ENVIRONMENTAL SCAN ASSESSING THE ACTIVITIES ENGAGED IN BY HEALTH UNITS AND COMMUNITY HEALTH CENTRES TO ADDRESS ACCESS AND EQUITY IN THEIR PROGRAM DELIVERY AND SERVICES

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Ontario Public Health Association
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Table of Contents

Table of Contents (cont'd)

List of Tables

Page

List of Figures

Page

Abstract

Public health is concerned with the health and well-being of the whole community, focusing on three areas including health protection, screening and health promotion. To be able to effectively and successfully pursue their goals and achieve their objectives, Public Health Units and Community Health Centres need to address access and equity issues as part of the overall planning, service delivery and evaluation agenda. Access and equity refer to the extent to which consumers are able to secure the services they need in a manner that ensures fairness and equal treatment of all members in the community.

The purpose of the study was to conduct an environmental scan to examine the policies, method and procedures engaged in by the Health Units and Community Health Centres in addressing issues relating to access and equity in their programs and service delivery. All the Health Units and Community Health Centres in Ontario were included in the study.

The overall findings indicated that almost all the Health Units and Community Health Centres, with very few exceptions (4-6 cases) had very good policies relating to access and equity, utilized several resources, including community partnerships and had very good records of incorporating access and equity in program development and dissemination. However, there were a few (six cases) that reported fair to poor performance of their agency's record. A comparison of the Community Health Centres and Health Units showed that the Community Health Centres had a better record of ensuring access and equity than the Health Units.

INTRODUCTION

Background

The World Health Organization presents a holistic view of health as the extent to which an individual or group is able to realize aspirations and satisfy needs; as well as the ability to change or cope with the environment (WHO, 2000). Health is therefore seen as a resource for wellbeing and quality of life with a focus on living up to one's potential in terms of being able to function physically, mentally, emotionally and socially. The availability of health care is an important aspect of having good health. There is also the general consensus that other determinants of good health include level of income, social status, education, employment opportunities, work place environment, physical environment, as well as family and friend supports. Public health is concerned with the health and well-being of the whole community, focusing on three areas: preventing conditions that may put health at risk (health protection), early detection of health problems (screening), and changing peoples' and societies' attitudes and practice regarding lifestyle choices (health promotion).

Health protection works particularly in the areas of food and water safety, environmental risks such as toxic waste handling and air pollution, second-hand smoke, public sanitation, spread of rabies, vaccination against major communicable diseases, and mandatory tuberculosis screening of immigrants to Canada. The screening programs are aimed at specific groups where the early detection of an illness or problem can lead to significant improvements in health. Examples of these programs are the healthy babies, healthy children program, preschool speech and language, school-age dental exams, and breast and cervical screening for cancer. The health promotion programs include the provision and education around tobacco use, nutrition, physical

activity, injury prevention, birth control and reproductive health, prevention of sexually transmitted diseases including HIV/AIDS, and breastfeeding.

Public health delivers its programs and services using a population health approach. This means that program outcomes are measured either on the public as a whole e.g. physical activity, dangers of second-hand smoke, or targeted sub-groups of the population such as expectant mothers (pre-natal health), high school students (drinking and driving), or women between the ages of 50-70 (breast cancer screening). Public health practitioners also aim to influence politicians and policy writers at all levels, to take into consideration the health implications of proposed policies.

A Public Health Unit is an official health agency established by the Ministry of Health and Long Term Care to provide all citizens of Ontario with prevention, protection and health promotion programs and services carried out by qualified staff. There are 37 public Health Units in Ontario. Health Units administer health promotion and disease prevention programs to inform the public about healthy life-styles, communicable disease control including education in STDs/AIDS, immunization, food premises inspection, healthy growth and development including parenting education, health education for all age groups and selected screening services. Each health unit is governed by a board of health, which is an autonomous corporation under the Health Protection and Promotion Act, and is administered by the medical officer of health who reports to the local board of health. The board is largely made up of elected representatives from the local municipal councils. The ministry cost-shares the expenses with the municipalities.

