Social Determinants of Health and Stories of Homelessness in Fort McMurray, Canada

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Abstract
Little research has been conducted to investigate the needs and challenges of homeless individuals living in FM. In this paper, the social determinant of health that exacerbated homelessness in Fort McMurray, Canada, were highlighted . The study implemented a participatory action research design. In-depth open-ended life history interviews were conducted individually with 15 participant which were experiencing homelessness at the time of the study. Common threads were identified across shared experiences embedded within the broad social, cultural, and institutional macro system. These adults face difficult daily challenges including finding adequate and affordable housing and food, securing a safe place to sleep, overcoming addictions and consequently avoiding the rampant availability of drugs and alcohol. Many of FM's homeless also deal with job loss, physical and mental health problems, dangerous environments, and traumatic histories of hardship. Many have been exposed to histories of addictions and depression. The homeless population of FM experiences multiple barriers to survival, including a limited number of available shelter beds, restrictive shelter rules, and high rental-housing costs. The unique economic situation in FM impacts homeless people as a result of the extremely high cost of living, and job turnover fuelled by pull factors associated with the oil industry.
Addressing homelessness in FM will need a multisectoral, multidisciplinary approach, and political commitment to attend to the SDOH that are exacerbating the problem. This can only be achieved by the full participation of all the different sectors involved and the people affected, the homeless.
Keywords: *Homelessness, Social determinants of health, Fort McMurray*

> *"Every year you lose a couple of people through the winter. It's getting ridiculous. Winter is coming. More people dying. I had enough of it all right here. I'm done. It's sad."* Brian

Introduction

Homelessness in Canada has increased since the late 1980s. Traditionally, it has been framed as an urban social problem primarily affecting men in large metropolitan cities such as Vancouver and Toronto. Gradually, the issue has become more wide spread, also affecting smaller cities and rural communities. The *State of Homelessness in Canada*, issued in 2013, is the first comprehensive report on homelessness in Canada (Gaetz, Donaldson, Richter & Gulliver, 2013). This report estimates that at least 200,000 people access homeless shelters or sleep outside every year, and 1.3 million Canadians have experienced homelessness or severe housing insecurity during the last 5 years (Gaetz, Donaldson, Richter & Gilliver, 2013).
The demographic profile of homeless people has changed to include key subpopulations such as youth, women and families, and Aboriginal Peoples. However, estimates of homeless people in Canada are difficult to obtain as there has been no effort to create a national count until recently. Methods used in the different cities were not standardized, and homelessness counts were scattered and difficult to combine.

A relatively small proportion of Canada's homeless population is living in Fort McMurray (FM). As an example, a 2012 point-in-time survey indicated that approximately "326 people identified themselves as being homeless in Wood Buffalo", the county in which Fort McMurray (FM) is situated (Regional Municipality of Wood Buffalo, 2012, p. 3). However, in comparison to any other metropolitan center in Alberta, FM has a much higher rate of homelessness (i.e. 6.78 homeless/1000 residents in FM is almost double that of the second highest rate of 3.98/1000 in Grande Prairie) (Regional Municipality of Wood Buffalo, 2012). The homeless number is essentially unchanged from 2010 despite the economic boom in the region that started with the construction of the Great Canadian Oil sands plant in 1964 with production starting in 1967 (RAMP Regional Aquatics Monitoring Program, 2007).

The causes of homelessness are associated with the interplay or cumulative effect of structural, individual and relational factors, and system failure. Structural factors include economic and societal issues that can affect the influence on the social environment, such as rent control. Individual and relational factors include personal circumstances such as traumatic events (loss of employment), personal crisis, and mental health and addictions problems, and relational problems (family

break up or abuse) (Gaetz, Donaldson, Richter & Gilliver, 2013). System factors often contribute to failure to develop interventions to keep people housed.

