SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

A snapshot of Regina organizations at work on the determinants of community well-being

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The views expressed in this document are those of the authors and not necessarily their organizations or the Regina Regional Intersectoral Committee.

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SUMMARY

Rationale

There are five good reasons to pay attention to these results. First, there is general acceptance that most of what causes us to be healthy comes from outside the formal health system; this research reports on findings from social service community-based organizations (CBOs) and quasi-government organizations working in communities. Second, despite our collective understanding about what causes and maintains health, Canadian society has not reduced health inequities significantly over the past few decades; it is time for further strategic action on determinants of community well-being (DCWB), also known as determinants of health. Third, the inequitable distribution of disease and death is a serious social justice issue that can wait no longer; human rights are social justice accountability tools that have already been created and adopted – we simply need to implement and enforce them. Fourth, engaging in public education about the determinants of community well-being and action on these determinants are hard to initiate and sustain for a variety of reasons (e.g., narrow public perceptions of health, government silos), but we must pursue public conversations with renewed conviction. Finally, the welfare state in Canada has been undergoing structural changes and questions persist about who should be responsible for the design and delivery of which human services – especially given many of these services are intended to meet basic human needs, which are DCWB.

Ten key results

Ten of the most important findings, implications and unanswered questions are now presented:

1. The 37 CBOs and 11 quasi-government organizations are actively engaged in work on the DCWB. **Social inclusion and social safety net** were ranked in the top three DCWB for both types of organizations. The key activities offered in this respect focused on social support activities and community engagement activities. These activities reflect an emphasis on social context and processes which coincides with a major theme in the population health literature.

   > Is it time for Regina organizations to measure the impacts of their social inclusion initiatives given some research shows social inclusion can reduce health inequities? Is a focus on social inclusion the most effective way to reduce health inequities?

2. **Education** also ranked in the top three DCWB for both CBOs and quasi-government organizations. Education is a theme in the population health literature which emphasizes links between higher education, better jobs, higher income, and increased problem solving skills.

3. **Income and its inequitable distribution** was the least frequently cited DCWB. This is not surprising given none of these CBOs or quasi-government organizations are responsible for income re-distribution; this redistribution is a government function (e.g., Ministry of Social Services).

   Given the major influence that income has on health status and health inequities, why has the Saskatchewan government, in collaboration with communities, not embarked on a comprehensive poverty elimination strategy with clear targets and timelines?

4. Despite the predominance of literature on the links between income inequities and morbidity/mortality rates, we wonder about the **cumulative and interactive effects of cultural discontinuity** on the health of our First Nations and Métis populations. The long term, negative impacts of government policies (e.g., residential school policies) should not be overlooked as we formulate healthier public policy for reducing inequities.

   How are different levels of government and different government departments working together on this policy challenge: to conceive and implement public policies that embrace the nested spheres of influence on health?

5. Approximately 90% of the CBO DCWB initiatives **served populations that are marginalized** (e.g., people with disabilities, visible minorities), thus, the initiatives were targeted and not intended to be universal. Universal interventions may serve to improve the overall health of populations but some research shows those who are better-off benefit disproportionately. It is noteworthy that these CBOs chose discrimination as a central identifier, which may indicate a collective perception of its salience and impact on people's health. Discrimination is a multi-dimensional concept linked to social exclusion.

   Does this mix of universal and targeted approaches lead to better health outcomes and a reduction in health inequities?

   In the quest for better health outcomes, what is the most advantageous blend of universal and targeted approaches, which sector (i.e., government, CBO) should be offering what programs and services, and how should these be financially supported?

6. CBOs' most commonly cited **sources of funding** for the DCWB initiatives included donations, fundraising and earned income (e.g., sale of products, fees-for-service). Multiple sources of funding for initiatives were also prevalent.

   Given CBOs are key actors and the DCWB are such important ingredients toward building healthier communities, is it appropriate that initiatives directed at enhancing these DCWB are relying on the generosity of others for donations and/or require CBOs to engage in a multitude of fundraising efforts to sustain initiatives?

   Should these funding models that do not support the long term sustainability of CBOs be modified?

7. In general, for both CBOs and quasi-governments, the DCWB initiatives had **multiple partner** involvement. There were not enough detailed data collected to state unequivocally, but cross-organization communication and a degree of service integration may be reflected in the sample.

8. Taken together these findings reaffirm the direction taken by the Regina RIC in 2009 regarding the adoption of a DCWB framework. Numerous national and international studies explain the importance of **acting on the broad social conditions** that affect people's lives in order to improve population health and reduce inequities.

   How can we find ways to ensure that the collection of DCWB continue to be a central theme on everyone's work agendas in order to reduce health inequities? How can the RIC ensure it maintains a wider lens of DCWB while also undertaking more focused efforts on housing and the early years? By focusing its energy on these two DCWB, is it expected the RIC will maximize a positive impact on health outcomes?

9. These findings also reaffirm another direction set, regarding human services integration, in Saskatchewan more than a decade ago that continues today with the Senior Interministry Steering Committee (SIMS). This kind of structure and its processes are essential for advancing population health. Again, national and international literature cite the importance of **cross-sectoral, cross-departmental, and integrated human service planning and delivery for reducing health inequities**. Using a common lens across all government departments is an important step toward this end. In addition, human rights agreements are intended to protect all people from social, economic, religious and political mistreatment and make governments responsible for enacting such protections. Canada is a signatory on numerous international declarations and convenants; there is general agreement that all people have the right to a standard of living adequate for good health and well-being.

   What have been the impacts of SIMS and RIC thus far? How will they take up the policy challenge to work on the "nested spheres" outlined in section 5.1? What successes have there been in both vertical and horizontal collaboration (i.e., among and between CBOs and governments) for service planning, implementation and impacts on communities? How can these successes be extended?

   Given governments have already created and adopted human rights tools, is it now simply a matter of implementing and enforcing them? Might the implementation and enforcement of human rights be a missing link in our society's quest for health equity?

10. The **DCWB inventory** is now ready to be launched on a publicly accessible website and promoted among human service organizations in Regina. It can be used as a tool for organizations working on the DCWB to find like-minded organizations to further their population health work.

    The three central questions that should be answered now appear to be: a) how is the RIC using the DCWB as a common lens to continue to make change; b) should the inventory be launched on a publicly accessible, free website; and c) can the existence of the inventory be used to encourage organizations to find each other and further their work on DCWB?

Introduction

This is a descriptive study about the work that social service community-based organizations (CBOs), quasi-government organizations and governments do on the determinants of community well-being (DCWB) in Regina. Using a population health model, this study focuses on the following DCWB: income and its distribution, employment, education, social safety net, housing, food security, social inclusion, health services access, culture and early life. This study was initiated by the Regina Regional Intersectoral Committee (RIC), but completed by the Saskatchewan Population Health and Evaluation Research Unit (SPHERU). The main research questions are: a) What determinants of community well-being are being addressed by a sample of Regina organizations and how are they doing this work; and b) How can we use the collected data as a catalyst for people to work together to further action on these determinants?

Method and sample

A semi-structured survey research design was adopted. A convenience sample using the RIC e-list was generated and an online, self-administered survey was created using Survey Monkey. Fifty-six organizations completed a survey and were classified as either CBOs (N=37), quasi-government (N=11), or government (N=8). Content analysis using summarization, explication and frequency counts was the analytic method used.

Results

This sample of organizations is working on a variety of DCWB, serving a variety of populations and age groups, offering myriad activities, funded by diverse sources and carried out with multiple organizational partners. The table on the next page offers a summary of the results. These results along with some critical literature were the basis for the 10 key messages presented above. In closing, as we think about our next decade of health equity work, let us recast our gaze beyond marginalized communities toward the structures, policies and practices that create them.

Results of survey

Variable	Social service CBOs (N=37) reported on 77 initiatives	Quasi-government organizations (N=11) reported on 33 initiatives
DCWB	The DCWB that received the highest cumulative score across all four priorities were social inclusion (frequency of 51), social support/social safety net (frequency of 41), and education (frequency of 38). The most frequently cited first priority was early childhood. The least cited was income and its distribution.	The DCWB that received the highest cumulative score across all four priorities were education (frequency of 23), social support/social safety net (frequency of 14), social inclusion (frequency of 13) and culture (frequency of 13). The least cited were income and employment/working conditions.
Age & sex	Young adults aged 19-24 years were the most frequently served by these initiatives (frequency of 54), followed closely by youth aged 13-18 years (frequency of 51) and then adults aged 25-64 years (frequency of 50). The majority of initiatives tended to serve both women and men, but the second most common response was women-only.	Young adults aged 19-24 years were the most frequently served by these initiatives (frequency of 19), followed closely by adults aged 25-64 years (frequency of 18), and then by preschool (3-6 years) and infant (0-2 years) (both with a frequency of 13 each). Initiatives tended to serve both women and men equally.
Populations served	The highest percentage of populations served by the initiatives was people/groups who are stagmatized or discriminated against (84%), followed by people living on low incomes (66%) and Aboriginal peoples (58%). Only approximately 10% of the initiatives were intended for “all” people, seniors, or students.	The highest percentage of populations served by the initiatives was people living on low incomes (67%), Aboriginal peoples (55%) and people with no social supports (52%). Only approximately 10% of the quasi-government initiatives were intended for “all” people, seniors, or students.
Types of activities	The highest percentage of activities delivered through these initiatives centred around social supports (56%), followed by community engagement activities (48%) and education (47%). Income security was the smallest percentage.	The highest percentage of activities delivered through these initiatives was education (67%), social support/networking (52%), followed by peer support (45%) and community engagement (45%), tied for third place. Income security ranked near the bottom.
Partners	CBO partners were noted most frequently, followed by governments and then quasi-governments. Although smaller in numbers, collaborative networks comprising CBOs and governments were mentioned too.	Both CBO and quasi-government partners were noted equally as frequently.
Funding	The most frequently cited source of funding for these 77 initiatives was donations (43%), followed closely by fundraising and earned income (42%), and then by provincial government and/or Regina Qu’Appelle Health Region funding (34%). The largest number of initiatives (N=34) tended to have annual operating budgets of less than $50,000 while the second largest category (N=24) had operating budgets of greater than $200,000.	The most frequently cited source of funding for these 33 initiatives was provincial government and/or Regina Qu’Appelle Health Region funding (48%). The largest number of initiatives (N=9) had annual operating budgets of less than $50,000 while almost the same number (N=8) had operating budgets of more than $200,000.
Developmental assets	A majority of the respondents (70%) were knowledgeable about “Developmental Assets” and 55 of the 77 initiatives (71%) were said to address Developmental Assets.	All of the quasi-government respondents (100%) were knowledgeable about “Developmental Assets” and 27 of the 33 initiatives (82%) were said to address Developmental Assets.

1. INTRODUCTION AND RATIONALE

This is a descriptive study about the work that voluntary human service organizations, Regina Qu'Appelle Health Region, Regina Police Service, the City of Regina, the school boards, and some government departments do on the determinants of community well-being. In Regina, voluntary organizations - known as community-based organizations (CBOs) – and these other institutions work to enhance the quality of life of marginalized communities specifically and the whole community generally. This study focuses on the following determinants of community well-being (DCWB): income and its distribution, employment, education, social safety net, housing, food security, social inclusion, health services access, culture and early life (Bolen & Ramsay, 2007; Hancock et al., 2000; Marmot & Wilkinson, 2006; Raphael, 2004b).

The Regina Regional Intersectoral Committee (RIC) which includes membership from governments, institutions and sector representation (including the United Way of Regina and Regina Treaty Status Indian Services), initiated this research in 2009 because of its interest in better understanding its local community as well as building strategic action toward a healthier community (see Appendix A for list of members). Understanding which determinants are the focus of CBOs and institutions will provide baseline data for similar research and will give the RIC a clearer picture about where there may be gaps in the service system. The Community Support Team (CST) (see Appendix A for list of members) was a group that intentionally functioned as a team developing a shared work agenda. It was supported in the pursuit of and the delivery on that agenda by the resources of the organizations from which each member was drawn, primarily the member agencies that form the Regina Regional Intersectoral Committee (RIC). Through their shared work the CST supported, facilitated, informed and coordinated the community's efforts for improvement within a Determinants of Community Well Being framework. Its primary focus was on strategies and initiatives that bridge across multiple organizations and sectors of the community to address root causes.

In 2010, after the Regina RIC shifted its priorities toward in-depth work on housing issues and early childhood development, the Saskatchewan Population Health and Evaluation Research Unit (SPHERU) offered to undertake analyses of the collected data. This was a natural fit for SPHERU given its interest in the broad determinants of community well-being. SPHERU's mission is to work with communities and policy-makers to improve the health of Saskatchewan people. SPHERU is an interdisciplinary team of population health researchers from the

Universities of Regina and Saskatchewan involved in collaborative research with policy-makers around shared research questions as well as collaboration with communities on sources of and strategies to reduce health inequities. The dataset was intended to be a publicly accessible and usable dataset for any organization to work with; SPHERU sought and received University of Regina Ethics Board and the RIC's approval to do this analytic work (see Appendix B). The analysed data in this document offer a descriptive snapshot of Regina organizations working on the determinants of community well-being. This document offers Regina organizations information to facilitate more comprehensive, collective and effective action on the determinants of community well-being. The resultant electronic inventory of organizations and determinants also provides practitioners with a user-friendly vehicle to network with each other.

The rationale for conducting this research is compelling. First, there is general acceptance that most of what causes us to be healthy comes from outside the formal health care system (Evans & Stoddart, 2003; Hancock et al., 2000; Marmor et al., 1994). Second, despite our collective understanding about what causes and maintains health, Canadian society has not reduced health inequities significantly over the past few decades (Johnson et al., 2008; Raphael, 2004b) (see also Green & Labonte, 2008). Third, generating public conversations about determinants of community well-being and action on these determinants are hard to initiate and sustain for a variety of reasons (e.g., narrow public perceptions of health, government silos) (Plough, 2006; Raphael, 2009a). Fourth, this study is particularly important given the restructuring of the welfare state in Canada and long-standing questions about who should be responsible for the design and delivery of which human services; most of these services are intended to meet basic human needs and are determinants of health (Brock & Banting, 2001b; Lightman, 2003; Mulvale, 2001; Rice & Prince, 2003). It is for these reasons that the Regina Regional Intersectoral Committee (RIC) decided to undertake a survey to better understand the determinants of community well-being landscape. The objectives of the research were:

- to document the DCWB that are the focus of human service organizations in Regina, Saskatchewan;
- to raise awareness of DCWB among CBOs, governments and the larger community;
- to use the collected data to facilitate more integrative and collective action on determinants of community well-being through the RIC, CBOs and other institutions; and
- to create a publicly accessible inventory such that CBOs, governments and other institutions can find each other and work together toward a healthier community.

From these objectives the following two research questions emerged:

a) What determinants of community well-being are being addressed by a sample of Regina organizations and how are they doing this work?
b) How can we use the collected data as a catalyst for people to work together to further action on these determinants?

2. LITERATURE REVIEW

2.1 Determinants of community well-being and population health

What are "determinants of community well-being" (DCWB)? This concept is often seen as synonymous with "social determinants of health" and has its origins in the population health literature. Let us explore health, population health and determinants of health briefly.

We intentionally approached this research defining health broadly:

> Health is "a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity … Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical abilities" (World Health Organization, 1998, p. 11).

We adopted the term "well-being" for this research because it is broad in scope; we did not want study participants thinking solely about foot care clinics and hospitals. This broad definition of health and the adoption of the term well-being are appropriate because they encourage us to think about a range of social conditions, or social determinants of health like poverty, which affect people's health.[1] Additionally this allows many sectors to see relevancy of the DCWB in their respective work. It is not solely the health sector's job to facilitate the development of healthy individuals and communities.

[1] Hancock et al. (2000) note there is not a consensus about well-being. Hancock et al. use a narrow approach to well-being (e.g., happiness, satisfaction), whereas the Canadian Policy Research Networks' *The Well-Being Diamond* is broad in that well-being and welfare appear to be used as synonyms. The *Canadian Index of Well-being* is even broader and includes seven domains (e.g., living standards, healthy populations, environment, civic engagement) (http://www.atkinsonfoundation.ca/ciw/). Within Aboriginal cultures, well-being is broader and incorporates a holistic construct, which is "historically and culturally mediated" (Adelson, 2000, p. 3).

Let us begin by situating the DCWB in its larger framework, population health. There are many definitions and descriptions of population health and these differ from health promotion and public health (Hamilton & Bhatti, 2002; Hayes & Dunn, 1998; Kindig & Stoddart, 2003). Population health is "more than traditional public health" in that it encompasses determinants of health and their inequities (Young, 2005, p. 5). For our purpose, the health of populations is:

> "… influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. … As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systemic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations" (Federal, 1999, p. 7).

Hancock, Labonte and Edwards (2000) operationalize similar components in their population health indicators work. In general, their model posits there are a variety of health determinants that manifest themselves across different spheres (e.g., individual, community, state) (see also Labonte et al., 2002), which interact over time and space through many different processes of change. These combinations of factors and processes result in a variety of health outcomes including positive health status, negative health status and health inequities across populations.

This current research initiative focuses on the determinants of health and well-being; these are the many elements that influence people's health. Different scholars and researchers often have different lists of elements. Hancock, Labonte and Edwards (2000) cite the following categories: sustainable ecosystems, environmental viability, liveable built environments, community conviviality (e.g., social support networks), social equity (e.g., inclusion, access to power), and prosperity (e.g., employment) (see also Evans et al., 1994; Heymann et al., 2006; Kawachi & Berkman, 2003; Kindig & Stoddart, 2003). Some scholars also cite examples of public policies which are intended to make people healthy but which actually make people sick (Neysmith et al., 2005; Raphael, 2003; Savarese & Morton, 2005) (e.g., income assistance policies which force people to live in poverty). Lynch and Kaplan (1999) further explain that the "distributional aspects of the economy" are determinants (p. 203), while Reid (2004, p. 3) states the "ultimate determinants" are the social and economic structures of society. In their report, Reading and Wien (2009) construct a different frame that incorporates many of these elements but through Aboriginal peoples' perspectives; they include an explanation of socio-political contexts, a holistic perspective of health, the salience of life course and then go on to explore proximal

(e.g., income and food security), intermediate (e.g., educational systems) and distal (e.g., racism, colonialism) determinants of health. Within the population health model, regardless of the Aboriginal or non-Aboriginal determinants of health frame, health care services play a relatively minor role in creating healthy populations when compared to these other factors (Evans & Stoddart, 2003; Keleher, 2007; Lalonde, 1974; Lawrence, 2006; Lomas & Contandriopoulos, 1994; Marmor et al., 1994). Thus, attaining individual and community health and well-being are the result of a variety of factors.

More specifically, let us examine "social determinants of health" because it is most closely aligned with the DCWB. Social determinants of health appears to have first emerged when researchers sought to understand the exposures "by which members of different socio-economic groups come to experience varying degrees of health and illness" (Raphael, 2004a, p. 5); today, research shows it is not just socio-economic groups but rather, a variety of marginalized groups reflect these varying degrees (Marmot & Wilkinson, 2006). A variety of social determinants – which are different than general determinants[2] – can enhance or inhibit health and include: income, housing, education, discrimination, employment and working conditions, sense of safety and security, perception of one's place in a social hierarchy, social connectedness, and culture (Lemstra & Neudorf, 2008) (see for example Hancock et al., 2000; Marmot & Wilkinson, 2006; Raphael, 2004b). Some researchers suggest that income equity and social cohesion are the roots of many determinants (Saskatoon Health Region, 2009). "Determinants of community well-being" (DCWB) is the term adopted by the Regina RIC for the current study and includes the following social determinants: income and its distribution, employment, education, social safety net, housing, food security, social inclusion, health services access, culture and early life (Bolen & Ramsay, 2007, 2008). The Regina RIC believes – as do others – that if we strengthen the determinants of community well-being, we will generate more positive health outcomes at both community and individual levels.

2.2 An important note about culture as a health determinant

In addressing culture as a determinant of community well-being, the CST struggled with how to best take action – weave culture into every piece of work (raising consciousness, using a

[2] General determinants of health would include biology, genes, health care, and lifestyle. These would not be considered "social" determinants.

common lens and measuring progress), or deal with it via a separate sub-strategy. At that time, the CST was considering Aboriginal citizens, however, a rapidly increasing immigrant population in the city of Regina at that time necessitated the CST to expand its discussions to include these groups, as well. In its second report to the RIC, under the Raising Consciousness pillar, the CST recommended to:

> Develop a distinct stream within the overall social determinants of health communication plan that will raise the profile and legitimacy of healing, spirituality, learning and social justice practices of other cultures (particularly Aboriginal) with the public and the formal sectors. Components of this strategy could include the:
>
> - Identification of opportunities for growth in this area within the operational plans of RIC member organizations; and
> - Development of dedicated resources or a department within each sector to explore and promote the inclusion of other cultures' perspectives into practice (i.e., RQHR has Eagle Moon) (Bolen & Ramsay, 2008, p. 7).

Work on this recommendation had not yet begun when the CST was dissolved in 2010.

The CST spent many hours deconstructing "culture" and believed it to be a central concept for health. Masi, Mensah and McLeod (1995) define culture as, "the way of life developed by a group of people which members acquire....that which is totally learned and it includes language, concepts, beliefs and values, symbols, structure, institutions and patterns of behaviour. A person's culture may or may not be the same as his or her ethnic origin or identity" (p. 7-8). This definition encourages us to embrace a broad conceptualization of culture that not only includes ethnicity but also religion, sexual orientation, gender and age, to name a few.

Culture generally and cultural continuity more specifically, are cited as critical elements in the health literature. "Cultural continuity might best be described as the degree of social and cultural cohesion within a community ... Cultural continuity also involves traditional intergenerational connectedness, which is maintained through intact families and the engagement of elders, who pass traditions to subsequent generations" (Loppie Reading & Wien, 2009, p. 18). Clearly, cultural discontinuity is a serious, longstanding determinant of health that resulted from a destructive legacy of government policies (e.g., residential school policies) dating back to the mid-1800s (Smylie, 2009).

Valuing cultural diversity involves acknowledgement and appreciation of other cultural practices. A community that is culturally diverse can look to this diversity as one of its strengths and a

valuable resource. Thus, culture must be recognized in planning: "traditional land ownership, heritage and stories, values of gatherings, arts, language...all opportunities for cultural exchange, local pride and leadership...Culture must be acknowledged as a local asset and used as a pillar in planning" (Badham, 2009, p.2).

Culture can be expanded further to include cultural activities, both those originated in different ethnic groups, but also activities related to the arts (visual arts, music, dance). The availability and community participation in cultural and artistic activities is one measure of community well-being used in other jurisdictions. The North Central (Regina) Community Cultural Indicators Project is one example, which based these measures of community well-being on work done by Victoria Health, Australia. Their measure of a 'diverse and vibrant cultural community' included the existence of the number of languages spoken in the community, opportunities and participation in cultural and/or arts activities, and cultural dialogue and exchange.

