Nova Scotia Department of Health, Primary Health Care

Understanding Primary Health Care Part II
Participant Materials

Building a Better Tomorrow Together:

Team Development for Primary Health Care Collaboration

2009

// Acknowledgements

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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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Understanding Primary Health Care Part II

Agenda

Introductions

What is population health?

What are the determinants of health?

How primary health care providers apply the determinants of health

What is health promotion?

How primary health care providers apply health promotion principles and strategies

Wrap-up

Understanding Primary Health Care Part II

Learning Objectives

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

- Define population health as it relates to primary health care.
- Explain the linkages between population health, primary health care and primary care.
- Understand how population health and a focus on the determinants of health help to contribute to comprehensive primary health care.
- Reflect on their team's approach to applying the social determinants of health in their primary health care setting.
- Understand health promotion as a principle of primary health care.
- Apply health promotion strategies and principles within primary health care services.

What is Population Health?

Population health…

is an approach to ____________ that aims to improve the health of the entire

_____________________ and to reduce ________________________________

among population groups.

In order to reach these objectives, it looks at and acts upon the

_________________ range of factors and _________________________ that

have a strong influence on our health.

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

Key Elements of a Population Health Approach: Determinants of Health

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 1996/7 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.

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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*

“Jason’s Story”

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of every Canadian.

“Why is Jason in the hospital?
Because he has a bad infection in his leg.

But why does he have an infection?
Because he has a cut on his leg and it got infected.

But why does he have a cut on his leg?
Because he was playing in the junkyard next to his apartment building and there was some sharp, jagged steel there that he fell on.

But why was he playing in a junkyard?
Because his neighbourhood is kind of run down. A lot of kids play there and there is no one to supervise them.

But why does he live in that neighbourhood?
Because his parents can’t afford a nicer place to live.

But why can’t his parents afford a nicer place to live?
Because his Dad is unemployed and his Mom is sick.

But why is his Dad unemployed?
Because he doesn’t have much education and he can’t find a job.

But why …?”

As this story suggests, health, illness and early death depend on a variety of factors or “determinants” that surround individuals, families and nations.

Getting to the root cause of Jason’s illness and the other major health problems we face in Canada today requires action on the broader determinants of health. It also requires that we continue to provide high-quality health services that will help Jason heal.

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*

Determinants of Health

Jared and Tracey Case Study

This is Jared. His mom, Tracey, is a 24 year old first time mother. She has high school education and works seasonally as a line processor in a fish plant. Tracey is ambivalent about breast feeding. She is 3 days post partum-vaginal delivery and has been discharged home. She went along with breast feeding in the hospital because the nurses and her obstetrician strongly recommended breast feeding as being the best nutrition for her baby.

Tracey is living common-law with her partner Steven, who also works at the fish plant. She was visited by her sisters and mother while in hospital. They were dismayed that she was breast feeding. Her mother warned her that the baby would never sleep properly if he was breast fed. Her sisters find the concept 'gross', and Steven reacted in a surly manner and indicated that things would change once Tracey got out of the hospital.

Case study questions:

1. Identify the key determinants of health that may impact Tracey and Jared.

2. Based on the determinants of health, what might be a helpful way to support Tracey in her choice?

What is Health Promotion?

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.

Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (WHO, 1986)

From World Health Organization (WHO) Web site:
http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

Health promotion is one way to take action on Population Health.

Health Promotion Strategies

We make health promotion happen when we:

1	Make public laws and rules that keep health in mind.	*Build Healthy Public Policy* Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.
2	Create safe and satisfying environments for work and play	*Create Supportive Environments* Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

		Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.
3	Encourage people to get involved and take action in decisions that affect their community's health	*Strengthen Community Action* Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavors and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.
4	Provide support, education and information to help people make health choices.	*Develop Personal Skills* Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and

		over their environments, and to make choices conducive to health. Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.
5	Create services which change the focus from illness to wellness.	*Reorient Health Services* The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

Ottawa Charter for Health Promotion (1986) Ottawa, Ontario, Canada

Public Health Agency of Canada (PHAC) Web site: http://www.phac-aspc.gc.ca/ph-sp/phdd/php/php2.htm#Did

Successful Health Promotion Activities

Many health promotion initiatives can only show impact on health after many years. Even then it is hard to measure the number of medical or hospital visits that do not occur and attribute them to a specific health promotion program.