The role of boards of health (Health Unit) is to promote and protect the health of the population. To identify minimum standards for public health programs and services the board

must have understanding of health needs, interventions that can have positive impact on the needs, and appropriate roles within the achievable capacity of Ontario's Board of Health. The purpose of the standards is to set out the minimum requirements for fundamental public health programs and services targeted at prevention of disease, health promotion and health protection. These standards reflect broad aspirations for the health of all in Ontario and the important role of boards of health in providing and /or ensuring relevant programs and services.

To ensure that everyone in Ontario has access to public health programs and to reduce educational, social and environmental barriers to accessing mandatory public health programs, requirements and standards developed by the Ministry of Health (1997) include the following:

1. The board of health shall provide mandatory public health programs and services whenever practical and appropriate, which are accessible to people in special groups for whom barriers exist. Broadening access may require adjusting existing programs, promoting accessibility and developing special programs including special educational materials, tailored service delivery and active outreach.
2. When planning to use facilities and sites for mandatory public health programs, the board of health shall select those which are barrier-free and have suitable access for special groups.
3. The board of health shall establish ongoing community processes to identify needs, recommend approaches and monitor progress toward achieving access to the mandatory public health programs and services.

Community Health Centers are also set up with a primary role of supporting its community in meeting its health goals. The objectives of the Community Health Centres' program are to improve equity and access to health services and to "promote health and prevent

illness to enhance the health status of the individuals and communities served" (Wanke, M., Saunders, L., Pong, R., and Church, W., 1995). The Community Health Centers use multidisciplinary teams to deliver treatment and other services, a reflection of health in the broadest sense as the physical, mental and social wellbeing of the individual.

According to the Association of Ontario Health Centers (2000), the principles of Community Health Centres include the following:

1. Support the community in health planning and health action.
2. Regularly evaluate their services, programs and activities in collaboration with the community.
3. Strive to remove barriers that prevent people and communities from achieving full health potential.
4. Strive to equalize access to health care among all members of the community.
5. Use a multi-disciplinary team approach to ensure holistic and effective health care.
6. Have a responsibility for the dissemination of health information and resources to their community.

For Health Units and Community Health Centres to be able to effectively and successfully pursue their goals and achieve their objectives, access and equity issues would be expected to be addressed as part of the overall planning, service delivery and evaluation agenda. The mission of Ontario Public Health Association is to strengthen the impact of people who are active in community and public health throughout Ontario. This mission includes access and equity responsibilities in all levels and activities as well as a commitment to be free of systemic barriers, discriminatory behavior and harassment practices in every level of the organization.

Access refers to the extent to which consumers are able to secure the services they need; and are represented and/or participate in the planning, development, delivery and administration of those services (Ontario Public Health Association, 2000). Equity is addressed when public resources are distributed according to individual and community needs in order to substantially narrow the gap between the advantaged and the disadvantaged and to achieve improved levels of health and well being for all in Ontario. Ontario Public Health Association (2000) notes that equity as a public policy goal requires the movement toward achieving three major elements. These include 1) access to services (removal of barriers to existing services to achieve the access necessary to ensure maximum benefit); 2) participation in decision-making (the opportunities for effective and broader participation for a fair distribution of power and representation); and 3) better outcomes (differential opportunities for improved health and well being across populations and between communities).

Purpose of the Study

The purpose of this study was to conduct an environmental scan to examine resources and policies relating to access and equity in all Health Units and Community Health Centers in Ontario Province.

Objectives of the study

The objectives of the study included the following:

1. To examine the availability of corporate access and equity or equal access policies in the Health Units and Community Health Centres.

2. To identify methods and processes used by Health Units and Community Health Centers to establish community connections.
3. To examine the organizational record relating to access and equity of the Health Units and Community Health Centres.

METHODOLOGY

Population

The population of all the Health Units and Community Health Centres in Ontario were used for the study. This included 56 Community Health Centres and 37 Health Units. These agencies were contacted and a survey was mailed out to each of them. Completed surveys were returned from 54 agencies. Out of these completed surveys, four of them could not be included in the analysis due to incomplete responses and lack of information about access and equity procedures in these agencies. As a result, completed surveys from 50 agencies were included in the analysis. These agencies were composed of 21 Health Units (57% of all Health Units) and 29 Community Health Centres (52% of all Community Health Centres).