While the contributing factors to homelessness in FM are similar to those discussed above, the unique economic situation associated with the oilfield development may influence the trajectory of homelessness. Almost 44% of the homeless people in FM have some source of income but are still unable to obtain safe, adequate and affordable housing (Regional Municipality of Wood Buffalo, 2006). The Homeless Coordinator of the Regional Municipality of Wood Buffalo noted that "the current program structure put forth by the Alberta government is about housing chronic homeless individuals, but there are barriers when it comes to housing these people as well as time restrictions. The inventory of housing in FM is low to begin with, which means that rents are typically higher than surrounding communities in Alberta. Higher rents, low incomes (if there are any), and complex needs compound the difficulty in housing individuals and helping them sustain that housing" (Ms. K. Snow, personal communication, 2011).

Social Determinants of Health and Health Equity

"The primary factors that shape the health of Canadians are not medical treatments of lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health" (Mikkonen & Raphael, 2010, p.7). It is known that health and social inequities exist globally and also in Canada. These inequities have a strong impact on those living in poverty. Health inequities are associated with disparities in the social determinants of health (SDOH) and arise from circumstances in which people live, work, and play, and the systems put in place to deal with illness and social disparities. These are, in turn, shaped by economic, political, and social factors. These factors are strongly associated with pathways into homelessness (Canadian Homelessness Research Network, 2012)

The Commission on the Social Determinants of Health (WHO, 2008) emphasises the importance of taking a holistic view of the SDOH, the social gradient in health within countries, and the interplay with hidden factors that contribute to inequities such as the unequal distribution of power, income and services. It is well known that people in less advantaged or powerless situations, such as people experiencing homelessness, have poorer health and social outcomes, and an unequal distribution of negative health and social experiences (Mikkonen & Raphael, 2010; Gardner, 2008). This unequal distribution of negative health experiences is exacerbated by a "combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities…" (WHO, 2008, p.1). Loppie, Reading and Wien (2009) wrote, "individuals, communities and nations that experience inequalities in the social determinants of health not only carry an additional burden of health problems, but they are often restricted from access to resources that might ameliorate problems" (p. 2). They went further by adding "distinctions in the origin, form and impact of social determinants, as well as the distinct peoples involved, must be considered if health interventions are to be successful" (p. 2).

The recognition of how health is "shaped by structural inequities like economic position and/or experiences of racism and racial discrimination is necessary if we are to move towards the creation of an equitable and just society for all Canadians" (Kobayashi et al, 2008, p.8). The homeless population in FM is a case in point. The primary means of addressing some of these inequities is to enact public policies to improve the SDOH and to guarantee living conditions needed for good health. Mikkonen & Raphael (2010) suggest strategies to address this: firstly, by education and awareness raising of Canadians about the SDOH and having this knowledge translate into action; and secondly to support candidates of political parties that are open to the SDOH concept. As well, Canadians should be motivated to support organizations that advocate for strengthening of the SDOH.

Equity related issues must be addressed in order to prevent negative social and health outcomes. Health equity is concerned with creating equal opportunities for good health for all and reducing avoidable and unjust differences in health among population groups. Equitable access to services that is based on needs, fairness in the distribution of resources, and provision of competent care to address the needs of homeless people can meaningfully reduce disparities in FM. The development of a society can be judged by the quality of its population's health and how fairly health and social resources are distributed to address the needs of the more vulnerable in a society (WHO, 2008).

Purpose

Little research has been conducted to investigate the needs and challenges of homeless individuals living in FM. The primary goal of this study was to empower homeless individuals by intervening at the individual and policy levels of the ecological system. A specific objective of the study was to explore the strengths,

struggles, and life context of homeless individuals in FM, using a life history interview approach. In this paper, the SDOH, as mentioned by our participants that exacerbated or affected their homeless status, were highlighted. Suggestions made by our participants as to how to address these inequities were described. Other articles have been prepared that explore the findings as they relate to the impact on policymakers, homelessness and their perception of family, and the strengths and daily struggles of being homeless in FM.

