

CASE 2

Good Food Box: Generative Relationships and Scenario Planning in Public Health

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As Amy Campbell walked down the gentle slope of North Bay's Fraser Street towards her meeting with the Good Food Box advisory committee at the Nipissing District Housing Corporation's (NDHC) head office, she was not prepared for the unpleasant news that was awaiting her. The first order of business on the agenda was a funding update from committee chairperson and NDHC employee Valerie Kelcey and, unfortunately, the message was not good. The Good Food Box's funding had expired and had not been renewed. In light of this information, the committee knew that if an alternative source of funding was not found, the coordination of the Good Food Box program in the North Bay region would cease to exist within two months, leaving hundreds of families with reduced access to an affordable source of fresh fruits and vegetables.

As the committee voice from the North Bay Parry Sound District Health Unit, Amy's mind was scrambling for a solution. She had a deeply personal connection to the project and its goal of increasing food accessibility for low-income individuals and families, as she was a key figure in the primary implementation of the Good Food Box program in other regional sites for the past five years. Ever since the NDHC took on the responsibility of the Good Food Box's coordination, the Health Unit's only involvement was through the Good Food Box advisory committee, which was comprised of a number of community partners whose insights strengthened the program. Amy wanted to provide as much assistance on behalf of the Health Unit as she could, and she had a number of questions for her manager and other members of the Healthy Living team. Was it the responsibility of the Health Unit to rescue the Good Food Box? How had the trajectory of the Health Unit changed since it first supported the implementation of the Good Food Box? Did the current mandates and policies of the Health Unit support a food-procurement program, such as the Good Food Box? And, if the Good Food Box is beyond the Health Unit's authority, how can the Health Unit's actions continue to support immediate food security issues addressed by the Good Food Box program if it no longer exists?

NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT

The North Bay Parry Sound District Health Unit is one of 36 public health units located within the province of Ontario and one of seven located in Northern Ontario. Based in the City of North Bay and with regional offices in both Parry Sound and Burk's Falls, the Health Unit serves most of the Nipissing District and all of the Parry Sound District for a total service population of over 120,000. Within this total catchment area, there are 31 municipalities, four unorganized areas, and six First Nation reserves (North Bay Parry Sound District Health Unit [NBPSDHU], 2017).

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The Health Unit provides many services and supports throughout the community under a number of organizational umbrellas. At a macro level, the Health Unit is divided into five executive teams: Clinical Services, Community Services, Corporate Services, Finance, and Human Resources. These five categories are then further subdivided into 29 programs/service areas. These include, among others, Communicable Disease Control, Environmental Health, and Planning and Evaluation. Amy and her coworkers work in the Healthy Living program, which falls under Community Services. The programming of the Healthy Living team focuses on health promotion for chronic disease, injury prevention, and substance misuse.

The provision of health care and public health interventions and programs in Northern Ontario is traditionally very difficult due to the diversity of the population in terms of language, culture, and geography. Covering an area of nearly 800,000 square kilometers and spanning two time zones, it is no surprise that Northern Ontarians face greater barriers to achieving good health than the rest of the province. The region has greater rates of smoking and obesity and reduced access to health services and the tools necessary to live a healthy lifestyle, such as healthy foods. These broader social determinants of health have resulted in a progressively widening mortality gap between Northern and Southern Ontario (Health Quality Ontario, 2017). This climate, under which the Health Unit functions, presents unique challenges for Health Unit employees in the design, implementation, and evaluation of regional programs. As a Health Unit employee, Amy is aware of these challenges, and her daily work is imbued with a focus on marginalized groups, equity, and an upstream approach to population health. The Good Food Box project meshed well with Amy's approach to supporting healthy eating as a foundation for good health.

THE GOOD FOOD BOX

The Good Food Box project in North Bay is a food volume buying program with the purpose of supporting chronic disease prevention through the promotion of increased fruit and vegetable consumption. Like all Good Food Box programs, the North Bay Good Food Box is rooted in the community and was informed and shaped by local wants, needs, resources, and demographics. It emerged organically in 2012, when the dietitians and health promoters in the Healthy Living team at the Health Unit observed a need for increased access to fresh produce for low-income individuals in the community.

As with any community-focused project, the development of the Good Food Box in North Bay required a rigorous planning process. Amy and her team followed a general model for the development of the Good Food Box business plan that was first outlined by McCue et al. (2011). First, a needs assessment was conducted to identify potential community partners and local interest groups as well as the breadth of need within the region. Next, the Healthy Living team hosted a strategic planning process to identify the guiding principles and objectives of the Good Food Box program. Strategic planning demands "broad-scale yet effective information gathering, clarification of the mission to be pursued and issues to be addressed along the way, development and exploration of strategic alternatives, and an emphasis on the future implications of present decisions" (Bryson, 2011). Finally, they used both the needs assessment and the strategic plan to inform the development and implementation of the Good Food Box program in North Bay.

The conceptual foundation of North Bay's Good Food Box is to increase the accessibility of healthy fresh fruits and vegetables for low-income individuals and families through a bulk-buying program. This is of vital importance, as low socioeconomic status (SES) households have greater access to unhealthy foods and reduced access to healthy foods, which has resulted in higher rates of obesity in these households (Ravensbergen, Buliung, Wilson, & Faulkner, 2016).

