Nova Scotia Department of Health, Primary Health Care

Building Community Partnerships

Participant Materials

Building a Better Tomorrow Together:

Team Development for Primary Health Care Collaboration

2009

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Building a Better Tomorrow Together

Team Development for Primary Health Care Collaboration

2009 Redesign Framework

GREEN: reflects 2008 BC IPC competencies and 2004 BBT needs assessment priorities and evaluation results.

BLUE: reflects 2004 BBT needs assessment priorities and evaluation results.

Understanding Primary Health Care (2 modules)

- History and language of primary health care
- The Nova Scotia context
- Population health and the social determinants of health
- Health promotion

Enhancing Collaboration (1 module)

- Assessing knowledge/skills in interprofessional collaboration
- Characteristics of effective collaborative practice teams
- Assessing current collaborative efforts

Generations and Learning Styles at Work (1 module)

- Assessing learning styles
- Appreciating generational differences
- Disclosing and providing feedback
- Exploring self-awareness

Interpersonal and Communication Skills (1 module)

- Understanding/respecting different communication styles
- Applying communication techniques
- Active listening
- Communication enhancers/blockers

Team Functioning (1 module)

- Building an effective team: vision, mission, operating guidelines
- Enablers and barriers to team functioning
- Conducting interprofessional team meetings
- Assessing meeting effectiveness

Roles and Responsibilities (1 module)

- Confidence in/knowledge of ones own role
- Confidence in/knowledge of others' roles to optimize patient care
- Clarifying scopes of practice
- Labeling and professional stereotyping
- Interprofessionality in teams

Decision Making and Leadership (1 module)

- Decision making strategies
- Problem solving methodology
- Testing for consensus
- Leadership roles within teams
- The sources and challenges of power in teams

Conflict Resolution (1 module)

- The nature of conflict
- Recognizing/managing triggers
- Distinguishing constructive and destructive conflict
- Understanding/respecting different conflict resolution styles
- Interest based conflict resolution strategies

Program Planning and Evaluation (3 modules)

- Program planning(steps 1-3)
- Program planning (steps 4-6)
- Program evaluation

Building Community Partnerships (1 module)

- The three levels of partnerships
- Exploring partnerships based on the social determinants of health
- Assessing partnership effectiveness

Reference documents:

- Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative (2005). The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care. www.eicp.ca/en/principles/default.asp
- *Building a Better Tomorrow* Atlantic Needs Assessment (2004)
- *Building a Better Tomorrow* Atlantic Evaluation Report (2006)
- Quality Improvement and Innovation Partnership (2008). Team Development Resource Guide for Family Health Teams. www.qiip.ca
- UBC College of Health Disciplines (2008). British Columbia Competency Framework for Interprofessional Collaboration. www.chd.ubc.ca/competency
- O'Neil, E.H. and the Pew Health Professions Commission (1998). Recreating health professional practice for a new century: the fourth report of the PEW Health Professions Commission. San Francisco: Pew Health Professions Commission.

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Building Community Partnerships

Agenda

Welcome and Introductions

Levels of Partnerships

Exploring Potential Partners based on the Determinants of Health

Building New Partnerships

Assessing Partnership Effectiveness

Wrap-Up

Building Community Partnerships
Learning Objectives

This practical workshop is designed for primary health providers who would like to enhance their knowledge, skills and confidence to build relationships in their community.

Through short presentations, exercises and group discussions, participants will reflect on how they currently connect with their community and explore ways to initiate new partnerships.

Upon completion of this session, participants will be able to:

- Explain the range of purposes for partnership building.
- Identify the levels of partnerships and relate them to their roles as primary health care providers.
- Identify existing and new potential partners, based on the determinants of health.
- Describe the critical factors that contribute to a successful partnership.

Positive Relationships Notable Quotes

"Community is about relationships among people that are the foundation of organization and institution partnerships."

"… we need to use our relationships and connections to go beyond traditional roles and build partnerships to create a strong community network."

" Relationships are the basis of broad based partnerships and networks that strengthen communities."

"The strength of relationships/social networks is the defining aspect of a strong community."

(Building Partnerships Workbook. (1998). Northwest Regional Educational Library, Portland, OR.)

From Communication to Collaboration

Communication	Coordination	Collaboration
Short term or long term	Longer term	Long term
Informal Relations	More formal relationships	More pervasive relationship
No clearly defined mission	Understand mission	Commitment to a common mission
No defined structure	Focus on a specific effort or program	Results in a new structure
No planning effort	Some Planning	Comprehensive planning
Partners share information	Open communication channels	Well defined communication channels at all levels
Individuals retain authority	Authority still retained by individuals	Collaborative structure determines authority
Resources are maintained separately	Resources and rewards are shared	Resources are shared
Very limited Risk	Power can be an issue	Greater risk: power is an issue
Lower intensity	Some intensity	Higher intensity
--informal, no goals are defined jointly, no planning together, information is shared as needed.	--some planning is required and more communication, thus, a closer working relationship is developed	--working together, having shared commitment and goals, developed in partnership. Leadership, resources, risk, control and results are shared. More accomplished than could have been individually

Adapted from the AASL "Collaboration" brochure, Fall 1996

Communication	Coordination	Collaboration
low	commitment formality personal contact	high
high	autonomy	low

Examples of high and low levels of commitment, formality, personal contact and autonomy:

	LOW	HIGH
Commitment	Verbal agreement to work together if the opportunity arises.	Memorandum of Understanding exists between partners.
Formality	No set procedures for any aspect of shared work.	Established procedure for managing disputes.
Personal Contact	Little or no interaction between partners.	Regularly scheduled partner meetings.
Autonomy	Partners consult with each other on a regular basis to plan each organizations schedule.	Each partner operates its own program with little thought of what the other partner is doing.

Source :http://www.sustainabilityonline.com/HTML/Collaboration/index.html

Notes:

Case Study: Youth Sexual Health Services

As a primary health care team you have set up a clinic to try and reach many of the teenage girls who do not receive a PAP test. During the screening many of the young women confirm that they are sexually active.

You remember in a recent report on communicable diseases from the provincial government that there is a rise in the number of cases of Chlamydia and herpes. You are concerned about an increase in sexually transmitted infections (STI's) and teenage pregnancies in your area.