METHODOLOGY

Design

The study implemented a participatory action research design. The underlying tenet of participatory action research is that researchers must first locate an actionable social problem and then bring together the different players involved in the situation in order to change and improve it. The study was guided by the ecological systems theory. Homeless individuals are seen as embedded in social ecology. This approach views street-living individuals as "normal" yet forced by societal inequality to survive under difficult circumstances (Karabanow & Clement, 2004). In this study, the views of homeless individuals were honoured and the relationships between these individuals and the SDOH that are contributing to their homelessness, were highlighted.

Recruitment

Fifteen people experiencing homelessness in FM were recruited with the help of an intermediary. Our community partners, the Community Services Department, Regional Municipality of Wood and the personnel at a drop in center for the homeless in FM, acted as intermediary. The study was introduced to potential participants and participation was sought by the workers at the drop in center. In addition, a snowball sampling technique was used in order to further recruit participants. Participants had to be over 18 years of age, either male or female, and self-identified as being recently or chronically homeless. The inclusion criteria included only single adults for methodological reasons, as homelessness in youth or in families is a different phenomenon. Both newly homeless and chronically homeless individuals were studied, as their experiences would be very different, thus contributing to the richness and thick description of the data. Participants were excluded if there was evidence of any condition that would impair their ability to understand and participate in the interviews or consent for research participation.

Ethics

Ethics approval was obtained from the Research Ethics Office of the University of Alberta for research conducted on human subjects. Participants were made aware of the risks and benefits of participating, and their right to withdraw from the study or withhold content derived directly or indirectly from information they provided during the course of their participation in this project. In order to ensure that participants did not feel coerced to participate in the study, they were informed that their participation was completely voluntary. Participants were told that if they decided not to participate in the study, they would not be penalized in any way and it would not interfere with any other services obtained through local service or community agencies.

Data Collection

In-depth open-ended life history interviews were conducted individually with each participant. These interviews were both audio and video recorded. A semi-structured approach was chosen to format the interview. This format allowed the interviewer to modify the questions during the interview process (Ary et al., 2006). The interview covered a range of topics including: stressful and traumatic life events; struggles of everyday life; involvement in substance use; difficulties and possible solutions for finding housing and employment; awareness of resources; personal strengths; and future hopes. At the start of the interview session, staying true to the participatory action approach, each participant was asked if he/she would like to review the interview video and was offered the opportunity to decide which aspects of their story they wanted to highlight. The recorded interviews were transcribed, the data was hand coded and categorized, and themes were developed based on the approach laid out by Erickson (1986) and Charmaz (2000).

FINDINGS

Demographics of Participants

Fifteen participants (homeless individuals), 12 males and 3 females, were interviewed. Thirteen participants were interviewed at a homeless drop-in center in FM and two participants were interviewed on the street. Participants' ages ranged from 24 to 62 years with a mean age of 44.3 years. The number of years

participants had been homeless ranged from 2 days to 15 years.

SDOH Contributing to Homelessness and Inequities

Various themes emerged from the life-history interviews that relate to SDOH: housing situation in FM, nature of the work, gender, access to health care and health services, and social support and social safety.

Housing situation in Fort McMurray

Participants talked about various housing related aspects but particularly emphasized how the economic development in FM has influenced the affordability, availability, and suitability of housing. The cost of housing and rented accommodation in FM has been influenced by economic pull factors. Better economic opportunities, more jobs, and the promise of a better life often pull people towards this economic hub. Tracy mentioned:

> "Yeah, see, the problems right now is that it's too expensive in McMurray to begin with. Like, I could not afford an apartment here now, never, no, no. So that's what I… I'm trying to realize that, coming here, like years ago, even like a year ago, apartment prices went up so high."