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Good Food Box programs provide not only increased physical access, but increased financial access to healthy foods. Health Unit staff collected regional data that indicated that the bulk-buying process is able to reduce costs for customers by up to 30% when compared to shopping for the same products at a traditional grocery store. Research evidence shows projects such as Good Food Box programs, which have grown as grassroots projects throughout Canada, have been proven to increase food accessibility among food-insecure families (Loopstra & Tarasuk, 2013). Furthermore, the increase in accessibility to fresh fruits and vegetables is negatively correlated with the development of poor health and chronic disease states, which results in a positive impact on quality of life (Rose Bell, Rose, Roll, & Dupont, 2014).

In conjunction with the provision of fresh produce, the Healthy Living team also incorporated tools to improve food education and nutrition literacy into the Good Food Box model. The Good Food Box team at the Health Unit wanted to focus on more than just food accessibility, as nutrition literacy is also linked to a healthier dietary eating pattern (Wall, Geary, Pearson, Parnell, & Skidmore, 2014). Overall, low health literacy, of which nutrition literacy is a key component, is associated with poor health outcomes (Spronk, Kullen, Burdon, & O'Connor, 2014). To incorporate the nutrition literacy piece into the Good Food Box model, it was decided to include a newsletter in each box that highlighted a seasonal fruit or vegetable and contained nutritional and storage information as well as a few easy and inexpensive recipes that incorporate the monthly produce. The newsletter also included information to support daily physical activity, as a healthy diet does not function in isolation in the achievement of good health.

Each Good Food Box is packed at a central site and delivered to pick-up sites within the community during the third week of every month. They are available in small \$10 boxes for single individuals or small families and in larger \$20 boxes for larger families. The Good Food Box has a number of committed volunteers who regularly donate their time to help pack the boxes and deliver them to pick-up sites. Individuals who have already placed an order for a box will then pick their box up on the third Wednesday of the month. For lower income families who use the Good Food Box, this timing provides support in the greatest time of need: when cupboards become bare towards the end of the month and before the next social assistance payment is scheduled.

The Good Food Box program is largely self-sustaining. Each month, the boxes are pre-paid for by the consumers at community partner sites. These community partners act as the liaison between the customers and the NDHC. The funds are then funneled to the NDHC, which uses the money to purchase the produce in bulk. The food is purchased from a local wholesaler, packed by volunteers, and paid for in whole by the consumers. Aside from the funding required to support the Good Food Box coordinator position and minor delivery charges, the program requires no extra injection of funds.

Over time, North Bay's Good Food Box project has become an established social venture with growing interest and recognition in the region. It has become a regional enterprise, with boxes regularly being shipped to smaller communities within the Nipissing District, such as Mattawa and West Nipissing. The program also provides much needed fresh fruits and vegetables for Temagami, a rural community within the Nipissing District but beyond the Health Unit's service area, which does not have a local grocery store. The program has a number of engaged community partners who provide similar services, such as the local soup kitchen which advertises the Good Food Box to members of the community at easily accessible locations and occasionally provides donations or food subsidies to the Good Food Box program. The program

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has developed into an example of the power of effective community engagement and interorganizational partnerships.

HISTORY

The Good Food Box program in North Bay was not the first of its kind, but rather one example in a long list of Good Food Box projects throughout the province. The first Good Food Box program was established in Toronto in January of 1994 by FoodShare, a not-for-profit organization established in 1985 to coordinate emergency food services and to gather and allocate food. In the wake of the hunger crisis in the 1980s and the failure of food banks to address rising hunger in the city, the Good Food Box emerged from an exploration of cooperative buying systems to find alternative avenues for change. Whereas food banks and the provision of emergency sources of food only have a short-term effect on individual hunger, the Good Food Box was able to have a longer lasting and more impactful influence on, not only hunger, but nutrition as well. The Toronto chapter grew from a small program packing 40 boxes in a basement facility to packing over 4,000 boxes a month in its 7,000 square foot warehouse. The FoodShare Good Food Box program has stimulated the creation of dozens of other Good Food Box programs throughout Canada (Morgan & Scharf, 2008).

Inspired by the success of other Good Food Box programs, Amy and the Healthy Living team at the Health Unit wanted to implement a Good Food Box in the North Bay/Parry Sound region. Particularly, the success and expansion of a Good Food Box program in another northern community, Thunder Bay, proved to the Healthy Living team that such a program had promising potential within a northern context. With passion and determination, Amy and her colleagues planned, implemented, and coordinated North Bay's Good Food Box project during its first years. The Good Food Box was integrated into the portfolios of members of the Healthy Living team, and the coordination of the project became part of their job responsibilities. After a year under the direct guidance of the Health Unit, the Good Food Box project organically shifted to the NDHC when funding was procured by the NDHC for a joint Good Food Box coordinator/tenant engagement position. The NDHC was a logical governing body for the Good Food Box, as the NDHC's organizational approach to programming was more downstream and hands-on and often involved direct client interaction. The set-up costs associated with the initial implementation of the project, such as the packing boxes and materials and the scales required to portion produce, had already been covered by the Health Unit in the first year of the program. Aside from the cost associated with a coordinator's salary, the Good Food Box program was self-sufficient and, as long as the funding continued for the coordinator's position, the project seemed to have a bright and sustainable future.