During each visit you ask the girls if they are protecting themselves. They inform you that they often don't use protection because they feel pressured by their partner and don't feel they can say no. Some say protection is expensive and they find it uncomfortable going to the pharmacy to get it. Others say that in the heat of the moment, not having protection does not stop them from having sex, especially when alcohol and drugs are involved.

After living in the area for a while you know that it is a very conservative community and many people are not supportive of talking about or addressing the issues. And, it is difficult for young people to access information, supports and resources related to youth sexual health and other issues.

In talking to the young women that came to your centre you learn that some of the girls have dropped out of school or are not attending on a regular basis. They have not expressed any concern over this to you, nor have they talked about their plans for the future. Some have some part-time work, but work opportunities are limited especially with no high school diploma. There is not much to do and not many youth-friendly places to go in the community.

You are concerned about these issues and wonder what options or solutions might be possible.

You begin discussing the issue as a team.

Case Study: Discussion Questions

1. **Identify the main issues in the case study:**

2. **Identify the determinants of health that are evident in the case study:**

3. **Identify the new partners you could connect with around these issues based on the determinants of health:**

Building Partnerships Worksheet

Level of partnership:	One example:

Our initial steps for building this partnership…

1.

2.

3.

4.

5.

6.

7.

8.

The Partnership Checklist

The Partnership Checklist summarizes the factors that contribute to a successful partnership and directs attention to the range of issues to be considered in assessing the effectiveness; it points out things to look for and consider. The checklist reflects on the current status and can also guide future action.[1]

Rate your level of agreement with the statements below.

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree	
1. Determining the need for the partnership						
There is a perceived need for the partnership in terms of areas of common interest and level of capacity.						
There is a clear goal for the partnership.						
There is a shared understanding of, and commitment to, the goal among potential partners.						
The partners are willing to share some of their ideas, resources, influence and power to fulfill the goal.						
The perceived benefits of the partnership outweigh the perceived costs.						
TOTAL						**Total**

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree
2. Choosing partners					
The partners share common ideas, approaches and interests.					
The partners see their core business as partially interdependent.					
There is a history of good relations between the partners.					

[1] Adapted from: *The Partnership Analysis Tool: For Partners in Health Promotion* (2003). Developed by John McCleod on behalf of VicHealth). www.vichealth.vic.gov.au (search under rural health – partnerships).

The partnership brings added prestige to the partners individually, as well as, collectively.						
There is enough variety among members to have a comprehensive understanding of the issues being addressed.						
TOTAL						**Total**

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree	
3. Making sure partnerships work						
Each organization or group supports the partnership.						
Partners have the necessary skills for collaborative action.						
There are strategies to enhance the skills or capacity of the partners.						
The roles, responsibilities and expectations of partners are clearly defined and understood by all the partners.						
The administrative, and communication structure of the partnership is a shared structure and is as simple as possible.						
TOTAL						**Total**

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree
4. Planning collaborative action					
All partners are involved in planning and setting priorities for collaborative action.					
Partners have the task of communicating and promoting the partnership in their own organization or group.					
Some staff have roles that cross the traditional boundaries that exist between agencies in a partnership.					

The lines of communication, roles and expectations of the partners are clear.						
There is a shared decision-making structure that is accountable, responsive and inclusive.						
TOTAL						**Total**

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree	
5. Implementing collaborative action						
Processes that are common across agencies such as referral protocols, services standards, data collection and reporting mechanisms have been standardized.						
There is an investment in the partnership of time, personnel, materials, funds or facilities.						
Collaborative action by staff and sharing between agencies is acknowledged and rewarded.						
The action is adding value (rather than duplicating services) for the community clients or the agencies involved in the partnership.						
There are regular opportunities for formal and informal/voluntary contact between staff from the different agencies and other members of the partnership.						
TOTAL						**Total**

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree
6. Minimizing barriers to the partnership					
Differences in agency priorities, goals and tasks have been addressed.					
There is a core group of skilled and committed staff to the partnership,					

that has continued over the life of the partnership.						
There are formal structures for sharing information and resolving conflict.						
There are also informal ways of achieving this.						
There are strategies to ensure alternative views are expressed and valued within the partnership.						
TOTAL						**Total**

	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly agree	
7. Reflecting on and continuing the partnership						
There are processes for recognizing and celebrating collective achievements and/or individual contributions.						
The partnership can demonstrate or document the outcomes of its collective work.						
There is a need and a commitment to continuing the collaboration to reach the common goals.						
There are resources available from the partners and/or external sources to continue the partnership.						
There is a way of reviewing the range of partners and bringing in new members.						
TOTAL						**Total**

Scores

1. Determining the need for the partnership		
2. Choosing partners		
3. Making sure partnerships work		
4. Planning collaborative action		
5. Implementing collaborative action		
6. Minimizing barriers to the partnership		
7. Reflecting on and continuing the partnership		
TOTAL		**Total**

Checklist Score

0 - 49	Re-assess the purpose and the level of partnership you need to achieve.
50 - 91	The partnership is moving in the right direction, keep working together to achieve further success.
91 - 140	A partnership based on genuine collaboration has been established. Continue to build on and celebrate the current success.

Appendix A: Additional Resources

Source: Quality Improvement and Innovation Partnership (March 2009). Community Partnerships Resource Guide for Family Health Teams. www.qiip.ca

Addressing the Determinants of Health Together: A Resource Guide for Hospital-Community Collaboration. University of Toronto, 2008.
http://www.hospitalcommunitycollaboration.ca
This guide provides an orientation with research findings, quotes, and practical tools to help assess or negotiate potential working relationships.

Alliances, Coalitions and Partnerships: Building Collaborative Organizations.
Joan Roberts, New Society Publishers, 2004. http://www.joanroberts.com/acpbcobk.htm
Aimed at non-profits but widely applicable, this book provides a step-by-step understanding of how to create effective collaborations, alliances and partnerships with outside agencies and organizations.