Data Collection

A survey instrument was developed and used to collect information for this study. The survey was composed of two major sections namely, demographic characteristics and organizational record. Demographic characteristics included information relating to contact of personnel responsible for access and equity issues in the agency and also the resources and community connections that were used. The organization record focused on the assessment of the agencies' practices relating to access and equity policies and financial support. It also

focused on areas relating to access and equity awareness; development and dissemination of resources; incorporation of access and equity in service delivery systems; development of partnerships with community groups, and hiring practices in reference to community representation.

The study included all the Health Units and Community Health Centres in Ontario. A majority of these centers (57 percent of Health Units and 52 percent of Community Health Centres) completed the surveys. From the follow up phone calls to the non-response group, it would be fair to assume that about half of the centers that did not respond to the survey did not find it applicable to their situation. This is because some of them did not have information about access and equity policy and practices in their agency and others did not respond due to the nature of their record. There may also be a bias opinion in the responses from the directors and Executive directors in their attempt to portray the image of their centers. However, in a majority of the centers, they were identified as the personnel in charge of issues relating to access and equity and so the surveys were sent to them.

Data Analysis

The SPSS statistical analysis program was used for the analysis of the data. Descriptive statistics, including frequencies, crosstabs and means were used for the analysis of the data.

FINDINGS

Title of Respondents

The respondents of the survey included individuals in a variety of positions (Table 1). They composed of Directors (7 cases), Executive Directors (13 cases), health promoters (6 cases)

and several other positions (23 cases). Only one respondent was identified as a multicultural health consultant.

Table 1. Title of respondents from agencies who completed the survey

TITLE OF RESPONDENT	FREQUENCY
Director	7
Executive Director	13
Health Promoter	6
Other	23
*Missing	1
Total	50

Years of Service Completed by Respondents

The years of service for respondents in these agencies varied from a minimum of one year to a maximum of 31 years (Table 2). The average years of service for all the respondents was 9 years.

Table 2. Years of service in the agencies completed by respondents

	Minimum	Maximum	Median	Mode	Mean
Years of service	1	31	9.5	6	9

Resources Used by Agencies to Ensure that Programs and Services are Accessible

The different resources used by agencies to ensure the accessibility of programs and services are presented in Table 3. The resource used most by agencies was staff (96 percent). Seventy-four percent also reported the use of multilingual resources to ensure the accessibility of programs and services. Outreach workers (69 percent) and other resources (45 percent) were also used by agencies to ensure accessibility of programs and services.

Table 3. Resources used by agencies in ensuring that programs and services are accessible

RESOURCES USED	FREQUENCY	PERCENTAGE
STAFF	47	96
MULTILINGUAL RESOURCES	37	74
OUTREACH WORKERS	34	69
OTHER (SPECIFY)	22	45

Willingness of Respondents to Share Resources

A majority of the respondents indicated a willingness to share their resources with other agencies (figure 1). Only two respondents indicated an unwillingness to share resources. However, 15 cases did not respond to this question. Contact information for the agencies are listed in Appendix A and Appendix B.