At the May Good Food Box advisory committee meeting, Valerie Kelcey, committee chairperson, provided the most recent service numbers for the program: 147 boxes for the month of March and 163 for April. In April, there had also been 30 delivered to West Nipissing and 47 delivered to Mattawa. It seemed that the program was on its usual summer uptick. Valerie also expressed the interest of increasing the Temagami packing to twice a month and expanding the program to South River, another regional municipality in Parry Sound District. The Good Food Box was performing well and increasing food accessibility for low socioeconomic status individuals and families throughout the region. Amy was pleased with the success of the local project and proud of her involvement with the initial implementation.

NIPISSING DISTRICT HOUSING CORPORATION

Valerie Kelcey and Isaac Hass, the Good Food Box program coordinator, were extremely passionate about the work they were doing with the Good Food Box program. Both Valerie and Isaac were employees of the NDHC, which is a housing corporation that serves the whole of the

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Nipissing District. Its primary roles were to manage geared-to-income housing units in the region, with a specialization in housing for seniors, single individuals, and families, as well as manage a rent supplementation program (District of Nipissing Social Services Administration Board, 2013). The NDHC also administered a number of programs that did not fall into the category of housing but did attempt to address food accessibility challenges for their clients in the region. These programs included the Good Food Box program and a Pantry Swap program, where individuals could trade canned items for fresh eggs, milk, and other perishable items (District of Nipissing Social Services Administration Board, 2016).

The NDHC facilitated their programming over a service area that encompassed a population of roughly 87,000 individuals over 17,000 square kilometers, which included 11 municipalities, two First Nation reserves, and two unorganized areas (District of Nipissing Social Services Administration Board, 2013). The service catchment area for the NDHC is different from the Health Unit, which can cause confusion in service delivery. The NDHC includes all of the Nipissing District and none of the Parry Sound District, whereas the Health Unit includes all of the Parry Sound District and only a portion of Nipissing District. Most notably, it excludes the town of Temagami and Bear Island First Nation, which are under the jurisdiction of the Timiskaming Health Unit. The responsibility of the NDHC within the Good Food Box program was to procure funding for and employ a Good Food Box coordinator on a part-time basis. This coordinator was to oversee the day-to-day functioning of the program.

CORPORATE MERGER AND FUNDING CRISIS

A few weeks prior to Amy's May meeting with the Good Food Box advisory committee, the NDHC had been reorganized and integrated into the District of Nipissing Social Services Administration Board to allow for increased alignment and integration of social services for clients in the region. The social services board has the same service area as the NDHC and works in affordable housing procurement for Nipissing District residents; however, the social services board has a broader portfolio of social services, which also includes childcare-related programs, the Ontario Works and Ontario Disability Support program, and the provision of emergency medical services throughout the area (District of Nipissing Social Services Administration Board, 2013). Upon the merging of the two organizations, the services that the NDHC had provided had come under review. It had to be determined if they would continue to fund many NDHC services within the new organizational body by evaluating the NDHC program's fit with the social services board's funding criteria and if the financial resources existed to support these programs.

Prior to the integration of the NDHC into the social services board, the Good Food Box program had received funding from a variety of funds and organizations over the years. In 2014, the NDHC secured funding for a Good Food Box coordinator through the Community Health Funds, which was a grant supported by the provincial government and funneled to municipalities within Ontario. The Good Food Box coordinator position and, therefore the Good Food Box itself, was supported by this grant for both 2014 and 2015. In 2016, the position was funded by another provincial grant: the Community Homelessness Prevention Initiative. When this funding was initially granted in 2014, the NDHC became a flow-through agency for the Good Food Box project, which meant that its role was to take the established vision and purpose of the Good Food Box set out by the Health Unit and operationalize the project within the community.

The Good Food Box itself required no extra funding once initial implementation was complete. The money paid by Good Food Box customers covered the cost of the fresh produce provided in the box, and the packing was done by volunteers. The funding that was being requested by the NDHC would cover the cost of the Good Food Box coordinator position as well as a few

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minor monthly delivery charges. Now that the program had a strong foundation, Valerie and Isaac expected the program to only cost between \$12,000 and \$15,000 per year. These funds would provide the salary required to support the coordinator position, which was currently being filled by Isaac, and the \$75 monthly flat charge for the delivery of the Good Food Box to surrounding communities.

In the months prior to the May Good Food Box advisory committee meeting, Isaac and Valerie prepared grant applications to support the Good Food Box coordinator position. As the grant applications were prepared, there existed, in the back of both Isaac and Valerie's minds, the inevitable expiration of funding along with the potential threat of non-renewal. They fully believed in the Good Food Box program and in the importance of the work they were conducting, which clouded their outlook on the possibility of funding. To Isaac and Valerie, non-renewal seemed impossible; however, after the merger with the social services board, their most promising funding application to the Healthy Communities Fund for \$30,000 was rejected, citing insufficient funds and a failure to meet criteria.

