of future activities within the community and the HNHSS division.

Introduction

Background

The purpose of a community needs assessment (CNA) is to collect information that describes the population of a community and outlines the needs of that population, aiming to determine what gaps and barriers exist to meet those needs[1,2,3]. Moreover, a CNA should be able to provide local context about the population and their needs and should provide information that helps develop actionable items from the findings. A CNA typically includes three key steps: (i) assessment; (ii) dissemination; and (iii) implementation[4].

The Haldimand Norfolk Health and Social Services (HNHSS) CNA 2022 builds on the methodological design of the HNHSS CNA 2019[3]. Specifically, both CNAs involved four key data collection methods: (i) a community profile consisting of a comprehensive environmental scan of available local data; (ii) a community-based survey; (iii) focus groups with priority population groups with various lived-experiences; and (iv) individual key informant interviews with HNHSS staff, partner agency staff, and individuals with various lived-experiences. These methods constitute the data collection portion of the assessment phase of the CNA.

Rationale for HNHSS CNA 2022

The CNA 2022 serves the immediate need of informing the HNHSS division on the status of community needs in Haldimand and Norfolk counties and will be used by the division's senior leadership, program managers, and program staff to inform future planning, amongst other critical reports. Moreover, the CNA integrates the voices of Haldimand and Norfolk community members into that planning process.

In addition to the ability to include CNA results in planning, the CNA 2022 serves a unique ability to demonstrate how the residents in Haldimand and Norfolk have fared during the COVID-19 pandemic and evaluate how priorities have changed since fall 2019, when the previous CNA was completed[3].

Finally, the CNA 2022 will also provide HNHSS with the information needed to target interventions according to the mandates of the Ontario Ministry of Health (MOH)[5]. This intentionality increases HNHSS's ability to be effective in serving the residents of Haldimand and Norfolk counties and to be resource effective in terms of available funds and time.

Objectives

Building on the success and lessons learned from the HNHSS CNA 2019, and recognizing the changes in the local community since that time, the objectives of the HNHSS CNA 2022 were to:

i. Describe current health, social status, and needs of residents in Haldimand and Norfolk;

ii. Describe the changes in health, social status, and needs of residents in Haldimand and Norfolk from 2019 to 2022, acknowledging the changes experienced as a result of the COVID-19 pandemic;

iii. Identify the needs and gaps in health and social services programming in Haldimand and Norfolk counties and outline changes in programming availability since 2019; and

iv. Support evidence-informed decision-making and program planning for health and social services in the two county service areas.

Methods

Approach

The CNA 2022 used a community-based, participatory, mixed-methods approach throughout. This includes a central focus on engaging the community in all aspects of the CNA 2022, an iterative and semi-structured approach to questions in interviews and focus groups (i.e., not all participants were asked the same questions or in the exact same way), and intentional integration of quantitative (i.e., numeric data) and qualitative (i.e., thoughts, opinions, and feelings) data into a single final product.

The CNA 2022 used a methodological approach that was approved by the HNHSS Research Advisory Council in 2019[3].

Community Profile

The CNA 2022 Community Profile aims to describe the communities of Haldimand and Norfolk counties as fulsomely as possible with available resources, encompassing any relevant data points related to the demographics, health characteristics, or social services behaviours of residents.

Initially, a list of interesting and relevant indicators was developed in 2019. The indicators were identified from the HNHU operational plans, Windsor-Essex County Health Unit 2016 CNA[1], and in discussion with HNHSS staff[3]. Further, an environmental scan was conducted in 2022 to scour available resources that provide additional data or population descriptors for Haldimand and Norfolk counties, such as available COVID-19-related reports.

The Professional Practice, Quality Assurance, Planning & Evaluation Team at HNHSS conducted the Community Profile, including the environmental scan. Data sources for the indicators varied and are presented with each of the relevant parameters in the results section. Each indicator was collected at the most locally-relevant level of data available (e.g., Haldimand County, Norfolk County, Haldimand and Norfolk Census Division, and/or Ontario).

Analysis of Community Profile

The Community Profile is primarily a summary of the available measures from relevant data sources and presents minimal additional statistical analyses. Data were collected in raw or aggregate forms and presented as summary measures, such as medians, means, or ranges. Statistically significant local differences and changes over time were investigated, where possible and appropriate.

Community Survey

The CNA 2022 Community Survey was used to collect quantitative data from as many community members as were willing to participate. The survey used primarily closed-ended questions (e.g., yes or no options or select all that apply) to collect responses. The HNHSS CNA 2022 Community Survey was similar to the Community Survey for the CNA 2019, which was adapted from an existing and validated tool1. Changes to the tool were outlined in the CNA 2019[3], and included appropriate language use (i.e. updating terms to be culturally appropriate), rurally relevant questions, and additions to sections focused on the environment and social services. Similar changes were made for the CNA 2022 Community Survey. The survey included sections for demographics, self-identification, preferences and priorities, health and social behaviours, and COVID-19-related experiences (survey available upon request).

The CNA 2022 Community Survey was primarily administered via the online survey tool Survey Monkey Enterprise™. The online survey was distributed via the HNHSS and Haldimand-Norfolk Health Unit (HNHU) social media accounts, email listservs to internal staff, and communications with external partners.

To ensure representation for all eligible residents in Haldimand and Norfolk communities, the CNA 2022 Community Survey was also available in paper form. Paper surveys could be retrieved and submitted at all three HNHSS offices, six Haldimand County libraries, five Norfolk County libraries, and via 11 survey pop-up events at partner agencies, such as pharmacies and recreation centers, across the two counties.

Survey participation was open to individuals ages 12 of older. The survey was open for online or paper submission from June 6, 2022 to August 2, 2022. Participants were able to choose to enter their name in a draw for one of three grocery store gift cards for completing the survey.

Analysis of Community Survey

The CNA 2022 Community Survey was analyzed primarily via descriptive statistical analyses in Survey Monkey Enterprise™ and Microsoft Excel ©. Descriptive statistical analyses included frequencies, rates, proportions, and cross tabulations for stratification of the data by demographic characteristics, such as town of primary residence, age or age category (i.e. under 18 years, 19-29 years, 30-49 years, 50-69 years, and over 70 years), gender, educational attainment, and income level.

Focus Group Discussions and Key Informant Interviews

Qualitative data collected from focus group discussions and key informant interviews provided a more robust understanding of the community experience. Focus groups and interviews were used to incorporate key informant expertise and lived-experiences into the CNA at large.

Sampling for focus group discussions and key informant interviews employed a purposive sampling technique where individuals working at partner health or social services agencies and individuals with various lived-experiences, such as addictions or homelessness, were directly requested to participate. A snowball sampling technique, which allowed participants to identify additional individuals to invite to contribute, was also used to ensure the voices of the community's most vulnerable groups were identified and included in the CNA. Additionally, community members who engaged in the CNA 2022 Community Survey were offered an opportunity to volunteer to participate in an interview. One attempt each was made by phone and by email to reach every individual who volunteered to participate.

Focus group discussions and key informant interviews were conducted using a semi-structured (i.e., conversational), participatory (i.e., engaging) interview strategy[6], as was done in the CNA 2019[3]. In order to maintain a flexible conversation that allowed for exploration or emerging ideas or tangential ideas, interview guides

focused more on the key ideas to be discussed in an interview or focus group discussion, rather than listing structured questions that must be answered in every session. This semi-structured technique is recognized to generate a more robust dataset that allows for the responsiveness to session topics that might highlight new ideas otherwise missed in a structured interview[6].

Notes taken by the lead researcher while conducting the sessions were used to record focus group discussions and interviews, with the explicit consent of the participants. Audio or video recordings were not used and verbatim transcripts were not recorded.

Analysis of Focus Groups and Key Informant Interviews

Detailed session notes were produced during every focus group discussion and interview. Notes were analyzed via thematic analyses, which aims to parse the data down into bite-sized phrases or ideas and determine an underlying structure for the data[7]. First, notes were uploaded into Dedoose v. 9.0.54 © then coded according to a comprehensive data codebook. The codebook included over 300 codes for all ideas or topics that were covered in the discussions and was applied systematically to the entire dataset. The codebook included data-driven (i.e., emergent) and theory-driven (i.e., supplemental code ideas from previous CNAs, such as the HNHSS CNA 2019) codes. Notes were coded line-by-line to assess the ideas, tone, and priorities of statements. Following the coding of the entire dataset, the key ideas were considered and an emergent data structure was proposed. Theming was conducted iteratively with the participation of the CNA Steering Committee and HNHSS leadership to identify the most reflective thematic structure for the entire dataset.

Comparisons to 2019 CNA Data

The CNA 2022 Community Survey tool was developed from the approved and validated tool for the CNA 2019[3]. In doing so, the 2022 dataset had substantial opportunities for comparison across years. Where the same question was asked in the same way, data points from 2019 were matched to data points for 2022. The direction or magnitude of changes were assessed and compared for statistical significance. Statistical significance was assessed, where appropriate and possible, using a standard Chi-square calculator. Statistical significance was defined as a p-value of alpha <0.05[8] (i.e. a standard definition for statistical significance).

The CNA 2022 Focus Group and Interview Guides were also developed from the approved tools used for the CNA 2019. The qualitative data was compared from 2022 to 2019 at the thematic level, identifying key areas of agreement and difference between the two datasets.

Data Validation

Data validation is a crucial part of qualitative and mixed-methods research that allows for the assessment of data interpretation and determination of fit of findings. Data validation can take many forms and works best when more than one method is used simultaneously[9]. For this project, the data were validated using triangulation, member checking, prolonged engagement, and researcher reflexivity[9] (Table 1).

Table 1. Descriptions of the data validation methods used in the HNHSS CNA 2022.