A Review of Collaborative partnerships as a strategy for improving community health.
Roussos, ST, Fawcett, SB *Ann Rev Public Health*, 21:369-402 (2000)
http://www.ncbi.nim.nih.gov/pubmed/10884958
Collaborative partnerships (people and organizations from multiple sectors working together in common purpose) are a prominent strategy for community health improvement. This review examines evidence about the effects of collaborative partnerships on (a) community and systems change (b) community-wide behaviour change, and (c) more distant population-level health outcomes. We also consider the conditions and factors that may determine whether collaborative partnerships are effective. The review concludes with specific recommendations designed to enhance research and practice and to set conditions for promoting community health.

Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. John P. Kretzman and John L. McKnight, ACTA Publications, Chicago, 1993.
http://www.northwestern.edu/ipr/publications/community/buildingblurb.html
This guide to what the authors call "asset-based community development" summarizes lessons learned by studying successful community-building initiatives in hundreds of neighbourhoods across the United States. It outlines in simple terms what local leaders can do to locate, assess and mobilize assets in communities.

Collaboration Math: Enhancing the Effectiveness of Multidisciplinary Collaboration. The Prevention Institute, 2003.
http://www.preventioninstitute.org/pdf/collab_math_web_020105.pdf
This paper describes Collaboration Math, a tool developed to help individuals and groups representing different disciplines, organizations or constituencies work together effectively. This practical tool was designed to make key differences and similarities within groups explicit, so that they are more likely to succeed in the challenging work of building and sustaining collaborations.

Collaboration: What Makes It Work – A Review of Research Literature on Factors Influencing Successful Collaboration. 2nd Edition. Paul W. Mattessich, Marta Murray-Close, Barbara R. Monsey, Fieldstone Alliance Publishing, 2004.
http://www.fieldstonealliance.org/productdetails.cfm?SKU=069326
The resources in this book include: a working definition of collaboration; details of the twenty factors influencing successful collaborations; a handy one-page chart comparing the elements of cooperation, coordination, and collaboration; and practical suggestions for using the research in the report.

Collaborative Leadership in Public Health. Leadership Development National Excellence Collaborative (USA), 2005.
http://www.collaborativeleadership.org/index.html
By their definition, collaborative leadership is leadership shown by a group that is acting collaboratively to solve agreed upon issues. This site offers tools, resources, and training information about collaborative leadership, with a special focus on developing public health leaders.

Community Health Collaboration Models for the 21st Century. Bolton, L.B., Georges, C.A., Hunter, V., Long,O. & Wray, R., *Nursing AdmQ*, 22, 6-17.
http://www.ncbi.nlm.nih.gov/pubmed/9624977
The development of partnerships with physicians and other health professionals is a key strategy to improving the community's health. This article reviews the role of nurse leaders as advocates for health care improvement and leading community improvement efforts.

Creating and Maintaining Coalitions and Partnerships. The Community Toolbox, University of Kansas. http://ctb.ku.edu/en/dothework/tools_tk_1.htm
This part of the Community Toolbox provides a framework and supports for creating your coalition or collaborative partnership. Available support includes:

- Outline for Creating and Maintaining Coalitions and Partnerships
- Outline with links to tools and other online resources
- How-to Information on Creating and Maintaining Coalitions and Partnerships
- Example(s) of Creating and Maintaining Coalitions and Partnerships

Developmental sequence in small groups. Bruce Tuckman, *Psychological Bulletin* 63:384-399,
1965. The article was reprinted in *Group Facilitation: A Research and Applications Journal*, Number 3, Spring 2001 and is available as a Word document:
http://dennislearningcenter.osu.edu/references/GROUP%20DEV%20ARTICLE.doc.
This paper is the original source for the theory of the "forming, storming, norming, performing" stages of group development.

Developmental Stages in Public Health Partnerships: A Practical Perspective. Laura E. McMorris, PhD, Nell H. Gottlieb, PHD, Gail G. Sneden, MA. *Health Promotion Practice* 6(2):219-226, April 2005. http://hpp.sagepub.com/cgi/content/abstract/6/2/219
The authors observed the start-up of a state health department/multi-university partnership for the evaluation of the state's tobacco settlement pilot project using the lens of the Tuckman four-stage model of group development.

Dynamic Partnerships. Ontario Prevention Clearinghouse (now Health Nexus), 2003.
http://www.healthnexus.ca/our_programs/hprc/hprc_resources.htm#dynamic
This tip-sheet provides reflections, references and resources about partnerships.

Evaluating Community Partnerships and Coalitions with Practitioners in Mind. Frances D. Butterfoss, PhD, Vincent T. Francisco, PhD *Health Promotion Practice,* vol.5,No.2, 108-114 (2004) http://hpp.sagepub.com/cgi/content/abstract/5/2/108
Evaluation plays a key role in developing and sustaining community partnerships and coalitions. We recommend focusing on three levels of coalition evaluation that measure (a) processes that sustain and renew coalition infrastructure and function; (b) programs intended to meet target activities, or those that work directly toward the partnership's goals; and (c) changes in health status or the community.

IAP2 Spectrum of Public Participation. International Association for Public Participation, 2007. http://www.iap2.org/associations/4748/files/IAP2%20Spectrum_vertical.pdf
This one-page table describes various levels of public participation and what they imply to the public, and also lists techniques that may be used at each level.

Networks and social capital: a relational approach to primary health care reform.
Catherine Scott & Anne Hofmeyer, *Health Research Policy and Systems* 5(9), 2007.
http://www.health-policy-systems.com/content/5/1/9
This article reviews the rationale for collaboration in health care systems; provides an overview and synthesis of key concepts; dispels some common misconceptions of networks; and applies the theory to an example of primary healthcare network reform in Alberta.

Partnership Self-Assessment Tool. Center for the Advancement of Collaborative Strategies in Health http://www.cacsh.org/psat.html
This tool was designed to help partnerships understand how collaboration works and what it means to create a successful collaborative process; assess how well their collaborative process is working; and identify specific areas they can focus on to make their collaborative process work better.