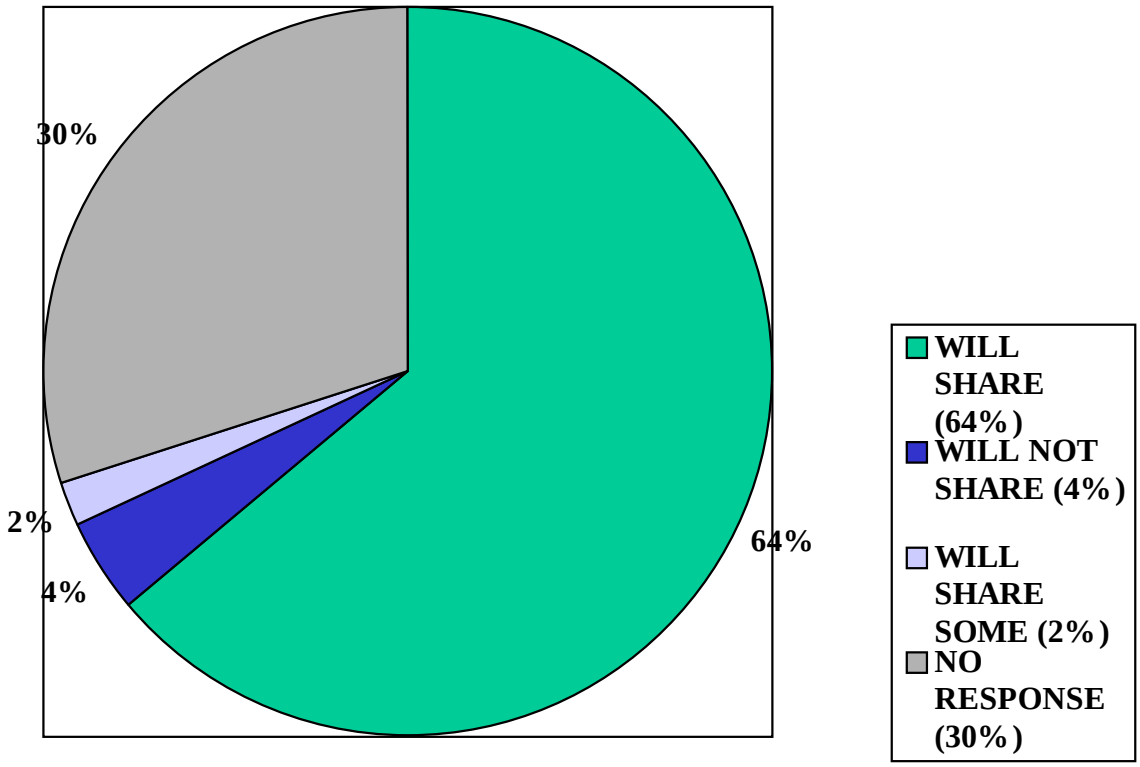

Figure 1. Willingness to share materials and resources used in agency

Community Connections Being Used by Organizations to Promote Access and Equity

The community connections being used by agencies to promote access and equity is presented in Table 4. The community connections most often used were partnerships (90 percent). Coalitions (60 percent) and working committee (52 percent) were also used for community connections. Only 32 percent of respondents reported the use of work groups.

Table 4. Community connections being used by organizations in promoting access and equity

COMMUNITY CONNECTIONS	FREQUENCY	PERCENTAGE
COALITIONS	30	60
WORK GROUP	16	32
WORKING COMMITTEE	26	52
PARTNERSHIP	45	90
TOTAL		

Development of Clear and Concise Policies on Access and Equity

A majority of the respondents (38 percent) reported that their agency had a very good record on the development of clear and concise policies on access and equity issues (Table 5). Those who reported an excellent record for their agencies were 26 percent. Only 21 percent (10 cases) of respondents reported that their agency had a good record while five respondents indicated a fair performance record for their agencies.

Table 5. Development of clear and concise policies on access and equity issues

PERFORMANCE RECORD	FREQUENCY	PERCENTAGE
Poor	1	2.1
Fair	5	10.6
Good	10	21.3
Very good	18	38.3
Excellent	12	25.5
*Missing	4	
Total	50	100

Provision of Financial and Staff Support to Address Access and Equity

About half of the respondents reported that their agencies had a very good record of providing financial and staff support to address access and equity issues (Table 6). Nineteen percent of the respondents reported that their agencies had an excellent record. Only 17 percent

reported that their agencies had a good record with 6 cases reporting a fair (4 cases) to poor (2 cases) performance for their agencies.

Table 6. Providing financial and staff support to address access and equity

PERFORMANCE RECORD	FREQUENCY	PERCENTAGE
Poor	2	4
Fair	4	8.3
Good	8	16.7
Very good	25	52.1
Excellent	9	18.8
*Missing	2	
Total	50	100

Creation of Awareness and Importance of Access and Equity

A majority of the respondents (70 percent) reported a very good (23 cases) to excellent (10 cases) record for their agencies on creating awareness of the importance of access and equity in their agencies (Table 7). Twenty-six percent of respondents reported a good performance. Only two cases reported a fair and poor performance.