Bobby talked about the economic pull factors and stated that it is good that people start recognizing that FM has a homeless problem, and that the traditional perception of "get to FM and all the streets are paved with gold" (Brian) is not true. Brian reiterated the pull factors that bring people to FM in search of work and contribute, also, to related issues:

> "We have a major homeless problem. Not only that, well, of course in any other city drug problems, alcohol problems, whatever, addictions, whatever. It's always gonna be here so we gotta somehow deal with it, right, so."

Bruce noted the changes in affordability of housing since the economic development started in 1964 (RAMP Regional Aquatics Monitoring Program, 2007):

> They [Aboriginal population] live in FM, yeah, all their lives. They're still here. They bought houses on [name of street] $16,500 for a brand new house. Today they go for $700,000. So that's part of the thing, eh.

Corry talked about the affordability of rental accommodation:

> "I ended up losing my job. When that ran out, I became homeless, because I still wanted to try to work up here, because the money is up here, but my physical problem ended up getting worse and accommodation at that time was very expensive and I would get a one-bedroom apartment, it was like $1400 a month, where I have $600 in my pocket after using up everything."

Participants in this study also reported struggling with the challenges of housing availability. Properties are rented very fast, and the rental fees increase as the need for housing rise. Brian described it as follows:

> "But every time I go… I call or I email or go to see the place, it's rented. And since then they gave me clearance a month ago to start looking. Rent has increased $400 to $500 on the same places that I checked a month before."

The unavailability of housing and the constant inflow of people to FM contribute to overcrowding and thus suitability of housing. Brian described it:

> "Like, I'm not a prejudice individual but I see an awful of people coming into the city lately, over and over and over and where are they going? Like, it just getting crowded and crowded and crowded."

Nelson emphasized: "..and what some of the people do… abuse the system by, I see a lot of people living in, ten people live in one apartment building."

Alternative housing such as living in the work camps[1]was perceived as suitable but was not seen as a home; it was described as "basically to sleep, shower, and change your clothes and go to work. Life's not too bad in them, but… you get claustrophobic after a while." Brian

The availability and suitability of temporary accommodation or shelter space for people experiencing homelessness also posed a problem. The participants shared that there is not sufficient numbers of shelter spaces available. Housing is one of the most important SDOH and need the most attention. Not only is housing a challenge but the number and suitability of shelter beds is questionable in FM.

> "The system is getting strained, you can see it. There's no bed, no mats[2], there's not enough absorbing the overflow of people that are coming here. I understand places they get maxed out for mat bedding, mat program and they have to close the doors, I understand that. You're talking to a human being. You wouldn't do that to a dog; keep them outside in minus 35, minus 40. You wouldn't. It wouldn't be very human." Nelson

[1]A work camp is temporary living facilities to contractors and their employees to provide living arrangement while working on site.

[2] A Mat program provides a warm, supervised environment for people without other accommodation in a safe environment. Users are supplied with a sleeping mat and blanket to use.

Nature of Work

Participants shared that the nature of the work and work environment in FM contributed to them becoming homeless. Frequent commute, accommodation and housing options during lay-offs, hiring practices, uncertainty with job availability, and work-related injuries, and delays in compensation are all factors that were mentioned. Nelson was outspoken about the hiring practices of the employer:

> "Employment right now up here is getting pushed to the point where people who are from different countries are getting a lot of employment for the people who need the jobs here. It's getting a little carried away but how they abuse it some of the places."

Participants shared that they often work 'shut downs[3]' which contribute to their homelessness. In between shut downs they could not afford the hotel fees in FM and ended up without accommodation and temporary homeless.

Brian shared:

> "So you chase the shut downs in the plants, right? Everyone's scheduling a different shut down on a plant. So you go do the shut downs. But as you get older, the shut downs get too hard on you. A maximum of 24 days on and four days off. [Interviewer: Okay. And when they lay you off, where do you go?] On the street. Well I usually have money, go for hotels for a while but that evaporates pretty quick in FM."