Tamarack: An Institute for Community Engagement
http://tamarackcommunity.ca/CL_index.html
Tamarack is building a learning community on collaborative leadership: "The pervasive concept of leadership is that of the heroic leader – they have a vision, they assert it, they persuade us and they gain followers. Collaborative leadership turns that concept upside down - if we bring good people together in constructive ways, we will be able to push forward." Source: Addressing the Determinants of Health Together: A Resource Guide for Hospital-Community Collaboration. University of Toronto, 2008.
http://www.hospitalcommunitycollaboration.ca

Asset-Based Community Development Institute (ABCD)
http://www.northwestern.edu/ipr/abcd.html
The Asset-Based Community Development Institute (ABCD), established in 1995 by the Community Development Program at Northwestern University's Institute for Policy Research, is built upon three decades of community development research by John Kretzmann and John L. McKnight. The ABCD Institute has produced many practical resources and tools for community builders to identify, nurture, and mobilize local assets.

Coming Together – Building Collaboration and Consensus
http://communitycollaboration.net/
This website is a concise, accessible introduction to what collaboration is and how it helps. Pete Peterson, a collaboration specialist working in Idaho, answers basic questions, such as "why collaborate?" and "what does collaboration look like?" He also offers a helpful online presentation (requires Flash). Peterson also provides a page of links to other resources about collaboration, offering information both general and specific.

Community-Campus Partnerships for Health
http://depts.washington.edu/ccph/
Campus Community Partnerships for Health has developed nine principles to facilitate and strengthen partnerships between communities and institutes of higher learning.
Their *Partnership Perspectives* publications outline these partnership principles and offer practical advice from experienced practitioners (these can be downloaded in pdf format from the site).

Community Organizing and Community Building for Health
Edited by Meredith Minkler, 2005, Rutgers University Press,
http://rutgerspress.rutgers.edu/acatalog/catalogbody.html
Written from a public health perspective, this book offers a wealth of insights into the process of community building and organizing. Topics covered include community assessment and issue selection, working within and across diverse groups and cultures, and building and maintaining effective coalitions.

Health Canada: An Inclusion Lens—Workbook for Looking at Social and Economic Exclusion and Inclusion
http://www.ifsnetwork.org/uploads/inclusion-lens-workbook-2002.pdf
Before community-members can collaborate, they must be included. This workbook, provided by Health Canada, will help groups and organizations determine how inclusive they are, and identify ways to improve if necessary. Collaboration can become a closed loop very quickly if it doesn't actively involve members of many different communities, who may come with different perspectives or ideas. Inclusiveness makes collaboration more effective and truly engages community.

The Health Communications Unit
http://www.thcu.ca/infoandresources.htm
The Health Communication Unit (THCU) provides training and support related to health communication, health promotion planning, evaluation, policy change and sustainability. There are many comprehensive and accessible resources and tools that can be downloaded from the THCU website.

Human Resources and Social Development Canada – Community Development links
http://www.hrsdc.gc.ca/en/gateways/topics/cyd-gxr.shtml
At this site, you will find links to a variety of resources related to community development. Two resources in particular will interest readers of this guide*: The Partnership Handbook* and *The Community Development Handbook* cover many of the topics covered in this guide in greater detail.

Ontario Prevention Clearinghouse: Dynamic Partnerships
http://www.opc.on.ca/english/index.htm
This tip sheet provides reflections, references and resources about health promotion partnerships. Follow links Home > Programs > HPRC > Resources > Dynamic Partnerships.

Wilder Foundation/Fieldstone Alliance
http://www.fieldstonealliance.org/client/consulting/pages/collaboration.cfm
Two practical manuals can be ordered from this site (Collaboration Handbook and Collaboration: What Makes it Work?).

Appendix B: Template for Partnership Collaborative Agreements*

The purpose of the template is to help partnerships to identify terms and conditions of an agreement that may be important to consider. The agreements will need to be negotiated with partner agencies who are likely to bring different experiences, perspectives and priorities with respect to necessary terms and conditions.

Background & Mandate
Specify how the partnership was initiated, identify who is funding the partnership, state the priority need/issue to be addressed, and the target population(s) to be served.

Purpose of the Partnership Agreement
Identify what the partnership agreement proposes to do, and who it is applicable to, for example:

- *The purpose of this partnership agreement is to document arrangements between the lead agency and partner agencies.*
- *All parties agree to be guided by the terms and conditions set out in this agreement.*

Partnership Values & Guiding Principles:
If possible, clarify the values and/or guiding principles that govern the partnership, for example:

- *Communities will be active partners in the project, and will be supported to participate in various project phases.*
- *All activities and practices will uphold the principles of diversity, equity, anti-oppression, respect, and inclusiveness.*
- *Project partners will have any equal voice in decision-making and equal voting privileges.*

Project Outcomes, Activities, and Timelines
Clearly state the shared outcomes and activities that all parties will endeavour to achieve. Outcomes are the expected accomplishments, for example, *To increase knowledge of community resources.* Activities are the specific actions that will contribute to the identified outcomes, for example, *Deliver parent workshops.* Specify the duration of the partnership, and the anticipated dates for specific outcomes/activities.

Roles & Responsibilities
Specify the roles and responsibilities of the following:

- Lead/Trustee Agency
- Partner Agencies
- Advisory/Steering Committee

- Working Groups
- Partner agency staff
- Staff hired by the partnership

Clarify reporting relationships.
Develop a terms of reference for any project committees (e.g. Advisory/Steering Committee, and Working Groups) detailing:

- Committee/Group Mandate
- Areas of responsibility (e.g. strategic planning, project activities, project evaluation, etc.).
- Process to elect/appoint Chair/other designates, and to address absenteeism of members.
- Permission to establish other committees to fulfill their responsibilities.
- Quorum (e.g. 50% +1 of the members must be present in order for the meeting to take place).
- Frequency of Meetings.
- Declaration of conflict of Interest

Policies & Procedures
Identify the policies and procedures that agency and partnership staff will adhere to. For example, the partnership may wish to identify particular policies and procedures for the partnership, or it may simply state that the policies and procedures of the lead/trustee agency will govern the partnership. Policies/procedures might include: staff hiring, supervision and training, conflict of interest, antidiscrimination, access and equity, and media and public relations.

Inter Agency Communication
Identify the frequency of meetings between partner agencies (consider advisory committee meetings and working group meetings) and specify who is responsible for initiating meetings, setting meeting agendas, and chairing/facilitating these meetings. Specify how partners will communicate between meetings (e.g. by e-mail or fax, providing all members are included in correspondence). Suggest how representatives will maintain ongoing communication within their own organizations to that their Board, Management, Staff and Volunteers are clear about project objectives and responsibilities.