Table 7. Creating awareness of the importance of access and equity

PERFORMANCE RECORD	FREQUENCY	PERCENTAGE
Poor	1	2.1
Fair	1	2.1
Good	12	25.5
Very good	23	48.9
Excellent	10	21.3
*Missing	4	
Total	50	100

Development and Dissemination of Appropriate Resources

A majority of the respondents (58 percent) reported a very good to excellent performance of their agencies relating to the development and dissemination of appropriate resources for access and equity (Table 8). Thirty-eight percent reported a good performance for their agencies. Only one case reported a fair performance and another case reported a poor performance.

Table 8. Developing and disseminating appropriate resources

PERFORMANCE	FREQUENCY	PERCENTAGE
Poor	1	2.1
Fair	1	2.1
Good	18	37.5
Very good	19	39.6
Excellent	9	18.8
*Missing	2	
Total	50	100

Incorporation of Access and Equity in Service Delivery System

Most of the respondents (54 percent) reported that their agencies had a very good record of incorporating access and equity in service delivery (Table 9). Twenty-six percent also reported an excellent performance while 10 percent reported a good performance. Only two cases reported a fair and poor performance.

Table 9. Incorporating access and equity in service delivery system

PERFORMANCE RECORD	FREQUENCY	PERCENTAGE
Poor	1	2.1
Fair	1	2.1
Good	5	10
Very good	27	54
Excellent	13	26
*Missing	3	
Total	50	100

Development of Partnerships with Community Groups

A majority of the respondents (88 percent) reported that their agencies had a very good (19 cases) to excellent (23 cases) record in developing partnerships with community groups (Table 10). Only 10 percent reported a good performance with just one case reporting a fair performance.

Table 10. Developing partnerships with community groups

PERFORMANCE RECORD	FREQUENCY	PERCENTAGE
Poor		
Fair	1	2.1
Good	5	10.4
Very good	19	39.6
Excellent	23	47.9
*Missing	2	
Total	50	100

Hiring Practices Relating to Community Representation

A majority of the respondents (38 percent) reported that their agencies had a very good performance relating to hiring practices that were representative of the community in which they worked (Table 11). Twenty-three percent reported a good performance and three cases reported a fair and poor performance.

Table 11. Hiring practices representing the community it serves

PERFORMANCE RECORD	FREQUENCY	PERCENTAGE
Poor	1	2
Fair	2	4.2
Good	11	22.9
Very good	18	37.5
Excellent	16	33.3
*Missing	2	
Total	50	100

Comparison of organizational record for Community Health Centres and Health Units relating to Access and Equity

A cross tabs analysis of the organizational record for the Health Units and Community Health Centres is presented in Table 12. More respondents from the Community Health Centers (21 respondents) reported that their agencies had a very good to excellent record of developing clear and concise policies on access and equity. Only nine respondents from the Health Units reported that their agencies had a very good to excellent record of developing clear and concise policies on access and equity. However, five respondents from the Health Units reported a fair to poor performance for their agencies on developing clear and concise policies on access, with only one respondent reporting a fair record on this for Community Health Centres.

Twenty-four respondents from Community Health Centres reported that their agencies had a very good to excellent record of providing financial and staff support towards access and equity concerns (Table 12). Ten respondents from Health Units also reported a very good to excellent record of their agency in providing financial and staff support for access and equity concerns. Six respondents from the Health Units reported a poor to fair record of their agency on providing financial and staff support and there were no reports of poor to fair performance for any of the Community Health Centres.

Twenty-one respondents from Community Health Centres and 12 respondents from Health Units reported that the record of creating awareness of the importance of access and equity in their agency was very good to excellent (Table 12). Only two respondents from the Health Units reported a poor to fair performance on their agency's record of creating awareness of the importance of access and equity. There was no report of poor to fair performance for Community Health Centres on the creation of awareness of the importance of access and equity.

A majority of respondents (21) who reported a very good to excellent record of their agency in developing and disseminating appropriate resources were from Community Health Centres (Table 12). Only seven respondents reported the same record for Health Units. A majority of respondents (12 respondents) from Health Units reported a good record of their agency in developing and disseminating appropriate resources. Only one respondent from a Community Health Centre reported a poor record and also, one respondent from a Health Unit reported a fair record.