2.3 Population health, health inequities and social justice

Over the past decade there has been a resurrection of discourse on social justice in public and population health, particularly in regard to health inequities. Indeed, “public health has its roots in social justice” (Edwards, 2009, p. 405). *The Saskatoon Health Disparities* study (Lemstra & Neudorf, 2008) as well as myriad other studies show health inequities exist for many marginalized populations (e.g. higher tuberculosis and diabetes rates in First Nations communities than others). Health inequity refers to unfair and avoidable differences in health status among different populations (Levy & Sidel, 2006).

In the health literature, the goal of social justice is to reduce health inequities (Hofrichter, 2003; Levy & Sidel, 2006; Reid, 2004). The health of the public is essentially a social justice issue because there are preventable deaths and disabilities (Beauchamp, 2003). In explaining health inequities, Levy and Sidel (2006) offer two ways to define social injustice. First, it is “the denial or violation of economic, sociocultural, political, civil, or human rights of specific populations … based on the perception of their inferiority by those with more power” (ibid., p. 6); health is “a

fundamental right of citizenship" (Reid, 2004, p. 3).[3] Second, Levy and Sidel (2006) use the Institute of Medicine's definition of public health, "it is what we as a society do collectively to assure conditions in which people can be healthy" (p. 6). This definition focuses on the policies and programs that positively affect people's health. This current document focuses primarily on the second definition, but the final section of the document touches on human rights.

Let us take a moment to explore social justice further. Social justice[4] may be conceived as a four-dimensional concept that can be used to help us confront health inequities – that is, the unfair distribution of morbidity and mortality rates in marginalized communities.[5] First, social justice focuses on reducing marginalization through *redistribution* of material resources (e.g., income) and nonmaterial social goods (e.g., rights, opportunities, power) (Fraser, 2003; Hofrichter, 2003; Mullaly, 1997). Second, social justice also draws attention to encouraging *recognition and respect for the dignity* of all people (Cohen et al., 2001); recognition aims to "revalue unjustly devalued identities" (Fraser & Honneth, 2003, p. 12). Third, social justice posits that *participatory obstacles* can exist independent of redistribution and recognition to systematically marginalize people from decision-making processes (Fraser, p. 67-68) (see also Mullaly, 1997). Fourth, Gindin (2002) suggests these three are not enough and that conceptions of social justice should shift to include human "*capacities, development and potentials*" (p. 12). He states that humans create social life and that we have "the dynamic capacity to change ourselves" (p. 12). He insists the focus should be on what we can become, not that we should have "fairer access …. to compensate us for what we are not" (p. 12). We can now see more clearly the connection between redistribution, recognition, participation and capacity development and various determinants of health; higher income, lower racial discrimination, increase in social inclusion, and access to education, respectively, are social justice goals as well as health goals.

[3] International human rights agreements make governments responsible for removing obstacles and creating conditions for people to achieve their rights – even if this means that governments grant special attention to marginalized groups (Gruskin & Braveman, 2006; Kly & Thériault, 2001).

[4] In general, social justice emphasizes that society is responsible for helping to create healthy populations, many social and political structures cause premature death, unhealthy choices (e.g., smoking) are connected to larger societal structures; and powerful people and institutions create an unfair distribution of illnesses (Beauchamp, 2003, p. 269-70). This is contrasted with neoliberal ideology which demands that individuals look after themselves, there are no collective community obligations, people are powerless to confront pre-mature death, a tendency toward blaming the victim for his/her problems, and over investment and over confidence in medical services (ibid.)

[5] Jenson (2000) states that marginalization refers to groups of people who may be excluded economically, politically, physically, psychologically and/or socially.

2.4 Variety of actors required to facilitate population health

Along with this evolution in understanding population health, there is growing recognition that the well-being of communities depends on a variety of actors. Today governments, quasi-government institutions (e.g., schools) and community-based organizations, CBOs, (e.g., food banks, emergency shelters) all play a variety of roles in influencing individual and community well-being. Regina has made some progress in developing more collaborative and integrative approaches across these sectors for public policy development, but more remains to be done (Bolen & Ramsay, 2007). Despite the myriad actors involved in the determinants of community-well-being, significant positive changes in population health status are lacking (Johnson et al., 2008; Raphael, 2004b).

Since the human service CBO sector is of particular interest in the current research, let us examine this literature for a moment. In general, CBOs refer to voluntary, nonprofit sector agencies that are institutionally separate from government and the private sector, have an organizational structure, exist to serve a public benefit, are self governing, do not distribute profits to members, and depend on volunteers to varying degrees (Government of Canada, 2002; Hall & Banting, 2000; Salamon & Anheier, 1997). CBOs undertake numerous functions in society. CBOs offer both products and processes designed to positively influence the determinants of community well-being (Bell, 2009; DeSantis, 2008). The CBO sector acts as a "social seismograph" leading the way in identifying new social issues (Hall & Banting, 2000, p. 3), provides services (e.g., food, shelter, training) and support (e.g., counselling) to people who are marginalized (ibid.), undertakes individual and collective public policy advocacy (DeSantis, 2008), facilitates the development of social capital and community cohesion (Jenson, 1998), encourages civic participation (Boris & Mosher-Williams, 1998) and is a source of social innovation (Goldenberg, 2004). The CBO sector also facilitates the development of health and well-being as shown in a recent study of social service CBOs across Saskatchewan wherein 35 of the 39 CBOs (90%) believed their programs and services contributed to the health and well-being of their program participants; some examples cited were recreation programs, food provision, cooking skills, housing and shelter provision, education and skills development, employment, encouraging social relationships and inclusion, creating a family atmosphere at their CBOs, getting people involved, and promoting independence (DeSantis, 2008). CBOs tend to work where determinants of community well-being and poor social conditions are prevalent (Browne, 1996; Hall & Banting, 2000; Shragge & Fontan, 2000). Some examples of CBOs that

work daily with the social determinants of health include: food banks, family counselling centres, neighbourhood multi-service centres, women's emergency shelters, and nonprofit housing organizations.

The focus of this study is on human service CBOs. Human service CBOs is used here to refer to a range of organizations that provide services to specific populations (e.g., people with mental health disabilities, people living on low incomes, single parent families, people who have been released from corrections facilities) to promote their social, mental and economic well-being as well as protect and advance their human rights. The human service CBOs that participated in this study fall into one of the following categories specified by the International Classification of Nonprofit Organizations (ICNPO) (Hall et al., 2004): social services, development and housing, advocacy for human rights, and health (mental).

2.5 Developmental Assets

Along with the DCWB, the RIC was interested in the degree to which Regina organizations were working on development assets. Developmental Assets are "the values, qualities and experiences that young people need in their lives to become caring, competent, responsible people" (Search Institute, 2004, p. 8).

The 40 Developmental Assets are organized into a framework that provides communities with a tool and a common language that helps unify efforts to create positive community change and thriving citizens (Search Institute, 2006). The framework includes two types (external and internal) and eight categories or broad areas of human development (support, empowerment, boundaries and expectations, constructive use of time, commitment to learning, positive values, social competencies, positive identity). It identifies determinants within each of the primary contexts (individual, family, school, neighbourhood, workplaces, and programs/services) that communities can focus on to promote well-being of the entire population.

The five action strategies of the Developmental Assets approach provide "a practical approach to identifying, encouraging, and linking all the important people, places, activities, and programs necessary for a powerful collective effort" (Search Institute, 2004, p. 10).

Communities find guidance in their work from the six basic principles of the framework:

- Everyone needs assets
- Relationships are key
- Anyone can build assets
- Asset building in an ongoing process
- Consistent messages are important
- Intention repetition is essential

The most important research finding about the Developmental Assets is that the more assets youth have, the more likely they are to develop positive behaviours (i.e., succeed in school, show leadership, take care of their health and value diversity). They are also less likely to be involved in high-risk behaviours (i.e., involved in violence, use alcohol and drugs, early sexual activity). It is clear that not only do the young people benefit but the entire community benefits when more young people have more of the assets in their lives.

3. METHOD

3.1 Research design

A semi-structured survey research design was adopted. A convenience sample (Berg, 2004) was created using RIC and its Community Support Team (CST) members' email contact lists. The group responsible for developing and distributing the online survey was the CST, a multi-sectoral working group of the Regina RIC. The members of the CST were individuals that each worked with a variety of stakeholders in both CBOs and formal institutions, in their everyday work on the DCWB. The online, self-administered survey was created using Survey Monkey.

3.2 Sample

Email contact lists that each of the members of the RIC/CST regularly used in her/his daily work were compiled to form the main distribution list for the survey. This email distribution list of 394 consisted of individuals, organizations (local, regional/district, municipal, provincial and federal), networks, community associations, project, programs, and the university. A wide net was cast in order to make contact with as many initiatives potentially having impact on the determinants of community well-being (DCWB) as possible.

The survey was sent to 394 email addresses (refer to Appendix C for the letter of introduction). Some larger organizations received the survey multiple times via various staff in different program areas; the 394 email addresses represent 169 discrete organizations. From this list, 56 organizations completed a survey – a response rate of 33%. A small number of respondents did not complete all the questions in the on-line survey but did provide partial information on their organization or initiative. A reminder to complete the on-line survey was sent to participants three weeks after the initial dissemination and the response deadline was extended by one week to encourage responses.

The 56 organizations (refer to Appendix C for the list of organizations) could not be analysed together as one dataset because they do not share basic characteristics. For example, community-based organizations (CBOs) such as Big Brothers of Regina and the Regina YWCA are very different from the Ministry of Corrections and Public Safety, and the Regina Qu'Appelle Health Region. We used the definition adopted by Hall et al. (2004) for our research. In the Hall et al. research, CBOs, also known as nonprofit or voluntary organizations, "are defined as organizations that meet all the following criteria:

- non-governmental (i.e., are institutionally separate from governments);
- non-profit distributing (i.e., do not return any profits generated to their owners or directors);
- self-governing (i.e., are independent and able to regulate their own activities);
- voluntary (i.e., benefit to some degree from voluntary contributions of time or money); and
- formally incorporated or registered under specific legislation with provincial, territorial or federal governments" (Hall et al., 2004, p. 7).

Following these criteria, 37 of the 56 organizations were CBOs. Further, Hall et al. (2004) note that some organizations are generally considered to be public sector agencies (e.g., school boards, public libraries and public schools) although technically they are nonprofits. We labelled these surveyed organizations "quasi-government" because they are not typically referred to as CBOs or governments; there were 11 quasi-government organizations including for example, the Regina Qu'Appelle Health Region, KidsFirst Regina, and Regina Catholic Schools. Finally there were eight governments that completed a survey, but their data were not analysed in the same manner as CBOs and quasi-government organizations because, in general, their

responses were more macro in scale (see section 3.5 for further explanation). Table 1 below and Appendix C show the categorization of CBOs and quasi- government organizations.

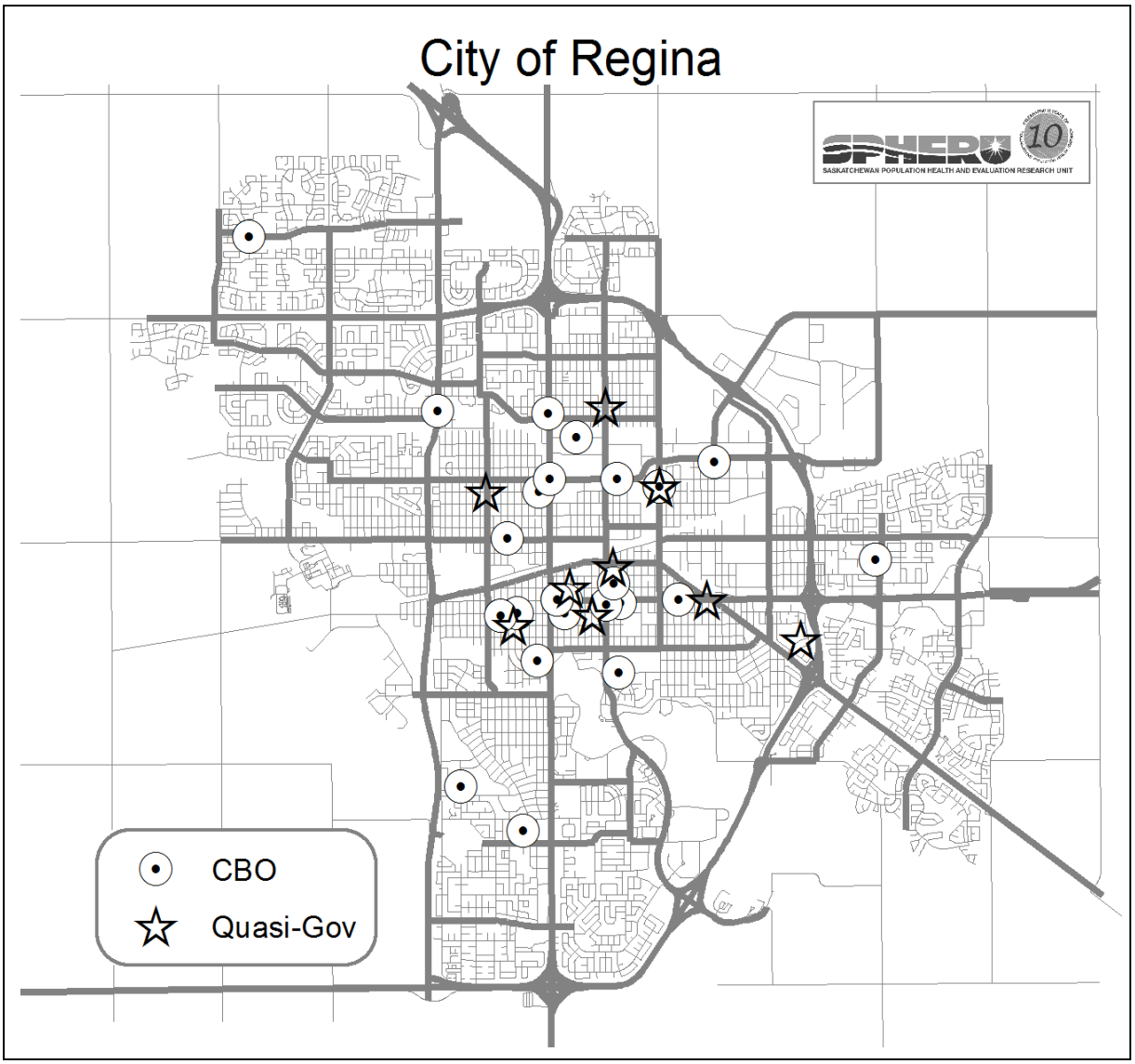
Table 1: Profile of surveyed organizations

Characteristic	CBOs	Quasi- government
Organization's level of action		
Local community/neighbourhood/sub-area of the city	5	4
Municipal (city wide) or regional/district	28	7
Provincial	4	0
National	0	0
TOTAL	**37**	**11**
Organization's estimated annual operating budget		
< $25,000	6	0
$25,000 - $99,999	6	1
$100,000 - $299,999	9	0
$300,000 - $499,999	2	1
$500,000 - $1 million	2	2
> $ 1million	11	7
No response	*1*	*0*
TOTAL	**37**	**11**
Major sources of funding*		
Federal grants	7	1
Provincial grants	10	3
Municipal grants	10	1
Federal funding	6	4
Provincial funding	**13	12
Municipal funding	3	2
Donations	17	1
Foundations	6	0
Fundraising & earned income*** – includes fee for service, registration fees, merchandise sales, social enterprises, garage sales, lotteries	23	1
Other – United Way for CBOs, municipal taxes through mill rate for quasi-government organizations	3	1
Number of people employed in organization		
< 25	26	4
25-49	4	2
50-74	2	1
75-99	2	0
100-499	2	1
500-999	0	1
> 1000	0	2
No response	*1*	*0*
TOTAL	**37**	**11**

Notes: * Government "funding" refers to operating funds while government "grants" refers to funding specific to a certain initiative which is usually not permanent.
** Includes organizations that also receive some funding from the Regina Qu'Appelle Health Region.
*** Refer to Hall et al. (2004) for rationale for this method of classification.

The CBOs and quasi-government organizations are dispersed throughout certain areas of Regina. Figure 1 is a map which shows the spatial distribution of these participating organizations.

Figure 1: Spatial distribution of Regina organizations that completed a survey



Notes:

- Please use caution when drawing conclusions about the spatial distribution of the organizations and their initiatives for a variety of reasons: some organizations do not appear on the map because they did not complete the address portion of the survey (i.e., 10 no responses), there are multiple organizations at some addresses, some of the addresses presented here are for organizations' head offices, and finally, some of the initiatives deliver services at multiple locations (e.g., Street Culture Kidz, Grow Regina).
- We could not map the 100 initiatives because we did not ask about the addresses for each.

There was a third category of respondents, governments. There were eight governments in the sample including: Citizenship and Immigration Canada; Public Health Agency of Canada; Service Canada; National Crime Prevention Centre; Ministry of Corrections, Public Safety and Policing; Ministry of Justice and Attorney General; Saskatchewan Housing Corporation; and the City of Regina. However, the wide range of responses from across these government respondents was too great to analyse; for example, some government departments summarized their entire organization's work on the DCWB while others chose certain initiatives to report on. As a result, government data were separated from the CBOs and quasi-governments and were analysed differently (refer to "Data Analysis" below).

3.3 Participation and ethics

The on-line survey was completely voluntary with no financial or other incentives provided for participation. The participants were informed through an introductory letter that members of the RIC, the CST, researchers and staff affiliated with the project would have access to the information collected. It was also explained that these data would potentially become a part of a comprehensive public inventory of agencies, projects and initiatives focused on enhancing the well being of our community, accessible by anyone in the community.

3.4 Data collection

The on-line survey was developed by two members of the CST in collaboration with the RQHR's Research and Development Department in Survey Monkey format. Various drafts were developed and the entire CST had the opportunity to contribute feedback to create the final version. The final online, self-administered survey included five general questions about participants' organizations (e.g., mandate, size, geographic focus, annual operating budget, funders) and 12 specific questions about community well-being initiatives (e.g., mandate of each initiative, target populations served, partners, key activities, funding, the DCWB addressed by each initiative, and the Developmental Assets addressed by each initiative) (refer to Appendix D for a copy). Organizations were able to report on a maximum of four initiatives that were implemented to improve the well-being of their community. The survey was expected to take about 10 minutes per initiative to complete.

Definitions of the DCWB and Developmental Assets were provided in the survey to assist the participants to decide if and how each of their initiatives fit. The phone numbers of two CST members were also provided to answer any specific questions that respondents may have encountered while completing the survey.

The survey instructions asked participants to exclude any kind of treatment program, intervention or early intervention service, screening program or diagnostic service. Since the focus of this survey was on population health, the survey was designed to exclude programs that intervened primarily at the individual level, whose intent was actual treatment or therapy, or programs that were meant to get people into treatment or therapy at an earlier stage of a disease process. The survey was intended to include programs that intervened long before people became symptomatic, that were more universal in nature or aimed at the root cause of such symptoms, rather than those that targeted a particular group suspected of, showing early signs of, or actually diagnosed with an illness or condition. So, this would exclude programs such as the Early Psychosis Intervention Program (targeted at people with the earliest signs of a psychotic illness), treatment or therapy programs, either individual or group (including programs, such as the mental health rehab program that includes housing and income support as part of the overall treatment plan), screening programs that look for early onset of illnesses such as diabetes or depression (in order to get them into treatment) or programs that provide assessment for the purpose of diagnosis. We recognize the complexity of this request and the difficulty of ensuring respondents understood this on an on-line survey.

Due to the limited research available on collecting data of this type we relied on a cursory literature review for direction, therefore the variables that were measured in this survey were based on best practices for the Community Support Team in collaboration with RQHR. The language and choice of variables were carefully constructed with consideration of the understanding and knowledge provided by the Community Support Team.

3.5 Data analysis

The following two research questions guided the analysis:

a) What determinants of community well-being are being addressed by a sample of Regina organizations and how are they doing this work?

b) How can we use the collected data as a catalyst for people to work together to further action on these determinants?

The unit of analysis was each initiative described by each organization. Content analysis using summarization, explication and frequency counts was the primary analytic method used on all the CBO and quasi-government initiatives data including DCWB, populations served, key activities, funding, and Developmental Assets (Berg, 2004; Titscher et al., 2007). For the government data, only summarization and explication of qualitative data pertaining to general organizational and initiative mandates, populations served and DCWB were undertaken because most of the responses either combined myriad initiatives together which made individual analysis impossible or the responses focused on more of a macro view of the organization. Governments are involved in work on the DCWB and this was an analytic method intended to capture the essence of their responses.

3.6 Data limitations

The response rate to this online survey was 56/169 or approximately 33%. We offer here our cautions about the limitations of the collect data. These limitations include:

- Given there is not one central database that we could consult containing a universe of organizations, we cannot say unequivocally, in what ways our sample compares and contrasts with such a universe.
- There appear to be some similarities and differences between the original e-list of 169 and the sample of 56. To obtain the original e-list a wide net was cast to as many contacts the RIC and CST members could generate. As such it included large organizations like provincial government departments and the Regina Qu'Appelle Health Region to community-based CBOs of all sizes. There were no guidelines provided to the larger organizations in terms of how to get the survey to the program or initiative levels, so depending on how each organization chose to distribute the survey, responses were received from high level administrators (who painted a broad, macro picture) as well as individual staff members responsible for specific initiatives (who provided more of the micro or initiative level information the survey intended to collect), with considerable overlap. So the similarity between the original e-list and the sample list is that each includes the full range of sizes of organizations, from smaller, grassroots CBOs, mid and large sized CBO and large public sector agencies and organizations. The differences between these two

lists are: 1) large government organizations with provincial mandates were excluded from the sample list and 2) the large organizations that were included on the sample list have initiatives that would be considered 'grass roots,' even though they are not being administered by a CBO.

- Given the on-line nature of the survey – much like a mail out survey where there are no interviewers for respondents to ask questions of clarification – we do not have any way to validate respondents' interpretations of the questions or their subsequent responses. For example, how many of the DCWB were misinterpreted by some respondents (e.g., the definition of education)?
- Our sample is biased in favour of organizations that understand and/or work with DCWB, those who understood the definitions and instructions, those who were skilled at computer and internet/online surveys, and those who were already on the RIC/CST email lists.
- There was much data-cleaning work done. For example, in some instances, respondents did not check off available boxes but rather entered a qualitative response which was essentially one of the check boxes; these responses were re-coded and any additional qualitative data were saved.
- Individuals completed the survey instead of small teams/groups from within organizations which would have affected the answers. Front line staff may have different perspectives of their initiatives than do their managers.

4. RESULTS

The CBOs and quasi-government organizations were analysed separately because they do not share some basic characteristics (refer back to section 3.2 and to Appendix C for the list). Thus, this section is divided accordingly. Please note the data tables for all the graphs presented in this section can be found in the appendices.