Decision-Making Processes
Clarify how ideally the partnership will make decisions regarding the partnership, including representatives and committees that are responsible for facilitating decision-making, and procedures to be followed by these individuals/committees.
For example:

- *The Steering/Advisory Committee will strive for consensus in all of its decisions. In instances where consensus is not possible, the Chair can request that an issue be put to a vote where each partner is entitled to one vote and a simple majority will decide the outcome.*

- *Decisions must have the agreement of a majority of all Project Partners (not merely a majority of those present at a meeting).*
- *A regular meeting schedule will be established, and agendas will be circulated at least 2 days prior to each meeting. Each agenda will include time for new business arising where members may bring forward any issues of concern.*
- *Any project partner may request additional meetings by providing a minimum of one week's notice to all project partners.*
- *In emergency decisions, the Lead Agency will have the responsibility to make decisions on behalf of the partnership (e.g. responding to emergency occurrences), providing they have made a reasonable attempt, wherever possible, to involve project partners, and as long as the mandate, values and objectives of the partnership aren't compromised by the decision.*

Resolving Conflicts & Complaints

Identify a process to resolve conflicts in a productive way, for example:

- *Invite project partners, staff and volunteers to deal with conflict in a positive way by naming, sharing and discussing issues as they arise, and taking all steps necessary to resolve issues.*
- *Where possible, project partners will attempt to resolve conflict at the operational/ working group level.*
- *Project partners share equal responsibility to bring unresolved issues of conflict or instances of unfulfilled partner responsibilities to the Advisory/Steering Committee for resolution. In the event that such issues are not brought forward, the representative from the lead agency will be responsible for bringing issues forward to the Committee.*
- *Parties should address conflicts involving 2 or more individuals/agencies in a face to face meeting where the conflict/complaint is named and described, and where a mutually acceptable solution is negotiated. Options include:*
    - *The Steering/Advisory Committee will convene a meeting to address any conflict/complaint in an open fashion.*
    - *The Committee will form a sub-group that will be responsible for managing the conflict resolution process.*
- *Conflicts and complaints should be documented (in a general way – without reference to names or complainants) by the Project Coordinator and/or the Advisory/Steering Committee for purposes of reporting to the relevant Management and Program Committees, and where applicable to Board Members/Management in the partner agencies. Discussions aimed at resolving disputes between individuals should be kept confidential at all times..*

Identify the process to resolve conflicts that can't be resolved using the above process, for example:

- *A neutral person/agency will be appointed to facilitate a conflict resolution process.*
- *Decisions arrived at through this process will be final.*

Addressing Proposed Changes to the Partnership
(e.g. termination of partnerships, project enhancements/proposals for funding, & membership changes)

Identify process to withdraw from/to terminate the partnership, for example:

- *Project partners will provide a minimum of 3 month's written notice to the Steering/ Advisory Committee regarding their intention to withdraw from the partnership, and will complete any outstanding reporting and service delivery commitments.*
- *The lead agency will provide a minimum of 3 month's written notice of their intention to withdraw from the lead agency role or the partnership itself, and will continue to act as the lead agency for the project until a process of changing the lead agency is completed with the funder.*
- *Instances where project partners are not maintaining their commitments to the project will be brought forward to the Steering/Advisory Committee for discussion and conflict resolution if required. Any monies already received or all monies received must be returned to the lead agency if this agreement is terminated before the date of termination agreed upon.*

Identify process to enhance/expand the existing partnership, for example:

- *Proposals to enhance/expand the existing partnership (e.g. seek additional funding to address new objectives, or to serve larger numbers of clients) will require discussion with the Board and Management of each of the partner agencies. Such enhancements will only be pursued if the lead agency, and partner agencies confirm that they have the support of their individual agencies to proceed.*
- *Proposals that seek to address objectives that are part of the existing partnership agreement should be discussed with the current funder before proceeding.*

Identify the process to add members to the partnership, for example:

- *The Steering/Advisory Committee will review written letters of intent from any partners wishing to join the partnership; will determine that the prospective partner shares the core values of the project; and will decide upon their inclusion as an Associate or Project Partner based on how their participation will enhance the project objectives and effectiveness.*

Finances & Administration
Specify who is responsible for setting and changing the project budget.
Indicate who is authorized to make spending decisions once the budget is set.
If applicable, clarify how and when partner agencies will receive payments for services rendered/expenses incurred (e.g. terms of payment, and documentation required).
Indicate who will have responsibility for providing accounting services.
Specify how administrative support for the partnership will be provided.

Outline how the partnership will address a budget deficit, for example:

- *The assumption of the Steering/Advisory Committee is that there will be no deficit because Agency Partners will have to live with assigned budget funds (Budget revisions may be proposed to the Steering/Advisory Committee through working groups and/or project staff/coordinator).*

Evaluation Plan

Indicate who is responsible for initiating and conducting the evaluation.
Outline the critical indicators of success, and the appropriate tools/mechanisms to measure these. (NOTE: These should link with the proposed work plan).

- *The Steering/Advisory Committee will develop a detailed evaluation protocol which will be used consistently for all Centre activities and services, regardless of site.*

Specify when and how this will take place.
Clarify who will participate (e.g. partner agencies), and what their roles and responsibilities will be. For example:

- *Service providers are responsible for providing data to the lead agency according to the identified data element definitions and established timelines.*

Identify how the Steering/Advisory Committee, and the Boards/Management of individual partner agencies will monitor and respond to the results of the evaluation.

- *In an effort to continually improve services, the Steering/Advisory Committee, and Partner Agencies will monitor program operations and examine client satisfaction of programs. Improvements will be incorporated into programs on an ongoing basis.*
- *One Committee meeting every six months will be dedicated to a partnership review where emerging issues/concerns will be discussed.*

Involvement of Program Participants and Community Members

Identify how community members or program participants will participate in program planning and evaluation. For example:

- *The Project Coordinator will have the responsibility to convene and support a Program Committee comprised of Associate and Community Partner representatives and program participants. This committee will identify program and service-specific concerns and broader issues of concern in the target community.*
- *Program participants will provide feedback at regular intervals via client satisfaction surveys.*

Signatures

Designated representatives of lead and partner agencies (Executive Director and/or Board Chair) will sign the partnership agreement.