Data Validation Method	Description
Triangulation	the utilization of various components of the dataset in conjunction with each other to evaluate agreement
Member Checking	collaborative interpretation of preliminary findings between the research team and the participants/ steering committee
Prolonged Engagement	assessment of the findings against what is known about the local community
Researcher Reflexivity	critical assessment of the fit of the data and themes

Community Profile Results

Demographics and Self-Identification

- With over 50% of the population in each county living in rural communities, Haldimand and Norfolk counties are defined as rural areas (i.e., <150 persons per square kilometer)10. Haldimand and Norfolk counties have a population density of 40.5 people per square kilometer compared to 15.9 people per square kilometer in Ontario[10].
- According to the 2020 census, 116,872 residents live in Haldimand and Norfolk counties (42.1% in Haldimand and 57.7% in Norfolk)[10], an increase of 6.5% from the previous census in 2016.
- There is a significantly higher proportion of older adults in Norfolk County: 25.9% of the population in Norfolk County is over the age of 65 years, compared to 20.6% in Haldimand County and 18.5% in Ontario[10].
- Haldimand and Norfolk counties have approximately 4,000 international agriculture workers who come to work on local farms each year[11]. This is more workers per capita than any other area in Ontario. The majority of workers come from Mexico and the Caribbean.
- Approximately 5,000 Low-German Speaking Mennonites reside in Haldimand and Norfolk counties, however, some migrate between Mexico and Norfolk[11].
- 3.6% of residents identify as Indigenous in Haldimand and Norfolk counties compared to 2.8% in Ontario[10]. This proportion is reflective of the population living off-reserve.

Social Services

Income and Poverty

- Haldimand County median total household income was $93,000 compared to $82,000 in Norfolk County. Provincially, the median total household income was $91,000[10].
- 7.9% of Haldimand County residents live in low-income households, compared to 10.0% of Norfolk County residents. Provincially, 10.1% of residents live in low-income households[10]. The proportion of residents living in low-income households varies amongst the towns in the two counties, ranging from 5.0% in Caledonia to 14.7% in Dunnville[10].
- In Haldimand and Norfolk counties, there are approximately 1,099 individuals accessing Ontario Works. This includes 1,864 beneficiaries, household members of a recipient. For 2022 (January to September), the average monthly percent of cases exiting to employment was 20.8%, compared to 23.7% in Ontario[11].
- In 2021, the hourly living wage for Haldimand and Norfolk counties was $17.35, which increased by $0.77 from 2019. In 2021, the minimum wage in Ontario was $14.25/hour; however, it has increased to $15.50/hour[12].
- There are eight food banks in Haldimand County and nine in Norfolk County[11].

Employment and Education

- The employment rate for Haldimand and Norfolk counties is 57.6% compared to 59.9% provincially[13].
- Significantly fewer Haldimand and Norfolk residents (77.2%) have completed a high school diploma (Haldimand County=79.1%, Norfolk = 75.9%), compared to Ontario (82.5%) residents[13].
- Over half (54.7%) of Canadian adults in 2021 score in the lowest two skill levels for numeracy, up from 2003 (49.8%)[14].
- 17% of Canadian adults in 2021 scored in the lowest skill level for reading, higher than the average across other Organization for Economic Co-operation and Development (OECD) countries[14].

Housing and Homelessness

- The 2021 Homelessness Enumeration study for Haldimand and Norfolk was conducted on November 17-18, 2021. At that time, the study identified 117 individuals who were experiencing homelessness[11]. The previous study, conducted in 2018, identified 79 individuals experiencing homelessness[11].
- 62% (n=73) of the individuals identified in the 2021 Homelessness Enumeration Study were identified as “hidden homeless,” which means that they do not have a home but have some sort of provisional accommodation, such as staying with family or friends. Another 20% (n=23) were listed as “fully homeless” and 16% (n=19) were in an emergency shelter on the night of the study[11].

Social Networks

- The Haldimand Norfolk Community Safety and Wellbeing Plan[15] identified mental health and addictions, rurality, and poverty and homelessness as three community-based areas of focus for the next number of years.

Safety

- The rate for all incident-based crimes in Norfolk is 3,417 per 100,000 population compared to 2,856 per 100,000 population in Haldimand. The provincial rate is higher at 4,170 per 100,000 population[16].
- Norfolk County had a crime severity index of 43.8 compared to 34.8 in Haldimand County and 56.2 in Ontario[17].

Childcare

- The Early Development Instrument, a tool that measures children's ability to meet age-appropriate development expectations at school entry, demonstrates that 25% of children in Haldimand and Norfolk are vulnerable on at least one domain compared to 30% of Ontario children. Roughly 10% of Haldimand and Norfolk children were identified to have one or more special concerns.
- There are 19 licensed childcare providers (5 in Haldimand and 14 in Norfolk) and 41 licensed sites (20 in Haldimand and 21 in Norfolk) in Haldimand and Norfolk[11].

Public Health and Wellness

General Health and Wellbeing

- 53.1% of Haldimand and Norfolk residents reported that they were physically active at or above the recommended level compared to 57.7% of Ontario residents[18].
- There are similar rates of self-reported adult obesity for Haldimand and Norfolk and Ontario residents (20.5% and 20.3%, respectively)[16].
- There are 63.3 family physicians per 100,000 population in Haldimand and Norfolk counties compared to 115.1 per 100,000 population in Ontario. As well, there are 17.5 specialist physicians per 100,000 population in Haldimand and Norfolk counties compared to 114.1 per 100,000 population in Ontario[19].

Chronic Disease and Injury

- The rate of hospitalizations for all injuries combined is significantly higher for Haldimand and Norfolk counties compared to Ontario (927 compared to 552 per 100,000 population, respectively)[16].
- Haldimand and Norfolk counties have significantly higher rates for emergency department visits (910 per 100,000 population) and hospitalizations (146 per 100,000 population) for motor vehicle collisions compared to Ontario (415 and 41 per 100,000 population, respectively)[16].
- The rate of hospitalizations for cardiovascular disease for Haldimand and Norfolk residents is 820 per 100,000 population compared to 788 per 100,000 population in Ontario[16].
- The hospitalization rate for chronic obstructive pulmonary disease in Haldimand and Norfolk is significantly higher than the rate for Ontario (139 per 100,000 population compared to 110 per 100,000 population)[16].
- The incidence rate of asthma in Haldimand and Norfolk is significantly lower than the rate for Ontario (160 per 100,000 population compared to 223 per 100,000 population)[18].
- Haldimand and Norfolk has previously reported a significantly higher rate of cancer-related mortality than the rate for Ontario (225 per 100,000 population compared to 190 per 100,000 population)[18]. However, due to the COVID-19 pandemic, provincial comparisons of cancer mortality by region are lagging ; data should be interpreted with caution as trends may have shifted over time.

Mental Health

- The intentional injuries hospitalization rate for Haldimand and Norfolk counties (102 per 100,000 population) is significantly higher than for Ontario (78 per 100,000 population)[18].
- In 2021, 23% of Haldimand and Norfolk residents reported that their life is quite or extremely stressful, compared to 22% in Ontario[15].
- In 2021, 75% (n=172) of Community Safety and Wellbeing Plan[15] survey participants reported feeling anxiety related to contracting COVID-19 and 29% (n=67) reported feeling anxiety about loss of income due to COVID-19.
- Also in 2021, 79% (n=186) of Community Safety and Wellbeing Plan[15] survey participants reported negative mental health impacts due to COVID-19 and 73% (n=171) reported some level of discord in their home due to COVID-19.
- As reported in the Community Safety and Wellbeing Plan15, the Coalition of Ontario Psychiatrists[20] indicated that Ontario is short 200 psychiatrists and the number of psychiatrists per population will decrease by 15% by 2030. As a stark contrast, the average annual number of outpatients seen by psychiatrists in Ontario increased by almost 20% between 2003 and 2013.

Addictions and Substance Use

- For Haldimand and Norfolk residents, the self-reported rate of exceeding the Low-Risk Drinking Guidelines is 52% compared to 44% for Ontario[16].
- There were 67.9 cases per 100,000 population of opioid-related emergency department visits (n=76) in Haldimand and Norfolk counties, compared to 63.4 cases per 100,000 population in Ontario[14].

Maternal and Child Health

- In 2020, approximately 25% of mothers in Haldimand and Norfolk counties were exclusively breastfeeding at 6 months. 66% of mothers were feeding their babies breastmilk in combination with other liquids and/or solids[11].
- 92.1% of mothers in Haldimand and Norfolk counties intend to breastfeed compared to 94.1% provincially[21].
- A significantly higher percentage of mothers smoke during pregnancy in Haldimand and Norfolk counties (7.8%) compared to Ontario (5.6%)[21].
- A significantly higher percentage of mothers in Haldimand and Norfolk counties use folic acid prior to and during pregnancy (37.8%) compared to Ontario (34%)[21].
- The average age of mothers at birth is significantly lower in Haldimand and Norfolk counties (29.4 years) compared to Ontario (31.3 years)[21].

Infectious and Vector-Borne Diseases, including COVID-19

- Haldimand and Norfolk Counties had a total of 9,328 reported cases of COVID-19 to date at the end of data collection, compared to 1,362,341 reported cases in Ontario (up to August 3, 2022[11]). By the end of 2022, the Health Unit had managed 6,194 cases from January 1 to December 31.
- The Health Unit managed 345 COVID-19 outbreaks from January 1, 2020 to December 31, 2022. In the same time, the Health Unit was responsible for managing many COVID-19 suspect outbreaks that did not meet outbreak definition. In 2022 alone, the Health Unit managed 126 confirmed COVID-19 outbreaks.
- The Health Unit managed 14 non-COVID-19 outbreaks in 2022. Outbreaks were caused by Respiratory Syncytial Virus (RSV), Influenza A, Parainfluenza, Norovirus, and Rhinovirus.
- The respiratory virus season that immediately preceded the pandemic (i.e. fall 2019 to winter 2020) included 90 laboratory-confirmed Influenza cases11. In 2022, there were 258 laboratory confirmed Influenza cases.
- The Health Unit is responsible for case management of many infectious diseases, known as Diseases of Public Health Significance. The most commonly reported infectious disease cases in the area in 2022 are presented in Table 2.

Table 2. The ten most commonly reported diseases of public health significance in Haldimand and Norfolk counties in 2022, excluding COVID-19.

