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Ontario Dietitians in Public Health
Diététistes en santé publique de l'Ontario

Actions by Ontario Public Health Units to Address Household Food Insecurity
Results of an Environmental Scan of Ontario Public Health Units

January 2020

Ontario Dietitians in Public Health (ODPH) is the independent and official voice of Registered Dietitians working in Ontario's public health system. ODPH provides leadership in public health nutrition by promoting and supporting member collaboration to improve the health of Ontario residents through implementation of the Ontario Public Health Standards.

Acknowledgements

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Table of Contents

Executive Summary

The Ontario Dietitians in Public Health Food Insecurity Workgroup (ODPH FIWG) is a group of Registered Dietitians (RDs) who provide opportunities for knowledge exchange, collaboration, and advocacy, working towards effective solutions for household food insecurity (HFI). Between June and August 2019, ODPH FIWG conducted an environmental scan to better understand the actions taken by public health units (PHUs) across Ontario to address HFI within their jurisdiction or region.

Key Findings

Of the 35 PHUs within Ontario, 33 PHUs (94%) (7 northern PHUs, 26 southern PHUs) responded to the survey. Four PHUs (12%) (0 northern PHUs, 4 southern PHUs) identified that they are unable to carry out advocacy work or that opportunities to advocate through their PHU are very limited.

Three themes emerged, each representing a variety of actions Ontario PHUs are taking to address HFI: awareness-raising and education; community partnerships; and government engagement. Thirty-three PHUs (100%) reported participation in awareness-raising and education activities by RDs and other public health staff (e.g., public health nurses, health promoters). Some of the activities reported were developing educational materials, conducting literature reviews, producing media releases, conducting social media campaigns, and leading training, presentations and other community events. Thirty-one PHUs (94%) (6 northern PHUs, 25 southern PHUs) reported collaborations with community partners by RDs and other public health staff. Some of the partnerships reported were with educational institutions, non-profit organizations, social agencies, community coalitions, local task forces, advisory committees, and provincial organizations. Thirty-one PHUs (94%) (7 northern PHUs, 24 southern PHUs) reported engagement with government by RDs and other public health staff. Some of the government engagement strategies reported were disseminating communication materials or organizing community events before government elections, writing letters, sending reports, meeting with government representatives, participating in consultations, and collaborating with municipal staff.

An additional area PHUs are exploring to reduce HFI is local level strategies to increase incomes directly or strategies to reduce certain costs of living (e.g., transportation, child care). PHUs reported various staff involved in this work, such as RDs, public health nurses, health promoters, and medical officers of health. Thirty PHUs (91%) (5 northern PHUs, 25 southern PHUs) reported supporting at least one local level strategy, with the nature or type of support provided varying widely across PHUs. Increasing access to affordable housing was the most frequent reported local level strategy among both northern and southern regions (21 PHUs (64%); 3 northern PHUs, 18 southern PHUs).

Six PHUs (18%) (0 northern PHUs, 6 southern PHUs) reported RD involvement with at least one local level strategy, with the nature or type of support provided varying widely across PHUs. RD involvement was reported in the areas of free income tax preparation clinics; affordable housing; affordable and accessible transportation; education and training; and child care/early childhood development.

Limitations

The environmental scan was sent to one RD key informant from each PHU. It is possible that some topics or activities were overlooked or under-reported. In addition, respondents may have interpreted survey questions in different ways, potentially causing under-reporting of certain topics or activities. No specific timeframe was stated for key informants to report on for the HFI-related activities. It is unknown whether including a specific timeframe would have captured additional responses for some activities. Answer prompts for the last survey question may also have limited the key informants from including topics not mentioned in the question. Finally, survey distribution during the summer may have impacted the key informants' ability to complete the survey and consult with other internal colleagues.