- *By signing this partnership agreement each agency in the partnership agrees to comply with the terms and conditions set out in this document.*

Source: *Heather Graham Consulting Services* (h.graham@sympatico.ca)

Appendix C: Key Elements of a Population Health Approach – Determinants of Health

This section cited from the Public Health Agency of Canada's (PHAC) Population Health *Web site, http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#determinants*

Our understanding of what makes and keeps people healthy continues to evolve and be further refined. A population health approach reflects the evidence that factors outside the health care system or sector significantly affect health.

It considers the entire range of individual and collective factors and conditions - and their interactions - that have been shown to be correlated with health status. Commonly referred to as the "determinants of health," these factors currently include:

1. Income and Social Status

Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.

Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But the effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally results in more control and discretion. And the biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.

There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health.

Evidence from **the Second Report on the Health of Canadians**

- Only 47% of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73% of Canadians in the highest income group.

- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race and place of residence.
- At each rung up the income ladder, Canadians have less sickness, longer life expectancies and improved health.
- Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole.

Evidence from **Investing in the Health of Canadians:**

- Social status is also linked to health. A major British study of civil service employees found that, for most major categories of disease (cancer, coronary heart disease, stroke, etc.), health increased with job rank. This was true even when risk factors such as smoking, which are known to vary with social class, were taken into account. All the people in the study worked in desk jobs, and all had a good standard of living and job security, so this was not an effect that could be explained by physical risk, poverty or material deprivation. Health increased at each step up the job hierarchy. For example, those one step down from the top (doctors, lawyers, etc.) had heart disease rates four times higher than those at the top (those at levels comparable to deputy ministers). So we must conclude that something related to higher income, social position and hierarchy provides a buffer or defence against disease, or that something about lower income and status undermines defences.

2. Social Support Networks

Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances.

The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems.

In the 1996/97 National Population Health Survey (NPHS), more than four out of five Canadians reported that they had someone to confide in, someone they could count on in a crisis, someone they could count on for advice and someone who makes them feel loved and cared for. Similarly, in the 1994/95 National Longitudinal Survey of Children and Youth, children aged 10 and 11 reported a strong tendency toward positive social behaviour and caring for others.

Evidence from **Investing in the Health of Canadians:**
Some experts in the field have concluded that the health effect of social relationships may

be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure.

- An extensive study in California found that, for men and women, the more social contacts people have, the lower their premature death rates.
- Another U.S. study found that low availability of emotional support and low social participation were associated with all-cause mortality.
- The risk of angina pectoris decreased with increasing levels of emotional support in a study of male Israeli civil servants.

3. Education

Health status improves with level of education.

Education is closely tied to socioeconomic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.

Evidence from the **Second Report on the Health of Canadians:**

- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy
- People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods.
- In the 1996/97 National Population Health Survey (NPHS), only 19% of respondents with less than a high school education rated their health as "excellent" compared with 30% of university graduates.

Evidence from **Investing in the Health of Canadians:**

- The 1990 Canada Health Promotion Survey found the number of lost workdays decreases with increasing education. People with elementary schooling lose seven work days per year due to illness, injury or disability, while those with university education lose fewer than four days per year.

4. Employment/Working Conditions

Unemployment, underemployment, stressful or unsafe work are associated with poorer health.

People who have more control over their work circumstances and fewer stress related

demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

Evidence from the **Second Report on the Health of Canadians:**

- Employment has a significant effect on a person's physical, mental and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job.
- Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being.
- Participation in the wage economy, however, is only part of the picture. Many Canadians (especially women) spend almost as many hours engaged in unpaid work, such as doing housework and caring for children or older relatives. When these two workloads are combined on an ongoing basis and little or no support is offered, an individual's level of stress and job satisfaction is bound to suffer. Between 1991 and 1995, the proportion of Canadian workers who were "very satisfied" with their work declined, and was more pronounced among female workers, dropping from 58% to 49%. Reported levels of work stress followed the same pattern. In the 1996/97 NPHS, more women reported high work stress levels than men in every age category. Women aged 20 to 24 were almost three times as likely to report high work stress than the average Canadian worker.

Evidence from **Investing in the Health of Canadians:**

- A major review done for the World Health Organization found that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families and their communities.

5. Social Environments

The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others.

The array of values and norms of a society influence in varying ways the health and well being of individuals and populations.

In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health.

A healthy lifestyle can be thought of as a broad description of people's behaviour in three inter-related dimensions: individuals; individuals within their social environments (eg. family, peers, community, workplace); the relation between individuals and their social enivronment. Interventions to improve health through lifestyle choices can use comprehensive approaches that address health as a social or community (ie. shared) issue.

Social or community responses can add resources to an individual's repertoire of strategies to cope with changes and foster health.

In 1996/97:

- Thirty-one percent of adult Canadians reported volunteering with not-for-profit organizations in 1996/97, a 40% increase in the number of volunteers since 1987.

- One in two Canadians reported being involved in a community organization.

- Eighty-eight percent of Canadians made donations, either financial or in-kind, to charitable and not-for-profit organizations.

Evidence from the **Second Report on the Health of Canadians**

- In the U.S., high levels of trust and group membership were found to be associated with reduced mortality rates.
- Family violence has a devastating effect on the health of women and children in both the short and long term. In 1996, family members were accused in 24% of all assaults against children; among very young children, the proportion was much higher.
- Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. In 1997, 80% of victims of spousal homicide were women, and another 19 women were killed by a boyfriend or ex-boyfriend.
- Since peaking in 1991, the national crime rate declined 19% by 1997. However, this national rate is still more than double what it was three decades ago.

6. Physical Environments

The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments.

In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.