Participants mentioned that the nature of the work gives rise to higher incidences of work related injuries. They perceived the compensation and payment for work-related injuries as often delayed, contributing to long periods without payment and subsequently to becoming homeless. Brian described it as follows:

> "Workmen's Compensation has not paid me. They called yesterday and said they'd made a decision on my claim. And they're saying the nurse there cleared me, I was okay for work the day of the incident. But the day of incident is not a question, it's the next day when you try to go to work and you're dizzy and you're sick to your stomach and you're vomiting. Concussion. Simple. But that's the game they play. So now I have to appeal that decision and it takes time. Eventually I'll be broke. Well, that's just the way the Workmen's Compensation Board is. They try to stretch you out so you're broke and force you back to work kind of deal."

Gender

Gender as a SDOH contributed to inequity. Participants mentioned that there were not sufficient services for women experiencing homelessness. Christina elaborated on it:

> "Yeah, that is really tough and so… I know one woman, thirty days she had to wait outside, because there was no mat program at that… just recently, no mat program; they just started that October 1st. So for the month of September, she had to stay outside; you know, a lot of rain in September and wind, you know, and she's alone, which means that there's been a lot of rapes and a lot of women being beaten downtown. [Name of shelter] has, I believe, ten beds for women, as opposed to twenty beds for men and a hundred beds for men at [name of other shelter]. You know, they believe that women may not need to be housed as much. …. if you go in and eat and shower, you don't get back by their curfew time, you're expected to not return for 30 days; 30 days without safe housing, a safe place to go as a woman."

The limited services for women and rules at some of the agencies contributed to women preferring to stay outdoors and being more vulnerable to abuse. A community profile, conducted in March 2012, indicated that 53.9% of FM's population was male at that time and 56.1% was female (Primary Health Care Division, 2013).

Access to health and social care services

Participants mentioned various factors that influenced their access to health care and services. One of the main factors identified was the shortage of health and social care workers, and specific disciplines and service. Consequently, the waiting times and short consultation times were mentioned as problematic. Bobby elaborated on it further: "Same time I, it's just now a waiting list in the hospital now, it's a three month waiting list. So now there's another wait, right."

Corry expanded further on this problem by saying:

> "And so okay, talk to my doctor… okay, well we'll try to find another specialist that will see. Well, his waiting list is so long. It's like… what do I have to do to get something done, you know?"

The quick turnaround of doctors was mentioned as a gap. Corry said: "I wish the doctors that we had up here would stay longer. I've had seven different family

[3] Shutdowns are scheduled events when one or multiple process units of an industrial plant are taken off line to carry out required maintenance and/or renewal work.

doctors in six years." The shortage of specific types of services and care workers were mentioned as one of the major problems. Participants voiced a shortage in follow-up care for people with addictions, and the need for more time with health care professionals. "It would be nice to have more quality time, or whatever you might call it, to have someone to talk to." Corry
Brian added:

> "I went to the detox centre; they said after-treatment care, there's none. I had to leave. So I'm back on the streets and start smoking dope again. But that's the thing, eh, there's no help here, eh, there's no help for addiction. They talk about it, they send you out for treatment but you come back there's no place to go. That's why we're back on the streets."

The need for mental health workers and psychiatrists was also mentioned:

> "So I think I need something more like where I had before a long time ago, was like claiming mental health, like some kind of one on one, where I could say what I want to say. Tell the truth, tell them my deepest, darkest secret, my shame, my guilt, whatever it's going to take. Take that pressure off me, so I peel that onion that they talk about, so I heal within." Christina

Bobby elaborated extensively on the availability of workers, the quick turnover of staff, the many agencies they have to deal with, and continuity of care:

> "But some of the problems I'm noticing with homelessness is how many agencies we have to deal with. Same time to try and get an appointment like it's hard, it's hard to how….. And then I go to talk to my caseworker and they got a month, off for a month. So now I got to find another caseworker but they're busy themselves or whatever. So I have to sit down there for half a day or whatever and I can't, I haven't seen anyone. But same time it's just, there's no notice. ….like social services doesn't tell the [name of agency] or whatever that [name of caseworker] what have you and so forth and so on, this caseworker's gonna be taking a leave of absence or whatever, such and such or is going to go on holidays or what have you. Like it's, no, I don't tell my life history like four or five different times, right. But that's the main issue man, is like communication."