Disease Name	Number of Cases Reported to the Haldimand Norfolk Health Unit in 2022
Influenza	258
Chlamydia	186
Lyme Disease	27
Gonorrhea (all types)	26
Pertussis	23
Salmonellosis	19
Campylobacter Enteritis	18
Hepatitis C	16
Group A Streptococcal Disease	15
Giardiasis	11
Total Infectious Disease Cases (all types, includes many not listed above)	**663**

- In 2020, the rate of Lyme disease in Haldimand and Norfolk counties was 5 per 100,000 population compared to 5.7 in Ontario. A total of 27 Lyme cases were reported to the Health Unit in 2022. Overall, since 2015, the number of cases has slowly increased, with 13 cases reported in 2019[23].
- In 2019, the rate of West Nile virus in Haldimand and Norfolk counties was 0.8 cases per 100,000 population compared to 0.2 cases per 100,000 population in Ontario[23].
- 217,693 COVID-19 vaccine doses had been administered to date in Haldimand and Norfolk counties compared to 34,344,783 in Ontario (up to August 3, 2022[11]).
- 82.1% of the Haldimand and Norfolk residents aged 5 years and older had received at least one dose of the COVID-19 vaccine at the end of the data collection period (August 3, 2022[11]).
- Immunization rates among 17-year-olds are presented in Table 3 for quadrivalent meningococcal conjugate (MCV4), human papillomavirus (HPV), and hepatitis B (HB) for Haldimand and Norfolk counties and Ontario, for the 2020-21 school year[22]. Vaccine coverage rates for students in Haldimand and Norfolk is below Ontario averages for most Immunization of School Pupils Act (ISPA) and publicly-funded optional vaccine antigens.

Table 3. Immunization rates among 17-year-olds in Haldimand-Norfolk and Ontario during the 2020-21 school year for the quadrivalent meningococcal conjugate (MCV4), human papillomavirus (HPV), and hepatitis B (HB) antigens[22].

	MCV4: UTD (%)	HPV: Series initiation (%)	HPV: UTD (%)	HB: Series initiation (%)	HB: UTD (%)
Haldimand-Norfolk	86.7	7.6	56.2	7.3	79.1
Ontario	93.8	8.9	63.4	9.2	77.7

Data Note: UTD= up to date

Environment and Health

- Climate change is already negatively affecting the health of Canadians and these impacts will increase as warming and climate uncertainty continues[24]. Impacts will vary across social determinants of health and may increase health inequities in Canada[24].
- In Haldimand and Norfolk, local climate change events, such as flooding in 2019, are already affecting health, safety, and the economy[25].
- In December 2020, Norfolk County Council unanimously voted to approve a local climate change adaptation plan, which includes the Health and Social Services Division[25].
- All cause emergency room visits increase significantly in rural communities in Southern Ontario during extreme heat periods, commonly known as heat waves[26].

Community Survey Results

Reading this section of the report:
The following results include the results of the Community Survey component of the 2022 CNA. To provide context to how community characteristics have changed, "2019=" represents the proportion of survey respondents in 2019 who answered the same question the same way. If an asterisk (i.e. *) follows the data for 2019, there was a significant difference between the findings from 2022 and from 2019. In some cases, the text does not refer to 2019 data. If 2019 is not mentioned, either the question was not asked or was changed from the original survey in 2019. Questions that were changed from 2019 to 2022 are not compared to avoid errors in interpretation of the data.

Survey Respondents

- A total of 2,094 individuals responded to the HNHSS CNA Community Survey in 2022.
- Following the exclusion of incomplete responses, 1,404 survey responses were included in the final analyses. This represents nearly 1% of all residents living in Haldimand and Norfolk counties. This is a significant increase in responses compared to 2019, where 427 useable responses were received. Respondents were able to skip questions if they chose to do so; therefore, the count of responses for each question is presented throughout the results.
- Despite the length of the survey, which took approximately 20-25 minutes to complete, the survey had a completion rate of 67% (2019= <30%).

Demographics and Respondent Representativeness

- Survey respondents were representative of Haldimand and Norfolk county residents based on community of residence, language spoken at home, immigration status, and employment status; however, survey respondents over-represented adults compared to youth, females compared to males and gender non-conforming individuals, higher educational attainment compared to individuals with less than a college diploma, and higher income brackets compared to individuals who lived in households that earned less than $50,000 per year[ii].

Self-identification

- 18.5% (n=312; 2019=23%*) of participants identified that they had a child aged 6-12 years, 16.1% (n=277; 2019=25%*) of participants identified they had a child aged 0-5 years, and 12.8% (n=217; 2019= N/A) of participants identified that they had a child aged 13-17 years. 4.4% (n=75; 2019= N/A) of participants identified as a caregiver for a child or children with a disability.
- 8.4% (n=143; 2019=14%*) of participants identified as a single parent who solely supports their household.
- 15.7% (n=267) of participants identified as a caregiver for an adult, including caring for adult children, parents, or an adult with a disability.
- 1.2% (n=20; 2019= 2%) of participants identified as currently pregnant.
- 6.3% (n=107; 2019= not comparable due to language changes) of participants identified as a person of colour; 6.4% (n=108; 2019= 4%) of participants identified as a visible religious minority ; 6.8% (n=115; 2019= 2%*) of participants identified as an Indigenous person; 6.5% (n=110; 2019= 3%*) of participants identified as LGBTQS2+ or gender non-conforming; and 5.3% (n=89) of participants identified as a seasonal agricultural worker.
- 10.4% (n=176; 2019= 25%*) of participants identified as a person with a disability.

Social Services

Employment and Education

- 68.9% (n=983) of participants agreed or strongly agreed that Haldimand and Norfolk needs more employment services.
- 10.8% (n=181; 2019=11%) of participants stated they are qualified for a better job than they can get.
- 8.2% (n=138; 2019=10%) of participants stated they have been unemployed, not by choice, in the past 12 months.
- 6.2% (n=104; 2019=3%*) of participants identified their job as being dangerous.
- 3.9% (n=66; 2019=8%*) of participants struggled to find transportation for work.
- 3.5% (n=59; 2019=3%) of participants identified that they have trouble reading.

Income and Poverty

- 66.5% (n=949) of participants agreed or strongly agreed that Haldimand and Norfolk needs more income support services.

Expenses

- 25.6% (n=431) of participants stated that they have little to no money left for extras after they pay for essentials such as food, housing, and utilities.
- 8.5% (n=143; 2019=15%*) of participants identified having used Ontario Works (OW) or Ontario Disability Support Program (ODSP) in the past 12 months.
- 5.1% (n=86; 2019=13%*) of participants self-identified as living in a low-income household (i.e., below the poverty line: $19,930 for a single adult or $28,185 for a family, per year, after tax).

Access to Food

- 48.8% (n=692) of participants reported growing some of their own food and 19.9% (n=283) reported raising their own animals for consumption.
- 17.3% (n=252) of participants disagreed or strongly disagreed that they could access healthy foods for their family.
- 14.1% (n=204) of participants stated they worried they did not have enough money to afford food in the past month.
- 7.9% (n=133; 2019= 16%*) of participants stated they had used a food bank in the last 12 months.

Housing and Homelessness

- 81.4% (n=1,161; 2019=72%*) of participants agreed or strongly agreed that Haldimand and Norfolk needs more affordable housing.
- 25.4% (n=363) of participants disagreed or strongly disagreed that they could access affordable housing for themselves and their family. Further, 18.3% (n=262) of participants disagreed or strongly disagreed that they could access safe housing for themselves and their family.
- When asked what supports would help individuals find and stay in their housing, participants most commonly chose financial help to afford utilities (24.3%, n=339; 2019=18%*), financial help to afford rent (23.6%, n=330; 2019=20%), and housing with accessibility features for persons with disabilities (17.8%, n=245; 2019=5%*).
- 5.9% (n=99, 2019=5%) of participants stated they had used affordable or social housing in the past 12 months and 4.7% (n=79, 2019=5%) identified that they have needed affordable or social housing and been waitlisted in the past 12 months.
- 5.8% (n=98) of participants identified they had lived in a shelter or on the street in the past 12 months and 8.7% (n=146, 2019=5%*) of participants identified they had lived in the home of a friend or family member in the past 12 months because they had nowhere else to go.

Social Networks

- Participants most frequently described their current overall social support network as good (37.7%, n=536), compared to very good (24.5%, n=349) or excellent (15.7%, n=224; combined= 40.3%, n=573; 2019 combined=58%*) or fair or poor (21.3%, n=303), which was significantly poorer overall social support networks than participants reported in 2019. When asked how their overall social health had changed over the course of the pandemic, 28.1% (n=401) of participants reported their social system had worsened and 9.4% (n=134) reported their social system had improved.
- 81.5% (n=1,223, 2019=72%*) of participants agreed or strongly agreed that Haldimand and Norfolk is a good place to raise a family.
- 72.8% (n=1,092, 2019=79%*) of participants agreed or strongly agreed that Haldimand and Norfolk is a good place to grow old.
- When asked who their primarily social supports were, most participants chose their family (76.6%, n=1,094; 2019=73%), friends (65.7%, n=939; 2019=81%*), or doctor (36.6%, n=523; 2019=52%*). There was a significant decrease in the proportion of participants who reported seeing their friends or doctor as a primarily social support, compared to 2019.
- 9.5% (n=161; 2019=12%) of participants stated that they felt they had little or no social support network and 7.6% (n=129, 2019=12%*) of participants stated that they felt socially isolated where they live.

Safety

- 79.5% (n=1,193, 2019=78%) of participants agreed or strongly agreed that Haldimand and Norfolk is a safe place to live, while 15.6% (n=234) disagreed or strongly disagreed.
- 76.9% (n=1,154, 2019=78%) of participants agreed or strongly agreed that Haldimand and Norfolk is a safe place to be their true self, while 18.3% (n=275) disagreed or strongly disagreed. However, when considered against key self-identification characteristics, individuals who identified as 19-29 years, 30-49 years, LGBTQ2S+, Black or a Person of Colour, Indigenous, having an unhealthy body weight, or having a disability were significantly less likely to agree or strongly agree that Haldimand and Norfolk is a safe place to be their true self ($p<0.05$ each).
- 12.0% (n=203; 2019=22%*) of participants self-identified as living in a sexually or physically abusive situation.