Evidence from the **Second Report on the Health of Canadians**

- The prevalence of childhood asthma, a respiratory disease that is highly sensitive to airborne contaminants, has increased sharply over the last two decades, especially among the age group 0 to 5. It was estimated that some 13% of boys and 11% of girls aged 0 to 19 (more than 890,000 children and young people) suffered from asthma in 199697.
- Children and outdoor workers may be especially vulnerable to the health effects of a reduced ozone layer. Excessive exposure to UV-B radiation can cause sunburn, skin cancer, depression of the immune system and an increased risk of developing cataracts

Evidence from **Investing in the Health of Canadians:**

- Air pollution, including exposure to second hand tobacco smoke, has a significant association with health. A study in southern Ontario found a consistent link between hospital admissions for respiratory illness in the summer months and levels of sulphates and ozone in the air. However, it now seems that the risk from small particles such as dust and carbon particles that are by-products of burning fuel may be even greater than the risks from pollutants such as ozone. As well, research indicates that lung cancer risks from second hand tobacco smoke are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined.

7. Personal Health Practices and Coping Skills

Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health.

Definitions of lifestyle include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play.

These influences impact lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible.

Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.

However, there is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play. Through research in areas such as heart disease and disadvantaged childhood, there is more

evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.

Evidence from **the Second Report on the Health of Canadians**

- In Canada, smoking is estimated to be responsible for at least one-quarter of all deaths for adults between the ages of 35 and 84. Rates of smoking have increased substantially among adolescents and youth, particularly among young women, over the past five years and smoking rates among Aboriginal people are double the overall rate for Canada as a whole.
- Multiple risk-taking behaviours, including such hazardous combinations as alcohol, drug use and driving, and alcohol, drug use and unsafe sex, remain particularly high among young people, especially young men.
- Diet in general and the consumption of fat in particular are linked to some of the major causes of death, including cancer and coronary heart disease. The proportion of overweight men and women in Canada increased steadily between 1985 and 1996/97 ‹ from 22% to 34% among men and from 14% to 23% among women.

Evidence from **Investing in the Health of Canadians:**

- Coping skills, which seem to be acquired primarily in the first few years of life, are also important in supporting healthy lifestyles. These are the skills people use to interact effectively with the world around them, to deal with the events, challenges and stress they encounter in their day to day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. These skills help people face life's challenges in positive ways, without recourse to risky behaviours such as alcohol or drug abuse. Research tells us that people with a strong sense of their own effectiveness and ability to cope with circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles.

8. Healthy Child Development

New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.

Evidence from the **Second Report on the Health of Canadians**

- Experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health into adulthood.

- Tobacco and alcohol use during pregnancy can lead to poor birth outcomes. In the 1996/97 National Population Health Survey, about 36% of new mothers who were former or current smokers smoked during their last pregnancy (about 146,000 women). The vast majority of women reported that they did not drink alcohol during their pregnancy.
- A loving, secure attachment between parents/caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others in later life.
- Infants and children who are neglected or abused are at higher risk for injuries, a number of behavioural, social and cognitive problems later in life, and death.

Evidence from **Investing in the Health of Canadians:**

- A low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and sense of control and mastery over life circumstances also come into play.

9. Biology and Genetic Endowment

The basic biology and organic make-up of the human body are a fundamental determinant of health.

Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.

Evidence from the **Second Report on the Health of Canadians**

- Studies in neurobiology have confirmed that when optimal conditions for a child's development are provided in the investment phase (between conception and age 5), the brain develops in a way that has positive outcomes for a lifetime.
- Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive capacity in old age. And studies on education level and dementia suggest that exposure to education and lifelong learning may create reserve capacity in the brain that compensates for cognitive losses that occur with biological aging.

10. Health Services

Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health. The health services continuum of care includes treatment and secondary prevention.

Evidence from the **Second Report on the Health of Canadians**

- Disease and injury prevention activities in areas such as immunization and the use of mammography are showing positive results. These activities must continue if progress is to be maintained.
- There has been a substantial decline in the average length of stay in hospital. Shifting care into the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, especially women. The demand for home care has increased in several jurisdictions, and there is a concern about equitable access to these services.
- Access to universally insured care remains largely unrelated to income; however, many low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs.

11. Gender

Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis.

"Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.

Evidence from the **Second Report on the Health of Canadians**

- Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Rates of potential years of life lost before age 70 are almost twice as high for men than women and approximately three times as high among men aged 20 to 34.
- While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence.
- While overall cancer death rates for men have declined, they have remained persistently stubborn among women, mainly due to increases in lung cancer mortality. Teenage girls are now more likely than adolescent boys to smoke. If increased rates of smoking among young women are not reversed, lung cancer rates among women will continue to climb.

12. Culture

Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

Evidence from the Second Report on the Health of Canadians

- Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were still twice as high as among the Canadian population as a whole and the prevalence of major chronic diseases, including diabetes, heart problems, cancer hypertension and arthritis/rheumatism, is significantly higher in Aboriginal communities and appears to be increasing.
- In a comparison of ethnic groups, the highest rate of suicide occurred among the Inuit, at 70 per 100,000, compared with 29 per 100,000 for the Dene and 15 per 100,000 for all other ethnic groups, comprised primarily of non-Aboriginal persons.
- The 1996/97 National Longitudinal Survey of Children and Youth found that many immigrant and refugee children were doing better emotionally and academically than their Canadian born peers, even though far more of the former lived in low-income households. The study suggests that "poverty among the Canadian-born population may have a different meaning than it has for newly arrived immigrants. The immigrant context of hope for a brighter future lessens poverty's blows; the hopelessness of majority-culture poverty accentuates its potency."

From the Public Health Agency of Canada’s (PHAC) Population Health *Web site, http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html#social*

Appendix D: Cultural Competence - Essential to Building a Better Tomorrow Together

Cultural Competence refers to the attitudes, knowledge, skills, behaviours and policies required to better meet the needs of all the people we serve. Culture…refers to a group or community that share common experiences that shape the way its members understand the world. It is multi-layered, evolving and includes groups that we are born into or become such as; national origin, levels of ability, gender, sexual orientation and identity, race/ethnicity, socio-economic class or religion. People have multiple cultures.[2]

So begins the *Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia*, first endorsed by the Nova Scotia Department of Health in 2006. These guidelines originated as a response to identified needs and barriers of identified through consultation with Nova Scotia's diverse minority communities. The guidelines provide us with clear direction for enabling culturally competent care. They also serve to remind us that healthcare providers, health promotion staff, health systems and health organizations are accountable for the delivery of such care.