We were interested in looking beyond the organizational level of analysis and into deeper examination of specific initiatives. The 37 CBOs and 11 quasi-government organizations reported details for 100 initiatives total that were intended to positively influence the DCWB. Some organizations reported one initiative while others reported as many as four initiatives. The CBOs reported a collective total of 77 initiatives while quasi-government organizations reported on 33 initiatives (refer to Appendices F and G for the lists of initiatives).

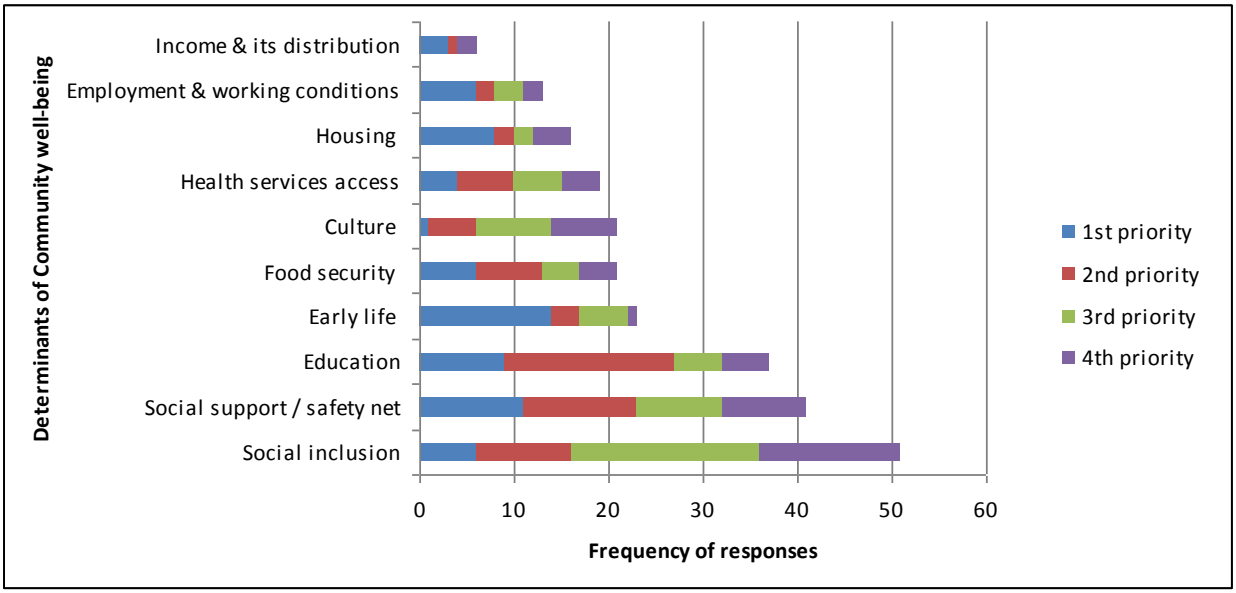
Respondents were asked, “please tell us about an initiative (e.g., program, project, activity, etc.) that addresses community well-being in your organization”. Organizations were asked to report on as many as four initiatives, including the name of the initiative, initiative mandate, target populations, level of action, main partners, key activities, estimated operating budget, major sources of funding, the top four DCWB addressed by the initiative, and the Developmental Assets addressed by the initiative (if any). This section is structured according to our classification of organizations beginning with CBOs in section 4.1 and followed by quasi-government organizations in section 4.2. A brief overview of qualitative responses submitted by government departments is included in section 4.3. That analysis will give readers a sense of the DCWB with which governments are working. Following these three sections is a summary of the data (section 4.4).

4.1 Community-based organizations at work on the DCWB

The main characteristics of the 37 CBOs were cited in Table 1 (refer back to section 3.2). In general, 28/37 (76%) of the respondents provided services on a city or regional scale, while five of the 37 provided services at a neighbourhood level or a few neighbourhoods combined. Four additional organizations provided services across the province. The largest number of CBOs had annual operating budgets of less then $100,000 (12 of the 37) while another 11 had operating budgets in excess of $1 million. The most frequently cited major source of funding was “donations”. The largest category of CBOs had less than 25 people employed in their organizations (26/37, 70%).

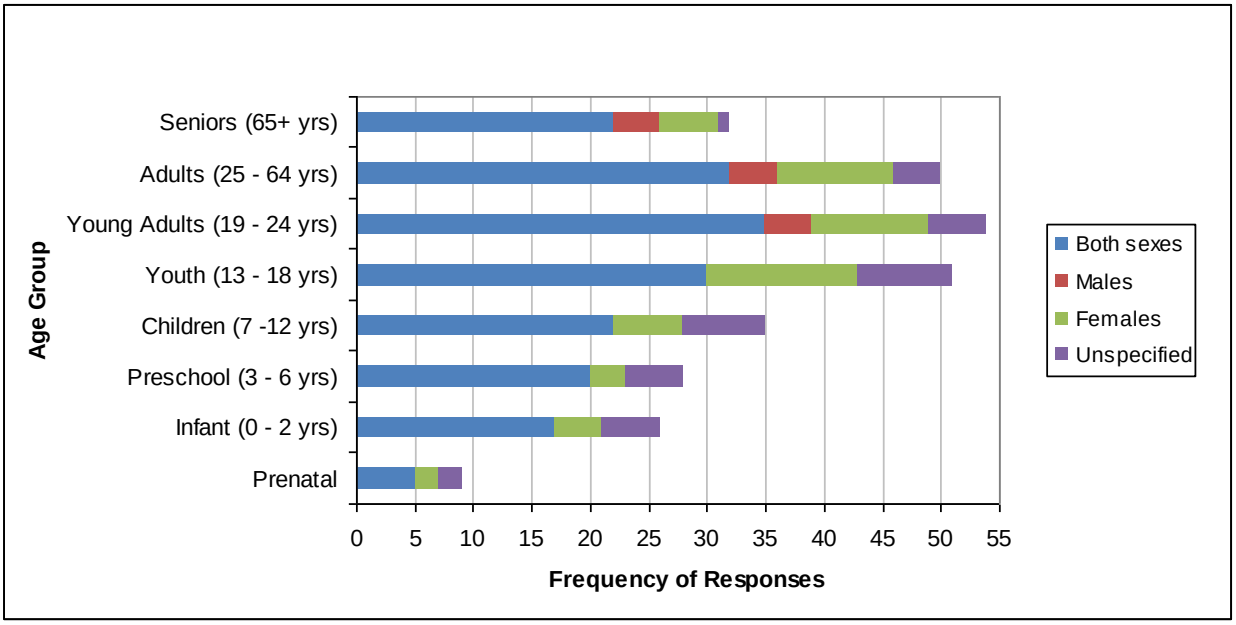
This sample of 37 CBOs reported on 77 initiatives. The main survey question was, “which determinants of community well-being are the top four priorities in this initiative?” The CBOs characterized their initiatives by DCWB order of priority. Graph1 presents a summary of these data; the list of initiatives can be found in Appendix F. Graph 1 shows that early life was the DCWB that was cited most frequently as first priority (frequency of 14) and education was noted most frequently as second priority (frequency of 18); social inclusion was noted most frequently as both third and fourth priority. Interestingly, the DCWB that received the highest cumulative score across all four priorities was social inclusion while social support/safety net was the second most frequently cited DCWB; CBOs noted social inclusion 51 times and social support/safety net 41 times as DCWB targeted by their initiatives.

Graph 1: DCWB reported by the surveyed CBOs



The CBOs were asked "what is this initiative's target population?" Respondents noted the age groups and sex of their program participants; they were permitted to check more than one category. Graph 2 shows that both sexes tended to be served by the initiatives, but for some initiatives women were targeted more frequently. Young adults (19-24 years), youth (13-18 years) and adults (25-64 years) were the three most frequently served groups.

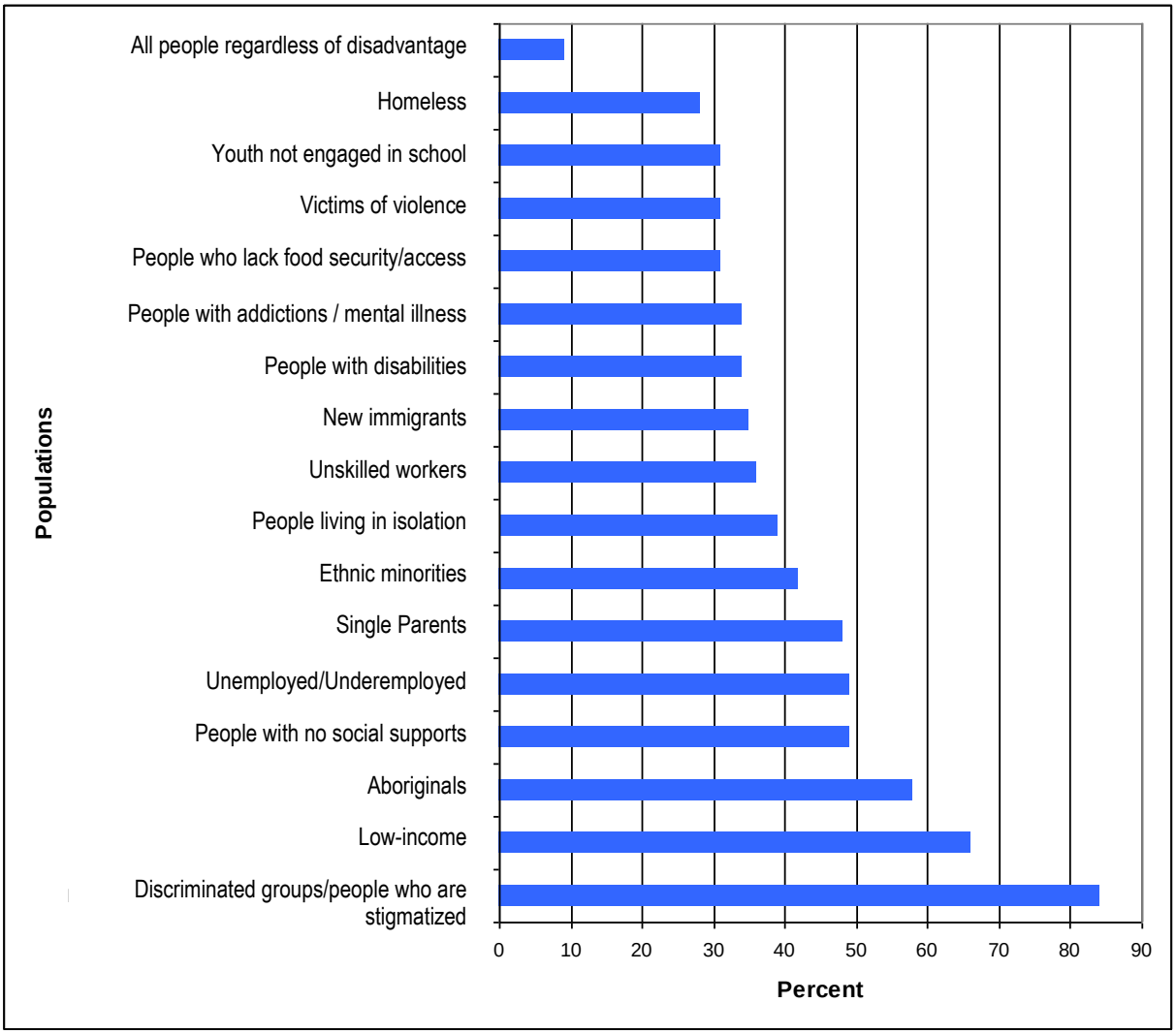
Graph 2: Population by age and sex served by the 77 CBO initiatives



Note: Numbers do not sum to 77 because initiatives could serve more than one age group.

CBOs were also asked "what best describes the target population of this initiative?" With this question, CBOs were asked to check which groups were the focus of their initiatives; once again, respondents were encouraged to check off multiple responses if they fit. Graph 3 shows the populations served by the 77 initiatives based on frequency. The most frequent response category was people/groups who were stigmatized or discriminated against (65/77, 84%), followed by people living on low incomes (51/77, 68%) and then Aboriginal peoples (45/77, 58%). Many of these categories are not mutually exclusive; for example, Aboriginal peoples often face discrimination, thus they could have been included in two categories. Thus, caution should be exercised about the implications of these findings.

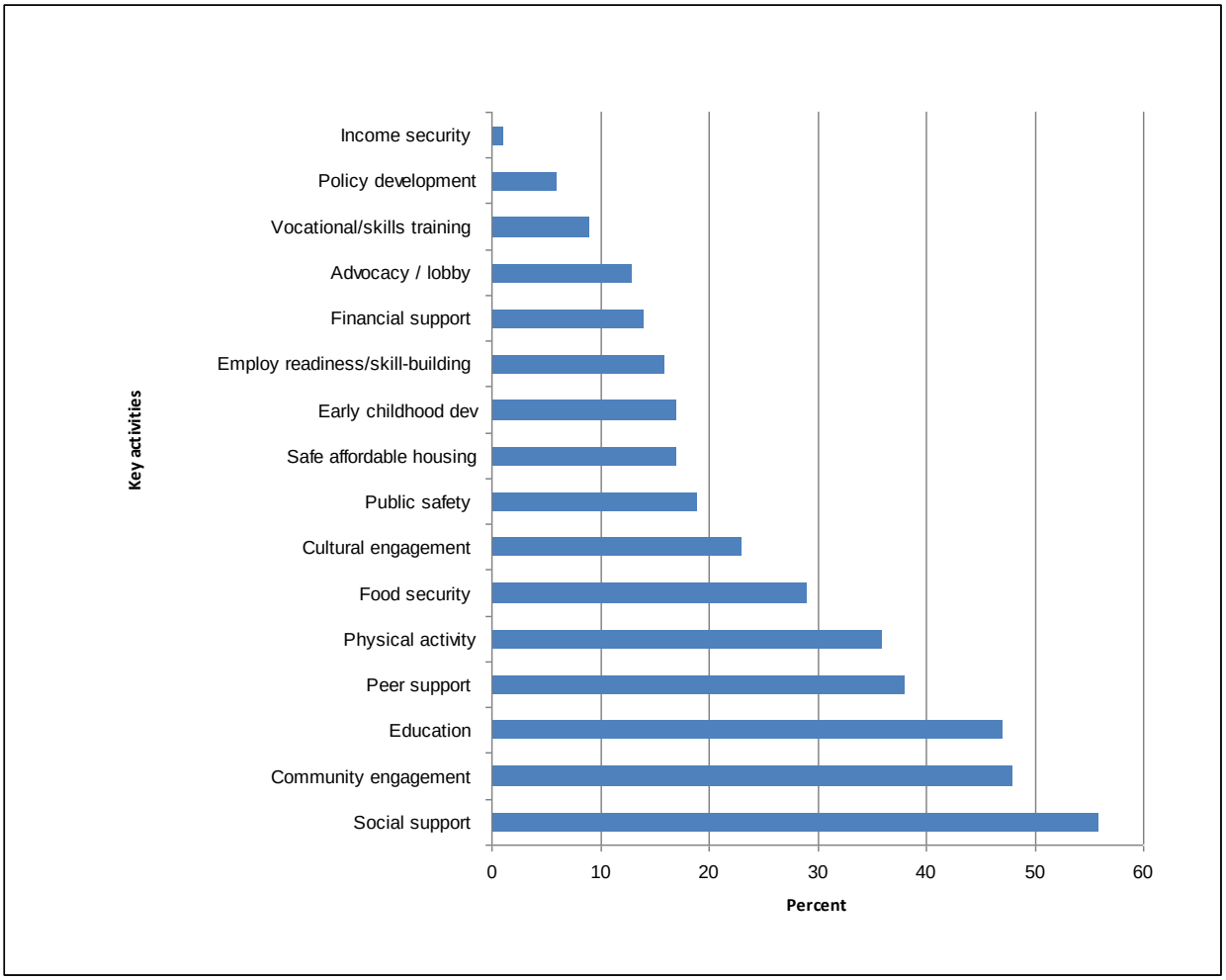
Graph 3: Populations served by the 77 CBO initiatives



Notes: - Percentages do not sum to 100% because initiatives could serve more than one group.
- Two respondents chose the "Other" category and added "seniors who have limited access to assistance from family members" and "foster families and prospective foster families".

CBOs were asked “what are this initiative’s key activities?” Answers to this question help us to better understand the depth of these initiatives. Graph 4 displays the activities offered through the 77 initiatives. The three most frequently cited activities offered are: opportunities for social support/networking (43/77, 56%), community engagement and community development (37/77, 48%), and education (36/77, 47%). The least cited activity was income security (1/77); this is not a surprise because income security is the responsibility of governments and this is a list of activities offered through CBOs.

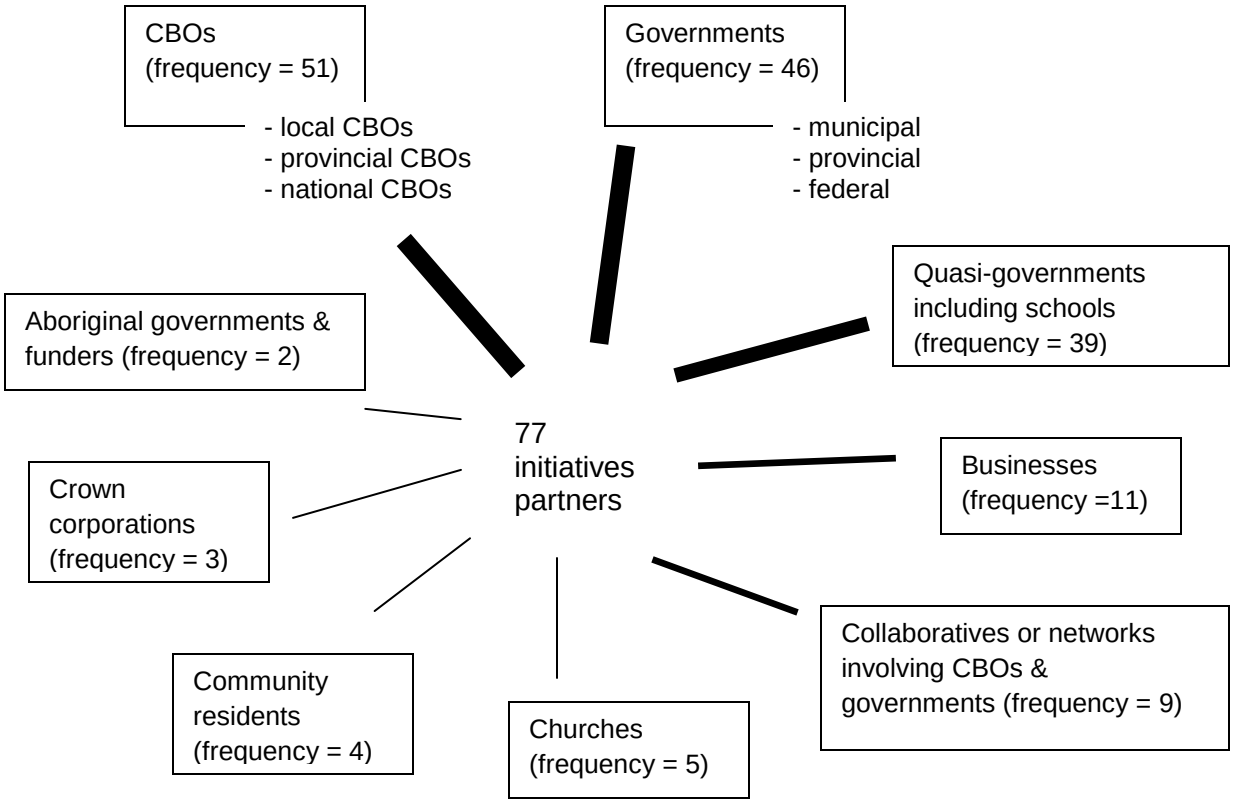
Graph 4: Key activities delivered through the 77 CBO initiatives



Note: Percentages do not sum 100% because initiatives could have more than one activity.

CBOs were asked “for this initiative, who are your main partners?” Figure 2 offers a schematic representation of the 77 initiatives and their partners. Respondents were permitted to list up to

six partners. The challenge with these data is that some respondents explicitly stated organizations' names (e.g., Regina Food Bank) while others spoke about their partners in generalities (e.g., nonprofit organizations). Thus, Figure 2 presents these data in more general terms. The most commonly cited partner was other CBOs, followed by governments and then quasi-governments. Although smaller in numbers, some respondents noted their partners on these initiatives were collaborative networks comprising CBOs and governments. Cited much less frequently as partners, were businesses, churches, crown corporations and community residents.



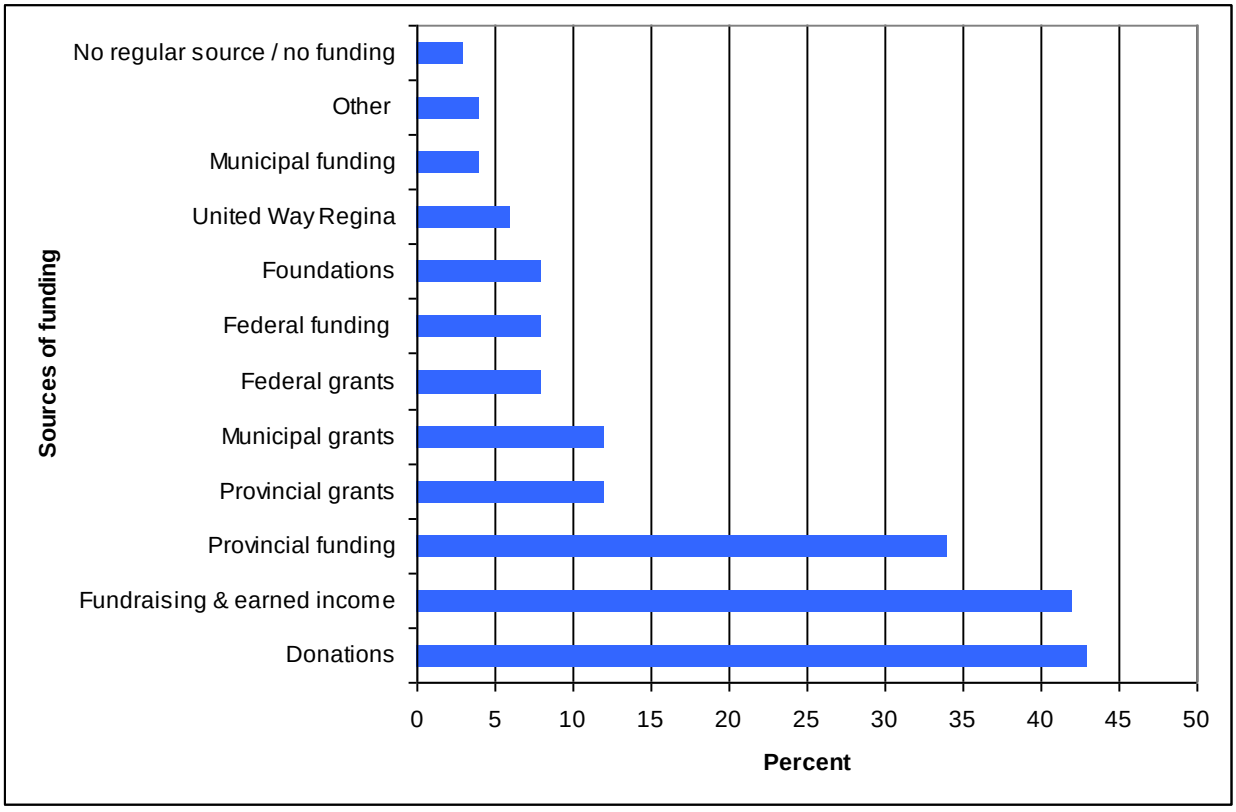
Note: - A thicker line reflects a greater number of partners.
- The "other" category contained a frequency of 12 and included the following examples: labour/union group, co-operatives, "other employment agencies", "other social programs", etc.