Isaac and Valerie were dumbfounded. They had to think quickly and determine what the next steps would be. Leading up to the May Good Food Box advisory committee meeting, Isaac and Valerie brainstormed a strategic plan. At the meeting, they presented their plan to the members of the advisory committee. Isaac was given advance pay until the end of June, and he kindly offered to volunteer his time until funding could be procured. Valerie and Isaac were also applying to the Grow Grant and the Local Poverty Reduction Fund for funding, which were both components of the Ontario Trillium Foundation. Additionally, they provided a letter to all committee members asking for donations from local businesses and city residents to support the Good Food Box program.

Although they had made good progress in the face of an alarming situation, Amy wondered if it was enough. How long would Isaac be able to volunteer his time? He was passionate, but eventually, he would experience program delivery fatigue. This did not seem to be a sustainable solution. Were Isaac and Valerie overconfident that they would receive funding through the Grow Grant or the Poverty Reduction Fund? If so, should they apply to more grants or focus more energy on raising funds locally? If they were to focus locally, were community businesses and local residents already being asked to donate too often? Would the community fundraising campaign be successful in supporting the Good Food Box program and, if so, for how long? There were so many questions and further considerations running through Amy's mind. She had to return to the Health Unit and discuss the situation with other members of the Healthy Living team.

HEALTH UNIT AND HEALTHY LIVING TEAM

Upon her return to the Health Unit's offices, Amy requested an emergency meeting. She had to relay the news from the Good Food Box meeting and discuss the situation with her colleagues. The meeting brought together a number of key individuals in Healthy Living. Included in the discussion was Amy herself, who brought to the table 15 years of experience as a Community Health Promoter at the Health Unit; Jessica Love and Talia Durand, both Registered Dietitians working in food insecurity; and Chris Bowes, Manager of the Healthy Living program. The news Amy communicated to her three coworkers from the Good Food Box committee meeting was distressing. The major question that was on everyone's mind was if the provision of emergency funding to the NDHC for the support of the Good Food Box coordinator position fell within the responsibilities of the Health Unit. To elucidate the answer, the Healthy Living team had to ask many more questions of the Good Food Box program, of the shifting organizational objectives of

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the Health Unit to align with the 2018 modernization of the Ontario Public Health Standards (OPHS), and of the broader environmental context.

The Healthy Living team wondered if the Good Food Box could be classified as an upstream societal response or as a downstream individualistic approach to food accessibility within the region. On the one hand, the Good Food Box had a specified target population and provided the boxes on an individual basis; however, the boxes were available to anyone who wanted to participate in a bulk-buying produce program, and they did provide an upstream approach from the perspective of chronic disease prevention. Jessica had done some further research into what other health units in Ontario do to support local Good Food Box projects. She found that the results were just as varied as the ideas being proposed at the Healthy Living meeting. Some health units had minimal to no involvement, others approached the Good Food Box distally by organizing volunteers or focusing on communication, whereas two provincial health units fully coordinated the Good Food Box. It seemed that there was no set precedent as to how the Health Unit should approach this challenge.

The internal and external climate of the Health Unit was also in a transitory period. The Health Unit was in the process of shifting its focus to align with the new OPHS that were set to be released in January of 2018. The new OPHS aimed to reframe public health within the broader context of healthcare and to utilize public health's strengths to "inform and reorient the health care system" (Ministry of Health and Long-Term Care, 2017). The new OPHS addressed the need for increased integration between public health and the health care system and had a strong focus on an upstream approach to public health programming. They filled in a health policy gap that existed in the old standards as they provided a policy framework for public health programs and services. Overall, the foundation of the OPHS was shifting towards upstream approaches to public health and advocacy for policy change and away from direct service delivery. A comparison of the old and new OPHS is included in Exhibit 1. To the Healthy Living team, the new OPHS seemed to exclude the direct coordination of a program such as the Good Food Box from the mandate of a health unit.

Recent developments in the greater public health environment were also having an influence on the decision-making process. The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) had recently released a position statement on how Registered Dietitians in Ontario working in public health were expected to confront household food insecurity through support and advocacy for income-related policy changes (Exhibit 2) (Ontario Society of Nutrition Professionals in Public Health, 2015). Announcements by the provincial government, made in 2017, to change income policies were also fresh in the minds of each individual at the Healthy Living boardroom table. Premier Kathleen Wynne had recently announced the basic income pilot project, where over a three-year period, the government would guarantee a basic minimum income to eligible participants and families regardless of employment status (Exhibit 2) (Government of Ontario, 2017b). Premier Wynne had also announced a gradual increase of Ontario's minimum wage over the coming years to \$15 per hour by January of 2019 (Exhibit 2) (Government of Ontario, 2017a). The increase was expected to allow individuals working minimum wage jobs to meet the cost of living, which includes the cost of eating healthy. It seemed that the approach to food insecurity was moving upstream and away from direct food provision programs such as the Good Food Box.