Another participant indicated the need for an outreach van to help provide services for the homeless who suffer from emotional and/or medical conditions since: "…people that will talk to you about would you like to do this, would you like to do that. You know, that's, they need something like that definitely." Adam. Another participant, Brian stated: "people on the street don't even know those services exist."

Social support

Participants shared how sad it was that many people were looking down on homeless people. Most of their social support came from other people also experiencing homelessness. Brian commented:

> "How many people… People turn blinds eyes to what… I can tell they're looking down. They drive by and you can tell they're looking down on you. It's a struggle. There's more need than just housing. Like I said, people to talk to, services have to be there. They have to be in place. You can't put it in after the fact. It has to be here now."

They talked about their family on the street and how they support each other. Bruce shared how he acted as a social support person to others because he knew the place and how things on the street operate:

> "It's just what I did. But I know a lot of people like I said I've been here 56 years. I know important people and they know me. They know what I do. Advice; street people come to me for advice because I lived here all my life and I know what's going on. I know who's who, what's what, where's where. And, yeah, there's a certain bond with us local people."

Christina shared how street people look out for each other:

> "…. there's some type of connection here with the people on the streets; you're like a family. I always wonder what they meant by that, but till taking part of it… They always look out for you, that they see you every day, they see you in the same condition, or trying new things, and they're proud of you and even if they're not proud of you, they still accept you. You know, there's no judgemental amongst us on the street that once…"

Homeless peoples' understanding of family is different; a comradery develops amongst the people living on the streets where they accept each other. A caring relationship often develops where they look out for each other.

DISCUSSION

The homelessness rate in FM is alarmingly high, especially in comparison to other metropolitan centers in Alberta. FM's northern climate and unique economic situation, including an extremely high cost of living, contributes to the challenges faced by the homeless. In the winter, FM is affected by the continental arctic air mass that brings extremely cold conditions from the

Arctic (Fort McMurray, 2014) and threatens homeless people's survival on the streets. This vulnerable population is in great need of various resources and supports.

In this paper, the life-history stories, and personal experiences of 15 homeless adults were presented, the SDOH as mentioned by the participants' were highlighted. Common threads across shared experiences embedded within the broad social, cultural, and institutional macro system, were identified. These adults face difficult daily challenges including finding adequate and affordable housing and food, securing a safe place to sleep, overcoming addictions and consequently avoiding the rampant availability of drugs and alcohol. Many of FM's homeless also deal with job loss, physical and mental health problems, dangerous environments, and traumatic histories of hardship. Many have been exposed to histories of addictions and depression. The homeless population of FM experiences multiple barriers to survival, including a limited number of available shelter beds, restrictive shelter rules, and high rental-housing costs. The unique economic situation in FM impacts homeless people as a result of the extremely high cost of living, and job turnover fuelled by pull factors associated with the oil industry.

The participants' personal feelings and emotions were shared, as well as their suggestions and recommendations for services and supports. Recommendations as suggested by the people experiencing homelessness are very important considerations for policy makers if they are to create policies that effectively meet the specific needs of homeless adults in FM, and decrease the prevalence of homelessness. It is important that these homeless adults have access to appropriate effective supports and services that target their specific needs. These services can be created and improved only if policy makers, service providers, and the community gain a more complete comprehension of FM's homeless population, their struggles and strengths, and their needs.