Next Steps

The compiled information will help inform ODPH members and other stakeholders and provide examples of actions to address HFI by public health that could be considered for adaptation and implementation within various regions and across the province. Inter-disciplinary collaboration among PHU RDs and other public health professions, such as public health nurses and health promoters, is essential. RDs have the foundational knowledge, skills, and experiences related to HFI and as such, are important frontline staff and consultants to help inform the HFI-related work of their multidisciplinary colleagues. Further research focusing on the evidence and effectiveness of the strategies included in this report is needed to better understand this important work.

Introduction

Household food insecurity (HFI) is the "inadequate or insecure access to food due to financial constraints" (PROOF, 2018). Although recognized by stakeholders as a serious problem affecting physical, mental, and social health, 1 in 7 households (15.1%) in Ontario are still food insecure (PROOF, 2019). Food insecurity is recognized as a key social determinant of health in the Ontario Public Health Standards (2018) and impacts health equity. As a result, health professionals working in public health units (PHUs) across Ontario have developed, collaborated, and contributed to actions addressing HFI.

The Ontario Dietitians in Public Health Food Insecurity Workgroup (ODPH FIWG) conducted an environmental scan to better understand the actions taken by PHUs across Ontario to address HFI within their jurisdiction or region. The purpose of the environmental scan was to help inform local and provincial stakeholders (e.g., local community partners, PHUs, ODPH FIWG) on priorities and actions to address HFI and/or income security.

Summary of Methods

In June 2019, an environmental scan consisting of three survey questions[1] was developed with the support of Algoma Public Health focusing on actions taken to increase stakeholder awareness of food insecurity; achieve a policy response at all levels of government with respect to HFI; and support local level strategies to increase incomes or decrease costs of living.

The environmental scan was emailed in a Word document to 35 Ontario PHUs between June to August 2019 by two dietetic practicum students from Brescia University College who were completing research and population health placements at the Middlesex-London Health Unit and with the ODPH FIWG. The students invited one key informant from each of the 35 health units to respond to the survey questions. Key informants were members of the ODPH FIWG or PHU colleagues identified by ODPH FIWG members. Additional reminder emails were sent out by the students and the students' preceptor. Of the total surveys distributed, responses were returned through email from 33 Ontario PHUs (94%).

Key informants were encouraged to collaborate with other internal health unit colleagues who were also responsible for HFI related activities so that robust responses reflecting the multidisciplinary work completed in this public health programming area were captured. However, key informants were not asked to identify whether they had consulted with colleagues for the responses.

[1] See Appendix 1

Data Analysis and Interpretation

The three question survey responses were first analysed by the dietetic practicum students. The students reviewed the survey responses and performed content analysis independently and simultaneously. Findings were then triangulated with their preceptor. Any discrepancies in the naming of themes or categorization of information into themes were discussed with the two students and the preceptor and agreement was made to reduce the original six themes into three. The three themes agreed upon reflected the type of work typically conducted by public health professionals (i.e., awareness-raising and education, community partnerships, and government engagement).

Once the three themes were set, each response from every survey was coded under each specific theme. A secondary thematic description was completed to add additional detail to the coded themes. This secondary coding was completed by the preceptor after the students had completed their rotation at the Middlesex-London Health Unit and with the ODPH FIWG.

The environmental scan responses were divided into two groups: those representing the northern region (7 PHUs) and those representing the southern region (26 PHUs) of Ontario.[2] Grouping the responses regionally helped reveal potential differences between these two geographic areas and may be of interest to individual PHUs when reviewing the reported descriptive statistics or full responses.

For the final survey question, frequency counts were also completed for each local level strategy reported. Counts were completed by region (i.e., northern PHUs, southern PHUs) and profession specific involvement (i.e., RD reported involvement, any PHU staff reported involvement).

Key Findings

Of the 35 PHUs within Ontario, 33 PHUs (94%) (7 northern PHUs, 26 southern PHUs) responded to the survey. Thirty-two key informants (97%) (7 northern PHUs, 25 southern PHUs) were members of the ODPH FIWG.