Childcare

- 71.6% (n=1,021, 2019=71%) of participants agreed or strongly agreed that Haldimand and Norfolk needs more childcare services.
- 6.9% (n=116; 2019=8%) of all participants stated they struggle to find childcare for work or school. However, 17.5% of participants who reported having a child(ren) under 12 years old reported struggling to find childcare for work or school

Social Services and Service Experiences

- 64.9% (n=974) of participants agree or strongly agree that they know where to find the social services they need.
- When asked what social services are needed to improve the social health of themselves and their family, participants most commonly chose more accessible mental health services (46.3%, n=714; 2019=48%), more recreational opportunities (40.6%, n=604; 2019=52%*), and more housing supports (34.7%, n=516; 2019=48%*).
- When asked what social services are needed to improve the physical health of themselves and their family, participants most commonly chose access to education or more schooling (22.6%, n=319; 2019=31%*), affordable housing services (21.7%, n=305; 2019=34%*), and public transportation services (18.7%, n=263).
- When asked what social services education they would most like to receive, participants most commonly chose available children's services (24.8%, n=343.7; 2019=30%*), access to education (22.4%, n=310), and employment skills training (22.2%, n=307).
- When asked where they get most of their social services information currently, most respondents chose their doctor or healthcare provider (41.7%, n=620; 2019=46%), family or friends (38.0%, n=565; 2019=41%), and websites (29.4%, n=436; 2019=43%*).
- When asked where participants usually go when in crisis, participants most commonly chose their family's home (35.6%, n=507; 2019=49%*), friend's home (31.0%, n=442; 2019=44%*), or doctor's office (25.96%, n=370; 2019=29%). There was a significant decrease in the proportion of participants who reported attending a family or friend's home in crisis, compared to 2019.
- When asked what barriers they face to access social services, participants most commonly chose that they were unsure where to go (22.1%, n=310; 2019=19%), cost of services (21.3%, n=299;2019=23%), or long waitlists (21.2%, n=298; 2019=29%*).

Public Health and Wellness

General Health and Wellbeing

- Participants most frequently described their current overall health as good (47.2%, n=682; 2019=33%*), compared to very good or excellent (combined= 28.3%, n=409; 2019 combined= 43%*) or fair or poor (combined= 23.2%, n=335; 2019 combined=22%), which was significantly poorer overall health than participants reported in 2019. When asked how their overall health had changed over the course of the pandemic, 36.0% of participants reported their health had worsened while 10.6% reported their health had improved.

- When asked what services are needed to improve the health of themselves and their family, participants most commonly chose more primary care supports (50.1%, n=752), more acute care supports (e.g., walk-in clinics; 42.3%, n=634), and more mental health supports (42.1%, n=632; 2019=50%*).
- When asked what public health services are needed to improve the health of themselves and their family, participants most commonly chose more exercise or physical activity opportunities (39.2%, n=584; 2019=47%*), more mental health supports (33.7%, n=499; 2019=54%*), and dental services for seniors (25.4%, n=377; 2019=20%*).
- When asked what public health education they would most like to receive, participants most commonly chose exercise or physical activity (30.5%, n=449; 2019=37%*), mental health supports (28.8%, n=423), and cancer prevention (20.9%, n=308; 2019=20%).
- When asked where they get most of their health information currently, most respondents chose their doctor or healthcare provider (62.6%, n=936; 2019=80%*), websites (37.9%, n=567; 2019=52%*), and family or friends (27.0%, n=404; 2019=30%*). Less commonly listed responses that increased significantly since 2019 include faith community (9.8%, n=147; 2019=5%*), media (19.6%, n=293; 2019=14%*), and workplace (8.4%, n=126; 2019=4%), amongst others.

Chronic Disease and Injury

- 70.6% (n=1,025, 71%) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to active transportation, such as bike lanes. 55.2% (n=783) of participants considered their community walkable (e.g., well-lit, sidewalks).
- 36.4% (n=528; 2019=45%*) of participants stated they exercised for at least 30 minutes at least three times per week, down significantly from 2019. 28.7% (n=417; 2019=35%*) of participants stated they had dieted or attempted to lose weight in the past month.
- 33.8% (n=489) of participants reported their physical activity levels decreased during the pandemic.
- Some risky behaviours, such as not wearing a helmet when riding a bike (79.8%, n=1,159; 2019=75%*) and using cannabis before or while driving (2.0%, n=29; 2019=0*), increased significantly since 2019

Food and Nutrition

- 23.4% (n=339) of participants reported their fruit and vegetable consumption decreased during the pandemic.
- 22.5% (n=380) of participants self-identified as having an unhealthy body weight.
- 12.3% (n=174) of participants wanted more education about disordered eating to support mental health for themselves or their families.
- 10.6% (n=154) of participants disagreed or strongly disagreed that they had basic skills to prepare healthy meals.
- 9.5% (n=160) of participants self-identified as having a “fat-phobia” or other major body image concerns.

Mental Health

- 80.3% (n=1,166; 2019=85%*) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to mental health services and counselling.
- 31.0% (n= 524; 2019=45%*) of participants self-identified as experiencing depression and/or anxiety and 6.9% (n=117; 2019=18%) of participants self-identified as having mental health difficulties other than depression or anxiety.
- When asked what mental health services are needed to keep themselves and their family safe, participants most commonly chose general mental health supports (46.4%, n=657; 2019=54%*), mental health supports for children and youth (28.1%, n=398), and support circles (15.6%, n=221; 2019=31%*).
- When asked what mental health education they would most like to receive, participants most commonly chose stress management and coping skills (39.2%, n=561; 2019=47%*), mental health and/or depression resources (38.2%, n=547; 2019=44%*), and available community resources (33.4%, n=478; 2019=26%*).

Less commonly listed but significantly increased from 2019 responses included the low-risk drinking guidelines (9.0%, n=128; 2019=5%) and safe consumption sites (8.3%, n=119; 2019=2%), demonstrating a shift toward substance use focus.

Substance Use and Addictions

- 11.8% (n=200) of participants identified that another adult and 4.9% (n=82) of participants identified that a teen in their house has a substance use disorder.

Treatment Resources

- 69.7% (n=1,012) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to supports for individuals who misuse alcohol and drugs.
- 66.8% (n=970) of participants agreed or strongly agreed that Haldimand and Norfolk needs more access to supports for individuals who want to quit smoking.

Alcohol

- 25.3% (n=338; 2019= 36%*) of participants stated that they were aware of the low-risk drinking guidelines for men and women.
- 17.2% (n=249) of participants reported their alcohol use increased during the pandemic and similarly, 17.0% (n=246) of participants reported their alcohol use decreased during the pandemic.
- 15.9% (n=231; 2019=9%*) of participants stated they consumed one or more alcoholic drinks per day, up significantly from 2019.
- 5.5% (n=93; 2019=3%*) of participants self-identified as having an alcohol use disorder, up significantly from 2019.

Cannabis and Tobacco

- 12.3% (n=208; 2019= 26%*) of participants self-identified as cannabis users.
- 11.9% (n=201; 2019=19%*) of participants self-identified as tobacco users.
- 7.4% (n=108) of participants reported their cannabis use increased during the pandemic while 10.2% (n=148) of participants reported their cannabis use decreased during the pandemic.
- 6.9% (n=100) of participants reported their tobacco use increased during the pandemic while 12.5% (n=181) of participants reported their tobacco use decreased during the pandemic.

Other Drugs

- 3.9% (n=66; 2019=3%) of participants self-identified as a person who uses drugs currently. 7.7% (n=130) of participants self-identified as a person who has used drugs in the last 12 months.
- 3.8% (n=55) of participants reported their drug use increased during the pandemic while 9.4% (n=135) of participants reported their drug use decreased during the pandemic.

Maternal and Child Health

- 13.2% (n=196; 2019=7%*) of participants wanted more family planning or sexual health support, such as birth control, condoms, and pregnancy planning, up significantly from 2019.
- 12.0% (n=173) of participants wanted more post-natal provisions to support the mental health of families with new babies.
- 9.0% (n=133; 2019=6%*) of participants wanted more information about breastfeeding.
- 5.9% (n=87; 2019=2%*) of participants wanted more falls prevention information for children.

Infectious and Vector-Borne Diseases

- 64.3% (n=913; 2019=75%*) of participants reported they check for ticks after outdoor activities, down significantly from 2019.
- 54.6% (n=793) of participants stated they were up-to-date on their recommended vaccinations (i.e., non-COVID-vaccines).
- 9.4% (n=139; 2019=4%*) of participants wanted more infectious disease information, up significantly from 2019.
- 8.6% (n=128; 2019=12%*) of participants wanted more vector-borne disease information, down significantly from 2019.

Environment and Health

- 84.4% (n=1,198; 2019=98%*) of participants considered a safe environment important for their health, down significantly from 2019.
- 76.4% (n=1,084) of participants reported having air conditioning at home.
- 61.3% (n=869) of participants felt that climate change was affecting their local environment and 44.7% (n=634) felt that climate change was affecting their family's health.
- When asked about their concerns for local weather and climate effects, 60.4% (n=857) of participants were concerned about wind and storms, 52.8% (n=749) of participants were concerned about extreme heat locally, and 36.5% (n=518) of participants were concerned about flooding.
- When asked about their concerns for local environmental issues, 51.1% (n=725) of participants were concerned about the risk of invasive species locally and 50.2% (n=712) of participants were concerned about food supply locally.
- 48.5% (n=689) of participants wanted more information about the impacts of climate change.
- 44.7% (n=634) of participants felt unprepared for a climate emergency locally, compared to 37.0% (n=525) of participants who felt prepared for a climate emergency locally.
- 16.3% (n=231) of participants reported having sufficient access to public transportation.

Health Service Experiences

- 68.7% (n=1,031; 2019=76%*) of participants agree of strongly agree that they know where to find the health services they need.
- When asked which healthcare providers participants see annually, participants most commonly chose their doctor (65.2%, n=945; 2019=97%*), dentist (56.8%, n=824; 2019=62%*), optometrist (37.0%, n=971; 2019=51%*), and pharmacist (36.6%, n=531;

2019=39%). There was a significant decrease in the proportion of participants who reported seeing their doctor, dentist, or optometrist annually, compared to 2019.