The complete list of *Guidelines* include:

1. Nova Scotia DHAs, CHBs, the IWK and primary health care organizations should ensure that their staff provide to Nova Scotia patients/consumers, primary health care that is respectfully delivered and responsive to cultural health beliefs, practices, lived experiences and linguistic differences in Nova Scotia.

2. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should work collaboratively with culturally diverse populations, including but not limited to: First Nations, African Canadians, Acadians, Francophones and Immigrant Communities, to design targeted, accessible and effective health initiatives in all aspects of primary health care.

3. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs, IWK and academic institutions should collaborate to devise and implement strategies for the recruitment, retention and promotion of diverse health staff, providers and leaders at all levels.

4. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs the IWK, primary health care organizations and health related, academic institutions should make cultural competence training available on an ongoing basis to all primary

[2] Province of Nova Scotia (2008). *Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia*

health care students, staff and providers at all levels and across all disciplines, and facilitate the development of cultural competence across the primary health care system.

5. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, the IWK and primary health care organizations should offer and provide services in Canada's official languages with the phased in recruitment of French speaking, bilingual staff and the use of cultural health interpreters.

6. Nova Scotia DHAs, the IWK and primary health care organizations should offer and provide cultural health interpretation services in languages provided by Nova Scotia's Community Health Information and Interpreting Service for any primary health care patient/consumer with English or French as a second language at no cost to the patient/consumer.

7. Nova Scotia DHAs, the IWK and primary health care organizations should provide written notice of the availability of cultural health interpretation services in all of the languages provided by Nova Scotia's Community Health Information and Interpreting Service and when possible, cultural health interpretation in the Mi'kmaq language.

8. Nova Scotia DHAs, the IWK and primary health care organizations should ensure that patient/consumer family and friends not be used to provide interpretation services except at the direct request of the patient/consumer.
9. Nova Scotia DHAs, the IWK and primary health care organizations should reflect Nova Scotia's diverse populations in pictures, written information and advertisements and post signage and provide written material for all literacy levels in the languages commonly spoken in their service areas.

10. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs the IWK and primary health care organizations should ensure that their vision, mission, strategic plans, job performance expectations and accreditation processes incorporate accountability for cultural competence and culturally appropriate services at the highest level of the organization.

11. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should work collaboratively and independently to develop public information and communication plans to explain the importance of race, ethnic and linguistic identifiers in epidemiological and health utilization data for the purposes of effective planning, program delivery and the development of a culturally competent, primary health care system.

12. DHAs, CHBs, the IWK and primary health care organizations should maintain up-to-date demographic, cultural and epidemiological profiles of their communities in order to effectively plan and provide services that respond to the racial, ethnic, cultural, spiritual and linguistic needs of the populations they serve.

13. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should ensure that data collected and updated through the MSI database, and other data collected by organizations incorporates, with patient/consumer agreement, information that specifies race, ethnicity and language of patients/consumers without individual patient identification.

14. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs, the IWK and primary health care organizations should ensure that data collected and research resulting from the data, facilitate best practice in culturally competent care, movement toward the elimination of health disparities among populations, and the improvement of health status of those populations most at risk for poor health.

15. The Nova Scotia Departments of Health & Health Promotion and Protection, DHAs, CHBs, the IWK, provincial programs and primary health care organizations should inform, increase and facilitate culturally appropriate screening among Nova Scotia's culturally diverse populations for chronic diseases including but not limited to; diabetes, cancers, cardiovascular disease, hypertension and sickle cell anemia.

Attention to cultural competence is essential for reducing health disparities, addressing inequitable access to care and respectfully responding to the diversity of Nova Scotians. We must thus integrate cultural competence considerations when designing and delivering health and health promotion services, working collaboratively with diverse populations.

But we must also strive for cultural competence by building inclusion and respect for diversity in the workplace. Diversity has been identified as one of five core values within *Values, Ethics and Conduct: A Code for Nova Scotia's Public Servants* (2009). This code supports creating work environments that are free of discrimination and where differences are valued and respected. Attention to diversity will enable our workplaces to be more representative of Nova Scotian society. It will also help us to ensure that the healthcare services promoted and delivered to Nova Scotians are themselves more culturally competent.

Considering diversity and inclusion in the workplace begins with you—understanding your own culture, your biases and beliefs, and continuing to learn about the culture of diverse Nova Scotians with whom you work. It means understanding and incorporating difference in your daily work. It means creating and fostering inclusive work environments for all staff during meetings and planning sessions. It means building relationships for appropriate and respectful community consultations and partnerships. It means paying explicit attention to culture, gender and diversity when planning, implementing and evaluating health and health promotion programs and services. Building a better tomorrow for all Nova Scotians means truly believing that "diversity fuels ideas and that ideas fuel progress."[3]

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[3] Province of Nova Scotia (2009). *Values, Ethics and Conduct: A Code for Nova Scotia's Public Servants*.

Building a Better Tomorrow Together Evaluation Questionnaire

Module Title: ____

Training Location: ________________________ **Date:** _______________________________

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. This module addressed my learning needs in this area.	1	2	3	4	5
2. The information which was provided was applicable to my practice/work.	1	2	3	4	5
3. My participation in this module has enhanced my knowledge and skills in this area.	1	2	3	4	5
4. My participation in this module will influence my practice/work in the future.	1	2	3	4	5
5. The facilitator was knowledgeable of the subject matter being presented.	1	2	3	4	5
6. The facilitator presented the information in a clear and concise manner.	1	2	3	4	5
7. The facilitator was enthusiastic and responsive to participant's learning needs.	1	2	3	4	5
8. There was opportunity to interact with other participants.	1	2	3	4	5
9. There was opportunity to interact with the facilitator.	1	2	3	4	5
10. The facilities were comfortable and conducive for learning.	1	2	3	4	5
11. The module was well organized.	1	2	3	4	5
12. I would recommend this module to others.	1	2	3	4	5

13.What did you like about this module?

____

14.What changes or improvements could be made?

____

15.What aspects of your practice/work do you intend to change as a result of participating in this module?

____

Notes

Notes