NEXT STEPS

Amy and the Healthy Living team have a difficult decision on their hands. With so many considerations and potential avenues to choose from, it will not be easy. Although many alternatives exist, the Health Unit has to consider its role within the broader health care system

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and its role within provincial public services as a public health unit; simultaneously, they also have to balance their responsibility to residents of the community of North Bay and of the larger Northeastern Ontario region. It will be difficult to determine how the Health Unit will continue to support immediate food security issues addressed by programs such as the Good Food Box, while also considering the Health Unit's OPHS-informed organizational focus to support policy change.

It seemed to the Healthy Living team that the next steps are to reach out to various stakeholders whose interests were intertwined with the Good Food Box program. Considering how to optimize stakeholder relationships is key in establishing generative relationships – relationships that generate novel solutions to a complex situation or problem. An excellent way to assess the potential for generative relationships among stakeholders is by using the “STAR” model. The “STAR” model can represent the four dimensions of a generative relationship. The four dimensions are **S**eparateness or differences, **T**alking and listening or “tuning,” **A**ction opportunities, and **R**eason to work together. Strong generative relationships will contain stakeholders that have differing backgrounds, skills, perspectives, or training (S); have opportunities to talk, listen, and challenge ideas (T); be able to act on the talk to create something new (A), and there must be a mutual benefit to working together (R) (Exhibit 3) (Zimmerman & Hayday, 1999).

While analyzing stakeholders for generative relationship potential, Amy and her team will also have to balance differing and opposing viewpoints to come to a solution that pleases all groups involved. Throughout this process, they must utilize an upstream lens to household food insecurity that fits within the role of health units being carved out by the new OPHS and the recent policy announcements from the provincial government. To do so, undergoing a scenario planning process seemed to be the perfect tool to analyze the situation and the stakeholders involved and to establish a plan to move ahead (Exhibit 3). The Healthy Living team wondered who would have to be involved in the Good Food Box conversation to diversify perspectives. Who were the stakeholders involved in the Good Food Box dilemma and what could each person bring to the discussion? In the absence of funding, the Healthy Living team would have to bring together all relevant stakeholders to determine the next steps for food insecurity programming in the region. In light of the new OPHS and shifting Health Unit focus, how would the Healthy Living team be able to maximize collaborative efforts while fostering a generative relationship between these stakeholders? It would not be easy, but Amy and the Healthy Living team were ready for the challenge.

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EXHIBIT 1

Ontario Public Health Standards Comparison (2008, 2018)

The Ontario Public Health Standards (OPHS) identify the minimum expectations for public health and services to be delivered by Ontario's 36 boards of health

OPHS (2008)

- No explicit definition of public health
- Comments on the scope of the OPHS in promoting the health of the population as a whole

- Does not provide public health policy framework
- Comments on public health being an essential part of the health care system
 - Public health compliments the health care system by reducing the demand for health care services
 - No comment on the integration of public health into the health care system

- Foundational Standards
 1. Population Health Assessment
 2. Surveillance
 3. Research and Knowledge Exchange
 4. Program Evaluation

- Relationship between the Principles, the Foundational Standard, and the Program Standards (Figure 2)

OPHS (2018)

- Provides definition of public health
 - The focus of public health is on the whole population
 - What unifies public health is its focus on prevention, upstream interventions, and societal factors that influence health

- Provides public health policy framework (Figure 1)
- Comments on the transformation of the public health sector since 2008
 - Changes in the role of public health within the broader health system
 - Changes aim to maximize public health's contributions to improve the health of the population and leverage public health's strengths to inform and reorient the health care system

- Foundational Standards
 1. Population Health Assessment
 2. Health Equity
 3. Effective Public Health Practice
 4. Emergency Preparedness, Response, and Recovery

- Description of the Principles, the Foundational Standards, and the Program Standards (Figure 3)

Source: Ministry of Health and Long-Term Care, 2018.