Four PHUs (12%) (0 northern PHUs, 4 southern PHUs) identified that they are unable to conduct advocacy work or that opportunities to advocate through their PHU are very limited. Two PHUs (6%) specified this restriction was due to their PHU structure within the regional government.

Themes

PHUs participated in a variety of core actions to address HFI through increasing stakeholder awareness of the causes of HFI, as well as having knowledge of income-based solutions, and

[2] See Appendix 2 for a map of the northern and southern PHU regions

achieving effective policy responses. Three themes emerged, each representing a variety of actions Ontario PHUs are taking to address HFI: awareness-raising and education; community partnerships; and government engagement.

Most of the reported activities below capture the key informants' PHU specific activities that may or may not be part of the ODPH FIWG activities.

Theme 1: Awareness-Raising and Education

Thirty-three PHUs (100%) reported participation in awareness-raising and education activities by RDs and other public health staff (e.g., public health nurse, health promoter).

Thirty-one PHUs (94%) (7 northern PHUs, 24 southern PHUs) reported monitoring food affordability using the annual Nutritious Food Basket (NFB) costing survey.[3] Survey findings were used to increase awareness of and educate on the problem of HFI through various strategies and products including media releases, social media campaigns, presentations, and infographics.

Eight PHUs (24%) (3 northern PHUs, 5 southern PHUs) reported participating in the ODPH *No Money for Food is Cent$less* campaign to increase awareness of and advocate for income solutions that address HFI.[4] The use of social media platforms as a method of communication was a recurring theme.

Some of the awareness-raising and education activities reported were:

- Developing educational materials (e.g., infographics, reports, web content, newspaper articles)[5]
- Conducting literature reviews (e.g., local level strategies to address food insecurity)[6]
- Producing media releases (e.g., related to poverty reduction, food affordability, HFI)[7]
- Conducting social media campaigns (e.g., related to elections, poverty reduction, NFB, HFI)[8]
- Presenting the OSNPPH Position Statement on Responses to Food Insecurity to the Board of Health and/or local community groups[9]
- Training (e.g., for community partners, Health Unit staff)[10]

[3] See Appendix 3: PHUs 20-24, 26, 29; Appendix 6: PHUs 1-6, 8, 10-15, 17-19, 25, 27-28, 30-31, 33; Appendix 7: PHUs 3, 6, 9-10, 13-14, 16-17, 30-31
[4] See Appendix 3: PHUs 20, 23; Appendix 4: PHUs 20, 22; Appendix 6: PHUs 1, 3-4, 25, 30; Appendix 7: PHU 25
[5] See Appendix 3: PHUs 20-21, 23-25, 29; Appendix 4: PHU 20; Appendix 6: PHUs 1-7, 10-19, 25, 27-28, 30-31, 33; Appendix 7: PHUs 1-4, 6, 9-11, 13, 16-18, 30
[6] See Appendix 4: PHU 24; Appendix 6: PHU 25
[7] See Appendix 3: PHUs 20-21, 23; Appendix 6: PHU 30
[8] See Appendix 3: PHUs 23-24, 29; Appendix 4: PHU 24; Appendix 7: PHUs 16-17
[9] See Appendix 6: PHUs 1, 10, 13, 17, 32; Appendix 7: PHUs 2, 4, 17, 19, 28, 30
[10] See Appendix 3: PHUs 22, 24, 26, 29

- Presentations (e.g., to Boards of Health, municipal council)[11]
- Community events and workshops (e.g., high school play, HFI forum, election candidate meetings, poverty awareness events)[12]

Some of the unique awareness-raising and education activities reported that may be of interest to other PHUs were:

- Creation and promotion of a video that tells the story of a local woman with lived experience of HFI[13]
- Authorship and performance of a one-act play by a local high school as an effort to increase awareness about food access[14]
- Investigation of internal policy opportunities for the use of standardized language during any fundraisers for food charities within their workplace[15]
- Consultations with local stakeholders to understand their beliefs and attitudes about the issue of food insecurity, its root cause, and solutions, and to identify the role they can play in addressing food insecurity, in collaboration with the local PHU[16]
- Use of specific communication strategies from "A New Way to Talk about the Social Determinants of Health" (Robert Wood Johnson Foundation, 2010)[17]