Figure 2: CBOs' partners involved in the 77 initiatives

CBOs were also asked "what is this initiative's major sources of funding?" Respondents were permitted to check more than one source of funding; 35/77 (45%) of the initiatives reported only one source of funding while the remainder reported multiple sources. The percentages of

different sources of funding are shown in Graph 5. The most frequently cited source of funding for these 77 initiatives was donations (33/77, 43%) followed closely by fundraising and earned income (32/77, 42%). The third most frequently cited source of funding was the provincial government and/or the Regina Qu'Appelle Health Region. Municipal funding was the least cited source of financing for these initiatives (3/77). Although many initiatives reported that donations are a major source of funding, this does not necessarily mean that these donations provide the most funding.

Graph 5: Sources of funding for the 77 CBO initiatives

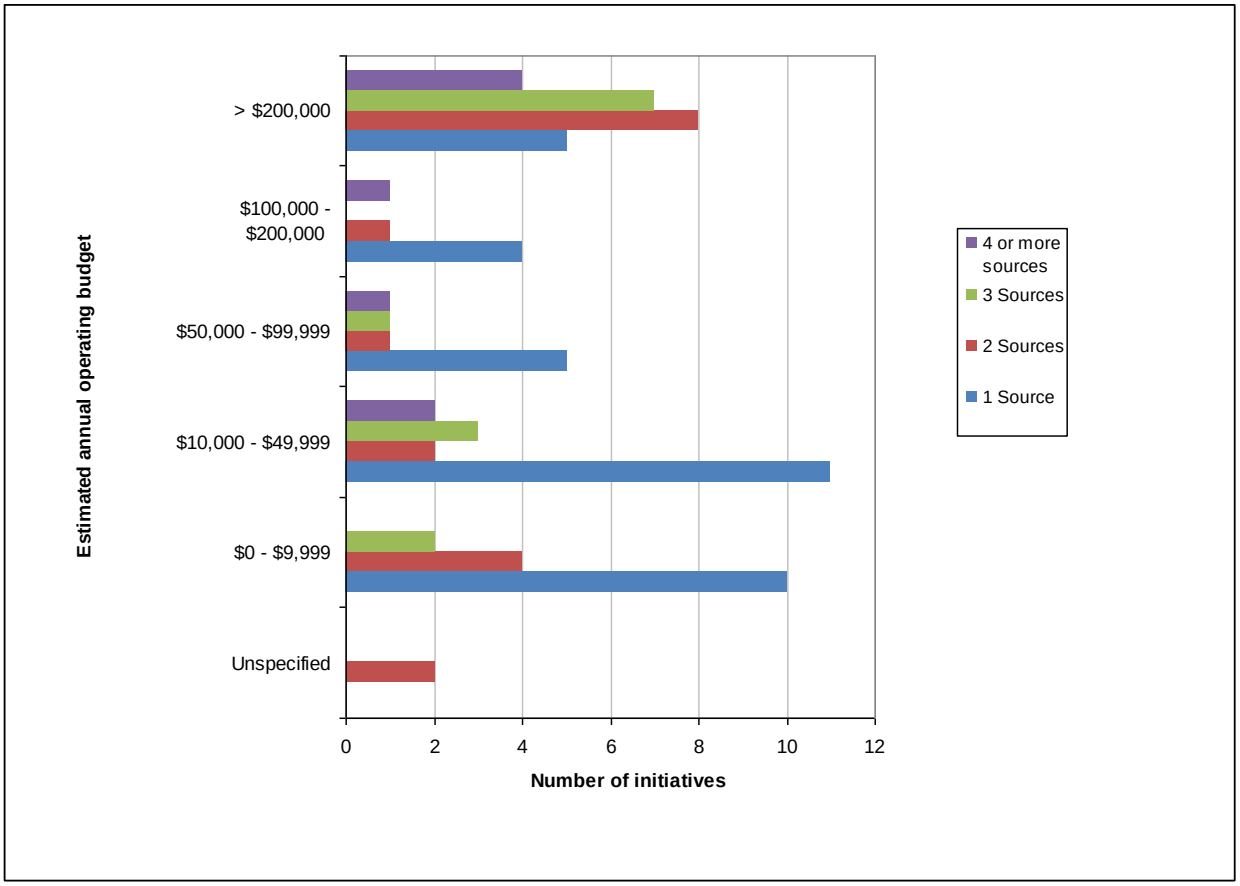


Note: - Refer to Hall et al. (2004) for rationale for this method of classification.
- Percentages do not sum to 100% because initiatives could have multiple sources of funding.
- One CBO stated two of their initiatives were funded through "self generated income" but it is not known if this refers to fundraising or donations; thus they are not categorized in this table.
- Government "funding" refers to operating funds while government "grants" refers to funding specific to that initiative and which is not permanent funding.

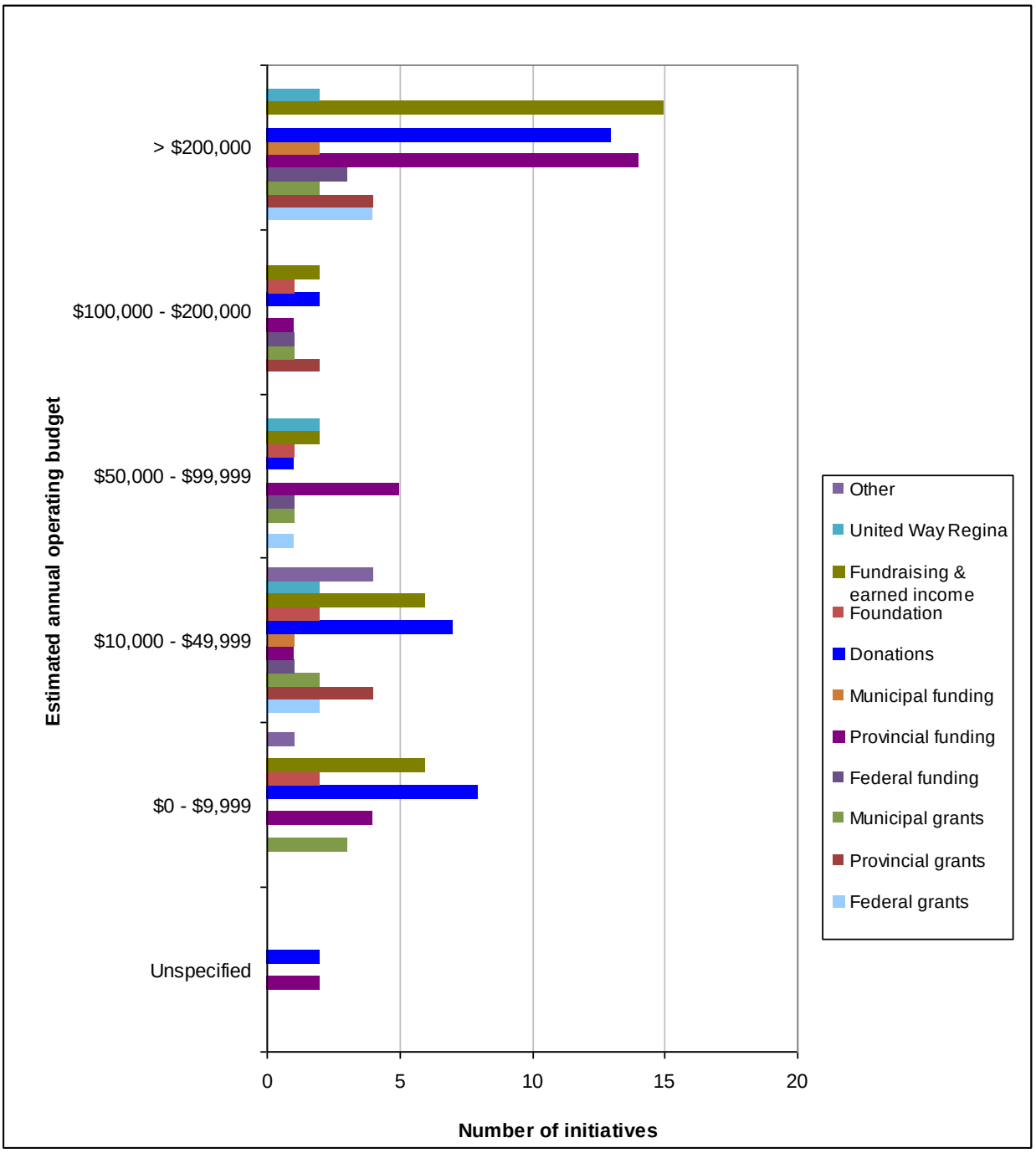
CBOs were also asked, "What is this initiative's estimated annual operating budget and what is its major source of funding?" Answers to this question help us to see how much money is going into DCWC work as a whole. Graphs 6 and 7 present summaries of the data. Graph 6 shows that for initiatives with budgets of less than $20,000, one funding source was the most

frequently cited (35/77, 45%).Graph 6 also shows that the largest number of initiatives (N=34) had annual operating budgets below $50,000 (i.e., 18 initiatives had $10,000 to $49,999, and 14 had $9,999 or less in their operating budgets). Collectively, these 34 initiatives had between one and four funding sources (with one funding source being the most common response). Graph 6 also shows that a second group of initiatives (N=24) had annual operating budgets of more than $200,000. These 24 initiatives had between one and four funding sources (with two or three funding sources being the most common response). Graph 7 shows that donations, fundraising/earned income and provincial funding, were the top three funding sources in initiatives operating on more than $200,000 per year. We can also see the prevalence of donations and fundraising, across all categories, from small-budget initiatives to the large-budget initiatives.

Graph 6: Estimated annual operating budget reported by number of funding sources for CBO initiatives



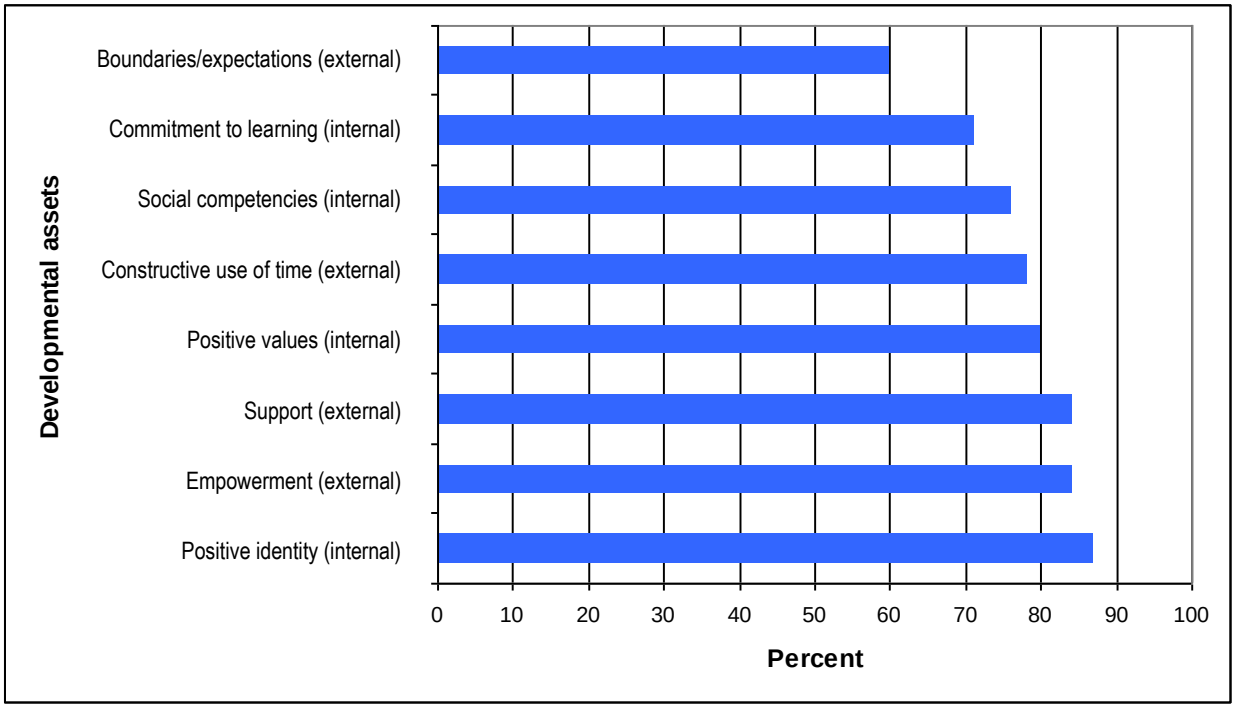
Graph 7: Estimated annual operating budget reported by major sources of funding for CBO initiatives



Note: Numbers do not sum to 77 because initiatives could have multiple sources of funding.

Finally, CBOs were asked to what extent they were knowledgeable about and working with the Developmental Assets. Twenty-six of the 37 CBOs (70%) said they were knowledgeable about the Developmental Assets. The CBOs that responded to the questions about Developmental Assets noted that 55 of the 77 initiatives (71%) address these Assets. Graph 8 below provides a list of these assets. The most frequently cited external assets were support (46/55, 84%) and empowerment (46/55, 84%). The most frequently cited internal assets were positive identity (48/55, 87%) and positive values (44/55, 80%).

Graph 8: Developmental assets addressed by 55 CBO initiatives



Note: - Percentages do not sum to 100% because initiatives could address multiple Developmental Assets.
- This graph is based on 55 initiatives, not 77, because respondents indicated that 22 initiatives did not address Developmental Assets.

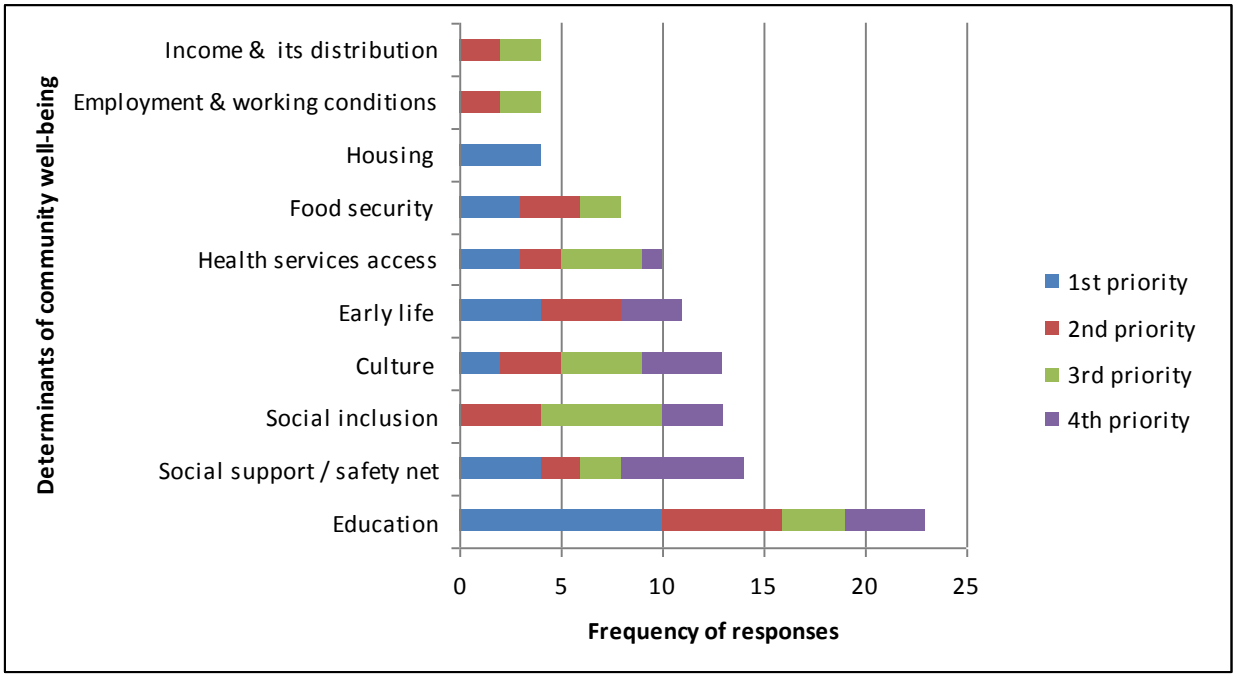
4.2 Quasi-government organizations at work on the DCWB

Now we turn to an examination of the survey data submitted by quasi-government organizations. As noted in section 3.2, many of these quasi-government organizations are registered as nonprofit charitable organizations, but they are heavily funded by different levels of government, thus they are different entities than many CBOs.

The main characteristics of the 11 quasi-government organizations were cited in Table 1 (refer back to section 3.2). In general, 7/11 (64%) of the respondents provided services on a city or larger, regional scale, while four provided services at a neighbourhood level or other sub-area of the city. The largest number (7/11, 64%) of quasi-government organizations had annual operating budgets in excess of $1 million. The most frequently cited major source of funding was “provincial funding”. Quasi-government organizations were almost evenly split across organization sizes (e.g., four had less than 25 employees, three had 25-74 employees and four had 100 or more employees).

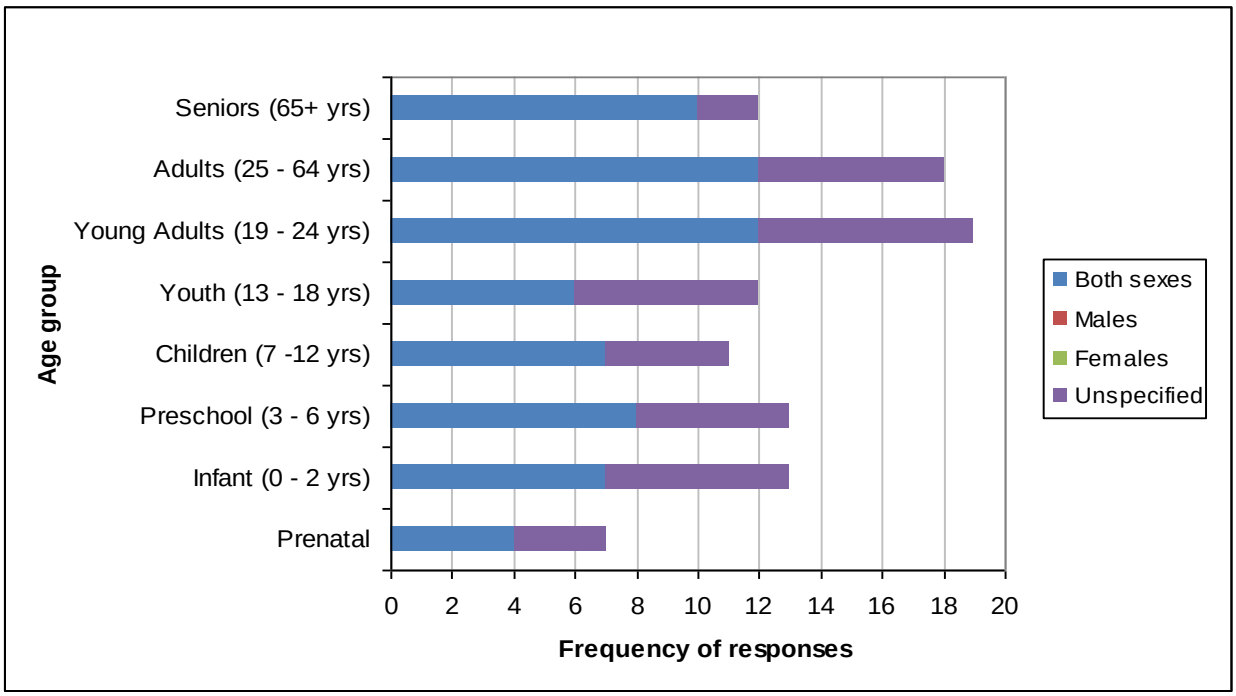
This sample of 11 quasi-government organizations reported on 33 initiatives (refer back to section 3.2 for a description of these organizations). The main survey question was, “which determinants of community well-being are the top four priorities in this initiative?” The quasi-government organizations characterized their initiatives by DCWB order of priority. Graph 9 presents a summary of these data; the list of initiatives can be found in Appendix G. The DCWB that received the highest cumulative score across all four priorities was education; quasi-government organizations noted education 23 times as a DCWB targeted by their initiatives. Graph 9 also shows that education was the DCWB that was noted most frequently as first priority and second priority, while social inclusion was cited most frequently as third priority and social support/safety net was the highest reported fourth priority. As was the case for the data about CBOs and their DCWB, income and its distribution was the least likely to be listed.

Graph 9: DCWB reported by the quasi-government organizations



Quasi-government organizations were asked “what is this initiative’s target population?” Respondents noted the age groups and sex of their program participants; they were permitted to check more than one category. Graph 10 shows that both women and men were served equally by the initiatives. The graph also shows that young adults (19-24 years) and adults (25-64 years) were the two most frequently served groups by these initiatives. Infants, preschoolers, youth, seniors and children were served in descending order.