Health care is considered as one of the many basic human rights. FM's homeless population is in great need of resources and supports to address their unique issues and concerns. Globally, including Canada, the health of the "most deprived and whose living conditions are less than adequate", is the worst (Benatar, 2011, p.2). It is common knowledge that Canada's health care system is considered as one of the best and most accessible in the world. The basic values of the system are built on fairness and equity (Health Canada, 2012); however, still not everyone has equitable access.

Equitable access to health care refers to the ability of groups to receive services and "is widely regarded as an important determinant of health" (NCCAH, 2013, p. 1). Equitable access does not mean that everyone receives the same amount of services but that services are distributed fairly and justly. However, accessing health care does not consequently flow from this premise. There are still huge global inequalities in the way certain groups of people are treated by health care workers.

It is well known that health is not only related to biomedical health care but is also influenced by many other social factors. Not all Canadians have equal access to health services. The case of the homeless people in FM is a poignant example of this. The challenge to equitable services for the homeless population in FM is to use resources fairly and to ensure optimal benefits for individuals and the community. This will have to be a long term social investment and should be driven by local knowledge and agreement.

"We understand that health [and social] equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international communities, in an "all for equity" and 'health for all" global action" (WHO, 2011, p2). In a recent Organization for Economic Cooperation and Development [OECD] working paper the argument is made that "…reducing income inequality would boost economic growth… The impact of inequality on growth stems from the gap between the bottom 40 percent with the rest of society, not just the poorest 10 percent" (Cingano, 2014, p. 1). Further argumentation in a recently published document on a discussion series on the SDOH, Martinez Valle, (2013) proposes intersectoral action for health and social equity.

Intersectoral action refers to processes in which "the objectives, strategies, activities and resources of each sector are considered in terms of their implications and impact on objectives, strategies, activities and resources of other sectors" (Solar et al, 2009). This approach helps to overcome policy fragmentation as every sector's objectives are considered in planning to address the SDOH. Different modes of engagement are proposed that involve sharing of information, cooperation, coordination, and integration alongside processes of compatibility and accessibility, autonomy loss, addressing of needed resources, formality, and interaction and interdependency with an end result of a focus on "health in all policies".

In order to address equity through an action on the SDOH, intersectoral collaboration needs to be strengthened between the Alberta government, the local government in FM and the oil companies. The Rio Political Declaration on the Social Determinants of Health (Martinez Valle, 2013) concurs and emphasizes that collaboration in terms of health in all policies and through intersectoral cooperation and action is necessary

to promote health and social equity. The declaration includes critical key action areas to address health and social inequities that includes better governance for health and development, promotion of participation in policy making and implementation, further re-orientation of the health sector towards reducing health inequities, strengthening of governance and collaboration, monitoring progress, and increasing accountability to inform policies on the SDOH (Martinez Valle, 2013). Change is needed at multiple levels of the ecosystem. In our study, intersectoral collaboration can be beneficial for both the local community and the oil companies. A healthy population that represents equal opportunities for all will contribute to a stronger workforce. This can only be achieved if researchers and service providers attend deliberately to the SDOH.

Limitations and Need for Further Research

The study included interviews with 15 single homeless people. The scope of our study and funding limitation did not allow the inclusion of homeless immigrant populations or any other homeless individuals from the temporary foreign workers categories. The inclusion of these groups could provide a holistic understanding of the needs of all different sub-populations within the homeless population. FM has a diverse population and the municipality needs to address this diversity with some initiatives, some of which are already in place. These include Mat programs, different types of shelter accommodation, feeding programs and drop-in centers. More research is needed to include an Aboriginal focus.

In the end, the voices of both the homeless and those who try to support them must be heard. Homelessness is a complex and multidimensional issue which requires all members of the community to work together to find better solutions. It is important for the homeless population to know that their voices have not fallen on deaf ears.