Twenty-six respondents from Community Health Centres reported a very good to excellent record of their agency's efforts in incorporating access and equity in service delivery (Table 12). Respondents from Health Units with the same observation were only 14. There was

also only one respondent from a Community Health Centre who reported a fair record and one respondent from the Health Centre who reported a poor performance.

Almost all respondents from Community Health Centres (27 respondents) reported a very good to excellent record of their agency's record on developing partnerships with community groups (Table 12). Only 15 respondents from Health Centres reported the same record for their agencies with one respondent reporting a fair record.

Most respondents from the Community Health Centres (21 respondents) reported a very good to excellent record on the hiring practices of their agencies in representing the community (Table 12). Only 13 respondents from Health Units reported the same record for their agencies. One respondent also from a Health Unit reported a poor record his / her agency's hiring practices in relation to community representation.

Table 12. Response distribution of organizational record for Community Health Centres and Health Units

Organizational Record	Poor	Fair	Good	V. Good	Excellent	Total
Developing Clear and concise policies						
Community Health Centre		1	4	10	11	27
Health Unit	1	4	6	8	1	20
Providing financial and staff support						
Community Health Centre			4	8	6	28
Health Unit	2	4	4	7	3	20
Creating awareness of importance of access and equity						
Community Health Centre			6	14	7	27
Health Unit	1	4	6	9	3	20
Developing and disseminating appropriate resources						
Community Health Centre	1		6	15	6	28
Health Unit		1	12	4	3	20
Incorporating access and equity in service delivery						
Community Health Centre		1	1	16	10	28
Health Unit	1		4	11	3	20
Developing partnerships with community groups						
Community Health Centre			1	13	14	28
Health Unit		1	4	6	9	20
Hiring practices representing the community						
Community Health Centre		1	6	10	11	28
Health Unit	1	1	5	8	5	20

DISCUSSION OF FINDINGS

Access and equity are essential to achieving health for all through effective health programs and services. Review of findings from the survey showed that a majority of the Health Units and Community Health Centres had policies relating to access and equity. Respondents indicated a good to excellent policy record for almost all the centers. There were only six cases that reported a fair performance record, relating to policy on access and equity.

A majority of the respondents (69 percent) also reported a very good to excellent record of awareness of the importance of access and equity. Twenty-seven percent of the respondents also reported a good awareness of their centers on the importance of access and equity with only one case reporting a poor awareness.

According to Wanke et al. (1995), the strengths of community-based services are its holistic and social oriented approaches to addressing individuals and population health needs. As such, its emphasis on partnerships with community groups in addressing the health of the community is critical. Findings indicated that the most popular method used to establish community connections was community partnerships for the centers included in the study. Other methods included coalitions, working committees and work groups.

An examination of the organizational records of the Health Units and Community Health Centres showed that a majority of them had developed clear and concise policies and provided financial and staff support to address access and equity. Respondents also reported a very good to excellent record of the development and dissemination of appropriate resources, and the incorporation of access and equity in service delivery systems. Findings also indicated that the centers were also engaged in very good hiring practices, which were representative of the communities in which they worked.

A comparison of the organizational record for Health Units and Community Health Centres showed that in general, the community centers had a better record relating to access and equity than the Health Units. About half of the respondents from Health Units reported a very good to excellent record of their agency's record on access and equity. However, there was almost twice as much respondents from Community Health Centres who reported a very good to excellent record of their agency's record on access and equity. There were also more reports of fair to poor record on access and equity by respondents from Health Units (15) than respondents from Community Health Centres (4).

Limitations of the study

1. Twenty of the respondents were directors and executive directors of their agencies who may be more likely to give a more positive assessment of their agency's record.
2. The degree of access and equity was not defined for the respondents so the responses were based on individual respondent's measurement of access and equity.
3. The survey used for this study did not include questions about evidence of outcomes claimed by the respondents.

Conclusions

The overall findings indicated that almost all the centers, with very few exceptions (2-5 cases) had very good policies relating to access and equity, utilized several resources, including community partnerships and had very good records of incorporating access and equity in program development and dissemination. However, there were a few (six cases) that reported fair to poor performance of their agency's record. A comparison of the Health Units and

Community Health Centres showed that the Community Health Centres had a better record than the Health Units.