- 21% (n=300) of participants reported they were seeking additional healthcare providers who they have been unable to access. Participants most commonly stated they were seeking a doctor/ primary care provider (30%, n=9), walk-in or after-hours clinic (13%, n=4), or a physiotherapist (10%, n=3).
- When asked where participants usually go when sick, participants most commonly chose their doctor (66.1%, n=958; 2019=86%*), the hospital emergency room (41.3%, n=599; 2019=51%*), or a walk-in clinic (27.7%, n=402; 2019=42%*). Less common answers that were selected significantly more often in 2022 than 2019 included community health centres (16%, n=232; 2019=3%) and family health teams (16.6%, n=240; 2019=7%).
- When asked what barriers they face to access healthcare services, participants most commonly chose hours that do not fit their schedule (20.9%, n=297; 2019=29%*), cost of services (19.9%, n=282; 2019=26%*), and they were unsure where to go (13.6%, n=193; 2019=6%*). Also, there was a significant increase in the proportion of participants who reported cultural or religious beliefs were a barrier to accessing services (6.27%, n=89; 2019=0%*).

COVID-19-Related Experiences

- 56.9% (n=826) of participants stated they were up-to-date on their COVID-19 vaccinations.
- 36.5% (n=611) of participants stated that the pandemic negatively impacted their mental health and 26.8% (n=443) of participants stated that the pandemic negatively impacted their child(ren).
- 27.3% (n=457) of participants stated that the pandemic negatively impacted their relationships with family or romantic partners and 29.7% (n=497) of participants stated that the pandemic negatively impacted their relationships with friends or colleagues.
- 23.5% (n=328) of participants reported they tested positive on a Rapid Antigen Test (RAT) and 15.5% (n=216) of participants reported they tested positive on a Polymerase Chain Reaction (PCR) Test for COVID-19.
- 23.4% (n=391) of participants stated that the pandemic negatively impacted them financially.
- 23.3% (n=387) of participants stated that the past two years were traumatic for them.
- 20.2% (n=338) of participants identified as a frontline or healthcare worker and 16.6% (n=278) identified as a non-healthcare essential worker.
- 14.5% (n=243) of participants stated that the pandemic did not really impact them.

- 13.0% (n=181) of participants reported that the pandemic impacted their access to medical procedures, such as delayed surgeries (44% of those who provided a response, n=7).
- 5.4% (n=90) of participants stated they lost their job or business due to the pandemic. 19.1% (n=266) of participants stated that the pandemic caused a loss of employment income for their family.

Health and Social Services Collective Programming

- 74.5% (n=1,034; 2019=75%) of participants reported they were only somewhat or not at all familiar with programming offered by HNHSS, compared to 20.0% (n=278; 2019=19%) who reported they were very familiar with programming offered by HNHSS.
- When assessed by demographics, familiarity with programming offered by HNHSS was typically lower for individuals who were over the age of 50 years compared to less than 50 years of age, had lower educational attainment compared to those with a college diploma or higher, lived on Indigenous Reserve lands or in more rural towns compared to more suburban communities, who identified as gender non-conforming compared to males and females, or who had lower or higher household incomes compared to families making $30,000-$80,000 per year.
- Participants reported that the public health programming they used most in the last 12 months was attending a COVID-19 vaccination clinic (52.2%, n=730), speaking to staff for COVID-19 advice (25.9%, n=362), and speaking to staff for COVID-19 case investigations (22.5%, n=314). 10.4% (n=146; 2019=33%*) of participants reported not using public health programming in the past 12 months.
- Participants reported that the social services programming they used most in the last 12 months was visiting the HNHSS website (28.6%, n=390; 2019=15%*), following HNHSS social media accounts (22.1%, n=301; 2019=12%*), and reading brochures (20.5%, n=279; 2019=34%*). 28.8% (n=391; 2019=49%*) of participants reported not using social services programming in the past 12 months.
- 57.0% (n=786) of participants agreed or strongly agreed that HNHSS showed they care in their interactions in the past 12 months, compared to 10.8% (n=149) who disagreed or strongly disagreed.
- 47.4% (n=654) of participants agreed or strongly agreed that it was easy to seek assistance from HNHSS in the past 12 months, compared to 19.6% (n=270) who disagreed or strongly disagreed.
- When asked how they would like to receive information from HNHSS, participants most commonly chose email (57.6%, n=802; 2019=60%), website (54.3%, n=756; 2019=66%*), and social media (50.7%, n=706; 56%*). Also, there was a significant decrease in the proportion of participants who chose to pick up print materials or receive mailed print materials from HNHSS, compared to 2019.

Focus Group and Interview Themes

Participants

- The qualitative portion of the CNA 2022 included 80 key informant interviews and nine focus groups with 44 participants, for a total of 124 participants (2019= 124 participants).
- Key informant and focus group participants included HNHSS staff, partner agency staff from across Haldimand and Norfolk counties, and individuals with various lived-experiences.

Emerging Themes

- Main ideas emerged from the dataset and can be displayed visually, according to their relative frequency (Figure 1).

Figure 1. Word cloud of relative frequency distributions for codes applied to qualitative data during coding and thematic analysis.

- Two frames and five themes emerged from the dataset (Figure 2). Frames were overarching ideas that each theme in the final structure was related to and that support the interpretation of each theme as part of the whole. The five themes represent the most prominently discussed ideas in the interview and focus group discussions.

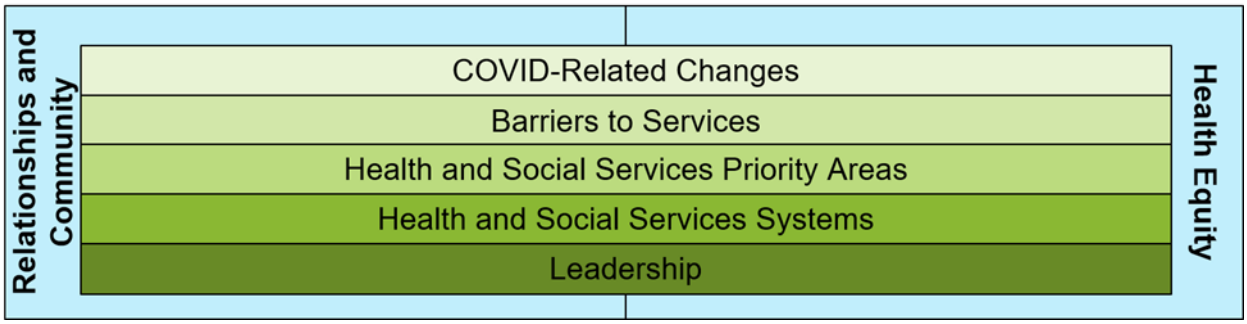

Figure 2. Emergent thematic structure of qualitative data for the Community Needs Assessment (CNA) 2022. The blue boxes represent frames, which are used to understand the five key themes. The five themes are presented in green bars.

- Each theme was broken down with descriptors, which are key words that described the five emergent themes (Figure 3).

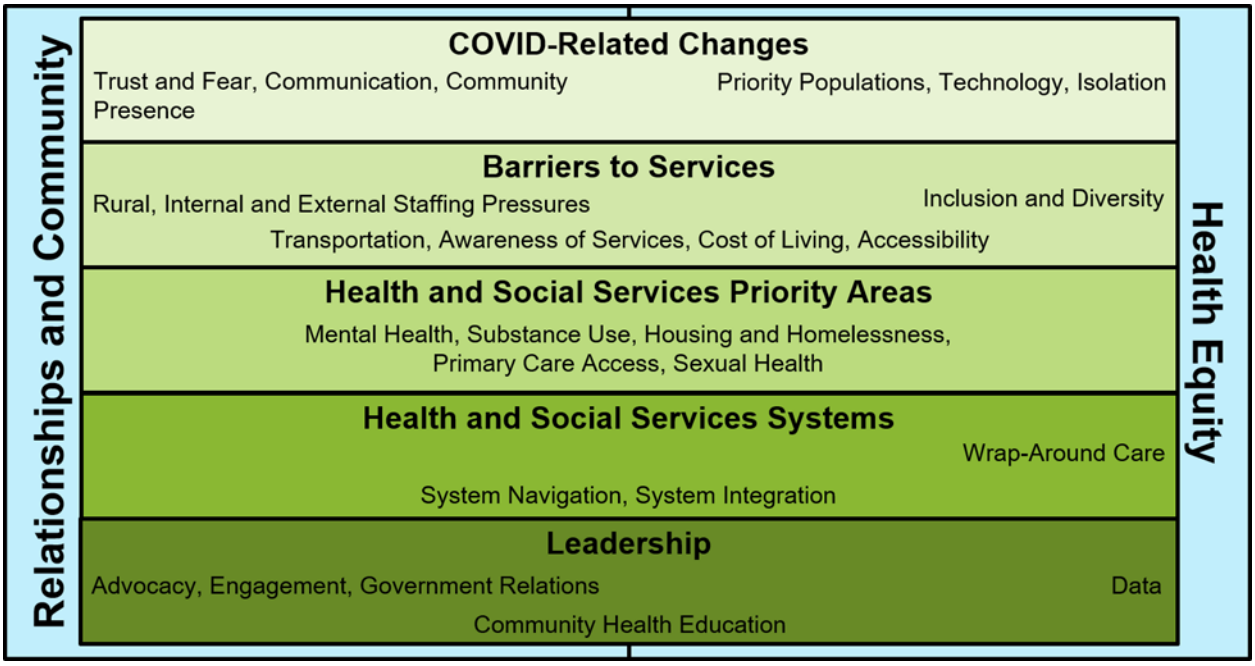

Figure 3. Descriptions of the emergent thematic structure of qualitative data for the Community Needs Assessment (CNA) 2022. The smaller text in each theme (i.e., green bars) ties each overarching theme to the two main frames (i.e., blue boxes). The descriptors positioned to the left are more closely related to the frame for relationships and community while descriptors positions to the right are more closely related to the frame for health equity. Descriptors positioned in the center were equally relevant to both frames.






COVID-Related Changes

Trust and Fear

- Participants expressed that community trust in HNHSS was damaged during the pandemic. Further, some participants described fear of the organization related to the pandemic.
- Comments around trust and fear were commonly discussed alongside COVID-19 "lockdowns," restrictions, and/or vaccines. In part, HNHSS's role in enforcing or implementing provincial guidelines contributed to these ideas.
- Comments related to trust and fear were often fraught with emotion and included some of the strongest and most frequently stated ideas.