Theme 2: Community Partnerships

Thirty-one PHUs (94%) (6 northern PHUs, 25 southern PHUs) reported collaborations with community partners by RDs and other public health staff (e.g., public health nurses, health promoters) (See Table 1). Some of the common partnerships reported were with:

- Educational institutions (e.g., colleges, universities)[18]
- Community organizations (e.g., non-profits, social agencies, social services) and community coalitions, local task forces and advisory committees (e.g., poverty reduction, food action, basic income, food network, housing, food policy council)[19]
- Provincial organizations (e.g., ODPH, alPHa, OPHA)

[11] See Appendix 3: PHUs 20-21, 23-24, 29; Appendix 4: PHU 23; Appendix 6: PHUs 1-3, 7, 10-12, 14, 16, 18-19, 25, 28, 30, 31; Appendix 7: PHUs 13-14, 16, 30
[12] See Appendix 3: PHUs 23-24; Appendix 6: PHU 11; Appendix 7: PHUs 5, 7, 16
[13] See Appendix 6: PHU 2
[14] See Appendix 6: PHU 11
[15] See Appendix 6: PHU 17
[16] See Appendix 7: PHU 25
[17] See Appendix 6: PHU 7
[18] See Appendix 6: PHUs 11, 18, 30
[19] See Appendix 3: PHUs 20-24, 26; Appendix 4: PHUs 21-22, 24; Appendix 5: PHUs 20, 24, 26; Appendix 6: PHUs 2-3, 5, 7, 9-13, 16-19, 25, 27, 30, 32-33; Appendix 7: PHUs 2-3, 7-8, 10, 16, 25, 27; Appendix 8: PHUs 1-4, 6, 8, 10-13, 16-19, 25, 28, 31-33

Table 1. Number of Public Health Units (PHUs) Reporting Community Partnerships

Region	**Number of PHUs Reporting Theme 2**
Northern	6/7 (86%)
Southern	25/26 (96%)
Total	31/33 (94%)

Many PHUs reported community partnership activities that may be of interest to other PHUs. Some of the activities reported were:

- Working with high school social justice committees to educate about the root causes of HFI, need for income-based solutions, and opportunities to raise the issue politically in student communities[20]
- Partnerships with local universities to collect data from residents with lived experience of poverty and/or HFI to help inform local work[21]
- Creation of a college campus advocacy tool related to student HFI[22]
- Medical Officer of Health chairs the local food action group. Partners report this is helpful in giving their messages a stronger weight in the community and when participating in advocacy strategies.[23]

Theme 3: Government Engagement

Thirty-one PHUs (94%) (7 northern PHUs, 24 southern PHUs) reported engagement with government by RDs and other public health staff (e.g., public health nurses, health promoters (See Table 2). PHUs reported various engagement strategies with various levels of government, including municipal, provincial, and federal.

Some government engagement strategies reported were:

- Disseminating communication materials or organizing community events before government elections[24]
- Writing letters and/or sending reports to municipal, provincial or federal government representatives[25]

[20] See Appendix 6: PHU 16
[21] See Appendix 6: PHUs 11, 30
[22] See Appendix 6: PHU 18
[23] See Appendix 6: PHU 7
[24] See Appendix 3: PHUs 20, 23-24; Appendix 4: PHUs 20, 22, 24, 26; Appendix 6: PHUs 2, 10, 16, 25; Appendix 7: PHUs 7, 10, 16-17; Appendix 8: PHU 10
[25] See Appendix 4: PHUs 20-21, 23, 26, 29; Appendix 6: PHUs 1, 3-4, 7, 10-13, 15, 19, 31; Appendix 7: PHUs 1-4, 7, 10, 12-14, 16-19, 25, 27, 30