CONCLUSION

Homelessness and its intersection with the SDOH in FM is unique in the sense that it is fuelled by the economic development in the oil industry. The purpose of our study was to highlight the SDOH as mentioned by our participants that exacerbated or affected their homeless status, and suggestions made by our participants to address these inequities. The homeless population in FM is in great need of resources and supports to address the issue of homelessness. Addressing homelessness in FM will need a multisectoral, multidisciplinary approach, and political commitment to attend to the SDOH that are exacerbating the problem. This can only be achieved by the full participation of all the different sectors involved and the people affected, the homeless.

REFERENCES

Ary, D., Jacobs, L. C., Razavieh, A. & Sorensen, C. K. (2006). *Introduction to Research in Education*, 7th edition. Canada: Thomson Wadsworth.

BC Partners for Mental health and Addiction Information. (2007). Housing Glossary. *Visions Journal 4*(1), pp. 5-6.

Benatar, S. (2001) *Sustaining excellent, accessible and equitable healthcare in Canada. The JBC Voice.* University of Toronto, Joint Center for Bioethics.

Canadian Homelessness Research Network (2012) *Canadian Definition of Homelessness.* *Homeless Hub*. Retrieved form www.homelesshub.ca/CHRNhomelessdefinition/

Charmaz, K. (2008). Views from the margins: voices, silences, and suffering. *Qualitative Research in Psychology*, *5*(1), 7-18.

Cingano, F. (2014). *Trends in income inequality and its impact on economic growth.* OECD Social, Employment and Migration Working Paper, no 163. OEC Publicing. Available at http://dx.doi.org/10.1787/5jxrjncwv6j-en

Erickson, F. (1986). Qualitative methods in research on teaching. In M. C. Wittrock (Ed.), *Handbook of research on teaching, 3rd ed* (pp. 119-161). New York: Macmillan.

Fort McMurray, Alberta (2014). Retrieved from http://www.grc.k12.nf.ca/climatecanada/fort_mcmurray.htm

Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The State of Homelessness in Canada 2013. A Homeless Hub Research paper*. Toronto: Canadian Homelessness Research Network Press.

Gardner, B. (2008). *Health Equity Discussion paper*. Toronto: Local Health Integration Network.

Heading home: The Right Thing to Do- 10 Year Plan to End Homelessness 2010 – 20120. *Housing*

Needs Count. A comprehensive report about the homeless population in Wood Buffalo. Regional Municipality of Wood Buffalo.

Health Canada (2012). *Canada's Health Care System*. Available at http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php

Housing First (2014) Available at http://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first

Kobayashi. K, Prus .S, Lin Z. (2008). Ethnic differences in health: Does immigration status matter? *SEDAP Research Paper No. 230*

Loppie Reading, C. & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health.* National Collaborating Centre for Aboriginal Health.

Martinez Valle A. (2013). Addressing social determinants of health through intersectoral action: Five policy cases from Mexico. *SDOH Discussion Paper Series 6 (Case studies).* Geneva, World Health Organization.

Mikkonen, J. & Raphael, D. (2010). *Social determinants of health;The Canadian Facts*. Toronto: York University School of health Policy and Management.

Primary Health Care Division (2013). *Alberta health primary health care – Community profile. Community profile: Fort McMurray health data and summary*. Alberta Government, Alberta, Canada. Available at http://www.health.alberta.ca/documents/PHC-Profile-FortMcMurray.pdf

RAMP Regional Aquatics Monitoring Program. (2007). *History of the oil sands*. Available from http://www.ramp-alberta.org/resources/development/mining.aspx

Soler, O. et al. (2009). *Moving forward to equity in health: What kind of action is needed?* Paper presented at the 7th Global Conference on Health Promotion, "Promoting Health and Development. Closing the Implementation Gap." Nairobi, 26 – 30 October 2009. Geneva, WHO.

WHO (2008). *Closing the gap in a generation. Health equity through action on the social determinants of health.* Geneva: WHO Press.

WHO (2011). *Rio Declaration on Social Determinants of Health, Brazil*. Geneva, WHO.