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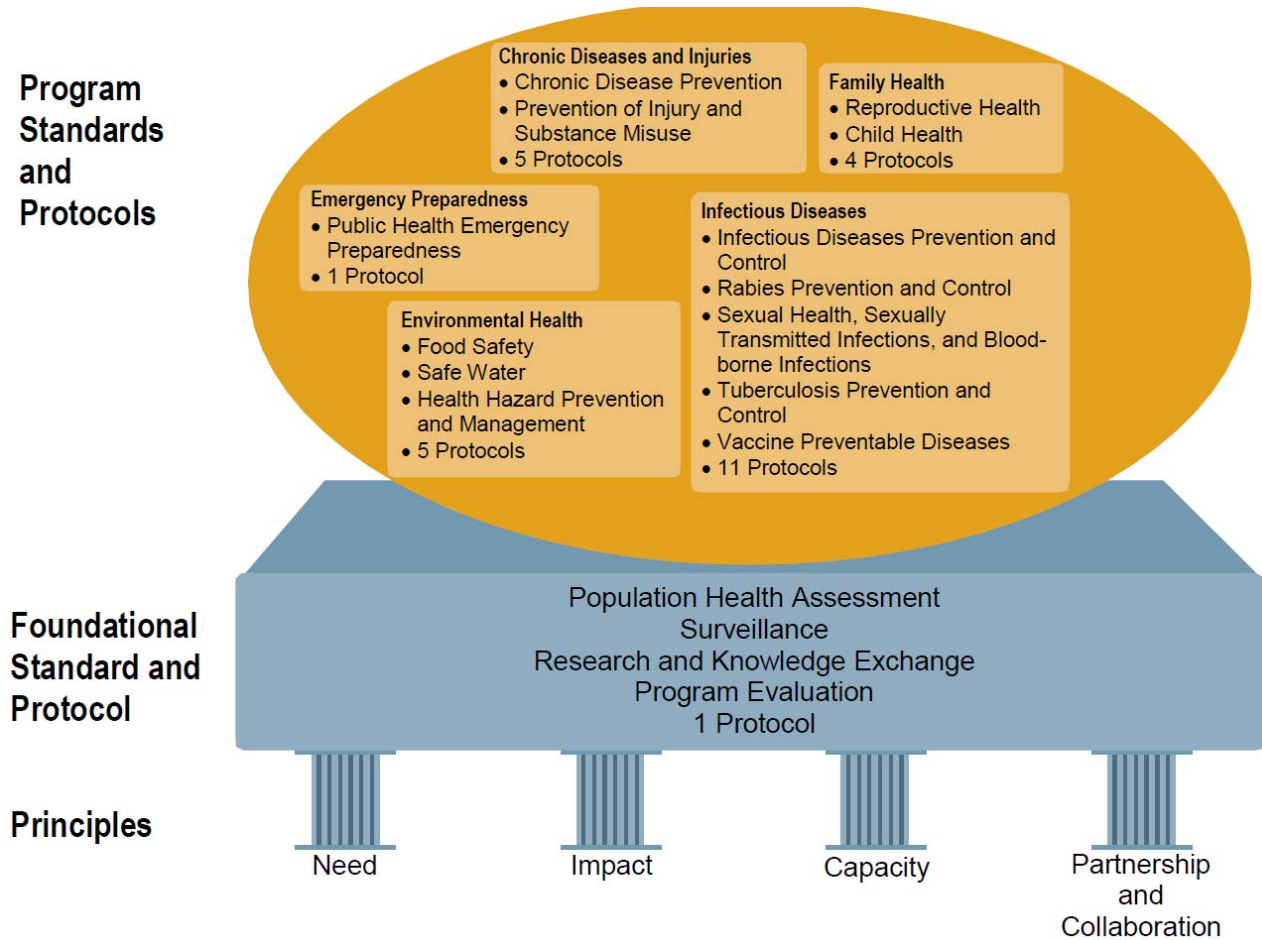
Figure 1: Policy Framework for Public Health Programs and Services

GOAL	To improve and protect the health and well-being of the population of Ontario and reduce health inequities					
POPULATION HEALTH OUTCOMES	<ul style="list-style-type: none"> Improved health and quality of life Reduced morbidity and mortality Reduced health inequity among population groups 					
DOMAINS	Social Determinants of Health		Healthy Behaviours		Healthy Communities	Population Health Assessment
OBJECTIVES	To reduce the negative impact of social determinants that contribute to health inequities		To increase knowledge and opportunities that lead to healthy behaviours		To increase policies and practices that create safe, supportive and healthy environments	To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
ENABLERS	Legislation	Funding	Evidence	Agencies & Associations	Municipal & Federal Governments	Partner Organizations
PROGRAMS AND SERVICES	GOALS					
	<ul style="list-style-type: none"> To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system To reduce health inequities with equity focused public health practice To increase the use of current and emerging evidence to support effective public health practice To improve behaviours, communities and policies that promote health and well-being To improve growth and development for infants, children and adolescents To reduce disease and death related to infectious and communicable diseases of public health importance To reduce disease and death related to vaccine preventable diseases To reduce disease and death related to food, water and other environmental hazards To reduce the impact of emergencies on health 					
PARTNERS	Health Care (including Primary, Community, Acute and Long-Term Care), Education, Housing, Children and Youth Services, Community and Social Services, Labour, Environment, Agriculture and Food, Transportation, Municipalities, Non-Governmental Agencies, Public and Private Sectors, Academia, and Indigenous communities and organizations					

Source: Ontario Public Health Standards, 2017.

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Figure 2: Relationship between the Principles, the Foundational Standard, and the Program Standards



Source: Ontario Public Health Standards, 2008.

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Figure 3: Description of the Principles, the Foundational Standards, and the Program Standards

Principles							
Need	Boards of health shall continuously tailor their programs and services to address needs of the health unit population. Need is established by assessing the distribution of social determinants of health, health status, and incidence of disease and injury.						
Impact	Boards of health shall assess, plan, deliver, and manage their programs and services by considering evidence, effectiveness of the intervention, barriers to achieving maximum health potential, relevant performance measures, and unintended consequences.						
Capacity	Understanding local public health capacity required to achieve outcomes is essential to ensure the effective and efficient delivery of public health programs and services. Boards of health shall strive to make the best use of available resources to achieve the capacity required to meet the standards.						
Partnership, Collaboration and Engagement	Boards of health shall engage and establish meaningful relationships with a variety of sectors, partners, communities, priority populations, and citizens, which are essential to the work of public health and support health system efficiency. Establishing meaningful relationships with priority populations includes building and further developing the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the community and/or organization.						
Foundational Standards							
Population Health Assessment		Health Equity		Effective Public Health Practice		Emergency Preparedness, Response, and Recovery	
Program Standards							
Chronic Diseases and Injury Prevention, Wellness and Substance Misuse	Food Safety	Healthy Environments	Healthy Growth and Development	Immunization	Infectious and Communicable Diseases Prevention and Control	Safe Water	School Health

Source: Adapted from Ontario Public Health Standards, 2008; Ontario Public Health Standards, 2017.