- Meeting with and/or presenting to government representatives[26]
- Participating in government consultations (e.g., related official plans, housing strategies, poverty reduction strategies)[27]
- Collaborating with municipal staff, including membership on committees (e.g., steering committees, task forces)[28]

Table 2. Number of Public Health Units (PHUs) Reporting Government Engagement

Region	**Number of PHUs Reporting Theme 3**
Northern	7/7 (100%)
Southern	24/26 (92%)
Total	31/33 (94%)

One PHU reported conducting an evaluation with key decision makers, including media and government representatives, to determine the usefulness of past advocacy efforts and resources and recommendations for future advocacy efforts.[29] Key recommendations to improve advocacy efforts included providing local data and local contact information for each region, and including a human story to illustrate a real life account behind the numbers. The recommendations informed the development of a multi-year campaign that addressed myths of people living in poverty. A local Member of Parliament referenced the campaign materials to the special committee tasked with the development of Ontario's previous poverty reduction strategy.

Local Level Strategies to Increase Incomes or Decrease Costs of Living

Thirty PHUs (91%) (5 northern PHUs, 25 southern PHUs) reported supporting at least one local level strategy, with the nature or type of support provided varying across PHUs.[30] Reported participation for each strategy ranged from 7 (21%) to 21 (64%) PHUs (see Table 3). Child care / early child development was the least frequent reported local level strategy (7 PHUs, 21%). Increasing access to affordable housing was the most frequent reported local level strategy among both northern and southern regions (21 PHUs, 64%). The type of support for increasing access to affordable housing varied widely among PHUs, including providing referrals, assisting

[26] See Appendix 3: PHUs 23-24, 29; Appendix 4: PHU 29; Appendix 6: PHUs 3, 7, 16-17, 19, 27, 31; Appendix 7: PHUs 3, 8, 13, 16; Appendix 8: PHUs 16, 25, 27
[27] See Appendix 5: PHUs 21, 26; Appendix 6: PHUs 1, 9, 16, 19; Appendix 7: PHUs 1, 4, 8-10, 13, 33; Appendix 8: PHUs 1, 7, 9-10, 12, 14, 16, 28, 32
[28] See Appendix 4: PHUs 21; Appendix 6: PHUs 12, 18; Appendix 7: PHU 16; Appendix 8: PHUs 3, 12-13, 16, 25, 32
[29] See Appendix 7: PHU 16
[30] The data presented include only those initiatives supported by public health staff; some PHUs reported initiatives supported only by city or social services staff. See Appendices 5 and 8 for all responses.

with paperwork, writing reports, presenting to municipal council, participating in consultations (e.g., housing reviews, official plan reviews, proposed zoning and by-law amendments), participating on local advisory committees and coalitions, and conducting research to help inform local affordable housing policies, programs, services, and strategies.

Table 3. Number of Public Health Units (PHUs) Reporting Local Level Strategies to Increase Incomes or Decrease Costs of Living

Region	**Free Income Tax Clinics**	**Increasing Access to Affordable Housing**	**Affordable and Accessible Transportation**	**Education and Training**	**Child Care/Early Childhood Development**	**Health Services and Benefits**
Northern	3/7 (43%)	3/7 (43%)	2/7 (29%)	3/7 (43%)	2/7 (29%)	2/7 (29%)
Southern	10/26 (38%)	18/26 (69%)	14/26 (54%)	8/26 (31%)	5/26 (19%)	8/26 (31%)
Total	13/33 (39%)	21/33 (64%)	16/33 (48%)	11/33 (33%)	7/33 (21%)	10/33 (33%)

One PHU reported involvement in a financial empowerment project that included income tax preparation for low income households at no cost.[31] Since the program started 1.5 years ago, an estimated $3.6 million has been received by local residents through refunds and tax credits.