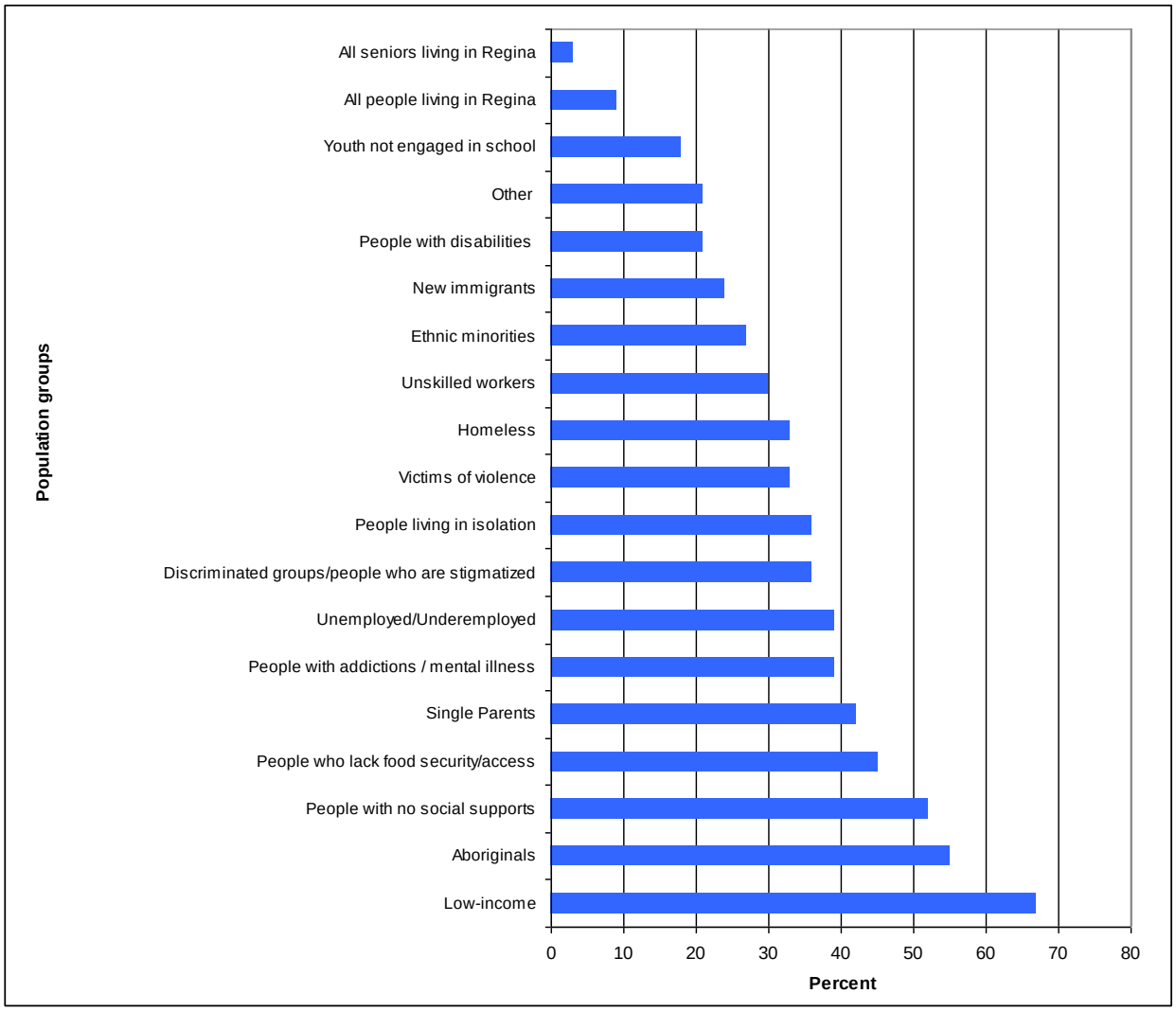
Graph 10: Quasi-government organization initiatives by age group and sex



Note: Frequencies do not sum to 33 because initiatives could serve more than one age group.

Quasi-government organizations were asked “what best describes the target population of this initiative?” With this question, quasi-government organizations were asked to check which groups were the focus of their initiatives; once again, respondents were encouraged to check off multiple responses if they fit. Graph 11 shows the populations served by the 33 initiatives in order based on frequency. The most frequent response category was people living on low incomes (23/33, 70%), followed by Aboriginal peoples (19/33, 58%) and then people with no social supports (18/33, 55%). The population least likely to be served by these 33 initiatives were youth not engaged in school (6/33, 18%). Many of these categories are not mutually exclusive; for example, people who have disabilities often live on low incomes, thus they could have been included in two categories. Caution should be exercised about the implications of these findings.

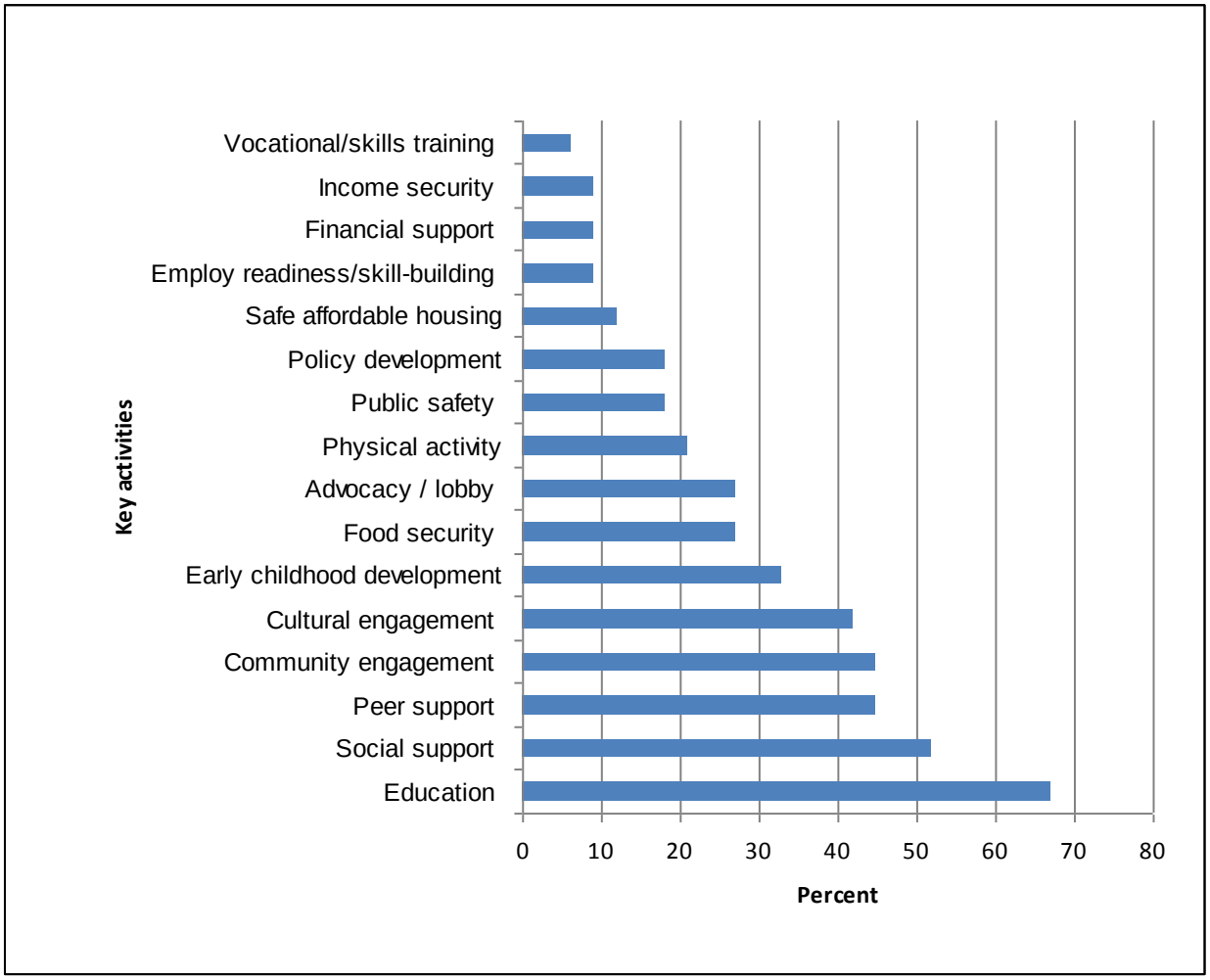
Graph 11: Populations served by the 33 quasi-government initiatives



Note: Percentages do not sum to 100% because initiatives could serve more than one group.

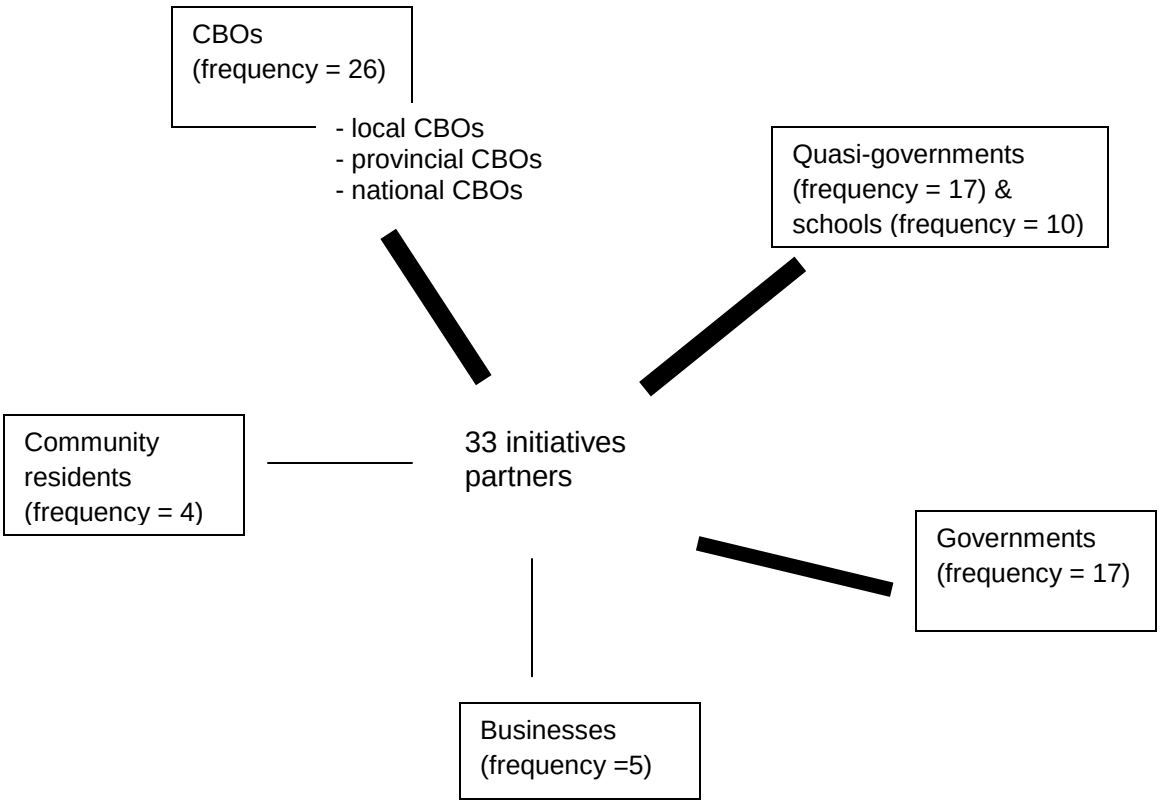
Quasi-government organizations were asked “what are this initiative’s key activities?” Answers to this question help us to better understand the depth of these initiatives. Graph 12 displays the activities offered through the 33 initiatives. The three most frequently cited activities offered are: education (23/33, 70%), social support/networking (18/33, 55%), and peer support (16/33, 48%). The least cited activities were vocational/skills training (2/33) and income security (3/33). This is not a surprise because income security is the responsibility of the provincial government and this is a list of activities offered through quasi-government organizations.

Graph 12: Key activities delivered through the 33 quasi-government initiatives



Note: Percentages do not sum to 100% because initiatives could have more than one activity.

Quasi-government organizations were also asked “for this initiative, who are your main partners?” Figure 3 offers a schematic representation of the 33 initiatives and their partners. Respondents were permitted to list up to six partners. The challenge with these data is that some respondents explicitly stated organizations’ names (e.g., Regina Food Bank) while others spoke about their partners in generalities (e.g., nonprofit organizations). Thus, Figure 3 presents these data in more general terms. The most commonly cited partners were both CBOs and quasi-governments. Governments were also cited as partners and placed third in the number of times respondents cited them. Businesses and community residents were also cited as partners, although much less frequently.

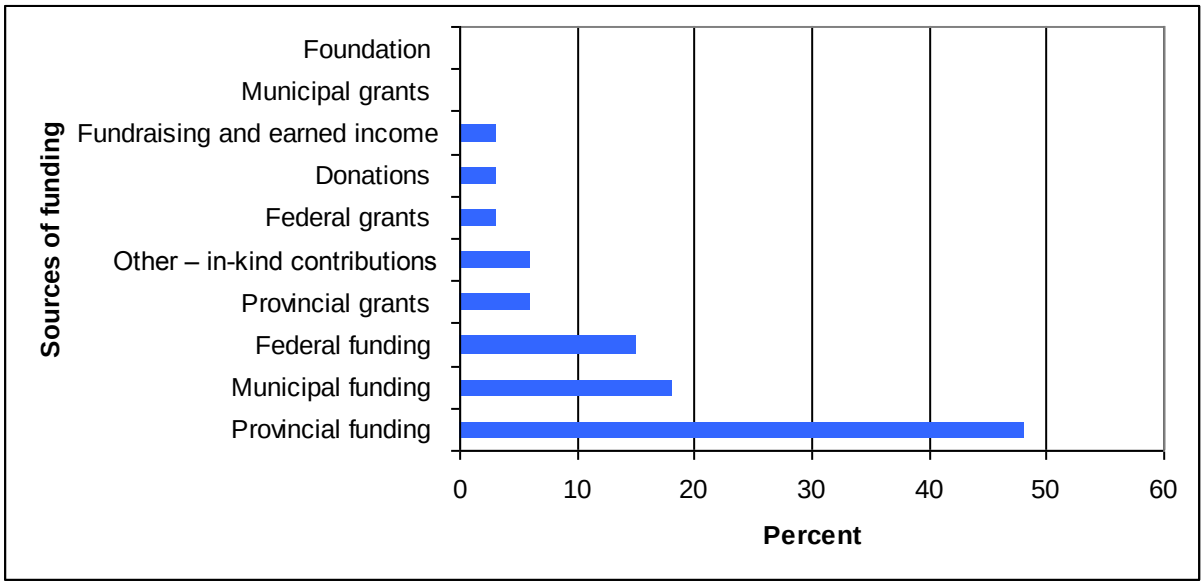


Notes: - The thicker the line, the greater the number of partners in that box.
- The "other" category contained a frequency of 4 and included the following examples which were too broadly stated to categorize: UEY partners, partners across the well-baby continuum, and two KidsFirst Partners.

Figure 3: Quasi-government organizations partners involved in the initiatives

Quasi-government organizations were also asked "what is this initiative's major sources of funding?" Respondents were permitted to check more than one source of funding. The percentage of different sources of funding are shown in Graph 13. The most frequently cited source of funding for these 33 initiatives was provincial funding (16/33, 48%). The least cited sources of financing for these initiatives were donations, fundraising, federal grants, municipal grants and foundations with one or fewer respondents choosing these sources. Although many initiatives cited provincial funding most often, this does not necessarily mean provincial funding provided the highest dollar amount.

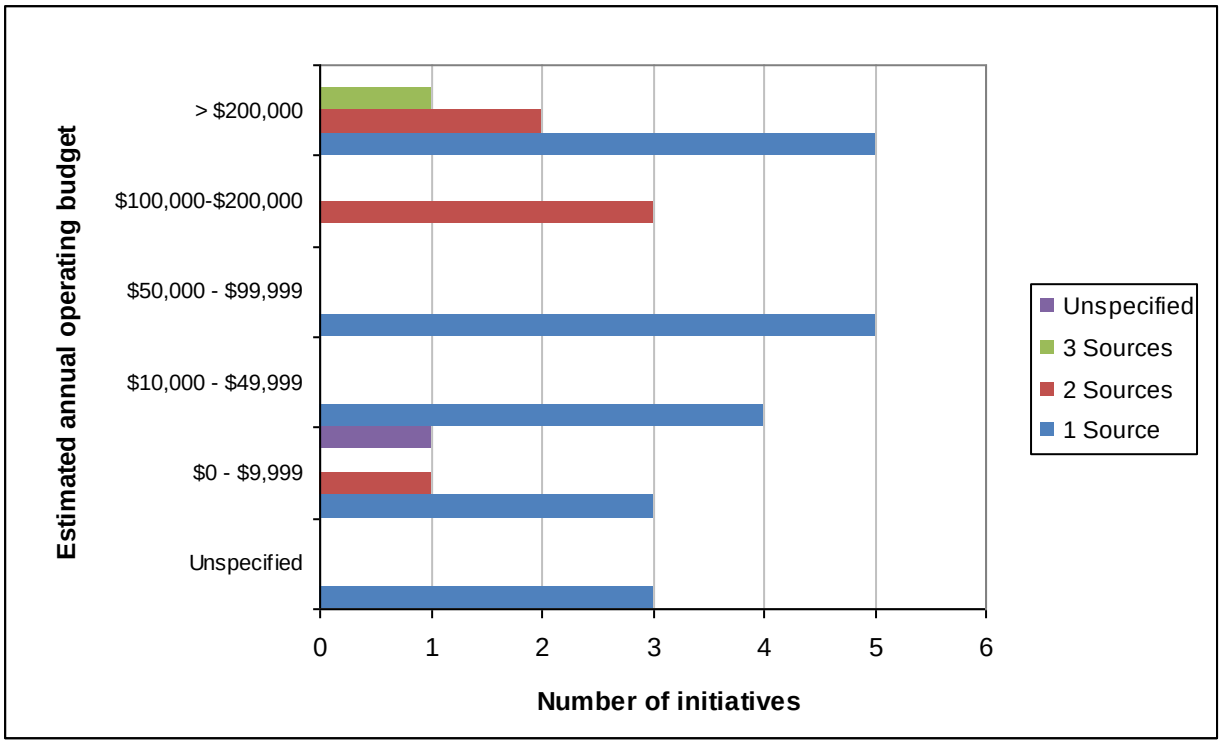
Graph 13: Sources of funding for the 33 quasi-government initiatives



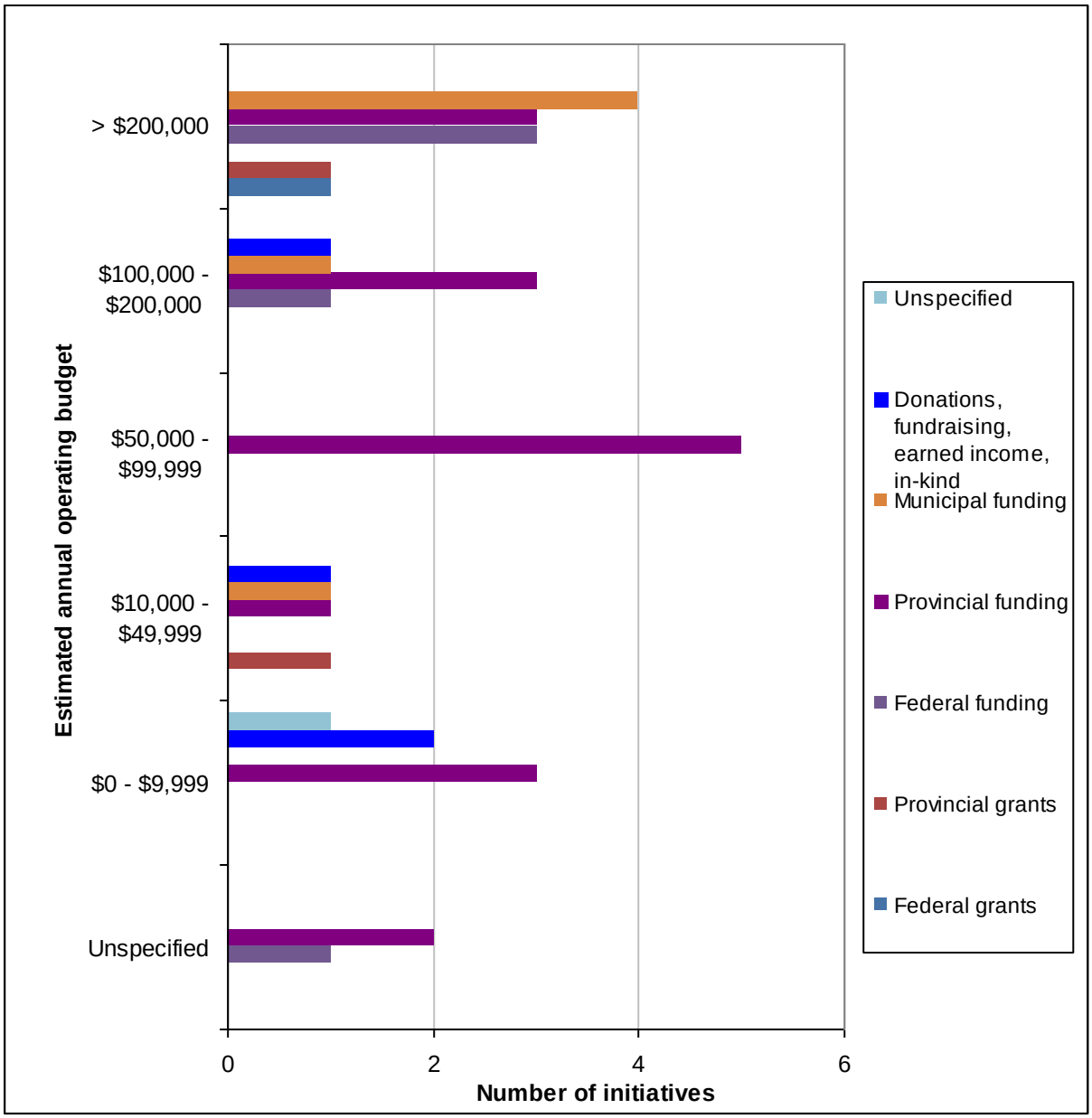
Notes: - Percentages do not sum to 100% because initiatives could have multiple sources of funding.
- Government "funding" refers to operating funds while government "grants" refers to funding specific to that initiative and which is not permanent funding.

Quasi-government organizations were also asked, "What is this initiative's estimated annual operating budget and what is its major source of funding?" Graphs 14 and 15 present summaries of the data. Graph 14 shows that the majority of initiatives only have one source of funding (20/33, 61%). This graph also shows that the greatest number of initiatives (N=9) had operating budgets of less than $50,000; seven of these initiatives had only one funding source. Initiatives with annual operating budgets greater than $200,000, coming from one to three funding sources, comprised the second largest group (N=8). In Graph 15 we see a number of funding sources involved in supporting initiatives with operating budgets of more than $10,000, albeit not as numerous as the CBO data in graphs 6 and 7. As was noted in Graph 13, above, the provincial government is shown to provide funding for the smallest initiatives, right through to the largest initiatives.