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EXHIBIT 2

Ontario Society of Nutrition Professionals in Public Health Position Statement, Basic Income Pilot, and Minimum Wage Increase

- | | |
|----------------------------------|---|
| OSNPPH Position Statement | <ul style="list-style-type: none">• Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario• The root cause of food insecurity is poverty• Adults in food insecure households have poorer self-rated health, poorer oral health, greater stress, and are more likely to suffer from chronic disease; children have increased risk of mental health issues; and teenagers are at a greater risk of depression, social anxiety, and suicide• Food charity does not work as it does not address poverty, and it absolves governments of their responsibility to ensure the basic right to food security• A basic income guarantee would ensure income at an adequate level to meet basic needs and for people to live with dignity, regardless of work status• The indirect costs of poverty are far higher than the costs of lifting people out of poverty |
| Basic Income Pilot | <ul style="list-style-type: none">• A basic income is a payment to eligible families or individuals that ensures a minimum income level regardless of employment status• Three-year pilot taking place in Hamilton, Brantford, and Brant County; Thunder Bay; and Lindsay• Up to 4,000 individuals will participate in the pilot• Participants will be randomly selected based of a set criterion<ul style="list-style-type: none">○ 18-64 years olds;○ living in one of the pilot locations for the past 12 months or longer, and;○ living on low income (under \$34,000/year if single; under \$48,000/year if a couple).• Participants will receive up to \$16,989 per year for a single person, up to \$24,027 per year for a couple, and up to an additional \$6,000 per year for a person with a disability (amounts will decrease by \$0.50 for every dollar an individual earns through work)• Other support programs will decrease payment dollar for dollar• Expected to have impacts in food security, stress and anxiety, mental health, health care usage, housing stability, education and training, and employment and labour market participation |
| Minimum Wage Increase | <ul style="list-style-type: none">• Ontario’s current minimum wage is \$11.40 per hour• The provincial minimum wage will be phased in over an 18-month period• It will rise to \$14 per hour on January 1, 2018 and to \$15 per hour on January 1, 2019• After that it will rise annually with inflation• 9.2% of Ontario’s population (540,000 people) earn minimum wage |

Source: Adapted from Ontario Society of Nutrition Professionals in Public Health, 2015; Government of Ontario, 2017b; Government of Ontario, 2017a.

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EXHIBIT 3

Stakeholder Analysis, Generative Relationship (“STAR” Model) and Scenario Planning Tools

Stakeholder Analysis

Stakeholder	Strengths, Weaknesses, Opportunities, Threats (SWOT)
Health Unit – Healthy Living Program	<ul style="list-style-type: none">- Initially began the North Bay Good Food Box program- Interest in the objective of the Good Food Box program, increasing food accessibility for low-income populations- Conscious of shifting OPHS, organizational trajectory, and broader public health context- Concerned about the optics of the decision- Unsure of where the Good Food Box would be positioned on the upstream/downstream continuum
Health Unit – Board of Health (BOH)	
NDHC	
North Bay low-income population	
Mattawa	
West Nipissing	
Temagami	
South River	

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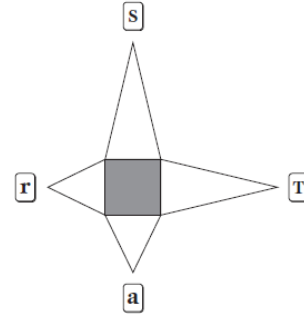
“STAR” Diagrams

Stakeholders

“STar” (BOH and NDHC)

- An ST relationship is one where the two parties who came together represented diverse perspectives, but had no reason to work together, so there were no real action opportunities (Zimmerman & Hayday, 1999)
- The relationship between the BOH and the NDHC would be an example of a “STar” relationship: both parties have a reason to discuss and listen and they have ‘separate’ viewpoints; however, the BOH does not have the ability to have direct actions that will influence the Good Food Box program and, due to this, the two parties do not have a reason to work together without other stakeholders involved.