Communication

- Some participants called for HNHSS rebranding post-pandemic. Ideas included suggestions to highlight the role of public health in the community, direct attention to non-COVID-19-related activities, and to consider stylistic changes that may help HNHSS reach new and younger audiences.
- Frequently, partners and internal staff expressed the need for strengthened communications between agencies. Participants outlined the challenges around COVID-19 communication. Some challenges noted included delays in communication of decisions and a lack of awareness of other agencies' roles in COVID-19 assessment, immunization, and so on.

Community Presence

- Participants commonly wanted to see HNHSS offering in-person service and being more available to the community at events and stakeholder meetings.
- Many participants relayed the desire to be present in the community in relation to the way things were before the pandemic, including having the supports of staff in offices, staff at community-based meetings, and the ability to attend events such as county fairs and early learning centers.

Priority Populations

- Participants outlined the ways that COVID-19 exacerbated health inequity amongst the most vulnerable individuals in our community.
- When discussing the impacts of COVID-19 on priority populations, many participants outlined the ways that the gap had widened between higher-income and lower-income

individuals and families. Some of the most discussed challenges faced were related to precarious work that required individuals to go to work in essential roles, experiences for individuals and families with low incomes, and challenges faced by individuals experiencing homelessness when shelters and food programs were generally limited.

- Separately, there were also a number of participants who outlined that some priority populations experienced intense stigmatization locally for not participating in certain COVID-19 measures or vaccination programs based on their cultural or religious beliefs.

Technology

- Technology use increased and became a necessity for health and social services access during the COVID-19 Pandemic.
- Participants highlighted both strengths and weaknesses of the use of technology, noting that technology often supported ongoing health and social services provisions during lockdown periods at the beginning of the pandemic and that use of this potential solution relied on individuals to have access and competencies with the technology and internet.
- Technology was also mentioned in context of the descriptor for community presence, suggesting that technology was sometimes becoming too comfortable and should not be used as a substitute for in-person service offerings, when safe to do so.

Isolation

- Participants described that lockdowns and other COVID-19-related measures increased challenges related to feeling isolated. Many participants also shared that this isolation often increased challenges with mental health for themselves or their loved ones.

Barriers to Service

Rural

- As in 2019[3], the rural nature of Haldimand and Norfolk was a commonly noted barrier to accessing services locally.
- Rurality often referred to ideas of the two county service area's vast geographical spread, the distance required to access services, and the resultant lack of specialized services due to the large area and relatively small population.

Internal and External Staffing Pressures

- Health Human Resources (sometimes referred to as HHR) challenges for HNHSS and other health and social services providers were common.
- Staffing pressures further added to key informants commenting on workload-related challenges, caregiver burnout, and an overstretched healthcare system.

Inclusion and Diversity

- During interviews and focus group discussions, many participants discussed ideas around inclusion, which referred to a broad list of identifiable and invisible characteristics including race, gender, sexual orientation, language, or religion.
- Moreover, many participants suggested there was an opportunity for HNHSS to lead change for creating safe and inclusive environments in Haldimand and Norfolk and provide teaching or training for other agencies and community partners.

Transportation

- Transportation was the most commonly noted barrier to accessing health and social services, including limited or no public transit, cost of vehicle/gas/maintenance, and was closely tied to rurality.






Awareness of Services

- A lack of awareness of services was one of the most commonly noted barriers to service.
- Participants sometimes described how they or clients were unsure of where to look for resources or that they were unclear on what services public health or social services provided.

Cost of Living

- Inflation, housing prices, and food cost concerns were top of mind for many participants. Individuals often shared challenges they had experienced recently with paying for essentials, such as utilities.
- When discussing the cost of living, many HNHSS and partner agency staff noted the implications for cost-of-service provisions when community members cannot afford to meet their most basic needs. Specifically, participants suggested that avenues for individuals to participate in programming for free or reduced fees would help many clients.

Accessibility

- Accessibility referred to ideas related to physical location of services as well as technological access, such as internet or phone for virtual appointments, related to COVID-19. Some participants described the exacerbation of health inequities in context of accessibility as well.

Health and Social Services Priority Areas

Mental Health

- Mental health was discussed independently and in context of virtually all other health and social services program areas.
- Mental health topics included overall wellness, individual resiliency, impacts of COVID-19, and access to necessary resources, such as counselling and psychiatric services, among others.

Substance Use

- Substance use was commonly noted as a high priority and a major concern for the

community, particularly around addictions and opioid or "harder" drug use.

- Substance use concerns often included mental health challenges, access to services such as detoxification beds and methadone clinics, community safety, and prominence of drug use and overdoses in "downtowns."

Housing and Homelessness

- Housing was often described as an urgent and ongoing crisis, particularly with regards to homelessness and access to affordable and available housing, or options for subsidized and supportive housing.
- When discussing housing and homelessness challenges, provincial housing issues and the regional scope of the housing crisis were frequently mentioned.

Primary Care Access

- A commonly mentioned challenge during interviews and focus group discussions related to obtaining a primary care provider locally.
- Access to primary care was often related to the number of physicians, options for alternate levels of care such as walk-in clinics and urgent care centers in Haldimand and Norfolk, and wait times for appointments with primary care providers, due to these care providers carrying very large patient rosters.

Sexual Health

- Lack of choice in providers of sexual health services and the locations of offices were mentioned in some interviews and focus group discussions. Comments were often related to health equity, stigma for seeking care, ability to provide "wrap-around care", and rurality.

Health and Social Services Systems

System Navigation

- One of the most commonly mentioned roles or responsibilities of HNHSS noted by participants was support with knowing what services exist, locating services, and accessing them.
- System navigation typically referred to both support for clients and support for other agencies to refer their clients to required services.
- Discussions about system navigation was also common during conversations related to Ontario Works clients.
- Several ideas for solutions came from participants who saw system navigation as a crucial priority for HNHSS. Examples included a web-based portal, a 4-1-1 number, and lists of resources for various topics.

Wrap-Around Care

- Wrap-around care referred to being able to provide fulsome care to members of priority populations who came to HNHSS for support.
- Participants desired to provide a warm-handover, where they could introduce a client to another program or service provider, for clients who come in needing a variety of HNHSS services, and more ability to walk alongside clients who are facing multiple complex and related vulnerabilities.

System Integration

- Participants from both HNHSS and external agencies noted the value of bringing health and social services closer together.
- Suggestions included options for data sharing and warm handovers to support clients. This also included ideas related to working as a team and institutional networks.
- Further, many partner organizations commented on the desire to bridge gaps between services with each other and HNHSS in a facilitated way that was led by HNHSS.

Leadership

Advocacy

- One of the most common roles of HNHSS described by participants was the need to advocate for clients and the community at large. Advocacy topics included OW payment increases and housing options. Opportunities for advocacy included discussions with the Board of Health and/or County Councils, where HNHSS could provide contextual knowledge around social determinants of health; applications for government funding, where HNHSS could champion the advocacy for necessary dollars to do additional health or social services projects; and more.

Engagement

- Participants noted the need for HNHSS to engage with the community and partner agencies to provide opportunities for individuals with lived-experiences to be involved at HNHSS planning tables.
- Additionally, participants described wanting HNHSS to be present at community roundtables that are led by other organizations as well.

Government Relations

- Tensions between HNHSS and other government-based agencies within the community were described as damaged or lost and needing to be intentionally rebuilt due to COVID-19. These comments were generally made in specific reference to government mandates or policies for COVID-19.

Data

- Participants sometimes described needing HNHSS to be the leader in local data collection and analyses. Moreover, participants sometimes noted HNHSS as having a responsibility to provide other health and social service providers local context for their planning through the dissemination of that data.

Community Health Education

- At times, participants noted the role that HNHSS should play in communicating health risks, healthy behaviour, and general health promotion for things like chronic disease or vector-borne disease.
- Similarly, there were many comments related to HNHSS's role as educators to other organizations in the community.

Discussion and Recommendations

The quantitative data (i.e., the Community Profile and the Community Survey) and the qualitative data (i.e., interviews and focus group discussions) for the HNHSS CNA 2022 were cross-validated (i.e., triangulation, member checking, prolonged engagement, and researcher reflexivity). Not only does the data validation process strengthen the robustness of the data interpretation, but it also provides support to the two frames and five emergent themes from the qualitative analysis as the overarching priorities of the data.

Representativeness of the Data

The CNA 2022 Community Survey statistically over-represents adults compared to youth, females compared to males and gender non-conforming individuals, higher educational attainment compared to individuals with less than a college diploma, and higher income brackets compared to individuals who lived in households that earned less than $50,000 per year. However, the qualitative data collected in interviews and focus group discussions for this study typically over-represented those with challenging lived-experiences such as homelessness, poverty, mental health or addictions challenges, or those partner agency staff who directly serve those priority population groups. The combination of the quantitative and qualitative datasets for the 2022 CNA provides a more robust dataset, representing the diversity of the community.

Additionally, the Community Survey had nearly 300% of the total participation of the CNA 20193, suggesting that the residents of Haldimand and Norfolk counties are particularly engaged in the process this year. This may be due to increased social media traction brought on by a larger local following over the duration of the pandemic, the political atmosphere locally and across the country, or that community-members have become increasingly responsible for their own overall health throughout the pandemic.

The recommendations presented in this report should be interpreted in context of the entirety of the dataset and the overall representativeness of the data. While the quantitative and qualitative components of the data have the potential to balance one another, they cannot be treated as separate and equal entities. Instead, the recommendations were weighed against what is known about the local population as a whole and recommendations presented in this report should be considered accordingly.

Relationships and Community

'Relationships and Community' was one of two key frames used to understand the themes that emerged from this data.

When considering the community's present state and how the community has changed over the course of the pandemic, relationships were often described as fraught with tension. These relationship tensions included family dynamics, friendships and professional relationships, and relationships between the public and organizations, such as HNHSS with the public or partner agencies.

While relationships were generally described as challenging, there was often a forward focus on rebuilding relationships to be even better than before the pandemic. These comments often highlighted the importance of relationship rebuilding and the necessity to rebuild fulsomely and intentionally, highlighting the amount of work needed to do so successfully.