Some PHUs reported participation in other local level strategies, in addition to the strategies included in the original survey question. The most frequent reported strategies were:

- Living Wage (13 PHUs, 39%) (0 northern PHUs, 13 southern PHUs)[32]
- Affordable access to recreation (5 PHUs, 15%) (1 northern PHU, 4 southern PHUs)

In addition, 2 PHUs reported creating an income supports document for internal staff and community nurses to discuss income and provide referrals.[33]

PHUs reported various staff involved in HFI-related activities, such as RDs, public health nurses, health promoters, and medical officers of health. Six PHUs (18%) (0 northern PHUs, 6 southern PHUs) specifically reported RD involvement with at least one local level strategy, with the nature or type of support provided varying across PHUs. RD involvement was reported in the areas of free income tax preparation clinics[34]; affordable housing[35]; affordable and accessible

[31] See Appendix 8: PHU 19
[32] Reported by PHUs 2-4, 7, 10-11, 13, 16, 19, 25, 27-28, 32
[33] See Appendix 6: PHU 3; Appendix 8: PHU 18
[34] See Appendix 8: PHUs 10, 17, 31
[35] See Appendix 8: PHUs 8, 17, 32

transportation[36]; education and training[37]; and child care/early childhood development[38]. Reported RD involvement for each strategy ranged from 0 (0%) to 4 (12%) PHUs (See Table 4). Health services and benefits was the least frequent strategy reported with RD involvement (0 PHUs, 0%). Increasing access to affordable housing was the most frequent reported local level strategy with RD involvement (4 PHUs, 12%).

RD involvement within each strategy varied among PHUs. For example, RD support for free income tax preparation clinics ranged from promoting clinics to increasing community capacity for clinics. One PHU RD reported actively working with community partners, including networking, planning, coordination, securing private business funding, addressing barriers for tax clinic coordinators, and establishing additional tax clinic locations.[39]

Table 4. Number of Public Health Units Reporting Registered Dietitian Involvement with Local Level Strategies to Increase Incomes or Decrease Costs of Living[40]

Region	**Free Income Tax Clinics**	**Increasing Access to Affordable Housing**	**Affordable and Accessible Transportation**	**Education and Training**	**Child Care/Early Childhood Development**	**Health Services and Benefits**
Northern	0/7 (0%)	0/7 (0%)	0/7 (0%)	0/7 (0%)	0/7 (0%)	0/7 (0%)
Southern	3/26 (12%)	4/26 (15%)	2/26 (8%)	1/26 (4%)	1/26 (4%)	0/26 (0%)
Total	3/33 (9%)	4/33 (12%)	2/33 (6%)	1/33 (3%)	1/33 (3%)	0/33 (0%)

Some PHUs reported RD involvement in other local level strategies, in addition to the strategies included in the original survey question. The most frequent reported strategy was:

- Living Wage (9 PHUs, 27%) (0 northern PHUs, 9 southern PHUs)[41]

Limitations

The environmental scan was sent to one RD key informant from each PHU. To fully capture the breadth of actions and multidisciplinary work PHUs were involved with, key informants were encouraged to collaborate with other internal health unit colleagues who were also responsible

[36] See Appendix 8: PHUs 17, 32
[37] See Appendix 8: PHU 16
[38] See Appendix 8: PHU 17
[39] See Appendix 8: PHU 10
[40] See Appendices 5 and 8
[41] See Appendix 6: PHUs 2, 13, 28; Appendix 7: PHUs 3, 16, 19, 27; Appendix 8: PHUs 11, 27, 32

for HFI related activities. However, key informants were not asked to identify whether they had consulted with colleagues for the responses. Some topics or activities may have been overlooked or under-reported due to the level of internal consultation. In addition, respondents may have interpreted survey questions in different ways, potentially causing under-reporting of certain topics or activities.

Another limitation with this environmental scan is that there was no specific timeframe from which key informants were asked to report on for their HFI related activities. For example, some key informants reported programs that occurred several years ago, but still had significant impact to warrant inclusion in the environmental scan. Other key informants appeared to report only activities within the last couple of years. It is unknown whether including a specific timeframe would have captured additional responses for some activities. If this survey was repeated, key informants should be requested to consider activities from a specific timeframe, so that a more comprehensive grouping of activities could be included in the data.