There were more responses from the Community Health Centres (29 respondents out of 56) than the Health Units (21 respondents out of 37). However, the non-response group composed of agencies that did not have information about their agency's record on access and equity or the record was not good and therefore, refused to report.

Future Research

An examination of individual agency's evaluation mechanisms on access and equity would be useful in a further study.

References

1. Association of Ontario Health Centres. (2000). Community health principles. Retrieved on 5th August, 2000. http://www.aohc.org/default.next.htm

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3. Ontario Public Health Association. (2000). Access and Equity Policy. OPHA: Ontario

4. Wanke, M., Saunders, L., Pong, R., and Church, J. (1995). Building a stronger foundation: A framework for planning and evaluating community-based health services in Canada. Health Quality and Outcomes Research Centre: Edmonton, Alberta

5. WHO. (2000). World Health Report 2000: Health systems – improving performance. Geneva: WHO, 2000.

Appendix A: Contact List of Personnel from Ontario Health Units

Health Unit	City/Town	Name / Title	Telephone #
Chatham-Kent Public Health Division	Chatham	Shirley Davies, Manager, Health Promotion	(519) 352-7270
Eastern Ontario Health Unit	Cornwall	Dr. Robert Bourdeau, Medical Officer of Health	(613) 933-1375
Leeds, Grenville & Lanark District Health Unit	Brockville	Dr. Charles Gardner Medical Officer of Health	(613) 345-5685
Muskoka-Parry Sound Health Unit	Bracebridge	Dr. Salawa Bishay	(705) 645-4471 www.mpshu.on.ca
Regional Niagara Public Health Department	St Catharines	Dr. David Klooz	(905) 688-3762 www.regional.niagara.on.ca
Northwestern Health Unit	Kenora	Bob Jeffery, Health Planner	(807) 468-3147
Oxford County Board of Health	Woodstock	Director, Public Health and Planning	(519) 539-9800
Peterborough County-City Health Unit	Peterborough	Maureen McKeen	(705) 743-1000
Porcupine Health Unit	Timmins	Director, Public Health and Planning	(705) 267-1181

Appendix A: Contact List of Personnel from Ontario Health Units (cont'd)

Health Unit	City/Town	Name / Title	Telephone #
Sudbury & District Health Unit	Sudbury	Dr. Penny Sutcliffe Medical Officer of Health	(705) 522-9200
Timiskaming Health Unit	New Liskeard	Esther Millar, Director, Health, Clinical and Preventive Services	(705) 647-4305
Toronto Public Health	Toronto	Wendy Kwong Multicultural Health Consultant	(416) 392-7401
York Region Health Services	York Region	Diane Bladek Willett	(905) 895-4511
Wellington-Dufferin-Guelph Health Unit	Fergus	Wayne Orr / Janet Fowler (Director of Nursing)	(519) 843-2460
Windsor-Essex County Health Unit	Windsor	Intake Nurse	(519) 258-2146

Appendix B: Contact List of Personnel from Ontario Community Health Centres

Community Health Centre	City/Town	Name / Title	Telephone #
Access Alliance Multicultural Community Health Centre	Toronto	Sonja Nerad, Health Programs Coordinator	(416) 324-8677
Carlington Community & Health Services	Ottawa	Michael Birmingham	(613) 722-4000
Central Toronto Community Health Centre	Toronto	Patricia O'Connor Health Promotion Coordinator	(416) 703-8480
Centre de santé communautaire de l`Estrie	Cornwall	Roland Beaulieu	(613) 937-2683
Centre de santé communautaire Hamilton-Wentworth-Niagara Francophone Community Health Centre	Hamilton	Florence Ngenzghlhoro	(905) 528-0163
Centre de santé communautaire Hamilton-Wentworth-Niagara	Welland	Annemarie Ersell	(905) 734-1141
Centre de santé communautaire de Sudbury	Sudbury	Lorraine Leblanc, Health Promoter	(705) 670-2274
Davenport-Perth Neighborhood Centre	Toronto	Cliff Leowds, Director, Community Support Services	(416) 656-8025

Appendix B: Contact List of Personnel from Ontario Community Health Centres (cont'd)