A key element to the entire relationship and community frame was the resounding internal and external desire to see HNHSS staff increasingly back in the community. As a way to rebuild relationships with the residents of Haldimand and Norfolk counties, HNHSS staff should be available at events, meetings, and in the offices to meet with clients, answer questions, and provide services.

Health Equity

'Health Equity' was the second of the two key frames used to understand the themes that emerged from this data. Health equity refers to creating fair opportunities for good health for all individuals, regardless of any characteristics of their life, such as age, ethnicity, gender, or income.

Throughout the conversations conducted as part of the CNA, individuals expressed the ways that the gap between the "haves" and "have-nots" in our communities has widened. In both quantitative and qualitative data for the CNA 2022, it was apparent that many of the community's most vulnerable individuals were struggling more than they had been pre-pandemic. Challenges spread the gamut of life experiences from mental health or addictions struggles, to increasing challenges affording housing and food, to increasing feelings of stigmatization or isolation in the community.

While inequities in the community were at the forefront of many people's minds, so too were ideas for solutions to make the community more inclusive and the role for HNHSS to play in that community growth. In much the same way as relationship rebuilding, comments often highlighted the importance of doing this work fulsomely and intentionally, recognizing the amount of effort needed to do so successfully.

COVID-Related Changes

A substantial proportion of the participants in the CNA 2022 reported that they had experienced traumas related to the COVID-19 pandemic. Traumas may have been related to damaged relationships, financial strife, and challenges with trust, which may have sometimes resulted in poorer mental health outcomes. Further, population-level inequities were exacerbated by COVID-19, particularly around low-income households, employment experiences, and health.

COVID-19-related impacts were not a surprising theme when considered against the existing literature, such as the HNHSS Community Safety and Wellbeing Plan[15] and the Public Health Ontario (PHO) Enhanced Epidemiological Summary on COVID-19 and Material Deprivation[27], which suggested that health and social service statuses were declining due to the pandemic and that the effects were inequitable. In particular, data from PHO demonstrated that community members in the most vulnerable groups, such as those experiencing homelessness[28] and racialized communities[29], experienced the greatest risks and challenges due to COVID-19. Additionally, the CNA 2022 results suggest that there may have been shifts in substance use patterns and that substance use supports continue to be a local priority (as seen in 2019[3]), as was highlighted by PHO in 2020[30].

Looking forward, adjusting to a new phase of public health and social services in context of COVID-19 should consider mental health implications of the pandemic, the impact of the pandemic on relationships, and the ways that COVID-19 exacerbated inequity locally.

Barriers to Service

Barriers to accessing HNHSS and other health and social services programming were numerous amongst the participant responses in the CNA. Participants highlighted how necessary it was to have a social network they could rely on for access to services due to the distance they needed to travel for services, awareness of services, and support with the cost of accessing or receiving services. Further, many participants noted how barriers to services were not equitable, but rather that hurdles to reach services were bigger for more vulnerable community members.

The barriers to service most commonly identified in the CNA 2022 are similar to those from the CNA 2019[3], which included transportation, awareness of services, rurality, and stigmatization. According to the Rural Health Systems Model developed by the Canadian Institutes for Health Information[31], travel time, travel cost, and travel availability are geographically tied parameters that impact health access in rural areas. Moreover, contextual factors such as infrastructure, partnerships and community readiness, service delivery models, and resource models and allocation also impact the ways that rural communities access healthcare[31].

Additional barriers to service arose out of the COVID-19 pandemic compared to those in the CNA 2019[3]. Specifically, local health and social services staffing pressures at HNHSS and other agencies have been extended. Reports from across Ontario highlight the extent of these challenges, including locally in Norfolk County[32], Haldimand County[33], and Niagara Region[34], and across the province[35,36].

Health and Social Services Priority Areas

Community members who participated in the CNA highlighted several health and social services priority areas for immediate action and focus. Participants noted programming areas that may have reflected their own needs or those of their community at large, such as homelessness, which was mentioned by individuals experiencing challenges with housing and those who are not facing those types of challenges alike. Comments about these priority areas reflected the desire of local residents to see dignity and respect in the form of health equity for their neighbours.

Mental health was extensively highlighted as a priority in the Community Survey and in the interviews and focus groups, as was true in 2019[3]. Participants described mental health services as a top-three need to keep their family healthy, a top-three need to protect the social health of their family, a top-three need for health education for their family, and highlighted significant decreases in their overall social supports or the likelihood they would seek crisis supports from family members or friends in crisis. These findings are similar to reports from across Ontario[37,38,39] and around the world[40], that mental health is a top priority as we emerge from the emergency response phase of the pandemic.

Similarly, substance use was highlighted by participants in both the Community Survey and interviews and focus groups, as it was in the CNA 2019[3]. Generally, survey responses suggest that alcohol consumption is increasing significantly in Haldimand and Norfolk counties, while tobacco and cannabis use may be decreasing. Trends for opioids and other drugs were less consistent in survey responses but suggest that substance use is still top-of-mind for local residents, along with related detoxification and rehabilitation services for the community. Throughout the pandemic, substance use-focused agencies have highlighted the concerns for increased substance use related to isolation, mental health impacts, and other challenges brought on by COVID-19[41,42,43].

Housing and homelessness was a third major priority from the CNA 2019[3] and remains a priority in Haldimand and Norfolk counties in 2022. In the Community Survey, participants chose housing supports as a top-three need to improve the social health of their family, along with options such as financial help to afford rent, and financial help to afford utilities to help them maintain their current housing. Housing and decreasing the risk of homelessness are essential priorities for maintaining the health and wellbeing of the community, as noted in the literature[15,44,45], as well.

Access to primary care providers was commonly mentioned in the quantitative and qualitative components of this assessment and is reflective of the findings in the CNA 2019[3]. There was also a significant decrease in the proportion of participants who reported seeing their primary care provider annually. As the available number of physicians for the two county service area stayed steadily around 50% of the average for the province per capita for Haldimand and Norfolk counties[19], it is not surprising that this concern continues to be important to local residents and is a demonstrated priority for local policy makers[46].

The health and social services priorities highlighted in the CNA 2022 suggest that priorities are very similar for the years ahead as what was identified as priorities in the CNA 2019[3]. Given the need to pivot HNHSS's priorities to emergency management during the earliest parts of the pandemic, limited progress was made on addressing these concerns in the past three years and exacerbations of these priorities due to COVID-19 have occurred in some instances.

Health and Social Services Systems

Health and social services is a large and complex system that includes HNHSS and many other local, provincial and federal agencies. The challenges that this complexity imposes on community members who require services and their allies is the resultant inability to identify necessary and available services. The ability to navigate the system more seamlessly has the potential to decrease health inequities.

Participants in the Community Survey and interviews and focus groups often noted a lack of awareness of services as a major barrier to using them, along with comments related to not being sure where to look to get started. Increasingly, local and regional health and social services agencies are developing tools[47,48] to help the public navigate service offerings, due to the inherent complexity[49].

Moving forward, development of tools that will help clients and their advocates, such as agency staff and family members, should be a priority for HNHSS. The magnitude of possible gains from such systems was noted by participants in interviews and should be considered in the prioritization of available funding.

Leadership

As the overseer of health and social services in the community and the organization mandated to fulfill community necessities[5], participants described this as a vital responsibility for HNHSS. According to participants, leadership must involve community engagement and relationship building to inform decision-making. Additionally, data provisions and health education are important to improve equity in Haldimand and Norfolk counties.

The National Collaborating Centre for Determinants of Health[50] describes advocacy, an element of leadership in the CNA 2022, as a "critical population health strategy that

emphasizes collective action to effect systemic change." Moreover, some of the key components in preparing advocacy efforts outlined by the Centre are the gathering and disseminating of data and working in collaboration with alliances[50].

Time and again the CNA highlighted the importance of health education and health promotion, including agencies hoping that HNHSS can lead community or partner education campaigns on key issues such as inclusion and diversity. The World Health Organization has prioritized health promotion action for more than three decades[51], including calls to build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, reorient health services, and move into the future. Inclusive settings are essential to positive health and social services provision, however, in 2019[3] and in 2022 individuals who identified as members of priority population groups, such as being a person of colour, LGBTQ2S+ or gender non-conforming, Indigenous, or having a disability, were less likely to agree that Haldimand and Norfolk is a safe place to be their true self. See the Community Profile for more information about priority population groups in Haldimand and Norfolk counties.

Locally, shifts have occurred in the desires for health promotion topics, such as increases in the proportion of participants who reported wanting infectious disease information (e.g., COVID-19, Influenza) coming into a different phase of the COVID-19 pandemic. Similarly, shifts have occurred in the needs for health promotion topics, such as Haldimand and Norfolk counties being endemic for Lyme disease and other vector-borne infections yet the proportion of participants who reported doing a tick-check after outdoor activity decreased since 2019[3]. Further, Community Survey results suggested that some risky behaviours, such as not wearing a helmet on a bicycle or driving while under the influence of cannabis may be significantly increasing locally[3].

Limitations

The CNA 2022 is filled with robust data and provides a thorough understanding of the local community. However, some limitations exist in any assessment of this magnitude. First, the dataset should be interpreted in context of the representativeness of the populationii. Some population groups are over or under represented in the CNA 2022 dataset. Second, the changes in the findings from 2019 to 2022 must be considered in context of the broader changes experienced during this time. Specifically, the CNA 2022 measures how the community has fared after more than two years of COVID-19 pandemic response locally (i.e., data collection occurred from June 6 to August 2, 2022). During the data collection phase, many HNHSS and other health and social service providers still had pandemic-related restrictions in place, such as reduced in-person programming. This impacted the survey respondents because the CNA 2019 included more than one-third of responses as paper surveys collected from participants in HNHSS buildings and local libraries[3]. This decrease in response rates from program areas like current Ontario Works recipients may artificially inflate the improvement in some parameters. An effort was made to adjust for this sampling bias by providing the 11 survey pop-up booths that went into the community and sought out participation that represented the community at large.

Recommendations

A number of recommendations for future activities for HNHSS and health and social services providers came from the CNA 2022 dataset. The following outlines those recommendations and outlines potential ties to the health and social services priority areas locally.