The last environmental scan question included potential topics and activities to encourage key informants to consider their programming and whether their PHU was involved with any related work. Most key informants only provided examples related to the topics or activities listed and did not include additional topics. While prompts are a good way to stimulate key informants to consider certain topics they may otherwise overlook, they also may limit the ability to think comprehensively and include topics not mentioned in the question.

Finally, the survey timelines may have been a limitation. Survey questions were distributed during the summer in 2019. Although key informants were initially asked to complete the survey within one month, summer schedules may have impacted the amount of time spent completing the survey or ability to consult with other internal colleagues. Key informants requiring additional time were able to submit the survey after the initial deadline, either through their request to do so or extensions offered by the report author.

Next Steps

This environmental scan helped identify the various types and range of actions in which PHUs have engaged to address HFI in their region. The compiled information will help inform ODPH members and other stakeholders and provide examples of actions to address HFI by public health across the province. These actions could be considered for adaptation and implementation regionally and across the province.

PHUs were asked to identify local level strategies with the goal to increase incomes directly or decrease certain costs of living (e.g., transportation, child care) to help ‘free-up’ income for other costs of living (e.g., food). PHU involvement, including the level and type of involvement, varied greatly across Ontario for local level strategies. Although PHU key informants were not asked about the potential impact of capacity limitations, this may influence the work that PHU

RDs can support to address HFI. The number of full-time RDs employed at each PHU varies widely across Ontario. Some RDs support a wide range of portfolios, including HFI, while other RDs have more capacity to focus on HFI.

PHUs reported various staff involved in food insecurity work, such as RDs, public health nurses, health promoters, and medical officers of health. This is expected because HFI is a key social determinant of health that impacts health equity, with the contributing factors to and impacts of HFI relating to many areas of public health. Interdisciplinary collaboration among PHU RDs and other public health professions, such as public health nurses and health promoters, is essential. RDs have the foundational knowledge, skills, and experiences related to HFI and as such, are important frontline staff and consultants to help inform the HFI-related activities of their multidisciplinary colleagues.

The purpose of this environmental scan was to highlight the range of strategies currently engaged in across province. Further research focusing on the evidence and effectiveness of these strategies is needed to better understand this important work. It is recommended ODPH members contact PHU key informants for additional information about HFI initiatives, evidence, and evaluation. [42]

[42] See Appendix 9 for PHU key informant contact information

Appendix 1: Environmental Scan Questions

For the following questions, please include activities your health unit leads, as well as activities your health unit works on with other community partners.

1. What is your public health unit doing to increase stakeholder awareness (e.g., public, community groups, government officials, media) of the causes of food insecurity and knowledge of the income-based solutions? Please specify a) what you have done (as the public health dietitian) and b) what other health unit staff have done. Please also share any related evaluations, findings or recommendations.

2. What is your public health unit doing (or what have you done) to achieve a policy response to food insecurity at the i). local, ii). provincial and/or iii). federal levels? Please specify a) what you have done (as the public health dietitian) and b) what other health unit staff have done. Please also share any related evaluations, findings or recommendations.

3. If applicable, what is your public health unit doing (or what have you done) to implement and support local level strategies to put more money in the pockets of community members? Such as in the areas of: Affordable housing; Affordable and accessible transportation; Education and training; Child care/early child development; Health services and benefits; Free income tax preparation clinics.
   Please specify a) what you have done (as the public health dietitian) and b) what other health unit staff have done. Please also share any related evaluations, findings or recommendations.