For this reason, success in health promotion is measured in terms of enhanced well-being, quality of life, sense of self-esteem and self-worth, and control over resources for health.

Successful health promotion activities:

- Involve the people who are most affected
- Build on people's experiences
- Bring groups together to work as a team
- Are accessible

From Guess What Tool distributed by the Community Health Promotion Network Atlantic (CHPNA).

Health Promotion Stories

In many communities we are doing health promotion,
even though we might not call it that!

1. What strategies and activities of health promotion are evident in the story?

2. Which determinants of health are considered in the story?

Story #1:
With funding from Health Canada, a senior's group developed a peer advocacy handbook for seniors in Nova Scotia. The handbook outlines the realities of the lives of diverse seniors; discusses barriers and discrimination in accessing services; and outlines a training session for recruiting, screening, training, and supporting community volunteers to act as peer advocates with seniors. A two day training session was held to introduce the handbook and help people learn to implement the program in their own communities. The program is adaptable to meet the needs of diverse groups.

Story #2:
In response to a community needs assessment, African Nova Scotia women gathered to learn about their health issues and the barriers they face in accessing health services. They are supported in organizing and facilitating women's health groups in their own communities. They are learning tools and leadership skills that be expanded to help in a variety of areas beyond the focus of health. Through this work, they are building self-confidence and feeling more empowered. This has enabled some women to break down barriers and move ahead with life-long goals and ambitions for themselves, their families and their communities.

Story #3:
When the local fish plant closed, women who had been working there gathered together to form a cottage industry. With a small retraining grant, they were able to form a successful business. Their goods are well-known throughout the area, and women from other parts of the province have been approaching them for ideas and support.

Story #4:
A group of volunteers committed to addressing the stigma and stereotyping about mental illness serve as a watchdog group for the media. Volunteers scan newspapers, magazines, television and radio programs, and advertisements. When a negative or misinformed picture of mental illness is portrayed, action is taken in the form of a letter and information package. This proactive approach to education has often resulted in letters of apology, free advertising to educate the public about the actual condition, and appreciation on the pars of the writers/producers.

Story #5:
The Youth Project is completely volunteer-based and has no funding. Volunteers run support groups for lesbian, gay, and bisexual youth twice a month, delivering workshops on heterosexism and homophobia to community groups, schools, health care professionals, and government throughout the province; and staff a toll-free peer-support phone line one evening per week. Youth Project members also sit on several community committees and work on developing gay positive policies in schools, government, health care, and community organizations.

Story #6:
The local Family Resource centre offers a variety of programs for community members. Many programs are run on a volunteer basis; others receive either project or ongoing funding from several sources. Examples of programs offered: academic upgrading, parenting support networks, stop-smoking courses, community kitchens, prenatal classes for single mothers, early learning opportunities for preschoolers, and craft workshops.

Story #7:
With administrative support from the local hospital, nutritionist volunteers to visit day cares, play groups, and schools, to share information with children and their parents about nutrition and healthy eating. Topics covered include nutritional guidelines recipes, strategies for dealing with picky eaters, interventions for poor habits, and recent nutrition information. She also offers grocery shopping tours for seniors. Shoppers are taught about reading labels, spending money wisely in nutrition-dense foods, and are given information on specific nutrition topics relevant to seniors.

Story #8:
It started several years ago as a way to celebrate Canada day. When the federal government stopped promoting it, people kept on doing it anyway. Neighbourhoods close off their streets, gather for parties, yard sales, BBQs and celebrations, and get to know one another. They host special events and celebrations, build up their local Neighbourhood Watch, and increase their sense of community. When action is needed around something that might impact the community, these people are ready for action.

From Guess What Tool distributed by the Community Health Promotion Network Atlantic (CHPNA).

Your Own Story

Think about what's happening in your own primary health care team?

What health promotion strategies are you already using?

What are your teams' health promotion strengths?

What can be improved in your health promotion work?

Appendix A: 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.[1]

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

[1] 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."[2]

[2] 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?

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Notes

Notes