Events, Meetings, and In-Person Service Options

Health and Social Services service providers, including HNHSS, should continue to consider safely (i.e. in context of COVID-19 considerations) and equitably (i.e. fairly, in context of various locations, needs, and preferences) increasing in-person service options and community

presence. Intentional planning to be present in both counties and to be available in more rural and isolated communities, including such activities as attendance at community events and stakeholder meetings, could be explored to fulfill the requests of residents. This recommendation aligns with the mental health priority area, amongst others, as it supports provision in more isolated areas.

HNHSS Service Hubs

In an attempt to address potential barriers to accessing health and social services through HNHSS and other agencies, development of a network of virtual hub spaces in HNHSS buildings or other partner locations could be considered. These hubs should have access to telephones, computers with internet access, a webcam, and a microphone, along with privacy barriers, to allow residents in more isolated areas of the two County service area to access the needed technology for virtual appointments. For example, this recommendation serves well to support those where housing is a priority, as they may not have access to these technologies in other ways.

HNHSS Communication Plan

A thorough Communication Plan that includes the types of activities and possibility of rebranding (i.e. reimagining the image of the HNHSS Division, including new logos, colours, etc.) should be considered. The Communication Plan could include insights from the Community Survey around awareness of services, preferred communication channels, and community demographics, as well as suggestions brought forward in interviews and focus group discussions around the broader idea of rebranding, which was described as a solution for general lack of program awareness.

Evaluation of Cost-for-Service Models

To make services more accessible and equitable across HNHSS programming, an assessment of which services currently require a cost to participate (e.g. in-person prenatal classes) and the target audiences for each program could be completed. A pilot project and evaluation program for improved program access could be undertaken later.

HNHSS Prioritization Activities

It is recommended that HNHSS uses the CNA as one of the guiding documents when completing annual Ministry service plans and determining service and program priorities. Using the CNA findings as a guiding document to inform the next several years of planning activities will help to put community needs at the center of the next strategic plan for HNHSS and will support relationship rebuilding by demonstrating that community engagement informs future action.

Health and Social Services System Integration

In response to staff and partner agency suggestions, health and social services agencies should work more closely together to reduce paperwork and redundancies in the intake system and in the transfer between programs or agencies. Specifically, participants noted that they were sometimes in a position of retelling their circumstances time-after-time

to work with multiple program areas simultaneously. For example, a client seeking housing supports, mental health supports, and substance use supports simultaneously may be asked to re-tell their story multiple times to multiple intake workers at various program agencies. An evaluation of programming intake processes and a continued quality improvement process should be considered.

Health and Social Services System Navigation Portal
Amongst the most commonly suggested ideas from participants was the idea for a system that would help community members identify available services. Internal staff, external partner agency staff, and individuals with various lived experiences each made some version of this suggestion. It was further substantiated by the high proportion of survey participants who reported they were 'somewhat' or 'not at all familiar' with health and social services programming (i.e. internally and broadly in the community). Moreover, many survey participants noted that a barrier to service was that they did not know where to look for services. Suggestions included an online portal system, 4-1-1-style phone line, or paper resources to help locate available services for various needs. An environmental scan of neighbouring areas and a comprehensive literature search should be conducted to determine the most effective and efficient models for implementing some sort of navigation portal at HNHSS. A diverse group of staff and individuals with lived-experiences could be engaged and consulted in this process.

Advocacy
A commonly noted responsibility of HNHSS was to encourage the prioritization of health and social services provisions within the community. This advocacy may take the form of leading the initiation of additional programming, requesting funding to operationalize programs, or other programming activities. The HNHSS Division may consider whether this perceived responsibility from participants is in line with the overarching operations of the Division.

Health Promotion Activities
Participants highlighted priority areas for education and information throughout the Community Survey and strategies and priorities for health promotion activities in the interviews and focus group discussions. The implementation of educational activities across a variety of formats is imperative for the success of a number of recommendations above. Specifically, health promotion activities could underpin recommendations such as attending events and meetings, development of an HNHSS Communications Plan, a health and social services navigation portal and related engagement activities, and provisions of education to the community and agency partners.

Next Steps

The HNHSS has demonstrated a desire to engage with the residents of Haldimand and Norfolk counties throughout the CNA 2022 process. The CNA 2022 serves as a launching pad for the HNHSS to move forward from the crucial and nearly all-consuming public health and social services emergency management tasks of the COVID-19 pandemic. The HNHSS is undergoing significant strategic planning initiatives and task prioritization that will be informed by the results of this CNA, and thus, the voices of the community.

Conclusions

The HNHSS CNA 2022 is one of the most comprehensive health and social services status reports available in the community at this time. The CNA aimed to describe current health and social status and changes since 2019, identify gaps in currently available health and social services provisions, and to support evidence-informed decision making locally. The CNA 2022 accomplished its goals and will be the foundation for related future activities.

The results of this assessment demonstrate that the community in Haldimand and Norfolk counties has changed in the last three years. There are many opportunities for HNHSS to grow and opportunities to fulfill the needs outlined by the participants. However, the role of partner agencies in accomplishing the goals set out in this report cannot be understated. The HNHSS Division may have a vital role to play in organizing partnerships and collaborations to accomplish these aims.

The HNHSS CNA 2022 will be considered within the new five-year strategic plan for the Health Unit. The CNA will be used in conjunction with multiple other documents and data. A move forward plan for health and social services in Haldimand and Norfolk will require a cohesive team of internal and external stakeholders who can address the identified needs together and lead where they have great strengths. The collaboration of other agencies will be essential to meet the recommendations contained in this report.

Additional Information

Requests for additional information, data, or presentations can be submitted to HNHSS by email at communications@hnhss.ca or by phone at 519-426-6170.

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Glossary

Beneficiary:
A beneficiary refers to an individual who indirectly receives Ontario Works money as part of a household that includes an individual who is supported by the program.

Community-Based:
Community-based research refers to research that is rooted in local participation. Active engagement is a crucial element of community-based research and work.

Data Validation:
Data validation refers to methods in qualitative or mixed-methods analysis that aim to examine the potential reflectiveness of the interpretation from the raw data and substantiate the claims made in the findings.

Environmental Scan:
An environmental scan refers to a broad, scoping assessment of available resources; aiming to cast a wide net that seeks to collect as much relevant information as available.

Health Equity:
Health equity refers to fair opportunities for good health for all individuals, regardless of any characteristics of their life, such as age, ethnicity, gender, or income.

Intentional Injuries:
Intentional injuries refers to all hospitalizations for individuals who were harmed due to self-inflicted, intentional injuries.

Low-Income Households:
Low-income status was defined according to the definition employed by Statistics Canada10 in the 2020 national census. Low-income households referred to a statistical threshold known as the "low-income measure, after-tax (LIM-AT)." According to Statistics Canada, LIM-AT is the fixed percentage of 50% median-adjusted after-tax income of private households. Specifically, at this time, the LIM-AT was: $26,503 (1 person), $37,480 (2 people), $45,904 (3 people), $53,005 (4 people), $59,005 (5 people), 64,918 (6 people) or $70,119 (7 people). Source: https://www12.statcan.gc.ca/census-recensement/2021/ref/dict/tab/index-eng.cfm?ID=t2_4

Mixed-Methods:
Mixed-methods refers to research that marries the use of both quantitative (i.e. numeric) and qualitative (i.e. text, visuals) methodologies or tools and datasets or outcomes.

Participatory:
Participatory research refers to research procedures that intentionally integrate community insights, activities, and opinions into the design, implementation, data collection, analyses, and interpretation of findings.

Priority Populations:
Priority populations referred broadly in this analysis to individuals who might experience health or social inequities as a result of social determinants of health, which are non-medical parameters that influence health outcomes, such as income or employment status.

Semi-structured Discussion:
A semi-structured interview or focus group discussion guide refers to a conversational guide tool that allows for increased flexibility compared to a traditional interview or conversation guide. Semi-structured guides allow for the probing of seemingly tangential ideas and the ability to skip questions entirely.

Statistical Significance:
Statistical significance refers to the likelihood that an outcome is due to chance alone, or is due to differing factors of interest. When applying a p-value of alpha <0.05, a statistical test assesses whether the outcome was likely to have occurred by chance alone, one in every 20 times.

Visible Religious Minority:
A visible religious minority, as it was intended in this survey, would include any identifying characteristic, garb, or otherwise, that an individual believes makes them identifiable to a group that is not the majority.

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Footnotes

[i]The most recently available cancer mortality data from Public Health Ontario's "Mortality from all cancers" snapshot is from the year 2015.

[ii]Survey respondents were primarily above the age of majority, with only 1.6% (n=33) of participants identifying as youth (e.g. aged 12-17 years).

Survey respondents represented a diverse cross-section of communities in Haldimand and Norfolk counties, with the largest proportion of participants coming from the two largest communities: Simcoe (20.6%, n=370) and Caledonia (12.4%, n=223).

CNA Community Survey over-represented females compared to males or gender non-conforming individuals, with 69.8% females (n=1,240, 27.7% males (n=492), and 1.1% gender non-conforming (n=20), but had better gender-diversity amongst respondents than in 2019 (2019= 80% female).

Survey respondents over-represented higher education levels, with 68.9% (n=1,228) of respondents having a college diploma or higher, which was similar to the representation across education levels in 2019 (2019= 67.8% college diploma or higher).

Survey respondents represented language distribution of Haldimand and Norfolk, with 93.5% (n=1,664) speaking English at home, compared to 93.0% for all residents[11].

Survey respondents also represented immigration status in Haldimand and Norfolk counties, with 7.6% (n=134) identifying as born outside of Canada, compared to 9.6% for all residents[11].

Survey respondents over-represented higher income brackets, with only 29.9% (n=533) of respondents reporting a household income of less than $50,000 per year, compared to 58.7% of all residents, which was less representative than in 2019 (2019= 46.4% with household income less than $50,000).

Survey respondents represented a diverse cross-section of employment statuses, with the largest proportion of participants reporting they were employed full time (47.2%, n=845), retired (21.2%, n=380), or employed part time (8.9%, 159).

[iii]Individuals were not provided with a definition or "example" of a visible religious minority in the survey.

Health and Social Services
Haldimand and Norfolk

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