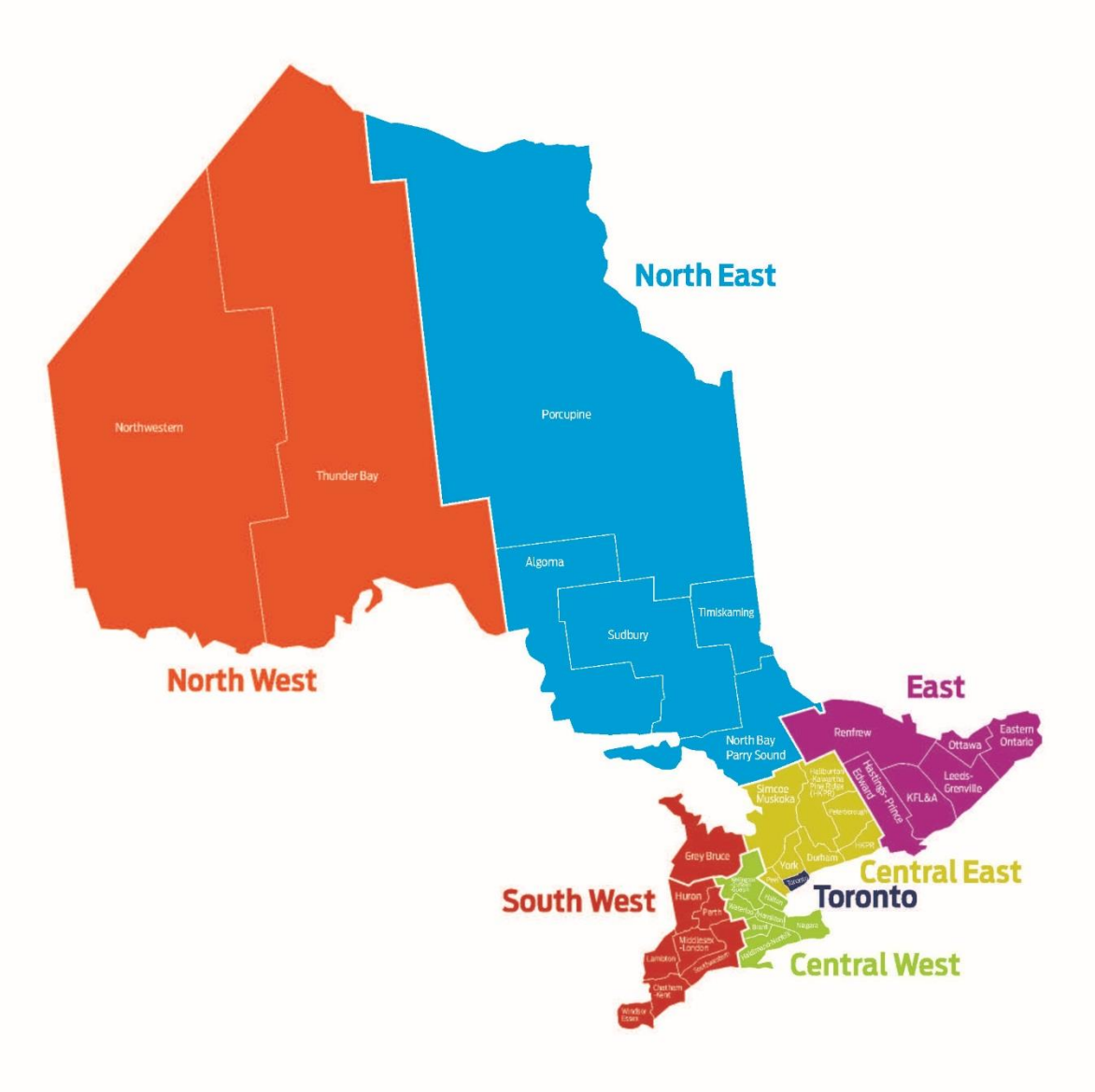
Appendix 2: Public Health Unit Regions

<u>Northern Region Public Health Units:</u>

- North West
- North East

<u>Southern Region Public Health Units:</u>

- South West
- Central West
- Toronto
- Central East
- East



Appendices 3-9: Refer to ODPH Member Only Document