Graph 14: Quasi-government organization initiatives: estimated annual operating budget reported by number of funding sources



Graph 15: Quasi-government Organization Initiatives: Estimated Annual Operating Budget reported by Major Sources of Funding

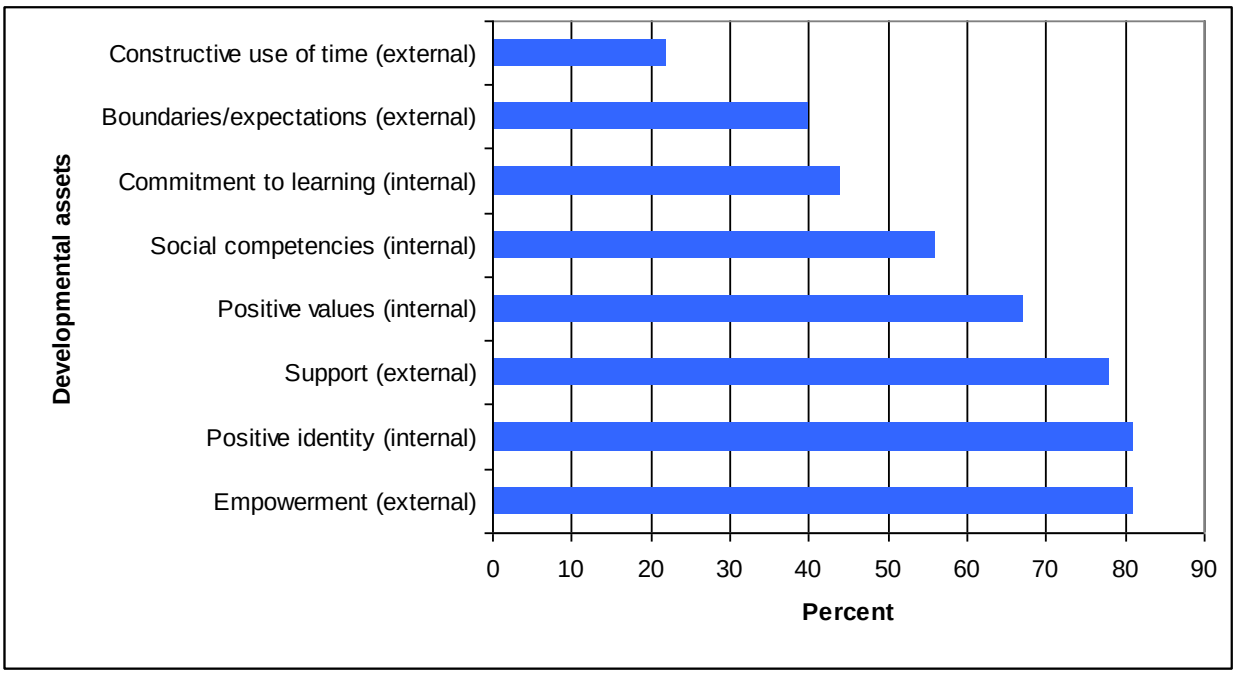


Note: Numbers do not sum to 33 because initiatives could have multiple sources of funding.

Finally, quasi-government organizations were asked to what extent they were knowledgeable about and working with the Developmental Assets. All 11 quasi-government organizations said they were knowledgeable about the Developmental Assets. These quasi-government organizations noted that 27 of the 33 initiatives (82%) address these Assets. Graph 16 below

provides a list of these assets. The most frequently cited external assets were empowerment (22/27, 81%) and support (21/27, 78%). The most frequently cited internal assets were positive identity (22/27, 81%) and positive values (18/27, 67%).

Graph 16: Developmental assets addressed by the 27 initiatives



Note: - Percentages do not sum to 100% because initiatives could address multiple Developmental Assets.
- This graph is based on 27 initiatives, not 33, because respondents indicated that six initiatives did not address Developmental Assets.

4.3 Governments at work on the DCWB

Eight governments participated in the survey. There were four federal level government departments and/or agencies including: Citizenship and Immigration Canada; Public Health Agency of Canada; Service Canada; and the National Crime Prevention Centre. There were three provincial level government ministries or crowns including: Ministry of Corrections, Public Safety and Policing; Ministry of Justice and Attorney General; and the Saskatchewan Housing Corporation. The municipal level was represented by the City of Regina. Within each of these government departments and ministries, a variety of different divisions or units exist. The qualitative analysis offered here is intended to give readers a general sense of what these governments offer regarding the DCWB - not a detailed analysis like the CBO or quasi-government analyses just presented. These governments described the 10 DCWB through a

description of their organizational and initiative mandates as well as their list of priorities and focal populations.

Taken together as a group, these eight governments were knowledgeable about the DCWB and provided explanations about their roles regarding the DCWB. These governments described both their funder role as well as their service deliverer role. Most of these governments explained they funded CBOs to design and deliver services intended to address the DCWB. As well, as a group, they acknowledged they are attentive to the 10 DCWB in the services they deliver (i.e., income and its distribution, education, social support/safety net, social inclusion, culture, early life, health services access, employment and working conditions, food security, and housing). There were two additional elements that emerged from their responses that were not part of the original list of 10 DCWB in Survey Monkey. First, some governments included safety as a DCWB. Second, some governments offered descriptions about the importance of fostering vibrant and sustainable inner city areas and other neighbourhoods as DCWB; thus, for some of them, physical space, urban design and urban planning were DCWB.

Some of these governments also offered responses about the populations served by their programs. Once again and in general, all age groups and both sexes were served. Some of the respondents noted their programs were intended to serve all residents, not just certain categories of people. Some respondents added to the list of characteristics including: individuals in contact with the justice system, young people who have multiple characteristics that put them at a disadvantage, and people who live in certain areas of the city (i.e., a spatial component).

Finally, the respondents noted key activities. In general, taken together as a group, these respondents covered the 16 activity areas in the survey (see Appendix D for a copy of the survey). However, once again they explained they funded other organizations to deliver programs and services which included those key activities.

4.4 Summary of results

This study reports on the results of data collected from 56 organizations. The research was not intended to be a comparative study of three different groups' work with the DCWB. However, these three groups could not be placed into one category for analysis because they do not share a number of organizational characteristics (refer back to section 3.2). This section simply offers a summary of the main findings for each of these three groups.

4.4.1 CBOs summary

The 37 CBOs reported on 77 initiatives that were directed at the DCWB. The following list offers a summary of their data:

- Across all four priorities, the three most frequently cited DCWB were social inclusion (frequency of 51), social support/social safety net (frequency of 41), and education (frequency of 38). The most commonly cited first priority DCWB was early childhood. The least cited was income and its distribution.
- Young adults aged 19-24 years were the most frequently served by these initiatives (frequency of 54), followed closely by youth aged 13-18 years (frequency of 51) and then adults aged 25-64 years (frequency of 50). The majority of initiatives were targeted at both sexes, but the second most frequent response was women-only.
- The highest percentage of populations served by the initiatives was people/groups who are stagmatized or discriminated against (84%), followed by people living on low incomes (66%) and Aboriginal peoples (58%). Only approximately 10% of the initiatives were intended for “all” people, seniors, or students.
- The highest percentage of activities delivered through these initiatives centred around social supports (56%), followed by community engagement activities (48%) and education (47%). Income security was the smallest percentage.
- Respondents were asked about their main partners for these initiatives; CBOs were noted most frequently, followed by governments and then quasi-governments. Although smaller in numbers, some respondents noted their partners on these initiatives were collaborative networks comprising CBOs and governments.
- The most frequently cited source of funding for these 77 initiatives was donations (43%), followed closely by fundraising and earned income (42%), and then by provincial government and/or Regina Qu’Appelle Health Region funding (34%). The largest number of initiatives (N=34) tended to have annual operating budgets of less than $50,000 while the second largest category (N=24) had operating budgets of greater than $200,000; for both these small and large initiatives, donations and fundraising/earned income were the most frequently cited sources of funding.
- A majority of the respondents (70%) were knowledgeable about Developmental Assets and 55 of the 77 initiatives (71%) were said to address these Assets.

4.4.2 Quasi-government organizations summary

The 11 quasi-government organizations reported on 33 initiatives that were directed at the DCWB. The following list offers a summary of their data:

- Across all four priorities, the four most frequently cited DCWB were education (frequency of 23), social support/social safety net (frequency of 14), social inclusion (frequency of 13) and culture (frequency of 13). The most frequently cited first priority DCWB was education. The least cited were income and employment/working conditions.
- Young adults aged 19-24 years were the most frequently served by these initiatives (frequency of 19), followed closely by adults aged 25-64 years (frequency of 18), and then by preschool (3-6 years) and infant (0-2 years) (both with a frequency of 13 each). Taken together, these initiatives tend to serve both sexes.
- The highest percentage of populations served by the initiatives was people living on low incomes (67%), Aboriginal peoples (55%) and people with no social supports (52%). Only approximately 10% of the quasi-government initiatives were intended for “all” people, seniors, or students.
- The highest percentage of activities delivered through these initiatives was education (67%), social support/networking (52%), followed by peer support (45%) and community engagement (45%), tied for third place. Vocational/skills training and income security were the smallest percentages.
- Respondents were asked about their main partners for these initiatives; both CBOs and quasi-governments were noted equally as frequently.
- The most frequently cited source of funding for these 33 initiatives was provincial government and/or Regina Qu’Appelle Health Region funding (48%). The largest number of initiatives (N=9) had annual operating budgets of less than $50,000 while almost the same number (N=8) had operating budgets of more than $200,000.
- All of the quasi-government respondents (100%) were knowledgeable about Developmental Assets and 27 of the 33 initiatives (82%) were said to address these Assets.

4.4.3 Governments summary

The eight governments that responded to the survey varied in the scale of data they reported, thus the in-depth level of analysis that was undertaken for CBOs and Quasi-

government organizations could not be undertaken. Nonetheless, there are some summary points that can be made:

- Governments said they play two roles regarding the DCWB – a service delivery role and a funder role (i.e., governments fund CBOs and Quaso-government organizations to work on the DCWB). Interestingly these governments did not explicitly state their public policy making role and its connection to DCWB.
- In general, these respondents acknowledged they are attentive to the DCWB. Two additional DCWB were cited by respondents: safety and urban design.

5. OBSERVATIONS, IMPLICATIONS AND QUESTIONS

Through this research initiative, we explored the determinants of community well-being in Regina. The objectives of this research were:

- to document the DCWB that are the focus of human service organizations in Regina, Saskatchewan;
- to raise awareness of DCWB among CBOs, governments and the larger community;
- to use the collected data to facilitate more integrative and collective action on determinants of community well-being through the RIC, CBOs and other institutions; and
- to create a publicly accessible inventory such that CBOs, governments and other institutions can find each other and work together toward a healthier community.

From these objectives the following two research questions emerged:

a) What determinants of community well-being are being addressed by a sample of Regina organizations and how are they doing this work?
b) How can we use the collected data as a catalyst for people to work together to further action on these determinants?

We offer our observations about these results in this discussion section as well as our thoughts about the implications of these findings for practice, public policy and action. Section 5.1 focuses on the first three bullets above and the first research question, what determinants of community well-being are being addressed by a sample of Regina organizations and how are they doing this work? Integrated within this section are descriptions about how to raise awareness about the DCWB and how to use the collected data to facilitate more integrative and collective action. We then shift our attention in section 5.2 to structural issues. Finally, in section

5.3, there are answers to the research question, how can we use the collected data as a catalyst for people to work together to further action on these determinants.

A brief reminder about the limitations of the survey data is important. Briefly, the following limitations were explained in section 3.6: there is no universe of CBOs to compare our sample to, thus we are unable to explain the extent to which these results are generalizable; there are numerous CBOs and initiatives missing from the study; there was no way to validate respondents' interpretations of the on-line questions; and the sample is biased in favour of organizations that understand and work with the DCWB.

5.1 DCWB initiatives: observations, implications and unanswered questions

Let us explore the results of individual questions and variables examined in this research. Before presenting this material, we must remember this sample is biased in favour of organizations that understand and work with the DCWB. The observations and implications offered below may only apply to the types of organizations that chose to respond to the survey. Caution in generalizing to other CBOs, quasi-government organizations and governments must be used.

Based on the results presented in section 4, CBOs, quasi-government organizations and government organizations are actively engaged in work that features the DCWB. In general, across the organizations there were different areas of emphasis on the 10 DCWB. For example, the sample of CBOs noted the importance of social inclusion choosing it most frequently. Social inclusion/exclusion is recognized as a DCWB in much of the literature (see for example, Loppie Reading & Wien, 2009; Raphael, 2004b). The key activities these CBOs offer through their initiatives reflect their work on social inclusion; the two most frequently cited activities were social support activities and community engagement activities. These key activities reflect an emphasis on the social context and socially supportive processes. Literature and theories about the salience of the social context and social processes abound (Bouchard et al., 2006; Brunner & Marmot, 2006; Kawachi et al., 1999). Social inclusion can be viewed as a cross-cutting theme that is found embedded in numerous other DCWB (e.g., low income, employment, culture). CBOs are known for their ability to work across artificial boundaries, often created by government silos, using instead, people's lived experiences to define, bound and resolve issues

(DeSantis, 2008). **Is it time for Regina's organizations to measure the impacts of their social inclusion initiatives given some research shows social inclusion can reduce health inequities (Baum et al., 2010). Is a focus on social inclusion the most effective way to reduce health inequities?**

Income and its inequitable distribution as a DCWB was cited the least frequently by both CBOs and quasi-government organizations, yet it is considered to be a root cause of other health determinants (e.g., quality of early life, social exclusion, food security) and inequitable health outcomes (Raphael, 2009b, p. 9). Interestingly, low income has been directly tied to social exclusion in some major public policy arenas over the past decade as well. For example, in 2002, the province of Québec passed Bill 112 and in so doing, created a new Act titled, *An Act to Combat Poverty and Social Exclusion*. It should be noted that none of the organizations sampled in this study have income distribution as their mandate, thus the under-reporting of this DCWB is not surprising; neither the federal government's Employment Insurance department nor the provincial government's Ministry of Social Services that have income distribution mandates participated in the study. Nonetheless, some governments in Canada (e.g., Québec) recognize an inherent link between poverty and social exclusion and have responded with new legislation (e.g., Bill 112). **Given the major influence that income has on health status and health inequities, why has the Saskatchewan government, in collaboration with communities, not embarked on a comprehensive poverty elimination strategy with clear targets and timelines?**

Moreover, we may need to question income as root cause of some DCWB as well as health status. Income may indeed be a root cause of poor health for some populations, but recent research on DCWB conducted from Aboriginal people's perspectives offers further insight. Research on Aboriginal people's health suggests a tight interconnectedness among some key concepts. "Life stages, socio-political contexts and social determinants of health [are] nested spheres of origin, influence and impact; each affecting the other in temporally and contextually dynamic and integrated ways" resulting in many different pathways to health (Loppie Reading & Wien, 2009, p. 25). Let us consider suicide rates as a health indicator. Loppie and Wein (2009) cite evidence from a study which showed that low rates of suicide among First Nations peoples in British Columbia "appear to be related to: land title, self-government (particularly the involvement of women), control of education, security and cultural facilities, as well as control of the policies and practice of health and social programs" (Loppie Reading & Wien, 2009, p. 18).

Thus, what might appear to be disparate concepts unrelated to health, are actually key elements located in multiple pathways to healthy outcomes. **How are different levels of government and different government departments working together on this policy challenge: to conceive and implement public policies that embrace the nested spheres of influence on health?**

We should also pause for a moment to ask, were there any DCWB *not* on the original list of 10 that respondents included in their survey responses? The two additional DCWB that were noted by government respondents included: safety and urban design (e.g., the importance of fostering vibrant and sustainable inner city areas and other neighbourhoods). Interestingly, only two government respondents listed these – none of the CBOs or quasi-government organizations noted these. However, this may be the result of the survey design in which there were no sections for additional comments. The government respondents that added safety and urban design as additional DCWB offered their explanations in the section set aside to simply name their initiatives.

In terms of the age and sex breakdown of the populations served by these 48 organizations, once again all age groups and both sexes were served by these organizations, but with different areas of emphasis. The CBOs' initiatives tended to serve young adults (i.e., 19 to 24 year olds) followed by youth (i.e., 13 to 18 year olds) most frequently; CBOs were least likely to serve prenatal and the 0-6 year age category. The quasi-government organizations also served young adults most frequently followed closely by adults (i.e., aged 25-64 years); quasi-governments were least likely to serve prenatal and children (i.e., 7 to 12 years of age). Interestingly, the CBOs tended to acknowledge initiatives for males and females whereas quasi-government initiatives did not differentiate between the sexes. This may reflect the more universal approach by quasi-government organizations than a targeted approach adopted by CBOs that must make optimum use of scarce resources. **Does this mix of universal and targeted approaches lead to better health outcomes and a reduction in health inequities?**

Respondents were asked to indicate which populations their initiatives were intended to serve. Approximately 10% of the CBO and quasi-government initiatives were intended for "all" people, seniors, or students; the remaining majority of initiatives were intended for specific populations (e.g., people with disabilities, ethnic minorities, Aboriginal peoples, unemployed). The CBOs most frequently cited three populations were: groups who experience discrimination, people

living on low incomes and Aboriginal peoples. The quasi-government organizations cited the following groups of people in descending order: people living on low incomes, Aboriginal peoples, and people who lack social supports. Since many of these categories of people are not mutually exclusive (e.g., groups who experience discrimination could include all of the other groups), it is difficult to derive conclusions about these responses. Nonetheless, two implications may be offered. First, the fact that the sample of CBO respondents chose discrimination as a central identifier may indicate a collective perception of its salience and impact on people. Discrimination is identified as a DCWB in the scholarly literature (Loppie Reading & Wien, 2009) and is a multi-dimensional concept tied to exclusion (Galabuzi, 2004). Second, approximately 90% of the initiatives are intended to serve populations with various vulnerabilities, thus they are targeted and not intended to be universal. This result has been found in other literature: "Programs are then tailored to the particular needs of the community … In so doing, community organizations create a safety net for the most vulnerable … " (Danaher, 2011, p. 4). **In the quest for better health outcomes, what is the most advantageous blend of universal and targeted approaches, which sector (i.e., government, CBO) should be offering what programs and services, and how should these be financially supported?**

Now let us consider how these DCWB are financially supported. In general, CBO initiatives' most common sources of funding were donations, fundraising and earned income, and provincial funding (in descending order). CBOs also tended to have a greater number and more diverse funding sources for their initiatives than quasi-governments. Quasi-government initiatives' most common source was provincial funding.[6] Let us examine the CBOs more closely. It is not surprising to observe a high occurrence of donations and fundraising/earned income because these are characteristic of the CBO sector. There has been a shift in funding models over the past two decades wherein CBOs now typically rely on multiple funding sources including donations, fees for service, fundraising and multiple, often short-term, government sources (Scott, 2003). However, this observation begs a question: if the DCWB are such important ingredients toward building healthier communities, is it appropriate that initiatives directed at enhancing these DCWB are relying on the generosity of others for donations and/or require CBOs to engage in a multitude of fundraising efforts to support initiatives? In addition, given some initiatives are funded through government "grants", their continuation is precarious (i.e., grants are typically short-term with no guarantee of re-funding). An example of this

[6] Unfortunately, we did not ask a question about whether respondents thought their initiatives were adequately funded, so we cannot comment on funding adequacy.

phenomenon is found within our current sample of initiatives: the Regina Partners for Healthy Living closed its doors in 2010 because its funding was cut. Literature exists which shows that trends in human service CBO funding include cuts to prevention-oriented programs, a shift toward short-term contracts and fees-for-service contracts, and a move away from core/operational funding (Banting, 2000; Brock & Banting, 2001a; Hall et al., 2005; Scott, 2003; Vaillancourt & Tremblay, 2002). **Given CBOs are key actors and the DCWB are such important ingredients toward building healthier communities, is it appropriate that initiatives directed at enhancing these DCWB are relying on the generosity of others for donations and/or require CBOs to engage in a multitude of fundraising efforts to sustain initiatives? Should these funding models that do not support the long term sustainability of CBO be modified?**

Respondents were asked about their main partners for these initiatives. Both CBOs and quasi-government organizations stated they have multiple partners with other CBOs, quasi-governments organizations, governments and networks in their initiatives. Only 13/77 (17%) CBO initiatives and 7/33 (21%) quasi-government initiatives listed one partner; the majority of CBO and quasi-government initiatives had three or more partners. Thus, in general, initiatives were supported by multiple partners. There are not enough detailed data collected for this study to state unequivocally, but cross-organization communication and possibly certain degrees of service integration, may exist in this sample. Additional research should focus on more detailed examination of the number and nature of partnerships in DCWB initiatives given the importance of cross-sectoral action required to move toward greater health equity in communities (Daghofer & Edwards, 2009; Johnson et al., 2008).

Developmental assets which are also determinants of well-being, are the values, qualities and experiences that young people should have in order to mature into caring and responsible adults (Search Institute, 2004). A majority of the CBO initiatives (71%) and the quasi-government initiatives (82%) address Developmental Assets. Based on the high response rate about their work on both internal and external assets, the sample of CBO respondents appears to understand the importance of working on these determinants in order to promote the well-being of the entire community.

It is noteworthy this study only focused on two major dimensions of the population health equation: determinants and processes of change (i.e., activities) (Hancock et al., 2000). Missing

from the study are outcomes and impacts of these initiatives on health status. Follow-up health outcomes research with this sample of 37 CBOs and 11 quasi-government organizations would be illuminating.

5.2 Structural issues: observations, implications and unanswered questions

The DCWB framework adopted by the Regina Regional Intersectoral Committee in 2009 places Regina in an optimal position to have an impact on health inequities for two major reasons. First, the implementation of a DCWB framework in Regina is supported by recommendations made by numerous national and international research and policy initiatives including the WHO's *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Commission on the Social Determinants of Health, 2008), and *Toward Health Equity: A Comparative Analysis and Framework for Action* (Daghofer & Edwards, 2009). Similarly, in the recently released Health Council of Canada report, *Stepping it up*, the Chairperson John Abbott states " ... many people told us that the determinants of health are being discussed with a new urgency. I have seen that myself at conferences across the country this year. There is a real appetite for action" (Health Council of Canada, 2010, p. 2). We must not forget that:

> Thirty-five years of developing knowledge in the health promotion field has unequivocally shown that taking action on the broad conditions that affect people's lives offers the greatest improvement in the health of the population. But this knowledge does not appear to be translating into action. In 2009, the Institute of Wellbeing stated that Canada is falling behind other industrialized nations in measures such as levels of poverty, the degree of inequality between the rich and poor, and investments in social programs (ibid., p. 5).

How can we find ways to ensure that the collection of DCWB continue to be a central theme on everyone's work agendas in order to reduce health inequities? How can the RIC ensure it maintains a wider lens of DCWB while also undertaking more focused efforts on housing and the early years? By focusing its energy on these two DCWB, is it expected the RIC will maximize a positive impact on health outcomes?

Second, the Senior Interministry Steering Committee (SIMS) (formerly, Human Services Integration Forum) and the Regina RIC are key Saskatchewan structures, along with their attendant processes, that can advance work on DCWB and positively impact health inequities.