Community Health Centre	City/Town	Name / Title	Telephone #
East End Community Health Centre	Toronto	Pallavi Kasyap	(416) 778-5858
The Four Villages Community Health Centre	Toronto	Kasia Filaber	(416) 604-3361
Gateway Community Health Centre	Tweed	Executive Director	(613) 478-1211
Kitchener Downtown Community Health Centre	Kitchener	Gebre Berihun	(519) 745-4404
Lakeshore Area Multi-Service Project (LAMP)	Toronto	Daniel McSweeney, Health Promoter	(416) 252-6471
Langs Farm Village Association	Cambridge	Bill Davidson, Executive Director	(519) 653-1470
Lawrence Heights Community Health Centre	Toronto	Karen Yik	416) 787-1661
London Intercommunity Health Centre	London	Anthoula Doumkou	(519) 660-0874

Appendix B: Contact List of Personnel from Ontario Community Health Centres (cont'd)

Community Health Centre	City/Town	Name / Title	Telephone #
Longlac Community Health Centre	Langlac	Brenda Lennon	(807) 876-2271
Misiway Eniniwuk Community Health Centre	Timmins	Angie La-Fontaine	(705) 264-2200
North Hamilton Community Health Centre	Hamilton	Nora Lopez, Community Worker	(905) 523-6611
North Lambton Community Health Centre	Forest	Willa Greenwood, Health Promotion Coordinator	(519) 786-4545
Ogden East End Community Health Centre	Thunder Bay	Alison McMullen	(807) 622-8235
Parkdale Community Health Centre	Toronto	Susan Gaptra	(416) 537-2455
Pinecrest Queensway	Ottawa	Debbie Johnson	(613) 820-4922
Rexdale Community Health Centre	Toronto	Executive Director	(416) 744-0066

Appendix B: Contact List of Personnel from Ontario Community Health Centres (cont'd)

Community Health Centre	City/Town	Name / Title	Telephone #
Somerset West Community Health Centre	Ottawa	Sheryl Smith / Maureen Morris	(613) 238-8210
South Riverdale Community Health Centre	Toronto	Elsie Petch, Health Promoter	(416) 461-1925
Southeast Ottawa Community Health Centre	Ottawa	Joanne Macdrew	(613) 737-5115
West Elgin Community Health Centre	West Lorne	Cynthia Roodzant	(519) 768-1715
Women's Health in Women's Hands	Toronto	Notisha Maseaqued	(416) 593-7655
Woolwich Community Health Centre	St. Jacobs	Robin Hicken	(416) 324-2731

ACCESS AND EQUITY POLICY SURVEY

A: DEMOGRAPHIC CHARACTERISTICS

Title of respondent: _____ Years of Service: _____

Name of Centre / Organization: _____ City: _____

1. Which of these resources are used by your organization in ensuring that programs and services are accessible? (check all that apply)

   ◘ Staff ◘ Multilingual resources (pamphlets / flyers) ◘ Outreach workers
   ◘ Other (specify) ……

2. Would your agency be willing to share resource materials used in your organization? ……...
   Name of contact person: ……

3. Which of these community connections are being used by your organization in promoting access and equity? (check all that apply)

   ◘ Coalition ◘ Work group ◘ Working committee ◘ Partnerships
   ◘ Other (specify) ……

B: ORGANIZATION RECORD

Please answer all of the following questions by checking the appropriate box. N/A= not applicable

How do you assess your organization's record on **access** and **equity** (A&E) in its service delivery:

	Poor				Excellent	N/A
	1	**2**	**3**	**4**	**5**	
4. Developing clear and concise policies on access and equity issues	◘	◘	◘	◘	◘	◘
5. Providing financial and staff support to address access and equity issues	◘	◘	◘	◘	◘	◘
6. Creating awareness of the importance of access and equity	◘	◘	◘	◘	◘	◘
7. Developing and disseminating appropriate resources	◘	◘	◘	◘	◘	◘
8. Incorporating access and equity in your service delivery system	◘	◘	◘	◘	◘	◘
9. Developing partnerships with community groups	◘	◘	◘	◘	◘	◘
10. Hiring practices representing the community it serves	◘	◘	◘	◘	◘	◘

Thank you