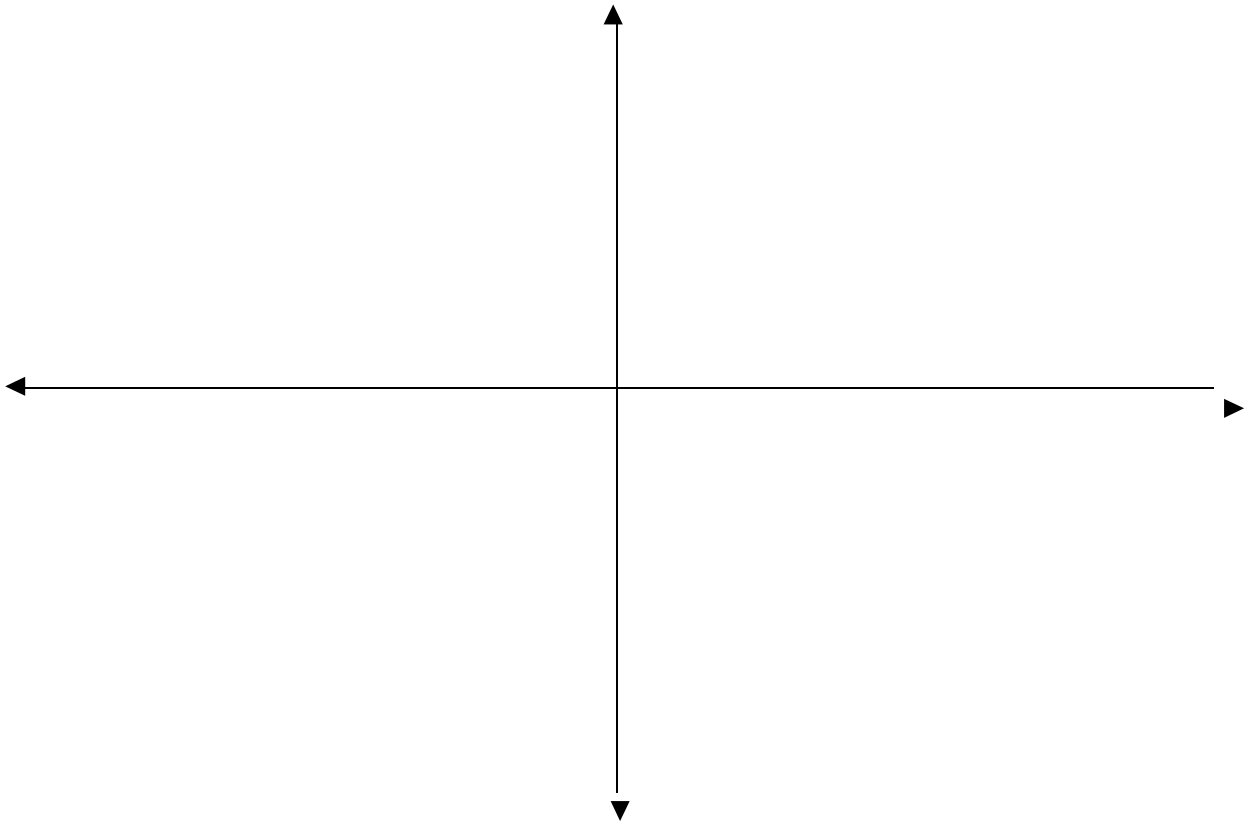
“STAR” Model



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Scenario Planning

1. Identify and understand the organization
2. Map trends (past) and driving forces (present)
 - Relevant trends (past)
 - Driving forces (present)
3. Identify stakeholders (previously completed) and key uncertainties
 - Key uncertainties
4. Create scenarios and assess their implications (Scenario Matrix)



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5. Create strategies based on scenarios (for actionable scenarios)

6. Decide on an action plan

Source: Adapted from Zimmerman & Hayday, 1999; Scearce & Fulton, 2004.

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INSTRUCTOR GUIDANCE

Good Food Box: Generative Relationships and Scenario Planning in Public Health

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BACKGROUND

The Good Food Box project in North Bay, Ontario is a bulk food-buying program with the purpose of supporting chronic disease prevention through the promotion of increased fruit and vegetable consumption. Good Food Box increases the accessibility of healthy, fresh fruits and vegetables for low-income individuals. Unfortunately, the Nipissing District Housing Commission, whose responsibility it was to procure funding for and employ the Good Food Box coordinator, was unsuccessful in renewing funding. Without funding, the Good Food Box program would cease at the end of June. Amy Campbell, North Bay Parry Sound District Health Unit employee and member of the Good Food Box advisory committee, and the rest of the Healthy Living team grappled with what the Health Unit could and should do in such a situation. This was especially difficult considering the trajectory of the Health Unit's programming towards more upstream interventions and the release of the new Ontario Public Health Standards (OPHS), which advocates for policy change. The broader public health context was also shifting towards more upstream solutions to food insecurity. All of this would have to be considered when determining the Health Unit's responsibilities and approach to the Good Food Box project.

OBJECTIVES

1. Identify and analyze stakeholders essential to planning.
2. Utilize scenario planning to brainstorm a number of potential action items for the Healthy Living team.
3. Define the role of public health units in accordance with the Public Health Standards, such as the new OPHS, set to be released in 2018.

DISCUSSION QUESTIONS

1. Why is it crucial to identify stakeholder relationships that will lead to generative relationships in complex situations? How can stakeholder analysis tools such as the "STAR" model be used as a tool to perform this task?
2. Why is scenario planning important for an organization undergoing a period of uncertainty and change? Why is it important to follow the detailed steps of the scenario planning process?
3. After the analysis of the Health Unit's role in the Good Food Box case, what niche do you see public health units filling within the broader health care system? Why is it important for organizations to delineate a role within a larger system and to maintain their services within these boundaries?

KEYWORDS

Food accessibility; generative relationships; scenario planning; OPHS.