Both Canadian and international literature cite the importance of cross-sectoral, cross-departmental, and integrated human service planning and delivery for reducing health inequities (Commission on the Social Determinants of Health, 2008; Johnson et al., 2008). Using a common lens across all government departments to critique public policy, for example, Health Impact Assessment (Health Council of Canada, 2010), is an important step toward this end. A health impact assessment tool is currently being used on a waste disposal initiative at the municipal level in Toronto. In other communities, common lenses are being used to vet all public policies and initiatives; take for example, the major government reorganization that occurred as a result of the Regional Chairperson's Task Force on Sustainable Development in Hamilton, Ontario in the early 1990s. These two Saskatchewan structures, SIMS and RIC, are well-positioned to change institutions and public policies toward better alignment for healthier communities. **However, what have been the impacts thus far? How will SIMS and the RIC take up the policy challenge to work on the "nested spheres" outlined above in section 5.1? What successes have there been in both vertical and horizontal collaboration (i.e., among and between CBOs and governments) for service planning, implementation and impacts on communities? How can these successes be extended?**

One final area that requires comment is the link between health equity and social justice. This is a growing field of research, policy and practice. Levy and Sidel (2006) summarize the work of others and operationalize equity in health as the lack of systemic disparities in the social determinants of health and health status among groups who have different advantages or vulnerabilities. *The Saskatoon Health Disparities* study (Lemstra & Neudorf, 2008) as well as myriad other studies show health inequities exist for many marginalized populations. Health inequity refers to unfair and avoidable differences in health status among different populations (Levy & Sidel, 2006); the existence of health inequities across marginalized populations is a social justice issue (Edwards, 2009). Human rights are social justice accountability tools that can and should be used to move us toward a more socially just Canada with fewer health inequities. Canada is a signatory to the *Universal Declaration of Human Rights* and the *International Covenant on Economic, Social and Cultural Rights*. Article 25 of the *Declaration of Human Rights* states "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care …" (Levy & Sidel, 2006, p. 18). In general, human rights agreements are intended to protect all people from social, economic, religious and political mistreatment and make governments responsible for enacting such protections (Gruskin & Braveman, 2006; Kly & Thériault, 2001).

In closing, if governments have already created and adopted human rights tools, is it now simply a matter of implementing and enforcing them? Might the implementation and enforcement of human rights be a missing link in our society's quest for health equity?

5.3 Data inventory as a catalyst to work together?

One of the original goals of this research initiative was to create a publicly accessible inventory of organizations at work on the DCWB. The major research question posed at the outset of the project was, how can we use the collected data as a catalyst for people to work together to further action on these determinants? The data inventory now exists and some of the data indicate that Regina organizations are already working together. Thus, one of RIC's goals about collaboration among and between CBOs and governments is happening, but it is not clear to what extent this is happening. **The three central questions that should be answered now appear to be: a) how is the RIC using the DCWB as a common lens to continue to make change; b) should the inventory be launched on a publicly accessible, free website; and c) can the existence of the inventory be used to encourage organizations to find each other and further their work on DCWB?** Three possible places to launch this inventory is through the 211 system[7], the website of a public or university library, or the website of a major community organization like the United Way. As well, plain language information about the contents of the inventory and its potential utility should be widely distributed throughout human service networks in Regina.

5.4 In closing ...

The data analysed for this study indicate a group of Regina organizations are at work on the DCWB albeit with different areas of emphasis. In the end, we must strike a balance between working with socially excluded groups, changing institutional structures and policies, and enforcing the implementation of human rights tools like declarations and covenants already in

[7] "211 is an easy-to-remember three-digit phone number providing free, confidential, multilingual access to information about the full range of community, social, health and government services. Just as 911 now means access to emergency services, 211 is the pathway to these non-emergency human services. All 211 calls are answered by live operators, certified information specialists who assess each caller's needs and link them to the best available services and programs, 24 hours a day, seven days a week. A user-friendly version of the comprehensive, continually updated 211 database for each community or region can also be accessed on the Internet." (http://www.211canada.ca/what.php, accessed Sept. 1, 2011).

place. Labonte (2004) believes we have spent too much time studying socially excluded groups and encourages us to think critically about "socially excluding structures and practices" instead (p. 253). As we think about our next decade of health equity work, let us recast our gaze to these structures, policies and practices.

> "Health is a product of many social, political and economic forces and institutions outside of health … The achievement of equity in health status is not about improving the management of disease or simply increasing resources. **Realizing health requires cooperation and coalitions among disparate organizations and communities in a coordinated campaign against social and economic inequality, including the institutions that sustain it.** Health inequities are not primarily the result of accidents of nature or individual pathology but result from long-standing conditions and injustice …" (Hofrichter, 2003, p. 33) (emphasis added).

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APPENDICES

Appendix A – List of RIC members (2009)

Name	Organization
Allan, Lynn	Ministry of Social Services
Anaquod, Della	SIAST College
Baragar, Sandra	Regina Catholic Schools
Boucher, Shirley	SIAST College
Carlson, Lorri	Regina Qu'Appelle Health Region
Cavers, Stephanie	Regina Qu'Appelle Health Region
Chief Troy Hagen	Regina Police Service
Clements, Linda	Ministry of Corrections, Public Safety& Policing
Cooper, Patrick	Saskatchewan Health
Cunningham, Joanne	Prairie Valley School Division
Currie, Rob	Regina Catholic Schools
Dedi, Barbara	Saskatchewan Housing Corporation
Diener, Dr. Tania	Regina Qu'Appelle Health Region
Enion, Greg	Regina Public Schools
Frasz, Cathy	Service Canada
Holden, Chris	City of Regina
Ives, Kimberley	City of Regina
Layne, Bob	Regina Qu'Appelle Health Region
Mann, Tracey	United Way of Regina
McKenna, Julie	Regina Public Library
Myers, Terry	HSIF
Pass, Danielle	Regina Qu'Appelle Health Region
Redenbach, Michael	Regina Qu'Appelle Health Region
Salm, Twyla	University of Regina
Schantz, David	University of Regina
Stone, Wendy	Regina Police Service
Swan, Joseph	Ministry of Justice
Thompson, Darlene	Ministry of Education
Wall, Sharon	Ministry of Corrections, Public Safety & Policing
Wells, Lynn	University of Regina

List of CST members (2009)

Name	Organization
Bolen, Carla	Regina Qu'Appelle Health Region
Braun, Gordon	Drug Strategy Coordinator
Edwards-Bentz, Robyn	Service Canada
Mann, Tracey	United Way of Regina
Misskey, Eunice	Regina Qu'Appelle Health Region
Pass, Danielle	RIC Coordinator
Pederson, Doug	United Way of Regina
Ramsay, Doug	Regina Qu'Appelle Health Region
Schiff, Rebecca	HIFIS
Stone, Wendy	Regina Police Service

Appendix B – University of Regina Research Ethics Board Approval and RIC letter

University of Regina

OFFICE OF RESEARCH SERVICES

MEMORANDUM

DATE: June 8, 2010

TO: Dr. Gloria DeSantis
SPHERU

FROM: Dr. Bruce Plouffe
Chair, Research Ethics Board

Re: **Regina CBOs at Work on the Determinants of Community well-being (Secondary Use of Data) (File # 88R0910)**

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☑ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F). **ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS.** Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB.** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB.** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

D. Bruce Plouffe

Dr. Bruce Plouffe

** supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca

Phone: (306) 585-4775
Fax: (306) 585-4893
www.uregina.ca/research

Danielle Pass, Coordinator

Regina Regional Intersectoral Committee
c/o KidsFirst
1672 Albert Street
Regina, Saskatchewan
S4P 2S6

May 10, 2010

Dr. Gloria DeSantis
Post-Doctoral Research Fellow
University of Regina
SPHERU
Room CK 115
Regina, Saskatchewan

Dear Dr. DeSantis:

Thank you for your interest in the data that the Community Support Team (CST) collected via its 2009 RIC Inventory Survey. I have been apprised of your research interest in the data and have discussed this with the Regina Regional Intersectoral Committee (RIC) co-chairs, Bob Layne (Regina Qu'Appelle Health Region) and Greg Enion (Regina Board of Education). Neither of the co-chairs or I have any concerns about your intended use of the data, and appreciate the benefits to the RIC that this more in-depth analysis of our data will provide. You have the RIC's permission to utilize the data for your proposed research, "Regina CBOs at work on the determinants of community well-being."

As you know, the data was collected with no expectation of privacy by the agencies that contributed. Participants were advised that the information they submitted would eventually reside in the public domain, and contributed on this basis. In this case, participation constituted permission to use and publish the data, including that done by researchers with whom the RIC chooses to associate.

We understand that you have a working relationship with Wendy Stone, who is also a member of the RIC. We have asked Ms. Stone to keep the RIC informed of your research's progress. We look forward to hearing more from you as your project unfolds.

Sincerely,

Danielle Pass

Appendix C - Letter of introduction/invitation to participate in survey and participant list

Dear Colleague,

I am writing to you on behalf of the Community Support Team (CST) – a group working in conjunction with the Regina Regional Intersectoral Committee aimed at **improving the determinants of community well-being** in a connected, well coordinated way. We would appreciate your participation in a unique survey.

We know that there are many excellent programs in our community with this same overall goal, and believe that **you** are a connection to one or more such initiatives. The determinants of community well-being include:

- income & its distribution
- employment & working conditions
- education
- social safety net
- housing
- food security
- social inclusion
- health services access
- culture
- early life

If your organization has programs or initiatives that contribute to these determinants, we would appreciate you completing the attached survey (via a link to Survey Monkey).

Programs that **do not meet our criteria** would be any kind of treatment program, intervention or early intervention service, screening program or diagnostic service.

By way of this survey, we have 2 overall goals:

- to link initiatives based on the determinants of community well-being they primarily impact; and
- to create a user-friendly inventory of initiatives that improve community well-being.

The survey will take you about 10 minutes **per initiative** to complete. It begins with 2 very basic pages about your overall organization, and then takes you into a few pages specifically about your initiative or program. At the end of the initiative specific questions, you will be asked, "Does your organization have another initiative that addresses community well-being?" If you click "yes" you will be able to enter another initiative up to a maximum of 4. If you click "no" you will be done!

Several people from one organization can complete the survey, so pass it on to others (or send me their email addresses and I'll send them the link). If you are not the one who has the most intimate knowledge of these programs, please pass the survey on to the individuals who know the most about specific initiatives.

Special note: You do not have to complete the entire survey in one sitting. As long as you open up the link to the survey **from the same computer**, you will be able to close it and re-open it at a later time. Just remember to click "Next" on the current page before closing the survey; this saves your data. Also, you cannot fill in part of the survey and pass it on to someone else to add to it.

We would appreciate your response to this survey by June 11th, 2009.

If you have any questions, please contact either:
Wendy Stone, 777-6646, wstone@police.regina.sk.ca
Carla Bolen, 766-7842, carla.bolen@rqhealth.ca

Many thanks for your participation!!

List of Research Participants

CBOs (N=37)	Quasi-government (N=11)
All Nations Hope AIDS Network Inc. Alliance of Asset Champions Big Brothers of Regina Cathedral Area Community Assoc Catholic Family Service Society Coronation Park Community Assoc Dream Brokers Dress for Success Regina Family Service Regina Girl Guides of Canada Grow Regina Healing Hearts Ministry Heritage Community Association Indian Metis Christian Fellowship John Howard Society La Leche League Canada North Central Community Association Planned Parenthood Regina Regina Anti-Poverty Ministry Regina Early Learning Centre Inc. Regina Education & Action on Child Hunger Regina Food Bank Regina Home Economics for Living Project Inc. Regina in motion (Pre-school Work Gr) Regina West Zone Recreation & Community Service Development Board Regina Work Preparation Centre Saskatchewan Abilities Council Saskatchewan Coalition for Tobacco Reduction Saskatchewan Foster Families Assoc Saskatchewan Towards Offering Partnership Solutions (STOPS) to Violence Inc Street Culture Kidz Project Inc. The Compassionate Friends Inc. The Salvation Army - Gemma House - Waterston Centre YMCA of Regina YWCA Regina - residences - programs	Al Ritchie Health Action Centre Cornwall Alternative School Eagle Moon Health Office Four Directions Community Health Centre KidsFirst Regina Regina Catholic Schools Regina Community Clinic Regina Partners for Healthy Living Regina Police Service Regina Public Library Regina Qu'Appelle Health Region

Appendix D – Survey administered using Survey Monkey

Regina Regional Intersectoral Committee (RIC) Survey

Introduction

Many sectors, organization and agencies in Regina and area are committed to improving the well being of this community. This is done through a wide variety of programs and initiatives that take action on the social determinants of health and well being. These Determinants of Community Well Being include:

- Income & it's distribution
- Employment and working conditions
- Education
- Social safety net
- Housing
- Food security
- Social inclusion
- Health services access
- Culture
- Early life

The Regina Regional Intersectoral Committee (RIC) has promoted the development of a Community Support Team (CST) whose mandate it is to facilitate collective action on the Determinants of Community Well Being. In order to do its work, the CST needs to know more about who is doing what related to the determinants. So, initially, the data collected in this survey will be for the use of the CST in facilitating more integrative and collective approaches to this work. As such, only members of the CST, the RIC and researchers and staff affiliated with this project will have access to the information collected. But eventually, it is hoped that these data will become a part of a comprehensive inventory of agencies, projects and initiatives focused on enhancing the well being of our community, accessible by any one in the community.

The survey will take about 10 to 15 minutes per initiative to complete. You do not have to complete the survey in one sitting and you can return to the survey as many times as you with to edit your answers. You can leave the survey at any point and access it later on by clicking on the survey invitation link sent to you via email. Please make sure you save your answers by clicking "Next" on the current page before you do so.

It is not necessary for one person to complete the entire survey alone. If there are a variety of initiatives within your organization with different people responsible for each, choose the people with the most intimate knowledge to complete the survey questions for each initiative.

Please note that the survey completion deadline is June 11, 2009.

Regina Regional Intersectoral Committee (RIC) Survey

Your Organization

The following questions are about your organization.

1. What is the name of your organization?

2. What is your organization's mandate?

3. What is your organization's level of action?

- ◯ Community-based
- ◯ Region/District
- ◯ Municipal
- ◯ Provincial
- ◯ Federal
- ◯ Other (please specify)

Regina Regional Intersectoral Committee (RIC) Survey

Your Organization

4. What is your organization's estimated annual operating budget?

- ○ < $25,000
- ○ $25,000 - $49,999
- ○ $50,000 - $74,999
- ○ $75,000 - $99,999
- ○ $100,000 - $149,999
- ○ $150,000 - $199,999
- ○ $200,000 - $299,999
- ○ $300,000 - $399,999
- ○ $400,000 - $499,999
- ○ $500,000 - $749,999
- ○ $750,000 - $1 million
- ○ > $1 million

5. What is your organization's major source of funding? (check all that apply)

- ☐ Federal grants
- ☐ Provincial grants
- ☐ Municipal grants
- ☐ Federal funding
- ☐ Provincial funding
- ☐ Municipal funding
- ☐ Donations
- ☐ Foundation
- ☐ Fundraising
- ☐ Other (please specify)

6. How many people are employed in your organization?

- ○ Less than 25
- ○ 25 - 49
- ○ 50 - 74
- ○ 75 - 99
- ○ 100 - 499
- ○ 500 - 999
- ○ 1,000 - 1,999
- ○ 2,000 - 5,000
- ○ Greater than 5,000

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

Please tell us about an initiative (e.g. program, project, activity, etc.) that addresses community well-being in your organization.

7. What is the title of this initiative?

8. What is this initiative's mandate?

9. What is this initiative's target population? (check all that apply)

- [ ] Prenatal
- [ ] Infant (0 - 2 years)
- [ ] Preschool (3 - 6 years)
- [ ] Children (7 - 12 years)
- [ ] Youth (13 - 18 years)
- [ ] Other (please specify)
- [ ] Young Adults (19 - 24 years)
- [ ] Adults (25 - 64 years)
- [ ] Seniors (65+ years)
- [ ] Female
- [ ] Male

10. What best describes the target population of this initiative? (check all that apply)

- [ ] Low-income
- [ ] Unemployed/Underemployed
- [ ] Unskilled workers
- [ ] Youth not engaged in school
- [ ] Single Parents
- [ ] People with no social supports
- [ ] People living in isolation
- [ ] Discriminated groups/People who are stigmatized
- [ ] Other (please specify)
- [ ] Victims of violence
- [ ] Homeless
- [ ] People who lack food security/access
- [ ] Aboriginals
- [ ] Ethnic minorities
- [ ] New immigrants
- [ ] People with addictions/mental illness
- [ ] People with disabilities

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

11. What is this initiative's level of action?

- ◯ Community-based
- ◯ Region/District
- ◯ Municipal
- ◯ Provincial
- ◯ Federal
- ◯ Other (please specify)

12. For this initiative, who are your main partners?

1:
2:
3:
4:
5:
6:

13. What are this initiative's key activities? (check all that apply)

- ☐ Financial support
- ☐ Income security
- ☐ Employment readiness/Skill-building
- ☐ Vocational/Skills training
- ☐ Education
- ☐ Social support/Networking
- ☐ Peer support
- ☐ Safe affordable housing/Shelter
- ☐ Food security/Access
- ☐ Community engagement
- ☐ Physicial activity/Recreation
- ☐ Public safety
- ☐ Cultural engagement
- ☐ Early childhood development
- ☐ Advocacy/Lobby
- ☐ Policy development
- ☐ Other (please specify)

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

14. What is this initiative's estimated annual operating budget?

- ◯ < $5,000
- ◯ $5,000 - $9,999
- ◯ $10,000 - $24,999
- ◯ $25,000 - $49,999
- ◯ $50,000 - $74,999
- ◯ $75,000 - $99,999
- ◯ $100,000 - $149,999
- ◯ $150,000 - $200,000
- ◯ > $200,000

15. What is this initiative's major source of funding? (check all that apply)

- ☐ Federal grants
- ☐ Provincial grants
- ☐ Municipal grants
- ☐ Federal funding
- ☐ Provincial funding
- ☐ Municipal funding
- ☐ Donations
- ☐ Foundation funding
- ☐ Fundraising
- ☐ Other (please specify)

16. Contact Information

Department/Section/Unit (if applicable):

Address:

Phone Number:

Email Address:

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

The impact of the environment, education levels, income levels, child development, housing and other social-environmental factors on health is well established. Most would refer to these as the Determinants of Health (DOH). In 2004 a national conference was convened from which a reconfigured list of Social Determinants of Health (SDOY) was created. The RIC and the CST have taken this a step further to define the Determinants of Community Well-being so as to be inclusive of all sectors interested in doing this work. It is not just "Health's" job, but that of the entire community; it's about more than just health, including overall well-being, a safe, inclusive community and a satisfactory quality of life for all.

The Determinants of Community Well-being include:

1) Income & Its Distribution: Well-being improves with higher income. Emphasis is also on the overall distribution of wealth/income as well as the individual's earning power or transfers in kind (e.g. consumption of public services such as health or education).

2) Employment & Working Conditions: Economic opportunities influence prosperity and well-being as well as social opportunities to build social capital, belonging, and citizenship. The working environment impacts well-being because of job satisfaction and stress levels associated with working conditions (ex. Job security, job status, physical conditions, work relationships, etc.).

3) Education: Refers to the stock of education, skills and experiences (knowledge) that we have accumulated over our lives. Higher or more education/ knowledge equates with greater literacy, a better job and higher income which results in increased coping/problem solving skills and greater prosperity for individuals, families and communities.

4) Social Safety Net: Support from families, friends, and communities provides significant benefits that result from those social relationships and support networks and improves well-being of individuals, families, and communities.

5) Housing: The core need of housing includes affordability, adequacy, and suitability of accommodation which also addresses issues of safety and security.

6) Food Security: When all communities, residents, at all times, have readily available and socially acceptable (i.e., purchase or grow) access to sufficient, safe, and nutritionally adequate foods for an active, healthy life from a sustainable food system.

7) Social Inclusion: Social inclusion ensures that all groups or individuals are able to participate fully in Canadian life and no groups or individuals are marginalized or stigmatized.

8) Health Services Access: Ensuring equal opportunity to develop and maintain health and well-being through fair and equal access to health services.

9) Culture: Valuing cultural diversity has a positive impact on well-being and involves acknowledgement and appreciation of other cultural practices and languages.

10) Early Life: Effective parenting and family functioning, nurturing caregivers, positive learning environments, good nutrition and supportive communities contribute to optimal child development and have a positive impact on long-term prospects for the individual, family, and community.

17. Which "Determinants of Community Well-Being" are the top four priorities in this initiative?

	Income & Its Distribution	Employment & Working Conditions	Education	Social Safety Net	Housing	Food Security	Social Inclusion	Health Services Access	Culture	Early Life
First Priority	○	○	○	○	○	○	○	○	○	○
Second Priority	◎	◎	◎	◎	◎	◎	◎	◎	◎	◎
Third Priority	○	○	○	○	○	○	○	○	○	○
Fourth Priority	◎	◎	◎	◎	◎	◎	◎	◎	◎	◎

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

The 40 Developmental Assets® were developed by the Search Institute in Minneapolis. They are concrete, common sense, positive experiences, qualities and environments essential to raise successful young people. The Assets promotes the notion that being supportive of and engaging children and youth is not just the responsibility of parents and teachers, but that of the entire community. The goal is for children and youth to thrive in a vibrant, healthy community. The Assets are divided into 20 internal assets and 20 external assets.

External assests are the structures, relationship, and activities that create positive experiences and environments for young people. They are divided into the following groups:

1) Support: Young people need to be surrounded by people who love, care for, appreciate, and accept them.

2) Empowerment: Young people need to feel valued and valuable. This happens when youth feel safe and respected.

3) Boundaries/Expectations: Young people need clear rules, consistent consequences for breaking rules, and encouragement to do their best.

4) Constructive Use of Time: Young people need opportunities - outside of school - to learn and develop new skills and interests with other youth and adults.

Internal assets are the characteristics and behaviours that reflect values, skills and beliefs that cause positive internal growth and development. They are divided into the following groups:

1) Commitment to Learning: Young people need a sense of the lasting importance of learning and a belief in their won values.

2) Positive Values: Young people need to develop strong guiding values or principles to help them make healthy lifestyle choices.

3) Social Competencies: Young people need skills to interact effectively with other, to make difficult decision, and to cope with new situations.

4) Positive Identity: Young people need to believe in their own self-worth and to feel that they have control over the things that happen to them.

* 18. Are you familiar with the Developmental Assets®?

- ◯ Yes
- ◯ No

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

External Assests
1) Support: Young people need to be surrounded by people who love, care for, appreciate, and accept them.
2) Empowerment: Young people need to feel valued and valuable. This happens when youth feel safe and respected.
3) Boundaries/Expectations: Young people need clear rules, consistent consequences for breaking rules, and encouragement to do their best.
4) Constructive Use of Time: Young people need opportunities - outside of school - to learn and develop new skills and interests with other youth and adults.

Internal Assets
1) Commitment to Learning: Young people need a sense of the lasting importance of learning and a belief in their won values.
2) Positive Values: Young people need to develop strong guiding values or principles to help them make healthy lifestyle choices.
3) Social Competencies: Young people need skills to interact effectively with other, to make difficult decision, and to cope with new situations.
4) Positive Identity: Young people need to believe in their own self-worth and to feel that they have control over the things that happen to them.

* 19. Does this initiative address any of the Developmental Assets®?

- ◯ Yes
- ◯ No

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

External Assests
1) Support: Young people need to be surrounded by people who love, care for, appreciate, and accept them.
2) Empowerment: Young people need to feel valued and valuable. This happens when youth feel safe and respected.
3) Boundaries/Expectations: Young people need clear rules, consistent consequences for breaking rules, and encouragement to do their best.
4) Constructive Use of Time: Young people need opportunities - outside of school - to learn and develop new skills and interests with other youth and adults.

Internal Assets
1) Commitment to Learning: Young people need a sense of the lasting importance of learning and a belief in their won values.
2) Positive Values: Young people need to develop strong guiding values or principles to help them make healthy lifestyle choices.
3) Social Competencies: Young people need skills to interact effectively with other, to make difficult decision, and to cope with new situations.
4) Positive Identity: Young people need to believe in their own self-worth and to feel that they have control over the things that happen to them.

20. Which Developmental Assets® are addressed by this initiative?

- [ ] Support
- [ ] Empowerment
- [ ] Boundaries/Expectations
- [ ] Constructive Use of Time
- [ ] Commitment to Learning
- [ ] Positive Values
- [ ] Social Competencies
- [ ] Positive Identity

Regina Regional Intersectoral Committee (RIC) Survey

Initiative #1

*** 21. Does your organization have another initiative that addresses community well-being?**

- ◯ Yes
- ◯ No

These survey questions were duplicated for additional initiatives if respondents wished to report on more than one initiative. Respondents were permitted to report on a maximum of four initiatives.

Appendix E – Glossary included with the survey

Determinants of Community Well-being (DCWB)

The impact of the environment, education levels, income levels, child development, housing and other social-environmental factors on health is well established. Most would refer to these as the Determinants of Health (DOH). In 2004 a national conference was convened from which a reconfigured list of Social Determinants of Health (SDOH) was created. The RIC and the CST have taken this a step further to define the Determinants of Community Well-being so as to be inclusive of all sectors interested in doing this work. It is not just “health's job”, but that of the entire community; it's about more than just health, including overall well-being, a safe, inclusive community and a satisfactory quality of life for all.

The Determinants of Community Well-being include:

1) **Income & Its Distribution**: Well-being improves with higher income. Emphasis is also on the overall distribution of wealth/income as well as the individual's earning power or transfers in kind (e.g. consumption of public services such as health or education).

2) **Employment & Working Conditions**: Economic opportunities influence prosperity and well-being as well as social opportunities to build social capital, belonging, and citizenship. The working environment impacts well-being because of job satisfaction and stress levels associated with working conditions (ex. Job security, job status, physical conditions, work relationships, etc.).

3) **Education**: Refers to the stock of education, skills and experiences (knowledge) that we have accumulated over our lives. Higher or more education/ knowledge equates with greater literacy, a better job and higher income which results in increased coping/problem solving skills and greater prosperity for individuals, families and communities.

4) **Social Safety Net**: Support from families, friends, and communities provides significant benefits that result from those social relationships and support networks and improves well-being of individuals, families, and communities.

5) **Housing**: The core need of housing includes affordability, adequacy, and suitability of accommodation which also addresses issues of safety and security.

6) **Food Security**: When all communities, residents, at all times, have readily available and socially acceptable (i.e., purchase or grow) access to sufficient, safe, and nutritionally adequate foods for an active, healthy life from a sustainable food system.

7) **Social Inclusion**: Social inclusion ensures that all groups or individuals are able to participate fully in Canadian life and no groups or individuals are marginalized or stigmatized.

8) **Health Services Access**: Ensuring equal opportunity to develop and maintain health and well-being through fair and equal access to health services.

9) **Culture**: Valuing cultural diversity has a positive impact on well-being and involves acknowledgement and appreciation of other cultural practices and languages.

10) **Early Life**: Effective parenting and family functioning, nurturing caregivers, positive learning environments; good nutrition and supportive communities contribute to optimal child development and have a positive impact on long-term prospects for the individual, family, and community.

Developmental assets

External assets are the structures, relationship and activities that create positive experiences and environments for young people. They are divided into the following groups:

1) Support – young people need to be surrounded by people who love, care for, appreciate and accept them.
2) Empowerment – young people need to feel valued and valuable. This happens when youth feel safe and respected.
3) Boundaries/expectations – young people need clear rules, consistent consequences for breaking rules and encouragement to do their best.
4) Constructive use of time – young people need opportunities – outside of school – to learn and develop new skills and interests with other youth and adults.

Internal assets are the characteristics and behaviours that reflect values, skills, and beliefs that cause positive internal growth and development. They are divided into the following groups:

1) Commitment to learning – young people need a sense of the lasting importance of learning and a belief in their own values.
2) Positive values – young people need to develop strong guiding values or principles to help them make healthy lifestyle choices.
3) Social competencies – young people need skills to interact effectively with others, to make difficult decisions and to cope with new situations.
4) Positive identity – young people need to believe in their own self-worth and to feel that they have control over the things that happen to them.

Appendix F – Alphabetical list of CBOs and their initiatives

Name of organization N=37	Title of initiative N=77
All Nations Hope AIDS Network Inc.	All Nations Hope AIDS Network's Annual Aboriginal HIV/AIDS & HCV Conferences
Alliance of Asset Champions	Healthy Community Healthy Youth Regina & Area
Big Brothers of Regina	Traditional Match, In School Mentoring, Big Group Activities
Cathedral Area Community Association (CACA)	Community Clothing and Book Swap Potluck Suppers
Catholic family Service Society	Rock 100
Catholic family Service Society	Four Leaf Clover Senior Independence Club
Catholic family Service Society	Baby F&ST
Catholic family Service Society	Marriage Preparation
Coronation Park Community Association	Community Programming
Dream Brokers	Dream Brokers
Dress for Success Regina	Suiting Program
Dress for Success Regina	Professional Women's Group
Family Service Regina	Choices for Change
Girl Guides of Canada	Girl Guide Program for Girls at Risk
Girl Guides of Canada	Muslim Girl Guide Program
Girl Guides of Canada	The Girl Guides of Canada - Guides du Canada program
Grow Regina	Plant a row - Grow a Row
Healing Hearts Ministry	Healing Touch groups
Heritage Community Association Inc.	Block by Block
Heritage Community Association Inc.	Heritage Community Child Care Centre
Indian Métis Christian Fellowship	Building a Christian Aboriginal worshipping working community through serving spiritual and social needs
John Howard Society - Regina Council	Justice Services & Residential Services
La Leche League Canada--Regina	Breastfeeding information and support
North Central Community Association	Go Green
North Central Community Association	Transition To Trades
North Central Community Association	Community Gardens
North Central Community Association	Hire a Neighour
Planned Parenthood Regina	Youth Educating About Health Y.E.A.H
Planned Parenthood Regina	Young Women's Wellness program
Regina Anti-Poverty Ministry	Regina Anti-Poverty Ministry - Individual advocacy, public education, and social justice

Regina Early Learning Centre Inc.	Preschool Program
Regina Early Learning Centre Inc.	KidsFirst Homevisiting
Regina Early Learning Centre Inc.	Parents as Teachers (PAT)
Regina Early Learning Centre Inc.	Family Support and Family Outreach
Regina Education and Action on Child Hunger	There are 3 program areas that all initiatives fall under Child Feeding Programs, Food Security Activities, Education Programs
Regina Food Bank	Adult Centre for Employment Readiness and Training
Regina Food Bank	The Village Market
Regina Food Bank	Emergency Food Distribution
Regina Food Bank	Village Lending Library
Regina Home Economics for Living Project Inc.	Summer Nutrition Camp
Regina Home Economics for Living Project Inc.	Everyday Living Skills for LIFE
Regina in motion (Pre-school Working Group)	LEAP (Learning Education Activity and Play) Leader Workshop
Regina in motion (Pre-school Working Group)	Moving Toward Health and Happiness DVD
Regina West Zone Recreation & Community Service Development Board	West Zone Board, Community Association & Affiliated Group Programs
Regina Work Preparation Centre	Youth Employment Outreach Initiative
Saskatchewan Abilities Council, Regina Branch	Quality of Life Services
Saskatchewan Abilities Council, Regina Branch	Partners in Employment
Saskatchewan Abilities Council, Regina Branch	Transition Services
Saskatchewan Abilities Council, Regina Branch	Training Centre
Saskatchewan Coalition for Tobacco Reduction	8 Prescriptions for Health
Saskatchewan Coalition for Tobacco Reduction	Producing a Population and Public Health Services booklet
Saskatchewan Foster Families Association	Support to foster families
Saskatchewan Foster Families Association	Recruitment and Retention of foster parents
Saskatchewan Towards Offering Partnership Solutions (STOPS) to Violence Inc	Community Connections Plan
Saskatchewan Towards Offering Partnership Solutions (STOPS) to Violence Inc	The STOPS Process
Street Culture Kidz Project Inc.	Not really titled. It is the purpose - at the base of what we do...what we do. Difficult to identify it as
Street Culture Kidz Project Inc.	Community Project

Street Culture Kidz Project Inc.	We have many, many projects that can be referenced. Please consider that the answers for all our initiatives will mirror the last two responses- with the exception of funding sources.
The Compassionate Friends Inc. - Regina Chapter	Regular monthly sharing meetings
The Salvation Army Gemma House	Gemma House
The Salvation Army Gemma House	The Salvation Army Grace Haven
The Salvation Army Waterston Centre	S.R.P. (Supportive Residential Program)
The Salvation Army Waterston Centre	The Nook
The Salvation Army Waterston Centre	Hostel, Dorms
The Salvation Army Waterston Centre	Waterston House
YMCA of Regina	Strong Kids Campaign
YMCA of Regina	Healthy Kids Day
YMCA of Regina	Community Development - Virtual YMCA
YMCA of Regina	YMCA FPSYIP
YMCA of Regina	YMCA Child Care
YWCA Regina	Kikinaw residence
YWCA Regina	Y Aunt's Place
YWCA Regina	Isabel Johnson Shelter
YWCA Regina	YWCA Big Sisters of Regina
YWCA Regina	GirlSpace
YWCA Regina	Big Boost
YWCA Regina	Y's Kids

Appendix G – Alphabetical list of quasi-government organizations and initiatives

Name of organization N=11	Title of initiative N=33
Al Ritchie Health Action Centre	Food Security Initiatives
Al Ritchie Health Action Centre	Seniors Programming
Al Ritchie Health Action Centre	Baby's Best Start
Cornwall Alternative School	Cyber school grade 10 program
Eagle Moon Health Office	General services
Four Directions Community Health Centre	Healthiest Babies Possible Program
Four Directions Community Health Centre	Chronic Conditions Nurse educator position
Four Directions Community Health Centre	Reclaiming our Lives creating Our Tipis and Focus on Fathers
Four Directions Community Health Centre	Speech and Language services
KidsFirst Regina	Fire department partnership
KidsFirst Regina	Mothers First
KidsFirst Regina	Housing Initiative
KidsFirst Regina	Make the Connection
Regina Catholic Schools	Understanding the Early Years
Regina Catholic Schools	Developmental Asset
Regina Catholic Schools	Drug Education
Regina Catholic Schools	Family Support Coordinator Service
Regina Community Clinic	Literacy for Adults with FASD
Regina Community Clinic	Lifeskills for People with FASD
Regina Partners for Healthy Living	Change to Physical Environment
Regina Partners for Healthy Living	Food Security initiative
Regina Police Service	Victim Services Unit/ Aboriginal Resource Officer Program
Regina Police Service	School Resource Program
Regina Public Library	Every Child Ready to Read
Regina Public Library	English as a Second Language Tutor Training
Regina Public Library	ESL Group Tutoring Sessions
Regina Public Library	Regina First Nation Language Speaking Circle
Regina Qu'Appelle Health Region, health promotion, nutrition	School/workplace food policy, school nutrition policy
Regina Qu'Appelle Health Region, population health	Oral health children's survey
Regina Qu'Appelle Health Region, health promotion, infants	Baby Friendly Initiative
Regina Qu'Appelle Health Region, Environmental Health Department	Environmental Public Health
Regina Qu'Appelle Health Region Environmental Health Department	Community Development
Regina Qu'Appelle Health Region, Seniors' Healthy Living Program	Seniors healthy living

Appendix H – CBO data tables

Table 2: DCWB reported by the surveyed CBOs

Determinants of community well-being	1st priority	2nd priority	3rd priority	4TH priority	TOTAL (rows)
Social inclusion	6	10	20	15	51
Social support/safety net	11	12	9	9	41
Education	9	18	5	5	38
Early life	14	3	5	1	23
Food security	6	7	4	4	22
Culture	1	5	8	7	21
Health services access	4	6	5	4	19
Housing	8	2	2	4	16
Employment and working conditions	6	2	3	2	13
Income and its distribution	3	1	0	2	6
No response	*9*	*11*	*16*	*24*	
TOTAL (columns)	**77**	**77**	**77**	**77**	

Table 3: Population by age and sex served by the 77 CBO initiatives

Population served by initiatives	Female	Male	Both sexes	Unspecified	Total
Age group					
Young Adults (19 – 24 years)	10	4	35	5	54
Youth (13 – 18 years)	13		30	8	52
Adults (25 – 64 years)	10	4	32	4	48
Children (7 -12 years)	6		22	7	35
Seniors (65 + years)	5	4	22	1	32
Preschool (3-6 years)	3		20	5	28
Infant (0-2 years)	4		17	5	26
Prenatal	2		5	2	9
No response					*1*

Note: Numbers and percentages do not sum to 77 or 100% because initiatives could serve more than one age group.

Table 4: Populations served by the 77 CBO initiatives

Population groups served by initiatives	Frequency (N=77)	%
Discriminated groups/people who are stigmatized	65	84
Low-income	51	66
Aboriginals	45	58
Unemployed/Underemployed	38	49
People with no social supports	38	49
Single Parents	37	48
Ethnic minorities	32	42
People living in isolation	30	39
Unskilled workers	28	36
New immigrants	27	35
People with addictions / mental illness	26	34
People with disabilities	26	34
Youth not engaged in school	24	31
Victims of violence	24	31
People who lack food security/access	24	31
Homeless	21	28
All people regardless of their disadvantage including: HIV/AIDS, all people looking for greener lifestyles, women needing mothering and breastfeeding support, all our programs available to all regardless of status, tobacco-reduction initiative is available to all but youth in particular, any parents who have experienced the death of a child, offenders,	7	9
Other (please specify)- seniors who have limited access to assistance from family members, foster families and prospective foster families	2	-

Note: Numbers and percentages do not sum to 77 or 100% because initiatives could serve more than one group.

Table 5: Key activities delivered through the 77 CBO initiatives

Key activities	Frequency (N=77)	%
Social support/networking	43	56
Community engagement	37	48
Education	36	47
Peer support	29	38
Physical activity/recreation	29	38
Food security/access	22	29
Cultural engagement	18	23
Public safety	15	19
Safe affordable housing/shelter	13	17
Early childhood development	13	17
Employment readiness/skill-building	12	16
Financial support	11	14
Advocacy/lobby	10	13
Vocational/skills training	7	9
Policy development	5	6
Income security	1	1
Other – public awareness	*2*	*2*
No response	*2*	*2*

Note: Percentages do not sum 100% because initiatives could have more than one activity.

Table 6: Sources of funding for the 77 initiatives

Source of funding	Frequency (N=77)	%
Donations	33	43
Fundraising & earned income* – includes fee for service, registration fees, merchandise sales, social entrepreneurial ventures	32	42
Provincial funding (includes funding from Regina Qu'Appelle Health Region)	26	34
Provincial grants	9	12
Municipal grants	9	12
Federal grants	6	8
Federal funding	6	8
Foundations	6	8
United Way Regina	5	6
Municipal funding	3	4
Other – school board, church, Saskatchewan Parks and Recreation Lottery	*3*	4
No regular source of funding or no funding at all	*2*	3
No response	*2*	

Note: * Refer to Hall et al. (2004) for rationale for this method of classification.
- Numbers and percentages do not sum to 77 or 100% because initiatives could have multiple sources of funding.
- One CBO stated two of their initiatives were funded through "self generated income" but it is not known if this refers to fundraising or donations; thus they are not categorized in this table.
- Government "funding" refers to operating funds while government "grants" refers to funding specific to that initiative and which is not permanent funding.

Table 7: CBO Initiatives: Estimated Annual Operating Budget reported by Number of Funding Sources

Estimated Annual Operating Budget	Number of Funding Sources			
	1 Source	2 Sources	3 Sources	4 or more sources
Unspecified		2		
$0 - $9,999	10	4	2	
$10,000 - $49,999	11	2	3	2
$50,000 - $99,999	5	1	1	1
$100,000 - $200,000	4	1		1
> $200,000	5	8	7	4
			No response	3

Table 8: CBO Initiatives: Estimated Annual Operating Budget reported by Major Sources of Funding

Estimated Annual Operating Budget	Major Sources of Funding										
	Fed grants	Prov grants	Munic grants	Fed funding	Prov funding	Munic funding	Donations	Foundation	Fundraise & earned income	United Way Regina	Other
Unspecified					2		2				
$0 - $9,999			3		4		8	2	6		1
$10,000 - $49,999	2	4	2	1	1	1	7	2	6	2	4
$50,000 - $99,999	1		1	1	5		1	1	2	2	
$100,000 - $200,000		2	1	1	1		2	1	2		
> $200,000	4	4	2	3	14	2	13		15	2	

Table 9: Developmental assets which are addressed by the 55 initiatives

Developmental asset	Frequency (N=55)	%
External assets		
Support	46	84
Empowerment	46	84
Constructive use of time	43	78
Boundaries/expectations	33	60
Internal assets		
Positive identity	48	87
Positive values	44	80
Social competencies	42	76
Commitment to learning	39	71
No response	2	

Note:

- This table is based on 55 initiatives, not 77, because respondents indicated that 22 initiatives did not address Developmental Assets.
- Numbers and percentages do not sum to 55 or 100% because initiatives could address multiple Developmental Assets.

Appendix I - Quasi-government data tables

Table 10: DCWB reported by the quasi-government organizations

Determinants of community well-being	1st priority	2nd priority	3rd priority	4TH priority	TOTAL (rows)
Education	10	6	3	4	23
Social support/safety net	4	2	2	6	14
Social inclusion	0	4	6	3	13
Culture	2	3	4	4	13
Early life	4	4	0	3	11
Health services access	3	2	4	1	10
Food security	3	3	2	0	8
Housing	4	0	0	0	4
Employment and working conditions	0	2	2	0	4
Income and its distribution	0	2	2	0	4
No response	*3*	*5*	*8*	*12*	-
TOTAL (columns)	**33**	**33**	**33**	**33**	

Table 11: Population by age and sex served by the 33 initiatives

Population served by initiatives	Female	Male	Both sexes	Unspecified	Frequency
Age group					
Young Adults (19 – 24 years)			12	7	19
Adults (25 – 64 years)			12	6	18
Infant (0-2 years)			7	6	13
Preschool (3-6 years)			8	5	13
Youth (13 – 18 years)			6	6	12
Seniors (65 + years)			10	2	12
Children (7 -12 years)			7	4	11
Prenatal			4	3	7
No response					*5*

Note: Numbers and percentages do not sum to 33 or 100% because initiatives could serve more than one age group.

Table 12: Populations served by the 33 initiatives

Population groups served by initiatives	Frequency (N=33)	%
Low-income	22	67
Aboriginals	18	55
People with no social supports	17	52
People who lack food security/access	15	45
Single Parents	14	42
People with addictions / mental illness	13	39
Unemployed/Underemployed	13	39
Discriminated groups/people who are stigmatized	12	36
People living in isolation	12	36
Victims of violence	11	33
Homeless	11	33
Unskilled workers	10	30
Ethnic minorities	9	27
New immigrants	8	24
People with disabilities	7	21
Youth not engaged in school	6	18
Other (please specify)- parents and their children who fit many of those categories, students using/experimenting with drugs, employees and clients using our facilities	7	21
All people living in Regina	3	
All seniors living in Regina	1	

Note: Numbers and percentages do not sum to 33 or 100% because initiatives could serve more than one group.

Table 13: Key activities delivered through the 33 initiatives

Key activities	Frequency (N=33)	%
Education	22	67
Social support/networking	17	52
Peer support	15	45
Community engagement	15	45
Cultural engagement	14	42
Early childhood development	11	33
Food security/access	9	27
Advocacy/lobby	9	27
Physical activity/recreation	7	21
Public safety	6	18
Policy development	6	18
Safe affordable housing/shelter	4	12
Employment readiness/skill-building	3	9
Financial support	3	9
Income security	3	9
Vocational/skills training	2	6
Other	*0*	
No response		

Note: Numbers and percentages do not sum to 33 or 100% because initiatives could have more than one activity.

Table 14: Sources of funding for the 33 initiatives

Source of funding	Frequency (N=33)	%
Provincial funding	17	48
Municipal funding	6	18
Federal funding	5	15
Provincial grants	2	6
Other – in-kind contributions	2	6
Federal grants	1	3
Donations	1	3
Fundraising and earned income	1	3
Municipal grants	0	0
Foundation	0	0
No response	*6*	

Note: - Numbers and percentages do not sum to 33 or 100% because initiatives could have multiple sources of funding.
- Government "funding" refers to operating funds while government "grants" refers to funding specific to that initiative and which is not permanent funding.

Table 15: Quasi-government Organization Initiatives: Estimated Annual Operating Budget reported by Number of Funding Sources

	Number of Funding Sources			
Estimated Annual Operating Budget	**1 Source**	**2 Sources**	**3 Sources**	**Unspecified**
Unspecified	3			
$0 - $9,999	3	1		1
$10,000 - $49,999	4			
$50,000 - $99,999	5			
$100,000-$200,000		3		
> $200,000	5	2	1	
No response				*5*

Table 16: Quasi-government Organization Initiatives: Estimated Annual Operating Budget reported by Major Sources of Funding

Estimated Annual Operating Budget	Major Sources of Funding								
	Fed grants	Prov grants	Munic grants	Fed funding	Prov funding	Munic funding	Foundation	Donations, fundraise, earned income, in-kind	Unspecified
Unspecified				1	2				
$0 - $9,999					3			2	1
$10,000 - $49,999		1			1	1		1	
$50,000 - $99,999					5				
$100,000 - $200,000				1	3	1		1	
> $200,000	1	1		3	3	4			

Table 17: Developmental assets addressed by the 27 initiatives

Developmental asset	Frequency (N=27)	%
External assets		
Empowerment	22	81
Support	21	78
Boundaries/expectations	11	40
Constructive use of time	6	22
Internal assets		
Positive identity	22	81
Positive values	18	67
Social competencies	15	56
Commitment to learning	12	44

Note:

- This table is based on 27 initiatives, not 33, because respondents indicated that six initiatives did not address Developmental Assets.
- Numbers and percentages do not sum to 27 or 100% because initiatives could address multiple Developmental Assets.